Quantum Transformation in Trauma and Treatment: Traversing the Crisis of Healing Change

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Three ideas are discussed from the vantage point of accelerated experiential dynamic psychotherapy (AEDP): Quantum changes operate not only in trauma, but also in healing; attachment plays a major role in whether fear or excitement is the response to novelty; experientially exploring the experience of transformation can itself lead to quantum change. Vignettes from an AEDP session show a patient's grappling with the startling novelty of experience that the transformational process, particularly when occurring in quantum leaps, evokes, and illustrate the phenomenology of cascading transformations. They illustrate how the therapist's emotional engagement and attachment orientation, experiential techniques, and metatherapeutic processing activate state transformations and entrain adaptive healing processes. © 2006 Wiley Periodicals, Inc. J Clin Psychol: In Session 62: 569–583, 2006.

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All of us already believe in quantum transformation. The centrality of trauma in many current understandings of psychopathology speaks to that (e.g., Eigen, 1996; Levine, 1997; Porges, 1997; Siegel, 2003). Trauma is the *definitum* of quantum transformation: in one fell swoop, everything changes. Nothing is ever the same again. But when we think about change in psychotherapy, we become skeptical, cautiously maintaining that enduring change need be slow and gradual. I propose that quantum change operates not only for bad, but also for good, not only in trauma, but also in healing (see also James, 1902; Magnavita, 1997; Miller & C' de Baca, 2001). Psychotherapeutic change can be, but *need not* only be, gradual and cumulative; it can also be discontinuous, sudden, and rapid. As a student once said, "Change happens in a heartbeat." Quantum transformational processes

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are there for the entraining, and it behooves us to entrain them, for encoded in them are huge therapeutic opportunities. This is my first theme.

The second theme, related to the sometimes thin line between trauma and healing, is the also sometimes thin line between, on one side, *fear* and, on the other, *excitement and curiosity* as reactions to new and surprising situations. Being taken by surprise means there has been a violation of our expectations. Such disruptions generate intense emotions. What those emotions are and how we deal with them have implications for our functioning. Do we respond with fear and experience the disruption as unwelcome, even traumatic? Or do we respond with curiosity, experiencing the challenge to our expectations as stimulating and growth-enhancing? Key to the way things go is the presence—or absence—of a trusted other. There is a world of difference between being alone with overwhelming emotions and being with a trusted other in the affect storm. Attachment decisively tilts whether we respond to life's challenges as opportunities for learning and expansion of the self or as threats to our integrity, leading to constriction of activities and withdrawal from the world.

The experiential exploration of the *experience* of change as a change process itself is my third theme. Through a process involving *alternating waves of experience and reflection*, it can become a transformational process of its own when it occurs in the context of a secure attachment, is somatically and experientially tracked moment to moment, and is worked through to completion.

These three themes are explored through the lens of accelerated experiential dynamic therapy (AEDP: Fosha, 2000, 2002; Fosha & Yeung, 2006; Lamagna & Gleiser, in press; Russell & Fosha, in press; Tunnell, in press), a healing-oriented, transformation-based treatment. In AEDP, we seek to harness naturally occurring, adaptive, discontinuous affective change processes, to help patients access resilience and the capacity to act adaptively.

Talking the Talk

Aloneness in the face of overwhelming emotions is seen in AEDP as being at the root of psychopathology (Fosha, 2000, 2003). Emotions that are too intense for an individual cannot be processed; to ensure psychic survival, individuals resort to defense mechanisms that exclude and constrict emotion so as not to be overwhelmed. However, having a "trusted companion" (Bowlby, 1988; see also Costello, in press) changes everything; together with a trusted other, instead of avoiding and withdrawing, the individual can approach and explore emotions and reap their adaptive benefits. The attachment relationship has the capacity to shift the motivational vector from moving away (fear activating shrinking and constriction) to moving toward (curiosity activating openness and expansiveness).

Engendering secure attachment in the therapeutic dyad is fundamental to AEDP's mode of action: Once patients feel safe, they can risk delving into the muck of painful, overwhelming emotions, knowing that, this time, they are not alone with these experiences. Note, however, that we view the attachment relationship as necessary but not sufficient: In and of itself, it is not what cures. It is what provides the secure base from which experiential exploratory work can be undertaken.

AEDP is a phase-oriented treatment in which interventions depend on the patient's state, and therapeutic goals are state-specific. A state has its own distinct characteristic organization; the principles by which arousal, attention, motivation, affect, cognition, communication, and subjective self-experience operate differ from one state to another. For instance, there is a big difference between the ways a person functions in sleep versus waking states, or in states of trauma-induced shock vs. states of relaxation. A state

transformation produces a state that is *discontinuous* with the one that preceded it. It is not just that the individual is feeling more or less, or better or worse: the way the individual goes about feeling is different.

