Bruce Ecker
CT Webinar Transcription
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Aníbal Henriques: So, again, thank you Bruce. Thank you so much for accepting this webinar format and, of course, for creating this inspiring and effective approach that so many of us here in Portugal - and I believe around the world - are willing to learn and use in their clinical practice. And welcome everyone! In order to facilitate the communication and the tape recording of this session I will remind again for keeping your micro closed until invited to share your questions. And we will start this session as agreed with a 25 minutes question-answer period and will finish with a case consultation 25 minutes period too, right?

Bruce Ecker: Good.

A.H.: So Bruce, if you agree we could start right now the question-answer period.

B.E.: Good.

A.H.: And as we talk before, a large majority of our tonight participants are Coherence Therapy beginners, they just had their first contact with the approach a couple of months and a few had their contact in 2009 when you visited us in Lisbon.

B.E.: Hum hum.

A.H.: So I will start inviting our fellow colleague Carla to share some questions on CT with you, ok? So please Carla, could you join us?

Carla Branco: Hello, can you hear me?

B.E.: Yes I hear you very well, hi!

C.B.: Hello. First I would like to thank you for joining us and being able to respond to our questions.

B.E.: Thank you. I've been looking forward to this very much.

C.B.: My name is Carla and I've attended your seminar in Lisbon back in 2009 and have since been very interested in learning more about Coherence Therapy. I've began to try to apply some of the principles and methodology of Coherence Therapy in my psychotherapy sessions but I confess that it isn't very simple - especially when you've been trained, like we have been trained, in counteracting the symptom. Most of our training is focused on that – cognitive-behavioral therapy and so on. What sometimes happens is that I get a bit stuck on discovery work - there are some emotional schemas that seem coherent with the symptom but it's hard to know which one prevails or on which one should I focus on more. Can you perhaps give us some clues on what indicators should we look for in the client that we are in the right track for the emotional truth of the symptom. I mean, when do we know that it is the right time to move forward to integration work. I don't know if I'm making myself clear.

B.E.: Yes, yes, very clear. I think you have asked two questions. One is, when you can see there is more than one emotional schema or pro-symptom position that

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is, that exists and is necessitating the symptom, which one to focus on - which one prevails, you asked right?

C.B.: Yes that's…

B.E.: And then you're also asking when to proceed from the discovery work to the integration work.

C.B.: Yes, they are two questions in fact, yes.

B.E.: Good, ok. All right, so the first one. If indeed you have recognized two different symptom requiring schemas – you know – in the end it's going to be necessary to do the entire Coherence Therapy process of change on each, each one each pro-symptom position, each symptom requiring schema needs to go through that entire process of discovery, integration and transformation. So, in a way it doesn't matter which one you pick first, because you'll have to do all them in that way. The symptom doesn't really completely stop happening until all of the pro-symptom positions have been dissolved - so it doesn't matter. So you don't have to worry too much about which one. In fact, you could even ask the client, which one the client feels would be best to start with.

C.B.: Ok.

B.E.: Or you might have your one subjective sense of which one is bigger and stronger in the client's life. And you might – if you do feel which one is bigger and stronger – that might mean that it would be best to start with that one or it might mean it would be best to wait and do the less intense one first if the client is not really comfortable with this kind of work yet. So really it's a clinical judgment issue. You really can use your own best judgment, not worrying too much because you'll have to do them both or all anyway, ok?

C.B.: Ok.

B.E.: Now, your other question about when to move from the discovery through integration. There too - in this also - there is much flexibility. Often - usually I should say - I do not wait until all parts of a pro-symptom position have been discovered before I begin integration, no. I often, immediately after some piece or step of discovery has been done – in other words, some material that is clearly newly in conscious pro-symptom material has come into awareness, it might be just a small piece, an initial piece, not at all the entire pro-symptom position, but once we have just even the first piece - I might and often do, go ahead and do some integration work on that piece. For example I might invite the client to make what we call an overt-statement of this new first piece of material *"try out saying this to your mother or father or sister or brother visualized and see how it feels to say it as your own emotional truth"* - and that's a step of integration of just that first piece. And then if that goes smoothly and the person, the client, feels *"yes, that feels true, yes… I have that, you know, that's clear"* well, then we would shift back into a next step of discovery starting from that. So really, the work alternates back and forth between the steps of discovery, step of integration, continuing with more discovery, then some more integration and so on until it seems that the entire pro-symptom positions is integrated, ok?

