

Case example of Coherence Therapy for Depression

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There is a moment that we therapists savor above all. We've just done or said something decisively effective and put our client in touch with a deep emotional reality. Before our eyes, a shift takes place--a shift in both mind and body--and the client slips from the grip of a lifelong pattern.

Such breakthroughs are the heart and soul of good therapy and they give most of us our greatest sense of professional satisfaction and purpose. Yet, few therapists like to admit how infrequently they occur in the average practice, no matter what the clinical approach. In much long-term therapy, breakthrough experiences seem to come almost randomly, and then only after months or years. In briefer therapies, on the other hand, deeply rooted emotional realities are often ignored altogether in favor of "reframes" and other forms of cognitive or behavioral change.

Two decades ago, seeking both depth and brevity in our clinical work, we began going over the process notes and audiotapes of thousands of our interactions with clients, especially those that yielded the most powerful turning points. What, we wondered, had happened differently in those sessions? Could we find a way to focus and organize depth-oriented therapy so that transforming moments could occur from the very first session? And could we fashion a brief therapy that could dive deep into unconscious emotional realities without sacrificing much-valued speed and focus?

We discovered that what distinguished the pivotal interactions was that--whether due to serendipity, curiosity, desperation or fatigue--we had completely stopped trying to counteract, override, or prevent the client's debilitating difficulties. We had ceased offering communication tools, more "rational," positive beliefs, insightful interpretations, better narratives, systemic interruptions or clever reframes.

In short, we had stopped treating the symptom like the work of a demon whom we were trying to drive out of the client's life. We had focused instead solely on learning from the client why their depression, panic attacks, stormy relationships or obsessions were somehow necessary--what unconscious benefit these seemingly nefarious symptoms served. We were fascinated to find that by focusing therapy in this way from the first session, we could get powerful results swiftly and reliably.

Carl Jung, Gregory Bateson and R. D. Laing, among others, have all written about the hidden cogency of symptoms that on the surface appear dysfunctional and irrational. But we were nevertheless surprised to encounter so consistently what we came to describe as the emotional truth of the symptom, or "symptom coherence": well-defined, compelling themes and purposes that, in one way or another, made the symptom a necessity.

We began to pursue a new therapeutic strategy, centered on the premise that from the first session, unconscious constructs requiring the symptom are immediately accessible. This was foreign to our training, and initially we had to bite our tongues and shed our habitual tendency to counteract, override or push away the symptom. Now, many years and clients later, we have developed an approach we call Coherence Therapy (formerly Depth Oriented Brief Therapy or DOBT) based on the insights we have gathered along the way. The following case demonstrates our approach and how we help clients by heading straight for the emotional truth of their symptoms.

A Black Cloud

Tina, a 33-year-old proposal writer, sluggishly began her first session in a dreary tone that matched her lethargic walk and slouch. Her stringy blonde hair was unwashed and she wore a dingy grey sweatsuit stretched across her bulky body. Her presenting symptom--the hated demon she wanted out of her life--was depression. "I've been feeling depressed and lousy for years," she said, almost without preamble. "I have a black cloud around me all the time."

Tina seemed bored with her own story and told it as though talking about someone else. Supposedly working full time for a nonprofit agency, she could bring herself to spend only 10 hours a week writing grant proposals from home. Her relationship with her partner, Ralph, consisted of little more than "parallel lives." Nothing she had tried had helped her--not two previous attempts at therapy, nor the two self-help groups she desultorily attended nor prescriptions for Prozac or her current medication, Wellbutrin. Gazing at the floor, she said, "I just don't know why I can't be happy."

When Bruce--the therapist in this case--asked her what was hardest about her childhood growing up in New York City, she spoke about her family in cynical tones. "In my family, the words 'I love you' are a way to hang up the phone," she said. "There was no affection--and no other feelings either. Except anger. Anger is fine. Putting each other down is fine. Which did wonders for my self-esteem. With self-esteem as low as mine is, why shouldn't I feel depressed?"

