1

Transforming Trauma Together with Emotionally Focused Therapy

All of us, at some time in our lives, need the help of others to deal well with our vulnerabilitiy. Life is trouble, the Buddhist teacher Jack Kornfield reminds us. It is also inevitably an encounter with terrifying uncertainty and loss. For the lucky few, these moments are fleeting and melt into a mosaic of comfort and confidence—our frailty becomes manageable. But for many, they morph into a dragon that stalks our dreams and hijacks our waking hours.

People often seek out the help of a therapist in these times, when their emotional pain can no longer be endured or when their way of coping with this pain becomes a problem in itself. In session, Ellen tells her therapist that she is so numb that she is hardly alive, and her only emotion is "irritation." Sunita says she is paralysed and caught in a state of constant planning and rumination interspersed with panic attacks, especially when she thinks of interacting with people. Dealing with human dilemmas around vulnerability is a therapist's stock in trade. Clients vary wildly, of course, in their resources, level of resilience, and the nature of triggering events in their lives. The most natural healing arena for any trauma is in the arms of someone you love, but many of us are still searching for that someone or do not know how to let supportive others in. There are limited ways to cope with human frailty. If not seeking to be seen and held, then we pray, meditate, exercise, recite poetry that adds meaning to a moment, write in a journal, or seek a wiser other: priest, seer, celebrity, or therapist.

In general, mental health professionals' increasing focus on traumatic events and their echoes as core mechanisms of mental and emotional problems seems to represent a shift from a key focus on inner personality

factors to a greater acknowledgment of the impact of external events. This is especially true with relational dramas where we are starved of the safe emotional connection with another that we all long for. A popular book, *What Happened to You?: Conversations on Trauma, Resilience, and Healing*, suggests that the key question for those struggling in the wake of traumatic experiences may not be "Who are you inside?" but "What happened to you?" (Perry & Winfrey, 2021). Attachment science suggests that many so-called dysfunctional responses are, in fact, not personality flaws but distortions of natural positive coping responses to impossible situations, where a truly functional solution to annihilating vulnerability was not to be found. These dysfunctional responses become habitual and automatic, and, literally, create a trauma trap, that is a pattern of triggers and coping responses that perpetuate emotional problems and prevent growth.

Henny described her life as a "whirlwind" and indeed, she spoke very fast, moving from story to story and from childhood to recent events in an intellectualized, haphazard way that was very difficult to make sense of. In initial sessions, she and her therapist struggled to piece together key events and timelines for childhood experiences and for more recent events, including a breakup. Most of the first 10 sessions were spent in empathic reflection mode, clarifying key moments in Henny's emotional life and how she dealt with these moments, and also the patterns in how she engaged with others in her life.

For most of us the word *trauma* conjures up an image of an overwhelming, life-changing event or a series of events that induce terror and helplessness—an emotional reaction that is burned into the nervous system of the victim and cannot help but have a lasting impact. The word itself comes from a Greek word meaning "to wound." This encounter with intense helplessness often shifts the existential axis of our world, imprinting us in a way that irrevocably shapes and changes how we see life itself and our sense of who we are, especially our sense of control, worth, and competence. *Traumatic experience is not just painful, it changes how we engage with ourselves and our world*. Some of us can integrate and grow from this experience, but some of us become stuck in recurring darkness. For these latter folks, what felt predictable becomes random, what felt safe becomes imbued with threat, what was manageable becomes a tsunami, what was potentially tolerable becomes a frantic search for escape.

WHERE ARE WE NOW IN OUR PERSPECTIVE ON TRAUMA?

