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Ana Ganho: Today I would like to discuss a case about Maria. She's agoraphobic, and Maria is a thirty-eight old woman, she's engineer and married for 10 years and has a young child of four years, a son. We have been together for almost one year already, and her main goal was to get rid of an overwhelming anxiety that she feels when…, every time she's out of her comfort spaces or routines, like her routine is home-kindergarten-work driving – this is the only spaces where she feels she's comfortable with – and everything else is accomplished only relying on her husband or on a friend, out of which her automatic and obsessive thoughts start looking around for who would be able, who would be available for her in case she has a sudden panic attack. So this paralyzing anxiety started first when she was nineteen, during the first year in the university when one day she – well, to university she had to move out from her parents' house - and this first panic attack happened inside the train when she was getting back to her parents' home during the weekend. To the sessions Maria comes always and invariably with her husband or friend, until now she's not able to come by herself. She describes herself as an over-protected child and she's the youngest of three – with five years distance from her younger brother. The housekeeper that lived with her – with the family or inside the family house – raised her from when she was three months old until she was five-years old.

Bruce Ecker: Ana?

A.G.: Yes, yes Bruce?

B.E.: Could you please say that again. Who raised her?

A.G.: The housekeeper.

B.E.: Ah, ok. Thank you.

A.G.: And… the housekeeper lived inside her parents' house along with her son of five-years old also. Well, the son was the same age – more or less the same age – as Maria. And then… I think there are two things, two episodes that are very important for: one was the death of this boy, he died in 1994 of overdose; and during the year of 1996 her three-year old nice, also called Maria, to which she was very close, dies in a car accident. All family members have university degree, her mother was teacher, her father is a well-known physician as well as her old sister, however she frequently refers herself as less intellectually gifted, which is obvious – especially for her – especially when all the family gets together and she feels invariably very different from them. All along the process I feel she protects her parents very much and she also assumes this, describing them as a very functional and always present every time she needed. However for some brief moments she connects also with some traumatic experiences in her early childhood, where she witnessed hard arguments between mum and dad, and normally during which she stayed quietly and all alone by herself in her room, faking that nothing was happening. In the sessions she's invariably unable to recognize emotions - during these episodes – that this little child may

have felt, which I have been interpreting as resistance. Even when we try to see this from outside or when we tried to visualize these moments as if it was happening to some other little girl other than Maria. We've reached some pro-symptom positions that I think may help us today, so probably I will refer some of them: "It scares me so much to feel I'm all alone and by myself in the world that I need to be sure I'm not alone and so I prefer this absolute dependency on others, despite all the suffering it brings me everyday", "If I dare to be myself and totally independent I'm freer to take decisions and to appreciate my life and live it with more joy. Therefore I can't live my independence without being afraid to lose my family because I'll be stronger and I won't allow myself to disconnect and be dragged to unpleasant feelings for so long", "If I allow myself the right to feel alone, sad and insecure, I feel I'm blaming my husband and parents. And that will move me away from them and that I can't accept because I love them with all my heart".

B.E.: Ana?

A.G.: Yes, Bruce?

B.E.: Please read the first part of that last one again.

A.G.: Ok. "If I allow myself the right to feel alone, sad and insecure, I feel I'm blaming my husband and my parents. And that will move me away from them".

B.E.: Hum, hum. Thank you.

A.G.: Ok. Then: "I must protect my connection to my parents at any cost, because I don't want to move away from them and this is the most important thing to me, even if for that I have to delete myself and delete my emotions, my pain and rage". And the last one "I won't allow myself to feel once again that I lost everything in this life, even if to accomplished that I'll have to make the biggest sacrifice of all". Then I have two dilemmas in this case, shall I bring them to you right now?

B.E.: Yes, yes, because focusing in your dilemmas may be the best way for us to talk. Good.

A.G.: Ok. So Maria asks frequently to get rid of this paralyzing and over-limiting anxiety symptom, even though she understands she's making good progresses. However once she had early experiences in psychotherapy processes - with some colleagues – where she was able to get rid of the symptoms by some months, she feels that at this moment her husband and parents are questioning about this new approach, why isn't she already ok, why isn't she already away from the psychotherapy process and ok to be independent and by herself. So should or shouldn't I correspond to these requests, because I know how to do these CBT protocol and actually we've done it, and we've done it aware that it was the opposite of the process that we have been taking together.

B.E.: Hum hum.