Tina was a daunting client for a therapist seeking in-depth resolution in a few sessions. Bruce first asked Tina to reenter a recent situation in which she had felt depressed. Rather than merely getting her to talk "about" her symptoms, Bruce guided her toward directly experiencing them so that the underlying themes and constructs sustaining them could more readily be brought into awareness. He asked questions rich in concrete cues: "Where are you sitting? What time of day is it? What are you wearing? How does your body feel on the chair?"

Tina closed her eyes and imagined herself on a recent late afternoon at home alone, sitting at the kitchen table in her bathrobe. She sighed, and her body seemed to sink even more deeply into her

chair. Moving beyond a merely cognitive description, she entered her felt experience--the core of her emotional life and the place where profound change is possible. She gave voice to leaden energy ("It's physically too hard to get up to answer the phone"), profound disinterest and inactivity ("I hate my job and heard about a much better one I'm qualified for, but I'm sitting here feeling, 'Who cares? Why bother?' And you know, I don't care about anything, I'm never motivated for anything.") She expressed self-denigration ("I'm a vegetable. I'm a worthless nothing that nobody could possibly find interesting, and Ralph must want to leave me"), social isolation and hopelessness. Identifying these specific features of her depression was an important initial step for gaining access to their underlying emotional truths.

As Bruce and Tina talked, it emerged that her symptoms had already appeared in childhood and were still at their most potent when she was with members of her family. To help her experience rather than only factually acknowledge this truth, Bruce asked her to visualize her mother, father and older brother. "Would you be willing to let the scene change now to your parents' house, and be there with your family and let yourself get into how you typically feel and how you act there with them?" Tina was silent for nearly a minute, then said, "I'm half dead. I'm an apathetic lump. I'm telling myself I have nothing interesting to say."

Bruce's job, as he saw it, was now to usher Tina into discovering why the inert state she just described was necessary for her when in the presence of her parents. "Okay," he replied. "You're a half-dead lump and inside you're actively telling yourself you have nothing interesting to say. Stay in that, and tell me: Was there ever a time with them when you did really have something to say, and you said it?" Bruce asked. "Something other than anger?"

"Hah!" scoffed Tina. "I'm stupid, but not that stupid."

"Mmm. Tell me how you know that would be a 'stupid' thing to do."

Tina recalled being 12, walking with her family out of the hospital where her grandfather had just died. She told her mother how sad she felt. Immediately her mother snapped, "Stop being so dramatic!" Her brother at once chimed in with disparaging jabs. "They cut me right down," Tina summed up matter-of-factly.

Bruce now understood that Tina's half-dead, inexpressive state was her means of protecting herself from being cut down again. It was also clear that although Tina had just articulated the reason that she kept herself in that state, she was not yet directly in touch with the emotional realness of it. To achieve this, Bruce simply reflected back to her the experiences she just described. "When you express your own sincere feeling, you get cut right down. Sounds pretty painful. But in the other scene, where you're a half-dead lump telling yourself you've got nothing to say, you don't get cut down. Is that accurate? How would *you* put it?"

Tina's eyes opened and her glance flicked around as she made the internal connections. Her words came with measured intensity: "Saying what I'm really feeling or caring about gets me shot down--so I don't go there."

"And how do you keep yourself from 'going there?'" Bruce nudged. Tina, perceptibly animated for the first time in the session, announced, "Being dead, apathetic and telling myself I have nothing interesting to say!"

She was now bumping into her own purpose for parking in that deadened state and beginning to glimpse her own agency in producing a symptom that until this moment had seemed to exist beyond her control. This pivot into conscious ownership of a formerly unconscious purpose is a milestone in the unfolding of Coherence Therapy.

It is, however, initially a very fragile new consciousness and, with most clients, needs sustained, deliberate integration to become woven into daily self-awareness. To that end, Bruce took two simple steps as the conclusion of the session neared. First, he asked Tina, "Would you tell them--your image of your parents--what you just got in touch with?" This "overt statement" technique is often effective for grounding a client in an emotional truth just brought into awareness. The client makes a simple, present-tense I-statement spoken to the emotionally relevant persons. Tina visualized her family "at a safe distance, so they can't hear me and won't react," and then said aloud, "I've got to be dead and mute in our family or you instantly mow me down. I hate how it feels to always be a lump, but that's much better than getting cut down."