Psychotherapy also proceeds differently in different states. In privileging the notion of quantum transformation, we differentiate between states that are optimally conducive to effective therapeutic work and states in which therapy is less likely to be productive. It has been our experience that the work proceeds better and more quickly in affective states in which there is fluid contact with authentic, bodily rooted emotional experiences. Thus, interventions aim to promote state transformations and deepen experiential access to states of unhampered emotional experiencing.

The Three States and Two State Transformations

Three states and two state transformations (see Figure 1) characterize the experiential processing of emotion to completion. State 1 functioning is dominated by defenses and inhibiting affects, such as shame and fear, which block the person's direct contact with his or her own emotional experience. Interventions here aim at building the experience of safety, establishing relatedness, bypassing defenses, alleviating fear and shame, and enlarging the glimmers of emotional experience that occasionally peek through. We directly

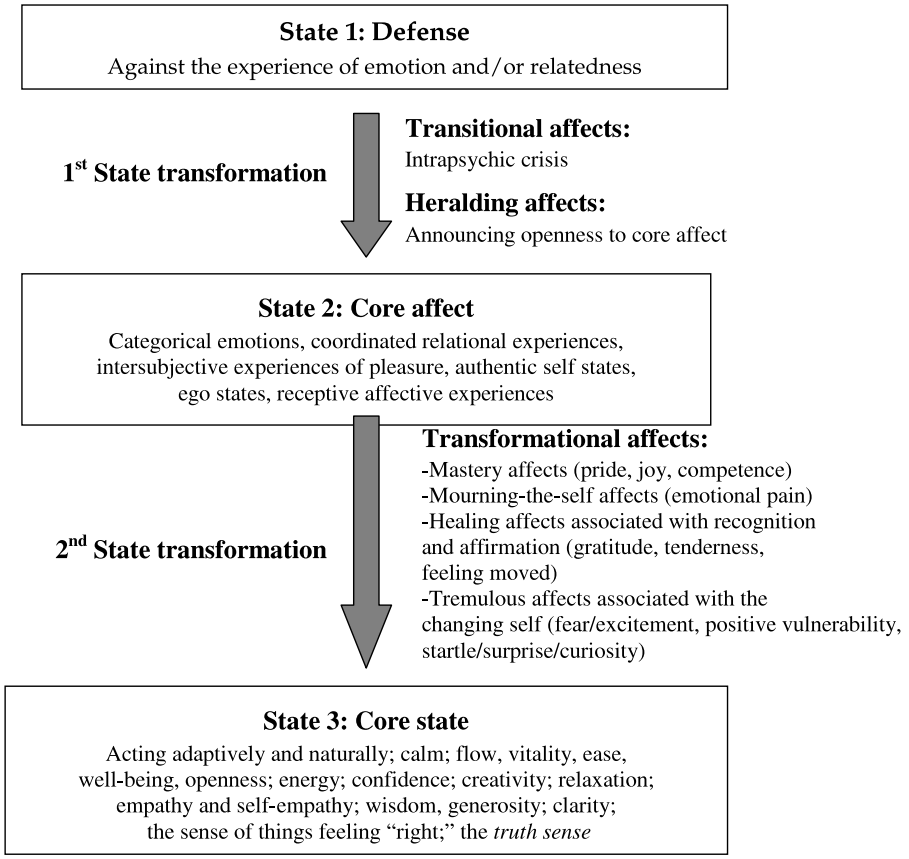

Figure 1. The 3 states and 2 state transformations of processing emotional experience to completion in AEDP

work to minimize defenses and to activate the attachment bond between patient and therapist. The need for defenses is obviated through undoing the patient's aloneness.

If in state 1 the secure base is being co-constructed as old patterns are being deconstructed, state 2 work is exploratory work par excellence. With defenses and inhibiting affects out of the way, the patient is viscerally in touch with bodily-rooted emotional experience. Again, the key here is the attachment relationship: Once it is in place, emotional processing work can now be launched. State 2 dyadic affect regulation has patient and therapist, side by side, sleeves rolled up, working together to help the patient access, deepen, regulate, and work through emotional experiences until their adaptive action tendencies can be released. We want what previously felt bad—relating with openness and having intense emotions—now to feel good. Instead of feeling disrupted and overwhelmed by emotions, the patient, aliveness enhanced, feels stronger and more resilient.

