Receiving Loving Gratitude: How a Therapist's Mindful Embrace of a Patient's Gratitude Facilitates Transformance

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"You'd rather get killed than be loved by your patient, right?"
(Steve Shapiro, Essential Skills Course, December 4, 2010)

"It seems to be all right and accepted to talk about anger and hatred and frustration, but love and caring and closeness are less safe."(Prenn, 2009, p. 85)

If treatment is moving forward successfully, a day will come when a patient thanks you, her therapist. Shocked and blown away by the mirror being turned towards you, you may ask yourself, "What should I do now?"

When a patient earnestly expresses gratitude toward the therapist for good therapeutic work, odd as it may seem, it often shakes up the therapist. Feeling overwhelmed, dysregulated or excessively shy for being the center of sincere recognition, we, as therapists, often struggle with gestures of appreciation from our patients. During such moments, it becomes hard for the therapist to make helpful therapeutic interventions, such as attunement, validation, and exploration of the patient's experience of expressing gratitude towards the therapist. This is unfortunate because when feelings of gratitude are explored thoroughly within the dyad, it becomes a precious opportunity for further healing, growth and transformation for the patient.

Placing personal reasons to the side for a moment, there are some professionally valid reasons as to why we struggle when we receive positive feelings from our patients. In the fields of psychotherapy and emotion theory, there has been almost an exclusive focus on negative emotions, but very little focus on positive affects, such as gratitude, pride, joy and happiness (Fosha, 2005; Fredrickson, 1998; Russell & Fosha, 2008; Tronick, 2003).

This may be a reflection of cultural and linguistic bias, too. For example, there are only 49 English words that fall under the category of "pleasure," while 129 words are identified for "distress" (Alpert, Rosenberg, Pouget, & Shaw, 2000). This fact suggests a substantially greater differentiation and sophistication for negative emotions than positive ones, at least within the English speaking culture. Thus, due to much less emphasis on positive affects in the English speaking culture at large and in the field of psychology training specifically, we are less trained on how to work with positive emotions to effect change.

However, despite the traditionally neglected status of positive emotions, recent neuroscience, emotion theory, and attachment research studies have shown the powerful influence of positive emotions on human development, interpersonal functioning, resilience, expansive growth, and emotional flexibility (e.g. Frederickson & Losada, 2005; Frederickson, 1998, 2004; Garland, Fredrickson, Kring, Johnson, Meyer, & Penn, 2010). One of the hallmarks of AEDP is that it privileges the power of positive emotions throughout the course of treatment (Fosha, 2000a, 2000b; Russell & Fosha, 2008).

Due to the neglected status of positive emotions in the field of psychotherapy and the greater culture, there is little literature, apart from papers by AEDP therapists (Fosha 2000a, 2000b, 2005), that elucidates a systematic clinical map for processing patients' positive affects, particularly gratitude and love that are directly expressed towards the therapist. For the purpose of this paper, I will specifically focus on the gratitude and love that emerge after completing deep emotional work. The term I use to describe this interpersonal experience is "loving gratitude." It is a deep and often powerful surge of appreciation and engagement that an individual feels towards the other who has facilitated transformative work. Fosha (2000a, 2005, 2009) describes this as the True-Self/True-Other relating. Loving gratitude may arise when an individual experiences the other as a True Other, a "real, actual, deeply felt

experience of the experiencing self" (Fosha, 2005, p. 11), and feels an impulse to express a strong sense of gratitude for the True Other's help during the moment of need.

Loving gratitude is an emotion distinct from "love" or "gratitude" in the general usage of the words and when they are used separately. Emotion theorists have said that "love" is not a single emotion but rather consists of a variety of different components, such as romantic, sexual, emotional, familial, and spiritual (e.g. Frederickson, 2004; Ekman, 2003/2007); emotion theorists also note that love is the most unspecific emotion that evokes a variety of positive emotions, such as interest, joy and contentment, and therefore love experiences need to be contextualized by the nature of relationships (Frederickson, 2004). "Love" is not as distinctive as some emotions, like guilt. The nature of "love" conveyed in loving gratitude is a type of emotion that is a "brief, momentary surge of extreme pleasure and engagement with the loved one" (Ekman, 2003/2007, p. 201).

"Gratitude" is described as an expression of appreciation for an altruistic gift that provides the receiver with benefit (Lazarus & Lazarus, 1994). Gratitude requires the capacity for empathy, strengthens social bonds, and builds skills for loving (Fredrickson, 2004). In the therapeutic setting, gratitude may arise when an individual experiences that the therapist has extended extra help in order to improve one's well-being; a good example of therapist's extra help may be when the therapist discloses that the patient exists in her "mind and heart" (Fosha, 2000a, p. 219) and that he or she has a significant impact on the therapist (Prenn, 2009, 2011).

