STUDIES IN MEANING 3: CONSTRUCTIVIST PSYCHOTHERAPY IN THE REAL WORLD

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Pace University Press
2008

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Coherence Therapy: Swift Change at the Roots of Symptom Production

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Coherence therapy is a methodology for dispelling a wide range of symptoms at their emotional and subcortical roots in far fewer sessions than is expected in conventional in-depth therapies. It is a system of personal construct therapy that shares certain fundamental assumptions with that of Kelly (1955/1991a, 1955/1991b), yet differs significantly in methodology.[1]

Originally developed and described entirely in phenomenological terms (Ecker & Hulley, 1996, 2000a, 2000b), a more neural and neuropsychological view of how coherence therapy works has also been articulated (Toomey & Ecker, in press; Toomey & Ecker, 2007). These two levels of description—the experiential and the neurophysiological—are mutually illuminating, and we combine them in the present article to best indicate how coherence therapy operates as a practical implementation of constructivism.

Basic to the approach is the constructivist understanding that any given thoughts, feelings or behaviors, including those that seem to be irrational, out-of-control clinical symptoms, arise from the activation and enactment of specific personal constructs, conscious and unconscious, held by the individual. In the view of coherence therapy, all personal constructs operate as knowings. The methodology consists of actively guiding the client to access, experience and revise the specific knowings that are the very basis of the existence of the presenting symptom or problem.

The clinical challenge inheres in the fact that (a) the brain forms and holds knowings (constructs) in several different memory

[1] The original moniker, depth-oriented brief therapy or DOBT, was used from 1993 through 2005. The change to "coherence therapy" and "coherence psychology" more clearly reflects the central principle of the approach.

systems (Milner, Squire, and Kandel 1998), and (b) the knowings driving symptom production are nearly always held not in the cortex's explicit memory, which is readily conscious and verbalized, but in subcortical systems of implicit memory, which are unconscious and nonverbal.[2] In short, the symptom-generating knowings are not known to the conscious personality, which is why clinical symptoms plague clients and appear to have a life of their own.

The knowings that make up implicit memory are multi-modal, that is, they exist in several different types of representation—a composite of sensory, emotional, interpersonal, kinesthetic, somatic and energic knowings. The specific regions of the subcortical brain that form, store and retrieve these various types of constructs are only partially mapped. Best understood to date is the role of the amygdala in encoding fear-based, aversive learnings in implicit memory circuits (Phelps & LeDoux, 2005).

The individual, of course, has a vast universe of implicit, unconscious knowings or constructs. In order to be swift and accurate in finding the specific few that generate a particular symptom, coherence therapy utilizes what Ecker and Hulley (1996) found to be the unique property of the symptom-producing constructs: they are coherent in relation to the symptom. That is, they define personal reality in a cogent, well-knit way that makes the symptom necessary to have, despite the very real suffering that it entails. For example, a woman's troubling inability to make progress in building her career was found to be necessary because, unconsciously, "working hard on career" equals "abandoning your family," a construction she formed in childhood when Mom divorced Dad and blamed it on his chronic absence for his work. A man with an attention problem that fit the checklist for Attention Deficit Disorder and kept him from learning skills needed at work had parents who often criticized him shamingly for allowing something to go wrong that could have been spotted and prevented. His coherent response was the self-protective tactic of

[2] Implicit memory is qualitatively different from the vernacular meaning of the word "memory" as denoting the conscious recall of past personal experiences (episodic, autobiographical memory) or facts (semantic memory), which are stored cortically. In contrast, an implicit memory of the type relevant here is experienced, when activated, as a bodily immersion in a particular emotional tone (such as anxiety, anger or sadness) typically with an urge to carry out a particular behavior, such as avoiding attention, talking incessantly or eating. There is no recall of past incidents in which this state was first experienced, no sense of experiencing a memory at all, and little if any awareness as to why this experience is occurring.

vigilantly covering all bases with a perpetual scanning of attention, but this had never been conscious. According to his subcortical brain, keeping attention steadily in one place was always absolutely the wrong thing to do.

The symptom-necessitating constructs are a complete mystery at the start of therapy, but therapist and client together can zero in on them efficiently by making use of their coherence, as the clinical example below shows. When the client consciously retrieves and directly experiences these specific knowings, he or she discovers a compelling, well-defined, personal theme and purpose with a deep core of emotion and meaning. This symptom-necessitating material is referred to *as the emotional truth of the symptom* and also, more technically, as the person's *pro-symptom position*, denoting an implicit knowing that is *for* having the symptom. A person may have two or more pro-symptom positions maintaining the same symptom.

Of course, the client is initially aware of the symptom only as a cause of great distress, and so construes it consciously as something entirely negative, senseless, defective, involuntary and unwanted. This conscious attribution of meaning is conspicuously *against* having the symptom, and so is termed the client's *anti-symptom position*.

The essence of these ideas is embodied in the principle of *symptom coherence*, coherence therapy's model of symptom production (Ecker & Hulley, 1996, 2000a, 2004): A person produces a particular symptom because it is compellingly necessary to have according to at least one unconscious, nonverbal, emotionally potent schema or construction of reality held in implicit memory. Conversely, the person ceases producing the symptom as soon as there no longer exists any construction of reality in which the symptom is necessary to have, with no need for counteracting the symptom itself.

A major milestone in the methodology of coherence therapy with each client occurs when a discovered pro-symptom position becomes fully experienced and well-integrated into conscious awareness. This has two important effects: (a) The client becomes lucidly aware of the deep sense and coherent necessity of having the symptom and in most cases has a direct experience of agency, that is, of producing the symptom to fulfill an important purpose; and (b) the knowings constituting the pro-symptom position become susceptible to immediate transformation (revision

or dissolution), which is now the next stage of the work. Coherence therapy spells out the steps of a built-in process of the brain-mind-body system for a transformation of constructs (Ecker & Hulley, 1996, 2000a, 2004), a process that matches the subsequently discovered neurological process for the depotentiation of conditioned responses in implicit memory (reviewed in Ecker & Toomey, in press). This specificity regarding how constructs change enables the work to achieve deep, lasting effectiveness with enhanced reliability.

Though simple in essence, the symptom coherence model of symptom production has been clinically found to be relevant for a broad range of symptoms.[3] With each client the process of coherence therapy phenomenologically reveals and verifies the presence of powerful, symptom-requiring personal constructs, the depotentiation of which directly yields symptom cessation.