The processing of an emotion to completion ushers in yet another state. In *core state*, AEDP's state 3, the patient has a subjective sense of "truth" and a heightened sense of authenticity and vitality; very often, so does the therapist. As in state 2, defenses or anxiety are absent in the core state. But whereas the turbulence of intense emotions defines state 2, calm, clarity, and centeredness prevail in state 3. Work with core state phenomena culminates in the assertion of personal truth and strengthening of the individual's core identity and sense of (true) self.

The Two Quantum Transformations

Effecting the state transformation from defense-dominated functioning (state 1) to core affect (state 2) has been the mission of all short-term psychodynamic therapies (e.g., Davanloo, 1990; Fosha, 2000; Magnavita, 1997; McCullough et al., 2003; Neborsky, 2003), as well as all experiential therapies (e.g., Gendlin, 1981; Greenberg, 2002; Levine, 1997). However, whereas the state transformation from core affect (state 2) to core state (state 3) has not been the focus of much clinical attention, it is of central concern here. What in most therapies is often seen as a natural endpoint of experiential work (the completion of a round of processing of emotion) heralds the beginning of another round of AEDP work. We use the term *metatherapeutic processing* to refer to this work because we are exploring what is therapeutic about therapeutic experiences. Metatherapeutic processing involves focusing on the patient's *experience* of transformation, which itself becomes a change agent.

The focus on the experience of therapeutic transformation evokes one of four characteristic sets of transformational affects; the processing of these affects to completion, which culminates in core state, is what constitutes the four metatherapeutic processes. The four metatherapeutic processes, with their identifying transformational affects indicated in parentheses are *feeling mastery* (pride and joy), *mourning-the-self* (emotional pain), *affirming recognition of the* (transformation of the) *self* (the healing affects: gratitude, tenderness, and feeling moved), and *traversing the crisis of healing change* (the tremulous affects: fear/excitement, startle/surprise, curiosity/interest, oscillating and vibrating sensations, positive vulnerability). The first three metatherapeutic processes have been described elsewhere (Fosha, 2000). Here, our focus is on the fourth metatherapeutic process, traversing the crisis of healing change, which is illustrated in the following vignettes. We will see the patient grapple with the startling novelty of experience that the transformational process, particularly when occurring in quantum leaps, evokes.

Two features distinguish AEDP's viewing of the therapeutic relationship in attachment terms: First, secure attachment in the therapeutic relationship is what we seek to

entrain from the get-go, so as to be able to do experiential work with intense emotions. Attachment is not the aim *of* therapy, but rather the sine qua non *for* therapy. Second, attachment does not operate only implicitly, working its magic as the background hum against which experience takes place. The patient's *experience* of the attachment relationship is a major focus of therapeutic work.

Walking the Walk

Patient Description

The patient is a 35-year-old married research physician who is seeking treatment after 6 months of severe anxiety and panic, difficulties in functioning at work (a first for her), social withdrawal, and a 30-pound weight loss. Precipitants included separations (a forced geographical separation from her husband at a time of illness), losses (death of her grandmother, suicide of a best friend), and career-threatening conflicts with a superior. Also noteworthy is a history of early trauma and loss, eating disorder in adolescence, and physical and sexual maltreatment as a young adult in relationships with men.

Course of Treatment

The patient sought treatment 2 months before a scheduled relocation to another part of the country, thus making it a *de facto* short-term treatment. We worked together for a total of 20 hours: an extensive initial evaluation session of 3.5 hours, followed by eight 2-hour sessions. Sessions were videotaped and the patient received videotaped copies of all the sessions.

The following six vignettes are from the initial treatment session, the first encounter between therapist and patient. Vignettes 1–3 are from the first third of the session, when the attachment relationship is being established and experientially explored, as defenses and anxiety are also addressed. Vignettes 4–6 come from the last hour of the session and show metatherapeutic processing at work. There is some formal elegance in these two sets: They show how attachment makes the difference between fear and excitement—and thus between withdrawal and exploration—at both ends of the therapeutic process.

The therapist opens the session by saying, "First of all, welcome." After the initial half-hour or so, in addition to the picture of the patient's difficulties and the precipitants thereof, three defensive means of dealing with anxiety and fear of loss of control are evident: self-denial and the avoidance of pleasure; the reliance on distancing, intellectualization, and dissociative mechanisms; and the somatic discharge of tension through facial grimacing and rather unusual contorted bodily poses. Moment to moment helping the patient attend to the bodily manifestations of her experience, the therapist is on the lookout for evidence of her strength and resilience, and for moments of opening within the session. When these occur, they are seized as precious opportunities. Given AEDP's focus on *dyadic* affect regulation in the processing of emotion (Fosha, 2001), the therapist's emotional engagement with the patient and her emotional responses are part and parcel of the therapeutic process.

