

Bruce Ecker, Robin Ticic, and Laurel Hulley

Unlocking the Emotional Brain



Memory Reconsolidation
and the Psychotherapy of
Transformational Change

SECOND EDITION



“Ecker, Ticic, and Hulley have outdone themselves in expanding and enhancing a book that is already considered by many a modern classic in the field. The first edition of this book influenced countless therapists around the world. I suspect this second edition is destined to have an even greater impact.”

Alexandre Vaz, PhD, *director of training, Sentio Counseling Center, and editor of the APA series The Essentials of Deliberate Practice*

“The first edition of *Unlocking the Emotional Brain* has been widely and rightly celebrated for its groundbreaking, integrative clinical framework, and this new edition offers the reader all that and even more. All psychotherapists and clinical researchers can find tremendous value in the clarity of this book’s teaching of the therapeutic power and unifying reach of memory reconsolidation. With its publication, the field of psychotherapy has made a significant, evolutionary, and transformative leap forward.”

David S. Elliott, PhD, *co-author of Attachment Disturbances in Adults*

FROM THE FIRST EDITION:

“Truly a revolutionary book.”

Jaak Panksepp, PhD, *founder of the field of affective neuroscience, Emeritus Professor of Psychology at Bowling Green State University*

“Beautifully written, the authors present an elegant integration of neuroscientific findings and psychotherapy technique, resulting in a step-by-step method for relieving longstanding symptoms and suffering. Even the most seasoned clinician will be inspired to learn from these masters.”

Patricia Coughlin, PhD, *clinical faculty at the University of New Mexico School of Medicine, author of Maximizing Therapeutic Effectiveness in Dynamic Psychotherapy*

“*Unlocking the Emotional Brain*... brings the recent ground-breaking brain research on memory reconsolidation to the mental health field... This is the first psychotherapy book to delineate the sequence of experiences the brain requires to heal. No matter how good a therapist you already are, reading this book will make you better.”

Ricky Greenwald, PsyD, *founder/Director, Trauma Institute and Child Trauma Institute, author of EMDR Within a Phase Model of Trauma-Informed Treatment*

“A transtheoretical, effective and efficient approach... for deep, transformational change in pernicious emotional implicit learnings... This is a significant ‘breakthrough’ book.”

Michael F. Hoyt, PhD, *author of* Brief Psychotherapies:
Principles and Practices

“A refreshing and audacious book that throws open the doors and blows the dust from the corners of clinical practice... [T]he authors... add a startlingly effective process to the repertoire of every clinician [and] build powerful alliances across clinical approaches...”

Ann Weiser Cornell, PhD, *author of* Focusing
in Clinical Practice: The Essence of Change

“*Unlocking the Emotional Brain* is destined to be a landmark publication... I’m sensing an emerging consensus in the field of psychotherapy... I think memory reconsolidation and this book could be the hub around which the various approaches unite... It is essential reading for therapists of all stripes...”

David Van Nuys, PhD, *Emeritus Professor of Psychology,*
Sonoma State University

Unlocking the Emotional Brain

This highly influential volume, now in a much-expanded second edition, delivers major advances for psychotherapy, all empirically grounded in memory reconsolidation neuroscience. A great increase of therapeutic effectiveness can be gained, thanks to a clear map of the brain's innate core process of transformational change—a process that does not require use of any particular system or techniques and is therefore remarkably versatile. Twenty-six case examples show the decisive ending of a vast range of major symptoms, including depression, anxiety, panic, shame, self-devaluing, anger, perfectionism, alcohol abuse, sexual aversion, compulsive eating and obesity, paralyzed self-expression, and teen ADHD—all transformed through deeply resolving underlying disturbances such as complex trauma, lifelong oppression by systemic racism and homophobia, childhood sexual molestation, parental narcissistic domination, violent assault trauma, natural disaster trauma, and childhood traumatic aloneness and neglect. This is a transdiagnostic, transtheoretical, lucid understanding of therapeutic action, based, for the first time in the history of the psychotherapy field, on rigorous empirical knowledge of an internal mechanism of change, and it achieves a fundamental unification of the confusingly fragmented psychotherapy field: diverse systems no longer seem to belong to different worlds, because they now form a wonderful repertoire of options for facilitating the same core process of transformational change, as shown in case examples from AEDP, Coherence Therapy, EFT, EMDR, IFS, IPNB, ISTDP, psychedelic-assisted therapy, and SE. It's now clear why therapy systems that differ strikingly in technique and theory can produce the same quality of liberating change. Practitioners who value deep connection with their clients are richly rewarded by the experiential depth that this core process accesses, where no awareness had previously reached, whether sessions are done in person or via online video. It is an embarrassment of riches, because in addition we gain the decisive resolution of several longstanding, polarizing debates regarding the nature of symptom production, the prevalence of attachment issues, the operation of traumatic memory, the functions of the client–therapist relationship, the role of emotional arousal in the process of change, and the relative importance of specific versus non-specific factors.

Bruce Ecker, MA, LMFT, is Co-Director of the Coherence Psychology Institute, co-originator of Coherence Therapy, and co-author of the *Coherence Therapy Practice Manual and Training Guide*, *Depth Oriented Brief Therapy: How to Be Brief When You Were Trained to Be Deep and Vice Versa*, and *The Listening Book*.

Robin Ticic, BA, HP Psychotherapy (Germany), is Director of Development and Training for the Coherence Psychology Institute, co-author of *The Listening Book*, author of the parenting guide *How to Connect with Your Child*, and a certified trainer of Coherence Therapy.

Laurel Hulley, MA, is co-originator of Coherence Therapy, Director of Education for the Coherence Psychology Institute, co-founder of the Julia Morgan School for Girls, and co-author of the *Coherence Therapy Practice Manual and Training Guide* and *Depth Oriented Brief Therapy: How to Be Brief When You Were Trained To Be Deep and Vice Versa*.

Unlocking the Emotional Brain

Memory Reconsolidation and the
Psychotherapy of Transformational Change

Second Edition

**Bruce Ecker, Robin Ticic,
and Laurel Hulley**

Second edition published 2024
by Routledge
605 Third Avenue, New York, NY 10158

and by Routledge
4 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

*Routledge is an imprint of the Taylor & Francis Group, an informa
business*

© 2024 selection and editorial matter, Bruce Ecker, Robin Ticic, and
Laurel Hulley; individual chapters, the contributors

The right of Bruce Ecker, Robin Ticic, and Laurel Hulley to be identified
as authors of this work has been asserted in accordance with sections 77
and 78 of the Copyright, Designs and Patents Act 1988.

All rights reserved. No part of this book may be reprinted or reproduced
or utilised in any form or by any electronic, mechanical, or other
means, now known or hereafter invented, including photocopying and
recording, or in any information storage or retrieval system, without
permission in writing from the publishers.

Trademark notice: Product or corporate names may be trademarks
or registered trademarks, and are used only for identification and
explanation without intent to infringe.

First edition published by Routledge 2012
Classic Edition published by Routledge 2022

Library of Congress Cataloging-in-Publication Data
A catalog record for this title has been requested

ISBN: 978-1-032-13913-5 (hbk)
ISBN: 978-1-032-13912-8 (pbk)
ISBN: 978-1-003-23143-1 (ebk)

DOI: 10.4324/9781003231431

Typeset in Times New Roman
by KnowledgeWorks Global Ltd.

For all who help others dispel the
thick mirages of emotional learning,
escape the prison cells of memory,
and enjoy the inner freedom to live
as their truest self

Contents

<i>List of Symptoms Ended in this Book's Case Examples</i>	xv
<i>Foreword by Alexandre Vaz</i>	xvi
<i>Preface to the Second Edition</i>	xix
<i>Acknowledgements</i>	xxi
<i>About the Authors</i>	xxiii
<i>List of Contributing Authors in Part 3</i>	xxiv

PART I

The Emotional Coherence Framework: Equipping Psychotherapists for Unprecedented Effectiveness 1

1 Maximum Psychotherapeutic Effectiveness: The Reality of Transformational Change 3

BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY

The brain's innate process of profound unlearning:

Memory reconsolidation 4

The coherence of symptom production and symptom cessation:

Emotional learning and unlearning 6

The overall framework 9

Book preview 10

*The Emotional Coherence Framework and your clinical
development* 13

2 How the Brain Unlearns: Memory Reconsolidation Explained 15

BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY

The key that unlocks emotional memory: Prediction error 15

The MR process of profound unlearning 18

x Contents

The unlearning sequence: A critical set of experiences 20
Transformational change defined by three markers 22
The many varieties of MR in psychotherapy 23
Therapists' most frequent questions about MR 24
The specificity of unlearning 24
Does the MR process of unlearning require emotional arousal? 25
How MR advances the "corrective emotional experiences" framework 26
How the unlearning sequence differs from extinction 28
What happens to the neural encoding of an unlearned schema? 29
Why neuroscientists discuss MR only for fears and addictions 30
From lab to therapy session: The therapeutic reconsolidation process (TRP) 31
The TRP is an evidence-based methodology 35
Transformational change versus emotional regulation 38
Use of the TRP for evaluation of therapeutic MR claims 40
Conclusion 41

3 The Transformational Psychotherapy of Emotional Unlearning 44

BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY

Total focus on the TRP: Coherence Therapy 45
Case example of anxious low self-esteem 48
Symptom identification (Step A) 48
Coherence of the symptom 49
Discovery phase (Step B) 50
Integration phase (Step B continues) 55
The anatomy of a symptom-requiring schema 59
Transformation phase begins: Finding contradictory knowledge (Step C) 61
Schema unlearning via juxtaposition experiences (Steps 1–2–3) 63
Verification of schema nullification (Step V) 66
Transformational versus counteractive change 68
The process in summary 68
The TRP applied for traumatic memory and PTSD 70

Defining trauma and traumatic memory 71
Two main types of traumatic memory 72
Complex attachment trauma 73
The TRP applied for dispelling resistance 74
The TRP applied for the neurodiverse population 75
Conclusion 77

**4 The Moments of Fundamental Change in Slow Motion:
 Three Case Examples of Coherence Therapy** 79

BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY

How to identify targets for unlearning 80
Sources of disconfirming knowledge 83
Case examples and techniques 83
Case example: Obsessive attachment to former lover 84
 Preview of technique for finding disconfirmation 84
 Symptom identification 85
 Finding the symptom's coherence 85
 Finding a disconfirmation: Mismatch detection 86
 Guiding a series of juxtaposition experiences 88
 Outcome 89
Case example: Pervasive underachieving 90
 Preview of technique for finding disconfirmation 90
 Symptom identification 91
 Finding the symptom's coherence 91
 Finding a disconfirmation: Mismatch detection 95
 Guiding a series of juxtaposition experiences 96
 *Resistance to transformation: Its coherence and
 dissipation* 97
 Verification step 99
 Outcome 100
Case example: Stage fright 100
 Preview of technique for finding disconfirmation 100
 Symptom identification 101
 Finding the symptom's coherence 101
 Finding a disconfirmation: Empowered re-enactment 102
 Outcome 104
 Commentary: Re-enactment 105
Conclusion and summary of techniques 106

5 Is It Always About Attachment?: Emotional Coherence and the Great Attachment Debate	109
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	
<i>The many domains of emotional learning</i>	109
<i>Attachment learnings</i>	115
<i>Terms of attachment</i>	118
<i>Optimizing attachment therapy</i>	119
<i>Varieties of TRP fulfillment in attachment therapy:</i>	
<i>Case examples</i>	121
<i>Schema disconfirmation via therapeutic dyad</i>	122
<i>Alternatives to the therapeutic dyad for disconfirmation</i>	125
<i>When disconfirmation via therapeutic dyad is not possible</i>	135
<i>Conclusion: A coherent resolution</i>	140
6 A Framework for the Unification of Psychotherapy: Introduction to Part 2	143
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	
<i>The core process shared by therapies of transformational change</i>	144
<i>Is it really always MR?</i>	148
<i>A unifying map of the psychotherapy universe</i>	151
<i>Unification of the specific versus common factors duality</i>	153
<i>Unification of psychotherapy and brain science</i>	155
<i>Unification summary</i>	157
<i>Welcome to Part 2</i>	157
PART II	
Hidden in Plain Sight: One Core Process in Therapies of Transformational Change	161
7 Accelerated Experiential Dynamic Psychotherapy (AEDP)	163
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	
8 Emotion-Focused Therapy (EFT)	172
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	

9 Eye-Movement Desensitization and Reprocessing (EMDR)	180
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	
10 Internal Family Systems Therapy (IFS)	190
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	
11 Interpersonal Neurobiology (IPNB)	207
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	
12 Intensive Short-Term Dynamic Psychotherapy (ISTDP)	212
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	
13 Psychedelic-Assisted Therapy: Ayahuasca	226
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	
14 Somatic Experiencing® (SE)	241
BRUCE ECKER, ROBIN TICIC, AND LAUREL HULLEY	
PART III	
The Versatility of Coherence-Focused Psychotherapy	247
15 A Father's Tormenting Guilt: Deep Resolution in Seven Coherence-Focused Sessions	249
PAUL SIBSON	
16 Up on Top from Down Below: Ending Compulsive Drinking Using Coherence Therapy	258
C. ANTHONY MARTIGNETTI	
17 Bypassing Bypass Surgery: Using Emotional Coherence to End Compulsive Eating	271
NIALL GEOGHEGAN	
18 Hearing Hostile Voices: Ending Psychotic Symptoms at Their Coherent Roots	276
TIMOTHY A. CONNOR	

19	Releasing Blocked Self-Expression from the Wounds of Systemic Racism: Coherence Therapy for a Deep Recalibration of Vulnerability	291
	BRUCE ECKER	
20	Don't Be That Way: Liberation from Lifelong Homophobic Oppression via Coherence-Guided Narratology	316
	GAIL NOPPE-BRANDON	
21	Life in the Stranglehold of Rules: Using Meditative Experience for Ending Insecure Attachment within Coherence Therapy	326
	MICHAEL LYDON	
22	Young Teen Medicated and Misdiagnosed ADHD: Ending Hyperactive Behavior by Finding Its Underlying Coherence	345
	GAIL NOPPE-BRANDON	
23	Plunging Moods and Erratic Behaviors "For No Reason": A Six-Year-Old Boy's Secret Fear Dissolves in Coherence Therapy	351
	MONIKA CIECHOWICZ	
24	It's My Fault: Group Coherence Therapy for Nine-Year-Old Children with Divorcing Parents	360
	RENEE BUSSANICH	
	<i>Glossary</i>	363
	<i>References</i>	370
	<i>Index</i>	386

List of Symptoms Ended in this Book's Case Examples

<i>Chapter</i>	<i>Symptoms ended</i>	<i>Therapy</i>
3	anxious self-doubting and lack of self-confidence	Coherence Therapy
4	obsessive attachment to former lover	"
4	pervasive underachieving	"
4	stage fright	"
5	reactive anger	"
5	avoidance of emotional closeness	"
5	social anxiety, perfectionism, unworthiness, complex trauma	"
5	aversion to marital sexuality	"
7	shame, depression, avoidance of affect, depersonalization, ungrieved grief, a dark aloneness and sense of being hunted, panicky anxiety	AEDP
8	depression, isolation, helplessness, shame, self-blame, feeling unworthy of love, complex attachment trauma	EFT
9	panic attacks, guilt, self-condemnation after natural disaster trauma	EMDR
10	terror of others' anger	IFS
11	flight from emotional involvement in couple relationships	IPNB
12	failed couple relationships, depression, severe ulcerative colitis	ISTDP
13	complicated grief after suicide of mother, family estrangement	Psychedelic-assisted SE
14	change of personality into being compulsively submissiveness and unpredictably explosive	SE
15	guilt, shame, self-blame, depression, sleeplessness, outbursts of aggression, isolation	Coherence Therapy
16	alcohol abuse, social anxiety	"
17	compulsive eating, obesity	"
18	paranoid delusions, hallucinations, depression, shame and self-hatred over disability	"
19	compulsive inaction on writing, painting	"
20	social anxiety and blocked self-expression in interpersonal interactions	"
21	obsessive, bossy self-talk preoccupied with following rules; panic	"
22	young teen's disruptive, unfocused, uncooperative behavior at school	"
23	plunging moods and erratic behaviors of a six-year-old boy	"
24	children's self-blame for parents' divorce	"

Foreword

It's one o'clock in the morning at a New York City diner in 2018. I'm having some very late-night pancakes with Bruce Ecker. As we discuss ideas for projects, I take in his intoxicating enthusiasm. After years of passionate discussions with him, I find myself thinking: "He *really* might be on to something."