Our view of trauma and the chaos it brings in its wake has changed. As Bessel van der Kolk notes in his splendid book on trauma, *The Body*

Keeps the Score (2015), "We are on the verge of becoming a trauma-conscious society." It is hard to remember that only a couple of decades ago, psychology textbooks would note that trauma was something that happened to only 1% of people, and the formal diagnosis of posttraumatic stress disorder (PTSD) was relatively rare. We now know that, in fact, up to 70% of us will experience at least one traumatic event in our lives, and many of us may go on to develop some or the full gamut of stress disorder symptoms and to be formally diagnosed with PTSD. In the course of a lifetime, 1 in 13 people will likely develop mild to severe PTSD, often with accompanying symptoms such as chronic depression. For some kinds of trauma, such as rape, these numbers are much higher—almost half of these clients go on to display full-blown PTSD. We have also become increasingly more aware of the devastating effects of early trauma, often called *developmental trauma*. Such wounds are most often inflicted by those who a child counts on for security and nurturing. The experience of suffering such wounds often results in what most clinicians call *complex PTSD*. Just a superficial glance at these effects, such as ongoing difficulties in trusting others and a deep fear that one is somehow contaminated, defective, and at fault, gives us a sense of how such trauma can undermine the very basis of any competent or acceptable sense of self.

We seem to have come full circle from minimizing the extent of traumatic experience to recognizing just how common traumatic experience is. We are also recognizing how many people encounter a cascade of traumatic experiences, beginning in childhood (Felitti et al., 1998), that sap physical and emotional vitality and render us more susceptible to ongoing trauma in adulthood.

The general public awareness of trauma and its impacts has changed significantly in the last decade, from a focus on pathology (the reification of the stance, "If you can't get over it then there is something wrong with you"), to a more *existential focus*. Specifically, experiences such as random violence, rape, childhood abuse of all kinds, the wounds of war and those of first responders, as well as traumas due to repeated discrimination, rejection, and abandonment, are now widely recognized as toxic, ubiquitous, and potentially self-perpetuating in nature.

As clinicians, we see how traumatic experience assaults our fragile sense of order and control, and pushes us headlong into a dance with the four existential demons that we all face (Yalom, 1980): the terror of death, along with a sense of our finiteness and the inevitability of loss; the need to shape meaning—a sense that one's life matters—into a short and often seemingly random life path; the dilemma of making choices when uncertainty and threat are everywhere; and the fear of isolation and not mattering to others. Amy tells her therapist, "I can't sleep, even now, 20 years later. I need all the lights on and noise. Those nights

locked in my room, alone in the dark as a child, were like death. What is the point? I can't escape this . . . this . . . horror. It comes for me. So, I don't eat and that helps me numb out. I want to connect with people but can't do it in the end. I hide in fear. I am always alone, and the more alone I feel, the more I hide."

We are also now recognizing the multidimensional nature of the impacts of trauma, both acute and chronic developmental trauma, and how it underlies and primes many other problems, such as addiction, chronic depression, and anxiety disorders. Some 70% of those diagnosed with PTSD also meet the criteria for serious depression. In short, our understanding of the phenomena of trauma and the injuries it inflicts has mushroomed in the last decade (Winfrey & Perry, 2021). Research has shown us that trauma creates huge difficulties in being able to deal with, grasp, and accept one's emotions. Pierre Janet, one of the great pioneers in the trauma field, defined PTSD as a disorder of "vehement emotions." In general, it is accepted that "stress exposure is an inherently emotional experience and an individual's ability to regulate their emotional response plays an essential role in their susceptibility or resilience to adversity" (Freidman et al., 2021). Traumatic experience also narrows attention, negatively impacting effective information processing and the maintenance of a coherent perspective. Attention is constrained by a constant vigilance for threat, as is the creation of a confident and competent sense of self. All of which, of course, get in the way of being able to explore, learn, grow, and adapt to new situations—that is, to leave the trauma in the past and live actively in the present. In our session, Ellen acknowledges, "I don't really take in much. I am on autopilot. I just check my body for signs of panic and watch for danger around every corner, in every face."

In the last two decades we have also learned much about the nature of resilience and the factors that can protect us from the pernicious effects of traumatic experience. We can note general personality factors such as optimism and openness to experience (Bonanno et al., 2011), as well as a sense of meaning and purpose in life, and a commitment to religion and spirituality. The two factors that really stand out are, again, the ability to regulate emotion and the presence and quality of supportive social networks—especially the felt presence of an attachment figure with whom a person has a sense of secure connection. It is the factor of having the support of a secure attachment figure that predicted resilience in the survivors of the 9/11 tragedy in New York (Fraley et al., 2006). In fact, secure bonds with others appear to predict better mental health and a lower susceptibility to every psychological disorder!