Fosha (2000a) observes that while the more traditional psychoanalytic psychotherapies are good at exploring the relationship between patient and therapist, they often fail to address positive experiences; whereas experiential and client-centered approaches, which actively facilitate positive experiences, typically do not focus on the relational aspect of therapy. Thus, processing patient's loving gratitude towards the therapist has, in essence, been overlooked in the field to date. AEDP is unique in that it sheds light on these blind spots through its emphasis on positive emotions and the relational aspects of the therapeutic process. In AEDP, gratitude and love toward the other are identified as the relational healing affects that bring about a patient's innate strivings for transformation.

In AEDP, an individual's motivation for transformation, revolutionarily and functionally, is fundamental for one's survival and thriving in the world, and it is termed transformance (Fosha, 2008). "Transformance is … the overarching motivational force… that strives toward maximal vitality, authenticity, and genuine contact" (Fosha, 2008, p. 3). In psychotherapy, transformance is observed in affective change processes, such as emotion, dyadic affect regulation, and empathic recognition of the True Self and True Other (Fosha, 2000a, 2005). In AEDP, the therapist is always on the lookout for glimmers of transformance in the moment-to-moment tracking of the patient's verbal and non-verbal affective expressions in order to release their fullest expression. The patient's expression of loving gratitude towards the therapist can be seen as one manifested form of transformance.

This paper proposes that the therapist's recognition and acceptance of the patient's loving gratitude towards the therapist facilitates an upward spiral of transformations beyond already accomplished therapeutic gains and transforms the landscape of the patient and therapist's attachment styles when processed to completion. This paper encourages therapists *not to leave their patients alone, especially during the heightened moments when loving gratitude is expressed towards the therapist.* When the therapist fails to take in the patient's loving gratitude, the patient is left alone, attunement is disrupted, and the process of transformation loses its natural flow.

Privilege Positive Affects and Interactions as Adaptive and Transformational

"…positive affects, positive interactions, and the process of healing transformation are organically intertwined. Positive, attuned, dyadic interactions are the constituents of healthy,

secure attachments and the correlates of neurochemical environments conducive to optimal brain growth" (Fosha, 2009, p. 173).

Recent papers on emotion, attachment and neuroscience suggest a plethora of benefits of positive emotions. For example, Ogden (2009) proposes that the therapist's encouragement of positive affects and associated physical actions expands the "boundaries of the window of tolerance" and cultivates the potential for increased social engagement, trust in relationship and capacity for play. Damasio (2003) states, "Joyous states signify optimal physiological coordination and smooth running of the operations of life. … The states of joy also are defined by a greater ease in the capacity to act" (p. 137), suggesting that the experience of positive affects widens a window of action tendencies. Furthermore, research and current clinical thoughts suggest that positive emotions are the major ingredients for developing complex self-organization (Schore, 2001) and adaptive attachment (Lipton & Fosha, 2011), and accumulating psychosocial and physiological resources over the long run (Fredrickson, 1998). As such, positive emotions are not simply extra frills to emotional wellbeing, but rather a central component to psychological, cognitive, and physiological thriving in the world (e. g. Frederickson, 2005; Kok & Fredrickson, 2010; Garland, et al., 2010). More specifically, Waugh and Frederickson (2006) demonstrated in their empirical research that positive emotions were associated with greater feelings of perceived relationship closeness (self-expansion with others) and complex understanding of others, suggesting that positive emotions be the foundation for building adaptive attachments.

In AEDP, the patient's gratitude toward the therapist is conceptualized as a green light to stay with and amplify the affect; it is not something to pass through, shy away from, or minimize (Fosha, 2000a; Russell & Fosha, 2008). Within AEDP's relational stance, the patient's love and gratitude toward the therapist is considered crucial and identified as one of the "adaptive relational action tendencies" (Fosha, 2000a, p. 144). In order for these relational action tendencies to be fully released, it is important that the therapist recognize the patient's empathetic capacities, maintain attunement, and facilitate metaprocessing of the very experience of expressing loving gratitude (Fosha, 2000b).

Based on the mother-infant research that studies moment-to-moment non-verbal interactions, Beebe and Lachman (1998) observe that the direction of affective state is co-influenced by both partners. Therefore, in order to fully facilitate the benefits of emerging positive affect in the patient, the therapist verbally and nonverbally needs to be ready for going in the direction of positive affect. Otherwise, the positive affect of the patient will be dampened, diluted and eventually lose its vitality.