So much of our lives is influenced by the fog of past experiences. We adapt to less-than-ideal circumstances, and we reshape our perception of both reality and ourselves. We do this without fully realizing the price that is often paid along the way. Now, the authors of this book ask: "Imagine a world where the past need not hold us captive"—where the burden of painful experiences could be gently unraveled and rewritten. This is the promise of memory reconsolidation (MR).

This book is a comprehensive guide to understanding and applying the principles of MR to promote deep and lasting change in psychotherapy. In these pages, you will find experts who have spent decades painstakingly going over the extensive body of MR research, creatively experimenting with its principles clinically, and developing a coherent framework for the unification of psychotherapy. This is all tied together by the many poignant case studies showing the transformative power of MR to dispel symptoms at their roots.

To find myself writing a foreword for this book is not only a luxury but, to a certain extent, an irony. For years I was skeptical of anything like this—a framework that could eloquently integrate different therapeutic approaches, while simultaneously providing clear steps to achieve profound therapeutic change. One needs only cursory knowledge of the history of psychotherapy to find fads and hypes of all kinds permeating through the decades. Would MR be another? Could neuroscientific lingo be, as some have argued, just the new religion of our times?

Possibly. However, despite my initial skepticism, I now feel optimism is warranted, largely because of MR's focus on *mechanisms* and *principles of change*, instead of treatment manuals or specific techniques. Put simply, there is now so much evidence that manualized treatments ("one size fits all") cannot hope to explain why some therapists are more effective than others. Many prominent researchers have argued persuasively that the qualities of the *therapist* are a

far better predictor of client outcomes than the use of any particular therapy model or technique. However, those who subscribe to this “common factors” understanding of psychotherapy face at least two daunting challenges. The first is that, in real-life practice, clinicians need mental maps complex enough to inform their interventions on a moment-by-moment basis. Second, we still need to understand why and how some therapists excel at producing lasting change in their clients. The therapeutic application of MR research answers these questions, through focusing not on theory and not on specific techniques, but rather on clear, empirically identified *principles of change* that can guide clinicians and explain moments of profound change. These principles, the *therapeutic re-consolidation process* (TRP), are at the heart of this book. And, frankly, they are something I wish I had learned as I was starting out in psychotherapy. (Funnily enough, my own current trainees recently said: “Why are we only now learning about this?!”)

An impactful experience in my own professional development was analyzing hundreds of hours of video-recorded sessions from different therapists and therapy models. In doing so, it became obvious that some therapists seemed to be promoting deep change in their clients, at least some of the time, while others seemed to be often stuck in a stalemate. While the effective therapists differed widely in their approaches, to my mind a few commonalities could be found. They tended to be highly focused on their clients’ internal experience, namely the core painful emotions and meanings that were at the roots of their problems; they skillfully promoted visceral, experiential activation of these painful emotions and meanings in the here-and-now; and they creatively facilitated powerful new experiences that directly targeted and fundamentally revised that core material. I saw this happen most often in experiential and relationally oriented psychotherapies, such as EFT, AEDP, ISTDP, EMDR, and Schema Therapy—for me an uncomfortable finding because it didn’t align with my initial, conventional assumption that, paraphrasing Alice in Wonderland, “all therapy models have won, and all must have prizes”—the prevailing view, based on the statistics from many randomized control trials, that all types of therapy have equal efficacy. I was later to find the first edition of this book, and saw that it went above and beyond in not just mirroring my surprising observations, but did so with an awe-inducing degree of detail.

Bruce Ecker is one of the most inspired and inspiring clinicians I have ever seen in practice. Bruce and his colleagues have outdone themselves in expanding and enhancing a book that is already considered by many a modern classic in the field. New and old readers alike will benefit from clarifications provided, for example, in Chapter 2, where the authors address therapists’ most frequently asked questions about MR. Indeed, the ideas presented here have such extraordinary potential for the future of psychotherapy integration, a topic masterfully covered in Chapter 6 and amply demonstrated in Parts 2 and 3 of the book. I will simply say that the MR framework has the rarest of advantages for the

unification of psychotherapy, in that it guides the clinician in a rigorous manner, while simultaneously respecting the multitude of ways in which deep change can be facilitated. Also, to the authors' credit, the enthusiastic voice that permeates this book is one that welcomes future findings and contributions. As readers delve deeply into these pages, they are urged to keep experimenting with and researching these principles, to enhance even more how future therapists and clients may benefit from them.

The first edition of this book influenced countless therapists around the world. I suspect this second edition is destined to have an even greater impact. I delight in anticipating the future generation of therapists who are blessed with having another piece of the clinical puzzle, if not entirely solved, illuminated better than ever.

Alexandre Vaz, PhD

Director of Training, Sentio Counseling Center
Series Editor, *The Essentials of Deliberate Practice*
(American Psychological Association Press)

Preface to the Second Edition

We predict that “How do I love thee? Let me count the ways”¹ is how the worldwide community of psychotherapists and counselors will come to feel toward memory reconsolidation because of the many major advances in both understanding and therapeutic effectiveness that our empirical knowledge of it generates.

This book’s first edition, published over a decade before this second edition, has been translated into Spanish, Italian, French, German, Polish, and Korean. What some practitioners value most is the great increase of therapeutic effectiveness thanks to having a clear map of the brain’s innate core process of transformational change—a process that does not require use of any particular system or techniques of psychotherapy. What others love best is the transtheoretical, lucid understanding of therapeutic action that unifies the confusingly fragmented therapy field. And all who greatly value deep connection with their clients are richly rewarded by the experiential depth that this core process accesses—truly at the very core of each client’s personhood, where no awareness had yet reached.

It is an embarrassment of riches, because we also gain the decisive resolution of several longstanding, polarizing debates regarding the nature of symptom production, the operation of traumatic memory, the prevalence of attachment issues, the functions of the client–therapist relationship, the role of emotional arousal in the process of change, and the relative importance of specific versus non-specific factors. This is not to mention how satisfying and enjoyable it is to acquire and inhabit this deeply natural integration of the subjective process and the objective understanding of transformational therapeutic change—the art and the science of psychotherapy at its most effective best.

Certainly it will take time for all of those gifts to register and reorient the many entrenched encampments that the vast psychotherapy field comprises, but there is already much progress. Responses to this book’s first edition, published when very few therapists had yet heard of memory reconsolidation (MR), have consistently

¹ The first line of Elizabeth Barrett Browning’s most famous and best-loved poem, Sonnet 43, in her collection *Sonnets from the Portuguese* (1850).

expressed a celebratory counting of the ways. One recent email to us read, “The core process of transformation via empirically validated neuroscience is one of the most appealing aspects of your work. Previously, real and enduring therapeutic change seemed completely shrouded in mystery. ... Thank you again on behalf of my patients and me personally as well. ... I am full of hope and seeing some great initial results!” And another: “I began experimenting with Gestalt 2-chair work and had some surprising results (i.e., rapid transformation that lasted)... but without an understanding of *why* it worked. ... Then, I came across *Unlocking the Emotional Brain*. It changed my clinical work and life.”

The fundamental relevance and importance of MR in psychotherapeutic change are now recognized widely throughout the field, so much so that workshops and trainings in most of the focused, experiential therapy systems, such as those featured in Part 2 of this book, now make a point of showing that the system’s methodology makes use of MR, usually with reference to this book’s first edition. There is, however, wide variation in the scientific accuracy of the explanations offered for how MR functions and how the specific elements of the MR process are fulfilled. One of our main motivations for this second edition of the book is to make it easier to understand MR and, therefore, less likely that claims of MR utilization are made for theoretical formulations of psychotherapy that in fact are inconsistent with how MR functions. That was the guiding spirit in our extensive revisions of the chapters in Part 1, which incorporate everything we have continued to learn, during the last decade, about teaching this material. Only if MR is *accurately understood* throughout the psychotherapy field will its great potential benefits be fully realized.

The doubling in size of Part 2—from four to eight different psychotherapy systems—expresses another of our main motivations, namely, to demonstrate how well MR serves as a framework of unification of the severely fragmented world of psychotherapy. That fragmentation into competing theoretical schools was free to develop because for a century, remarkably, the field of psychotherapy had no consensus of empirical knowledge of an internal mechanism of psychological change. We now have that knowledge from MR research findings, and unification emerges unambiguously—hence our title for Part 2, “Hidden in Plain Sight: One Core Process in Therapies of Transformational Change,” even including psychedelic-assisted therapy (Chapter 13).

Part 3 expands from four to ten cases the book’s contributed demonstrations of transformational change achieved for a tremendous range of presenting conditions and core issues, by therapists who have an equally wide range of personal styles. Change is “transformational,” as we define the term, when a major symptom (unwanted pattern) ceases *completely* and never again occurs, without any further efforts to prevent it. In Part 3 our purpose is to show not only how real it is that transformational therapeutic change is possible to produce with great versatility in a systematic manner, but also that the stage is fully set for transformational change to now become the standard of effectiveness in the psychotherapy field. That, we feel, is the fundamental message of this book.

Acknowledgements

Finding words to properly acknowledge the contributing authors of the case examples in Part 3 of the book is a challenge. We want them to feel deeply thanked for sharing with us their daring adventure with each client—because each case *is* a daring adventure when your aim is guiding your clients first to recognize, and then to dissolve and liberate themselves from, their most distress-laden emotional learnings. Our contributors' accounts of their therapeutic journeys, allowing readers to glimpse both their therapeutic skills and acumen and their clients' courage and depth of heart—normally so well hidden in each person—are a wonderful gift. We thank them as well for their patience with our rounds of editorial development.

We want to express a very big thanks to Barcelona psychotherapist Michał Jasiński for bringing to this book the case examples of psychedelic-assisted therapy in Chapter 13 and child therapy in Chapter 23. Notes in each of those chapters describe his quite substantial roles and efforts in producing those important cases for inclusion here. Our appreciation goes to him also for bringing this book's framework to the psychotherapy field in his home country of Poland through conducting numerous trainings and presentations there, resulting in the Polish translation of this book's first edition.

Lisbon-based clinical psychologist Alexandre Vaz collaborated extensively with one of us (BE) to illuminate how the findings of psychotherapy outcome research serve to reveal the full significance of memory reconsolidation for the psychotherapy field. That collaboration generated two presentations at international conferences¹ and two journal articles,² and here has strongly enriched Chapters 1 and 2 with the expert knowledge that Alex generously provided. We are grateful to him also for providing the Foreword to this second edition of the book.

The same one of us (BE) expresses thanks here for helpful responses clarifying memory reconsolidation research findings received from neurosci-

1 Videos of these presentations are available online at <https://youtu.be/IHnn2Wf4NFI> and <https://youtu.be/WzdxMNz6YRc>

2 Vaz and Ecker (2020) and Ecker and Vaz (2022)

entists Alejandro Delorenzi, Cecilia Forcato, Timothy Jarome, Emiliano Merlo, and Javiera Oyarzún.

Melissa M. Reading has our gratitude for her unstinting support and generosity in reading closely our chapter manuscripts and finding where and how to enhance their conceptual and linguistic clarity. If ever we've known anyone who is at least as obsessed with clarity as we are, it is Melissa, and it has been a joy to receive her help, in which her astute understanding of our framework was always apparent. Happily this was a two-way street, as one of us can comprehend her physics doctoral thesis and various research publications.

Routledge publisher Anna Moore invited this second edition of the book, and then helped the project along with the same kindness and tuned-in responsiveness that we remember vividly from the first time around. Her supportiveness of our work is our great good fortune. We also appreciate the assistance received from Kasra Koushan in enhancing our references to supporting research.

Our gratitude flows also to our dear international colleagues who brought about the translation of this book's first edition into various languages: Guillem Feixas Viaplana in Barcelona, Laura Bastianelli in Rome, and Sophie Côté and Pierre Cousineau in Quebec. Such dissemination of this body of knowledge is really marvelous.

Each of the three authors also wants to express thanks here to the other two for an unwavering spirit of good-natured collaboration based on our shared recognition of the extraordinary value of the body of knowledge represented in this book. Working together to firmly install this knowledge in the psychotherapy field has been its own very rich reward.

We will stop there, though rivers of acknowledgment are due also to many pioneers of both psychotherapy and neuroscience research on memory reconsolidation, on whose shoulders we are standing.

Bruce Ecker
Robin Ticic
Laurel Hulley
June 30, 2023

About the Authors

Bruce Ecker, MA, LMFT, is Co-Director of the Coherence Psychology Institute, co-originator of Coherence Therapy, and co-author of the *Coherence Therapy Practice Manual & Training Guide*; *Depth Oriented Brief Therapy: How to Be Brief When You Were Trained To Be Deep and Vice Versa*; and *The Listening Book*, as well as numerous psychotherapy journal articles and book chapters. Clarifying how transformational therapeutic change takes place is the central theme of his clinical career, and he has contributed many innovations in concepts and methods of experiential psychotherapy. Since 2006 he has led the development of the clinical application of the neuroscience of memory reconsolidation, driving major advancements in the effectiveness and unification of psychotherapy and identifying its most potent underlying mechanism of change. He has been a frequent presenter at conferences and workshops internationally, and leads the Institute's team of researchers. He resides in New York City.

Robin Ticic, BA, HP Psychotherapy (Germany), is director of development and training for the Coherence Psychology Institute, co-author of *The Listening Book*, and author of the parenting guide *How to Connect with Your Child*, as well as numerous psychotherapy journal articles. She is in private practice, specializing in trauma therapy, near Cologne, Germany, and is a certified trainer of Coherence Therapy, following many years as a psychologist for the Psychotraumatology Institute of the University of Cologne. She has extensive experience in parent counseling, courses, and presentations, and has been honored for community service.

Laurel Hulley, MA, is co-originator of Coherence Therapy, Director of Education and Paradigm Development for the Coherence Psychology Institute, a co-founder of the Julia Morgan School for Girls in Oakland, California, and co-author of the *Coherence Therapy Practice Manual & Training Guide* and *Depth Oriented Brief Therapy: How To Be Brief When You Were Trained To Be Deep and Vice Versa*, as well as numerous psychotherapy journal articles, book chapters, and clinical video viewer manuals. She is a lifelong denizen of Greenwich Village in New York City.

List of Contributing Authors in Part 3

Renee Bussanich, MA, is a licensed clinical mental health counselor in practice in Asheville, North Carolina, USA.

Monika Ciechowicz, MA, is a child and adolescent psychologist in independent practice in the Polish town of Rumia near Gdańsk.

Timothy A. Connor, PsyD, is a licensed psychologist on the staff of Oregon State Hospital in Portland, Oregon, USA.