A.G.: So, once she's asking me to take this counteractive role, how much this can be of prejudice to the process. And the other dilemma is that I'm not sure if is the integration work that was not reached yet, or if it was the discovery work that wasn't deep enough and then there remain more pro-symptom positions to uncover.

B.E.: Hum, hum… Ok… All right, good! What I would like to do is begin with the last question or dilemma that you just described, ok?

A.G.: Ok, ok, wonderful.

B.E.: Good. The several pro-symptom positions that you described seemed to me to be very, very important. You've clearly done very good work of finding pro-symptom positions, powerful and emotional needs for maintaining these symptoms, for maintaining the need for so much help and dependence on the important people in her world. But you're wondering if it's a lack of integration work or a lack of depth of discovery work.

A.G.: Hum, hum.

B.E.: In other words, why isn't anything really shifting after finding these pro-symptom positions, yeah?

A.G.: Yes, hum hum.

B.E.: So that's the right question to be asking – first of all. So let's see, let's see… What I imagine as the process going forward from where you are now with her would be very much… a process of… the between session work would be actually the most important work, combined with using each session to go over and really examine together the between session experiences. In other words, having her examine her behaviors – her agoraphobic feelings and behaviors – as they happen or soon after they happen each day, and to have a list of all the pro-symptom positions that she looks at as she thinks about the agoraphobic behaviors and feelings and thoughts that she has recently had earlier in the day. And for her to find or identify which pro-symptom position she was in fact carrying out with those responses.

A.G.: Hum, hum.

B.E.: Not as… - I'm sure you'd understand – I mean not as an intellectual insight or a self-analyses exercise, but to really connect on a body level with the emotional truth of … "yes! In that situation I was feeling too on my own, too alone and too much like I'd be losing connection with everyone if I did that for myself" - whatever, you know, for her to do the integration work in that way, using the situations of life, day-to-day, hour-to-hour, really using each situation to do the integration work.

A.G.: Ok.

B.E.: And then in the next session to review all of that with you.

A.G.: Hum, hum.

B.E.: And that's how I think the integration work would go forward perhaps best with Maria.

A.G.: Yes, I hoped so. The thing is that she barely looks at the index cards between sessions.

B.E.: Ah, ok! All right, so in that case… You mean even when you give the kind of assignment I was just describing?

A.G.: Yes, yes so… probably - I'm not sure – I may have been… I don't know, probably I'm not very focused when I present the task for her…or… I'm not sure.

Usually I feel she's very resistant to it. Almost as if… at the beginning she said to me also already this, at the beginning she had fun with these index cards. Now she doesn't like to look at it.

B.E.: Ok. In that case the main focus of the work that needs to be on her resistance of staying aware of these pro-symptom positions between sessions. And I think we can make a very good guess about what the resistance is – based on everything you already know. Because you already know that feeling alone and on her own is perhaps the main thing to avoid. Is that your view at this point?

A.G.: Yes, yes it is Bruce.

B.E.: Master pro-symptom position is – you know, in words – "I've got to keep myself strongly connected to the people in my life and I got to avoid feeling – or actually being – strong and independent and on my own and sending signals to others that it's ok to leave me alone doing things on my own".

A.G.: Hum, hum.

B.E.: So the challenge - a big part of the challenge you're up against with her – is that the integration work itself requires her to be on her own, with her own emotional truth. That's the very thing she is urgently avoiding.

A.G.: Hum, hum.

B.E.: Yeah, so… so, let's see. The sessions therefore really need to focus on her opposition, her unwillingness to do that, her need to not do that. And what I would recommend is that you very emphatically address that with her, or begin again to address that with her – and you can be, it would be fine to be very transparent with her - that you understand how important it is to not be alone with these emotional truths that are on the card. And I want to suggest inviting her to make an overt-statement to you.

A.G.: Hum, hum.

B.E.: For example an overt-statement of "Ana, I… I've…" – let's see how it would be. May you can help right here to come to some wording, you have a feeling for her way of thinking and her sensibility but the essence of it would be an overt-statement saying "Ana no! I am not going to read this card and I'm not going to get in touch with these things between sessions, because I would feel very alone and I would be agreeing to have that kind of independence, and I'm not going to agree to that, I'm not going to do it". And then to stay there with that and have her… - you know, it's the wound of aloneness and the terror of aloneness that really is the center of all this, as you already know. So this would be a way into that. There're other ways into that, you could do it along a different path other than working on her resistance, but that is really what further progress is going to require, is for you and she to look very deeply – in fact as we speak it gets clearer to me.