C.B.: Ok, it makes sense. Thank you!

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B.E.: You're welcome.

A.H.: Good. Now will invite Bruno. Bruno could you join us please?

Bruno Afonso: Yes, of course. Hello Bruce, hello Aníbal.

B.E.: Hello Bruno.

B.A.: Hello the others. Well, nice being here, and I'll head straight into the questions maybe. To not to spend too much time…

B.E.: Ok.

B.A.: Well, my first one is: as you wrote in the Depth-Oriented Brief Therapy book it should always be the client current capacity - not the therapist assumptions - that limits what can happen in the session. And my question focuses on the fist part, how do you notice or what kind of indicators do you use to understand that the client is currently not able to go further or that a client is just overwhelmed, instead of being naturally processing difficult material and how do you bring them back to resume discovery or integration work, or do you choose different roads for then on.

B.E.: Ok, all right, just making a note of your question, ok, good. So what are the indications that the client has reached his or her limits of ability to participate in the process at the moment, yeah?

B.A.: Yeah.

B.E.: Hum hum, well the indications that the client is participating are both verbal and non-verbal. In a way you can follow … the therapist can follow his or her own emotional common sense – if you know what I mean. In other words, for example, imagine a social situation, imagine being in a social situation, you can tell when the person you're talking to is really with you, right?

B.A.: Hum hum.

B.E.: Is really tracking, is really with you tuned in the details of what you're saying or describing, and without getting into many technical details about what these various markers are, usually your own native or natural skill at perceiving whether the person you're interacting with is really tuned in with you or not, is all you need. You know, there are some very obvious indications that the client is not staying in the process. For example, a client who has been clearly feeling emotion suddenly is talking much faster and clearly from up in the head and has changed the subject, all right? There's a really clear indication that something has happened, that the client has needed to break the immersion or the involvement in the material. And so if I saw signs such as those, immediately I would say, something such as "*geee… I notice something like a shift in what you just said. A few minutes ago you seemed to be really feeling some of this things and now I notice that you're talking about this in a different way, and I wonder if something about what you're feeling… hum, became perhaps a bit uncomfortable for you. Or perhaps I just suggested a step that was too big of a step. Did anything like that just happened in the last few minutes?".* So, in other words, my typical way of responding when I begin to feel I'm seeing some indications that the client is not able to continue with the process at the moment, I inquire in a very transparent manner. I basically ask the client, I have deliberately learned and trained myself to be able to ask in ways that do not sound like criticism or

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blame. I ask with empathy, I'm clearly giving permission that if the client needed to step away or step out of the process because of this too big of a step, that's fine, but I just need to understand that's what it is. So, let's see, let me ask you right now if that's enough of an answer or are there some specific aspects that you'd like me to speak too?

B.A.: Well, the first part, it sounds like resistance. My question now is what if we accidently encountered trauma and the client is crying desperately and continuously, what do you do then?

B.E.: Ah, I see! So if the client actually went into an area that's too intense, what do you do then? Well, you know, there're many techniques that Trauma Therapy is used for this – and really it's no different in this case – I'd immediately stop doing Coherence Therapy and I immediately – (again I use transparency) - I'll say, you know, *"clearly you just got in touch with something that's very intense for you, can you tell me what's happening?"*. First thing for me is to inquire *"Can you tell me what's happening for you?"* and usually if the person can describe what they're experiencing that's too intense, for them to see that I understand and that I'm with them in the experience to some degree by understanding and I will also say, *"Well this seems to be to big of a step, if this is too intense let's put it aside, can you look at me? Can you look me in the eyes and see that I'm here with you? And we can put this aside, you don't have to stay in touch with this, it's perfectly ok if something came on that's too strong"*. And I'll use whatever, I'll keep changing my approach until I successfully offer the client a way to disengage from what feels too intense and recover from it.

