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“Learning is not only procedural but contextual. We rarely learn lessons that apply everywhere and at all times.”

On the Corrective Emotional Experience (continued)

The rejection of Alexander’s concept of the corrective emotional experience was likely the single biggest misstep in the history of psychoanalysis, and it took decades for psychoanalytic thinkers and therapists to recover. There were many reasons for this rejection—some, according to various accounts, having to do with Alexander having had an abrasive personality, some related to the politics and economics of psychoanalysis at the time, some related to an ideological commitment to insight as the crowning glory of the psychoanalytic method and hence to an aversion to Alexander’s point that insight often follows change, that it was the icing rather than the cake.

A more serious critique had to do with ways in which Alexander could be read as “manipulating” the patient, as taking a stance counter to that of the parents in a simplicistically mechanical way rather than as an organic outgrowth of the relationship and the perception of the patient’s needs. But as the presentations by my fellow panelists make clear, that is not a necessary implication of the concept. Most ideas in our field need to be refined over time. As Erik Erikson said about Freud’s libido theory, “True insight survives its first formulation.” Part of the rigidity of the psychoanalytic establishment was that even as they repeatedly argued for increasingly sophisticated understandings of the essence of Freud’s ideas, they insisted on a static, literal and constraining understanding of Alexander’s as a justification for their continuing rejection of his dangerous heresy.

As my fellow panelists highlight in different ways, deep therapeutic change depends not so much on what is put into words as what is learned in a directly experiential way. This does not make words and verbal learning irrelevant. Psychotherapy remains in important ways “the talking cure.” Even in the vast majority of cognitive-behavioral therapies, if one looks at what is going on, the two people are talking. Human linguistic capacities are not checked at the door of the consulting room like guns in the saloons of some Western movies. Those capacities are essential to even identify and define the nature of the problems to be addressed. They are essential to establishing the relationship that is at the heart of the corrective emotional experience. And they help consolidate and extend the largely nonverbal emotional and relational learning that the corrective emotional experience generates. But it also the case that both in traditional psychoanalytic practice (especially in the older versions that preceded contemporary more relational models) and in aspects of cognitive therapy, there is an overemphasis on and an overvaluation of words. Put differently, both place too much emphasis on declarative, explicit learning and insufficient emphasis on procedural or implicit learning (which contemporary neuroscience shows us constitutes the vast preponderance of what our brain does).

But it is essential to be clear that the learning is not only procedural but contextual. We rarely learn lessons that apply everywhere and at all times. Put in the terms of learning theory, both stimulus generalization and stimulus discrimination are universal attributes of any successful species. Without being able to generalize something learned from the specifics of the context in which it is originally learned to a broader set of cues, learning will be ineffective and of little use, and adaptation becomes almost impossible. But species that survive are also able to discriminate between situations, to learn where opportunities are present or absent and where it is safe or unsafe. Without that ability, survival for very long is also impossible. But many approaches to psychotherapy—in virtually all the major theoretical orientations—are problematically overweighted toward generalization. They implicitly assume that the relearning that occurs in the session will automatically be applied throughout the person’s life space. In essence, they assume that the relearning is context-free, that when the patient has had a deep and powerful disconfirmation of problematic assumptions in relation to the therapist, that lesson will now be applied in all contexts and all relationships. What gets short shrift is the importance of corrective emotional experiences with people other than the therapist—and the range of further therapeutic efforts and skills required to ensure that this happens.
On the Corrective Emotional Experience (continued)

There are several reasons why it is easy to lose track of the importance of this dimension of the change process. To begin with, in recent years, it has become increasingly apparent that the therapeutic relationship in itself is a key element in therapeutic change. In formal studies, it often accounts for more of the variance in whether change occurs than does the therapist’s theory or the specific techniques used. In addition, the experience with the therapist in the room is particularly vivid, and so easier to track, notice, and work with. And in recent years important concepts such as Safran and Muran’s conception of rupture and repair in the alliance and the Boston Change Process Study Group’s work on now moments and moments of meeting have further illuminated how events transpiring in the therapeutic relationship can have a direct impact on therapeutic change.

But more fundamentally, these and related developments point to not only the importance of the therapeutic relationship per se but of the relational nature of personality more generally. Our personality is not monolithic or just “in our head.” We experience ourselves differently in different relational contexts. We are not like machines needing to be structurally repaired and then simply able to leave the shop and function. We are sensate, interacting, meaning-making creatures, and our experience must always be understood in relation to the people and events that inhabit and define our lives. When we conceptualize change as deriving substantially from corrective emotional experiences, rather than exclusively from insights or cognitive restructuring, we are building on that relational foundation.