The most pressing question in the field now appears to be, "How do we begin to effectively heal the aftereffects of traumatic experience?"

We know that some factors, like physical activity and exercise, can help modulate stress, down regulating the nervous system, increasing compounds that affect mood like dopamine, and decreasing stress hormones, like cortisol (Averill et al., 2021). But the question still remains, "What is necessary and sufficient to get to the heart of the matter and significantly transform or bring closure to the echoes of trauma?" What must happen for Henny, sexually and physically abused by her father in her youth with no recourse or island of safety, to be able to access the core of her trauma, tolerate it, and move into and through it in a way that changes her relationship to her dreadful history, and also the relationship to herself and to others?

HOW DO WE BEST TREAT TRAUMATIC STRESS?

Even with the increased attention the field has given to trauma and its impact on human beings, the key question of how to help people heal from trauma is still hanging in the balance. There are a myriad of different interventions to address various elements that are viewed as maintaining posttraumatic symptoms and blocking movement into growth and resilience. However, the core, necessary, and sufficient factors that determine recovery, that offer the promise of a sense of competence in managing threat and closure to past wounds, are still vague in much of the psychological and psychotherapy literature. People tell therapists that they spend their lives doing yoga and mindfulness practices, acupuncture and exercise programs, which all help to reduce stress and awaken their bodies, but they still cannot break the tenacious grip that trauma has over their emotional realities, their minds, and their relationships.

It is useful to consider the difference between different levels of change. The Austrian biologist, Ludwig von Bertalanffy, who wrote in the 1960s about how living systems worked, suggested that there are two levels of change. First-level change modifies various individual elements or parts of a system, such as building specific muscles in someone's legs or finding a more positive thought to replace a negative one, perhaps reducing the stress hormone, cortisol. Second-level change, on the other hand, addresses the organization of the system as a whole and involves a reorganization of self-maintaining patterns and ingrained habits into a new whole. This concept really helped me (Sue), as a crazy young graduate student, to sort through all kinds of changes in client symptoms that different models of therapy measured, and to keep asking the question "What are the core elements that *have* to change to really make a difference to this client?" This sparked an even bigger question: "What kind of change is the therapist really supposed to go for—a reduction in

symptoms, less negative thoughts, or maybe even a more fully flexible, growing and alive client?" The last answer seemed pretentious, at the time, but after 35 years of practice and research in emotionally focused therapy (EFT), for couples (EFCT), and for individuals (EFIT), perhaps we can, after all, now embrace it.

How do we grasp the core organizing elements that we need to focus on to transform the echoes of trauma? Do we look at labels from the American Psychiatric Association's DSM-5-TR or from the World Health Organization's ICD-11? These labels tend to be abstract and confusingly overlap. If, instead, we stay close to our traumatized clients, how do they describe their experience? Again and again, we hear:

- *Despair about ongoing, overwhelming emotional pain that cannot be managed.* Clients repeatedly tell us, "I am in chaos, always overwhelmed; all these negative feelings hijack me. I cannot tolerate this or find a way to make sense of it. I spend my whole life trying to shut down my inner demons." Fear predominates here to the point where this emotion is scary in itself. Sarah says, "I cannot count on me at all. If I get triggered, I lose it."

- *Crushing emotional isolation and loneliness.* Statements like the following abound: "I am so alone." "I am unseen, invisible." "Nobody cared or cares about me." "I am not important." "I do not matter to anyone." Sadness and longing are the dominant emotions here, often hidden beneath anger or apparent indifference. Negative cognitive models of others also make opening up impossibly risky. Tara says, "My husband loves me. He is great. But when I am upset, I just barricade myself in my room and shut him out."

- *The negative self-sustaining impact of trying to cope with the above experiences on meaning making and sense of purpose.* Saul states, "I am empty. I am so frozen most of the time. I am shut down or just watching for danger cues to the point that I am hardly alive. I live in a fog, numbed out or preparing for the next freak out. There is no point to my life."