If the therapist minimizes his or her own impact on the patient's accomplishment through humility (e.g., the therapist says to the patient, "YOU are the one who did the amazing work; I just supported you"), a growth opportunity for transformance will be missed because the patient will then be left alone with a positive, but intense emotion at the heightened moments of revealing one of his or her innermost vulnerable feelings to the therapist. By denying the patient's positive emotion towards him or her, the therapist creates the potential for shaming the patient who boldly took an emotional risk in connecting with the therapist on a deeper level. This is a moment where "joining" is called for. The therapist's open-armed embrace of the patient's loving gratitude works to undo the patient's aloneness and to strengthen a sense of attachment safety. It increases the patient's self-esteem and confidence, and empowers him or her to cultivate self-empathy (Fosha, 2000a). In short, it is a golden opportunity for an upward *spiral* of transformations (Fosha, 2009).

Sounds nice – but how do you do that? Mindful Attunement: Staying with the self; staying with the other

For the AEDP therapist, affective attunement through non-verbal, right brain-mediated activities is crucial in order to stay affectively in touch with the self and other. Affective

attunement is accomplished not only through words, but also by moment-to-moment tracking of non-verbal – often fleeting – somatic markers that reveal an individual's internal world.

Attunement can be conceptualized in two ways: "internal and interpersonal" (Siegel, 2010b). The first refers to focused attention on one's self state*,* and the latter on the relatedness between self and other (patient and therapist in the therapy context). The differentiation of two kinds of attunement helps us develop two channels of focused attention for two different purposes. The individual's internal attunement to the self's affective state may be referred to as "mindsight" (Siegel, 2010a), emotional mindfulness (Frederick, 2009), or "felt sense" (Gendlin, 1981), a reflective, non-judgmental capacity to objectively observe one's internal self-state; whereas interpersonal attunement can be understood as an act of taking in the other person's internal states, "not only their words but also their nonverbal patterns of energy and information flow" (Siegel, 2010a, p. 34). For both therapist and patient to release the treasure of transformance, these types of attunement are needed: when an individual has internal attunement, he or she is more likely to have direct access to core affects and thus to action tendencies and transformance strivings. On the other hand, interpersonal attunement is vital in engendering a sense of safety, an experience of "feeling felt" by the other (Siegel, 2010a; 2010b), which is fundamental for one's motivation to explore the internal and external world.

As for cultivating the patient's mindful internal attunement, the therapist can encourage the patient to take a moment to notice, experience, and deepen right-brain mediated affective attunement to the self. When the therapist catches somatic markers that signal glimmers of core affect experience in the patient, such as fleeting eye contact or a sigh, he or she can make internally focused, experiential interventions to help the patient affectively attune to him or herself. For example, the therapist can ask the patient, "What's happening inside of you right now?" "Wow, you have a beaming smile on your face. Can you stay with that?" or "You just took a big sigh. Can you check inside and see what you're experiencing in your body?" Attunement to the patient's affective and visceral self-state helps the patient become aware of core affective experience at any given moment, and thus makes room for emerging adaptive action tendencies and transformance strivings.

Internal attunement to the therapist's own affective and visceral self-state needs to be cultivated through the same type of focused awareness directed internally. This is a challenging task, particularly because the therapist simultaneously needs to maintain interpersonal attunement to the patient. Slowing down the process during a session significantly helps the therapist to notice internal subtle nuances of affective, visceral experiences within the self. Additionally, paying attention to one's internal reactions while reviewing one's work on videotapes is an effective way of creating and sensitizing one's own internal attunement channel.

Interpersonal attunement cultivates the potential for the patient to experience a "corrective emotional experience*".* Fosha (2008) states, "The aim of AEDP treatment is to provide the patient with a new experience, and that that experience should be good*"* (p. 9). When the patient feels seen, heard and understood by the therapist through close affective moment-to-moment attunement, he or she experiences something *new and good* in relating to another human being unlike other disappointing times in the past.

Not only does it just feel new and good, feeling understood has an evolutional value. Siegel (1999) postulates that the "feeling felt (p. 149)," the subjective experience of attunement, has a great survival value because when an individual experiences "feeling felt" by another, such a resonant connection creates a pleasurable response. He suspects that this may be built into our brains as a genetic inheritance for an evolutionary purpose: "For us as social animals, our having such as sense encourages group behavior, which has been of great survival value to our species as we evolved" (p. 149). If our ancestors had experienced "feeling felt" positive experiences with others often enough, they would have had greater odds at survival and

thriving because they would have made more social connections and thus had access to more group resources.