Bruce Ecker, MA, LMFT, is co-creator of Coherence Therapy and Co-Director of the Coherence Psychology Institute. He is located in New York City, in private practice with a California clinical license.

Niall Geoghegan, PsyD, is a licensed psychologist in Berkeley, California, USA, and a Certified Advanced Practitioner of Coherence Therapy.

Michael Lydon, LCSW, sees clients online from Ipswich, Massachusetts (Boston North Shore area). He is a Certified Practitioner of Coherence Therapy and a Realization Process assistant teacher in online certification trainings, and is a senior teacher in private practice.

C. Anthony Martignetti, PhD, before his passing in 2015 was in practice in Lexington, Massachusetts, USA as a Licensed Mental Health Counselor, a Certified Diplomate of the American Psychological Association, and a Doctoral Addictions Clinician of the National Board of Addiction Examiners.

Gail Noppe-Brandon, LCSW, MPA, MA, is in private practice in New York City and is an Associate Instructor of the Coherence Psychology Institute and a Certified Advanced Practitioner of Coherence Therapy.

Paul Sibson, Dip-Counselling, Dip-Psychotherapy, before his passing in 2023 was in practice in Kendall, UK as a Licensed Psychotherapist under the British Association for Counseling & Psychotherapy (BACP) and the UK Council for Psychotherapy (UKCP).

Part I

**The Emotional Coherence
Framework**

Equipping Psychotherapists for
Unprecedented Effectiveness

1 Maximum Psychotherapeutic Effectiveness

The Reality of Transformational Change

Bruce Ecker, Robin Ticic, and Laurel Hulley

Presume not that I am the thing I was.

—William Shakespeare, *King Henry IV, Part 2*

The sessions that we therapists find most fulfilling are those pivotal ones in which a client experiences a deeply felt shift that thoroughly and lastingly dispels longstanding negative patterns of emotion, thought, behavior, or somatic disturbance—a transformational change. Such profound change is the maximum possible level of therapeutic effectiveness.

In the clinical literature, transformational change has been reported and documented in detail for a wide range of symptoms and for various different systems of psychotherapy (e.g., Badenoch, 2011; Coughlin, 2006, 2017; Ecker, 2018; Ecker & Hulley, 1996; Greenberg, 2010; Lipton & Fosha, 2011; Manfield, 2003). However, in the psychotherapy outcome research literature, what has long been defined as successful therapy is a partial, moderate reduction of symptoms. For over 40 years, the level of therapeutic improvement measured in randomized controlled trials (RCTs) and meta-analytic reviews has consistently been a change of about one standard deviation in the mean score on outcome measures, which usually represents merely a 20 to 25 percent reduction in the measured strength of symptoms (Shedler, 2015; Smith & Glass, 1977; Wampold & Imel, 2015). Based on those RCT results, mild incremental change has long been the standard of successful treatment in the clinical field.

Any occurrences of transformational change in outlier cases within an RCT remain invisible and buried under the overall statistical analysis of the data. As a result, there has been scant, if any, recognition of even the possibility of transformational change in psychotherapy outcome research literature. The therapy systems that do recognize and aim for transformational change have quite different conceptual models for how and why it happens, as well as very different methods and techniques for inducing it. That fragmented situation begs the question of whether those different systems achieve transformational change through

4 *The Emotional Coherence Framework*

fundamentally different internal mechanisms of the mind or brain, or through embodying a shared core process that engages the same internal mechanism.

The brain's innate process of profound unlearning: Memory reconsolidation

The answer to that centrally important and basic question was a mystery until relatively recently, due to the fact that for a century, the psychotherapy field had developed without empirically identifying *any* internal mechanism of the mind or brain that produces lasting change (Ecker & Vaz, 2022; Goldfried, 2019, 2020). Nor had any internal mechanism of lasting change been found by either psychologists or neuroscientists conducting memory research throughout the twentieth century. Lacking such shared empirical knowledge, the psychotherapy field fragmented into hundreds of competing systems, all of them free to postulate how change occurs, with a corresponding methodology for inducing it.

That situation changed fundamentally after the 1997–2000 period, when neuroscientists discovered *memory reconsolidation* (MR), an innate, experience-driven mechanism of the brain for unlocking and revising memory holding previously acquired knowledge of the world. (For a detailed account of that discovery, see Riccio et al., 2006.) A 2006 psychotherapy conference had the first keynote address on the therapeutic potential of MR (Ecker, 2006). Of greatest significance for psychotherapy are the dozens of studies with both animal and human subjects that have used the MR mechanism to achieve the full unlearning and nullification of an acquired emotional response (reviewed by Clem & Schiller, 2016; Ecker, 2018, 2021). Those observations made MR a strong candidate mechanism for transformational change occurring in therapy sessions.

In those dozens of laboratory studies demonstrating complete unlearning, the details of behavioral procedure varied widely, but in every study the procedure induced *the same series of subjective experiences* in subjects (Ecker, 2015a, 2018, 2021). (If that idea initially seems strange, just consider that many different behavioral procedures can induce in a person the same recognizable, distinct experience of *laughing*.) That crucial set of experiences will be spelled out in Chapter 2. In this book's case examples of transformational change from nine different, widely used therapy systems, that same distinct set of experiences is shown to have occurred in each case just before the appearance of the markers of transformational change, which include the lasting disappearance of a chronic emotional reaction. The prompt timing between creation of the distinct experiences and the unique, strong effect of transformational change—shown to occur across diverse symptoms presented by diverse persons in therapy with diverse therapists—is a strong indication of causation, not merely correlation.

Therefore the question posed above can now be answered: Different systems of therapy achieve transformational change through a shared core process that engages the same internal mechanism: memory reconsolidation. A unifying framework has

emerged, within which “transformational therapeutic change can be recognized as a process that is both deeply subjective and scientifically well defined” (Ecker & Vaz, 2022, p. 9). This makes it possible for transformational change to now become the natural standard of effectiveness in the psychotherapy field.

In order to map out, lay bare, and show the remarkable versatility of the MR process of transformational change, the chapters in Part 1 use cases of Coherence Therapy, and then Part 2 shows the same process fulfilled in a representative case example from each of these eight therapeutic systems:

- AEDP (Accelerated Experiential Dynamic Psychotherapy) in Chapter 7
- EFT (Emotion-Focused Therapy) in Chapter 8
- EMDR (Eye Movement Desensitization and Reprocessing) in Chapter 9
- IFS (Internal Family Systems Therapy) in Chapter 10
- IPNB (Interpersonal Neurobiology) in Chapter 11
- ISTDP (Intensive Short-Term Dynamic Psychotherapy) in Chapter 12
- Psychedelic-Assisted Therapy in Chapter 13
- SE (Somatic Experiencing®) in Chapter 14

Case examples of transformational change from five other systems, not included in this book, have likewise been shown to embody the same core process (Alexander Technique, Neurolinguistic Programming, Progressive Counting, Social-Cognitive Transactional Analysis, and Tapping; for an online list of all such demonstrations, see <https://bit.ly/15Z00HQ>). All of these systems can carry out the MR process of transformational change despite the fact that the specific steps of this process are not recognized or identified in how each system defines its own particular methodology and conceptual framework. These various methodologies don’t automatically *always* fulfill that core process, but when they do, that is when transformational change occurs, as shown in Part 2. The methodology of Coherence Therapy, on the other hand, consists explicitly of exactly the steps of the core process, which makes case examples of Coherence Therapy particularly instructional for teaching and demonstration purposes in Part 1.

Based on both MR research by neuroscientists (summarized in Chapter 2) and extensive clinical observation and experience, it is now empirically justified to view this one core process as the universal, direct cause of the markers of transformational change whenever they begin to appear in any therapy session. So, whatever therapy system(s) you prefer to use—including those not in the thirteen noted above—the frequency of your own sessions producing major, liberating breakthroughs will increase significantly by *knowingly* using your system(s) to fulfill this process of MR. That is what we’ve heard from psychotherapists around the world who have adopted this framework, and that is the promise that this book holds for you. In Part 3 are cases contributed by practitioners of Coherence Therapy, illustrating the applicability and facilitation of the core process to a huge diversity of challenging symptoms of adults and children.

The coherence of symptom production and symptom cessation: Emotional learning and unlearning

It turns out to be demonstrable unambiguously in therapy sessions that the vast majority of the unwanted patterns or “symptoms” presented by seekers of psychotherapy are generated by the contents of memory—specifically by learned *mental models*, or *schemas*, consisting of particular constructs, held in implicit memory, outside of awareness. The brain’s completely nonverbal, implicit, yet highly specific meaning-making and modeling of the world is innate and begins very early in life. For example, infants three months old form expectational models of contingency and respond according to these models (DeCasper & Carstens, 1981), and 18-month-old children can form mental models of other people as wanting things that differ from what they themselves want and will give the other what he or she wants (Repacholi & Gopnik, 1997), and can form models that distinguish between intentional and accidental actions (Olineck & Poulin-Dubois, 2005).

Mental models or schemas are perceived patterns generalized and extracted from specific experiences. Such models live in a different memory system from the memory of the original experiences and events, which researchers term *episodic* memory. Rather, it is *semantic* memory systems that hold one’s learned mental models. The term “memory” in common usage narrowly means only memory of events or facts, but it is schema memory, semantic memory, that matters most for facilitating transformational change in therapy sessions. Reactivation of a particular schema by current perceptions or circumstances is not, as a rule, accompanied by reactivation of any episodic memory of the experiences in which the schema was originally learned; nor does the schema itself come into conscious awareness, though it can *become* experienced consciously with suitable therapeutic facilitation. Here are examples of emotional schemas that have been put into words after coming into direct affective awareness:

- Making a mistake means I’m worthless and unacceptable and deserve the shaming that will come, so I’ve *got* to do everything perfectly.
- If Mom shows emotional distress, it’s immediately my job and my responsibility to get her out of it, or else I’m an unlovable, worthless failure.
- It’s really dangerous if too much is going well for me, because that would attract some major blow from the universe, so I *must* avoid having anything I’m really happy or satisfied with.

The mental models that generate symptoms are versions of the world that were learned and installed into memory during emotionally intense life experiences, but with no awareness of forming and learning them and no representation of them in words or concepts. We therefore often refer to these schemas as *emotional learnings*, but remember: It is the learned model of the world, not the

emotion that arises from that model, that is at the root of the problem and that is the crucial target of change.

According to the distress-laden mental model underlying a particular symptom, that symptom is intensely necessary to have, adaptively and emotionally—which is why it is produced. That memory-based, coherent process of symptom production will be directly apparent in every one of the twenty-six case examples in this book. Transformational change results from subjecting a symptom’s revealed, underlying mental model to the brain’s innate process and mechanism of *unlearning*, which is memory reconsolidation. Profound unlearning of a mental model means its version of the world no longer feels at all real or true, whereas previously it felt compellingly real and inherently true. This fundamentally resolves the distress generated by that mental model and ends the symptom(s) it had been necessitating.

When reduction of a symptom is mild, obviously its source and cause still exist, so relapses can and do occur. In contrast, after the mental model at the root of symptom production has been unlearned and nullified, relapse is not possible and the symptom is fully eliminated.

The brain has numerous types of memory, including, for example, spatial, object recognition, body movement sequence, procedural, and smell memory, among others—each of which can be a component of an episodic memory of an event, or of a semantic memory of a pattern. Memory reconsolidation, the brain’s versatile mechanism of memory modification, can produce many different types of change in many different types of memory (Nader, 2015). It can strengthen, weaken, or modify the details of memory contents and expression, and it can incorporate new elements into an existing memory or join the memory of a new experience to an existing memory (e.g., Agren, 2014; Lee et al., 2017). So, using MR to cause the full unlearning and annulment of a particular schema is just one specialized use of MR—but it is the use that is most important for psychotherapy, because that is transformational change, the most liberating and effective result of psychotherapy.

Therapists witness daily in their practices the extraordinary durability and tenacity of implicit emotional learnings, such as those listed above, which continue to trigger and rule life with full strength in adulthood, decades after they were learned in childhood. That unfading persistence of underlying, symptom-generating learnings across decades of life, long after the original circumstances that induced their formation have ceased to exist, is often taken as meaning that they are “maladaptive” or “pathogenic” and that the symptoms they produce signify a dysregulation of emotional brain networks. However, when the revealed schemas turn out to have full coherence as emotional learnings in the context of a person’s actual life experience, as well as an adaptive, protective purpose, such pathologizing conceptualizations seem ill-founded (Ecker, 2015a, 2018; Ecker & Hulley, 2000; Neimeyer & Raskin, 2000). Furthermore, memory research has established that learnings accompanied by strong emotion

form neural circuits in subcortical implicit memory that are exceptionally durable, normally lasting a lifetime (e.g., McGaugh & Roozendaal, 2002). The brain is working as evolution apparently shaped it to do when, decades after the formation of such emotional knowledge, this tacit knowledge is triggered in response to current perceptual cues and launches behaviors and emotions according to the original adaptive learning. Such faithful retriggering is, in fact, the proper functioning of the brain's emotional learning networks, not a faulty condition of disorder or dysregulation—unless one is prepared to say that it is a dysregulation of evolution itself, not of the individual. Of course, having a non-pathologizing view of emotional schemas does not make their tenacity any less impressive. So it is indeed a big deal that we now have clear, empirical knowledge of the brain's own rules for thoroughly depotentiating emotional learnings through MR.

The understanding that a person's unwanted emotions, behaviors, or thoughts may be generated by non-conscious emotional learnings or conditioning has of course figured centrally in many forms of psychotherapy. The approach in this book embodies two major advancements: first, the swift and accurate experiential retrieval of those emotional learnings, bringing them into direct awareness, and second, the non-theoretically based, research-corroborated methodology of memory reconsolidation for prompt unlearning and dissolution of those retrieved learnings at their emotional and neural roots.

Viewing symptom production as having a psychological cause in emotional learning is quite at odds with neuroscience research that aims to identify the molecular and cellular processes involved in, for example, anxiety responses, in order to develop drugs that would block or moderate such responses (e.g., Mucha et al., 2023). That reductionistic approach assumes that flawed operation of molecular or cellular processes is causal of unwanted psychological conditions. While such bottom-up, neurobiological causation certainly occurs in some conditions, it is shown to be untrue in all those cases, such as those documented in this book, where the unwanted psychological condition disappears promptly and permanently after a particular emotional schema has been thoroughly unlearned, so that it no longer reactivates or feels subjectively true. In such cases, the true cause of, for example, the person's chronically high anxiety was the schema in implicit memory, and the molecular and cellular processes involved in producing that state of anxiety were functioning properly in service of adaptive emotional learning systems. Therefore, the strategy of preventing that person's experience of anxiety by pharmacologically disabling the bottom-up mechanisms of anxiety generation leaves the distress-laden implicit schema intact and only blocks its affective expression into conscious experience. That is what some individuals do non-pharmacologically by maintaining a state of emotional dissociation, which is well known to psychotherapists as the principal cause of somatizing, the creation of somatic symptoms due to blocking affective experience of distress (for an example of which, see

Chapter 12). So, it seems likely that the treatment of psychological symptoms by pharmacological interference of bottom-up processes may be a major cause of somatic symptoms in that manner.