- *The lack of connection with a coherent acceptable sense of self.* Amy tells us, "I am crazy. Just so defective and damaged. How did I let these things happen to me? I hide out because I don't want anyone to see me. I don't want you to see me. You will think I am disgusting." Shame and self-denigration are a constant here.

Each of these negative emotional states builds on and feeds the others and induces helplessness and lack of agency. The result is a recurring

cascade—a treadmill of threat cues, emotional chaos triggering dysfunctional coping, and alienation from self and others. The impact of secrecy and stigma can also be added to the emerging picture here. It is worth stating that twice as many women get diagnosed with PTSD as men and the best predictor of PTSD is sexual abuse before the age of 18. As Ellen reminds her therapist, "I had to suffer in silence, to save the family. No one wanted to know about my pain, and when it was revealed, it was called a mistake. It was dismissed as unimportant, or I was questioned as to why I had 'let it happen.' Never mind that it started when I was 8 years old."

The key organizing factor in the ongoing set of processes that constitute PTSD, the patterned processes that must be modified in effective therapy, appears to be, first and foremost, the nature and dysregulation of compelling negative emotions. Modifying these processes first requires the creation of a sense of safe connection with a therapist—the supportive other who creates safety as the dragon roars into the client's view.

The second organizing factor that arises from these client's descriptions of their experience is a disturbance in identity, a negative (or incoherent) internal model of self. The self is seen as alien, not belonging with others, and unacceptable to others. Trauma survivors do not feel in charge of their bodies, cognitions, emotions, or interactions with others. This negative view of self often renders them incapable of making the open, safe connections with others that are key to the healing process.

So how does a therapist, in a series of therapy sessions, bring about these core second-order changes? All well-known and tested treatments seem to set up encounters or include some kind of exposure to traumatic memories. The purpose is most often stated in terms of helping clients discover that the trauma is in the past and now tolerable and assisting them in re-evaluating negative thoughts associated with the trauma. Descriptions of interventions such as prolonged exposure (PE), cognitive processing therapy (CPT), cognitive-behavioral therapy (CBT), and eye movement desensitization and reprocessing therapy (EMDR) can be found in the third edition of *Handbook of PTSD: Science and Practice* (Friedman et al., 2021). Some, such as CPT and CBT, focus, more than others, on challenging distorted thoughts arising from trauma. EMDR focuses on reprocessing toxic stored memories, theoretically, by using eye movements guided by the therapist's hands to help integrate these memories. With all assessments of improvement, there are issues due to factors such as whether treatment protocols are faithfully implemented and varying dropout rates. In clinical care, dropout rates seem to range from 38 to 68% (Kehle, 2016). Interestingly, the problem of emotion regulation seems to be mainly targeted by attempts to habituate clients

to fear and encouraging new thoughts, termed *cognitive reappraisal*. All of these approaches recognize that in those with PTSD, fear does not seem to extinguish with time, but in fact, generalizes, so that even objectively safe situations are seen as threatening, leaving people beset with increased vigilance for and sensitivity to threat.

Experts agree that PTSD is essentially an emotional disorder, and we suggest that, like depression and anxiety, PTSD fits with the specific outline of such a disorder as presented by behaviorist David Barlow and by EFIT. To experiential therapists such as ourselves, treatment based on those other approaches generally seems to skirt around emotion, rather than address it directly, and use its power to shape positive change. As Carl Rogers put it, all treatments, in some sense, try to "discover the order in experience." Most seem to do this from a cognitive distance, rather than accurately attuning to and diving into the client's lived experience and following what we refer to as "the hot trail of emotion" to get to the heart of the matter.