When we learn, from interactions with the therapist, that things can be different, we have learned a relational lesson, a contextual lesson. And more often than is appreciated, the (unverbalized) lesson ends up as “wonderfully, in here it is safe to be myself, to express my deepest yearnings or my most unpleasant thoughts or demands; but outside of this room things remain as they were.” The therapist may be struck by the vivid evidence of the patient changing right before her eyes, and this shiny object may obscure that in the rest of the patient’s life he remains largely the same.

The discrimination the patient makes between the “safe” confines of the consulting room and the “not so safe” contexts in the rest of his life can lead him to act outside the room the way he always has—and thus to evoke the same responses from others, and thereby to “prove” to himself (again mostly without words, or even focal awareness) that what happens in the consulting room is different from what happens in the rest of his life. The self-perpetuating vicious circles in the patient’s daily life must be interrupted and modified if the change the patient entered therapy to achieve is to become an enduring reality in his life. What happens with the therapist is a crucial part of the process; but working to ensure that corrective emotional experiences occur with others as well is the key to generating the change for which the patient has come in the first place.

Memory Reconsolidation Research Confirms and Advances the Corrective Experience Paradigm

Bruce Ecker

For adherents of the corrective experience paradigm, the findings of memory reconsolidation research by neuroscientists might seem too good to be true. That research, launched in 1997–2000, has developed explosively since I began closely studying it in 2005. According to some of the clinical field’s longstanding, ingrained assumptions about change, these lab findings aren’t even possible.

For example, Hebb’s law—“neurons that fire together, wire together”—underlies the assumption that in order for healthy new beliefs, behaviors and states of mind to replace old, unhealthy ones, it’s absolutely necessary to enact repetitions of the new pattern for months. The preferred new pattern competes against the unwanted pattern, which remains retriggerable and retains its own memory encoding. The myriad repetitions build up the preferred new pattern to win that competition.
On the Corrective Emotional Experience (continued)

That’s what I term the counteractive process of change. It requires the ongoing effort of choosing and enacting the preferred pattern. However, a decisive, stable change proves elusive through this counteractive process, as therapists know too well. Relapses occur because the old, unwanted pattern is rooted in potent, subcortical emotional learnings that are influenced little, if at all, by the preferences of the neocortex (the conscious personality).

Therapists also know—because we have witnessed it in clients and in ourselves—that a very different process of transformational change exists, manifested as three unambiguous markers: a long-term pattern of distress or problematic behavior completely ceases to occur in the situations that had reliably evoked it; the accompanying emotional activation or distressed ego state likewise disappears; and those two changes persist permanently and effortlessly. This liberating, relatively sudden shift brings unprecedented well-being.

The corrective experience (CE) paradigm is essentially the quest to identify the critical ingredients and process that produce such transformational change. What could be more important to the psychotherapy field than fulfilling that quest, enabling therapists everywhere to produce such results with regularity?

Alexander and French first gave that quest firm form in 1946 and, based on clinical observations, identified specific factors for inducing transformational change. Then Goldfried in 1980 recognized the universality of those specific factors across therapy systems and also across all experiential channels, beyond the “emotional” channel emphasized in 1946. Many others have continued to develop the CE paradigm.

Transformational change clearly is not governed by Hebb’s law. What is the neurological mechanism of change that does govern it, and what induces that process?

We now have empirical answers to those key questions. Memory reconsolidation is the brain’s innate process for transforming what was previously learned and is now carried in memory.

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Nearly a century of extinction research appeared to show that wasn’t possible. Researchers finally happened to do exactly what the brain requires for neurochemically changing the neural encoding of an emotional learning from its stable, “consolidated” state in long-term memory, to a destabilized, de-consolidated, labile state that is susceptible to immediate re-encoding by a contradictory, disconfirming experience.

However, if the target learning is not in a de-consolidated neural state when the disconfirming experience occurs, there is no re-encoding of the target learning. Then the contradictory experience merely creates its own separate encoding and competes against the unwanted target learning. Sound familiar? Yes, that’s counteractive change, and that’s why guiding our clients to learn and build up preferred states, beliefs and behaviors tends to be only counteractive and is not a reliable pathway to transformational change.

