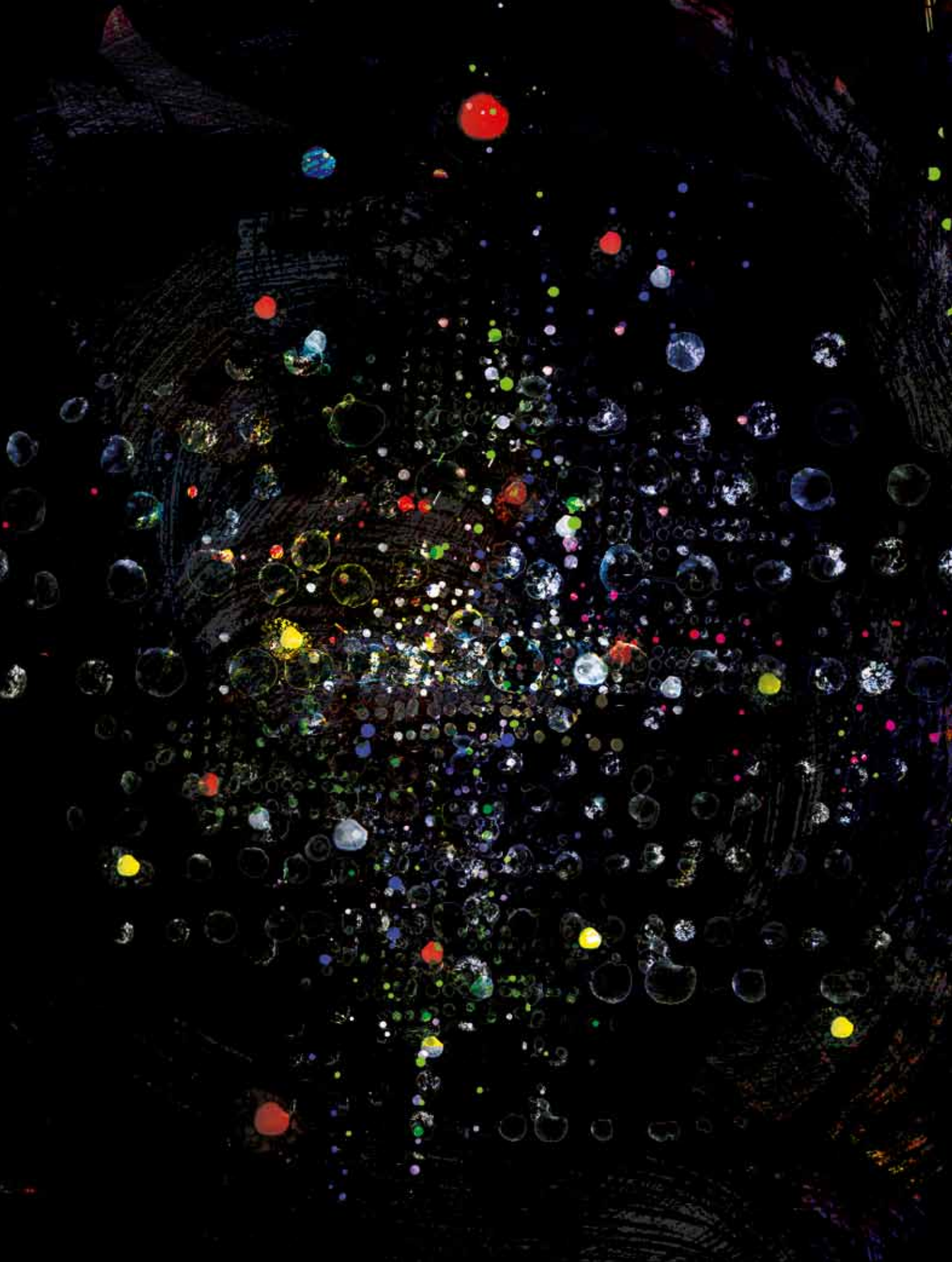

Remembering in order to forget

Paul Sibson and Robin Ticic describe how the process of uncovering and releasing emotional memories buried deep in the unconscious can free a client *Illustration by Simon Pemberton*

Prior to 2004, implicit emotional memories – the root cause of the vast majority of clinical symptoms such as depression, anxiety, panic, PTSD etc – were thought to be ineradicable, a fixed 'life sentence'. The best therapy could hope to achieve was to counteract the symptom-generating memories by over-riding the symptoms. This strategy is widely applied throughout the various forms of cognitive-behavioural therapy (CBT), solution-focused therapy and the positive therapies.

Since 2004, however, neuroscience has evidenced the specific experiential steps required to first unlock these emotional memories in the brain and then permanently modify them or erase them altogether.