Methods of change that attempt to counteract, override or avoid the symptom and replace it with a desired state follow a clinical strategy antithetical to that of coherence therapy because they increase rather than decrease the dissociated, unconscious status of the constructs causing symptom production. Counteractive methods[4] compete against pro-symptom positions without changing or eliminating them, and so are always vulnerable to relapse. To counteract symptoms is to side with the weaker, anti-symptom, cortical position against the always-more-powerful, pro-symptom, subcortical position of the client. In contrast, the aim in coherence therapy is to embrace, integrate and then transform the symptom-generating constructs, truly eliminating rather than opposing the cause of symptom production. (For a detailed

[3] Symptoms that have been dispelled by coherence therapy include depression, anxiety, panic, agoraphobia, low self-worth, attachment problems, sequelae of childhood abuse, sexual problems, food/eating/weight problems, rage, attention deficit, complicated bereavement, codependency, underachievement, procrastination, fidgeting, and a wide range of interpersonal, couple and family problems. For case examples of anxiety and panic, see Ecker (2003); for depression, Ecker and Hulley (2002a). Ecker and Hulley (1996) provide a wide range of examples.

[4] Examples of counteractive methods include some of the most widely used methods in the field, such as teaching a relaxation technique to a client who has anxiety attacks; building up hopefulness in a depressed client; teaching communication skills and tools to an adversarial couple; reframing the meaning of the problem situation; having therapy group members describe what they do to keep themselves from isolating; and getting a client with low self-worth to take in clear evidence of worth (loved by friends, recognized as talented and competent at work, etc.).

neuropsychological account of these points see Toomey & Ecker, in press; Toomey & Ecker, in press.)

The methodology of coherence therapy consists, then, of three therapeutic activities: discovering, integrating and transforming unconscious pro-symptom positions. These activities must be experiential, because subcortical implicit knowings are accessed by subjectively experiencing them, not through having cognitive insights or other thoughts *about* them in the neocortex. Experiences yield cognitive insights in this approach, not the other way around. The therapist creates experiences that discover, experiences that integrate, and experiences that transform the person's pro-symptom constructs. In creating these experiences, the therapist is active and leading as regards process but defers to the client's authority as regards content. (For detailed methodological procedures and techniques, see Ecker & Hulley, 1996, 2000a, 2004.)

A Coherence Therapy Session[5]

A 36-year-old married professional woman, whom we will call Susan, phoned one of the authors (B.E.) seeking therapy for "a problem I've had for twenty years." She began her first session in a fast-talking, cerebral, incongruently cheerful manner, describing "basically an overeating issue—a weight issue . . . I've, like, processed it to death in therapy, so I can tell you exactly where it came from, exactly when it started, you know, why I do it, why I'm uncomfortable when I get thin . . . I'm so intellectually aware of every part of it but it's not helping me change, like, one bit. And I also know everything there is to know about dieting. I know exactly what to eat, when to eat . . . But I just decided I'm not going to pay for one more diet 'cause it has nothing to do with the diet. It's in my head. So, I just have, like, an enormous amount of insight but it's not really helping me."

Susan's twenty years of fruitless efforts make her a "poster child" for the ineffectuality of counteractive methods and cognitive insights to produce change. The therapist replied:

[5] We recognize that much of what can be learned from case examples is apparent only in seeing and hearing the nuances of the process. A video of the following session will be available for study. Here, due to length constraints, we present excerpts that best illustrate the unfolding of coherence therapy methodology. Every deletion is indicated by an ellipsis (. . .).

> *Therapist*: So, do you have a sense of where amongst the several, or many, different inner emotional causes of your pattern with food we should focus? Or should I just begin my own way of looking?
>
> *Client*: . . . When I was 16, I started gaining weight and my Mom, my Mom would actually say things to me like, "Nobody's ever going to love you, no one's ever going to marry you if you don't lose weight." You know, I mean she'd really tell me and, like, in a way, in my family's world that's true: that everything has to look perfect, everyone has to be perfect or else you can't be loved . . . But even now I think I'm sort of the black sheep of my family, you know, I'm just, I'm not thin[6] . . . They all live in like mansions and their lives are perfect and I live in this little house and, you know, they just don't, they just can't comprehend me . . . They almost disowned me at the election time because I voted for [a certain candidate] and that's just so not right . . . The whole thing is that I just refuse to get thin because I refuse to acknowledge that they're right about that. You know, like I refuse to get thin and have them look at me and go, "Oh, she's finally fitting in . . . She finally realized that we were right this whole time" . . . So, I know that the, the crux of the problem is in there somewhere. [Laughs.] But knowing all that doesn't seem to—I mean it pisses me off but I still totally overeat, you know, even though it doesn't make sense to me . . . because I want to be thin . . . not because I want to look perfect or I think that's gonna, sort of make my life perfect, but I want, I more want to be fit. Like I want to be healthy, I don't want to get diabetes or, you know, like stomach cancer because I was defying my family, you know, it doesn't make sense to me . . . When I think back on the times when I've gotten thin, I can see that I was uncomfortable with like fitting in with them in some way. I just immediately became uncomfortable even though one side of me was so happy about it, but the other side of me was just uncomfortable that I was somehow, you know, proving them right . . . So, that's kind of where I get stuck. That's as far as I can kind of go but then I don't know how to actually work that into some sort of a change in my behavior.
>
> *Therapist*: Ok. Well, thanks. You've rapidly put me on the trail with how much you already know about this and, and so I do have some ideas.

Along with her views *against* having the symptom—her anti-symptom position—Susan has expressed some apparently

[6] Susan was not slender, but neither was she particularly noticeable as being overweight.

pro-symptom ideas and insights about why her symptoms of over-eating and being overweight are necessary for her, citing an autonomy struggle. The therapist cannot yet know whether these ideas will prove to be an accurate description of deeper emotional truths requiring the symptom. Even correct ideas about pro-symptom positions are only ideas, only a map, not the territory itself. The therapist will use experiential methods to have Susan find and directly feel and inhabit her living pro-symptom material.

Susan has described her ongoing struggle against her parents' *terms of attachment*, the specific rules and roles they demand in exchange for giving acceptance, connection and nurturance. By Susan's convincing account, she has received little if any attuned understanding or acceptance of her authentic self from them, and instead perpetually receives messages of nonacceptance and demands for compliance with their definitions of how she should think and live. What Susan has suffered under these terms of attachment is very likely to be involved in her pro-symptom position(s) maintaining her eating and weight. This too will be brought to light through the creation of experiences that non-speculatively and accurately reveal the operation of these themes.