B.A.: Ok, thank you. I think that is fine**.**

B.E.: Well, I'd like to add one other thing very shortly/briefly. Sometimes it happens that the material that was found to be too intense is truly pro-symptom material that we must finally access and retrieve and experience in order to do Coherence Therapy successfully. And when that's the case I tell my client that *"Now that I understand how very vulnerable and intense this area is, that from now on I'll make sure that we take very very small steps whenever we are heading in that direction"* and I tell my client *"I will ask you if this is a small enough step at each step along the way and let's make sure that every step is small enough to feel workable for you".* And almost always Bruno that approach has cleared the way for the work to proceed.

B.A.: That sounds good, yeah, ok. Then may I proceed to another area? Couple and Family Therapy. I imagine that additional resistance may came into play since, well, perceived price to play for revealing owns/ones PSP, pro-symptom position, maybe too high. I mean one might be afraid of letting others know like *"who knows how this information may be used against me in the future?"* and I'd like to know if you confirm that experience and if so, how do you deal with that?

B.E.: Yes, yes, good question. Yes indeed, the delicacy of the work is greater in couple and family therapy, that's right. The therapist must be sensitive to all of those possibilities that you just described and proceed with great sensitivity to everyone in the room and sort of have everyone's back sort of speak, you know? Have a protective view and yet not so protective that you collude with avoidance of key material either. So, it's a delicate process, there're couple and family sessions I do that after the session I feel that I needed every little bit of all

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of my skill to succeed in doing the work well. So this is a very complex topic, and I don't know that I can get into details here in this format, but what I would like to say is… in learning Coherence Therapy I would like all of you who're learning it to feel, to be able to give yourself permission to do most of your learning with the clients with whom you feel comfortable at present. In other words - <u>don't try to learn Coherence Therapy in sessions or with clients that feel quite beyond your skill level yet, you know what I mean</u>? Your skill level will expand and grow steadily and in a few months you'll be able to handle situations that right now seam unworkable.

B.A.: Ok, yeah. Well my next question in this field – I don't know – I'll posit anyway. Necessarily I think the focus - well by what I read - will be at times upon one family member only and what I imagine is that that family member or other family members may protest. The one focused upon may protest because he believes some other family member is the problem and others may protest because they believe they should be telling the story or explaining things to the therapist. And well, how do you deal with that, if that's true?

B.E.: Yes, yes. Well, yes, absolutely, the therapist… it's very important for the therapist to keep all that entire dimension of the situation in mind and I try to distribute the time and attention more or less equally among the people in the session but - as you're pointing out - sometimes that just isn't possible, sometimes the process really does require more focus on one person to go optimally but then, yes, others may be upset about that in some way or the person receiving most of the attention maybe upset about it. Sometimes I've seen that happen, I've seen a client – the one who's getting most of the attention – say *"Gee… does this, does this mean you think I'm the problem, I'm the cause?"*. So I've learned from experience I don't wait until someone expresses a concern about the lack of symmetry, when I notice there's a lack of symmetry in the session I speak up about it first and I comment, I say – you know, in a natural manner, in my own style, you would you your own style – I would say *"You know, I just want to acknowledge that I've been spending so much time talking to this person and I'm doing that because…"* and I'll explain why, very transparently, whatever the really reason is, and I'll say *"You know, it doesn't mean either that I think you're the problem or you're the solution and I guarantee all of the rest of you that you'll have your turn. It is not always possible to make it equal in any one session but overall you'll have as much time"* or I may joke, I may say *"I'll give you as hard time as I may giving he or her!"*, you know? So I take care as much as well as I can, actively.