This same sequence of experiences had already been identified a decade earlier by Ecker and Hulley, based on clinical observations.[1] Not only is the therapeutic 'holy grail' of permanent symptom relief without relapse now possible; we now also know how to achieve it routinely in clinical practice.[2] Arguably this is the brain-science breakthrough with perhaps the greatest ramifications for improving the clinical efficacy of psychotherapy and bringing deep integration across its many modalities of practice.

The term given to the sequence of experiences required for this process to occur is 'therapeutic reconsolidation' – 'memory reconsolidation' being the technical term for the opening up of synapses and subsequent modification or erasure of emotional memories.[2] This process is not tied to any particular mode of therapy; indeed, it is theory-independent because it is a natural process of the brain itself. The process has been documented and illustrated many times over in coherence therapy, and has been demonstrated as the engine of change in therapeutic practices as overtly different as accelerated experiential dynamic psychotherapy (AEDP), emotion-focused therapy (EFT), eye-movement desensitisation and reprocessing (EMDR), and interpersonal neurobiology (IPNB).[2] Indeed, this very universality is vital to fostering integration across the disparate therapeutic modalities.

Three phases comprising seven distinct steps form the completed and successful therapeutic reconsolidation process as described below.

1. The accessing sequence

This first phase comprises three steps. The first involves identifying the client's presenting symptom. In the second, the unconscious schemas producing this symptom are brought into the client's full consciousness and fixed into their everyday awareness. The third step involves identifying instances in the client's life that contradict, or disconfirm, these unconscious schemas.

Symptom identification

Jill* was in her early 30s and presented with a paralysing inability to move out from her mother's home, despite a conscious, desperate desire to do so. Both her fiancé and her mother agreed that moving out was the only way forward for everyone concerned. Such was Jill's despair at the situation that she was on antidepressants and had seriously considered ending the relationship with her partner. This inability to move out and leave her mother's side was Jill's identified symptom. The next step was to find out what in Jill's unconscious made this specific symptom so necessary.

Retrieving the schema

In her first session Jill revealed that whenever she seriously began planning to move out she was gripped by a deep fear and became both defensive and prone to angry outbursts. The therapist (co-author PS) began exploratory work

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into why this particular fear existed, knowing it would make coherent sense within at least one of Jill's currently unconscious models of how the world works. When he guided Jill to experientially imagine she had actually moved out, what began to emerge into her awareness was a powerfully held but previously unconscious belief that her mother would die if she physically left her to live alone. Further exploration revealed that, as a child, Jill had stepped between her violent father and her mother and, in her mind as a child, believed it was her physical presence that had actually 'stopped him killing her'. Now well into adulthood, she realised this unconscious learning was still compelling her to stay with her mother.

No matter how long ago they were formed, if the rules of survival they describe remain sealed away in the person's unconscious, these unconscious emotional learnings continue to influence his or her perception of reality. Sealed off from conscious awareness, they are impervious to disconfirming evidence in the here and now, and will continue to operate throughout a person's life, regardless of the symptoms they engender and the conscious wishes of the individual. This is why discovering these unwritten 'rules' about how the world functions is a goal across all non-counteractive therapeutic modalities.

In Jill's case, the therapist used a guided imagination exercise to uncover these rules, but he could have used numerous experiential techniques to reveal the same emotional truth – person-centred counselling, Gestalt-type chair work, focusing, inner child work, psycho-drama methods, and many more. Indeed, the therapeutic reconsolidation process provides a central organising principle, framework and rationale for why practitioners in one modality of psychotherapy may wish to borrow from – and integrate into their practice – techniques of other, overtly different modes of psychotherapy. It is the central mechanism of change that they can all share and aim to facilitate.

With Jill now conscious of the schema producing her symptom, the next task was to root this in her everyday awareness, where it would be available to be modified or erased permanently in the next phase, the transformation sequence. To this end, the therapist and client together crafted a statement for Jill to say out loud that articulated her newly discovered emotional truth: 'If I move out of Mum's house, and leave her alone there, she will die, as she needs me beside her to live.' Jill said it felt strange to verbalise this previously unconscious learning, but that it also felt emotionally true and real. She was, for the first time, explicitly articulating her non-verbal and implicit memory.

To strengthen and deepen this newly formed connection between her implicit and explicit memory, the therapist wrote Jill's statement on a piece of card to take home with her so she could read and emotionally re-experience it daily over the following week. The aim of this between-session task was to maintain her awareness of the emotional truth that produced her symptom, not to override that truth: 'The curious paradox is that, when I accept myself just as I am, then I can change.'[3] And the first step in that direction for Jill was to know explicitly what 'just as I am' constituted for her.