Picking up on Susan's theory of why she felt uncomfortable being thin, the therapist said, "becoming thin and fit would mean that your family has won that long-standing battle over defining and controlling you . . . It would look to them and feel to you like you admitted they're right . . . And [avoiding] that apparently outweighs your own desires to be thin and fit." Susan confirmed this summation. This initial focus on Susan's experience of the problem has led the therapist to understand that he should regard as a presenting symptom not only her eating and weight, but also her intense need to keep her family from thinking that she admits they are "right" about how she should think and behave.

From various possible ways of proceeding with the discovery work, the therapist chose to guide Susan into an experience of *symptom deprivation*. In this technique, the client samples what she will experience in living without the symptom. Because a given symptom is in some specific, coherent way necessary to have, being without it is likely to bring some form of unwelcome experience, which normally is avoided unconsciously through *having* the symptom. This technique reveals the client's previously unconscious need to avoid that unwelcome experience by having the symptom—

a need that is, by definition, a pro-symptom position. The point of symptom deprivation is *not* the counteractive aim of arranging for the client to be symptom-free. Rather, the technique is used solely to cause the client's symptom-requiring implicit knowings to begin to reveal themselves. Symptom deprivation elicits a response from the subcortical pro-symptom constructs, a response that is noticeable to the conscious personality, submitting those constructs to cortical attention for the first time. In this way symptom deprivation, like other techniques of discovery, selectively finds and draws forth pro-symptom constructs through their unique property of being the constructs that coherently require the symptom to exist.

The therapist guided Susan to get a glimpse of being without both symptoms: her excess weight and also her need to keep her parents and two brothers from thinking that her becoming thin has proven them right. Symptom deprivation can be carried out in a variety of ways with different levels of experiential immersion. Here, it seemed best to match Susan's strongly cognitive style. The therapist began by prompting a somewhat conceptual preview of *not* feeling disturbed by her family thinking she has proven them right by being thin, and of thinness therefore being viable for her. This was put as an invitation to look at "where you would have to get to in yourself in order to lose weight and keep it off . . . You could tolerate what your thinness means to them and how they talk about it, and you could just let it be . . . You would have to tolerate not feeling seen and understood by them."

Susan immediately described a new awareness of an unwelcome result of being without her symptoms:

> *Client:* . . . the thing is, they misunderstand me anyway. I mean they misunderstand me now. I'm overweight and they still misunderstand me. I *still* don't feel seen by them. So what *difference* does it make, you know what I mean? It's not helping that I'm overweight 'cause they *still* don't see me. I mean they don't, they don't . . . They're not seeing me and understanding me anyway, so it's sort of like: so what's it getting me to continue in this behavior 'cause [laughs] it's really not getting me anything.
>
> *Therapist*: . . . I have a sense it might be really useful here for you to let that sink in, drop down below the neck that, wow, the battle I feel I'm winning by being heavier than they approve of, I'm not winning. And by being thin, I'd hardly lose more than I already don't get from them. What if that really got very real, um, not just as an idea? . . .

> *Client*: Yeah. Yeah, I mean, I'm already tolerating it in some way. I already am, all the time.
>
> *Therapist*: And so let's look at how much *more* of feeling unseen, treated like a child you would be if they thought you'd come 'round to their view about body and weight and thinness. How much more painful or vexing or futile would it be for you than already? *[This is a further step of symptom deprivation.]*
>
> *Client*: Um, I think I've been—It's like they already don't see me but now, they still wouldn't really see me or acknowledge me, but in their minds—It's again that "winning" thing. Like, it's not that they would see me or acknowledge me more, it's just that, like, I would sort of feel like, I don't know how to put it, like they could almost think about me *less* because now they're not quite as worried about me as they were before, or something. You know what I mean? Like, they, they would say like, "Ok, she's coming around so now we don't, you know, we can even brush her aside a little bit more, even, 'cause now she's started coming around." You know, like the only attention I get from them is them being worried about me because I'm not measuring up . . .
>
> *Therapist*: I see. Well, that—You just brought into the picture a whole other major dimension there.
>
> *Client*: Yeah, and I haven't really thought of that part before. Yeah. Hmm. It's like, I guess, the only attention that I get from them is that I'm not fitting in. So even though it's not [the kind of] attention that I want, at least I know my brother's speaking about me 'cause I voted for [the candidate disapproved by the family], whereas if I voted for [the candidate approved by the family] maybe he wouldn't think about me at all! . . .

A coherence therapist is always listening closely for any spontaneous pro-symptom indication in what is emerging verbally and nonverbally. In conducting symptom deprivation, the therapist does not know what the client will find. Here the exercise consisted of prompting Susan to envision becoming thin, tolerating her family thinking this means she has agreed with them about how to live, and tolerating being neither seen nor understood by them. As a result of sampling this symptom-free state, she has bumped into implicit, pro-symptom knowings, and turned them into explicit, conscious knowings: (a) Not fitting in, such as by being overweight, is how she keeps family members worried about her in order to extract the little attention that

she does get from them, which she expects to lose if she fits in. (b) Not fitting in is supposed to result in her family seeing and understanding her. Awareness of these emotional truths in turn led her immediately to recognize that (c) actually "it's not helping," that is, not fitting in is failing utterly to get them to see and understand her, leaving her with all of the costs but none of the hoped-for benefits of being overweight; heavy or thin, they do not see who she is.

A key component of a pro-symptom position is a well-defined, compelling *purpose* that necessitates producing the symptom either as part of how this purpose is carried out or in consequence of how it is thwarted. A specific purpose for being overweight and for other forms of "not measuring up" has just emerged: getting caring attention and personal understanding from family members through keeping them "worried about me," which, according to Susan's implicit knowings, is the only way to get any caring attention from them at all. The therapist now understands that her eating and weight symptoms, which seemed to be the problem, are actually part of Susan's *solution* to the problem of getting her attachment needs met in a family that demands conformity and forbids differentiation and individuation.

Becoming conscious of these knowings and meanings makes sense of her symptoms in an entirely new way. Previously Susan understood her weight only in terms of defying family dictates. Now she is beginning to experience her own agency in resorting to excessive weight as her way of struggling to make her family pay attention to her, negative attention being better than no attention. She has for twenty years felt "stuck" in excessive eating and weight only because of being unconscious of her own coherent purposes for creating this condition. Her distress over being heavy and her desire for healthy thinness are very real, but are no match for the passionate urgency of her desire for caring attention, which she gets for being heavy.

In contrast to her intellectual mode at the start of the session, Susan has now begun attending more directly to her emotional themes, so the therapist, pacing with her, will use more fully experiential work.

> *Therapist*: Ok. Alright. So I'd like to try something at this point, now that we've bumped into this, if you're willing.
>
> *Client*: Sure.