B.A.: Yeah, I understand, ok. Well maybe I would like to ask you one last question - a general one - that is if you'd like to comment upon using Coherence Therapy with… in groups, tobacco cessation, other addictions and performance enhancement - anything you'd like to say about that in 1 minute maybe, if you like.

B.E.: Yeah, yeah, it works beautifully in groups or at least it did the way I used to do it. I'm not running groups currently but for many years I ran both men's groups and groups for men and women and they weren't focused on a topic but they were focused on whatever problems or symptoms the group members would

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bring in and bring up in a given meeting. And the way I conducted the groups, each person would take a turn, each person who wants time to work on something in that meeting, would take a turn – I mean, first I would go around and write a list of everyone who wants a turn so that I could try to guide the group overall – and then in turn each person would take a turn. First I would work in one-on-one with them, in front of the group (usually we're just sitting in a circle),/. I would work with that person as if it was a one-on-one session, trying to reach the point as soon as possible where we have drop down (you know how it feels in Coherence Therapy when a deeper accessing happens, it's a palpable feeling in the room that *vrumm* sort of we took the elevator down and now in deeper living emotional truth in some rich way) as soon as we're down there I would then ask the person, you know, *"Is this a moment that/where it feels ok to you to hear about what other people in the group might be feeling or might feel a shared experience about this or might have something to offer you about this".* So I turn the process from the one-on-one format to the group sharing interaction format once we're down into a depth level, and the group members became very sort of implicitly trained to expect that and really looking forward to that pivot, that switch to the group process and it worked beautiful that way.

B.A.: Sounds very interesting.

B.E.: Yeah, I really enjoyed those groups.

B.A.: Ok, well, since time is passing by so quickly and there's other questions I guess I think we'll leave that to the end if there's time. So I think I'm happy by now, thank you!

B.E.: You're welcome.

A.H.: Good, thank you Bruno. I'll invite now Teresa Alfama to join us and to share with us a question too. Is it possible Teresa, can you join us?

A.H.: Good.

Teresa Alfama: I hope so.

B.E.: Hi Teresa.

T.A.: Hi Bruce, wonderful to hear you again.

B.E.: Thank you.

T.A.: What I have to… well I do have many questions but due to time restrictions I will ask only two. Referring to the manual, there says… to the different types of material that can be pro-symptom relevant…

B.E.: Yeah.

T.A.: There's a warning that to regard affect as necessary point of access to deeper material greatly limits the many ways and opportunities through which the therapist can usher the client into the material. Well my understanding is that experiential work doesn't need to be mostly emotional and I would like you to comment on this, on the difference between experiential work and emotional work, please.

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B.E.: Ok, I'll try to. I think experiential work always is emotional but not necessarily mainly emotional or dramatically emotional. In other words, experiential work always feels emotionally real and true to the client as distinct from merely intellectual considerations, and that warning in the manual is really intended for therapists who by, because of their previous training were trained to look for emotion - strong clear emotion - and always select strong emotion as the focus for the work. Sometimes that is the fruitful focus in Coherence Therapy too but not always. And very often I find in my sessions, in selecting for pro-symptom relevance - you know - when you're listening to everything the client says, through that filter or through that lens of, you know, asking myself about each communication, each part of communication *"is this telling me how the symptom is necessary to have?"*. The most vivid example is when the client mentions something in a very intellectual manner, no emotion at all – the client might mention in a very dry quick matter of fact manner – some fact about childhood or some fact about a situation that is a very strong indication of what the pro-symptom position is and I will select that and begin doing discovery work, sort of borrowing in, starting from that point as the focus, and that is often very fruitful. So, I'm listening for any kind of material. Sometimes the client will do a nonverbal response, the facial expression might winks or a clinch a little bit over something, even though the words or the emotion give no indication of the response.