A.G.: Hum, hum.

B.E.: Because really this was a lot of information for me to take in very quickly. But as we speak… that together – in fact now I'm getting clearer in a way that makes me want to change what I recommended to you.

A.G.: Ok, ok.

B.E.: Because now I see that what's needed is working in the sessions with her only. Only during being together in the sessions, on what she suffered of aloneness. The deep and deepening emotional truth – going deeper and deeper into the emotional truth – of what she suffered of aloneness in her life. There are several experiences – you've mentioned a few and there may be more, earlier in life – being the youngest, perhaps being… What did you said about being over-protected.

A.G.: Yeah. Hum, hum.

B.E.: Yeah. She calls herself an over-protected child so she was… it might be the opposite of… yeah, she didn't necessarily suffer aloneness, she suffered… - it didn't seem like suffering at the time – she was not prepared to experience or feel aloneness, is too terrifying.

A.G.: Hum, hum.

B.E.: Because she was over-protected or she was maybe never left alone or she was… but she said… did she receive messages in a fact that she's not able to do things on her own, she should be helped?

A.G.: Hum, I don't think so. What I think is that she was…, she was really alone during her childhood.

B.E.: That she was…

A.G.: Well, not alone but she was left alone in her room as she was the youngest, her parents weren't very present while she was playing for example. Her father wasn't able to play with her. The first school work that she had to do at the first grade she asked help to her father, and he came with an encyclopedia, when she wasn't even able to read.

B.E.: Yes… Ok.

A.G.: And she's very resistant to these emotions, she invariably says to me that they were always present, they were always there, they are good parents. These little moments when she connects with this loneliness are things of… moments of one, two, three minutes in session.

B.E.: Hum, hum. And then she disconnects.

A.G.: Yes and then she disconnects.

B.E.: Ok, well I think the path, the main path, is to focus on the aloneness and everything involved in the emotional truth of being alone and on her own being intolerable for her. Finding what she experienced in life that sated up, let her to feel that it's intolerable, too frightening, etc. And if it can only happen for a few minutes at the time at this point that's fine. What I would recommend is that, after a few minutes when she shuts it down, you give her a few minutes to breath and recover from that and then focus on asking her to describe to you what was she experiencing a few minutes ago that was not tolerable.

A.G.: Hum, hum.

B.E.: Exactly what. What sensation in her body, what image, what feeling or emotion and debrief or really go over together - exactly what she was feeling that was so distressing that she had to cut-off from. And you'd be expressing –

you know – empathy and understanding that it was necessary to cut-off from that and giving her permission to do so – in fact – but then looking closely with her at what it was. I think that would be very important.

A.G.: Ok. And always in the session, as you told before.

B.E.: Yes, only in the sessions. Yes, I think it will be… in order for this work to be successful or effective, I think you will need to tell her – to begin with now – that you'll be doing this with her only in the session, you want her not to think about it at all between sessions.

A.G.: Hum, hum. So I shouldn't give her any index card.

B.E.: That's right, that's right. And explain to her very explicitly, very transparently, that you understand that being alone with any of these feelings and any of these meanings is too uncomfortable to do between sessions. And so that now her between session task is to not think any of that, because you understand that it's just not feasible, practical.

A.G.: Yes.

B.E.: And that only when together in the session will the two of you take short looks into these material, in a way that she's likely to stand. Yeah, that's it!

A.G.: Hum, hum. It makes sense, yes.

B.E.: Yes, that's it. And it's not a trick, it's just working with her where she is, with the capacities that she has. In this way you won't evoke resistance in the old way. There will still be the resistance when she shuts-down after two or three minutes, but then you'll look together on the emotional truth of that resistance. In other words, exactly what experience was happening that was too strong, too intense, too distressing to continue.

A.G.: Hum, hum, yes.

B.E.: You will be essentially doing Coherence Therapy on that intolerable experience and the need to shut it down and that will transform that. That process will transform that if you really persist, but this is going to take great persistence on your part.

A.G.: Hum, hum, ok. I will try.

B.E.: Yeah, yeah. This is relatively severe situation you're dealing with.

A.G.: Hum, hum. Yes, I suppose so also. It has been very hard for me to deal with this process.

B.E.: Yeah. You've done well so far getting to the material you have actually with this person, but her pro-symptom positions themselves are so strong at not allowing the between session process, so you'll have to do it all in the session in this way.