The overall framework

This book provides a unifying account of:

- *emotional learning and memory*, with emphasis on its adaptive, coherent nature and the specific content and structure of symptom-generating emotional implicit learnings
- *the unlearning and nullification of emotional implicit knowledge* through the sequence of experiences required by the brain for memory reconsolidation to operate
- *the therapeutic reconsolidation process*, which is the entire set of steps needed for consistently putting into practice the required sequence of experiences in psychotherapy sessions

We call this unified body of knowledge the *Emotional Coherence Framework*, and we predict that it will expand your clinical vision and mastery invaluablely, as it has ours. The therapeutic reconsolidation process, or TRP, consists of steps that guide you as therapist without cramping your individual style. An unlimited range of techniques can be used to create the set of experiences that fulfills this process, which is largely why your creativity and individual style of working continue to have great scope of expression in this approach. It involves richly experiential work that utilizes your skills of emotional attunement and focuses the use of your empathy so as to cooperate closely with the brain's rules for accessing and dissolving the emotional learnings at the root of your clients' presenting symptoms. Major, longstanding symptoms can cease as soon as their very basis no longer exists, as shown in the many case examples in this book. All of the depth, intimacy, and humanity of talk therapy at its best are preserved in this approach, for these valued qualities of therapy are key ingredients for successfully using the TRP to free clients from entrenched negative reactions, old attachment patterns, unconscious core schemas, traumatic memory, emotional wounds, and compulsive behaviors.

New learning can create new neural encoding throughout one's lifetime, but it is only when new learning also revises and *replaces* the encoding of old learning that transformational change occurs, and this is precisely what the TRP achieves. The process fulfills the brain's requirements for allowing a new learning to rewrite and nullify an old, unwanted learning—and not merely suppress and compete against the old learning or “regulate” it. The result is lasting transformational change, as distinct from incremental change and ongoing symptom management.

The emotional learning and memory system converts the past into an expectation of the future, without our awareness, and that is both a blessing and a curse. It is a blessing because we rely daily on emotional implicit memory to navigate through all sorts of situations without having to go through the relatively slow, labor-intensive process of figuring out, conceptually and verbally, what to do; we simply know what to do and we know it quickly. It is easy to take for granted the amazing efficiency and speed with which we access and are guided by a truly vast library of implicit knowings. Yet our emotional implicit memory is also a curse because it makes the worst experiences and emotional learnings in our past persist as felt emotional realities in the present and in our present sense of the future, keeping us “prisoners of childhood.”

In the three examples of schemas listed on p. 6, it is apparent that what seems and feels to the person so real about the world is not an external reality at all, but rather a vivid illusion or mirage maintained by emotional memory. It hardly seems an exaggeration to regard the limbic brain’s power to create emotional reality as a kind of magic, or *maya*, that immerses one in a potent spell that feels absolutely real and would last for a lifetime. However, we now know how to induce the emotional brain to use its power to break and dissolve emotional spells that it previously created. The prison of emotional memory, built over the aeons in the course of evolution, comes with a key, and that key has now been found. The limbic life sentence can be commuted. That is what this book spells out.

Of course, learning and memory are not at the root of *all* of the conditions that therapy seekers present. Examples of conditions not based in memory, and therefore not fundamentally dispellable by any type of MR process, include hard-wired neurological situations (such as those causing difficulties with learning or sensory experience) and biological conditions (such as hypothyroidism that causes a mood state of depression). Viewing symptom production as dysregulation may be accurate in such cases, but they are a small minority of those encountered by psychotherapists in general practice.

Book preview

The twenty-six case examples of this book show the TRP applied to dispel a very wide range of symptoms and sufferings. If a particular symptom that you want to see addressed by the TRP is not covered here, you may be able to find a published case for it in the online index at <https://bit.ly/2tKXdyX>.

Here is a broad view of the territory ahead in the chapters of Part 1:

Chapter 2 explains how memory reconsolidation works by telling the story of the dramatic scientific turnaround caused by its discovery and showing why our knowledge of this phenomenon sets up major advances for psychotherapy. A clear, scientific distinction emerges between transformational change (in which

problematic emotional learnings are fully depotentiated and symptoms cannot recur) and incremental, partial change (which results from the counteracting of symptoms, requires ongoing effort to maintain, and remains susceptible to relapse). We map out how MR research findings optimally and directly translate into psychotherapeutic application, defining the therapeutic reconsolidation process as a versatile experiential methodology that undergirds psychotherapy for the first time with empirical knowledge of an internal mechanism of change.

Chapter 3 presents the case of a man seeking therapy for his daily self-doubting and anxious insecurity at work, in order to demonstrate how psychotherapy can focus on carrying out the steps of the TRP for a given presenting symptom. This chapter also covers the basics of MR, so that the more detailed account of MR in Chapter 2 need not be fully digested in order to understand and begin using this therapeutic framework. It may be surprising to see that in following a potent process of change confirmed by neuroscientists in the laboratory, the richly human and humane qualities of the client–therapist relationship and the depths of personal meaning experienced by the client are not sacrificed at all. If Chapter 2 of this book is its scientific bedrock, Chapter 3 is the heart of its vision for therapy: facilitation of the TRP. The TRP is an integrative and open-access methodology because it is phenomenological and avoids theory-based interpretations, and because it does not impose particular techniques to be used for guiding clients into the necessary sequence of experiences. Thus any case example that illustrates the TRP for instructional purposes shows some particular set of techniques or system of therapy applied for creating those crucial experiences. For that instructional purpose in Part 1 of this book, we use a particular form of therapy—Coherence Therapy—because, as noted earlier, its methodology follows the TRP steps explicitly and recognizably. It is especially easy and transparent, in other words, to see the TRP in case examples of Coherence Therapy. The chapters of Part 2 show the TRP occurring in other systems implicitly, embedded within their methodologies.

Chapter 4 puts the key moments of transformational change under still closer scrutiny in three case examples, so that you can see exactly what is involved and how well-defined and guidable the necessary experiences are. The examples—involving obsessive attachment, pervasive underachieving, and stage fright—all show the collaborative journey with each client and the therapist’s choicefulness and creativity in finding how to guide each client into the key experiences. The journey metaphor is an apt one, because knowledge of the TRP serves very much as a compass and a map for working effectively in the territory of the client’s non-conscious emotional learnings. Coherence Therapy supplies the therapist with a set of versatile techniques designed especially for the steps of the TRP, while always encouraging the therapist to improvise variations, or adapt techniques from other therapies, or invent new techniques as best suits the unfolding process with each client. Once again—because it bears repeating—the process is not defined by any particular techniques (the journey’s concrete modes of

transportation), including the basic techniques normally taught in Coherence Therapy, though of course the techniques have to be *experiential* because the core process consists of certain *experiences*, as distinct from cognitive insights.

Chapter 5 focuses on working with insecure attachment using the TRP and the conceptualization of attachment work in the Emotional Coherence Framework. We will see that the fully experiential retrieval of a given symptom's underlying emotional learnings—the shift from implicit knowing to explicit knowing, as required for consistent success with the TRP—makes apparent whether these underlying learnings are attachment-related, not attachment-related, or a combination of the two. This allows a non-speculative, non-theoretical determination of whether a given presenting symptom is or is not a manifestation of insecure attachment—often a matter of considerable controversy among both clinicians and researchers. Such clarity regarding the nature of the underlying learnings in turn sheds light on the optimal role and possible uses of the client–therapist relationship with a given client; there is quite a range of strongly held opinions about this, as well. Here, too, the Emotional Coherence Framework provides an illuminating perspective of a non-theoretical nature, and can help steer us clear of theoretical biases in clarifying some of the more complex and thorny issues in psychotherapy.

Chapter 6 expands upon the TRP serving as a unifying framework for the psychotherapy field, thereby setting the stage for Part 2 in which that unification is demonstrated concretely and unambiguously for eight major therapeutic systems. The discussion here includes the challenge that the TRP poses to non-specific common factors theory and why this may auger a fundamental shift in perspective on common factors theory; and we note supporting findings from psychotherapy process research.

Part 2 of the book consists of Chapters 7 to 14, which examine case examples of transformational change from the eight quite different systems of psychotherapy listed above. The original account of each case is fine-grained, allowing the kind of moment-to-moment scrutiny required for detecting whether the component experiences of the therapeutic reconsolidation process occurred. We show that they did, demonstrating the unifying value of the TRP. This framework of unification is also supported by the fact that memory reconsolidation, the existence of which was first established in 2000, remains (as of this writing in 2023) the only type of neuroplasticity known to neuroscience that is capable of fully depotentiating and functionally eliminating a specific emotional learning, as in each of these eight case examples.

Part 3, comprising Chapters 15 to 24, consists of case examples contributed by practitioners of Coherence Therapy. We selected these cases because they complement and extend the illustrations of the TRP in Parts 1 and 2 in various ways: different, important types of symptoms dispelled (indicated in the table of contents), child clients from six to fourteen years old, the therapists' diversity

of styles and choices, larger numbers of sessions in several cases, and candid accounts of how the therapist grappled with challenges and obstacles along the way, including client resistance and the need for technique improvisation. We think you will be fascinated and inspired, as we were, by these true tales of therapeutic adventure and triumph.

The Emotional Coherence Framework and your clinical development

In conducting trainings in this approach since 1993, we have seen that most psychotherapists and counselors—ourselves included—seek certain kinds of satisfaction in their practices in order to sustain the inspiration and meaningfulness that originally attracted them to this challenging, difficult work. To conclude this introductory chapter, we list common dilemmas that our therapist colleagues and trainees have described as developing over time in their clinical work, motivating them to seek some revitalizing approach. Along with each dilemma, we preview how this book helps meet these professional challenges.

As a therapist I feel I ought to know, in advance, the interventions that will eliminate my client's symptoms, and that burden gives me angst. That assumption and the angst it generates are dispelled by understanding symptom production in terms of coherent, implicit emotional learnings that are unique to each client. For example, each of your panic attack clients has a unique emotional learning history. It is only after finding and revealing a client's specific emotional learnings that a pathway to a liberating change can then be found, without needing to know in advance what the pathway will be.

My client's symptoms seem to be maintained by some powerful but elusive force that has a life of its own. Client and therapist can readily find and thoroughly demystify the source of the power driving unwanted states and behaviors. The source consists of implicit emotional learnings that are urgently committed to certain tactics for avoiding suffering and ensuring well-being. You can bring about transformational change through welcoming, valuing, and cooperating with these learnings instead of battling them.

Searching for relevant information in a client's past too often feels like looking for a needle in a haystack. Bringing to light the truly relevant elements in your client's emotional memory can become quicker, easier, and more accurate by using simple coherence-guided experiential methods designed for that purpose.

I feel that my efforts are too easily rendered ineffectual by clients' resistance. Like other seemingly negative responses, resistance is coherent and full of accessible emotional meaning that can pivotally assist the therapeutic process if it is honored and sensitively “unpacked” and understood.

14 *The Emotional Coherence Framework*

I frequently help clients deeply understand the causes of their symptoms, yet no real shift occurs and their suffering persists. That's because revealing and understanding the underlying emotional learnings is only the first half of the process of transformational change. The rest of the process is well-defined in the TRP, but doesn't just happen by itself, as a rule.

I want my sessions to provide me more often with learning experiences for growth of my clinical skill and understanding. The process explained in this book will teach you to make new uses of your existing skills as well as add new skills to your repertoire. Guiding clients to retrieve implicit emotional learnings into awareness involves steady tracking of a client's experience in each session, supplying you with ongoing feedback on your clinical choices, as does eliciting client feedback early in each session on the effects of the previous session and between-session task.

At the end of my workday, I seldom feel satisfied that I've facilitated new breakthroughs that end my clients' sufferings. Real breakthroughs can be a frequent occurrence in your day-to-day practice, thanks to the knowledge we now have of the brain's built-in process for profound change of existing, core emotional learnings. For us clinicians, hearing a client report a decisive change in glowing terms is a moment of deep professional fulfillment. Imagine enjoying several such moments every week...

Subject Index

- abandonment 173, 185, 187, 209, 282, 286, 287, 289, 341, 346
- abuse in childhood 71, 75, 91, 96, 126, 129, 163, 173; sexual 163, 274
- Accelerated Experiential Dynamic Psychotherapy (AEDP): case example of 163–70; juxtaposition experience in 164, 165
- Acceptance and Commitment Therapy (ACT) 3, 66
- accessing sequence 68; complications in 33; definition of 33, 46; time required for 33; variations of 147
- accompaniment, therapist's 54, 132, 174, 207, 269
- accountability, need for 92, 84, 112, 136, 177; *see also* justice
- addictive/compulsive behavior, case example of 258–70
- ADHD, case example of teen diagnosed with 345–50
- AEDP *see* Accelerated Experiential Dynamic Psychotherapy
- affect avoidance *see* emotional suppression
- affect regulation *see* emotional regulation
- agency, becoming aware of 55, 86, 93, 94, 124, 129, 252, 263, 265, 285, 286
- Ainsworth, Mary 113
- alcohol abuse, case example of 258–70
- Alexander Technique 4, 146
- alliance, therapeutic: and non-specific common factors 47, 153, 155
- aloneness 99, 116, 122, 163, 280, 281–2, 346–48
- amygdala 19, 113
- anger 47; as resistance to grieving 97; case example of 111–12, 173, 177, 251; evoked in ISTDP 213, 217–19, 220, 221, 224; feared from others, case example of 190–205
- anniversary relapse 277, 285
- anxiety 25, 47, 81, 117; case example of 48–67, 100–5, 125–35, 258–70, 316–25; maternal, during pregnancy 142; over being gay 316–25; social 258–70, 316–25; social predictors of 110
- artistic domain of learning 111
- athletic domain of learning 111
- attachment: as a focus for psychotherapy 109, 115; as one domain of learning 109–15; terms of 118–19; types of insecure 115–18
- attachment learnings, insecure: absence/presence revealed experientially 12, 111–12, 121–40, 208–9, 261–5; case examples of 85–90, 105, 121–40, 163–70, 172–9, 207–11, 258–70, 290, 316–25, 326–43, 345–50, 362; cases unsuitable for reparative attachment work 120, 136–9; disconfirmed by therapist's empathy 122–4, 163–70, 207–11, 258–70, 345–50; disconfirmed by other than therapist's empathy 86–8, 95–6, 102–4, 121, 125–35, 136–9, 190–205, 212–25, 226–40, 326–43, 351–9, 360–2; examining childhood for 100, 122, 137, 173–4, 262–4, 316, 341–2, 346; family rules/roles causing 105, 136, 326–43; generating panic 330, 341; as not

