

A **Theory and Treatment**
of Your
Personality
- a manual for change

Dr. Garry A. Flint

Chapter 1

**The Discovery
of the**

**Process
Healing
Method**

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Editor's Notes:

Thank you for downloading this free copy of Chapter 1 from Dr Flint's book: **A Theory and Treatment of Your Personality - A manual for change.**

Those of us who have downloaded the original free PDF of this chapter, (or read Dr Flint's book in full), will know that the material is quite dense and sometimes difficult to digest.

The original font, spacing and general organization of the sections and subsections are clustered together and unnumbered. Also, the way the text wraps around the illustrated figures leaves very little room for longer words which become hyphenated and distract from the reader's concentration.

The flowable ebook versions do not have this problem and, as in this version, the table of contents are clickable and will take you directly to the relevant sections. However, more can be done to make the material appealing and presentable, especially for those who wish to read Dr. Flint's work on paper.

So here is a spruced up edition – a sort of printable “study-guide” version – with more space, **color-coded sections and technical terms**, some of which have been put into single quotation marks to help them stand out. The text is the same as the original but when it is helpful to clarify or rephrase words, they have been inserted within these wobbly brackets { }.

Helpful additions and clarifications, are marked by double asterisks on either side, like this: ** **

Finally, there are passages of the text that read more as side-notes rather than as part of the main text. These passages have been grey out and put in bold - **like this** - to distinguish them. Doing so also breaks up the text, which is hopefully refreshing on the eyes.

Happy studying!

The Discovery of the Process Healing Method

The Process Healing Method is a treatment intervention for a wide variety of mental health issues. The discovery of the Process Healing Method took me by surprise. I was an experimental psychologist, a man of science and, though what I was seeing was extraordinary, I could hardly deny what was happening before my very eyes. The theory behind Process Healing is unusual and forced me, as a psychologist, to shift my way of thinking about what causes us to think and behave. This is a shift that I invite my colleagues to make with me.

A major part of this shift in thinking is that this method uses the Subconscious in all stages of therapy. The Subconscious is a part of us that has been there from the beginning. It is a brain process that starts to learn before we have sensory experience. I learned to trust the use of the Subconscious to direct treatment, to do treatment interventions, and to certify the adequacy of my metaphors designed to model our mental processes and behavior. This first chapter takes you through the experiences that led me to this novel understanding. You may wonder if the Process Healing Method is worthy of study and use by either individuals or mental health professionals. Here is some empirical support for the practical effectiveness of this method:

Dr. Joaquin Andrade, M.D. (personal communication, January 10, 2001), spearheaded finding an effective treatment method for patients served in 11 outpatient clinics in Argentina and Uruguay. He was looking for treatment methods to get better results. About 16 years ago, his clinicians started experimenting with Thought Field Therapy (TFT) (Callahan, 1985). This treatment involves tapping on acupressure points to remove pain. For 15 years, the research team collected data to assess effectiveness of treatment. The team contacted patients who had received treatment in a double-blind format at 3, 6, 9, and 12 months (Andrade and Feinstein, 2003). They found the tapping treatment routinely achieved 60 to 70 percent positive outcomes with 29,000 patients.

In 2001, Dr. Andrade (personal communication, January 10, 2001) discovered the Process Healing Method by visiting my web site (Flint, 2005). By following the instructions of the Process Healing course, he learned how to teach The Subconscious to treat trauma and tried this treatment method in several clinics. With the first 64 patients who were failures with routine tapping, he realized 60 percent positive results (J. Andrade, personal communication, July 13, 2002). With more experience and some coaching, after treating 200 patients, he found that he obtained positive results with 65 percent of the patients treated (J. Andrade, personal communication, December 14, 2002). The Process Healing Method would probably be

effective with all the success cases he had previously treated with tapping. If this were true, then one could estimate that Process Healing would be effective with 84 percent of patients who came to the clinics.

The discovery of the Process Healing Method took me by surprise: The Subconscious could do the treatment inside the patient. The Subconscious learned the tapping treatment method as the patient did Thought Field Therapy interventions. This discovery process continued over the next 12 years of personal study and research. Trained as an experimental psychologist with an emphasis on the theory of learning, I studied the behavior of rats, pigeons and squirrel monkeys. This training taught me that observation was important (Skinner, 1953, Flint, 1968). I now use this practice of observation in my work with patients. I carefully watch and listen to my patients to notice what I do that causes change in their present experience and in their experience of their issues. I have little formal education in clinical theories to interfere with my insight into personality dynamics. This combination of observation, ignorance of clinical theory, and training in hypnosis, Neurolinguistic Programming and several new, effective treatment methods, resulted in the development of Process Healing as a powerful treatment method. Preliminary research shows that the Process Healing Method is remarkably effective.

