

# Case examples of Coherence Therapy for Anxiety & Panic

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Carmen, a stylish freelance writer, was 35 and happily married, but she experienced intense panic attacks every day or two. “When they started five years ago, I thought it was a heart attack,” she said. “Before that, I had strong depressions that lasted weeks at a time. Then the panic attacks replaced the depression.”

I asked Carmen to walk me through a recent panic episode. She said she’d been in her dining room the previous evening waiting for her husband to arrive home from work. When he was a few minutes late, she began imagining a terrible car crash and went into escalating panic.

In the old days, when psychoanalytic psychotherapy was dominant, Carmen’s panic would have been considered a symptom of repressed conflicts, hidden desires, primal dreads, and guilty secrets. Relief required insight into the underlying psychic dramas stoking such terrors. Today, we tend to regard anxiety almost exclusively as a set of behavioral and physical symptoms, sustained usually by irrational beliefs. Treatment protocols require either that the symptom be quashed, often with medications, and the specific beliefs be “exposed” or “corrected” into nonexistence or that reframes and resources be set up to override and avoid symptom production. To focus on the unconscious psychological roots of an individual’s anxiety--the hidden system of personal meaning that might be generating it--has become an anachronism.

But how many of us, with a toolbox full of today’s methods, reliably bring about a decisive cessation of our clients’ intense anxiety and panic? In the first few years of my clinical career, I found that with standard methods I could often help clients mildly relieve their anxieties, but that I rarely achieved a radical reduction of symptoms. At the same time, there were occasional sessions in which I abandoned conventional clinical wisdom and followed my

own instincts by tapping into a deep layer of personal meaning in the symptoms. When I did that, I often discovered that clients' symptoms ceased from one session to the next, and never recurred. For several years, my therapy partner and wife, Laurel Hulley, and I systematically examined what was different about those sporadic sessions that yielded such profound change. We wanted to know exactly what elements had made the difference, so that we could achieve such results quickly and predictably with our clients.

What we found was a surprise. Again and again, it turned out that the seemingly out-of-control symptom was actually *necessary* for some completely cogent purpose harbored by the individual. We rediscovered the once-revolutionary idea that what may appear to be an irrational "disorder" is actually full of personal meaning and deep sense when viewed from the underlying emotional context from which it arises. Our transformative sessions were always those in which the client directly experienced and accepted this previously unrecognized purpose, without taking any measure to "counteract" the anxiety.

Anxieties and panics understood in this way aren't merely neurobiological dysfunctions linked to irrational beliefs, but arise directly from life-organizing constructs formed during specific circumstances and struggles in peoples' lives. *Symptom coherence* is how we refer to this view that there always exists a well-defined, cogent set of personal themes and purposes that necessitate the symptom--and that's why the person produces it. At the moment when there no longer exists any purpose needing the symptom, the person ceases producing it. This discovery led to a clinical methodology that we first named Depth Oriented Brief Therapy, or DOBT, and now call Coherence Therapy because it is shaped from start to finish by assuming symptom coherence.

For a therapist who can find this inner coherence and utilize it, therapy becomes a process of actively guiding the client experientially into retrieving and then further evolving or dissolving the constructs that have been requiring the symptom. Along the way, many clients encounter strong, deep emotions, but the work is paced so that there's never more affect-laden material than clients can handle at any step.

The methodology of Coherence Therapy isn't a one-size-fits-all approach. The symptom's emotional truth is made up of constructs unique to the individual, and to uncover and transform them requires a custom-tailored, experiential process in each session. Furthermore,

there are several different ways in which anxiety and panic symptoms are “necessary” to have, as the following examples illustrate.

### **Panic with a Purpose**

“It’s so irrational,” Carmen said after describing the panic she’d felt when her husband was late.

“It may look that way,” I replied, “but let’s see how it looks when we’ve found out what it’s really about.”

The underlying coherence of Carmen’s panic began to surface in our second session. Using a technique we call symptom deprivation, I guided Carmen to reimagine the moments when she noticed her husband was late, but now without any accompanying panic. The goal wasn’t to counteract her panic response. Rather, if panic was in some way compellingly necessary, then being without it was likely to yield a consequence so dire that it was worth going into panic to avoid it. “This is an exercise in simply imagining what-if,” I explained. “See what it’s like for you if he’s late and no panic is cropping up. You’re at the window, the sky’s darkening. Just get a glimpse of what you start to experience as you’re waiting, if there’s no panic when he’s late.”

Carmen was silent for a time, and then said, “Well, I know it sounds strange, but I start to feel scared over *not* having the panic.” I asked her what was scary about not having the panic. She said, “It just feels kind of darker, like something bad will happen, but I don’t know what or why.”