The first vignette illustrates affirming work with the adaptive aspects of defenses, then experiential work with the patient's response to the therapist's affirmation. The vignette begins as the therapist shares her growing appreciation of the patient's defenses. Twenty-eight minutes has elapsed since the beginning of the session.

Vignette 1: Response to Affirming Recognition

PATIENT (P): (*rapid speech*) And I also think . . . what had manifested as an eating disorder at that point (*early 20s*) wasn't really an eating disorder; it was more separation anxiety and separation stress from my parents . . . .

THERAPIST (T): (*leaning forward, sounding intrigued*) So I'm very interested. . . . I am now very very very curious. . . . So you basically have never been in treatment before?

P: No, never before . . .

T: (*astonished tone, eyebrows raised in surprise*) You mean, this level of awareness and analysis and understanding . . . you've gotten all that on your own?

P: Yes, (*giggles, blushes*) . . . it sounds a little silly when you say it but . . .

T: Why silly? I am astonished; I am astonished. . . . Whatever the difficulties and whatever all the feelings that are on the other side of this control, we'll get to. . . . But in the meantime, I am really really really in awe of what you've been able to do on your own . . . hmmmm? (*therapist affirms and affectively heightens adaptive aspects of patient's defenses via her own admiring reactions*)

P: I think. . . . (*a heralding of an intellectualizing defense*)

T: You have a feeling about my saying that? (*refocus on feeling*)

P: Not really . . .

T: You giggled. (*mirroring of affect*)

P: Not really . . . I think I sort of understand what you mean. You know, my mother was very unbalanced. . . . (*intellectualization, rather than being in the moment*)

T: (*interrupts*) The other thing I notice is that when something happens in terms of our communication that is a little more personal, you look away. (*ups the ante: explicit mirroring of somatic defenses in the context of the relationship*)

P: (*laughing*) Yes. (*green light: rises to the challenge and meets it*)

T: Are you aware of that?

P: A little. . . . yes. (*giggles, squirms*)

T: OK.

P: And I also tend to, when someone says something nice to me, I tend to shrug and do that (*shakes head, makes a face*). . . . Yes, I am aware of that kind of . . . (*green light: collaboratively, patient labels her own defenses and shares them with therapist*)

T: (*interrupts*) So what happens inside you? You had some feelings about what I said to you. . . . (*refocus on feeling in the context of the relationship*)

P: Well, I felt a bit flattered (*begins to acknowledge pleasure*) and I felt like I didn't really deserve it (*pleasure initially evokes guilt*) and of course I felt a little bit of confirmation too because on some level . . . (*begins to take in affirmation*)

T: (*interrupts*) You mean validation from me? (*refocus on the positive aspects of the interaction*)

P: Yes, yes. (*positive affect as transformational marker*)

By the end of this vignette, there is a new healing experience. The patient is able to take in the therapist's affirmation and acknowledge its pleasurable impact.

We go on to explore her self-destructive tendencies, including a relentless self-denial of pleasure. The history of physical and sexual abuse emerges in this context. The patient relates an incident in which she was attacked with a knife and suffered significant wounds, after which she took self-defense training. A year later, when a drunk mentor attempted a sexual assault, she responded with a well-placed kick and escaped. Impressed, I applaud her competence. Here vignette 2 begins: We focus in on a pleasurable moment that occurs

serendipitously between us. Note how focusing on an experience changes it (Gendlin, 1981).