To arrive at those unflinchingly candid, succinct phrases, Bruce suggested possible wordings, but always deferred to Tina's own expressions. He prompted her to repeat the finished statement a second time, then a third and with each repetition she deepened her grasp of its emotional reality. Then Tina sighed. "It's just so sad," she said, "that that's how it is."

Tina's depressed state had seemed to be the problem, but she was learning that it was actually her solution to the unrecognized problem of getting "mowed down" by her family. Her depression, in other words, was not her enemy but her ally. To maintain and develop her new experience of this emotional truth, Bruce set her a simple task. He wrote the exact words of her overt statement on an index card, and asked her to read it every day. To further deepen her understanding of how her depressed state was a solution to a problem, Bruce set her another task: on an upcoming visit to her parents, she was to "play possum" as usual, but do so knowingly and deliberately, in order to be safe from the hostile attacks that were sure to come if she showed any signs of life. This was not a "paradoxical" strategy of assigning the symptom--it was a straightforward strategy of integration by having Tina experience her own underlying reason for producing the symptom. In this way, Tina would be grappling consciously with her real problem.

At her next session, Tina reported new realizations. She had known all along that her family members almost never expressed love or affection, but now she had recognized that in dealing with them she was "swimming with sharks." By "playing possum" on purpose, she also realized how reflexively she had done so in the past. Tina's new awareness had firmed up. The involuntary muscle that had unconsciously protected her with depression was coming under her conscious control.

This was Tina's first real breakthrough, but it addressed only one of several different, unconscious ways in which her depression was vital to her. Over the next two months, she returned for three more sessions, each time discovering, embracing and dissolving other deeply

held constructs that made her symptoms necessary. By the fourth session, her sweatsuit was gone, her hair was clean and she was wearing earrings that sparkled as she tossed her head and reported on improved interactions with her partner. At the fifth session, remarking on her "relief and hopefulness" and confident she would find new work and explore new interests, she decided not to schedule further sessions.

Symptom Deprivation

Five months later, she was back, disappointed that though she still felt noticeably better, lasting motivations and pursuits had not jelled. Her apathy had continued. "I'm still a big nothing," she said with discouragement, "and not very nice about it." Again, Bruce did not chase away her demon, but continued to coax it out of hiding. He took Tina's complaint as a sign that although many unconscious constructs had been unlocked, others still needed to be brought to consciousness, integrated and dissolved. So he used another Coherence Therapy technique that we call "symptom deprivation." He ushered Tina into a textured visualization of life without her apathy, in the presence of her family members.

Bruce searched his imagination for something of universal appeal, then in a relaxed, soft voice began by saying, "You notice it was enjoyable to, let's say, hear about how dogs are trained--or anything that has a simple, natural appeal for you." Bruce paused 10 seconds, observed Tina's physical signs of moving into this naturalistic trance, then went on. "And you notice a little feeling of interest in hearing more about it. [Pause.] And a few weeks later, in a bookstore window, you happen to see a book on it, and what the heck, you get it. [Pause] And then, a couple of months later now, you mention to your brother, or your folks, that you're taking an Adult Ed course in it. . . ."

Tina began rapidly bobbing one leg up and down on the ball of her foot. "How are you feeling right now?" asked Bruce. "Starting to feel pretty tense," she said. Symptom deprivation was working. Bruce continued by using the technique of "sentence completion," inviting Tina to say out loud the sentence fragment, "If they know I'm doing things that matter to me--," and let the sentence finish itself.

"Nothing. Nothing's coming," Tina said after her first try. She then repeated, "If they know I'm doing something that matters to me--". Bruce waited. "--she'll take it," Tina suddenly said quietly. She became motionless and stone silent. Then with obvious amazement she almost shouted, "I erased myself!" Her voice was low but edgy and full of bitterness and pain. "She takes everything! She fucking takes it all! So I've *got* to erase myself! She always, always, always makes it *her* accomplishment, not mine. So why *should* I be anything!"