Because the exercise had been fruitful, I assigned a continuation of it as homework. “When you notice you’re starting to have a panic attack,” I said, “that’s now your signal to see, just for a moment, if you can glimpse what you’d experience if you didn’t have panic--the same exercise you did here.” I wrote down this exercise and gave it to her on an index card, an indispensable tool for maintaining a new awareness and staying on track with between-session tasks.

In the next session, Carmen reported that one evening when her husband was again late and her panic began, she took out the card and did the task. It now was clearer to her why not having a panic attack was scary. “If I don’t worry that he’ll crash,” she told me, “it means I

believe nothing bad will ever happen to us--and having that belief will make bad things happen! I really feel that if I panic, if I just suffer, it keeps anything bad from happening.”

I prompted her: “Let your next words come from that feeling, and tell me why bad things happen.” To her surprise, Carmen then described certain metaphysical rules of suffering that she hadn’t known were a powerful subjective reality to her. She felt that her family lived under a weekly quota of suffering, and she could spare her husband an auto crash or some other family disaster by suffering intensely herself, thus meeting the quota. Having always prided herself on being free of any religious beliefs or superstitions, this discovery rattled her sophisticated self-image.

Carmen had become conscious of the emotional truth of the symptom as a direct experience, not just a cognitive insight. She realized she had the ability to whip up a physiological state of panic on the spot, whenever the rules of her unconscious worldview indicated that her suffering was necessary for the safety of loved ones. Carmen’s initial thought that panic was something that happened mysteriously *to* her had been replaced by a clear recognition of her own purposeful agency in producing it.

It would be bad therapy, it seems to me, to attempt merely to “refute” and “correct” Carmen’s “irrational” beliefs. This amounts to pitting the client’s neocortex against her limbic system--her conventional ideas against her living, emotional knowledge--which isn’t at all likely to be effective. Furthermore, it’s questionable therapeutic strategy for the therapist to presume to know the “correct” reality for a client to believe.

Accepting the realness of Carmen’s world of meaning just as it was, I named the possibilities contained in her newly discovered constructs. “What you’ve found means there are two ways you could stop having panic. Just as when you switched from depression to panic, you can again switch to a different type of suffering, like eating live worms or standing with your arms straight out for an hour, to keep bad things from happening. Or you could deeply reconsider your beliefs and find whether they remain real to you. Because if they don’t, you wouldn’t have to keep suffering to keep everyone safe.”

Carmen sat quietly for a time and then calmly informed me that the idea of changing her beliefs had no traction whatsoever for her--so the only alternative was to find a different type of suffering. I accepted this and suggested that between sessions she think seriously about what type of suffering she could switch to, and let me know next time.

The following week, Carmen told me she'd had no panic attacks for several days. She hadn't yet settled upon a different suffering to adopt, so I suggested she keep on with that project.

A guiding principle of my work is that once the symptom's emotional truth is found, I stay right there. I kept working with Carmen to get fully in touch with her symptom-requiring worldview, encouraging her to feel it and verbalize it in the most concrete form. By the end of the session, she said, "I really feel that if I think we'll be happy and fine, the universe will smash us in some way. I've *got* to suffer--by expecting disaster and feeling terrified every day or two--to protect us from that." Another index card carried these words home with her.

In the next session, Carmen reported she'd had no panic attacks at all for two weeks, which was unprecedented. With a bemused look she added sheepishly, "Panic attacks seem silly to me now." She said she'd considered alternate ways to suffer, but still hadn't got one up and running.

Carmen was now in a process of dismantling the basis of her panic attacks--her emotional schema of having control over her family's suffering by suffering herself--despite her earlier statement that this was so real to her that it couldn't be changed. Here we glimpse the operation of another of Coherence Therapy's guiding principles: people are able to change a construct they experience having, but aren't able to change one they don't know they have.

Carmen now wanted to see how she'd do on her own. Nine months later, I mailed her a follow-up query. She left me a voice message saying that panic attacks were now very infrequent and she was still working fruitfully on the themes we'd unearthed. She ended with, "I'll call you if I want to speed things along." She didn't.

### **Another Kind of "Necessary"**

Sometimes, panic and anxiety have no function--they aren't the means of fulfilling a hidden purpose for the sufferer--yet in a different way, they're still necessary to a coherent underlying pattern. Marlene, subdued in manner and neatly dressed, sat before me describing months of feeling "paralyzing" anxiety and helpless vulnerability to disaster. There were several very real sources of anxiety: her parents were in medical crises, she and her husband were in a legal battle threatening the family's home and savings, and some neighbors had become

frighteningly aggressive over a squabble between their children. But why had Marlene's anxiety become oceanic?

We made little progress at first unearthing the personal constructs driving her anxiety. Then I switched to a two-step approach that's effective with functionless symptoms. "Let's revisit in your mind one of the situations you told me about," I suggested. "It's Tuesday morning and it's raining; You've opened up a piece of mail notifying you of the other party's new legal maneuver. And you start to feel a whole new wave of vulnerability and fear. Okay? Good. Now, try to imagine what change or shift of any kind--whether in your attitude, your behavior, your beliefs, or perspective--would diminish this fear?"