The discovery of an innate process of de-consolidation was an upheaval in the neuroscience of learning and memory. It was found that the de-consolidated state lasts for about 5 hours, after which the neural encoding re-consolidates automatically. That’s why this process was named memory reconsolidation (MR).

It took neuroscientists four more years, until 2004, to identify the specific experiences required by the brain for triggering de-consolidation. The MR process is neurological, but it is experience-driven, controlled in a top-down manner by behavioral experiences. It was Héctor Maldonado’s group in Argentina that first demonstrated, in an animal study, that de-consolidation is triggered by the simultaneous occurrence of two subjective experiences: the experience of the reactivated target learning, plus an experience of perceiving that the world is not as the target learning knows and expects. That combination of experiences is referred to as memory mismatch and also as prediction error by neuroscientists. De-consolidation is almost immediate after mismatch occurs. The mismatch requirement was subsequently confirmed many times (see references online: https://bit.ly/2b81bH). Those studies decisively falsified the pre-2004 notion that de-consolidation occurs from reactivation alone, and from every reactivation. That misconception still shows up in the literature.

Do these lab findings apply to psychotherapy? The fact is, the necessity of a mismatch experience for inducing...
transformational change was detected by psychotherapists long before neuroscientists recognized it: The both-at-once experience of the reactivated target learning and a disconfirmation of it is a specific ingredient called for by Alexander and French. Now we have rigorous, empirical confirmation of that requirement from brain science.

We call it a juxtaposition experience in Coherence Therapy, which I co-developed with Laurel Hulley for focusing from the first session of a new client on facilitating juxtaposition experiences with efficiency. We and colleagues in the Coherence Psychology Institute have published many case examples showing the three markers of transformational change ensuing from juxtaposition experiences, for a wide range of presenting symptoms (references listed at https://bit.ly/2tKXdY). Neuroscientists regard these three markers as strong evidence that MR and erasure have occurred. In many cases, powerful, lifelong emotional learnings completely wither immediately, sometimes as early as the client’s first or second session. In other cases, the target learning does not immediately lose all force in response to a juxtaposition experience because it is entangled with other potent schemas not yet disconfirmed.

From extensive clinical experience with this process, it’s clear to us that the brain is always equipped for unlearning and nullifying its longstanding, negative emotional learnings. That is an innate, profound resilience. The fact that target learning reactivation is required explains why emotional arousal has been found to have a strong, positive correlation with effective therapy: While not all of a person’s implicit learnings are emotional, the ones involved in therapy almost always are, so reactivation naturally entails experience of that accompanying emotion. The task of skillfully guiding the emotional process can therefore loom large in therapy, even though the MR process does not itself inherently involve or require emotion, as shown in many lab studies using non-emotional target learnings.

To utilize the potency of MR, therapists have to meet the brain’s requirements by facilitating a disconfirmation that is both experiential and highly specific to the client’s unique target learning. Specificity of disconfirmation is critical. That’s another key guideline for therapists. For example, the therapist’s empathy and kindness can disconfirm the emotional learning maintaining a client’s symptom if that emotional learning was created by interpersonal mistreatment, but not otherwise; and not every type of interpersonal mistreatment creates learnings disconfirmable by a client-therapist relationship. In Coherence Therapy we’ve mapped out a methodology for finding potent disconfirmations of any target learnings.

It is momentous that the psychotherapy field now has an empirically confirmed process of erasure (ECPE), the set of specific experiences that the brain requires for transformational change. The ECPE is defined transcategorically and independently of any procedures or methods for inducing those experiences. No type of therapy is privileged (though not all facilitate the ECPE equally). We’ve been examining case examples of transformational change from diverse therapy systems and have found that the steps of the ECPE are detectable in every case scrutinized so far (ten different systems; see https://bit.ly/15Z0HQ). In that way, support is building for our hypothesis that the ECPE is always the cause of transformational change and unifies the panoply of psychotherapies.

Also, by providing empirical confirmation that specific factors are necessary for transformational change, the MR findings are a direct refutation of non-specific common factors theory. That does not mean non-specific factors are unimportant for effective therapy. The point, rather, is that transformational change results from certain specific factors required by the brain.

A comprehensive, rigorous account of all this good news and more is provided in my recently published journal article, “Clinical Translation of Memory Reconsolidation Research,” downloadable here: https://bit.ly/2Mmmwg1.