Vignette 2: The Experience of Pleasure, Relationally Explored

T: So we got into this by focusing on the present, right? Your telling me about your denying yourself the pleasure of food, denying yourself the pleasure of Jim's (*a friend*) company, and that's when I started to ask you about other pain-inflicting behaviors and we got back to the instance of violence against you and also this attempted sexual assault, which you fended off with your own very competent aggression.
P: (*smiles*)
T: That pleases you. (*noting patient's smile at "your own very competent aggression" and shifting focus to that reaction*)
P: It does, yes; it does.
T: So stay with it for a moment . . . tell me how it feels to you to have me say that to you. . . . (*experiential exploration of reaction to admiration*)
P: Actually . . . more empowered, I think.
T: Physically . . . (*shift to the body*)
P: Yes.
T: . . . what do you experience?
P: I think sometimes I don't trust my own judgment. You noticed before I was saying, "They think I should do this. . . ." (*goes back up to the head*)
T: (*soft, tender, clear voice*) Physically, in your body . . . there was this very nice big smile, a lot of containing with your shoulders. . . . What are you containing in your chest? You know, there was this little very spontaneous remark on my part, but clearly, it meant something to you. . . . What does that pleasure or validation feel like? You know, what does that momentary little pleasure feel like? (*pressuring with empathy*) (*pause*) You said you felt more empowered by my statement. Right?
P: Yeah . . . this sounds really silly . . . I felt like a warm spot here. (*after mild embarrassment, drops down into sensory experience; pats her heart*)
T: (*encouraging, soft tone*) OK.
P: But usually breath control . . . (*uprise of defense*)
T: (*interrupt*s) Wait, wait, wait. . . . (*very soft voice)* What's this warm spot? Stay with that for a moment . . . just that sensation of warmth . . . what's that like, physically? (*refocus on sensation*)
P: (*slowing of speech; soft, slow, dreamy tone*) It's warm and it's . . . it is relaxing in the limbs, more than in the torso. . . . (*dropping down, body shift: decrease of anxiety, slowing of speech, increase in contact with somatic experience*)
T: (*smiling, soft tone*) Uh-huh.
P: (*soft tone, shy*) It makes me want to blush . . . .
T: (*smiling, soft tone, encouraging*) Uh-huh . . .
P: I think I'm thinking a little bit more slowly. . . . I'm reacting more than thinking. (*starts to look misty eyed*)
T: (*tender soft tone*) . . . So it touches something inside you . . . .
P: (*soft, open tone*) Yes, it does . . . .

The patient has "dropped down" into her experience. She is in touch with her somatic experience of emotion (undoing of defenses against emotion) and is openly sharing it

with the therapist (undoing of defenses against relatedness). The first state transformation (from state 1 to state 2) on its way, the focus shifts to the therapeutic relationship and explicit experiential work with the patient's experience of attachment. Note that we do not stop with validating the patient's spontaneous expression of feeling safe: We explore the bodily correlates of her experience. Also note that being an attachment figure means being viewed as being "bigger, wiser, stronger, and kind" (Marvin et al., 2002). In this context, the therapist has to tolerate being looked up to by the patient. Attacks of therapeutic modesty and self-effacement are counter to the therapeutic work necessary to solidify the attachment experience.

Vignette 3: The Exploration of the Experience of Attachment

T: You have an initial feeling or reaction to me? And how you're feeling with me? (*explicit exploration of patient's experience of the relationship with the therapist*)
P: . . . How I am feeling? . . .
T: . . . reacting, responding . . . your experience of me?
P: . . . a little wary, a little careful, I am not bothered by the camera, by the way . . . (*honesty, a green light*)
T: I'm glad. (*welcoming the patient's collaborative generosity*)

There is a noticeable shift here.

P: (*tone changes from tentative to declarative*) I feel pretty safe, actually. . . . Yeah, I think . . . my feeling right now is that I . . . was right in putting trust in you and that . . . it is important to me that you are more intelligent than I am. . . . (*attachment statement*) It would have been very bad for me, I think, if I would have thought that you could not follow me.
T: So by more intelligent, you mean that I am following you. (*attempt to dodge patient's compliment*)
P: You're following, *and* you're leading. (*patient corrects therapist; does not allow dodge*)
T: That must be a relief. (*therapist undoes her own defense, accepts her attachment status for the patient, regains capacity to empathize with patient's experience*)
P: Yes, it is . . . so I think . . . what I feel here is quite safe, and that is something that I don't feel often with strangers. (*patient takes the initiative, elaborates*)
T: Uh-huh.
P: . . . so I think it's good. (*continues to lead; signal that safety is permitting exploration*)
T: Let's take it one step further. . . . Tell me again: if you allow yourself to move out of your head, what does the experience of safety in the moment feel like? (*rooting new emotional reaction in bodily experience to solidify it*)

There is another noticeable shift here.

P: (*soft, slow tone; patient is herself discovering what she is feeling as she is communicating it)* It feels like . . . it feels like it doesn't matter what time it is . . . and it feels like it doesn't matter what I say because you can help me find the meaning . . . and it doesn't really . . . well, it feels like I don't have to lie for any reasons. And . . . that I feel quite comfortable doing what you ask me to when you ask me to. When you ask me to look at you, when you ask me to disconnect the logical reasoning function, I

don't feel bad about doing that. I don't feel like I am exposing myself. I don't feel exposed and I'm not scared of being hurt. (*corrective attachment experience*)

The patient's saying that in sharing her experience with the therapist she does not feel exposed and does not feel scared of being hurt clinches it: A corrective attachment experience is being forged. Her defenses and inhibiting affects are diminished and the first state transformation is effected. State 2 work can now proceed.