The AEDP therapist often uses experiential interventions to increase interpersonal attunement by focusing on such things as on the other's non-verbal cues, such as eye contact, gaze, vocalization (e.g., huh…, oh…), rhythm of speech or posture, which emerge in relation to the therapist (Prenn, 2011). Based on the information gathered, the therapist may intentionally adjust the way of relating to the patient via his or her nonverbal channel (e.g. vocal tone, rhythm of speech, posture) to either match the patient or compensate for the patient's lack of affective experience based on the subject matter (see detailed description of nonverbal matching in Beebe & Lachman, 1998). The AEDP therapist may also make verbal interventions in order to make interpersonal attunement explicit and amplify the relational connection (Fosha, 2000a; Prenn, 2011). The therapist may say something like, "I'm right here with you. I don't want you to feel alone with this deep sadness. Can you feel my presence?" "I see you smiled when I expressed my excitement for your accomplishment. Can you tell me what that was like for you to hear me congratulate you?" or "if you look at my eyes right now, what do you see?"

Internal and interpersonal attunement channels are often closely interrelated. For example, in order to maintain interpersonal attunement to the patient, the therapist needs internal attunement in order to be in touch with authentic core affects, particularly during affectively charged moments. Mindful moment-to-moment attunement to the therapist's own self-state allows him or her to make effective interventions by differentiating between pathogenic affects (e.g., shame, guilt, anxiety) and core affects within the therapist himself or herself. Such internal attunement helps the therapist avoid making interventions driven by pathogenic affects and utilize the wisdom of core affects. For example, self-disclosure, a central tenet of AEDP, is one of the most powerful clinical interventions (Fosha, 2000a; Prenn, 2009, 2011) that a therapist can use. In order for the therapist to make useful and authentic self-disclosure statements – the therapist's revelation of the heart and mind to the patient –, the therapist needs to be attuned to his or her own core affects so as not to let pathogenic affects interfere with the patient's healing process. For example, the therapist's feelings of guilt may get in the way of accepting the patient's loving gratitude possibly because of our traditional therapy training's focus on neutrality and/or perhaps our own insecurities about our own self-worth, and perception that accepting anything good from patients is self-indulgent or narcissistic (Fosha, 2000a).

Another example of interrelated internal and interpersonal attunement and effective use of both channels of attunement comes from the literature on self-disclosure. Self-disclosure theorists suggest that interventions seem to work more effectively when the recognition and exploration of interpersonal attunement come before the internal exploration of one's affects (Prenn, 2009; Maroda, 1999; Vygotsky, 1978; Schore, 1994), Looking at affect regulation from a developmental perspective, interpersonal affective reactions occur first and then the internal (intrapsychic) (Maroda, 1999). From a neurobiological point of view, Shore states that "practicing phase-specific, external, interpersonal, caregiver-modulated arousal regulation … supports *internal, intrapersonal regulatory functions* subserved by prefrontal internal working models" (p. 358; italics added). When an individual is faced with overwhelming affects – particularly new and powerful ones, it is critical that those affects be regulated by the other in the dyad so that the individual can neurologically develop internal affect regulation capacities. Simply asking the patient to explore his or her internal experience of expressing a direct relational emotion towards the therapist without the therapist's affective response first runs a risk of leaving the patient alone and making such an affectively loaded revelation unsafe. If we translate this into clinical terms, when a vulnerable and powerful emotion like loving gratitude is expressed by the patient towards the therapist, the therapist must be emotionally available to receive and regulate the expressed emotion in the relationship verbally and/or nonverbally *before* proceeding to deepen it intra-personally (i.e., within the patient). Obviously, this is more of a guideline than a rule; all AEDP interventions are guided by clinical phenomenology in each unique dyad and its developmental stage (Fosha, 2010).

Therapist's Receptivity to Patient's Loving Gratitude Facilitates Transformance

When the therapist fearlessly recognizes and accepts a patient's *loving gratitude*, it creates an opportunity for a relational action tendency to be released, in which the existing internal working model of the individual can be transformed. This leads to "new meanings and potentials for new ways of being" (Fosha, 2009, p. 201). No longer alone within and in relation to the other, the individual can explore the transformed edge of the attachment horizon as transformance guides the way; "… corrective emotional experiences [occur] in a corrective emotional attachment relationship" (Prenn, 2009, p. 91). If the therapist is able to take in and acknowledge the patient's *loving gratitude*, he or she gives a priceless opportunity for the patient's emerging impulse of transformance to manifest itself and be metabolized in the here-and-now relationship. In this sense, the therapist's earnest recognition and acceptance of the patient's *loving gratitude* is a precious opportunity for expansive growth and healing for the patient.

The following case example illustrates ways in which the therapist's embrace of the patient's *loving gratitude* helped the patient make shifts in her internal working model and broaden her view of self and others.