Therapist: It would be to picture, visualize in your mind's eye your whole family: it's your parents and…your two brothers . . . Picture them, as if in the same room with you, and then—do you have them?

Client: Mm-hm.

Therapist: To try out saying to all of them, ah, "Any attention I get from you is for how I *don't* fit in with the family, and your attention is so important to me that I know I'd better *not* fit in, because [if I fit in] I'll be brushed aside."

Client: Do you want me to say that?

Therapist: Yeah.

Client: [Sighs.] Ok. I'll get them in my mind again. [Closes her eyes, then says to family members:] The only attention that I get from you is for not fitting in, and your attention is so important to me that I'd better not fit in because then I won't get any attention from you at all. I'll just get brushed aside. [Pause.] The funny thing is, I already feel brushed aside, though . . . I'll say it like I'm saying to them [closes eyes again]: The only attention I do get from you is, like, minuscule as it may be, is that like if my weight is, you know, up for discussion or, you know, you say you can't come visit me because you don't want to cram butts in our little house or whatever, and so at least like, you know, even if it's disparaging remarks, that's all I get from you but at least I get something, [crying] something. Yeah.

The work has now become fully experiential. In coherence therapy, "experiential" means a subjective immersion in the symptom-requiring themes and purposes. Here the therapist has prompted such an immersion by guiding Susan to make an *overt statement* of her just-discovered emotional truth, a present-tense, highly candid I-statement spoken directly to her family members, visualized. This simple technique is a reliable way to bring about a deepening into the material, so that the person is no longer only talking *about* it and instead directly inhabits the material, feeling and knowing it as her own emotional truth. In this way, an *integration experience* is created—an experience of relating to the problem *from* and *in* her pro-symptom position. The simultaneous feeling-knowing (occurring in the subcortex and right cortex) and verbal-knowing (involving the left neocortex) brings about the experiential and neural integration of the material.

Integration experiences incorporate the pro-symptom position into the client's conscious experiential world. Generally, a series of integration experiences is required, spanning a few days to a few weeks, for stable integration to be achieved, rendering the pro-symptom position open to transformation.

Susan, for the first time in her life, is now aware of being overweight as her own tactic for keeping family members troubled about her and therefore responding to her with what little caring attention is available from them. Her pro-symptom position consists of all of her knowings, tactics and behaviors involved in this. As noted previously, the client's recognition of her personal agency in producing the symptom is an integral aspect of experiencing a pro-symptom position in most cases, and is a key milestone in the methodology.[7] A symptom that previously seemed to be a mysterious affliction with a life of its own now makes deep sense in terms of important personal meanings and purposes. This in itself is a deeply therapeutic relief for many clients who had been regarding themselves as defective or deficient due to having the symptom.

Imaginal methods, such as the visualization of family members used here for the overt statement, can be highly effective for creating both discovery experiences and integration experiences because, as brain research has shown, subcortical brain systems such as the amygdala respond to imagined situations almost as strongly as they respond to actual, externally perceived situations (see for example Kreiman, Koch, & Fried, 2000).

Note that the therapist's role is to guide the client into inhabiting and experiencing her own symptom-necessitating themes, purposes and tactics. Working phenomenologically, the

[7] An exception regarding the encounter with agency occurs when the symptom is a mood state, such as depression or anxiety, that arises unconsciously in response to past or present suffering of a loss, violation, or the thwarting of a purpose or need. Common examples are depression that expresses ungrieved losses or unconscious despair over being neglected, and anxiety that expresses an unconscious state of insecure attachment, dread of aloneness, or reactivation of traumatic memory. In such cases the mood symptom is entirely coherent, the symptom coherence model fully applies, and the client awakens to the emotional truth of how the mood makes deep sense to have, but there is no accompanying experience of agency. Agency is involved only in relation to a symptom that has a function, that is, a symptom that is the very means of carrying out an unconscious purpose. It is the discovered pro-symptom material that reveals whether a particular client's mood symptom is a functionless (but coherent) response to suffering or a functional tactic that carries out a purpose (such as depression that keeps oneself well hidden and therefore safe from attack).

therapist has done no interpreting and has not used any methods or words that attempt to change, stop, override, avoid, fix, get away from, or in any way counteract either the client's symptom of compulsive eating or the underlying themes maintaining that symptom.

Susan's sufferings clearly center on emotional wounds of insecure attachment and lack of attunement. This would lead many therapists to assume that her therapy should centrally make use of the client-therapist relationship to create reparative attachment experiences. Reparative attachment work is an option within coherence therapy, but it is appropriate only if the client's attachment pattern is maintained by a pro-symptom position amenable to being discovered, integrated and transformed through working in this way (see Toomey & Ecker, in press, for criteria regarding that clinical discernment). As this session illustrates, coherence therapy provides other experiential methods that are effective with troubled attachment patterns.

The therapist continued to foster Susan's integration experience:

> *Therapist*: So how is it to openly acknowledge that to them like that?
>
> *Client*: Huh. I guess it's sad. Yeah, I feel sad, because when I acknowledge that I don't get any attention from them, I also have to acknowledge that I probably never will, you know. I don't see any point that I'll ever get from them what I've always wanted. I think, fat or thin, I'm not going to get it.
>
> *Therapist*: It's not available from them.
>
> *Client*: No. [Cries.]
>
> *Therapist*: It's how they are.
>
> *Client*: Yeah. It's just how they are. Yeah. I guess, I don't think I've ever like acknowledged that to myself before. I keep hoping that, you know, somehow I'm gonna get it.
>
> *Therapist*: . . . [Get] their attention—what little bit you do get.
>
> *Client*: Teeny tiny bit.
>
> *Therapist*: Teeny tiny bit. And I'm inferring that since that teeny tiny bit is all you get, it's precious.
>
> *Client*: Mm-hm.

> *Therapist*: And, and if you let yourself look like you're fitting in, you feel you'll lose that little bit you get.
>
> *Client*: Yeah. Yeah, that's it. [Cries.] . . . I guess this is the whole struggle about like separation from your family or whatever. It feels lonely, you know, to think like that if I conquer this problem then they're going to think, "Ok, she's fine, I don't need to worry about her anymore," and then, you know, like what if I never hear from them again? You know, I mean like, what if I never, ever like even hear from my Mom or anybody that they thought about me, you know? . . .