In the 90 or so minutes that elapse between vignette 3 and vignette 4, we explore the patient's long suppressed experiences of fear and anger that necessitated the building of a wall (composed of dissociative strategies, splitting, defensive self-reliance, and other defenses) for the protection of the self. In response to the terror of growing up with a psychotic mother given to unpredictable rages, and with a father threatening to abandon the family, from an early age she developed a split self and assumed a caretaker identity. Afraid to disrupt either parent, she used those defenses to maintain a happy façade. The patient shared several chilling experiences. Upon processing the emotions associated with one such episode, she realized with astonishment that she had just revealed the secret that no one was to know: that she had been deeply unhappy. The patient responded to my first metatherapeutic intervention, asking her how she felt sharing her secret with me. She said, "It feels liberating to not have the secret and not have to hide it." We rejoin the therapeutic process, an example of work with the metatherapeutic process of *traversing of the crisis of healing change*, and *the tremulous affects* that characterize it.

Vignette 4: Traversing the Crisis of Healing Change

P: It feels liberating to not have the secret and not have to hide it . . . .

T: If you let your body tell you a little bit what the feeling of liberation feels like? (*somatic exploration of the experience of transformation*)

P: (*eyes wide open, eyebrows raised, laughing, on the edge of surprise, fear)* Well, actually, now I am scared again in a different kind of way. . . . It's like a bigger feeling of fear, like . . . like I released something, untied a big knot, so there's more room for the fear to bounce around . . . and I opened up something . . . and . . . (*fear and the sensation of bouncing: tremulous affects in response to positive, but unexpected experience of change*)

T: (*encouraging*) And . . .

P: And it felt good. But now it feels really different and I'm not sure about what it means. . . . (*unsettled facial expressions, taken aback*) It feels *really* different. (*articulation of the subjective experience of quantum change*)

T: It's *really* different. (*mirroring intonation*)

P: (*eyes wide open, eyebrows raised, laughing*) Yes . . .

T: (*gentle, reassuring, open-ended tone*) OK. And it feels scary. . . . (*empathy*)

P: Yes. It feels really very scary and. . . . Yes, (*it feels scary*) both from going back and from being here, it feels different, and I'm not used to that. . . . (*empathy promotes coherent articulation*)

T: Right. And that's good. (*validation, valuing what is happening*)

P: It's like a big change. . . . I don't know. . . . The furniture in there has not been rearranged for such a long time. (*metaphor for the experience of change*)

T: For so long . . .

P: Because I decided how things were; I decided what my memories were going to be

T: So stay for a moment, OK? Stay with the feeling . . . the experience. . . . This is where you are a gift because you've got such huge capacity, so I know that I ask you these things and they seem a little crazy, but in a funny way. . . . (*affirmation; calling on patient's resources through self-disclosure of therapist's experience of patient resourcefulness; explicit statement of therapeutic intentions, and of explicitly asking consent to continue*)

P: (*giggles*) OK. (*consent given*)

T: . . . in a funny way, I can ask it of you. 'Cuz given what you've done . . . Stay with that experience of change, and I realize that there is fear attached to it, but let yourself at the very same time be very aware of my presence with you, of my not just witnessing it, but *being with you*. (*explicit urging to make use of attachment relationship in exploring something scary*)

P: Yes. (*green light*)

T: So what does that big change inside feel like? . . . What's the experience of it? . . . (*metatherapeutic processing: experiential exploration of the subjective and somatic aspects of the experience of change*)

P: (*arched back, hands behind her back tracing an upward movement*) Yes, it was like an upward feeling. . . . I felt something going up my spine. (*tremulous affect: upward sensation*)

T: (*interested, engaged tone)* Follow it. Follow it and let it speak. What was going up your spine? What was the sensation? (*inviting experience-specific language*)

P: (*soft tone, head cocked to one side, absorbed*) The sensation was of something relaxing that I didn't know was tense . . . and sort of unclenching a bit.

T: And the unclenching is where? (*precisely localizing somatic experience*)

P: All the way from the small of my back to here (*makes motions that illustrate her words)* It's really pleasant in a way that I feel slightly suspicious about, because that is new, too. (*shift from fear to pleasure upon articulation of sensation, though the pleasantness is disorienting and still evokes suspicion*)

T: Yes.

P: And, like, I also feel like I should. . . . I don't know about this change. . . . It happened really fast. (*eyebrows raised, on the border of apprehension and surprise*) I don't know. . . . (*the experience of quantum change is unsettling*)

T: I'm going to ask you something. . . . Tolerate it for a few more minutes while we explore it, and then we'll put it in context . . . then we'll give your brain something to do. . . . We won't forget about your wonderful mind. . . . Can you give us 5 more minutes of experience? (*making explicit therapeutic intensions, seeking explicit consent to continue, introducing structure through heralding the finiteness of the process*)

P: (*open face, soft smile, sincere*) I'll try. (*consent granted genuinely*)

T: It's scary?