The Subconscious is explained further in Chapter 2. My patients taught me that The Subconscious is a useful ally in identifying and treating issues in therapy. The Subconscious is a language process that has access to the neural activity of the entire brain and body. It can learn to change the role of memories by removing or adding emotions. These three properties of The Subconscious — ease of communication, access to all memories, and a method of changing memories — make The Subconscious an excellent ally in any treatment setting.

I also assume that unique memories cause all brain, behavior, and body processes such as muscle movements and organ activity. An active memory, such as thinking a thought or word, is neural activity. Your automatic response of “Great” to someone who says, “How’s it going?” is a learned response caused by remembered neural activity. When you learn a memory, like meeting someone’s handshake, the memory runs the body automatically to meet the handshake without your even thinking. Memory involves learned neural connections that manage your physiology to create the learned response, namely to run the muscles that cause you to meet the other person’s hand. Memories run all conscious and unconscious learned behavior. Mental problems or issues are memories with associated negative emotions. It is easy to change learned neural connections. Since The Subconscious can change the emotions connected to memories, the therapist can try to treat any learned brain or body process when working with The Subconscious. I

now believe that it is possible to heal any learned mental or physical dysfunction.

The Subconscious employs our native language and is open to communication. I have learned to use The Subconscious to choose which psychological issue to address and the interventions that would be best. In short, I routinely use The Subconscious to direct the treatment of my patients.

The strategy of having The Subconscious direct treatment has moved me from doing therapy directed by the therapist to doing therapy directed by the patient. This patient-directed therapy is clearly respectful to my patients. It has also changed my problem-solving approach. I no longer look for solutions from my own knowledge. My problem-solving has become patient-oriented. I now look for solutions to problem behavior in some feature of memory caused by the learning process. Some forms of traumatic experience always cause problem behavior. Any trauma memory from the past distorts our behavior to some extent. I can treat these trauma memories with Process Healing. I use The Subconscious to discover solutions to problems and to carry out the interventions.

Solving problems this way has led to the development of a model of learning and memory. Based on clinical observations and the solutions to real problems, this model is practical. Changes in patients' experience and behavior confirm the effectiveness of using interventions based on this model. The model has become a useful tool, as it provides ways to explain and treat maladaptive behavior. Best of all, solutions to problems with one patient have worked with other patients.

Over the years, I had been looking for faster ways to treat trauma. I learned several different treatment techniques. The most significant treatment technique learned, and the basis for Process Healing, was training to diagnose specific sequences of acupressure points to treat mental issues (Callahan, 1993). The treatment involved tapping on the diagnosed acupressure points. After I returned from this worthwhile training, my next patient taught me that The Subconscious could do the tapping treatment. This internal treatment was the basis for the treatment approach that I eventually called Process Healing.

The practice of observation and using directions from the patient are both respectful and essential when working with this theory. This respectful approach and the basic premises of the theory give flexibility to problem-solving and treating difficult mental issues. The theory, then, is the basis for responding to and understanding a patient's description of his or her mental health issues.

The keys to our personality dynamics are amnesic and dissociative parts. Largely ignored in traditional therapy, these parts act like mini-personalities that serve some function in our behavior. People are not usually aware of amnesic and dissociative parts. I am going to describe how I discovered that amnesic parts could be barriers to hypnosis and that various pre-birth amnesic parts could disturb adult behavior. I also found that the effects of preverbal trauma could have a strong impact on later behavior, while *in utero* trauma could cause subtle lingering effects on our behavior. Another significant finding was that amnesic and dissociative parts could fool the therapist. The possibility of deception keeps me alert to explore unusual results further. Another finding, contradictory to my beliefs, was that I could damage The Subconscious. I will describe this later.

The journey started when a patient showed me how The Subconscious could teach me to do better interventions. This experience challenged my more traditional approaches in my clinical practice. If The Subconscious could teach me how to do therapy better, why not routinely use The Subconscious to become a better therapist? This patient's Subconscious helped me to create an intervention to move traumatic pain out of conscious experience into the unconscious while doing Eye Movement Dissociation and Reprocessing (EMDR) (Shapiro, 1995). EMDR involves having the patient focus on both a painful issue and on the movement of my fingers, which are moving back and forth in front of the patient at the same time. Though underwhelming to my EMDR teachers at the time, the intervention that I developed effectively reduced the intensity of emotional pain experienced while doing the eye movement treatment. It also served to control the problem of emotional flooding when doing eye-movement processing. Emotional flooding occurs when the patient experiences all the traumatic pain as if the trauma were happening again. It also clarified the role of the dissociative process. The intervention causes the experience of the active memory not to be in the conscious experience, but in the unconscious experience.