As we will present in this book, our clients show us that the core of change with traumatized people is captured by the tried-and-true phrase, a *corrective emotional experience*. This was coined by psychoanalyst Franz Alexander in the 1940s to identify the essential curative element in psychotherapy. Such an experience, an *emotional epiphany* if you will, does not simply expose or habituate clients to the key aspects of their trauma, or offer them insight or a coping technique. It restructures the experience—adding to it and configuring it in a way that leads to growth, rather than paralysis. This must be done in a way that sings to the emotional processing center of the brain and sends a message that the client's nervous system is biologically prepared to hear, will code as supremely relevant, and will hold onto. Such an experience restores emotional balance, elicits core emotions, and shapes a new *identity drama*—a new narrative of the self, a new way of seeing and connecting with the self. Saul, a war vet, shares, "I can name it and hold it in my hand now, all that self-disgust. I see that it is deep sadness and longing, really. I can even feel compassion for the solider who limped from the battlefield as a failure—a traitor. That is new—that is heresy for the old Saul, but does it ever feel good. I can believe in me again."

More than three decades of practice and research has taught EFT therapists how to target and shape these emotional epiphanies with consistency and precision. In our research, these events—captured on video, coded, and verified—predict shifts in both distressing symptoms, and in personality growth and resilience (Burgess-Moser, 2012; Dalgleish et al., 2015; Burgess-Moser et al., 2017; Spengler et al., 2024). They create a positive cascade of openness to experience, to self and others, and the ability to engage with and respond to new situations.

HOW DID WE DISCOVER THESE POTENT CORRECTIVE EXPERIENCES?

Earlier in my career, I (Sue) became obsessed with helping couples find a way through conflict to connection. This idea held my interest, perhaps because no one seemed to know how to do it, but also because it was like solving my parent's fights—the nightmare of my childhood and the tragedy of my father's life. However, I also saw individual clients, such as war vets suffering from flashbacks and depression. At a certain point, women diagnosed with a myriad of different disorders, began turning up in my office with horrific stories of childhood sexual abuse. Female partners in distressed couples also disclosed issues with intimacy and trust, arising from sexual abuse by men in their families of origin. My reaction was to be appalled, angry, and overwhelmed. What could I do to help these clients? The topic of early sexual abuse by fathers, uncles, and brothers, had never even been mentioned in my graduate program! I remember a severely anorexic client came to me who had been through the best treatment program in my city. She told me her history and, in a voice filled with pain, noted that she had shared her abuse in the program but that it had not been commented on. I was thunderstruck, but then I thought, "We don't know how to respond, how to help these folks, so we just screen this out—much as Freud did all those years ago in Vienna."

At the beginning of my recognition of this clinical need, the client who taught me the most was Paula. She came because every morning she had to walk across a bridge over a canal to get to work. In the middle of the bridge, she would be overcome with severe panic and become so dizzy that she had to literally crawl across on her hands and knees to get to the other side. She was also experiencing "rage storms" at her teenage daughter, and she admitted to regularly taking four times the maximum recommended amount of an antianxiety medication, given to her by her GP for her "nerves." I could not understand how she was even walking. As I focused on what happened on the bridge, she gradually revealed that the cars coming toward her felt like missiles about to smash into her and that the space under the bridge seemed to be hundreds of feet deep. She suggested that she was simply "crazy" and losing her mind. Already using the set of interventions that became the EFT model, I did all I could to help her feel safe with me and noted her strengths: She faced the bridge going to work every day and was competent in her job. She kept silent about these panic episodes and the strange images that kept her awake at night in an effort to "protect" her "kind" husband of 25 years and her teenage daughter from their impact. We noted places where she felt safe and relaxed—being in a hot bath with the door locked and

candlelight was her best refuge. She had finally confided in her sister, who told her to come to me, and she had found the courage to come! Her problems had worsened as her daughter grew up and reminded Paula of how she looked in early adolescence.

I began to feel my way into Paula's world—her emotional ups and downs, her descriptions of who she was, and her stories of her key relationships. When she talked about her upbringing, she seemed distant and vague, but when she mentioned her mother, she always brushed her hand across her body in what seemed like dismissal. Her family were very religious and her older sister was always destined for the convent, which she entered and stayed in for more than a decade. She noted that her sister had a deadbolt on the inside of her bedroom door, but there was no deadbolt on Paula's door. Her parents split up when she was about 13 and she had then lived alone with her mother with a series of lodgers. Her father had died when she was about 15. A little lost as to how best to help, I did what I was learning to do with distressed couples: I followed and stayed with the most powerful thing in the room, the emotion. I intentionally slowed and lowered my voice to offer a sense of comfort and acceptance, holding and regulating the emotion as I followed, reflected, and explored it with Paula. I already knew how to identify the key elements in the flow of emotional experience and merge them into a coherent whole, reaching for the pain under the reactive surface emotion, which was often anger or simply a numb emptiness.