Clinical Case Presentation:

Grace is a thirty-five-year old, divorced, Japanese female who works at a Japanese company. She sought psychotherapy treatment about a year prior to this session when she became severely depressed due to bullying in the workplace by two older female coworkers. She has a long history of emotional abuse by her parents and older sister. As such, she suffers from a chronic sense of feeling defective, particularly in her capacity to relate to others. The following section presents a microanalysis of a last session with Grace who was about to move to Pittsburgh because of her company's relocation. It was decided that Grace would continue therapy with this writer long distance after the relocation. It is noteworthy that this is the last session in which therapist and patient physically are in the same place before separation. In this particular session, Grace looks back on the therapeutic work and her progress and is in touch with gratitude towards the therapist about 30 minutes into the session. For the purpose of this paper's objective, the selected segment starts at a point where Grace's defenses and pathogenic affects, such as anxiety, are sufficiently reduced; i.e., she is ready to go forward to express gratitude toward the therapist. We will see if the therapist is ready.

Note: The italics in parentheses indicate the nonverbal aspects of therapist and patient's interactions. The comments in bold are made by this writer on the process, linking theory to the micro-movements of activity. The treatment was conducted in Japanese. The patient's demographical information is modified for purposes of confidentiality.

Pt: I'm also thankful to the room that allowed me to see YOU (*to Th*). … There was a time when coming to this room was a lifeline that kept me alive. … I am really, really happy now.

Th: (*Nods empathetically towards the patient but does not explicitly recognize the patient's gratitude*)

Pt: I also learned about myself, who I am. I now know that I am not a hateful person. I sometimes talk to myself, like when I am using a copy machine (*smiles*). I was listening to what I was saying to myself, and I found it so funny! (*laughs*)

Th: It sounds like you've come to lovingly appreciate yourself (**Recognition of the patient's self-validation**)

Pt: Yes. … (*Looking around the room; slowing down*) This room – this room IS you. So I'm grateful to you. (**Taking a bold step here to connect with the therapist at a deeper level**)

Th: Oh… (*Tender voice*) Thank you. Hearing what you just said, I now clearly understand how much the time that we spent in this room has changed your life. (**Recognition of the patient's gratitude toward the therapist; nevertheless, the therapist is not affectively taking in the patient's gratitude; the therapist's focus here is on "the time that we spent," and therefore she is avoiding the immediate interpersonal connection between patient and therapist that contributed to the patient's changes. The therapist is affectively reserved**)

Pt: (*Deeply nodding*) My words just are not enough to capture it … I am so happy… I remember the last time (referring to the session the previous week: due to the patient's moving schedule, it was thought that she could not come back to the office in which her sessions were usually conducted; her schedule changed in the last minutes so that the pt was able to come back to the same office for the final session), you said to me, "it was the last session in this office today," and you also said, "please remember this room, too," at the very end of the session. I was about to cry or wanted to leave as fast as I could but when you gave me some time, I felt a variety of emotions as I was looking at this room. I realized for the first time that I could feel one emotion at a time, at my own pace, one by one. (**the patient's recognition of hard-earned self-regulating capacity**) It was the moment that I learned it. (*slower speech*) … Up to that point, I was just preoccupied with other people's pace, "if I do this, it would bother that person," or "in this situation, I have to behave this way; otherwise, it will be a trouble for other people." I was full of these thoughts. I tried my best not to bother others' pace and would leave as quickly as possible when I needed to. (**acknowledging her own defense and its origin**) (*putting the palms of her hands together in front of her heart*) I've learned that I can check in to see how I am feeling, not in my head (*putting her hand on her head*), but in my heart (*putting her palms over her heart*) (**patient is calm, reflective**)

The therapist is reticent when the patient is expressing appreciation for her help. Looking back on this segment, the author notices her hesitation in taking in this praise from the patient. This gets in the way of embracing the patient's appreciation. Luckily, the patient does not retreat from the therapist and continues to give her a chance to accept her gift of gratitude.

A few minutes later, the patient talks about a sarcastic verbal exchange with a mean-spirited, middle-aged administrative employee who was laid-off and therefore not assigned to the Pittsburgh Office along with the executives (the patient was the only one who was asked to move to Pittsburgh among locally hired employees). The female coworker – the person who was also the main source of patient's misery in the office – said to the patient, "I've heard that there is nothing worth seeing in Pittsburgh. I'm surprised that you took the offer!" The patient, who used to get hurt from this colleague's verbal attacks, gracefully responded to her and said, "I'm sure I can find something to do over there."

Pt: I didn't feel miserable. I didn't get hurt at all. I don't feel anything about her sarcasm. Instead (of getting hurt), I said to myself, "I've got an interesting joke to tell my boss!" (*laughs*) (**Her relationship with her immediate boss became stronger over the course of a year; he became her safe-base at work**)

Th: Yeah… that's great!