My interest in theory led me to meld ideas based on learning theory (Skinner, 1953, 1957) and chaos theory (Freeman, 1991) to explain the active ingredients of EMDR (Flint, 1996, 2004). The theory explaining EMDR is the basis for Process Healing. The following is a brief introduction to the theory underlying Process Healing.



I want to emphasize to the reader's **entire personality** that the purpose of this book is to provide information. Some aspects of the personality may be threatened or triggered by the information in the book.

The treatment method, which is taught to The Subconscious, can be seen as the primary threat that has to be assessed carefully. Before The Subconscious learns to treat trauma, **all the barriers** to treatment must be resolved.

If some of the content of this chapter triggers emotions or internal voices as you read, perhaps you should consult a therapist before continuing. If you feel a flood of emotions at any time while reading this book, please stop reading, use your best judgment about continuing, and consult a therapist.



The Theoretical Basis for Process Healing

About 13 years ago, I started thinking of the brain as a chaos process (Freeman, 1991) and wrote a paper describing the active ingredients of change when using EMDR (Flint, 1996, 2004). Since that time, this theory, described in greater detail later, has helped me establish rapport with my patients. I explain to patients that memories start forming shortly after conception, not after birth, which is the common opinion. All areas of the brain begin storing memories while the brain is developing. At some point, the brain starts developing responses to sensory stimulation. The auditory stimulation by words, phrases, and sentences that come through the mother's body and stomach wall are remembered. By the time of birth, the fetus has many verbal memories, but no language.

After birth, learning continues with remembered verbal memories, but now neural representations of objects and actions are associated with the words. The memory of words associated with objects and actions becomes a functional language. This language, learned without sensory experience, becomes The Subconscious. Because The Subconscious has no sensory experience, he or she is able to "see" learned history and the internal dynamics of active memories. The Subconscious can also control internal processes to cause changes in the experience of memories and behavior by treating the emotions associated with them.

At the same time as this language of The Subconscious is developing, the Main Personality starts learning. The language learned by the Main Personality initially associates with internal and external sensory experience and, later, with pleasure and pain and basic needs. The Subconscious and the Main Personality, therefore, learn two different neural representations related to the same experience. The Subconscious learns without sensory experience and the personality learns with sensory experience and, later, with other properties.

Active memories are in the Active Experience, which is part of our Behavior System (see Figure 1-1). Before I make the distinction between conscious and unconscious active memory and dormant memory, I am going to tell you about dissociation. Because of the vast amount of information caused by active sensory experience and different memory activities, a process called dissociation is created. Dissociation reduces the quantity of information that we experience in our conscious experience.

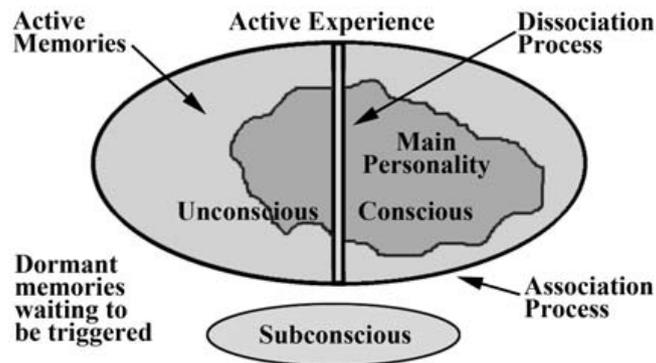


Figure 1-1 Our Behavior System

In Figure 1-1, the double lines shown crossing the Active Experience represent the dissociation process. The dissociative process causes all or part of a memory or sensory experience not to be experienced in our conscious experience and, therefore, creates the unconscious Active Experience. Unnecessary or painful parts of a memory can be “flagged” by the dissociative process in order to move the unwanted parts of a memory into the unconscious. These flagged memories are called “dissociated.” The activity of dissociated memories is in the unconscious experience and not the conscious experience.

Memories that are not part of the Active Experience are called dormant. While all dormant memories are by definition inactive, they are all potentially active – waiting to be triggered. They are ready to be switched or triggered into activity in the Active Experience. The terms memory activity or active memories used here always refer to those memories that are active in either the conscious or the unconscious Active Experience, or both. Memories that are available to be triggered are called dormant.