- underlying all symptoms 12, 109–15;
 primary vs secondary 119, 137; role of
 client–therapist relationship in changing
 100, 119–40; role of, in terms of
 attachment in 118–19, 127, 136, 263–7,
 288–90; transformation of 85–90, 90–
 100, 119–40, 163–70, 207–11, 290;
 types and content of 116–18; *see also*
 disconfirmation: of attachment
 learnings; juxtaposition experience:
 targeting attachment schemas;
 reparative attachment therapy
- attachment patterns, insecure: coherent
 basis of 85, 115–17; dismissive type
 116; as emotional learning/schema 94,
 115–17; dismissive type 116; infant's
 learning of 115–17; insecure-
 ambivalent 116; insecure-avoidant 116;
 insecure-disorganized 117, 125;
 insecure-resistant 116; and merging 85–
 90; preoccupied type 116; unresolved
 type 117
- attachment relationship: definition 115
- attachment research 109; by Mary
 Ainsworth 113; by Mary Main 115
- attachment therapy case examples:
 complex attachment trauma 90–100,
 125–35, 163–70, 172–9, 190–205, 212–
 25, 326–43; obsessive attachment 85–
 90, 149–51; other than reparative
 attachment work 85–90, 90–100, 105,
 114, 121–2, 125–35, 136–9, 149–51,
 326–43
- autism spectrum 39
- autobiographical memory: lack of 71; non-
 impairment of 21, 24; therapeutic
 formation of 133
- autonomy, as issue in therapy 220–1, 263,
 269
- avoidance of affect 164, 167, 214–25
- avoiding emotional intimacy: case
 examples 122–4, 207–11
- ayahuasca in psychedelic-assisted therapy
 226–240
- Bastianelli, Laura *xxiii*
- behavioral updating via reconsolidation 18,
 20–1; advantages of, over
 pharmacological erasure 19, 21
- betrayal 110, 112, 224
- between-session task: eliciting results of
 14, 57; for integration 57–81, 94, 118,
 132, 250, 251, 253, 265, 273, 281, 282,
 283, 284, 287, 313–15, 321, 347, 355;
 for juxtaposition 89, 255; for terms of
 attachment 118; of writing 321, 318; *see*
also index card
- bilateral stimulation: in Coherence
 Therapy 280; in EMDR 180–8
- bodily experiencing 56, 101, 132, 128,
 164, 168, 182, 241–3, 261, 272, 283,
 287, 304–5, 334, 337
- bottom-up versus top-down: causation of
 symptoms 8, 42; process of
 transformational change 42, 75, 77;
 therapeutic methodology 241, 242
- boundary conditions: allowing
 reconsolidation 17
- Bowlby, John 109, 111, 119
- brain, emotional: coherent functioning of
 6–9, 52, 117, 133, 146
- brain imaging 113
- brain's rules for unlearning 4–5, 20–3, 144;
 and psychotherapy unification 147; *see*
also reconsolidation; reconsolidation
 research; therapeutic reconsolidation
 process; unlearning
- Bridges, Sara K. 136
- bullying 110
- Bussanich, Renee 360, 362n1
- case examples: listed by chapter, symptom,
 and type of therapy *xvi*
- causation of symptoms *see* symptoms,
 causation of
- causation versus correlation, determination
 of 4, 36
- CBT *see* cognitive-behavioral therapy
- challenging defenses 212–25
- characterological avoidance of emotional
 vulnerability 40
- child therapy, case example of Coherence
 Therapy for 351–9, 360–2
- Ciechowicz, Monika 351, 359n1
- class, social 110

- client-therapist relationship: choice of use of 12, 114, 135; reparative attachment work using 122–5, 207, 258–70, 289–90; role of, in outcome research 153; schema-specific use of 114
- codependency 110, 114; as emotional learning 117
- cognitive-behavioral therapy 66; as emotional regulation 39
- cognitive defusion 66
- cognitive dissonance 65
- cognitive insight, ineffectiveness of 11, 54, 134, 186
- cognitive re-appraisal techniques 3
- cognitive regulation *see* emotional regulation
- cognitive restructuring 66, 278
- coherence: of autobiographical narratives 133, 158; of emotional brain 6–9, 52, 117, 133, 146, 158; of implicit-learning-based symptoms 6–9, 49–51, 60, 85–6, 91–5, 101–2, 115–18, 127, 269–70; of insecure attachment patterns 115–18; of panic attack 186; of self 77; *see also* symptom coherence
- coherence empathy: definition 53; example 55, 263–6, 346
- Coherence Therapy: agency experienced in 55, 86, 93, 94, 124, 129, 252, 263, 265, 286; anti-symptom position in 52, 68; applicability of 47; for attachment insecurity 85–90, 100, 105, 121–40, 268–70, 288–90, 326–43, 57–8, 86–7, 94, 132, 250, 251, 253, 265, 273, 281–285, 287, 314–15, 321, 342, 347, 355, 359; bilateral stimulation within 53, 279–82, 285; client populations suitable for 47; as clinical discovery of unlearning sequence 44, 46; construed meanings in 51, 123, 128, 183, 280, 281, 288, 299, 312, 342; counter-indications for 47; cross-cultural use of 47; definition of 45–8; as demonstrating therapeutic reconsolidation process 11, 45–8, 48–68, 79–106, 121–40; de-pathologizing effects of 52, 77, 94; discovery phase of 46, 50–4, 85–6, 122, 126, 249–55, 260–5, 271–3, 279–87; dream work within 53, 101, 105; and the Emotional Coherence Framework 47, 61; emotional truth of the symptom in 52, 112, 122, 127, 137, 260, 265, 273, 280, 297, 300, 302–4, 319, 321, 341, 347, 355; as evidence based 47; experiential nature of 50, 51, 52–4, 55–6, 58, 61, 62, 67, 80, 84, 87, 91, 93, 96, 101–104, 112, 118, 131, 281, 283, 332, 342, 354, 356; as explicitly matching therapeutic reconsolidation process 5, 11–12, 45–8, 50, 68, 70, 77, 80, 147, 151; finding contradictory knowledge step of 46, 61–3, 68, 79, 80, 82–3, 84–5, 86–8, 95–6, 102–4, 106, 114, 119, 121–2, 123, 127–8, 134, 135, 138–9, 141, 254, 274, 288, 319, 342, 347, 356, 359; Focusing used within 53, 260, 283, 284; functional symptoms 52, 53, 81; functionless symptoms 53, 81; history of 45; index of published case examples of 45; integration phase of 46, 55–9, 86, 93–4, metacognitive awareness in 62; methodology of 45; mindfulness of therapist in 49, 50; non-counteractive nature of 58, 57, 68, 90, 267, 268–9, 359; non-interpretive nature of 47; number of sessions needed in 75, 274; parts work within 53, 86, 272, 287; as phenomenological 47, 61; pro-symptom position in 52, 56, 57–9, 62, 66, 68, 80–1, 84, 251, 264–5, 269, 274, 280–1, 283, 285, 287; re-enactment used in 100–5; resistance addressed in 74–75, 86, 93, 97–9; stance of therapist in 51, 77, 12, 267; steps of methodology of 46; symptom identification as first step in 46, 48, 91, 101; symptoms dispelled by 47; target of change in 62, 31, 80–3, 95–6, 127; the two sufferings 52, 137, 253, 264, 273, 282, 284; therapist's creativity within 9, 11; transformation phase of 46, 62–6, 86–9, 95–9, 102–4, 122–5, 127–35, 139, 255–7, 274, 319–20, 321, 326, 331, 332–40, 347, 348, 356–7, 361; verification of schema dissolution in 46, 64, 66–7, 41, 90, 99, 104, 315, 340–3, 349, 358; *see also*

- contradictory knowledge,
finding/creating; integration phase;
juxtaposition experience;
transformation phase
- Coherence Therapy for attachment work:
case examples 121–40, 258–70, 316–
25, 326–44, 345–50, 351–9, 360–2;
disconfirmation by therapist's empathy
in 122–4, 258–70, 316–25;
disconfirmation other than by therapist's
empathy in 85–90, 90–100, 125–35,
136–9, 326–43, 351–9, 360–2
- Coherent Narrative Therapy, case
examples of 316–25, 345–50
- coherent narratives 133
- common factors *see* non-specific common
factors
- common factors theory 153; critique of 12,
153–5; research refuting 153; and
specific treatment effect 154; *see also*
non-specific common factors; specific
factors
- compassion as a marker of change: toward
another 177, 223, 230; toward self 132,
133, 168, 172, 191, 192, 288, 317, 323,
347
- complex attachment trauma: case examples
of 90–100, 125–35, 172–9, 190–205,
212–25, 326–43; conceptualization of,
in Coherence Therapy 73–4
- complicated grief, case example of 226–40
- compulsive: attachment behavior 85–90;
drinking 258–70; eating 271–5;
perfectionism 125–35, 249–57; pleasing
117; underachieving 90–100
- connecting up 304, 309
- Connor, Timothy A. 276, 290n1
- consolidation, memory 15–6
- constructivism 61
- constructs, implicit: disconfirmation/
dissolution of 61, 63, 79, 80–4, 87, 95–
6, 97, 102, 104, 114, 124, 130, 138,
274; as knowings 82; as maintaining a
mirage or spell 10, 44, 106, 114, 140;
symptom-generating operation of 51–2,
53, 70, 89, 95, 106, 123, 134, 137
- constructs, problem-defining *see* problem-
defining constructs, solution-defining
see solution-defining constructs
- contextual range of schema 67, 70, 124,
130
- contradictory knowledge: definition 33,
62; sources for 83, 106, 135, 141; as
Step C of therapeutic reconsolidation
process 32–3, 46, 61–3, 80, 106;
summary listing of techniques in
examples 107, 141; *see also*
contradictory knowledge,
finding/creating
- contradictory knowledge, finding/creating:
in attachment work 86–8, 95–6, 119–22,
127, 135, 327, 331, 342, 356; in client's
existing knowledge 83, 86–8, 95–6,
106, 274, 310, 331; as guided by
retrieved schema 80–3, 95–6, 342; as
launching transformation phase of
Coherence Therapy 46, 61–3, 356; as
needed for juxtaposition experience 21,
83, 127; in new learning 62, 83, 102–4,
106, 122–5, 356, 361; resistance to 97–
99; for traumatic memory 72, 100–105,
127–9, 141, 274; using client's
experience of therapist 123, 163–70,
212–25, 258–70; using empowered
reenactment 102–4; using *I'm in
memory* practice 131–5; using imaginal
techniques 127–30; using opposite
current experience 62, 90, 356; using
overt statement/mismatch detection 84–
5, 86–8, 90, 96, 106, 127–9, 139, 141,
274, 310; *see also* juxtaposition
experience; memory mismatch;
transformation phase
- control, need for 263–5
- corrective emotional experiences:
enhanced creation of 26–7, 142;
fulfillment of the unlearning sequence
by 26–7, 142
- Côté, Sophie xxiii
- Coughlin, Patricia 212–14
- counteractive methods/strategy of change:
affirmations 184; clinical situations
requiring 39; in Cognitive-Behavioral
Therapy 39; contrasted with
transformational change 10, 38–40, 65,
151–3, 267, 269; definition of 38, 57,

- 151; divided self persisting in 38, 68; emotional root of symptom persists in 68, 151; emotional regulation as 38–40; extinction as prototype of 39; incremental change produced by 10; ongoing effort required in 22, 38; in positive psychology 39, 48, 184; relaxation techniques as 40; suppressive effect of 28, 57, 65, 151; susceptibility to relapse of 38, 38, 68; thought-stopping as 90; as utilizing Hebb's law 39; varieties of 40, 90; *see also* emotional regulation
- counteractive reflex 57, 58
- counter-indications for therapeutic reconsolidation process 39
- couple relationship: case example of repeated failures of 122–4, 207–11, 212–25
- Cousineau, Pierre *xxiii*
- crisis intervention 39
- cross-cultural therapy 47, 291–315
- Davanloo, Habib 212
- decision path for reparative attachment 120, 127, 137
- deconsolidation *see* destabilization
- Deep Brain Reorienting 146
- delusions, case example of 276–90
- denial 287–9
- de-pathologizing of symptoms 7, 38, 45, 53, 55, 77, 94, 104, 124, 146, 158, 191, 207, 265, 347
- depersonalizing 164
- depression 40, 42, 47, 142; case example of 172–9, 212–25, 226–240, 276–90; hypothyroidism-induced 10, 39; social predictors of 110
- despair 112, 279, 284
- destabilization of neural encoding 15–18
- de-suppression of traumatic memory 30, 71–2, 101–2, 133
- developmental trauma *see* complex attachment trauma
- DID *see* dissociative identity disorder
- differentiation: from family rules/roles 105; as a goal of therapy 110
- disconfirmation: of attachment learnings 86–89, 96, 102–4, 121–40, 164–6, 269; context-specific nature of 124, 130; by existing knowledge 83, 86–8, 95–6, 274; of generalized learnings must have experienced; in juxtaposition experience 62–6, 86–8, 96, 122–4, 140, 229–32, 255–7, 274, 361; of mental model/constructs 59–66, 90, 102, 125, 130, 185, 229–32, 288, 361; by new learning 61–6, 83, 102–4, 122–4, 164, 269, 288–90; in reconsolidation research 20; in reparative attachment work 122–4, 164–6, 269, 288–90; specificity of 27, 61, 80, 106, 124, 147, 154, 216, 229, 238, 290, 336, 342; of traumatic memory 70–4, 100–5, 134, 180–8, 290, 326–43; *see also* contradictory knowledge, finding/creating; juxtaposition experience; transformation phase
- discovery experiences in Coherence Therapy: altered state during 55, 266; bilateral stimulation used for 280–1, 285, 290; creation of 50–1, 85–6, 91–5, 111, 122, 126, 136, 249–53, 260–4, 271–3, 327–31, 345–7; definition of 50; experiential nature of 51; sentence completion for 85, 92–4, 252, 254, 272; symptom deprivation for 50–1, 91–2, 250, 260–5, 271–3, 287, 346; therapist stance for creating 51
- discovery phase *see* Coherence Therapy: discovery phase of
- dissociation 53, 57, 71, 72, 116, 117, 134, 207
- dissociative identity disorder 78
- dissolution cascade 82
- domains of experience/learning 109–15, 140, 144, 146, 157; case example of 111–12
- dream work: for schema discovery 53, 101–2, 105; markers of change in 105
- dual focus: in EMDR 180, 184, 187; phenomenology of 187, 188–9
- dyadic regulation of affect *see* emotional regulation

- Ecker, Bruce 291, 315n1
- ecological validity of MR lab studies 35–6
- effectiveness of psychotherapy 3, 4, 7, 23, 27, 30, 114, 35–7, 121, 135; and common factors 153–5; enhancement of, via reconsolidation 4, 5, 36, 37, 143; and outcome research 3, 37, 153–5
- EFT *see* Emotion-Focused Therapy
- Elliott, Robert 172
- EMDR *see* Eye-movement Desensitization and Reprocessing
- emotion: effects of de-suppressing 25, 132, 154, 172, 280, 280; as generated by mental model 25, 60, 159–79, 175; process of change of 20, 25, 111–12, 159–79, 172; role of, in reconsolidation 25–6, 159–79; specific factor of experiencing 153
- Emotion-Focused Therapy (EFT): case example of 172–9; parts and chair work in 176; therapeutic reconsolidation process in 172–9
- emotional arousal: role of, in memory reconsolidation 25–6, 159–79
- emotional brain *see* brain, emotional
- emotional closeness avoidance, case example of 122–4, 207–11
- Emotional Coherence Framework: complex trauma conceptualized in 71; components and definition of 9, 61; and constructivism 61; as de-pathologizing 117, 146, 158; and the emotional brain's coherence 117, 146, 158; and formation of coherent narratives 133; as enhancing therapist growth and satisfaction 13–14; emotional learning conceptualized in 71, 113, 117; as guiding Coherence Therapy 47; as guiding clinical use of attachment theory 12, 109, 113, 117–118, 120, 121, 124, 140; as guiding the therapeutic reconsolidation process 146; as non-theoretical 9; as phenomenological and non-interpretive 47; as schema-specific approach 114
- emotional deepening: examples 55, 92, 122–123, 126, 132; factors that enhance or block 56; schema retrieval as 51, 92, 122–123, 126
- emotional learnings/schemas 6–9; adaptive, self-protective nature of 7, 13, 48–49, 115–18, 158, 272–3; apparent indelibility of 15; attachment or non-attachment content of 7, 10, 12, 42; clients' insecure attachment patterns as 115–18; coherence of 6–9, 49, 85–6, 91–5, 101–2, 111, 113, 127, 158, 254, 270; construed meanings in 51, 123, 184; definition of 6, 49; domains of experience that form 109–15; as emotional truth of the symptom 52, 56, 127; examples of 6; experience of disconfirmation/unlearning of 63–5, 86–8, 95–6, 102–4, 122–5, 135, 138, 269; formation of, in early attachment experiences 115–18; formation of, in existential experiences 110; formation of, in social experiences 110; generalization of 122–23, 125, 244–5; as implicit knowledge and implicit memory 6–9, 10; and limbic system/subcortical brain 8, 10, 52, 133; mental models in 6–9, 49, 80–3, 114, 122, 124; non-conscious functioning of 8, 49–50, 68, 83, 84, 111, 125, 137; as the past living in the present 8, 111, 114, 131; as root of symptom production 9, 49, 54, 127; schema structure of 59–61, 80–3, 127; specificity of nonverbal constructs/knowings in 49, 80–3; symptom caused by two or more 33, 65, 69, 89; symptoms not caused by 10, 39, 42, 113; tenacity of 7, 15, 41, 111; terms of attachment as 118–19; *see also* constructs, implicit; mental models; schema, implicit; symptom-requiring schema
- emotional memory *see* emotional learnings
- emotional necessity of symptom: as adaptive implicit knowledge 7, 49, 115–18; as avoidance of suffering 49, 52, 81, 86, 115–18; as non-conscious learning 7, 49–50, 81; retrieval and experience of 50–4, 85–6, 91–5, 124; as symptom's coherence 7, 49–50
- emotional regulation: basic process and strategy of 38; competitive nature of 38;