Pt: Yes. (*looks pleased and smiles*) (**a sense of pride, mastery affect – "I did it!"**)

Th: I am realizing how much you've grown over the course of only a year. (**Explicit recognition of the patient's growth; taking delight in the patient with heightened affect of excitement**)

Pt: Yes. (*Pt takes a deep breath*) Yes, when I was coming here for sessions, I often felt, "Oh I got this one solved." I was glad to see that I solved those big issues. Yeah, but none of those sessions alone made me happy at once… Nevertheless, as I was solving problems one by one, I've grown so much. (**Pt is receptive here taking in the therapist's positive feedback; again, a sense of pride – mastery affect – is salient here**)

Th: Mmmmmm. (**Impressed, taking delight in the pt's ability and her emotional growth**)

Pt: (*Looking at the therapist*) I'm happy. (*Nods slightly*) (**Healing affect, gratitude, is emerging more explicitly**) Yeah. Let's see… I knew gratitude, feeling grateful, was important for people, but I didn't realize that I am someone who can be grateful this much. (**Recognition of her newly emerging emotional capacity, loving gratitude; the range of her emotional experience is expanding**)

Th: Mmmmmm…

Pt: I didn't know what it meant to be grateful. It is difficult for a miserable person to be grateful. (*Her voice weakening)* (**Mourning-the-self – emotional pain for the old impoverished self**)

Th: I see… I feel as if deep gratitude is flowing out from a very deep place in you. (**Recognition of the patient's gratitude**) (**Choice point – The therapist consciously highlights the healing affect of gratitude and amplifies it, instead of focusing on the mourning-the-self emotional pain, as in this moment she feels the greater healing opportunity is here**)

Pt: Yes, it is truly flowing out of me. …This cannot be exchanged for money. I wonder how I can give this back to you and realize that this gratitude cannot be exchanged for anything else. (**The patient is expressing deep gratitude – loving gratitude – here towards the therapist; healing affect**)

Th: I feel your deep gratitude and it's touching my heart… it brings me tears. (*Th's eyes welling up with tears*) (**The therapist is finally able to openly accept the patient's *loving gratitude* and shares her receiving experience via verbal and nonverbal self-disclosure; healing affect in the therapist**)

Pt: (*Nodding, getting tearful*) (**bi-directional attunement here**) Thank you. I'm so happy to hear you say it. (**True Other experience**)… Uhnn…I wonder… (*struggles with words as she closes her eyes*)… If I did not see you… I could have gone back to Japan (*wiping tears with hands*). I'm glad that this is not my last session … but I am sure that I will be back in this office because I want to see you. (*Almost whispering*) (**the patient is taking a bold step here to connect with the therapist even more deeply, expressing her vulnerable longing before separation**)

Th: Our sessions will continue. (the plan was to continue the treatment with phone sessions) (**The therapist is unknowingly attempting to diffuse the intensity of affect**)

Pt: But this is the last one that I can see you in person. (**The patient corrects the therapist and gets her back on track with the reality that this is indeed the last session they will be physically together**) Yeah, this is it for now, I cannot see you for a while… but I'm sure I will come back here because I want to see you. (**The patient takes another bold step to connect**)

Th: Uhnnn… (*Therapist nods*, *taking in the patient's open loving gratitude, and finds herself speechless*) (**receiving direct *loving gratitude* is dysregulating for the therapist**)

Pt: I will come back once in 6 months… (*Therapist and pt make locked eye contact*)

Th: … I've been crying like this and am curious what it is like for you to see me cry? (**The therapist initiates metaprocessing and explores the impact of her self-disclosure on the patient**)

Pt: (*Nodding, taking a sharp breath*) I don't have a hidden agenda – like hoping how you feel about me or wishing how you will think of me – at all. I'm just putting things into words – because this is a session – that's it. I am glad that you're getting what I'm saying. (**Patient is emphasizing her self-at-best via statements about her own self truth. Patient is also grateful that the therapist has caught up with her in that she now feels the therapist can take in the gratitude. The patient is articulating her True Other experience of the therapist, making her implicit receptive affect explicit**)

There is a hidden context to what the patient is referring to here. There were multiple missed opportunities in the past when the patient expressed gratitude towards the therapist and the therapist dodged them. The therapist's typical reaction to the patient's gratitude was treating the patient as the only contributor to her progress while minimizing the therapist's share. Though this humble reaction appeared socially appropriate, it always stopped the process of unfolding, which makes sense because the therapist was emotionally leaving the patient alone in her own vulnerability. The above vignette marks the first time that the therapist does not negate her contribution to the patient's growth, explicitly acknowledges the patient's impact on the therapist, and affectively stays close to the patient.