The Subconscious has access to everything experienced in the brain in both the conscious and unconscious experience. The Subconscious does not experience any form of hurt; in other words, trauma never damages The Subconscious. Later, I will explain how I was able to hurt The Subconscious by having The Subconscious do something not normally done. Fortunately, I recognized the problem and was able to repair The Subconscious. It is important to stress the fact that The Subconscious appears to be always whole and healthy with no barriers to inhibit the view of the internal “reality.” When I talk to a patient about the formation of the personality, I explain the reasons why intense traumas cause amnesic parts. I explain that these parts are normal personality parts learned during the span of a trauma, but having few neural connections to the Main Personality. Amnesic parts also have executive function and can create novel adaptive behavior, while dissociative parts are more like skills and can only create adaptive behavior that was previously learned.

Patients often hear comments in their thoughts or experience a “Yes” feeling while I talk. This makes the model of the personality I am presenting true for them. However, in most cases, The Subconscious will communicate in the first session by using finger responses, signaling “Yes,” “No,” “I don’t know,” “I don’t want to tell you,” or by making no finger response.

My Neurolinguistic Programming Training (NLP) (Rice and Caldwell, 1986) taught me about auto-treatment. Auto-treatment is obvious when personality changes occur without any outside influence. One can teach an NLP intervention, called the six-step reframe (Cameron-Bandler, 1985), to treat issues at night while the patient sleeps. When this works, the patient asks to change beliefs or behaviors when he or she goes to bed and awakens with the change completed. After an experience with a certain patient, which impressed me with the power of The Subconscious, I decided to extend the auto-treatment notion. Since then, I have found barriers to auto-treatment in other individuals. The Subconscious can treat these barriers to enable it to treat issues automatically and to perform independently of the active personality.

The Subconscious Can Teach the Therapist

The first clinical experience that caught my attention occurred when I was seeing many patients with multiple personality disorders. One of my patients allegedly had 200 dissociated or amnesic personality parts. These parts were all amnesic or unaware of one another because they could not communicate. This patient was difficult. Often, the part that came to the session did not believe there were any other parts. Sometimes she didn't know who I was. She learned that by talking as fast as she could, she could prevent dissociation. When she dissociated, a trauma part would begin to run the body. She always dissociated during the latter half of the session. The active amnesic part was usually willing to work with me. I treated parts using Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1991). I had to be careful using this treatment with the patient because of the possibility of emotional flooding. This patient taught me something important that changed my life.

One day, after completing a session, I turned my back on the patient to write an appointment card. I heard a loud gasp. As I turned around, I saw her pushing her chair back with her feet. The chair was bouncing across the floor. When she stopped bouncing, I saw the patient's eyes open wide and moving back and forth rapidly. I noticed that her eyes focused just above her knees. She said in a panicked tone, "I see a white light; I see a white light." I calmly reassured her that the experience was not unusual. I asked if I could talk to her Subconscious. The Subconscious said, "Yes." She said, "No." Most of her parts did not like me talking to her Subconscious and parts. Her response almost always came out, "Yes, No." I asked, "Subconscious, are you telling me that I should do the eye movements down near the knees?" The Subconscious said, "Yes." The visual hallucination immediately stopped. This experience prompted deliberate exploration, using The Subconscious to orchestrate and refine my treatment interventions.

From this point, I increasingly began to use a semi-hypnotic technique with my patients. While the patient was awake, I used finger responses to talk to The Subconscious. I communicated by asking leading questions to which The Subconscious said, "Yes" or "No." The Subconscious advised me in which order to treat issues and indicated which therapeutic technique to use to treat an issue. I felt that my therapy was becoming more respectful to all parts of the patient while addressing treatment goals that were more relevant to the patient.

Treating Emotional Pain in the Unconscious

By working with a patient's Subconscious, I developed a treatment intervention to control flooding while doing EMDR. The treatment intervention provides for painless treatment of trauma pain by combining EMDR and the dissociative process. By suggesting that the pain be dissociated while treating the trauma with EMDR, the dissociation process takes place and the trauma pain moves from the conscious experience into the unconscious experience as the processing continues. The patient does not feel the painful trauma emotions during the treatment.

Stimulation of the brain with the eye movements causes an exchange of the painful trauma emotions with the relaxed or neutral emotions that are active (Flint, 1996, 2004). With repeated eye movements, the pain gradually reduces to the point where the trauma memory is no longer painful. I used this process with four or five other patients who also helped with minor details in developing this treatment technique. The technique has been effective in treating severe trauma because it lowers the chance of emotional flooding into the conscious experience. Patients ranging from nine to 52 years have responded well to this procedure.

Subconscious Directed Treatment

My theory is that different neural patterns of eye movement are active during trauma. This neural pattern becomes associated with the memory of the traumatic pain. Bearing this in mind with many of my patients, I have asked The Subconscious to tell me the direction of eye movement that is most helpful for treating the patient. I have received many unique and interesting instructions from The Subconscious.