P: It's scary to disconnect the frontal cortex. (*remember, the patient is a physician*)

T: (*really laughing; disbelieving tone*) . . . to disconnect the frontal cortex?

P: Yes.

T: (*big grin*) Uh-huh, all that executive stuff you put to the side.

P: Yes, go back into the limbic. . . . Actually now (*eyebrows up, head cocked to the side, pleased and surprised tone*) . . . it's starting to feel pretty good. (*from scary, through pleasant but suspicious to change's starting to feel good*)

P: It's like 2 minutes ago, I wasn't at all sure I liked it, and then it started settling down, rearranging itself a little bit, like the natural order, you know, like gravity. . . . (*articulation of the changing sensations of transformation; metaphors of steadying*)

T: It started to settle a little bit. (*mirroring*)

P: Like it's more symmetrical once again . . . (*new metaphor of order*)
T: And again, in the body what are you feeling, 'cuz you pointed to the belly? (*grounding new feelings in the body*)
P: Yeah, it's not bouncing around as much anymore. It seems like something I could learn to live with. Work with . . . a new set of order, maybe . . . It's still not totally comfortable, but it's starting to feel, not just overwhelming and frightening, but a little bit exciting. A little bit exciting. Like I have a whole new grip on it. I'm feeling . . . not exactly control. But some kind of faith that it will eventually settle down . . . I would like to not overcontrol it or force it, but sit back and watch it. . . . (*confidence and interest as fear morphs into tentative excitement; note increased capacity to articulate*)
T: And watch it a little bit. That's a beautiful way of describing it, that sort of like this train of sensation and experience that's moving . . . And I just want us to describe it, to share it with me, to notice it . . . and to notice the change quality. (*therapist not quite coherent here, but affect carries message of validation, valuing*)
P: Because it doesn't feel like it's all settled. . . . It's moving around, but it's not like this anymore (*makes turbulent movement*), but more like this (*calmer softer movement*). . . . (*change in experience of tremulous affects: shift in frequency of oscillating sensations*) Maybe more two-dimensional . . . and I am trying to figure out where I am going to go, where is my place . . . .
T: And where your place is within it.

We are witnessing fear transforming into excitement. Three aspects of the process deserve comment: (1) Collaborating through *making the implicit explicit* and through *asking for explicit permission to proceed* promotes the patient's sense of being in control of experiences that can feel out of control. (2) Connecting experience with its correlates in the body with words that do justice to the essence of the experience has a positive effect. (3) As each new and unsettling experience is attended to—through alternating waves of experience, somatic localization, and reflection—first, it settles; then it transforms, leading to a new experience, to which we attend next. The exploration of one sensation and its articulation begets another sensation. We are evoking a process of *cascading transformations*.

Through the patient's articulation of her experience of these cascading transformations, we gain access to the systematic regularity of the phenomena that seem to be part of the phenomenology of quantum healing change. We note a trembling, a sense of vibration or rhythmic oscillation, and a sensation of upward motion, all of which, when processed, transform and calm down.

The next round of metatherapeutic processing focuses on the relational aspects of traversing the experience of healing change, together with another. The patient had expressed appreciation for my professionalism, saying she felt good with me as a guide. We rejoin the process:

Vignette 5: Receptive Experiences of Attachment

T: First of all, thank you . . . and I appreciate what you're saying . . . a lot. . . . But can you take in that in addition to respect and professionalism and the sense of me as a guide, can you take in my affection? (*reintroducing attachment relationship; self-disclosure*)
P: Maybe . . . I'm not sure. (*honesty, direct communication*)

T: I know; I know; that's really pushing it. Let me just share something with you. Because just as you're experiencing this big change inside, and as you were describing it to me, I felt very touched and very moved by what we did together. I just felt this enormous rise of fondness and tenderness. (*self-disclosure of positive feelings; attachment a two-way street*) That's just what I felt.
P: I might be a little scared that if I like you too much, I will start saying things to please you and I don't want to do that. I am not sure that that is going to happen. It's just felt like sometimes I want to do what people I love and like, what they want me to do. (*Evidence of the depth of the therapeutic alliance: patient wants to make sure that her experience is authentic, not the result of compliance*)
T: I am glad you said that so that we can watch out for it. (*acceptance, validation*)
P: But I don't know. . . . But it's also part of the work, part of the job . . . I want to do well. (*charming, smiling, a bit shy, but very open*) I want to do well. I want to be like a success. (*positive vulnerability*)
T: Yes.
P: And sometimes . . . I don't want . . . I do want more to be honest with you than for you to think, oh, she's doing really good, you know . . . .
T: Well, you know, the fondness really comes from the connection and the connection really comes from the honesty and the sharing . . . and it made me very happy when you said "thank you" because I just had a sense that you took it in. (*with fears welcomed and respectfully considered, the path toward positive dyadic experience has just become safer*)
P: And I didn't try very hard; I just did. . . . (*receptive experience of attachment*)