The therapist's accurate empathy toward Susan's pro-symptom position—the *coherence empathy* that is central to this methodology—has made it possible and even natural for her to stay attentively immersed in the material. As a result she has dropped into a still deeper recognition of how she construes her dilemma: she expects her family members to cease contacting her and to have nothing at all to say to her if she appears to be fine and proper. What is at stake is emotional abandonment, which she prevents by keeping them concerned about her weight, her politics, and so on. This is a further discovery experience of the knowings and constructs that make up her attention-seeking pro-symptom position. The deepening encounter with emotional truth continued about two minutes later:

> *Client*: . . . I've always sort of felt like I kind of landed in a family in which I didn't belong . . . You know, even when I was little and, I mean, I just never felt like they got me, you know . . . They have all the nice things, they have all the right cars they've bought, but they don't spend a lot of time thinking about how people might feel or you know, it's just really not important to them. And it's highly important to me so I've never, you know, I've always been struggling to get, um, kind of acknowledged, you know what I mean? To get acknowledgement from them, and I never can.
>
> *Therapist*: Mm-hm—never can.
>
> *Client*: Uh-uh . . . They're just not like that.
>
> *Therapist*: They're not like that . . . They don't have it to give, that kind of attention that you're struggling your whole life to get from them.
>
> *Client*: Right.

Therapist: . . . And you don't want that to get severed—that little bit you *do* get.

Client: Mm-hm. 'Cause then it's like I'll be an orphan. Ha, I mean, I'll be familyless, you know, like then I'll just—then they'll just expect me to be happy with what *they* get, which is kind of nothing, you know. I'm not happy with that, you know.

Therapist: Well, that's putting it mildly. You're not happy with that but you would feel like you're an orphan. That sounds like it means that to you, the very essence of family attachment or family connection would go down to zero for you.

Client: Yeah. Yeah.

Therapist: It sounds catastrophic.

Client: Hm. I think that's—I don't know. When, when I overeat it's almost like I dissociate, you know, it's almost like I, I'm not present, you know. And I think that's why it's like so traumatic for me to, you know, to even think about that. It's like I can't watch myself doing what I'm doing because I hate that about myself but I can't stop doing it because I hate what I think the result would be, you know.

Therapist: Yes, it's even worse.

Client: So I'm stuck. So, I have to just like not be present, you know, 'cause I can't stand either eventuality.

Therapist: You can't stand knowing either eventuality, but you pick one of those eventualities as the lesser misery.

Client: Right. But in the moment I pretend like I'm not choosing that.

Therapist: Yes. Yes.

Client: [Small laugh.] Yeah.

Early in the session, Susan described how "uncomfortable" she has become over being thin, and she attributed this discomfort to her view that her family members were thinking they were "proven right" by her finally "fitting in with them." That these conscious notions were incomplete is now apparent. She has now brought her awareness and attention to the unconscious emotional truth of why her fitting in warrants such discomfort: she expects that if she fits in, they will no longer worry about her, and if they

no longer worry about her, they will have no real interest in her and pay no attention to her at all, leaving her "familyless" and "orphaned."

This is "so traumatic" a jeopardy that she must avoid awareness of it by dissociating through eating compulsively, which is yet another distinct purpose for eating, a second pro-symptom position discovered in this session. Not to overeat would be to feel the raw truth of an unbearable absence of genuine connective tissue in the family, as she experiences it.

The coherent necessity of overeating consists, then, of at least two distinct purposes discovered thus far: to get caring attention by causing worry, and to avoid feeling unbearable, desolate aloneness. Until now these urgent purposes and the implementation of them by overeating were implicit (unconscious) knowings held subcortically. They are now being translated into explicit (conscious) feeling-knowings and verbal-knowings.

In saying, "I can't stand either eventuality," Susan indicated that now, with awareness of her pro-symptom positions, she sees the structure of her dilemma, a terrible choice and tradeoff that is always facing her: She must either overeat, in order to avoid awareness of disconnection and to elicit attention, at the cost of harming her health and hating being an overweight overeater; or, she can eat healthily, at the cost of plunging herself into the crisis of being emotionally familyless and abandoned.

Here we see another distinctive feature of what unfolds in coherence therapy: having the symptom entails a very real suffering, yet the symptom is necessary to have because *not* having it is expected, unconsciously, to bring an even worse suffering (here, feeling "familyless," "orphaned"). The predicament of being caught between *the two sufferings* (the one with, and the one without, the symptom) becomes conscious in the course of the work as a direct awareness of emotional truth, not as an interpretation or rational explanation from the therapist. In bumping into the *greater* misery—the misery encountered by *not* having the symptom—the client awakens to an existential dilemma that has been unconscious. Susan is now facing the reality that the caring attention and personal understanding that she has always been aching for and striving to get from her family members is simply not available from them. She is facing the disconfirmation of her unconsciously construed fantasy and hope that they *could* understand her, a big step of separation and individuation. In other

words, she is now in a position to solve the existential dilemma of unavailable attunement and fragile attachment in a new, conscious way.

The therapist will immediately work to create ongoing integration experiences of these key emotional truths by structuring a simple way for Susan to keep having daily experiences of them.

> *Therapist*: Well, right there is perhaps a new path for you in this, especially given the new—the emotional truths that are newly in view now about *attention* being what's really at stake here.
>
> *Client*: Right.
>
> *Therapist*: I'm wondering if it could work for you to have a personal practice of staying present when you eat too much, and in particular staying present to this emotional truth of how come it's really necessary to be doing this right now. I'll write on a card for you these simple words: "I've *got* to eat like this to keep what little attention I get from them from disappearing completely and making me an orphan."
>
> *Client*: Mm-hm. Yeah.
>
> *Therapist*: Is that—I wonder if that's too big a step?

Writing freshly discovered, key material on a small, yellow index card for daily reading is a mainstay method of creating daily integration experiences in coherence therapy. The phrasing again embodies the qualities needed for verbalizing subcortical emotional truths: first-person, present tense, succinct and emotionally vivid in naming what is at stake and what response is necessary. The content stays very close to Susan's own words and meanings; again there is no interpreting or explaining, and no attempt to counteract her overeating or build up healthy eating patterns. The aim at this stage is to gain access to the constructs driving symptom production by integrating them.

In response to being asked if the task is too big—engaging the client in task design is always important—Susan replied, "I don't know," and explained why she was unsure about being able to do the task. She revealed that she heavily overeats secretly at any and every opportunity to do so throughout the day, and that she has no self-awareness while doing so. "I'm just *compelled* because I'm alone and I have this opportunity. It's almost like I don't even

wake up until I'm half-way through," she said, indicating that the task as described by the therapist wouldn't work because it required her to be mindful of her actions. The therapist now regarded the incessant quality of the compulsion to eat as a specific symptom in itself and saw in it an opportunity for further coherence-focused discovery.