For example, with one patient, The Subconscious told me to move my fingers in random, smooth, circular strokes while moving my hand closer to and farther away from the patient. In addition, The Subconscious told me that I should hold a silver pen with a gold tip in my hand for the patient to follow with his eyes. Though I forgot about the pen nearly every session, The Subconscious always reminded me to use it. For five weekly sessions, this unique procedure, "ordered" by The Subconscious, continued. During this time, the patient had a continuous severe headache. The headache stopped, indicating the completion of treatment. The Subconscious no longer reminded me to use the gold-tipped pen. For this patient, this unusual treatment neutralized the pain of seven years of viewing frequent gory traumas and deaths.

Discoveries

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1. Barriers to hypnosis

In hypnosis, some patients were difficult, if not impossible, to put into a deep trance. There seemed to be a barrier blocking the trance induction. While addressing this problem, I received strange finger responses. I discovered that pre-birth traumas caused pre-birth parts. In some ways, pre-birth parts are just like the amnesic parts previously described. However, the experience of pre-birth parts in utero is similar to the young Subconscious; namely, it is always awake. Pre-birth parts learn to relay information from The Subconscious to the personality. These pre-birth parts can become barriers to getting deep trance. I learned to establish rapport and talk to the pre-birth parts. I usually got them to accept treatment with EMDR or to become quiet. With these barriers quiet, I was able to put the patient into a deep hypnotic trance.

2. Pre-birth parts and behavior

The awareness of pre-birth parts helped me to overcome barriers to communication with The Subconscious. Often, while I was building rapport with The Subconscious, I discovered the presence of pre-birth parts. When I treated a pre-birth part with EMDR, I asked The Subconscious to manage the rate of experience of the traumatic memories of the pre-birth part. I provided eye movements to treat the part's trauma. This approach was effective with many of my patients. The effect sometimes resulted in a subtle but pervasive change. One case example is a patient who had a tendency to wail like a baby when she was upset. She had been a difficult, disruptive patient during treatment at the local clinic. Treating the trauma of the pre-birth part that caused the wailing made the wailing behavior stop. At the end of the session, she told me her mother said that her father had kicked her mother during the pregnancy. The mother started bleeding and had a cesarean delivery.

3. Preverbal trauma

A therapist can use the same treatment procedure to treat preverbal traumas – traumas that occur before the development of verbal skills. One can access preverbal traumas by asking directly or by presenting stimuli to elicit the trauma part. In one case, a young boy had had earaches between the ages of six and twelve months. I triggered emotions associated with the trauma of the earaches by putting my hand next to his ear. After I treated this trauma with EMDR, he would allow me to put my hand near his ear without an emotional response and showed no emotional reaction. This resulted in a marked change in his behavior at school. In the next session, I tested his response to the trauma-related stimuli by moving my hand near his ear, and he had no fear. I told him to imagine that I was wearing a white coat, and I put my hand near his ear. Again, emotions flooded his experience. Matching the conditions of his trauma evoked even more intense emotions than I had previously seen. I treated these emotions by using EMDR.

4. Lingering early trauma

A patient complained of mood swings, which resembled something like manic-depressive behavior. I considered novel ways to explain the cause of manic-depression or at least the mood swings experienced by this patient and others. What if some pre-birth and preverbal neural activity was switching in and out, causing the rapid mood changes? Could it be that some form of trauma occurred during the pre-birth and preverbal periods before the brain structures and functions developed fully? I hypothesized that a specific trauma occurred and that this trauma associated with the neural activity of memories of the entire brain. This led to guessing the possibility of lingering trauma picked up in utero.

I speculated that the first trauma that a fetus would experience would be the emotional response caused by the limitation of movement. The limit of physical activity causes a memory of the emotional response, or at least a neural response associated with hurt. During this frustration, the brain is working without well-defined neural patterns. Under these conditions, a trauma would associate with all the neural activity of the entire brain. Later, specific areas of the brain would increase their activity and assume muscle control, midbrain activities, and other functions. Later still, those specific areas that actively serve particular functions can erase the early trauma memories. Finally, after active pathways of brain functions and muscle movements had fully developed, the early trauma memory would only remain in the relatively inactive neural areas of the brain. A great portion of the brain may not have constant repetitive neural activity, and this is where the traumatic memory of the early constriction trauma lingers. I call it lingering pre-birth trauma.

I tested this theory with an intervention I carried out with many patients, a treatment I discovered by working with The Subconscious of my patients. To treat this supposed condition of lingering trauma, I used a treatment intervention developed to treat trauma pain associated with eye position and the shifts between brain-hemisphere activities during trauma. The intervention involved the Callahan 9-Gamut Procedure (Callahan, 1985) in the following way.