A.G.: Hum, hum. Yes, is true.

B.E.: The integration, yeah. Ok?

A.G.: Ok Bruce, thank you, yes.

B.E.: Oh, we didn't get to the other question but I'm not sure if we should keep going. Aníbal, what do you think?

A.H.: I think we have to do the best of our short time. I thought of a short period of question-answer for you, and then if possible maybe another colleague will put you some consultation and supervision again for finishing this session. Would you agree? Good?

B.E.: Ok. Good.

A.H.: Ok. Thank you so much Ana, thank you so much Bruce.

A.G.: Thank you very much Bruce.

B.E.: You're very welcome!

A.H.: And now I would invite José Serra, I think he has a couple of questions to share with us. Ok, Zé? Are you there? Are you listening? Ok.

José Serra – Yes, I am here. Hi Bruce! Hi everybody, good evening. How are you? Ok?

B.E.: Yes, yes!

J.S.: So, Bruce, first of all I would like to thank you for your clinical expertise and mastery, which I think is very important for me on guiding my clinical practice and reflection. I feel that in some ways that Coherence Therapy principles are enhancing my clinical skills and efficacy so, although its complexity, so I'm really, I really thank you so much for your expertise and mastery. I would like to put you some questions, yes Bruce?

B.E.: Yes, good, I'm ready.

J.S.: Ok. First of all I would like to know how do you come to realise that not counteracting the symptom, any symptom, is a major road to clinical efficacy. And second, I would like to know your opinion if all psychotherapy approaches should assume this principle and not try to fix, or replace or work against the symptom. Do you think that suspending the counteractive reflex should be, let me say it, the next level all psychotherapy models should arrive or acquire.

B.E.: Hum.

J.S.: Ok. And then I have another question, do you want to answer or to know all the questions?

B.E.: I think I would like to answer the last question now, right away.

J.S.: Ok.

B.E.: Thanks.

J.S.: Ok, ok. Thank you.

B.E.: Uh, it seems to me that there are some situations where non-counteracting, uh…, work, where deep emotional learnings or emotional schemas are retrieved and transformed, as in Coherence Therapy, that that approach is best practiced in some situations, many situations, but that there are also situations in which counteractive work is best practice. For example, let's see, hum, crisis situations in which very rapid symptom relief is needed, I think counteractive work is best practice there. Hum, anytime the client, a therapy client, is very strongly, hum…, requesting and insisting that there should be no in-depth work, no emotionally vulnerable work, for the clients' own reasons, whatever they are - then

counteractive work is best practice. And of course then your client's at the more extreme end of the spectrum of what is so widely called a character disorder, you know personality disorder, narcissism, borderline, schizoid, uh, at the extreme degree of those conditions accessing underlying emotional truth or unconscious emotional learnings can be so difficult that for all practical purposes it's almost impossible, at the extreme end of that spectrum. And perhaps in some of those situations also counteractive work, symptom relief through counteractive work may be best practice, so…, and maybe in other situations I'm not remembering at the moment similarly in which counteractive work is…, is…, should be considered best practice, but there of course is such a wide range of therapy clients, and situations where the client is capable of doing the in-depth work, and in those cases it may be appropriate to think of the Coherence Theory type work or other therapies that do in-depth retrieval of underlying emotional schemas as being best practice because the results, when that type of work is possible of course, the results are the best, because the underlying material can be truly dissolved, uh, so the emotional roots of the symptom or problem are actually eliminated and so it's profound change, it's permanent change, when that process can be done, so that's best practice when it's possible. Oh, and there's another category of symptoms that are not caused by underlying emotional learnings or schemas, right?

J.S.: Hum, hum.

