

## Case example of Coherence Therapy for Couple Therapy

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Coherence Therapy is based on its core principle of symptom production, *symptom coherence*: A symptom or problem is produced by a person because he or she harbors at least one unconscious construction of reality—one set of reality-defining themes, purposes, meanings, frames—in which the symptom is compellingly necessary to *have*, despite the suffering or trouble incurred by having it. Conversely, when there is no longer any construction within which the presenting symptom is necessary to have, the person ceases producing it.

At the start of therapy, of course, the symptom is viewed by the client as having no coherence at all. She or he regards the symptom as senseless, valueless, something involuntary and victimizing, laden with negative meanings about the self or others (bad, sick, stupid, crazy, deficient). This set of initial, predictable views of the symptom is in Coherence Therapy referred to as the client’s *anti-symptom position*—“anti” meaning simply *against* having the symptom. However, clinical experience shows that this is an incomplete account of the client’s emotional relationship to the symptom.

Coherence Therapy is based on the empirical finding that the coherence of the symptom—how it is necessary to *have*—is inevitably present in a very separately held, unconscious position of the client. We refer to this as the client’s *pro-symptom position*—“pro” in the sense of being *for* having the symptom. The themes and purposes in this pro-symptom construction of reality comprise the deep sense and strongest emotional significance of the symptom in the client’s world of meaning. To find the client’s pro-symptom position is to find *the emotional truth of the symptom*.

The principle of symptom coherence should not be narrowly construed as merely a function-of-the-symptom model. It is far more comprehensive than that and applies to the production of functionless as well as functional symptoms. Which type the symptom is becomes

apparent in Coherence Therapy empirically and non-speculatively as the symptom-necessitating construction is revealed.

### **Therapeutic Strategy of Coherence Therapy**

The therapist begins the work by providing accurate empathy for the client's suffering (his or her anti-symptom position) and clarifying what the client regards as the symptom—the specific thoughts, feelings, behaviors and/or circumstances the client wants changed but has been unable to change. The discovery work then begins, and is guided by this central logic: *What construction exists, that makes the symptom more necessary to have than not to have?*

The real answer to this question is unconscious, and the therapist's task is to elicit the key material that finds the answer experientially and rapidly. The goal of the discovery work is for the therapist to understand the emotional truth of the symptom very clearly—the client's specific themes and purposes that necessitate the symptom.

On the basis of that clarity, the therapist ushers the client into *integrating* this material. Symptoms are generated by living as though their emotional truth is not the case. Integration reverses this: the client lives in direct awareness of how the symptom's emotional truth *is* the case. Once the client's pro-symptom emotional reality has been discovered, we “pitch a tent” right there. We “set up camp” and go nowhere else, for several sessions if necessary, so that the client comes to experience every occurrence of the problem or symptom *from* and *in* the emotional reality of how and why, in the client's world of meaning, it is necessary to have. A remarkable experiential shift results: The mysterious power of the symptom to persist is discovered by the client to be none other than his or her own power to persist in carrying out themes and purposes that feel urgent to carry out. In a word, the client experiences *agency* in relation to the symptom. It is as though the involuntary muscle whose flexing produces the symptom has become a voluntary muscle. The suffering entailed in having the symptom is real, but is worth enduring because it is far preferable to the much worse suffering expected from living *without* the symptom. None of this is apparent from the client's initial, anti-symptom view of the problem, but when the client integrates his or her pro-symptom position, it becomes not only apparent but vividly real—not as an interpretation or reframe received from the therapist, but as the client's own emotional truth, discovered (not invented) in the sessions.

When the coherence and deep sense of the symptom have become self-evident, former notions of being defective, irrational, and powerless are dispelled. This natural depathologizing is a significant shift in the client's view of self and is one of the more important and broad therapeutic effects of this approach, beyond symptom relief.

*Transformation* of the client's pro-symptom construction, ending symptom production,

frequently occurs spontaneously during sustained integration. This can be understood intuitively: people are able to change a position they (experientially) know they have, but are unable to change a position they do *not* know they have. Every individual, as the creator/installer/authenticator of his or her own reality-defining constructs, has the capacity to revise or dissolve those constructs but is quite unconscious of wielding that power or of having already used it to set up versions of reality that are now causing problems.