Direct the patient to tap steadily on a point on the back of the hand, a half-inch behind both of the large knuckles of the ring and little finger. While tapping, direct the patient to look straight ahead, close her eyes, look down to the right, look down to the left, whirl her eyes in a circle in one direction, then whirl them in the other direction. Then direct the patient to hum a tune, count from one to five, and then hum a tune again. The Subconscious said that this procedure would work to treat these hypothesized traumas lingering in quiet areas of the brain.

The following case had a pre-birth trauma so I tried treating lingering trauma. I tapped on the 9-Gamut spot on the back of both hands of the patient and had the patient do the 9-Gamut treatment. The patient said that after doing three 9-Gamut treatments, she was dizzy. After three more 9-Gamut treatments, she had pain in her side and stomach. After four more treatments, she had anger and pain. After four more, The Subconscious signaled the completion of the intervention. Then she had pain in her head. I followed the directions of The Subconscious. After two more 9-Gamut Procedures, this pain was gone. The treatment was obviously having some effect on neural activity and produced some behavioral effects. She reported that the procedure weakened self-limiting beliefs involving guilt.

I used this procedure of repeated 9-Gamut treatments with a child. He experienced dizziness, sleepiness and then dizziness that he described as "like emptiness in my whole head with something swirling around." Then he felt more dizziness. Then he felt clearer and I assumed that we had completed the intervention. In the following session with this young fellow, The Subconscious led me to develop another procedure, working on the entire brain. This time, the patient repeated the following intervention suggested by The Subconscious: Tap eight times on his forehead and eight times on the back of his head. In the following replications of this intervention, the patient felt progressively more tired and dizzy. Then he had a headache, and then he felt a little "drunk." The Subconscious told me to treat this last feeling with the eye movement procedure (EMDR).

A week later, this patient said that he was doing better at school, that he felt it was easier to concentrate, and that he was becoming more independent in his play.

5. The Subconscious as the treatment agent

One month after I completed the Thought Field Therapy diagnostic training with Callahan (1993), I received an incredible learning experience from another patient. This woman came into my office complaining of feeling incapable of handling her financial problems. I used the Callahan diagnostic and treatment techniques to treat the belief: "I can't control or manage my life." She immediately had the insight that her boyfriend was reinforcing her feeling of being incapable. While I was talking to her about this possibility, she said, "I feel this tickle on my upper lip." I asked her Subconscious, "Subconscious, are you trying to tell my patient to tap on her lip?" The Subconscious said "yes" by raising the index finger. I had the patient tap on her upper lip. We continued talking.

Again, she felt a series of sensations at different points on her head and face. I inquired again, and The Subconscious told her to tap on the points where she felt the tickles. At one point, she said, "Oh, God. They're going too fast! They're going too fast!" I said, "Hold it, Subconscious. Hold it." I asked The Subconscious if she could do the tapping on the inside to treat the trauma while the patient just sat. The Subconscious said, "Yes." I asked The Subconscious if she would do it. The Subconscious said, "Yes." Consequently, the patient sat there with her left arm on her lap and her right arm pointed up. After a minute or so, she said, "Wow! All this energy is flowing out of my fingertips." She said that she felt clearheaded and capable, and knew what she wanted to do to resolve her present financial predicament. I believe her Subconscious had completed treating some traumatic history having to do with competence. The Subconscious, to my surprise, had learned to treat internally. This experience showed me that it was possible to have The Subconscious treat a patient's issue without my intervention.

6. The Subconscious in trouble

After this experience, I systematically started to teach The Subconscious of my patients how to do self-treatment — the internal tapping. I had another patient who had 60 parts that were ready to receive treatment. After treating many parts, I wanted to find out the number of untreated parts remaining, and so I asked The Subconscious. To my surprise, what I learned from The Subconscious was that she had independently treated nine parts in the preceding weeks. I asked her if she had tried to treat the suicidal parts that I had identified in an earlier session. She said, "Yes." With further inquiry, The Subconscious said that she became frightened when she provided treatment of those parts on her own. By asking leading questions, I discovered the suicidal parts had flooded into the Active Experience and had started to run the body. They presented a serious suicidal threat. The Subconscious was "frightened;" in other words, she recognized the danger of suicide. Other parts that became active had difficulty protecting the patient from the intent of the suicidal parts. Since then, I usually try to treat suicidal parts as soon as possible. It is easier to do this now because I have learned a strategy to treat dangerous parts slowly and safely. This strategy removes the possibility of having suicidal thoughts or parts motivated by emotional flooding. It is respectful to all parts of the personality.