Identifying disconfirming knowledge

Once the previously unconscious, symptom-generating material has been successfully integrated into conscious awareness, the next stage is to permanently transform or erase it. This is achieved through finding a 'here and now' emotional reality that specifically disconfirms the unconscious version of reality. In Jill's case, the actual truth of her mother's situation, and of her own, could not have been more different to the version of reality she had previously stored unconsciously. Jill's mother was a fit, well and independent woman who was now in a very nurturing long-term relationship with a new partner. The last violent encounter in which Jill had been involved was over 15 years ago. In complete contrast to that time, both the explicit and implicit messages from Jill's mother now were that Jill should move out to live her own life with her partner.

With Jill now fully conscious of both her symptom-generating version of reality and a current contradictory version of reality, the conditions were in place for the transformation sequence.

2. The transformation sequence

At the heart of the second phase of the therapeutic reconsolidation process is the core discovery that, when a previously unconscious schema is brought into routine consciousness and repeatedly shown to be at variance with reality, the synapses holding that model in place can be permanently modified or erased altogether. This transformation sequence consists of three steps. Importantly, autobiographical memory remains intact.

The first step is the reactivation of the symptom-requiring schema. For Jill, this first step occurred easily whenever her attention was guided back to the statement that encapsulated the emotional truth of this schema: 'If I move out of Mum's house, and leave her alone there, she will die, as she needs me beside her to live.'

The next step is the activation of disconfirming knowledge, challenging the version of reality in the unconscious. This step was inherent in Jill's knowledge of her mother's changed situation now, and all the ways her daily experience contradicted the version of reality held in Jill's symptom-requiring schema.

'Not only is the therapeutic "holy grail" of permanent symptom relief without relapse now possible; we now also know how to achieve it routinely in clinical practice'

The final step of the transformation sequence simply involves the 'bumping together' – or experiential juxtaposition – of the old, unconscious version of reality with the disconfirming reality. In practice, the therapist guides the client's attention back and forth between the two versions to repeatedly foster their meeting (although in approximately half of cases, this process begins to happen spontaneously when the previously unconscious material is brought into stable consciousness). The therapist continues to facilitate this process until sufficient mismatched experiences have occurred to permanently transform or dissolve the previously unconscious version of reality.

Neuroscience shows us that it is through this repeated 'bumping together' in the same field of awareness that the 'synaptic encoding of the old learning is replaced by the synaptic encoding of the new learning'.[2]

In Jill's case the therapist facilitated this process simply by asking neutrally how she made sense of the contradictions between these two versions of reality. Answering this question required her to hold the two mismatching versions of reality simultaneously in her conscious awareness. Between sessions, Jill's reading and re-experiencing of the emotional truth written on her piece of card while she was experiencing the current reality of her life with her mother and her partner added to the availability and potency of the mismatch between these experiences.

It is important to note that merely bringing symptom-generating implicit memories into conscious awareness is not enough in itself to launch the reconsolidation process. The client will not change and symptom production will continue unless they concurrently experience a disconfirming version of reality in their consciousness. This can occur spontaneously or it can be guided by the therapist.

3. The verification phase

The final step is the verification phase. The therapeutic reconsolidation process permanently dissolves the emotional learnings responsible for symptom production, so relapse cannot occur. Verification involves actively probing for key markers that this process is complete, and can be observed in the client's self reports and way of being. 'The result of construct dissolution is a fundamental change in one's experience and perception of the world. Something that seemed self-evidently true about the world no longer seems true at all.'[2]

By the end of the work with the therapist, Jill reported finding the previously compelling emotional truth written on her piece of card implausible. When the therapist invited her to read the card to him in the penultimate session, she said it evoked no emotional reaction in her at all. She went on to say: 'It seems daft to me now, how I've felt so responsible for Mum over the years. She'll be fine!'

The therapist further checked for emotional reactivation by inviting Jill to deeply imagine that she had moved out from her mother's house and that she was not seeing her so frequently, and to report any part of her that felt resistant to this prospect. Jill was unable to identify any resistance and, with a smile, proclaimed herself 'totally free'.

By the close of the work together, which spanned eight sessions over 11 weeks, Jill's healthy separation-individuation had continued to the point where she and her fiancé had found a place of their own. Jill had been able, for the first time, to go with her work colleagues on a social night out. She also reported feeling far less personally responsible for solving any and all conflicts that arose in her workplace.

When the therapist talked to Jill six months later, she reported complete cessation of her initial symptoms and that she and her fiancé were settled in their new home. Further inquiry confirmed that her old symptoms had in no way recurred since the work had ended, even during periods of greatest stress, and she was making no effort at all to stop them doing so. ■

** Jill is a pseudonym. The client is not recognisable from the text and has given her informed consent.*

Details of coherence therapy workshops to be held in London in July can be found at www.CoherenceInstitute.org or requested from maggie@crisalida.co.uk

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