I began to focus on her vague distant style as she talked about her childhood and the fragmented images that assailed her at night. She remembered, in vivid detail, the wallpaper in her childhood bedroom. This image brought waves of terror, and she began to piece together a sense of how she "went into" the pattern of the wallpaper to escape the "fire" in her body and the feeling of being pinned down. Specific memories now emerged in our sessions, such as being roughly picked up and washed in the kitchen sink by her mother, who kept shouting at her father, "How could you?" A clear picture of her childhood abuse by her father (and later by the various lodgers mentioned above) then emerged, together with her mother's inaction and inability to comfort or protect her. Paula taught me many things, but mostly she taught me to follow my mentors, Rogers and Bowlby, and to accept her truth as it unfurled. I thought we would spend much of our time dealing with fear in many forms. In fact, we spent most of our time grieving for her childhood pain, longings, and isolation. Together we also learned how to build islands of comfort as places of refuge. Paula's nightly bath became an elaborate ritual of calm and connection with herself. As I accepted and went into her pain with her, she began to feel less ashamed and

"contaminated," and became more emotionally balanced. She reduced her anxiety medication and found she could walk across the bridge to her workplace, looking ahead and reassuring herself all the way. She brought her husband into two sessions and told him what she had been struggling with all these years. She admitted that she had never actually been present in their lovemaking. She had always been in the wallpaper. They wept together and she was able to tell him how to hold and comfort her. Paula began to experience herself as competent, able to order and deal with her inner chaos and pain.

As we moved into the second stage of therapy, the restructuring of the patterns of emotional experience and the deepening of engagement in core emotions, it seemed natural to ask Paula to do a form of the "softening" conversations that we were finding so transforming in our couple therapy sessions (Johnson 2008, 2020). In these conversations, core vulnerabilities are owned and enacted in a relational context. In this case, the enactment was not with a partner as in couple therapy, but with the key attachment figures that were alive in Paula's mind and heart. We all have constant conversations with such figures, and it is in this context that we constantly decide who we are and how worthy we are. I had assumed that this new emotional experience, the new emotional music when turned into a dance with another, would involve Paula's father, but very often therapy does not move in the direction of confronting the abuser or those involved in the actual traumatic experience. As Paula moved into and through her grief at being abandoned and used, the terror and threat cues that still hijacked her, and her sense of shame, it was her mother that became alive in the room. Paula still looked for birthday cards from her now aged mother, but they never came. As Paula played out her now clear and coherent response to her mother's abandonment and denial of her pain, she became more assertive and confident. She ended up traveling across the country and confronting her mother in person, not expecting a healing response, but as a way of standing with the small, vulnerable part of herself that she had contacted and held and learned to value in our sessions.

By the end of therapy, Paula no longer had panic attacks or nightmares, could relate to her adolescent daughter on a different level, and confide in and receive comfort from her husband. I became more and more caught up in my quest to develop a truly effective couple therapy, to come up with a definitive solution to relationship distress and lack of secure attachment in couples. I learned so much and continued to practice with individual survivors until the pressure to explicate, write about, and research EFIT—how we helped people move out of the trap of trauma, anxiety, and depression—could no longer be resisted.

WHAT ARE THE CORE ELEMENTS IN TRAUMA RECOVERY?

What stands out from our observation of countless video sessions, clinical practice, and client stories is that recovery involves:

- A more open and deeper level of engagement in one's emotional experience, including the ability to access, tolerate, and ORDER this experience, increasing emotional balance and coherent information processing.
- Several increasingly significant, absorbing corrective emotional epiphanies that address the helplessness and loss provoked by the client's trauma. Inevitably, these emotional epiphanies address the core emotions of sadness and longing, shame and fear.
- A restructuring of the client's model of self into a new sense of competence, worth, and agency. This restructuring may be formulated as the creation of a secure sense of connection with a now accepted and acceptable self.
- The creation of more engaged and supportive relationships with others, including the ability to reach for others when vulnerable, to trust them, and be able to take in their reassurance.