Th: Hunn…

Pt: It really makes me happy to know that you're so happy to see my growth. (**The patient articulates the importance of her*loving gratitude* being received**)

Th: I'm SO happy. (**Echoes pt's words and amplifies it**)

Pt: (*Smiles with closed eyes*) (**regulating intense positive affect**)

Th: Really…

Pt: (*Taking a deep breath*) I'm so grateful that you're that happy for me. Thank you so much. (**co-engendering of secure attachment and the positive valuation of the self and other; 3rd state transformation**)

Th: Thank YOU. I'm so grateful that you've shared such deep feelings with me. (**Appreciating the patient's courage to share vulnerable feelings with the therapist; self-disclosure of *loving gratitude* towards the patient**) I feel very happy. (**Another self-disclosure based on the therapist's internal attunement to a core affect**)

Pt: I, too, am very happy. (*Smiles happily; maintains eye contact*)

Th: I am so grateful for this. (**Self-disclosure, continue to amplify bi-directional exchange of *loving gratitude*; True-Self/True-Other relating**)

Pt: (*Nodding, tearing up again*) Uh… (*Closes the eyes again for a second as if to let this intense positive feeling sink in*) I feel we are feeling the same emotion… aren't we? (*Again maintains direct eye contact*) (**The patient is taking another bold, leading step to make implicit bi-directional attunement explicit**)

Th: (*deeply nods in agreement*)

Pt: I am so happy. (*Choking up; smiling with tears in her eyes*) I'm so grateful.

This is a good example of how an interpersonal intervention – i.e., recognition and acceptance of the patient's loving gratitude towards the therapist— works effectively when it comes first before internal exploration. The therapist's open embrace of the patient's loving gratitude co-regulates the affective intensity and increases relational safety. From here, the patient spontaneously moves into the internal exploration process.

Pt: This is what it feels like when I am emotionally connected to another person… (**3rd State Transformation: deepening the healing affect of gratitude, shifting to Core State**) I don't need many people with whom I can do this deep sharing … I started to appreciate a kind of superficial emotional communication this year (for the first time in my life). I began to enjoy non-serious conversations. I told you that just having a light conversation made me happy. (**suggesting serious emotional deprivation in the past. Without the therapist's help, the patient spontaneously reflects on her emotional growth and puts it in the context of a coherent narrative**)

Th: I remember that clearly.

Pt: Yeah… it's like… It is such a surprise that I can do this deep emotional sharing… I thought just having a light conversation was fun. …I just get a sense that my next marriage will be well. (**Core State (State 4); after the pt metaprocessed her experience of the therapist's embrace of her loving gratitude and made the "implicit explicit and the explicit experiential" (Fosha, 2010), she shifts into the Core State. The pendulating movements between expressing and receiving attachment experiences of the therapist creates an upward spiral of transformations (Fosha, 2009). The pt experiences confidence in her affective competence (Fosha, 2000a) with others in the external world; now her autobiographical narrative is oriented toward the future, using newly emerged gratitude and deep relational connection as a platform**) I wonder if this is what loving someone feels like. It's not like "what will he do for me next?" But rather, "what can I do for him?" "I'm happy that I did it for him" or "I'm glad that I said that to him" (**Still core state – generosity, empowerment, and kindness are expressed; a relational action tendency is released**) … if both of us can feel this way, then I will be just happy. (*Choking up*) And if a couple can do that, that means it's a good match. (*Nodding, making eye contact with the therapist*) Uhnnn… I think so. … I will be happy even if I'm poor. (*Laughs*) I used to be really materialistic. Everything was about "money." When I came here, I told you that I wanted to become a CPA because it would increase my salary. Of course, I'd prefer a higher salary to a lower one. But I don't need excessive money. (**Again the patient is exercising a capacity to construct a coherent life narrative looking towards the future, based on her experience of authentic connection and its priceless value. The patient continues her internal exploration**) I imagine that I'd be happy if I am having a cup of coffee at Starbucks and debating whether I should buy that $50 dress or not; and after I get it, I will be happy, "I got this dress today!" (*Laughs*) That's it. If I can do that type of thing, I'll be just simply happy.

Th: You're saying that if you can have this type of deep connection with someone, you'll be happy no matter what you have or what you don't have?

Pt: YES. (*Strongly nodding*) YES. (*Clear, declarative tone of voice*) This is what "happiness" is, isn't it? (*nodding, choking up, trying not to cry; good eye contact*) (**Feeling moved and asking for joining**)

Th: We, two of us together, have been working really hard to get to this happy place. (**The therapist receives the pt's invitation and joins her. The therapist validates the patient's experience of happiness in making a deep emotional connection and emphasizes the "we-affect," not leaving the patient alone**)

Pt: YES. (*Deeply nodding*) (**A sign of relief – end of a big emotion wave**) Truly.