B.E.: Such as autism or aspergers type of problems, uh… , what else?, hypothyroid induced depression, right? Depression due to hypothyroidism. And there're a few others, there are a few other conditions that are not caused by underlying emotional schemas. Well, in that case Coherence Therapy should not be used to help a person with those conditions. Should be basically the, what we would call the counteractive, the building up of preferred helpful resources and responses, … yeah. So that's my answer to your second question. Your first question was how did you come to this? I'll try to answer to that very briefly. Uh, when we studied for several years, five, six, seven years, we focused on what we though of as profound change events in therapy sessions, when very powerful lasting deep change suddenly happened for a client in a particular session or two, we studied very closely what happened. And when we finally studied many such profound change events, after those years, we identified a process or set of steps, that was always present whenever profound change had happened and those steps became Coherence Therapy. Well first they became what we called Depth Oriented Brief Therapy but then we renamed that, into Coherence Therapy, but it's all the same steps and methodology. Well, what surprised us was that the essential steps that were always present, for profound change, never included counteractive process. In fact it was when we stopped trying for counteractive process and did only these non-counteractive steps of, you know, retrieving just the emotional learnings that are present without any counteracting, that's when profound change would happen. So it became apparent to us in that way. And the more we thought about it made sense. As soon as you start to counteract you're sending a message to the client to disconnect from the, uh, everything inside that is causing the trouble and to try and set up this preferred alternative responses or conditions. So it became clear, once we understood the process that does produce profound change that counteracting is the opposite process –

it disconnects from the material which for profound change must be connected with and retrieved and embraced and directly experienced, so they're actually opposite processes. Ok, so I think I'm ready for your third question.

J.S.: [Laughs] Thank you, thank you Bruce. It's a more general question, a more broader question, uh, from your point of view, which will be the main features of psychotherapy tout court on the next, let's say, two decades. Do you think we will have a general common factors model of psychotherapy, or an evidence based model or do we still have the proliferation of several models. And what about Coherence Therapy? What's next?

B.E.: Hum… Very interesting question. It's very interesting to me or curious to me that you ask this question right at this moment. Because right now I'm writing some articles, which I think I'll try to publish in psychotherapy journals, uh…, that really are my answer to that question. But to say it as briefly as I can, what I see coming is a recognition that whenever profound change occurs, and by profound change I mean that an emotional response and an emotional schema disappears, is eliminated, it dissolves, erased, a powerful emotional response and a powerful emotional theme that has been ripping the person's life and generating responses for decades or a whole lifetime, literally fall away and no longer exist. That's what Coherence Therapy achieves and is designed to achieve and that kind of result is also observed in other therapies at times too. What I see coming is the recognition that whenever that happens in any therapy, or also whenever that happens outside of therapy, it's because of a process that is well defined and it's the same process, whenever that happens. And I believe we now have discovered what that process is and it's the process that we built into Coherence Therapy back in the early 1990's and it's the process that has now been empirically corroborated by what the reconsolidation researchers have found. Are you familiar with memory reconsolidation?

J.S.: Yes, somehow, yes.

B.E.: Yeah. That's the brain's process of actually unlocking the synapses of a stored emotional memory, an emotional learning with the circuits, the neural circuits that encode and store that emotional learning, uh, were believed to be permanent once formed until about 10-11 years ago, when neuroscientists found that actually there is a mechanism by which the brain can unlock the synapses of an emotional learning. And that memory can then actually be erased, removing the emotional learning. And in 2004, only seven years ago the neuroscience researchers, uh…, identified a behavioural process that accomplishes that, and we then recognized that it's the same process that was built into Coherence Therapy, step for step, exactly the same process. And I believe that in any therapy, when that kind of profound change occurs, it is that process that has actually happened, because it's the only known process that can erase an emotional learning. Neuroscientists, so far, this process, the neurological process and the behavioural process that makes it happen, it's the only way known to neuroscience for the brain to be able to erase an emotional learning. So, on that basis I think that we will find that that behavioural process it's actually what's taking place in any therapy when profound change is accomplished, and I'm writing a set of articles that is my attempt to bring the field's attention to this process, so that we can begin to arrive at an unified understanding of deep lasting change and recognize how that same process can

be carried out through many different techniques and methods of therapy. So, best probably if I stop right there, that's probably enough of an answer to give you a sense of where I see of the field heading.

J.S.: Ok, Bruce, thank you so much for your answers and your time. Thank you.

B.E.: You're welcome. Gladly. Thank you for asking.

A.H.: Thank you, Zé. Thank you, Bruce. I think it's time for having another question. This time it's coming again from Ana, she's giving voice to Teresa, she has no voice – she is following us but she has no voice today, so it's Ana who is going to put her question, ok?

B.E.: [Laughs] Ok.

A.G.: Ok. Let's see if I can [Laughs.], if I do it right. As said by Teresa: "In the article Reconsolidation a Universal Integrative Framework for Highly Effective Psychotherapy you, Bruce, presented a very useful six step procedure of the entire erasure process. Personally I find very hard to even imagine how the last step actually occurs in the session. Guide attention alternately to the target learning and incompatible knowledge, several times, so that the two are experienced concurrently, side by side for a few minutes, and maybe this is the crucial step for effective reconsolidation. It is not sufficient to activate vividly the incompatible knowledge or experience - performed at step five. I guess there's an almost natural tendency to stop at step five. Could you give us a clinical example on how the last step should occur in the session?