If integration does not spontaneously trigger transformation, the therapist applies the following methodology to do so. First, prompt the client into vividly accessing the already discovered and integrated target of transformation, the pro-symptom emotional reality. Then, simultaneously and along with it in the *same field of awareness*, prompt the client to access and vividly experience a different, compelling construction of reality that sharply disconfirms the pro-symptom construction. Faced with incompatible constructions of emotional reality in the same field of awareness, the client will revise or dissolve pro-symptom constructs in order to restore consistency (a process indicated by Piaget, 1971, and Festinger, 1957).

### **Case Example: Couple Therapy**

“Kim,” 34, and “Mel,” 35, said every attempt to talk on their own about their deepening conflict only made it worse. Fighting had reached crisis level at the point they came for therapy.

Kim described the problem as Mel “quietly gathering up all the power, financially and otherwise,” by not sharing information and decision-making, keeping her always “in the dark” and “under his control.” She described how “being really in charge of my life” was centrally important to her; how she used to *be* powerfully in charge of her life, successful in a position of managerial responsibility in a male-dominated field. She said, “I picked Mel because he was strong enough to be okay with *my* strength—he wouldn’t get blown away by it.” Then, when she became pregnant with the second of their two girls, now 3 and 5, “somehow nearly every way I’d set up to have control over my life began to crumble,” including what she had thought was a relationship based on power-sharing. “Now I’m a stay-at-home Mom, and Dad’s out making the money and the decisions, and I don’t want to live like this!” The stress of surviving from paycheck to paycheck would be bearable, she said, “if he didn’t cut me out of the loop and leave me living basically alone doing child care.”

For Mel, the problem was that “I run my own small business and I work my butt off for our family day and night, and instead of ever hearing any appreciation from Kim, she’s always angry at me and picking fights.”

With these definitions of the “symptoms,” the therapist began searching for pro-symptom themes, meanings and purposes that would answer these (unasked) questions: How is it *necessary*

to be usually angry and fighting, rather than harmonious and close? How is it *important* to have Mel in charge, leaving Kim out of decisions and information on finances and other worrisome matters?

Midway through the first session, after unfruitful initial attempts at discovery, the technique of symptom deprivation yielded important clarity. The therapist asked them, both at once, to simply imagine sitting down together and having a kind of “business meeting,” in which he is briefing her on all the main facts of their current situation, including upcoming financial decisions, uncertainties and risks. The therapist said, “I’m not saying I think you *should* have such a meeting. I’m only asking if you would *imagine* doing it, because I want to find out a little of what that experience would be like. Just imagine—and if it helps you can close your eyes to really *picture* the scene—in which Mel is fully spelling out for Kim, one major piece of the situation, and then another—[pause]—and another—[pause]—and just notice how this *feels* to you—[pause]—and also, how the other seems to be feeling or responding, there in your image.”

After a short silence with closed eyes, Mel spoke first. He smiled nervously and said, “It’s a real definite image I get of Kim becoming really pale and she starts talking a-mile-a-minute and her eyes look kind of panicky over what she’s hearing from me. And it’s like she wants me to know how to take care of it all, but she can tell from the facts that it’s not like that, there are real risks here and I *don’t* know how to make everything okay. And that scares her even more.” An unwelcome experience—Kim’s intense fear—had arisen for Mel as a result of no longer excluding her from information and decisions.

In order to usher Mel further into experiencing this emerging theme, the therapist asked him if he would look right at Kim and complete this sentence: “I don’t tell you things because if I did—.” Mel said, “I don’t tell you things because if I did—you’d get real scared. [Pause.] You know, it’s a relief to say that because it’s like something I’m always tense about, without even knowing it.” Prompted to do the sentence completion again, Mel said, “I don’t tell you things because if I did—you’d see how shaky *I* am about some things, and that would *really* scare you.” And again: “I don’t tell you things because if I did—things would be even harder, with you scared and me then having to calm you by explaining things as they develop day by day. I’m exhausted as it is! I think I’d actually rather have you angry that I’m *not* telling you.”

The therapist turned to Kim and asked her, “Does this makes sense to you? Did you *know* that not telling you things is his way of trying to protect you from great fear and insecurity? And himself from exhausting emotional efforts?” She replied, “No, I didn’t. And what’s surprising to me—and, actually kind of embarrassing—while we were imagining our business meeting, and also when Mel was saying that stuff, imagining actually hearing about everything sort of *scared* me! I had a feeling of, ‘Fine, fine, please *don’t* tell me!’” The therapist recognized that Kim had now bumped into one of her own pro-symptom positions, a position of fearfulness in which she *wants*

to be shielded from knowing life's dangers; a position very different than the strong, tough self with which she consciously identifies.