After silently sampling various possibilities, her somewhat hesitant words were a big surprise to me. "I'd have to fight back," she said. "Fighting back would make it less frightening." I now understood what was maintaining her paralyzing anxiety: if you're under serious assault and you don't protect yourself by fighting back, you feel unbearably open to disaster.

It was now clear to me that not fighting back, even though under attack, was what I should regard as Marlene's "real" symptom. However, rather than assuming a deficit of assertiveness skills, which I needed to teach her, I assumed she had some definite, unconscious purpose for not fighting back when under attack. To find that purpose, I guided her into imagining fighting back in various bold ways. My aim wasn't to get her to marshal her resources, but rather to get her to bump into whatever made it necessary *not* to fight back. While she was actively visualizing fighting back--hiring an attorney known for aggressiveness, telling her friends she'd done so--I asked her to notice what she was feeling. She described a distinct discomfort, and as we stayed focused on this, what came into awareness were the rules of being a Good Girl in her strict Roman Catholic childhood. I collected and gave her back the key phrases she used to describe them on an index card. It read, "All my life I've worked hard to be a Good Girl, and I'm supposed to get to have the protected life of a Good Girl. If I get fierce and fight this battle, I'd no longer be a Good Girl--I'd be a crazy troublemaker. So, *no way* will I fight back, even though that leaves me so unable to protect us that I'm full of anxiety."

By getting directly in touch with how her anxiety stemmed directly from her own deepest assumptions about the world and how to be in it, Marlene was also now in touch with her own agency in bringing about this symptom. With the underlying material fully in view, I saw that Marlene's anxiety actually didn't have a function-- it wasn't the means of carrying out her

purpose of being a Good Girl. Rather, the unrepresented symptom of *not fighting back* carried out this purpose, and her anxiety was its necessary by-product.

With Marlene, as with Carmen, I'd done nothing whatsoever to counteract her symptoms. I worked only to help these clients experience and "own" the unconscious position that required them to have their symptoms. I recommended to Marlene that she read the index card daily to stay in touch with this newly conscious position, a crucial task for ongoing integration.

Six months after this session, Marlene reported that she'd soon begun to fight back through assertive communications and a demonstrated readiness to follow through with action. She said her anxiety was "hugely eliminated." By making conscious her symptom-requiring position, she'd been able to revisit and revise that earlier life strategy.

### **Anxiety Obscured**

Of course, anxiety is sometimes an appropriate response to circumstances. All sorts of "symptoms" can result when people suppress awareness of valid anxiety or of what's engendering it.

Tall, lanky Albert had a good reason for his anxiety. All his life, his father had regularly ridiculed him for showing any signs of emotional "weakness," such as fear, feelings of insecurity, or hurt. Humiliation by Dad could come at any moment, so Albert lived in continuous anxiety, which it was also necessary not to feel or show. What's more, Albert didn't perceive his father as either frightening or abusive. Rather, he just assumed he deserved his dad's criticisms.

Banned from awareness, Albert's anxieties found expression in his body. He described bands of chronic tension throughout his torso and neck. Among his suppressed anxieties were some valid fears over his current situation--for example, his business partner's escalating procrastination and lack of cooperation. Because Albert was ignoring fear signals of real dangers in both his personal and professional worlds, he, like Marlene, wasn't protecting himself adequately, making the situation even scarier.

The linchpin in Albert's material, it seemed to me, was his stance of agreeing with his father's definitions of what was unacceptable about him. Of course, he wasn't conscious of agreeing or of why agreeing was necessary for him, so I set out to turn on the "limbic light bulbs" in this area.

Gently and gingerly, I ushered Albert into explicitly experiencing his emotional truth of agreeing with the negative messages sent by Dad. Then, I had him picture Dad while privately *not* agreeing with those messages, to see what that would feel like. What this brought to light over three sessions was finally verbalized as, “All along, I’ve agreed with Pop that it’s my personal failing if I feel any of the anxiety, vulnerability, stress, and strain that are built into life. I don’t want to know he could be so wrong--about life and about me. He wouldn’t be my God anymore. I’d rather keep on agreeing that he’s right.” I asked Albert to actually speak those words to me. I also asked him to visualize being with his father and, while looking across at him, to think, “I don’t want to know he could be so wrong.”

With these phrases Albert was beginning to access his own purposes for taking his father’s messages as reality. On several occasions, I helped him face and feel the fears that naturally arose in this work, and together we recognized the validity of these fears. Then we revisited his boyhood and appreciated the validity of his fear of his father, which he couldn’t allow himself to feel back then.