(*The patient and therapist breathing out together)* (**both are somatically in sync here; high attunement**) (*The patient looks up the clock, it's almost the end of session*)

Th: It's okay – we can go over a few minutes because I started a little late.

Pt: (*Nods*)

Th: So looking back on today's session **–** how was it? We talked about our deep connection between us, both of us shedding tears… what is that like for you now? (**Shifting to State 3, Metaprocessing**)

Pt: I feel my stomach area really hot. (*Putting her hands on her stomach*) (**internal attunement to the somatic self-state, an ability that she has gained from treatment**) Uhn… And I'm noticing that I have a desire to get to know people more. I feel confident that I can make emotional communication with anybody – deep and superficial. (**calm confidence – Core State**) I feel that I do have good interpersonal skills to communicate emotionally. (*putting her hand over her heart, makes steady eye contact with the therapist and smiles*) I really have confidence…

The patient is in the exploratory mode, a sign of transformance, as the patient has safety interpersonally as well as internally. When a person is no longer alone within, exploration into the external world becomes a natural impulse. Readers may notice that the patient's wording is general here, i.e., "people," and "anybody." The author believes that the general language here is the patient's attempt to apply a newly acquired emotional schema to a larger world in general. Transformance is fully at work, seeking "maximum vitality, authenticity, and genuine contact" (Fosha, 2008, p. 3). We can observe an expansive relational action tendency released by the patient here after the patient felt deeply safe with and understood by the therapist in the dyad.

Th: You have confidence… (**amplifies the positive**)

Pt: I really have confidence.

Th: Uhnn…. (**Therapist impressed with the patient's firm confidence in herself; this is someone who came in for treatment, feeling deeply hopeless about her capacity to relate to others**) You just said it in such a clear, decisive manner that you have confidence.

Pt: YES! (**The patient is very clear, calm, and centered – easy flow – with no defense at all; a sense of pride here**) As I was talking, I was thinking that I could have this deep connection with you, AND I had created a pretty good connection with a sullen lady at a Motor Vehicle Center (*Laughs*) (**Flexible, nuanced and socially adaptive action tendencies released**)

Discussion and Summary

From the clinical case example, we learned the importance of the therapist's recognition and acceptance of the patient's loving gratitude expressed towards her. It increases interpersonal attunement between the two and thus strengthens a sense of relational safety. When the patient has an experience of "feeling felt," it boosts her confidence, self-empathy, empowerment, and her motivation to connect; different forms of transformance come to flourish, creating an upward spiral of transformations (Fosha, 2009).

When the therapist metaprocesses the patient's experience of expressing loving gratitude, the patient can weave her new and good experience into her autobiographical narrative, which transforms her view of herself and others. Transformation occurs within the internal world of the patient, triggered by the positive corrective emotional experience in the here-and-now relationship with the therapist. Metaprocessing allows the patient to digest a "new and good" experience, cement the shifts in her internal working model and metabolize the experience of releasing adaptive relational action tendencies in the here-and-now relationship and projected expansive relationships in the future.

In this light, the therapist's resistance against accepting the patient's loving gratitude and processing such experience is a huge loss for the growth, healing and empowerment of the patient (Fosha, 2000a, 2005). In a paradoxical way, by willingly accepting the gift of loving gratitude from the patient, the therapist multiplies its value. Acceptance of an emotionally priceless gift from the patient is not an act of the therapist's self-indulgence, gratification or narcissism; rather, it is an act of giving loving gratitude in return.

Because of the rare exposure to intense positive affects in the psychotherapeutic and cultural context at large, our understanding of, sensitivity to, and tolerance of positive affects are limited. In order for the therapist to embrace positive affects, the therapist can employ several strategies. First, the therapist can cultivate her own internal attunement to self-states by simply directing awareness to his or her internal visceral, affective experiences; some internally focused, mindfulness practices, such as meditation, guided imagery, or yoga may help facilitate the growth of such sensitivity and tolerance. Second, the therapist can look for ways in which she can widen her affective window of tolerance with positive affects by watching other clinicians' work on tapes/DVDs. Third, the therapist can seek consultation to work on his or her resistance to positive emotions when and if this arises.

This is a unique time in the history of psychotherapy. We are witnessing a paradigm shift from an exclusive focus on psychopathologies and negative emotions to resilience and positive affects. Supported by the findings from attachment research, mother-infant studies, positive psychology, emotion theory, affective neurobiology, and studies of transformations, we are witnessing an expanding horizon of clinical practice that goes well beyond eliminating psychopathologies and allows human thriving resilience to flourish in our consultation rooms and beyond.

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