- contrasted with transformational change 22, 38–40; effort required to maintain 11, 38; in Cognitive-Behavioral Therapy (CBT) 22; in exposure therapy 22; in positive psychology 22; incremental change from 38; persistence of divided self in 38; susceptibility to relapse in 38; *see also* counteractive strategy of change
- emotional safety/stability: detecting problematic reactions 54; dissociation 54; in EMDR 182; learning client's emotional capacity 54, 281; permission to re-suppress for 54; small enough steps for 54, 72; suicidal ideation 286; and therapist's accompaniment 54, 132
- emotional suppression: case example of 163–70
- emotional truth of the symptom 52–4, 56–7, 81; definition 52; emergent moments of 55, 112, 122, 127, 137, 265, 281–2, 297, 300, 302–55, 319, 347; *see also* pro-symptom position; symptom coherence; symptom-requiring schema
- empathy, therapist's: to both sides of juxtaposition experience, 65, 123; coherence empathy as special form of 53, 55, 346; disconfirmation of schemas by 112, 120, 123, 136, 137–8, 166; as experience of secure attachment 120, 123; as a non-specific common factor 153; and voice tone 56; *see also* coherence empathy
- engram: changes in, due to unlearning 20, 29–30
- erasure of an emotional learning: as demonstrated in laboratory studies 15–23, 24, 35, 29–30
- ethnicity 110
- evaluation of reconsolidation claims 40–1
- evolution: and tenacity of emotional memory 8, 10, 42
- existential domain of learning 110, 112
- existential difficulties 54, 99
- expectation, implicit learning-based 6, 10, 15, 17, 20, 21, 25, 27, 29, 63, 72, 74, 82, 88, 106, 117, 126, 131, 138
- experiences, internal: as distinct from external procedures 4, 17, 19, 22, 45, 148, 152
- experiential dissonance 65
- experiential work: as defined in Coherence Therapy 50, 51, 52; example in AEDP 163–70; examples in Coherence Therapy 48–68, 85–105, 111–12, 122–4, 125–35, 136–9; example in EFT 172–9; example in EMDR 180–9; example in IFS 196–206; example in IPNB 207–11; example in ISTDP 212–25; example in SE 241–6; limbic language for 56; tone of voice for 56, 128, 271; *see also* bodily experiencing; Coherence Therapy: experiential nature of; retrieval of symptom-requiring schema; techniques, experiential
- exposure therapy: as counteractive 39; as extinction training 39; as susceptible to relapse 39
- extinction: as distinct from reconsolidation 28–9; competitive, temporary nature of 15, 22; in exposure therapy 39; as prototype of counteractive methods 39; during reconsolidation window 28
- Eye-Movement Desensitization and Reprocessing (EMDR): case example of 180–8; combined with Coherence Therapy 279–82, 286, 290; dual focus in 180, 184, 187; therapeutic reconsolidation process fulfillment in 180–8
- family of origin rules/roles: case examples focused on 105, 125–35, 316–25, 326–43; as terms of attachment 118–19; *see also* attachment learnings; attachment patterns
- family system therapy 34, 47, 105, 114; *see also* terms of attachment
- fantasy *see* ideal fantasy solution
- Faulkner, William 111, 114
- Feixas Viaplana, Guillem *xxviii*
- flashback 105, 133
- Focusing 53, 260, 283, 284, 290; felt sense in 66, 260, 283

- Fosha, Diana 163
- fragmentation of psychotherapy field 3, 42, 143
- functional symptoms: as avoiding a worse suffering 52, 81; case examples 52, 112, 124, 263, 273; definition 52, 81
- functionless symptom: examples 53; definition 53, 81
- gender 110, 114
- Gendlin, Eugene 260, 283
- generalization of implicit learning 25, 122, 125, 127, 223
- genetic predisposition: to addiction 39; as inborn temperament 113; research findings on 113; role of, in schema production 42, 114; role of, in symptom production 113–14, 142n2
- Geoghegan, Niall 271, 275n1
- Gestalt therapy 34, 101, 290; and EFT 172
- glossary 363–9
- González, Débora 227, 234
- Greenberg, Leslie 172–3, 178–9
- grief/grieving 47, 66, 68, 95, 97–9, 112, 123, 133, 167, 173, 176, 184, 187, 213, 223, 226–7, 233, 252, 255–6, 296, 349; resistance to 98, 167, 253–4
- group therapy for children: Coherence Therapy in 360–2
- guilt 182–4, 185, 187, 213, 223, 249–57
- Hakomi 146
- hardship, objective: as addressed in Coherence Therapy 54; client's recognition of 174
- Hebb's law 39
- helplessness 53, 100–5, 106, 116–17, 112, 126, 173, 176, 198, 219, 241, 245, 252–3, 254, 267, 277, 279–80, 286, 322
- history, searching in client's 13, 60, 112, 122, 125, 137, 262–3, 288, 317, 327–31, 346; *see also* original sufferings, revisiting
- homophobic oppression: case example of 316–25
- hypothyroidism 39
- hypervigilance 71, 73
- ideal fantasy solution 96, 99
- identity: defined by insecure attachment learnings 126, 288; and feasibility of reparative attachment 139–40; as mental model defining self 126, 185, 281; loss of 185; protection of 287; as unlovable/worthless 126, 281; *see also* dissociative identity disorder; low self-esteem; self
- IFS *see* Internal Family Systems Therapy
- I'm in memory* practice 131–5; calming and de-pathologizing effects of 132, 134; instructions for 132; as integration of original sufferings 132–3; juxtapositions created by 134; as mindfulness of retriggering 133
- imaginal therapeutic process 34, 36, 53, 58, 63, 70, 85, 91, 100, 102, 102–4, 122, 128–30, 131, 135, 174–5, 177, 202–3, 209–10, 218–22, 242–3, 249–51, 254, 260–2, 283, 284, 287, 317, 342, 346, 354–5; brain's response to 100
- implicit knowledge *see* emotional learnings; mental model
- implicit to explicit retrieval 12, 14, 32–3, 49–50, 61, 79, 81–2, 84, 87, 113, 114, 118, 121, 125, 133; examples 50–1, 85, 91–3, 111, 122, 126, 136–7, 271–3, 327–30, 346–7; *see also* retrieval of symptom-requiring schema
- incremental (partial, mild) change: contrasted with transformational change 3, 9, 10, 38, 157; as produced by competitive new learning 9, 15, 22, 28, 29, 38, 38, 39; as type of change detected by RCTs 3, 37, 153; ongoing effort required to maintain 11, 38; *see also* counteractive methods/strategy of change
- index card for between-session task: for integration experiences 57–8, 62, 86–7, 94–5, 98, 126, 251, 253, 265, 273, 281–4, 287; for juxtaposition experiences 66–7, 89, 98, 130, 255; for verification of schema nullification 99; *see also* between-session task
- inner child work 34, 53, 88, 191–205

- insecure attachment *see* attachment learnings, insecure
- integration experiences in Coherence Therapy: definition 55; experiential, visceral quality of 56; felt purpose/function of symptom in 55, 58, 62, 86, 93–4, 124, 137, 250, 252, 264, 287; via *I'm in memory* practice 131–3; as mindfulness of symptom-requiring schema 57–8, 355; via overt statement technique 55–6, 58, 86, 93, 250, 251, 252, 254; *see also* between-session task; index card; integration phase; markers of integration
- integration of brain functions 207
- integration of psychotherapy *see* psychotherapy integration
- integration phase in Coherence Therapy 55–9; as completing retrieval/Step B of therapeutic reconsolidation process 55, 59, 60; definition 55; experience of purpose/agency in 55, 58, 62, 86, 93–4, 124, 137, 250, 252, 264, 287; *see also* integration experiences; markers of integration
- Intensive Short-Term Dynamic Psychotherapy (ISTDP) 212–25
- Internal Family Systems Therapy (IFS) 190–205
- Interpersonal Neurobiology (IPNB) 207–11
- invisibility 71, 81, 89, 117, 284
- IPNB *see* Interpersonal Neurobiology
- isolation 172–9, 249–57, 276–90
- ISTDP *see* Intensive Short-Term Dynamic Psychotherapy
- Jasiński, Michał *xxii*, 234, 240n3, 351
- Johnson, Susan 172
- justice/injustice 49, 60, 92, 95, 99, 112, 136; *see also* accountability
- juxtaposition experience: client's experience of 21, 65, 125, 184; confirmed by markers of transformational change 67, 90, 99, 104, 129, 139, 223–5, 230–6, 269, 288, 315, 324, 339–43, 349, 357–8; context-specific nature of 67, 70, 124, 130; definition 65; as empathy toward both sides 65, 88, 123; examples 63–5, 88, 104, 123–4, 128–9, 174–5, 184–5, 187, 198–9, 209, 220–2, 244, 250, 256, 274, 288, 289, 311–12, 319, 326, 332–3, 335–8, 342, 348, 356–7, 361; fulfills the unlearning sequence (Steps 1–2–3 of the therapeutic reconsolidation process) 46, 63–5, 79–80, 84, 123, 165, 169, 176, 177, 184–5, 239; via *I'm in memory* practice 134; implicit/tacit/unnoticed occurrence of 104, 148–51, 169, 175, 229, 230, 239, 244, 246, 305; index card for repetition of 66; meta-cognitive/mindful awareness in 64, 168; in psychedelic-assisted therapy 229–39; via re-enactment 102–64; resistance to 74–5, 97–9, 120, 333–82; resulting from mismatch detection 84–5, 87, 90, 95, 128–9, 139, 255, 274, 319; somatically created 242–3, 335; as specific factor in transformational change 155; targeting a master construct 82, 83, 128–9, 139; targeting attachment schemas 119–25, 128–9, 135, 139, 164, 269, 330; via therapist's empathy 123–4, 164–5, 269, 290; *see also* contradictory knowledge; disconfirmation; memory mismatch; transformation phase; transformational change; unlearning sequence
- Kagan, Jerome 110, 113
- Lane et al. (2015) 23, 26, 40
- latent cause 17, 28
- laughter as marker of change 64, 66
- limbic language 56, 130
- limbic system 10, 56
- Lipton, Benjamin 163, 164, 167, 170
- living knowledge 32, 56, 62, 77, 80, 83, 87, 106, 114, 118, 122, 135, 140
- living memory 132, 134
- low self-esteem/self-worth: as adherence to terms of attachment 127, 288, 289; as badness 174; coherence of 50–1, 123, 126, 289; as feeling incapable 48, 265; of a gay man 316–25; as perfectionism

- 126–9, 250–1, 253; as response to mistreatment 122, 125–6, 175; as response to powerlessness 265, 280–1; as self-blame 135, 173, 184–5; as shame 173, 282; as unlovable/worthless 126, 282; *see also* identity; self
- Lydon, Michael 326, 344n1
- Main, Mary 100
- map of schema contents/structure 59–61
- marijuana: used for relief from anxiety 320, 324
- marital sexual aversion 136–9
- markers of integration: awareness of revealed themes 58, 86, 274, 284; disorientation 254, 265; experience of agency/purpose 55, 58, 86, 94, 124, 265, 274; relief of de-pathologizing 55, 94, 124, 132, 265
- markers of transformational change: as aiding therapist's learning 70; as caused by reconsolidation only 22, 41, 69, 145; client's report of 64, 67, 90, 99, 104–5, 129, 139, 167–70, 175–7, 185–6, 205, 210–11, 223–5, 233–6, 243, 255–7, 269, 274, 285, 288–9, 315, 337, 338, 338–40, 343, 349, 357–9; as confirming juxtaposition experience 139, 145, 210; definition 22, 69, 145; with grief/distress 66, 97, 129, 186; with mirth/laughter/joy 64, 66, 139, 169; as not due to extinction 18, 22, 28–9; as verification of TRP fulfillment and unlearning 33, 46, 67, 99
- Martignetti, C. Anthony 249, 270n1
- master construct: definition 82; examples 82, 95, 138, 255; how to identify 80–3; as primary target 82
- materring 118, 122–4
- meaning, implicit constructs of 6, 20, 31, 35, 47, 50–1, 52, 54, 55, 58, 61, 64, 66, 76, 77, 89–90, 118, 125, 126, 129, 134, 154, 251, 282
- mechanism of change: memory reconsolidation as first identification of an internal 4–5, 36, 148, 156; reconsolidation empirically identified as 23
- meditation: used for disconfirmation of target schema in Coherence Therapy 326–43
- memory mismatch: as boundary condition 17; brain's detection of 84–5; through contradiction 20, 27; finding, via overt statement of schema 84–5, 87, 90, 95, 106, 128, 139, 141; as juxtaposition experience 16, 17, 28–9; as required for reconsolidation 16–17; as Step 2 of unlearning sequence 20, 21, 34, 46, 63; as violation of expectation 17, 63; *see also* contradictory knowledge; juxtaposition experience; mismatch detection; reconsolidation; reconsolidation research
- memory reactivation: as required for reconsolidation 16, 21; as Step 1 of unlearning sequence 21, 34, 46, 63, 84; of target construct 63, 84
- memory reconsolidation *see* reconsolidation; reconsolidation research
- memory types 7; autobiographical 21, 25, 44, 71; classical fear conditioning 16, 18, 20, 35; declarative 19, 26; episodic 6–7, 21, 30, 59, 72, 78; semantic 6–7, 25, 30, 59, 73, 78; traumatic 54, 70–4, 100–5; *see also* autobiographical memory; emotional learnings/schemas; traumatic memory
- mental model: adaptive functioning of 60; constructs within 6, 60–2, 80–3, 114, 118, 127, 254; of defectiveness of self 76; as generator of emotions 25–6, 175, 177–9; as driver of symptom production 6, 49, 60, 60, 115, 127, 207, 281; emotion as arising from 7; examples 6, 81, 122, 127, 130, 166, 186, 254, 274, 281, 358; as expectation of how the world functions 6, 123, 127, 166; formed in infancy 6, 49, 60, 81, 122, 127; insecure attachment based in 116, 118; map of structure of 59–61, 81–3; modular nature of 60; as non-conscious instruction to self 60; non-verbal nature of 6, 81; "problem" defined in 59–60, 81–3; resistance arising from 74; as