7. The Subconscious can learn barriers

One of the most helpful qualities of The Subconscious is that it is not subject to damage by trauma and physical sensations. The Subconscious can accurately see life history and help diagnose and treat traumatic issues. However, I managed to damage a patient's Subconscious. (This damage was easy to repair, as you will see.) I caused the damage by having The Subconscious step into her body experience and converse with me directly. I wanted to expand my understanding of the internal processes and thought that direct communication with The Subconscious using spoken language would promote this goal. The Subconscious was able to do this, and in one session we conversed readily.

In a later session, I noticed The Subconscious was not as effective in identifying and treating issues as she had been previously. Using leading questions, I discovered that The Subconscious process, while in the Active Experience, had associated with physical sensations. The physical sensations created barriers to "seeing" internal history and was restricting her view of the inner dynamics and her control of internal processes. I corrected this mistake by having The Subconscious look through the patient's eyes while I did eye movement processing. After treatment, The Subconscious again became very effective in identifying and treating issues. Since this experience, I believe that it is inappropriate and even harmful to ask The Subconscious to run the body and communicate with spoken words. Covert communication seems to cause no problems.

8. Parts can fool the therapist

The following is an example of the usefulness of working with The Subconscious to solve a problem. In a session with a torture survivor, I identified at least three new parts that I had not met in previous sessions. I asked The Subconscious if she could treat these parts. The Subconscious said, "Yes." I asked her to treat these parts and to let me know when she had finished. After she finished, I asked if she had joined these parts with "Barbara," as I normally had her do. She said, "Yes." I asked Barbara to become the active personality. She spontaneously commented that the three parts that had recently joined with her had made her experience chaotic. I returned to The Subconscious to discover that I had been working with a surrogate Subconscious – a fake Subconscious. The integrated parts still had trauma emotions associated with them. The trauma emotions associated with the parts caused a disturbance in Barbara. While the surrogate Subconscious was

the active personality, I asked the true Subconscious if she could treat this part. The Subconscious signaled “No” with a thumb response.

I communicated with The Subconscious by asking leading questions and getting “Yes” and “No” answers. It is similar to the game of 20 questions. I discovered the surrogate Subconscious was a programmed part, a part deliberately created by the use of torture. One of its activities was to repeat “I won’t do it” continuously in the unconscious. This repetitive, unconscious behavior caused a barrier to treatment. It disorganized the patient’s unconscious behavior so treatment would not work. It was like receiving therapy while repeatedly singing “Bongo, bongo, bongo, I don’t want to leave the Congo.” I reassured The Subconscious that painful emotions motivated the “I won’t do it, I won’t do it” program. The patient learned these emotions from the trauma during the programming. I stressed that the repeating response would become less motivated as she treated the trauma emotions associated with the program. She said she would try to treat the programmed part as I had previously requested. I waited while The Subconscious was doing the treatment and talked to the programmed part. After several minutes, the surrogate said, “I’m beginning to feel confused” and then, within a minute, she gradually went into a dormant state; my patient’s eyes closed and her head slumped. Barbara returned to become the active personality. She said spontaneously that another fragment joined with her. Therapy continued.

9. Flexibility when treating with The Subconscious

In a recent case, a patient came in complaining that she felt confused after she exercised. She had stopped exercising for about 10 days and started feeling clearheaded. Conversation with her Subconscious suggested there was a part that was co-conscious in her conscious experience when she was exercising that gave her the lingering confusion. I set up rapport with all parts and was soon teaching The Subconscious how to diagnose and treat parts. I then ran into a barrier. I was not seeing any finger responses.

I dealt with this barrier by assuming it was caused by a part. My approach was to set up rapport with the part and then treat it. I told her that all parts, including the pre-birth parts, parts formed at birth, preverbal parts, or any other traumatic parts, were members of one personality. Trauma created those parts that seemed independent. They had experience in the body that gave them a false sense of ownership or fears about treatment. If they were all treated by neutralizing their trauma emotions, they could join the Main Personality. They would then experience more satisfaction in life and be able to protect themselves more effectively. With this explanation, I was hoping to

get permission from this part and other parts to teach The Subconscious how to treat trauma memories. By being respectful of all parts and by educating them and answering their objections, all parts eventually wanted treatment and to join with the Main Personality.

After getting permission from the parts, I taught The Subconscious to locate the treatment points by tapping the points on myself. My demonstration taught The Subconscious how to treat the painful emotions associated with the trauma memories learned during the trauma experience. The Subconscious eventually signaled that she was able to treat a part that was co-conscious with the patient and who was the cause of her confusion. I asked The Subconscious to start this process and chatted lightly with the patient as The Subconscious continued to treat the part. After three or four minutes, the patient said she felt clearer. I asked The Subconscious to signal with a finger response when she finished. Within a few moments, The Subconscious signaled that she was finished. The patient felt much clearer by the end of the session. She later reported that she had no confusion after exercising.