> *Therapist*: . . . I think maybe you're pointing us to another piece of this, another part of the emotional truth of this, perhaps. Let's see . . . Thinking of what you just described, how continual is that compulsion to eat whenever there's an opportunity . . . The part that might be the emotional basis or truth of the eating at every opportunity is a big part of what you've told me about in connection with *how little attention* you get from your family: . . . you're a person who's *starving* for that, *all* the time . . . You're clearly a person who's been running on empty for a certain major, fundamental kind of emotional food your whole life.
>
> *Client*: Yeah.
>
> *Therapist*: Is that an exaggeration for you, to put it like that?
>
> *Client*: [Much softer, slower, quieter voice than previously.] No, I think it's true. Yeah.
>
> *Therapist*: Attention, caring attention. *Attuned* attention to who you are and what you're experiencing.

Here the therapist, in introducing the word "starving," was somewhat leading on content, which is to be avoided in coherence therapy. It needs to be the therapist who learns from the client what the symptom-requiring emotional truth is, not the other way around. However, he was transparent about not presuming to know whether his inference is actually the client's emotional truth, and he submitted it to her for verification. Aiming to make explicit the coherence of her *always-present* compulsion to eat, he has named the truer nature of the hunger that she always feels—the hunger for caring attention. (A less leading way to usher Susan into the same emotional truth would be to have asked, "On a feeling level, *what's the connection*, if any, between always, always feeling attention-deprived, and always seizing any chance to eat?")

This recognition of being starved for attention is yet a further step of discovery. It remained the focus of the last fifteen minutes of the session. Susan now began describing various areas of her life that were coming to mind, making new sense of them:

"Most of the guys I dated, when they would break up with me they would say, 'You're just too needy,' you know, like this is the major flaw in my personality." "And my husband . . . [T]he only time when we have arguments is when I can't get his attention . . . It's like our major thing if I feel like I can't get his attention." "It's just so interesting, this connection about attention . . . [M]y best friend just had a baby a couple weeks ago and I've been really emotional the last couple days 'cause, you know, she's like unavailable and my husband's been a little unavailable and I'm like, you know, there's times when it gets so pressing that I actually have to admit it consciously like, 'I need attention,' you know. But I never thought about it being connected to my eating . . . "

The following dialogue about her deprivation of attention occurred in the midst of this focus.

> *Therapist*: . . . [T]hat's a powerful distress to be carrying around all the time . . . And when one is carrying a distress that powerful, one needs continuous doses of something that soothes . . . So I'm wondering if that might be why part of you gets into that urge to eat whenever there's an opportunity.
>
> *Client*: Yeah. I think that's a lot, that has a lot of truth to it . . . And after I eat like that, although I'm like super guilty and feel terrible about myself, there is a certain, like, just very calm, like I'm full, you know?
>
> *Therapist*: Exactly. It works, in other words.
>
> *Client:* Yeah, it does work. Yeah.
>
> *Therapist*: Yes. That deep distress, that deep ache, the desperation is temporarily gone.
>
> *Client*: Yeah. Yeah.

As a result of discovering and for a few minutes integrating (staying in touch with, and speaking *from* and *in*) the emotional truth of feeling always starved and desperate for caring attention, Susan has now recognized that she eats for the purpose of having a respite of "calm" from that specific emotional ache. It was found earlier in the session that eating blocks her intense distress over feeling always on the verge of being "orphaned." These seem to be two related but different facets of what Susan suffers in relation to her family, and suppresses by eating.

Susan's emotional purposes for eating were now clearer still. Five minutes later she said, "I can see that I have this hunger that never got met, so now I have this huge, gaping appetite for it which, yeah—I mean it's not my fault. It's just that I didn't get it." Her voice was now considerably quieter and slower than during the first half of the session, and her eye movements indicated a great deal of internal processing. When, about a minute later, the therapist commented that "eating handles the emotional reality of the ache of getting no attention," Susan replied, "Yeah. I mean it does a really good job of handling that problem."

This session's progression through several layers of alternating discovery and integration is typical of how coherence therapy unfolds, often across several sessions. The session was now nearly out of time, so the therapist again focused on creating a post-session task of reading an index card to produce ongoing integration experiences.

> *Therapist*: . . . Tell me if this fits for you and let's tune it up and revise it if it's off in some way and get it to feel accurate to you, ok? . . . So you would eat, but first you would just insert 30 seconds of tuning into this. "I've *got* to eat because if I don't, I'll feel how much I'm hurting and starving for the attention I never got, and I'd get thin and lose the little bit of attention I do get for not fitting in."
>
> *Client*: Yeah. I think that's pretty much it. That feels really true to me.
>
> *Therapist*: . . . Now, it won't be easy to open this space of mindfulness in that trance that powerfully sets in . . . You might want to read this once in the morning just to keep it near awareness, and then carry the card and each time there's the opportunity to eat and you're about to do that, take out the card, look at it, just see if you can give yourself enough seconds of focus on it to feel, to touch into the feeling like you're having right now, the realness of it. And then eat knowing it's true, even if it feels tragic. Even if it feels sad.
>
> *Client:* . . . Yeah, that feels like a good plan 'cause I think if I could do that then I would like sort of realize after eating that that's not helping. You know, I mean it's not actually feeling, it's not actually doing what I'm trying to do . . .

After the card was written, Susan and the therapist discussed scheduling a second session. Susan felt she had plenty to work with

and was uncertain as to how much time it would take for her to be ready for more, so she opted not to schedule and to call as and when needed. She sent a short email to the therapist at one week and again at one month after the session, the latter saying, "I have been doing well since our session. I am still working on this issue every day, but so far haven't hit any blocks."

Five months after the session, the therapist sent Susan an email asking how these matters had developed. Susan replied as follows:

> Thanks for the follow up. Our session was very helpful, but not in the way I expected or necessarily wanted when I went in. I wanted some shift that would help me lose the weight I'd been wanting to lose—to take care of all the baggage. Well, the session was very effective and got me in touch with the core issues in a different and better way. But I also saw that I didn't have to buy into my family's push for me to be thin in order to be acceptable. The decision that I made was to start a daily yoga and meditation practice. I want to be healthy and fit, but not necessarily to buy into the thinness issue. Yoga has helped me to accept myself and my body exactly the way it is, with the nice effect that this acceptance helps me choose healthier foods and lifestyle choices, etc. I am a LOT stronger and more fit. My weight on the scale hasn't really changed and I'm a lot more okay with that than I have ever been. I can't say I'm TOTALLY okay with it, but I practice being okay with it every day as I just do my best to try to make healthy choices and exercise.
>
> So yes, it was very helpful, mostly in releasing me from the MIND games I and my family was playing with me [sic], not in changing my weight. And that's a great result. . . . [W]hen I start giving myself those old messages [I] remind myself of what the cycle is in my family and that accepting myself is the only answer.