T.A.: Or dissociates maybe…

B.E.: Yes, that's right, sudden cut-off or change of topic. You know, in Gestalt Therapy there's that classic moment where the therapist says "Ah! What is this foot trying to say?", you know? 'cause the foot just suddenly started moving, right? So, really, you're observing in all channels and watching closely, listening closely for indications of where is the pro-symptom pathway and is not always emotion.

T.A.: I have another one about the importance of doing discovery work while we are still in the dark.

B.E.: Yes.

T.A.: And the dangers about having talk a lot about the symptom and thing like that.

B.E.: And so, what is your question about that?

T.A.: What are the dangers of talking a lot.

B.E.: Hum hum, ok. So I think what you're asking is 'What is the danger of the assumption that you must first use talking to begin to reveal the pro-symptom theme before you begin the experiential discovery work in that area. And the danger is that you can go on and on and on and spend many sessions without it being very effective. Or at least it will take a lot longer if that is what the therapist is requiring before starting experiential discovery work. We try to teach therapists to become comfortable doing experiential discovery techniques, in the dark without knowing what the pro-symptom material is because then the discovery work begins to find the material very soon, very quickly, it makes the therapy process much more efficient and effective. And the several techniques that we teach at a basic level – the techniques that are

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described in the manual –all have the quality that they can be used in the dark, blind - the therapist does not need to know anything about the pro-symptom position to begin using these techniques in order to evoke or draw the pro-symptom material out into become in visible. And the work is so much more effective that way.

T.A.: Ok. One last question very rapid. The transformation experiences, when we see you on the videos, it seems like a moment in the session. Like in that moment we can almost see reconsolidations of synapses or something like that, and I would like to hear you talk about it. If the transformation is a moment or if it takes longer. What do you think about it?

B.E.: Yeah, this is one of the most fascinating aspects for me. Yes, it does seem to me that the transformation, the dissolving of the pro-symptom emotional theme, or constructs, or the original emotional learning, however you want to think, the schema, yes when finally the juxtaposition experience that causes the dissolving, when finally the conditions are happening, it does seems that the change - the transformation of that material- is very, very, rapid, it does seem to happen in seconds, once it finally happens, and the entire methodology of Coherence Therapy exists in order to arrive at that moment, that's all it's for. And once that moment is happening it does seem very, very, fast. I've seen lifelong powerful emotional learnings - pro-symptom positions - suddenly lose all their power in seconds. It's a very wonderful experience and it seems magical until you study and understand the details of the process that does accomplish that, it's teachable and learnable, there's really no mystery or magic, even though experiencing it or witnessing it in the room has a marvelous quality to it. Now, I should also add that –and I'll try to be brief – sometimes resistance develops right at that point. There are different types of resistance that can develop at different stages, there's resistance to discovery, there can be resistance to integration - you know, a client can allow discovery but then resist integration, resist staying in touch with the discovery. And then there are clients who stay in touch but then resist letting that material dissolve, or in other words, letting that material stop feeling real, because sometimes to let the material stop feeling real is to either experience a deep loss – in one way or another, an emotional loss – it maybe grief, it may be a decrease of connection to someone, it may be simply a feeling of disorientation – when an important part of personal reality suddenly no longer feels real, there can be, in some cases, significant disorientation. So there're various uncomfortable, unwelcome, immediate results that sometimes are waiting to happen if the transformation happens and the client's mind knows it. The client does not consciously know it, but the client's deeper mind knows it and will not let the transformation happen because it's too scary or will bring too much distress. And so when I see that - even though it looks like I'm guiding a perfectly proper juxtaposition experience but nothing is changing as a result - then I begin to actively look for, I begin a discovery process with the client looking for what will be the uncomfortable results if this falls away. And so the resistance has to be worked with and it has to be… at the point where client really does feel ready for the changes that will come, then when I do the juxtaposition experience again, it works. The transformation happens.

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T.A.: Ok, if I understand than transformation can take very long to accomplish but maybe the reconsolidation of the synapses is in a moment. Something like that?