B.E.: Hum, hum. Ok.

A.G.: Thank you.

B.E.: All right. Yes. Well, thank you Teresa and hello Teresa and thank you. All right, let's see if I can describe that, in clear and brief terms. Yes, an example is best. Now, for everyone else who's listening, step five is, well, let's see, am I certain I know what step Teresa means by step five, I'm not…, so I'll say it this way, uh... As you all know in Coherence Therapy it's very important to find the pro-symptom position, the emotional learning or the emotional schema that the client formed and that is powerfully generating the presenting symptom or problem, and it is very important to guide the client into the direct emotional experience of that pro-symptom position. Uh…, I wonder if that's what Teresa meant by saying it is very natural to stop there. Many therapists expect or believe that reaching that point, the integration and the direct experience of the emotional schema, the emotional learning requiring the symptom, is what should lead to a shift and a breakthrough and a transformational change. But actually what we found is that, although sometimes that does happen, it also happens with some clients that no, they integrate the pro-symptom position, they feel the emotional meanings and constructs and feelings involved and it continues to feel completely real and true. For example, I'm going to use an example that I used in my article in the Psychotherapy Networker in 2008, so any of you who want to really…, read in detail this example you can do it there. This was a man who came to therapy because he was now in his fifties, I think he was 52, for all of his adult life he changed his jobs every two or three years, changed the job, changed the area, the career, all sorts of things, he was a carpenter, and then he was an assistant to field researchers doing geology, all

kinds of things, he was a salesman in a camping supply store. He kept changing and now that he is 52 he is very distressed that he has never become very good at anything and he doesn't make much money because he hasn't, you know, stayed in one career and developed it, and he is very concerned. So, and he keeps, he keeps, he always tells himself he will stay in one thing and then he changes again compulsively. Well, what we found is that in childhood he lived in a …, he's family lived in a small town. His father was in one job, one career, year after year, decade after decade. His father was miserable and depressed and very bitter about being stuck in this one job, in this…, an industrial job, small industrial town. And living close up with his father's intense misery and depression was very frightening to him and he learned very deeply that staying in one job makes a man this miserable, puts a man in hell, kills a man's spirit, if he stays in one job. That's what he learned. But he was not conscious that he had learned that. That's what we found in doing Coherence Therapy, and in a couple of sessions I brought him into being very conscious that by changing jobs he was making sure that the misery that had happened to his father would never happen to him. Even though he was conscious of this, it stayed in force, it continued to feel true that he better keep changing jobs or he'll wind up in the same hell as his father. So this is an example of how integrating the pro-symptom position does not necessarily create a change, what creates a change are these last two steps that Teresa is asking about. What creates a change is for the person, now that he is conscious of the emotional knowledge of the pro-symptom position, the emotional knowledge that requires the symptom, the therapist's job now is to guide him, my job was to guide him into an experience of a personally, an experience of a personal knowledge, a vivid knowledge, that is the opposite, a vivid knowledge that contradicts his learning that staying in one job kills a man's spirit and makes him depressed and bitter like his father. There are actually several different ways to help a client find this contradictory living knowledge. But of course you have to first find the pro-symptom position, to know what needs contradicting. Uh,… with this man my first way of trying to find the contradictory knowledge was to think about everything I'd learned from him, about him, and to review everything looking forward to …gee…, has he told me anything about his life that might be a contradictory knowledge, because often the contradictory knowledge is actually already in the client's possession, but in a very separate compartment from the pro-symptom position. What's needed is to find the contradictory knowledge and make the pro-symptom position and the contradictory knowledge touch. What does 'touch' mean? It means experiencing them both simultaneously, side by side. You are probably aware of the concept of cognitive dissonance, right? When two ideas are present side by side and both cannot possibly be true, right? Well, what we call this juxtaposition experience in Coherence Therapy is an experiential version of that. It's experiential business, it's not just ideas it's an entire emotional reality, uh, one of which is the pro-symptom position, the other something very contradictory, side by side - both cannot be true but both feel true. Well, what I remembered this man telling me was that, uh.., in present time, present day, he volunteers each week, one day, in helping the doctors in the emergency room of a local hospital. And very briefly in our first session he mentioned this and I remembered how his face light up when he mentioned these doctors. And how dedicated they are, how turned on they are, how