The therapist invited her more deeply into this material through an overt statement to Mel: "Would you stay right where you are, in touch with that, and say it again, directly to him? I know there's an incredibly *strong* side of you, and this fear isn't the whole picture at all, but it's what you're in touch with right now, so just see what it's like to say it right to him." She looked at Mel and said, "Those things are scary and I'm sort of glad you're *not* telling me what they are." The therapist asked how it was to say that to him. "It's weird because it's so not how I think of myself," she said, "but it sure is what I'm feeling." With this confirmation of emotional accuracy, the therapist offered a trial sentence by saying, "I wonder if it would be true for you to tell Mel, 'I *appreciate* how you're shielding and protecting me from these scary things.' See if that fits for you to say, or let us know if it doesn't."

She voiced this trial sentence and her eyes immediately became teary. After a silence she said, "Wow—that brings up a *lot*." The trial sentence had acted as a verbal magnet and pulled into awareness important unresolved material formed in childhood. She told the therapist of a father who "basically abandoned us all" when she was nine, and a mother who was not at all up to the ordeal of surviving as a single parent in poverty. Evictions occurred. Kim and her younger sister always keenly felt their mother's fretful anxiety, insecurity and indecisiveness, and Kim resolved never to let her own life get so out of control, or ever to be so "weak" like mother. "I had to take care of *her*; I had to be the strong one," Kim explained.

The therapist now understood that in the unconscious emotional reality of Kim's pro-symptom position, she was about nine years old, feeling unprotected and very frightened of the dangers of the big world, and needing a strong, protective adult presence. Bravely making *herself* be that strong protector who is in control of circumstances was her key life-strategy for keeping those unresolved childhood terrors in check.

Working now to foster integration of this position, the therapist guided Kim to feel and know the coherence of all this material explicitly by prompting, "Tell Mel the simple connection between what you went through with Mom, and how you appreciate him shielding and protecting you now." She was silent as she felt for and found this connection, and then verbalized it to Mel, saying, "I always felt so *unprotected*. Nobody ever gave *me* protection and it was so *scary*. I'm always so focused on having to be strong that I don't even notice how scared I really am—how much I want *my* turn being protected. [Pause.] I *do* appreciate how you shield and protect the children and me."

As underlying themes emerge during Coherence Therapy, the therapist prompts the client to experience how these themes are connected with the concrete presenting symptoms. Seeing such an opportunity here, the therapist continued, "And see if you can also feel the connection to

your anger. [Pause.] Tell Mel how it *also* makes sense that what's been coming out of you so often is *anger*." She looked at Mel again and said, "It's that—when I'm angry I feel strong, like I have some control. It's what I just said: If I'm angry I don't feel how scared I really am."

As a between-session task to promote integration of the themes and purposes that had been found so far, the therapist collaborated with Kim and Mel to write index cards for each of them to read daily. Mel's card read, "The side of her that *wants* to feel protected *wants* me to shield her from our troubles, and not tell her things. But then she has no way to feel *she's* being strong—and then old fears flare up. So she gets angry, which makes her feel strong again. When Kim seems angry, it often means she's scared." Kim's card read, "He knows how scared I can be. He shields me from our troubles—keeps me out of the loop—because he'd rather I be angry than feel my fear. And so would I."

The rich crop of symptom-maintaining, unconscious material unearthed using Coherence Therapy in this session might give the deceptive impression that these clients must have been highly self-aware and therefore "easy." Actually they were not particularly self-aware or even growth-oriented. The flow and effectiveness of the work was due to the therapist adhering closely and continuously to Coherence Therapy's way of thinking (symptom coherence) and way of working (experientially accessing clients' *pro*-symptom positions, without judging, pathologizing or even trying to change these positions).

In closing the therapist commented, "It's striking that keeping Kim from feeling fear has been so important to both of you. It's like you've both been on the same team but didn't know it." This was not a facile positive reframe invented by the therapist, but an acknowledgment of an emotional truth that both partners had discovered for themselves in the session.

In the second session, one week later, both partners agreed that the main effect of the cards was in feeling "much friendlier" toward each other than they had for months. They didn't know how "solid" this friendlier feeling was, however, and this in itself was a kind of tenseness, but "overall it felt much better to finally be on the same page about the problem, even though the problem itself isn't actually solved yet," as Mel put it.

The therapist understood that full sharing of information might frighten Kim, but it also would empower her. In order to probe for how it might be important to Mel to keep the latter from happening, the therapist used sentence completion, saying to Mel, "What I'd like you to try out now is to say and complete this sentence, without pre-thinking it, as you look at Kim: 'If you have *all* the information and reach your *own clarity* about what we should do,—'" This sentence fragment was designed to act as a verbal magnet for material revealing how, in Mel's world of meaning, it is necessary for him to have far more control over information and money than Kim does.