- semantic memory 6; "solution" defined in 59–60, 81–3; specificity of 62, 80, 114; as target of unlearning for transformational change 7, 21–2, 25–6, 30, 32, 60, 62, 69, 106, 127, 130, 154, 177–9; of terms of attachment 118, 122; in traumatic memory 72, 127, 183, 187; *see also* constructs, implicit; disconfirmation; emotional implicit learnings/schemas; schema, implicit; symptom-requiring schema
- merging: case example of 85–90
- metacognitive awareness, therapeutic use of 62, 167, 194, 228; in creating juxtaposition experiences 168
- mindfulness, therapeutic use of: in cognitive defusion in ACT 66; in integration experiences 57–8, 64, 78n3, 133, 355; in juxtaposition experiences 64, 166, 239; for the therapist 49–50, 81
- Minuchin, Salvador 110
- mismatch of memory *see* prediction error
- mismatch detection creates juxtaposition experience 84–5, 86–8, 90, 95–6, 128, 139, 187, 255, 274, 304; *see also* contradictory knowledge, finding; juxtaposition experience; prediction error
- Mnemonic Therapeutic Action Unification (MTAU) framework 152
- multiplicity of mind systems 190
- narratology 316
- natural disaster trauma, case example of 180–8
- needs: accessed via emotion in EFT 172
- neural encoding of target memory: changes in, due to unlearning 20, 29–30; destabilization of 15–18; revision of, via reconsolidation 18–22
- neurobiological, bottom-up causation of symptoms 8, 42
- neurodiverse population, applying the TRP for 75–6
- Neurolinguistic Programming (NLP) 5, 146
- neuroplasticity, reconsolidation as type of 12, 44
- neuroscience's implications for psychotherapy: as changed by reconsolidation research 4–5, 36, 148, 155–7
- neurotransmitters 42
- non-specific common factors: catalytic role of 90, 135–136, 155; components of 47, 140, 153; definition 153; as having limited role for transformational change 125, 154–5; as prerequisites of Coherence Therapy 48; research indicating minor role of 154; as supporting specific factors 155; suitability of, for reparative attachment therapy 125; and therapist as attachment figure 140; in unifying synthesis with specific factors via the unlearning sequence 153–5; *see also* common factors theory; specific factors
- Noppe-Brandon, Gail 78n6, 316, 325n1, 345, 350n1
- obesity, case example of 271–5
- obsessive attachment, case example of 85–90, 107
- online video sessions: case examples of 190–205, 326–43
- original sufferings, de-suppression of: and de-pathologizing of self/symptoms 132, 134, 265; and forming coherent narratives 133; and grieving 97, 98, 133, 176; and past versus present discernment 134, 186; via *I'm in memory* practice 131–3; requires small-enough steps 54, 72; as requiring empathetic accompaniment 54, 173; serving schema retrieval in original context 122, 137, 174, 254, 273; and self-compassion 132, 288; for traumatic memory work 72; *see also* de-suppression of traumatic memory; traumatic memory
- outlier sessions: in creation of Coherence Therapy 46; in outcome research 3, 37, 153
- overt statement technique: for integration of discovered schema 55, 57–8, 86, 93, 250–1, 254, 273, 297, 300, 355; for

- mismatch detection of contradictory knowledge 84–5, 86–8, 90, 95–6, 128, 139, 187, 255, 274, 304, 356; for resistance to be explicit 97; for verification of schema nullification 99, 358; *see also* techniques, experiential
- panic: case example of 125–35, 180–8, 326–43; revealed coherence of 142n3, 186, 341, 343
- paradoxical intervention 59
- parts, concept of 190
- parts work 53, 86, 176–177, 272–4, 287, 190–205
- past versus present discernment 186, 207; via *I'm in memory* practice 131–3, 134
- perfectionism 6, 126–30, 135, 250–1, 254–5
- permanence of symptom cessation 8, 22, 34, 42, 46, 69, 145
- pharmacological blockade of reconsolidation 15, 19, 21
- pharmacological treatment: appropriate situations for 39; inappropriate situations for 8
- phenomenology of mental life 61, 109, 113, 121, 135, 158; *see also* constructivism
- physical assault trauma, case example of 241–6
- play therapy, case example of 360–2
- Polyvagal Theory 159n2
- positive psychology: as counteractive 39; as emotional regulation 39; relapses of low self-worth with 48
- “post-retrieval extinction” as misnomer 28
- post-traumatic symptoms (PTSD): cessation of, in suicidal adolescents 41; cessation of, via TRP 70–4; list of 71; TRP conceptualization and strategy for 70–4
- post-traumatic symptoms (PTSD), case examples of: using Coherence Therapy 100–5, 125–35, 271–5, 276–90, 326–43; using EMDR 180–9; using *I'm in memory* practice 131–5; using re-enactment 100–5; using SE 241–6; *see also* complex trauma; traumatic memory
- powerlessness *see* helplessness
- prediction error: as launching memory reconsolidation 15–18; as required for memory destabilization 15–18; as violation of expectation 17; range of degrees of 17–18
- preparation phase of the TRP 31–3, 46, 148
- Presence Psychotherapy 146
- problem, implicit knowledge of a 59; insecure attachment learnings as 116–7, 120, 122, 127, 138; as knowledge of vulnerability to specific suffering 59, 73, 89, 92, 122, 127, 138, 267; as mental model of world or self 60, 122, 127, 138; as major part of symptom-requiring schema 60, 62, 81, 86, 89, 92, 116; as target for unlearning 81–3, 102, 107, 141; *see also* mental model; solution-defining constructs; symptom-requiring schema
- procedural knowledge 7
- procedures: as distinct from internal experiences induced 4, 17–19, 22, 148, 152
- Process-Experiential Psychotherapy 172; *see also* Emotion-Focused Therapy
- procrastination: Coherence Therapy case example of 291–315
- Progressive Counting 5, 146
- pro-symptom position–pro-symptom schema: definition 52; examples 56–60, 62, 81, 86–7, 94, 249, 251, 264, 269, 274, 279–81, 283, 285–90, 318; ownership (integration) of 58, 280–1, 287; resistance to ownership (integration) of 86, 93, 285–7; *see also* emotional truth of the symptom; mental model; purpose; symptom-requiring schema
- psychedelic-assisted therapy: case example 226–40; criteria for using 239–40; integrative processing in 239
- psychoanalytic paradigm 212
- psychodynamic paradigm 212

- psychosomatic symptom 214, 217, 223–5
 Psychosynthesis 190
 psychotherapy integration/unification:
 attachment as a basis for 109, 140;
 therapeutic reconsolidation process as a
 basis for 140, 144–57
 PTSD *see* complex trauma; post-traumatic
 symptoms; traumatic memory
 purpose in symptom-requiring schema:
 adaptive nature of 7, 52, 81, 136, 254,
 267, 269, 274, 287; de-pathologizing
 effect of recognizing 7, 53, 56, 94, 130;
 experience of retrieving 51–2, 55, 58,
 86, 93–4, 129, 137, 250, 252, 253–4,
 266, 287; *see also* emotional truth of the
 symptom; mental model; pro-symptom
 position; symptom coherence;
 symptom-requiring schema
- racist/ethnic oppression: as a source of
 emotional learning 110; Coherence
 Therapy case example addressing 291–
 315
- randomized controlled trials (RCTs): as
 basis of common factors theory 153; as
 measuring mild, incremental change 3,
 37, 153; as unable to detect
 transformational change 3, 37, 153
- RCTs *see* randomized controlled trials
 "reactivation-extinction protocol" as
 misnomer 28
- reactivation of schema: as ended by the
 unlearning sequence 8, 22, 35, 37, 69,
 89–90, 99, 105; as insufficient for
 schema memory destabilization 16–17;
 as engaging semantic but not episodic
 memory 6; as Step 1 of the unlearning
 sequence 20–1, 25, 31–4, 41, 46, 63, 69,
 84, 100–2, 154
- reconsolidation: boundary conditions for
 17; as brain mechanism for unlearning
 4–5, 18–22; definition 4, 16, 24;
 discovery of 15–17; as following
 memory de-consolidation
 (destabilization) 16; as initiated by
 prediction error 15–18; neural encoding
 revised by 9, 18–21, 29–30; as
 mechanism of lasting change in
 psychotherapy 4–5, 7, 22–3, 35–6, 39,
 42, 148, 156–7; as neurologically
 distinct from extinction 22, 28; as only
 type of neuroplasticity that nullifies
 emotional learning 12, 22, 35, 41, 69,
 145; permanence of symptom cessation
 from 8, 22, 34, 42, 46, 69, 145;
 pharmacological disruption of 16, 19,
 21; precision of unlearning through 24;
 reconsolidation window 16, 18, 24, 69,
 151; and strategy of psychotherapy 31–
 3; and transformational change 22–3,
 38–40; *see also* therapeutic
 reconsolidation process
 reconsolidation window 16, 18, 24, 69, 151
 reductionist view of symptom production 8
 re-enactment, empowered: counter-
 indication for 106; for depotentiating
 traumatic memory 40, 100–6, 135; *see
 also* post-traumatic symptoms
 re-encoding of memory via reconsolidation
 9, 18, 20–1, 24, 29–30, 41, 47, 69, 154
 relaxation techniques 40
 repair process, interpersonal 48, 93, 96, 98,
 136, 230–6
 reparative attachment therapy: in AEDP
 163–70; in Coherence Therapy 122–4,
 258–70, 289–90; common factors not
 sufficient for 140; conditions
 allowing/disallowing 135–40; critique
 of 110; decision path for suitability of
 120, 127, 137–8; emotional regulation
 via 38; examples of lasting change via
 122–4, 141, 163–70, 207–11, 135–40;
 in IPNB 207–11; as optional for
 attachment work 90, 114, 121, 127, 131,
 137–8; rationale for 119, 207; as
 requiring non-adult identity state 139;
 schema-specific suitability of 114, 120,
 127, 135–40; *see also* attachment
 learnings; attachment patterns;
 disconfirmation: of attachment
 learnings; juxtaposition experience:
 targeting attachment schemas
 reparenting 110, 114, 119, 121
 research: on attachment 113, 115–17; on
 factors influencing development 110,
 113; on memory 7–8, 39; on memory

- reconsolidation 4, 15–19, 23, 26, 28–30, 35, 46; on psychotherapy outcome 3, 26, 37, 153–5; on psychotherapy process 36–7; using randomized controlled trials 37, 153–5; on the TRP as cause of transformational change 36–7; *see also* attachment research; reconsolidation research
- resistance: coherence of 13, 97–9, 252–5, 283; Coherence Therapy's methodology for dispelling 74; examples of Coherence Therapy dispelling 86, 93, 97–9, 252–5, 264–9, 278–88; to integration of schema/emotional truth 86, 93; to juxtaposition experience and schema annulment 74–5, 97–9, 120, 252–5, 333–5; overt statement of 97, 253, 266; to symptom deprivation 283
- resource utilization 39, 74, 100, 153
- retrieval of symptom-requiring schema: accuracy of 8, 31, 49–51, 60, 81, 114, 121; as awareness of how symptom is emotionally necessary 7, 52–3, 58–60, 68, 69, 72–3, 81, 85–6, 92, 112, 137, 266, 273, 287, 320, 326–8; completeness of 55, 58–9, 60–2, 86; as experiential deepening 56, 92, 112, 122–3, 126; as finding symptom's coherence 7, 49–50, 53; as launching mismatch detection 84, 86, 90, 95, 106, 128, 139, 255, 274; limbic language for 56, 130; non-counteractive nature of 38, 57, 59, 65, 151, 266, 268; non-interpretive nature of 50–1, 112; as not dissolving schema 155; as opening schema to disconfirmation 62, 84, 274; phenomenological nature of 112, 121; as revealing domain of learning 111–12, 146; as source of coherent narratives 133; as Step B of therapeutic reconsolidation process 32–4, 46, 51, 59, 176, 183, 209; *see also* agency, becoming aware of; de-pathologizing of symptoms; discovery experiences; discovery phase; emotional deepening; experiential work; imaginal therapeutic process; implicit to explicit retrieval; integration experiences; integration phase; meaning, implicit constructs of; mental model; problem, implicit knowledge of a; purpose in symptom-requiring schema; small enough steps; solution, implicit knowledge of a; target construct for disconfirmation; terms of attachment; traumatic memory; verbalization using limbic language
- reverse resolution 78n4
- reward 60
- "rewriting" of implicit learning 18, 21, 28, 47, 151
- Rice, Laura 172
- Ritalin, case example of child medicated with 345–50
- schema: definition 6
- schema, implicit *see* constructs, implicit; emotional learnings; mental model; symptom-requiring schema
- Schema Therapy 158n1
- Schnarch, David 110
- Schoninger, Beverly 180
- Schwartz, Richard 190
- Scott, Derek 191
- SE *see* Somatic Experiencing®
- self: de-pathologized sense of 77, 124, 132, 134, 265; disconfirmation of implicit constructs/mental model of 104–5, 125, 134, 175, 185; divided 38, 68; *see also* identity; low self-esteem
- Self, essential 190
- self-blame: for avoiding helplessness 129, 253; case examples of 129, 184–5, 249–57, 276–90; by children 360–2; *see also* guilt; low self-esteem; self-hatred
- self-compassion 132, 133, 168, 172, 191–2, 288, 317, 323, 347
- self-doubt: case example of 48–68, 81; *see also* low self-esteem
- self-expression, inhibited: case examples 48–68, 291–315, 316–25
- self-hatred 242, 250, 280–1, 287; *see also* low self-esteem
- self-talk, critical: case examples 48, 326–43
- Sensorimotor Psychotherapy 146

- sentence completion technique 85, 92, 97, 128, 252, 254, 272, 284, 327
- serial accessing 282
- sexual abuse, childhood 163, 272–4
- sexual orientation 47, 316–25
- sexual problem, case study of 136–9
- shame/shaming 6, 25, 47, 52, 54, 73, 76, 91, 124, 126, 165, 173, 175, 177–9, 207–8, 252, 279, 286, 288–90, 299–303, 314, 317, 320, 347, 349
- Shapiro, Francine 180, 188
- Sibson, Paul 249, 257n1
- silence 56, 64
- skill-building 39, 153
- small enough steps 54, 72
- social anxiety: 67; case examples of 125–35, 258–70, 316–25
- Social-Cognitive Transactional Analysis 5, 146
- social domain of learning 111, 112, 114
- social factors: as predictor of mood symptoms 110; role of, in development 110
- social narratives 114
- solution, implicit knowledge of a 59; formed in attachment learning 116–17, 137; as ideal fantasy 94–5, 99; as knowledge of urgent protective tactic 59–61, 73, 87, 89, 92, 124, 267; as major part of symptom-requiring schema 60, 62, 81, 86, 89, 92, 116, 272, 274; as mental model 60; protective tactic defined by 59; as symptom's direct cause 52–3, 81; symptoms expressing lack of 53; *see also* mental model; problem, implicit knowledge of a; symptom-requiring schema
- Solution-Focused Brief Therapy (SFBT) 351, 353, 359
- Somatic Experiencing®: case example 241–6
- somatic symptoms: caused by somatizing 8, 212–25; post-traumatic 71
- specific factors: definition 153; as experiencing avoided emotional meaning 154; psychotherapy process research evidence for 154; in relation to common factors 153–5; and specific treatment effect 154; in unifying synthesis with common factors via the unlearning sequence 153–5; *see also* common factors theory; non-specific common factors
- specific treatment effect: and common factors theory 154; definition 154; of the unlearning sequence 154; *see also* common factors theory; specific factors
- spiritual bypass 327
- spiritual domain of learning 111
- stage fright, case study of 100–5
- stance of therapist: as anthropologist 51, 114, 251, 270; learns from client 51, 77, 114, 270; non-counteractive 57, 59, 65, 90, 96, 266; not-knowing 51, 114, 270; phenomenological 11, 47, 112, 158; trusting client's capability to revise learnings 65, 77
- storage deficit versus retrieval deficit 29–30
- strategies of psychotherapy: counteractive vs transformational 22, 38–40, 41, 65, 68, 96, 151–3; *see also* counteractive strategy of change; transformational change
- suicide of mother, case example of 226–40
- symptom cessation: as caused by unlearning a schema/mental model 7, 22, 42; as caused by the unlearning sequence of MR 18–19, 35–6, 42, 90, 105; as effortless to maintain 22, 34, 35, 46, 49, 69; as explainable only by MR 12, 22, 35, 41, 69, 145, 155; permanence of 7, 22, 34, 46, 69, 90; *see also* markers of transformational change
- symptom coherence: as adaptive emotional necessity of symptom 7, 49, 52, 60, 73, 113–17, 124, 158, 264; definition 7, 49; of functional symptoms 52, 81, 112, 124, 263, 273; of functionless symptoms 53, 81; as guiding efficient discovery/retrieval 13, 50, 51; as knowing to avoid specific suffering 52, 60, 73, 113–17, 124, 253, 264, 273, 282, 287; as knowledge of two sufferings, with and without symptom 52, 98, 253, 264, 273, 282; as revealed