Over several sessions, Albert realized that seeing his dad as right was his only way of feeling connected with him. Albert’s experience of agency in relation to his low self-worth came from seeing that he agreed with his father only because he’d feel like an orphan if he didn’t. At first, this was frightening. Later, it brought anger, and then the deep sadness of true grieving for the fatherly acceptance he was never given. The work had to proceed in small-enough steps so that Albert could tolerate the feelings that arose at each point. By his 18th session, he’d turned the corner and begun to accept in himself a range of feelings and qualities that were on his dad’s “unacceptable” list. His somatic tensions, now “down to about 20 percent of what they were,” were gone after coming in once a month for another half-year.

### **Trauma and Its Aftereffects**

The coherence that underlies panic and anxiety has another, neurobiologically distinct, form: flashbacks of unresolved, unconscious traumatic memory. Flashbacks are part of the reptilian brain’s way of recognizing and responding to extreme danger previously experienced. A flashback of traumatic memory can consist of any separate somatosensory component of the original experience (sight, smell, touch, etc.). Sometimes, only the feeling of fear flashes back,

unaccompanied by any perceptual memory--so that it's not at first apparent to the client or therapist that the intense fear is a flashback.

Angie, an aspiring actress, came to see me because, as an important performance approached, she experienced stage fright so intense that it was seriously interfering with her rehearsals and threatening her stage career. As usual, I began the discovery process with methods designed to reveal an unconscious purpose underlying her anxiety, but without much success. Then Angie mentioned having had a high-anxiety dream. In the dream, she was a terrified passenger on a wildly careening bus driven at high speed by a crazy old woman. To search the dream for how the coherence of the stage fright might have been appearing in it, I used Gestalt experiential dreamwork with Angie to relive the dream action.

In the midst of this process, she suddenly said that an extremely frightening childhood memory was resurfacing. In this real incident, she was with her family in the car when her father was driving drunk. She felt the car swerving around, then it scraped against the guard rail. Angie sat in the back seat, consumed by terror and a sense of "doom" as she saw a bridge ahead. I was struck by the common feature shared by both this traumatic incident and her stage fright: heading straight toward a frightening place with no escape. It occurred to me that her stage fright could be a flashback of that traumatic car ride.

I recognized that the trauma-creating element was young Angie's assumption of being imprisoned in the death car and powerless to get out of it. To dissolve that key construct, I guided Angie to vividly relive the original situation in the car, but this time, to do whatever it took to get the car to stop and get out. She screamed at her father to stop the car. He wouldn't. She flung open the car door, he slammed on the brakes, and she jumped out, yelling for help. The police arrived. In about five minutes of revising the original action, Angie experienced intensely her power to exit the car's doomed trajectory and get to safety.

Two weeks later, Angie reported a complete cessation of her stage fright, which never came back. For my own understanding, I asked her whether there was a connection between approaching the performance and approaching the bridge. She confirmed, "Yes. Once you get there--onto the bridge or onto the stage--there's no turning back or quick way to get off. You have to make it all the way to the other side or die up there!"

It's important to note that the reenactment technique I used with Angie is appropriate only for traumatic situations like Angie's that began with perceptible signs of impending danger

and plausibly allow for some form of physical rescue, escape, or self-protection. With traumas that lack these features (a bomb going off with no warning, for example) reenactment will only be retraumatizing.

### **The Discipline of Coherence**

A therapist focused on underlying emotional coherence is always working to help clients experience the “part” of themselves that requires the symptom, because that’s the part that actually has control over it, while other “parts” that want to be rid of the symptom are ineffective in influencing it in a decisive and lasting way. In this Coherence Therapy has many similarities to a range of other experiential therapies that are “coherence-friendly,” including Internal Family Systems, Emotionally Focused Therapy, Imago Therapy, the Passionate Marriage approach, EMDR, TIR, Focusing, Gestalt Therapy, NLP, Voice Dialogue, the Heart of Addiction approach, and Dialectical Constructivism.

While practitioners of all these approaches share a respect for the importance of bringing underlying emotional truths to light, rather than just trying to squelch symptoms, this isn’t an easy focus to maintain. Coherence awareness isn’t in the modality; it’s in the therapist. Even after years of experience with Coherence Therapy, I still sometimes found myself needing to unlearn the therapeutic habit of rushing in to counteract symptoms. What’s helped me unlearn that habit over time is the experience that every time I follow that counteractive reflex, therapy immediately seems to go stale, waking me up to the overriding importance of seeking the deeper reality.

By sticking with the coherence model—sometimes on blind faith—and by heading straight into the core of meaning at the heart of the symptom, therapy becomes a place where a deeper sense of order replaces the apparent senselessness of presenting complaints, and clients awaken to areas of self that have control over what previously seemed utterly out of control. The emotional truth of the symptom is always there, waiting to be discovered and embraced. Searching for it with each new client is always a rich and poignant adventure.