However, to truly understand vulnerability with no solution and how to deal with it, we must first understand the nature of human fear. Attachment science offers us this understanding. It gives us a profound way of grasping human suffering that allows us to shape the pathway to further development and growth. The intervention technology acquired in the practice and study of EFT also gives us the specific tools to effectively work into and through that suffering, whether it is our own or that of others. This book will elaborate on both attachment science and the techniques of EFT.

WE HOPE TO INSPIRE YOU AS OUR CLIENTS HAVE INSPIRED US

We seem to mostly grasp enormous, multifaceted realities mainly through stories, images, and metaphors, so you will encounter many here.

A metaphor, taken from Celtic mythology, to capture the experience of trauma was previously used to open a book on EFT with traumatized couples (Johnson, 2002). In the Celtic stories, life is portrayed in dark terms indeed. This metaphor is about standing in a dark, narrow passageway with your back against a wall, facing a dragon. There is no

escape. For the Celts, a warrior people, the only question is how well you fight.

There is also a famous Buddhist story (Pema Chodron, 2002) that describes life in terms of a woman running from tigers. She runs but the tigers get closer. She comes to the edge of a cliff. She sees a vine, and climbing over the cliff, holds onto it. Then she sees that there are tigers below her as well. She then notices that a mouse is gnawing away at the vine she is holding onto. As she turns her head, she sees a beautiful clump of ripe strawberries growing just beside her. She looks up and down, and at the mouse. Then she reaches for a strawberry, pops it in her mouth, and enjoys it thoroughly.

Both stories paint dark threats and deep vulnerability as unavoidable. In existential terms, if we see it clearly, life is filled with terrors. We all face the same monsters. Some of us become consumed by these monsters. Nevertheless, many of us manage to deal well with these threats and various moments of fragility. We find ourselves able to access our strength and fight against overwhelming odds. We find ourselves still able to feel the sun on our face and to reach for joy. Our clients have taught us—and can teach all of us—how to find the strength to face the dragon of trauma well and how to reach past it for joy and aliveness.

In the first half of this book, you will learn how to understand traumatic experience through the lens of attachment theory and science—a science of how we get stuck in dark places and how we let in the light and grow. Attachment links our biology to the ways we see the world and dance with others, and that is a fascinating intellectual leap. There is a structure to our nervous system, to our emotions, and to the ways we deal with helplessness. Once we grasp the structure, it is easier to change it. You will also learn about how therapists using EFT tune into their clients and use a certain vision, a way of seeing, to kick-start change.

In Chapters 3 and 4, we offer a summary of what EFT therapists actually do in a session and how these interventions impact those who come for help. We hope these chapters will particularly appeal to health professionals, but we think it's relevant for all of us to know the techniques and moves that have been shown to help folks face dragons and emerge, not just intact, but whole. We share our clients' stories and offer you snapshots of therapy sessions to help you connect with these brave people and so learn from them as we have.

In the second half of the book, we will introduce you to clients facing different kinds of trauma and show you how therapist and client come together to transform the echoes of trauma on the level of emotional patterns, connection with others, and how the self is defined. We

know you will enjoy meeting them and that you will see yourself and your life in their struggles.

Finally, we will share with you what we see as the promise of the vision laid out in this book. This is the promise that resilience is our birthright and that there is a way home for any of us, once we find the path through the darkness and the mist.

We hope to inspire you, offer you hope, and maybe even capture your heart with our stories. We believe passionately in psychotherapy, which is a refined and deliberate elaboration on the natural healing power of safe relationships and the healthy ways our species has of facing overwhelming challenge and lack of control, and of reaching for aliveness in the face of impossible odds.

It helps us all to know how survivors grow and thrive, and how to aid them on their way. It helps all of us to know how to hold and grow the most vulnerable and wounded part of ourselves.