B.E.: Yes. Well, the way I think of it is this - that it's not a mechanical process. In other words, you do a juxtaposition experience perfectly well, it's not a mechanical process that will bring about reconsolidation and transformation. The client's mind has to basically agree to this change. And so, if there's no resistance then it takes seconds for reconsolidation and transformation and dissolving to happen. If there's resistance, then what can take time or even several sessions is working with the resistance so that you arrive where there is no resistance anymore.

T.A.: Ok, thank you so much.

B.E.: You're welcome.

A.H.: Thank you Teresa. Bruce if you agree we'll proceed to the consultation, we are running out of time, and I will ask Carla to share with you some ideas on a case she wants to share with you, ok?

B.E.: Very good.

C.B.: Hello again.

B.E.: Hello Carla.

C.B.: I'm not sure I'm going to be able to summarize this, but I'll try.

B.E.: We'll do what we can.

C.B.: I'm going to talk to you about a case with which I only had seven sessions so far. Let's call her Laura, she's a 38 old woman who has been an anorectic from the age of 12 and she has tried almost every kind of therapy we know exists – she has tried Group Therapy, Psychoanalysis, Art-therapy, Psychodrama, Cognitive-behavioral Therapy, Family Therapy, it's like the list never ends. She has been admitted, she has had a lot of hospital admissions due to low weight and she has had some periods when she's sort of ok but she always relapses. So in the first session Laura talks a lot about her anorexia. She knows everything there is to know about (apparently) about anorexia, she knows the connection between thoughts, emotions and behavior. She knows a lot about obsessive-compulsive disorder as well because there are times when she eats fairly well but she can't stop cleaning and washing herself. She knows something about the meaning of her anorexia but at the emotional level it's like nothing ever happens - it's all very, how can I say, cerebral or very intellectualized.

B.E.: Yes, yes.

C.B.: So, first of all, before I move on, what I would like to know is what's your opinion about using Coherence Therapy in anorexia, if there has been some research on this or if you have some experience in working with this kind of cases and if you think it is a good approach for a person who is in the end of the line… I don't how to say this… basically in terms of her problem and who has tried practically everything there is to try.

B.E.: Yeah, well, yeah. Ok, good, good. That's a good… You've given me good information that enables me to respond, I think. Yes, I think Coherence Therapy is a suitable, a very suitable approach for working with Laura – of course I

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assume you have a…, I assume you're in connection with her doctor or, you know, the proper medical and safety condition…

C.B.: Yes, yes… and monitoring her weight, which is very low and we have to keep attention on that because she can be readmitted.

B.E.: Yes, good, good, OK. So I won't speak to any of those sort of things, just the Coherence Therapy aspect. You have mentioned two different things that could be the very effective focus for good Coherence Therapy with her and I think Coherence Therapy is very suitable because the emotional issues maintaining anorexia are very, very coherent and specific – I'm not assuming it's the same for every person who's anorectic but for each person who is anorectic there are very well defined underlying emotional themes and purposes and needs maintaining these behaviors. So, the two things that you mentioned that strongly grabbed my attention are this: first there're periods when she eats relatively well, or at least not anorecticly, right? But then relapses, right? So, one important focus for doing Coherence Therapy with her is to invite her to examine with you, very closely, to examine or to compare very closely, periods when she was eating – and specifically the beginning of times when she was eating – what were the conditions, what were the circumstances, what were the specific aspects of the circumstances that made it different in her life when she began eating again, in any of those times. And then compare that to what were the conditions, very specifically at the end of that period that made a difference and she again stopped eating. So this is under the category that I think of as exceptions, when the client can point out – and this is in general, not just for anorexia – when the client can point out exceptions, in other words, times when the symptom did not happen and then again happened after that, very closely studying what made the difference, assuming coherence. You assume that something in the clients experience was what made it emotionally necessary to begin eating again, or similarly what something in the client's perceptions and experiences made it allowable to eat.

C.B.: May I interrupt you? I'm sorry Bruce.

B.E.: Yes.