Discussion

This kind of outcome, with resolution through changes in areas unexpected by the client, is not uncommon in coherence therapy because the client invariably finds that the presenting symptom, which at first seemed to be the problem, is a surface manifestation of a more central problem that was not conscious. An authentic resolution of that deeper problem may or may not entail the changes originally sought.

In the session Susan became aware of her central, lifelong dilemma of having a family in which she feels so starved for personal understanding, acceptance and caring attention that she feels very nearly familyless and orphaned, and is unbearably distressed over this. Previously her knowledge of that dilemma and those feelings had been almost entirely implicit (unconscious). She had been responding according to three distinct implicit knowledges (pro-symptom positions): (a) eating whenever possible is necessary in order to avoid feeling the unbearable distress; (b) causing worry and consternation by not fitting in, such as by being overweight, is necessary as the only way to get any attention at all from family members; (c) not fitting in with their standards of perfection is necessary for making them come to see and understand her as a distinct individual. Each of those three knowings is a coherent, compelling emotional truth that makes her symptoms of excessive eating and weight more important to have than not to have. Each became conscious experientially in the session.

The loss of the subjective realness of a pro-symptom construct is the main indication that it has been transformed. Susan's email message indicates that a degree of transformation has occurred in the three different pro-symptom positions just enumerated. Her sense of feeling a "release" from the longstanding "mind games" in the family suggests this. She also refers to a positive change in her food habits and is "a lot more okay with [my weight] than I have ever been." The last phrase in the message, "accepting myself is the only answer," more specifically indicates a fundamental shift in the implicit knowings defining how to respond to her dilemma of insecure attachment. Her phrase implies that, having consciously revisited and reassessed how she strives to solve that dilemma, she is arriving at a very different solution in which she accepts rather than struggles against the profound unavailability of attuned understanding and acceptance from her parents and brothers. As a result she has begun to be *self*-accepting and *self*-nurturing, because of seeing that this is the only basis of well-being that actually and always is available to her. This is a liberating step of separation-individuation and emotional health, and Susan recognizes it to be an even bigger prize than the weight loss she initially was seeking.[8]

[8] Ordinarily, a coherence therapist actively seeks a confirmation of transformation, that is, a confirmation of the loss of subjective realness of key pro-symptom constructs. This is best done through applying experiential cues and triggers that have reliably activated the pro-symptom constructs in the past, in order

Integration of pro-symptom positions leads to their spontaneous transformation about half the time, as appears to have occurred for Susan. If, on the other hand, an integrated pro-symptom position does not transform spontaneously and persists in its felt realness, the therapist must deliberately prompt an experience that transforms it.

Coherence therapy delineates a specific methodology for this transformation of constructs. The methodology is designed to utilize the brain-mind-body system's inherent process of construct revision, a process that was identified phenomenologically by Ecker and Hulley (1996, 2000a, 2004) and that receives support through its close correspondences with the recently discovered neural process of *reconsolidation* of implicit memory (detailed in Ecker & Toomey, in press). Conditioned response schemas in emotional implicit memory (such as pro-symptom positions) had been believed indelible and immutable throughout the 20th century, a conceptual pillar that was toppled in the year 2000 by evidence of reconsolidation, a neural mechanism that can alter and even erase implicit memory through a previously unsuspected type of neuroplasticity (synaptic change).

The critical condition for a transformation of pro-symptom constructs consists of a *disconfirming juxtaposition*: the client simultaneously experiences as real both a pro-symptom knowing and some other, contradictory knowing. Experiencing an incompatible construct can disconfirm and dissolve the pro-symptom construct

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to determine whether those constructs still exist and activate. An overt statement of the original pro-symptom material is one of several suitable methods. For example, Susan would be asked to picture her family members and say out loud, "If I got thin and fit in with your standards, it would be the end of my chances of getting you to see who I am. And then you wouldn't be worried about me and wouldn't pay *any* attention to me any more, and that terrifies me, so *no way* am I willing to get thin—even though I *hate* how being heavy hurts my health and how I feel about myself. But I'd rather endure that than be invisible and orphaned." Overt statements properly facilitated are quite effective in deepening the speaker into the subjective, emotional realness of the constructs being spoken, but only if those constructs still exist in the brain's emotional systems (subcortex and right cortical hemisphere). An overt statement of pro-symptom constructs that no longer exist fails to evoke any felt realness. Rather, the previously dire, vivid material now seems implausible, silly, lifeless, absurd or even laughable. (For an example of that test of transformation in a real session on video, showing the client describe a major, lifelong, newly conscious pro-symptom position as seeming quite funny at the end of one session of therapy, see Ecker and Hulley, 1997.) The work during Susan's one session did not go quite far enough for a confirmation of transformation to be carried out.

if the client experiences both at once, in the same field of awareness, in juxtaposition: both knowings seem real, yet both cannot be true. This produces a recognition of the more archaic and limiting pro-symptom construct as false, which rapidly decommissions it as a representation of reality. Thereafter the pro-symptom construct no longer has subjective realness and cannot be re-triggered, which is the primary indicator of actual transformation.

Like the rest of coherence therapy, disconfirmation through juxtaposition is a non-counteractive process. The therapist says and does nothing that opposes the pro-symptom position and guides the client to stay in touch with it, not to get away from it, while also attending to some other, contradictory knowledge. The therapist lets the contradiction speak for itself, never tries to indicate how to resolve it or which construct to regard as more valid, and trusts the client's native process to do that and to carry out the depotentiation of the pro-symptom knowings and synapses.

If instead, as occurs with counteractive methods, the client were to focus attention only on experiencing the disconfirming construct, without sustained, *simultaneous* awareness of the pro-symptom construct, then the disconfirming construct is set up separately and merely opposes and competes against the pro-symptom construct.[9] This situation fails to actually transform or dissolve the more powerful pro-symptom construct, which retains its realness and remains re-triggerable, causing relapses. Counterintuitively, it is by *maintaining* awareness of the trouble-making pro-symptom construct alongside the contradictory, disconfirming construct that transformation occurs.