The patient who dealt with fears of loss of control through the denial of all pleasures (e.g., food, friendship) can now tolerate taking in affection and nurturance. The early grimaces and postural contortions are long gone. She is relaxed and direct, even in articulating her fear and worries. Accepting her fear and anxieties instead of trying to talk her out of them has the paradoxical effect of alleviating them. The therapist meets the patient where she is. One transformation becomes the plateau for the next, and so on, until we get to core state (next vignette).

Vignette 6: Amazed, Peaceful, Calm, Curious

T: We should talk about how we proceed from this point, but does it feel OK to stop at this point?
P: Yes, it does. (*the patient is calm, clear-eyed, engaged*)
T: How does it feel to be able to have done what we've done? (*one last round of metatherapeutic processing*)
P: Well, this is the grown-up talking, and the part that doesn't want to run away . . . but I still can't believe I did it, and that we did it.
T: It's pretty amazing. So you feel proud?
P: Yes. I guess proud would be next, but right now I'm just amazed, I'm disbelieving, yeah, but not the bad kind of disbelieving. . . . And peaceful, I think, too . . .
T: That's good.
P: . . . and calm . . .
T: That's very nice.
P: And curious too about next time . . .
T: Let's see where we go next. . . .

Clinical Issues and Summary

The turbulence of the tremulous affects associated with traversing the crisis of healing change settles into the calm of core state. Two state transformations later, we inhabit a different world from the one where we started. The attachment relationship solidly in place ("we did it"), her capacity to experience pleasure reengaged ("I'm amazed"), the patient declares her positive anticipation of future work. Curiosity, the affective marker of the exploratory drive, moves to the fore in response to the prospect of new experiences, to fuel the growth-enhancing exploration of both inner and outer worlds.

The changes that took place in the initial session held and were augmented for the remainder of the therapy and thereafter. The eating disorder and depressive symptoms disappeared after this initial session and did not recur. By the end of the 20 hours of therapy many things were different. The patient's level of professional functioning was restored and isolative trends were largely reversed. Characterologically, the caregiver identity and the capacity to tolerate the experience of pleasure, especially in relational contexts, became restructured. Behaviorally, as she became increasingly aware of her tendency to accommodate the needs of others and detach from her own, the patient became increasingly assertive of her needs, wishes, and preferences.

A telling series of incidents occurred toward the end of treatment when, in the context of relocating, the patient was dealing with issues of separation and good-byes, both in sessions and in her life. She told me with pride that she had not only accepted the offer of friends to help her move, but asked for help with a few additional tasks. Furthermore, she allowed her colleagues to give her a good-bye party. She was able to tolerate hearing how much she was valued, and how much she would be missed. In turn, she was able to be vulnerable and share with her colleagues how hard it was for her to say goodbye.

A spontaneous e-mail a year or so after treatment ended provides some follow-up. Her gains continued to hold, and there was no symptomatic relapse. Her struggles at that time involved her marriage, but she expressed confidence that she and her husband, who enjoyed singing together, would see their way through them. In reference to the caregiver and pleasure issues, she wrote: "I've been very selfish these past few months and enjoyed it, but any longer and it would become self-indulgence and sloth." She also offered an observation: "What amazed me so very much, from the very start, was how you read my body language. Sometimes I could feel myself being read, not only eyes and face, the way most people do, but every movement and nonmovement. The body can't lie."

The moment-to-moment tracking of fluctuations in bodily-based emotional experience is indeed one essential key to the relative rapidity and effectiveness of emotion-focused treatments. Having an intimate knowledge of phenomena and their naturalistic course of unfolding enhances the therapist's ability to track and stay present. The description of the process of traversing the crisis of healing change and the tremulous affects that mark it contributes to the map that allows therapists to assess better where they are relative to where they want to go. The more precise the map, the more efficient the course to the final destination.

The combination of a well articulated phenomenology, with elaborated strategies of interventions, tailored to the state characterizing the clinical moment in the context of a healing-oriented, attachment-based framework is what AEDP contributes to time-conscious emotion-focused treatments. These factors synergistically provide a setting in which the intrinsic healing power of adaptive emotion can be released and harnessed in the service of the patient's healing.

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