C.B.: I'm very happy to hear you say that because that's actually what I've done also with her, and the only time when she ate relatively well was when she got pregnant. Her excuse was that she wasn't eating for herself.

B.E.: Oh, wow. Great, great, so that good example of how this examination of exceptions begins to reveal the makeup of the pro-symptom position, because what you've learned is she must not feed herself. It's ok to eat if it's feeding someone else, her child.

C.B.: Yes, yes and to feed herself is associated for her with something filthy or dirty, like she is doing… when she eats is like she is being dirty - that's the thing she associates more with eating. That's why she cleans, when she doesn't eat she cleans everything. For example she cleaned her baby, when she was born, her child, she cleaned her a lot of times, when she was eating fairly well, she had these other symptoms.

B.E.: Ok. Yes, I was going to go next into that when she does eat she cleans, compulsively cleans, so this clearly righted indicates that at the very root of all

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of this is something… - you know, maybe just to sort of leap to where I'm heading here./- I think what I'd recommend, or what I believe I would do if I were her therapist, as soon as possible, I would work to get to where I can say to her – and I think this could happen probably in the next session – I would want to say to her *"Laura… we know that at the very center of all this, at the very core of all this, there is that feeling of being dirty and there is that urgent feeling to avoid being dirty, it's so necessary for you to not be dirty!"*. So I would remind her of that, I would engage her on focusing on that again, returning to that, and then I would say something like this, I would say *"We need to look closely at what you experienced in your life that taught you, you know, where in your life, where is it and when is it that you learned that it is so important to not be dirty*".

C.B.: May I…

B.E.: And maybe you know about that already…

C.B.: Yes, yes. She has learned about that already, it's a very painful experience of child abuse, at the age of 5. And it's a bit, it's not a very ordinary experience – if we can say that – because it was with another child aged 12 that forced her to, forced her to have oral sex with her and it was a child, a female child. And this at the age of 5 and she was educated in a religious school where from very early on she was taught to that she had to be… to sacrifice herself to be pure and she describes – well I think it's very important – she describes her parents as always very absent, you know, of this and maybe leaving her unprotected and alone and… angry perhaps also.

B.E.: Yeah, ok I need to say this quickly because I'm afraid I have to end.

C.B.: Yes, I'm sorry it's a very complex case.

B.E.: Well, yeah, this is quite complex but it's getting clearer to me as we speak. I think the main need, the central focus needs to be a Trauma Therapy for that experience, whether it's EMDR or some other specialized Trauma Therapy to help access and dissolve the traumatic learnings and impressions formed in that experience. Now that clearly, that alone may not be enough because this is so entangled with the religious education, you know, sin, bad girl, whatever is involved in all that. It may be necessary to work to co-operate with the religious education and look with her – I mean, I think the trauma work would come first. The basic knot knot, the tangled knot, the traumatic memory needs to be released. Then working with her within the religious values, and training, to look at how does a person become forgiven by God. Or whatever, you know, there must exist some kind of legitimated process of atunement within her belief system…

C.B.: So she can forgive herself.

B.E.: Yes, after the traumatic memory is released that then becomes possible.

C.B.: Ok.

B.E.: So that's my sense of the direction given what I've learned from you so far and I'm afraid I have to stop there.

C.B.: Thank you so much.

B.E.: Your welcome.

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A.H.: Well Carla thank you so much. We are coming to an end, it's time to close this session, Bruce has to leave for another session in minutes. Bruce let me just remind everyone that we will meet in March sixteen and we will have another opportunity for the questions we couldn't share tonight or for all other questions or case consulting that will arise meanwhile, ok? And again, thank you so much Bruce for willing to have this webinar format and for joining us.

B.E.: Good.

A.H.: It was wonderful as expected to have this opportunity with you. See you in a month.

B.E.: Thanks, thanks, it's a pleasure for me and I'll see you in a month all of you.

A.H.: Bye, bye. Thank you everyone for attending and for so good contributions.

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