- through schema retrieval 85–6, 91–5, 101–2; as symptom production model in Coherence Therapy 6–7, 49, 52; *see also* de-pathologizing of symptoms; purpose in symptom-requiring schema; symptom-requiring schema
- symptom deprivation technique: case examples 50, 85, 91, 249–51, 260–5, 271–2, 283, 287, 346, 354; principle of 50
- symptom identification: case examples 48, 91, 101; definition 32, 48; as Step A of therapeutic reconsolidation process 32–4, 46, 48, 68
- symptom-requiring schema: attachment vs non-attachment related 115, 120–1, 111–12; in complex trauma 73–4; contextual range of 67, 70, 124, 130; as disconfirmable, or not, via reparative attachment 111–12, 120, 127, 137; as durable mental object 41, 53; as emotional learning 6–9; as emotional truth of the symptom 52–3, 56, 127; as findable/accessible 49, 51; as implicit knowledge of how to avoid a suffering 49, 59, 81, 86, 116–17, 124, 126, 137, 253, 265, 273, 282, 287; map of structure of 59–61; specificity of 6, 9, 59, 62, 69, 72, 80, 274; symptoms having more than one 33, 65, 69, 89; tenacity of 7, 41, 53, 44, 116; uniqueness of 13, 20; *see also* agency; attachment learnings; emotional learnings/schemas; emotional truth of the symptom; mental model; overt statement; problem, implicit knowledge of a; pro-symptom position; reactivation of schema; solution, implicit knowledge of a; symptom coherence; terms of attachment
- symptoms, causation of *see* agency; attachment learnings; bottom-up versus top-down; emotional learnings/schemas; emotional necessity of symptom; emotional truth of the symptom; genetic predisposition; mental model; neurobiological causation; pro-symptom position; symptom coherence; symptom-requiring schema; temperament
- symptoms dispelled in case examples, listed by chapter and type of therapy *xvi*
- target construct/schema for
 disconfirmation: as basis for finding contradictory knowledge 32–3, 62, 80–2, 84, 102, 106, 119, 121–2, 127–8, 138–9, 141; selection of master construct as 80–3, 95, 102, 127, 183; summary list of target examples 106, 141; in traumatic memory 101, 127, 183; *see also* constructs, implicit; contradictory knowledge; disconfirmation; discovery experiences; master construct; mental model; mismatch detection; symptom-requiring schema
- target of change: schema versus emotion 25, 48, 51, 60, 68, 175, 159–79
- techniques, experiential *see* bilateral stimulation; bodily experiencing; chair work; challenging defenses; coherence empathy; dream work; dual focus; Focusing; *I'm in memory* practice; ideal parent figure; imaginal process; index card; inner child work; juxtaposition experience; mismatch detection; overt statement; parts work; re-enactment, empowered; sentence completion; serial accessing; symptom deprivation; welcoming resistance
- temperament, inborn: research findings 113; role of, in symptom production 113–14, 142n
- terms of attachment: definition 118; examples 118; case examples 122–4, 127, 136, 136–9, 220–2; as primary vs secondary attachment learnings 119, 137; and reparative attachment work 120; sexualized 136–9; *see also* attachment learnings; attachment patterns
- theory-free framework for psychotherapy 8, 11–12, 34, 36, 45, 49, 50, 112, 121, 135, 145, 146, 152, 158

- therapeutic reconsolidation process:
 accessing sequence in 34; in AEDP 163–70; applicability of 30, 39, 144, 148, 156; for attachment schemas 119–40; case example for initial demonstration of 48–67; clinical discovery of 44, 45–7, 156; in Coherence Therapy 45, 48–67, 85–105, 249–62; collaborative nature of 11; as common factors theory disproof 39, 153–5; as core process of therapies of transformational change 3–5, 23, 144–8, 163–246; counter-indications for 39; cross-cultural use of 47, 291–315; as defined by experiences, not procedures 4, 17, 19, 22, 45, 148, 152; detection of, in therapy sessions 12, 145, 163–246; definitions of steps of 21, 32, 68–9; in EFT 172–9; as embodying brain's rules of unlearning 9, 22, 26, 79, 84, 143, 144, 147; in EMDR 180–8; as an empathetic process 9, 53, 55–6, 64–5, 74, 88, 122–3, 125; as an experiential process 4, 9, 12, 17, 19, 22, 34, 44, 49, 80, 148, 152; as evidence-based 35–7; as guiding reparative attachment work 122–5; in IFS 187; in IPNB 207–11; in ISTDP 212–25; list of steps of 21, 34, 46, 84, 144; as new learning nullifying old learning 9, 18, 21, 31, 38, 39, 41, 44, 47, 65, 69, 119; as non-counteractive 38–40, 57, 65, 68, 69, 90, 96, 134, 150–1, 157; as non-pathologizing 38, 45, 53, 55, 77, 94, 104, 124, 146, 158, 191, 207, 265, 347; as not requiring lengthy repetition 39, 41, 65; permanence of symptom cessation from 8, 22, 34, 42, 46, 69, 145; preparation phase of 31–3; in psychedelic-assisted therapy 226–40; re-encoding of memory by 9, 18, 20–1, 24, 29–30, 41, 47, 69, 154; as schema-specific approach 114, 120, 127, 135–40; in SE 241–46; sequence of steps in various therapies 147; spectrum of fulfillment of 152; steps of, as same as Coherence Therapy 45–8, 156; technique independence of 9, 11, 17, 22, 34, 40–2, 44, 68, 70–2, 72, 80, 114, 144, 146, 157; theory independence of 8, 11–12, 34, 36, 45, 49, 50, 112, 121, 135, 145, 146, 152, 158; therapeutic effects of, vs emotional regulation 38–40, 68; therapists' freedom/creativity within 9, 11, 34, 45, 70, 83, 114, 131; transformation phase of 34; for traumatic memory 100–5, 125–35, 180–8, 241–46; as unifying framework of psychotherapy 3–5, 12, 23, 143–57; unrecognized occurrence of 34, 45, 148–51; *see also* juxtaposition experience; markers of transformational change; reconsolidation; reconsolidation research; target construct/schema; transformational change; unlearning sequence
- therapist freedom/creativity 9, 11, 34, 45, 70, 83, 114, 131
- therapist learning/growth: as enhanced by choiceful process 14; from markers of change 69; by observing juxtaposition experiences 151; by tracking client's step-by-step responses 14
- therapist dilemmas 13–14
- therapist satisfaction 3, 13–14, 44; from effectiveness 3, 36, 121, 143, 158; *see also* effectiveness of psychotherapy
- top-down versus bottom-up: causation of symptoms 8, 42; process of transformational change 42, 75, 77; therapeutic methodology 241, 242
- Transactional Analysis 5, 146, 190
- transference reaction, 100, 219
- transformation phase of Coherence Therapy: as carrying out the unlearning sequence of MR 46, 61–6; case examples 61–6, 86–9, 95–9, 102–4, 122–4, 127–35, 137–9, 254–7, 274; as creation of juxtaposition experiences 61–6; resistance arising in 74–5, 97–9, 120, 252–5, 333–5; as Steps C–1–2–3 of therapeutic reconsolidation process 46, 61–6; *see also* contradictory knowledge, finding/creating; disconfirmation; juxtaposition

- experience; transformational change; unlearning sequence
- transformational change: of attachment patterns 119–42; brain's rules for 4–5, 20–3, 144; contrasted with counteractive change 10, 38–40, 65, 151–3, 267, 269; contrasted with emotional regulation 22, 38–40; definition 22–3, 44, 69; distress accompanying 66, 95, 97–9, 129, 252; documented in clinical literature 3; as confirmation of reconsolidation 35; of generalized learnings 123, 244–5; markers of 22, 69, 145; of mental model/constructs 7, 21–2, 25–6, 30, 32, 60, 62, 69, 106, 127, 130, 154, 177–9; as not occurring via Hebb's law 39; as occurring promptly in definite moments 22, 39, 79, 96, 104, 184, 312; psychotherapies of 144–48, 151–3; as regular event in clinical practice 14, 77; as resulting from the MR unlearning sequence only 12, 22, 35; resistance to 74–5, 97–9, 120, 252–5, 333–5; as standard of effectiveness of psychotherapy 5, 36; of traumatic memory 72, 100, 104, 126–9, 181–5, 242–6, 271–5; as unrecognized by researchers 3, 37, 153; *see also* juxtaposition experience; markers of transformational change; permanence of symptom cessation; unlearning sequence; verification of transformational change
- translation of MR lab research to therapy 17, 22, 31–3
- Traumatic Incident Reduction (TIR) 146
- traumatic memory: affective flashback of 105, 133; “big-T” versus “little-t” trauma 71; definition of 71; de-suppression (accessing) of 30, 72, 133; disconfirmation and depotentiation of 72, 100, 104, 126–9, 181–5, 242–6, 271–5; dissociated (suppressed) state of 72–3, 134, 280; as emotional learning 102, 104, 106, 131, 244, 274; episodic memory form of 59, 72; helplessness as core component of 100–2, 104–6, 241; *I'm in memory* practice for 131–5; indications of 54, 71; integration of 131–5, 274; and past/present distinction 134, 186, 274; preventing hyperactivation of 54, 182; retrieval of 101–2, 121–7, 242–3, 271–3; semantic/schema memory form of 59, 72; window of tolerance for accessing 72; *see also* post-traumatic symptoms; posttraumatic symptoms, case examples of
- ulcerative colitis, case example of 212–25
- underachieving, case example of 90–100, 136
- unemployment 110
- unification: via the Mnemonic Therapeutic Action Unification framework 152; of psychotherapies by memory reconsolidation 23, 143, 155–7; of specific versus common factors duality 153–5
- unlearning/nullification of implicit emotional learnings: autobiographical memory unaffected by 21, 24, 69; behavioral sequence for 21, 34, 46, 68–9, 84, 144; brain's rules and readiness for 4–5, 20–3, 39, 144; client's experience of 21, 61, 64, 67, 87, 89, 99, 104, 129, 138, 255, 269, 274, 288–9, 339–41, 343, 349, 357–9, 361; clinical discovery of process of 44, 46; and Emotional Coherence Framework 47, 61; as ending the influence of the past 114; grief in response to 66, 97, 186; identifying target for 80–3, 101, 127, 138, 165, 182; markers of 22, 69, 145; by new learning of contradictory knowledge 9, 18, 21, 31, 38, 39, 41, 44, 47, 65, 69, 119; as occurring in definite moments 39, 79, 96, 104, 184, 312; as occurring in juxtaposition experiences 46, 63–5, 79–80, 84, 123, 155, 165, 169, 176, 177, 184–5, 239; as occurring via reconsolidation 4–5, 21, 41, 44, 79; permanence of 8, 22, 34, 42, 46, 69, 145; as re-encoding 9, 18, 20–1, 24, 29–30, 41, 47, 69, 154; as requiring emotional brain's consent 74–5, 97–9;

- as requiring specificity of
 disconfirmation 27, 61, 80, 106, 124,
 147, 154, 216, 229, 238, 290, 336, 342;
 research demonstrating 15–23, 24, 29–
 30, 35–6; resistance to 74–5, 97–9, 120,
 252–5, 333–5; as rewriting of memory
 18, 21, 28, 47, 151; specificity of 24;
 swiftness of 39, 79, 96, 104, 184, 312;
 as therapeutic reconsolidation process
 outcome 33, 41, 69, 143; as updating of
 memory 18, 20–1; advantages of, over
 pharmacological erasure 19, 21; *see*
also contradictory knowledge;
 disconfirmation; juxtaposition
 experience; target construct; therapeutic
 reconsolidation process;
 transformational change; unlearning
 sequence
- unlearning sequence 20–2; brevity of 33;
 clinical discovery of 44, 46, 156;
 definition of steps of 21, 84, 148; as
 distinct from extinction 28–9; implicit
 occurrence of 148–51; as juxtaposition
 experiences 63–6, 84; list of steps of 21,
 84; as nullifying a schema, mental
 model, or construct 9, 18, 21, 31, 38,
 39, 41, 44, 47, 65, 69, 119; as present in
 diverse therapies 4, 144–8; as producing
 markers of transformational change 22,
 33, 46, 67, 99, 145; repetitions of, for
 range of contexts 67, 70, 124, 130;
 research that identified the 15–23, 24,
 35, 29–30; resistance in response to 74–
 5, 97–9, 120, 333–82; serendipitous
 occurrence of 34, 148–50; as a
 specialized recruitment of
 reconsolidation 23; specificity of 24;
 and specific treatment effect 154;
 technique independence of 9, 11, 17, 22,
 34, 40–2, 44, 68, 70–2, 72, 80, 114,
 144, 146, 157; theory independence of
 8, 11–12, 34, 36, 45, 49, 50, 112, 121,
 135, 145, 146, 152, 158; as unification
 of psychotherapy and brain science
 155–7; as unifying the panoply of
 psychotherapies 4–5, 23, 144–8; as
 validity criterion for models of lasting
 change 36; *see also* disconfirmation;
 contradictory knowledge; juxtaposition
 experience; markers of transformational
 change; transformational change
- unlocking of neural encoding *see*
 destabilization
- updating of memory *see* behavioral
 updating; re-encoding of memory;
 rewriting of implicit learning;
 unlearning
- Vaz, Alexandre *xix, xxii*
- verbalization of discovered emotional truth
see index card; integration phase; limbic
 language; overt statement; sentence
 completion
- verification of transformational change
 (TRP Step V): as final step of
 therapeutic reconsolidation process 34,
 41, 46, 66, 175–7, 186, 202, 205, 210–
 11, 223–5, 233–6, 243, 339–43; in lab
 studies 22, 33; markers to be observed
 for 22, 34, 69, 145; question for
 initiating 64, 66, 89; by re-cueing target
 response 33, 67, 99; response to failure
 of 340–3; *see also* markers of
 transformational change
- video, sessions done via online 190–205,
 326–43
- Watson, Jeanne 172
- welcoming resistance 13, 74
- well-being 13, 44, 49, 49, 60, 66
- “What’s under this?” 112
- writing: as between-session task 321, 318
- yoga 40