Summary

A language process starts forming *in utero* and later becomes our Subconscious. By explaining how The Subconscious and the personality are formed, one can get rapport with The Subconscious and all aspects of the personality. The Subconscious is useful to direct the path of treatment, to help create new ways to treat difficult issues, to organize treatment plans, and to learn how to treat the effect of trauma. In addition, The Subconscious can learn how to treat negative experiences automatically and independently of the Main Personality. The Subconscious can treat active memories (negative beliefs, simple memories and life experiences) in different ways. The Subconscious can apply these techniques to treat unknown trauma in a person's history, such as self-limiting beliefs and other traumatic experiences and memories. While this form of treatment lacks support from published research, it has been effective for scores of patients treating themselves, as well as patients in my office and patients in clinics in Latin America.

The Process Healing Method is a treatment intervention that developed out of my relationship with my various patients' Subconsciences. To summarize the process, the therapist first educates and works with all aspects of the personality to convince the aspects to want to receive treatment and join with the Main Personality. This approach is both respectful to the patient and makes later treatment easier. I call the process of getting parts on the Treatment Team the Education Process. The goal is to get all aspects of the personality to want to be treated and join the Treatment Team. During this process, the patient learns a way to communicate with The Subconscious and aspects of the personality. When all aspects are on the Treatment Team and give permission, the therapist then teaches The Subconscious how to treat painful emotions. Then in the treatment process, the patient or therapist asks The Subconscious to treat painful or problematic issues.

This tale started in October 1991. By 1994, I was teaching the Process Healing Method to my patients by modeling the tapping treatment process. At first, I physically showed each of the acupuncture treatment points to The Subconscious, point by point. Now, a 30-second metaphor, which always works, teaches the treatment process.

- The next chapter, Chapter 2, introduces and gives an overview of the theory and procedure of Process Healing. It includes a transcript of the first session of the Process Healing Method and several examples of treatment interventions.
- Chapter 3 describes the entire basic procedure for getting all parts on the Treatment Team and teaching The Subconscious the treatment method. The procedure to obtain rapport with The Subconscious and all parts is now routine.
- In Chapter 4, I give detailed examples of many useful treatment interventions and aids. I use these treatment interventions routinely with most patients.
- The theory of the development of the personality and memory structures is presented in Chapter 5. **This is the most challenging chapter in the book.** This knowledge is useful when problem-solving new structures and finding solutions for complex personality issues.
- Chapter 6 will teach you how to problem-solve and resolve difficult or complex barriers to treatment. Many readers won't have to solve complex problems, but the interventions are included for those who do.
- Chapter 7 describes the treatment of dissociative and amnesic parts and all the complexities that can arise when treating parts.
- Chapter 8 introduces the more complex features of memory, namely memory structures and other constructs. These structures and constructs were discovered while solving patients' issues and are frequently found to be the cause of problematic behavior and unusual experiences.
- Chapter 9 describes many treatments that are useful for relatively simple issues.
- Chapter 10 focuses on several complex disorders like depression, addictions, obsessive-compulsive behavior, psychotic behavior, and so forth.

Chapters 9 and 10 are written primarily for therapists. Now you know how my patients taught me and helped me learn a new respectful and effective treatment intervention. For those who have read some books about psychology and have opinions about brain, mind, and behavior, I want to point out what I think may be a paradigm shift for some readers. If you can suspend your previous learning and research-based ideas and accept the clinically based truisms presented here, this book offers a refreshing description of the development of the personality and explanations for complex mental issues. Here are what I consider to be the major shifts in beliefs.

1. The Subconscious is accessible in everyone. It is not the unconscious. The Subconscious is a unique process, with whom a therapist can communicate.
2. Dormant memories are available to be triggered into activity in the conscious or unconscious. They are not located in the unconscious.
3. Behavior and all brain activity are collages assembled from previously learned memories active in the conscious and unconscious.
4. Dissociation causes the conscious and unconscious experience of active memories.
5. Memories that are dissociated and cause intrusions are different than amnesic parts. They are more like dissociated skills and, most importantly, don't have executive function. Amnesic parts, on the other hand, are compartmentalized memory structures (Blizard, et al., 2005) created in novel, severe trauma who have executive function.
6. Different processes cause dissociative and amnesic parts.

I hope you find this book both fascinating and useful, personally or professionally.

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** A free copy of the Introduction and Chapters 2 & 3 along with additional free resources can be found, at www.ProcessHealingMethod.com/free **