meaningful their work is to them, he could see clearly up close with them how alive and meaningful and satisfying their work is to them. And this is what came back to my mind now here in session, what?, three or five, or whatever it was - when now I need to find a contradictory knowledge in contrast to what he learned with his father. So I asked him, I said, you know "Tell more about these doctors. What is it you see in them?" and sure enough he describes this aliveness, this satisfaction. And now I knew I had it, I had the contradictory knowledge. So, I began to do this juxtaposition experience that Teresa is asking about. And I understand why in reading about it seems very mysterious and difficult to understand sometimes, but the actual doing of it turns out to be very simple. And I think that if you read this Psychotherapy Networker article you'll see how simple it really is, because all I did with him and it took two or three minutes - once you have the pro-symptom position, once you have the contradictory knowledge, it can take just a few minutes to do the juxtaposition experience, which is the transformational change. I simply said to him "Let´s review some things that seem true for you, and please let yourself really feel and imagine these things vividly as we review them. You learned with your father, you suffered with your father, seeing how deadened, how miserable, how stagnant, how depressed he was from having one job. And in your life with him it looks and feels so true that having one job and staying in one job, year after year, kills a man's spirit and makes him miserable and dead and depressed, that's so true for you. And stay in touch with that as we now add this: in your work at the hospital it is also so clear and vivid to you that these doctors, staying in their one job year after year are so alive and so dynamic and this is so meaningful to them, the service and the help that they give to people, every day and the use of their skills that they have to come up with right moment to moment is so alive for them, and then you see how much they love their work, it's so clear to you. And how is it for you?" And so right there, right at that point, there's the first setting up of the juxtaposition experience, that very first setting up is what the neuroscientists who study reconsolidation call a mismatch experience. It's a mismatch of what the original learning expects. My client's original learning expects that for a man to stay in one job will only be deadening and miserable for him. So I'm guiding my client to have this experience that is a mismatch of that, a contradiction of what the target learning, the learning we want to dissolve, expects, ok? So, the first time I set up the juxtaposition, that's the mismatch experience number one. The reconsolidation research has shown that that mismatch experience is what unlocks the synapses of the target learning. Now if I keep guiding him to have repeated mismatch experiences of the same kind, the same material, the mismatch experience, the juxtaposition experience now serves as new learning that will re-write, in other words write over or erase the old learning. So I simply, using a very natural style of empathy, I repeated the same juxtaposition. I said "How is it for you to be in touch with both of this?" and then I repeated that by way of an empathic review: "It was so real to you that staying in one job is always so miserable for a man and yet now in your own experience you see – here are these people, these men, these doctors, who are so alive and satisfied staying in one job. And both of these seem true for you, how is that for you?" And, since we're out of time I have to stop. You can read the article to see how it went, but indeed that did transform and liberate him from the original learning. It no longer felt true. Uh, didn't

immediately disappear, there was some complications we had to deal with that are described in the article, but that's the essence of what neuroscientists found about what it takes to unlock the synapses of an existing emotional learning and how we implement that, the same process, in Coherence Therapy. And I believe that that is the same process that has happened in any therapy session when profound change has resulted, even if the techniques look very different from what we do in Coherence Therapy and even if the therapist doesn't know anything about juxtaposition experiences or reconsolidation, and was not trying, uh…, knowingly trying to create a juxtaposition experience, they can happen accidentally and they often do. So, that was many many words. I hope it wasn't too many, I hope you are still awake out there at your computers [Laughs] and I think we have come to the end of our time. Is that right Aníbal?

A.H.: It's time to close this session, Bruce, and we are all very grateful to you for willing to have this webinar and share all your clinical wisdom and experience with us. And we will have to schedule another consulting session somewhere in the future, if you agree.

B.E.: I would love to. This is a pleasure for me. I really appreciate your interest and the quality of the questions. It makes it a really enjoyable experience for me. Thank so much for inviting me.

A.H.: We will be looking forward to another opportunity to join and learn with you and we will have the transcript to share with all of us, as you know, and we will keep in touch and thank you again. And thank you everyone for attending and for so good contributions. Bruce, see you soon, I hope. We'll keep in touch. Good bye, thank you so much.

B.E.: Yes, very good. I'll be looking forward for it. Good bye everyone!

J.S.: Goodbye Bruce!