When a pro-symptom position transforms spontaneously following integration, as it did for Susan, the same process is responsible. Upon becoming integrated, a pro-symptom construct is suddenly susceptible to being juxtaposed spontaneously in the same field of awareness with all manner of other knowings held by the individual. For example, one of the pro-symptom constructs transformed by Susan is (in verbalized form), "By visibly *not* fitting in, they will see me and understand me." This emotionally urgent

[9] According to mounting neural evidence, the medial pre-frontal cortex (mPFC) is the brain's storage site for knowings that counteract and compete against activation of aversive, fear-based pro-symptom construals and schemas, which are stored in the amygdala, presumably. For details see Ecker and Toomey, in press.

knowing, carried in her subcortical library of nonverbal knowings, became conscious and was disconfirmed by being juxtaposed with a new knowing that Susan formed and articulated fairly early in the session, "They have *no* capacity to see me and understand me in *any* case, heavy or thin." Both of those constructs were real to her, but both cannot be true.

Conclusion

Coherence therapy is defined by its methodology of experientially discovering, integrating and transforming pro-symptom positions. Within that methodology, a coherence therapist has a wide latitude for moment-to-moment choices of technique and interactional style. We teach trainees about a dozen specific techniques (Ecker and Hulley, 2004) that are particularly versatile, simple and reliable (such as symptom deprivation, overt statement, what's the connection, and index card techniques illustrated in the case example), but the therapist is free to adapt or invent any experiential methods that can serve this methodology. Our case example of Susan should therefore not be taken as defining the particulars of technique and style, but only as showing how the core methodology was carried out in this instance. The therapist had sessions with other clients on that same day with a quite different quality and rhythm, while carrying out the same methodology. (For a discussion of coherence therapy [depth-oriented brief therapy] in relation to the broader context of constructivist psychotherapies, see Neimeyer and Bridges, 2003 and Neimeyer and Raskin, 2001.)

The principles of change followed in coherence therapy can be summarized in simple terms in this way (Ecker and Hulley, 2004):

- Change of a symptom is blocked when a person tries to make the change from a position that does not actually have control of the symptom—a position merely against having the symptom (an anti-symptom position).

- For a person to achieve rapid change of the symptom, first have him or her experience, inhabit, verbalize and embrace the emotional truth in the symptom-requiring position, because that is the

position that does have control over producing the symptom (a pro-symptom position).

- People are able to change a position they experience having, but are not able to change an unconscious position that they do not know they have.

- Counteracting is counterproductive: it fails to transform and only maintains the split-off, unconscious condition of the person's symptom-requiring knowings.

- A person will transform a pro-symptom position when this position is experienced simultaneously and in juxtaposition with other living knowledge that is incompatible with it, so that the two knowledges cannot possibly both be true, yet both are present in the same field of awareness.

Several integral aspects of coherence therapy are not addressed in this short introduction, such as working with resistance; the functions and use of client-therapist relationship; the internal, hierarchical structure of constructs in a pro-symptom position; and coherence-focused work with couples and families. These and other features of the methodology are described in detail elsewhere (Ecker & Hulley, 1996, 1996a, 1997, 1997a, 2000a, 2000b, 2002b, 2004; Ecker & Toomey, in press).

Usually more than one session is needed; a majority of clients require five to ten sessions, and a small minority requires more than twenty. Our experience with coherence therapy tells us that the human capability for swift, accurate, in-depth change is far greater than was recognized during the first century of the psychotherapy field; that surprisingly effective work can happen routinely, in most every session, if the therapist remains coherence-focused continually. In the session detailed here, the significant progress and appearance of easiness and inevitability is due largely to the coherence-mindedness maintained by the therapist. Whether it is easy or difficult for a trainee in coherence therapy to learn to maintain coherence-mindedness moment-to-moment depends on how many *non*-coherence-oriented constructs and commitments he or she has.

References

Ecker, B. (2003). The hidden logic of anxiety: Look for the emotional truth behind the symptom. *Psychotherapy Networker, 27* (6), 38-43, 58.

Ecker, B., & Hulley, L. (1996). *Depth oriented brief therapy: How to be brief when you were trained to be deep, and vice versa.* San Francisco: Jossey-Bass.

Ecker, B., & Hulley, L. (Producers). (1996a). *Stuck in depression.* [Video and viewer's manual.] Oakland, CA: Pacific Seminars. Online: www.dobt.com/video.htm

Ecker, B., & Hulley, L. (Producers). (1997). C*ompulsive underachieving.* [Video and viewer's manual.] Oakland, CA: Pacific Seminars. Online: www.dobt.com/video.htm

Ecker, B., & Hulley, L. (Producers). (1997a). *Down every year.* [Video and viewer's manual.] Oakland, CA: Pacific Seminars. Online: www.dobt.com/video.htm

Ecker, B., & Hulley, L. (2000a). Depth-oriented brief therapy: Accelerated accessing of the coherent unconscious. In J. Carlson & L. Sperry (Eds.), *Brief therapy with individuals and couples* (pp. 161-190). Phoenix: Zeig, Tucker and Theisen.

Ecker, B., & Hulley, L. (2000b). The order in clinical "disorder": Symptom coherence in depth oriented brief therapy. In R. A. Neimeyer & J. D. Raskin (Eds.), *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 63-89). Washington, DC: American Psychological Association.

Ecker, B., & Hulley, L. (2000c). A new zone of effectiveness for psychotherapy. *New Therapist, 6*, 31-33.

Ecker, B., & Hulley, L. (2002a). Deep from the start: Profound change in brief therapy. *Psychotherapy Networker, 26*(1), 46-51, 64.

Ecker, B., & Hulley, L. (2002b). DOBT toolkit for in-depth effectiveness: Methods and concepts of depth-oriented brief therapy. *New Therapist, 20*, 24-29.

Ecker, B., & Hulley, L. (2004). *Depth-oriented brief therapy practice manual and training guide.* Oakland, CA: Pacific Seminars. Online: www.dobt.com/manual.htm

Ecker, B., & Toomey, B. (in press). Depotentiation of symptom-producing implicit memory in coherence therapy. *Journal of Constructivist Psychology.*

Kelly, G. A. (1991a). *The psychology of personal constructs. Vol. 1: A theory of personality.* New York: Norton. (Original work published 1955)

Kelly, G. A. (1991b). *The psychology of personal constructs. Vol. 2: Clinical diagnosis and psychotherapy.* New York: Norton. (Original work published 1955)

Kreiman, G., Koch, C., & Fried, I. (2000). Imagery neurons in the human brain. *Nature, 408*, 357-361.

Milner, B., Squire, L. R., & Kandel, E. R. (1998). Cognitive neuroscience and the study of memory. *Neuron, 20*, 445-468.