Mel said, "If you have all the information and reach your own clarity about what we

should do—then what do you need *me* for?” Note the difference between the therapist making an interpretation versus having the client bump into his own emotional truth. Mel was asked to say and complete the sentence again, and then again. Two other endings formed, “—then you’ll know when I screw up” and “—then you might *see* me as a screw-up.” The therapist then offered the fragment, “If you see me as being a screw-up—” and Mel without delay completed it with, again, “then what do you need *me* for?”

Right here the therapist “pitched a tent.” The whole session was spent at this campsite, unhurriedly but very persistently drawing forth, deepening and integrating Mel’s unconscious position of fearfully expecting emotional abandonment unless he supplies vitally needed abilities and resources that the other does not have. *That* construction of reality was the emotional truth of his power-gathering in the relationship. In the course of the session he had a sustained, subjective experience of that construction, feeling and expressing very specifically that his security of connection to Kim requires making himself vitally needed by her. Feeling and “owning” this emotional truth was uncomfortable for him, but he proved able to do it. This work was carried out with a few more steps of sentence completion, some focusing (attending to a nonverbal “felt sense” of emotional meaning until it can be verbalized), overt statements to Kim and to images of his parents, and some construct substitution work with Kim based on what Mel had revealed. Finally the therapist wrote down on index cards the overt statements of the most important themes that had emerged.

One card was written as a statement to Kim and his parents jointly, visualized as standing together in front of him: “I’m sure that you don’t want me for myself, but only for what I can do for you. I expect you to cut off from me if I don’t come up with something you totally need, and I’m always hiding how afraid of that I am and how urgent it always feels to get you to really, really need me.”

A second card combined some of his overt statements to Kim: “I couldn’t bear to be without you, so I want you to be unable to be without me, or the insecurity I feel is intolerable. You’re so strong, and I’m scared that if you have all the information and reach your own clarity about what we should do, you won’t need me. So I have to keep you from knowing what’s going on.”

Kim too collaborated on the card she received: “I’m enormously important to him, even though his behavior looks like I’m not.” This was a sweeping and obviously vital construct substitution for her.

The themes and purposes brought to light in these first two sessions proved to be all that was needed to substantially eliminate the problem patterns they had presented. Over the next seven sessions, these same emotional truths were reexperienced from many different angles and further integrated as life circumstances activated them in different ways. Sessions were two weeks apart

after the fourth, for a total of nine sessions over three months. It was a case of people being able to change positions they now experience having. Kim's great wish for being and feeling protected became a very familiar, routinely consciously part of herself, which both amused and confused her for a while, because her strengths and bravery were very real too. Her confusion ended when she realized that she did not have to have a policy defining which side was more real or how to know which to go with in any given situation with Mel. *Both* were real, and she would know at the time which to go with. She had been very touched by discovering Mel's awareness of and concern for her fearful, unprotected, young side, and this permanently detoxified his role as information controller. This role itself changed, as he described by saying, "My 'default setting' has changed from making damn sure she's *not* getting to the information, to just being the *keeper* of the information and handing it over as she wants." His previously unconscious model of attachment was now something he and Kim frequently joked and teased about. He was hardly free of it yet, but the notion of being loved and wanted for who he is, rather than for what he does, was an intriguing if still hard-to-trust possibility, and he was in an ongoing process of getting used to it. Now that he no longer felt unappreciated by Kim and was experiencing greatly diminished anger and accusations from her, spending time with her and the children became appealing again and he engaged in more coparenting, alleviating what for her had been one of the worst problems when therapy began.

### **Conclusion**

Deep, swift, lasting change is made possible in Coherence Therapy by the therapist's conviction in: the coherence of symptom production; the immediate accessibility of unconscious constructs; and the use of experiential-phenomenological methods. With these convictions, the therapist can consistently carry out Coherence Therapy's methodology: the discovery, integration, and transformation of clients' symptom-maintaining constructions of reality (pro-symptom positions). Coherence Therapy challenges the long dominant view that unconscious emotional constructions formed in childhood and maintaining symptoms for decades require much time to reach and revise. It defines clearly which constructs are pivotal (those of purpose and ontology) and how to guide the client to find and change them. It shows that clinicians can work time-effectively and still fully engage the deep-rooted, passionate themes and purposes most important in people's lives.

### **References**

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