Her rage at her mother rose to unprecedented intensity. Recognizing that Tina had just expanded her awareness of the necessary role her apathy played in her life, Bruce did nothing but express empathic understanding, acknowledging what she had suffered with her mother, and how much sense it made for her to protect herself by "erasing" all motivation into blankness. "I really can see why you then feel so hopeless, if being forever a blank feels so necessary," he said.

As always, Bruce spoke to the subjective validity and coherence of Tina's emotional truth, making no attempt to change it. This empathic acceptance does not necessarily mean we agree that what is subjectively real to the client is objectively factual. When necessary, we tell our clients something like this: "Our purpose in helping you face the pain you feel is not to judge or vilify your mother, but to find what will enable you to get free of it and move on." But in this case, it would have been ill-timed and, as things turned out, unnecessary.

Tina was now in touch with her core dilemma of being pillaged. She no longer saw her apathy and blankness as a fundamental deficiency over which she had no control, but as her own effective, powerful way of protecting herself against being plundered or attacked. She now experienced the symptom's baffling persistence as her own power to persist in a specific behavior that served a beneficial end. Her symptom had shifted shape, from a despised demon to a dedicated protector.

Stepping back for a wide-angle look at Tina's "solution" of vacuity, Bruce asked himself if still deeper, unquestioned constructs might exist as its wellspring. It occurred to him that to the young daughter of a take-everything mother, maintaining a private inner life with appropriate boundaries between self and others might seem impossible, even unthinkable. If adult Tina was still living within this child's model of an entirely visible and unprotected self, then that was the root problem, not the vacuity and lifelessness that protected her from the pain this caused.

Nevertheless, Bruce knew from experience that even if this speculation were accurate, supplying it to Tina as an interpretation would only send her "into her head." Instead, he gently posed a deceptively simple question intended to engage Tina's ability to change her constructs: "Tell me, in what ways do people keep other people from just reaching in and taking away things?" he asked.

Tina's eyes blinked the unique blink that often accompanies the first realization of one's own utterly unquestioned, but suddenly questionable, assumptions about reality--what Gestalt therapist John Enright has called "presupposition shock." Over the next few minutes, she realized that she was obeying what she called a "no walls" rule. Simultaneously, she grasped the amazing possibility of "having walls" and keeping her personal affairs "behind walls" and totally unknown to her mother or others.

It was the most significant breakthrough of her therapy--the moment when the major linchpin came undone and old emotional enslavements were released. Never before had Bruce seen her in such an unabashedly happy mood. "If I can stay in touch with this," she said at the end of the session. "There's no limit to what I can do!"

Tina had just reeled in a big fish, but even an emotional truth this big, lucid and close at hand can easily slip back down into the dark waters from which it came. Immediately taking a step of integration, Bruce invited Tina to make an overt statement. "Say it in your own words--the uncensored version of why you've *got* to be a blank," Bruce said. When the phrasing was finalized, Tina was saying out loud, "Even though I'm left with being a nothing, a vegetable, I've got to erase everything about myself that Mom might take away and make hers. There's no other way to be safe! I have no walls and no power to keep my own things totally private and unknown

to her." Bruce wrote those words on another index card that would keep Tina in touch with this every day.

Why keep Tina focused on her symptoms when she had begun to move beyond them? Realizations of unconscious constructs occur in a kind of altered state and so must be anchored into the client's ordinary daily awareness. The index card would maintain Tina's direct reckoning with what we call the "two sufferings": the suffering due to having the symptom (in this case, feeling lifeless, depressed and self-devaluing), versus the even greater suffering anticipated from not having the symptom (being freely plundered).

These measures turned out to be enough. Tina did not schedule any more sessions. Two months later, when we called her for a follow-up, she referred to the sixth meeting as a "major breakthrough" and joked and giggled about significant personal developments that she had kept fully private from her family. She described a period of intense rage at her parents in the month after the session, but now experienced only an occasional negative attitude toward them or others.

When we called her two years later--last May--Tina was nine months into a new career in computer programming and full of enthusiasm about her future. She said she was free of the "black cloud" and was no longer taking antidepressants. She added, "The work I did about my Mom and her self-centeredness helped me a lot. I could step back--that's been really nice. Things are good, in many ways," she said, and the vitality in her voice was fully congruent with her words. "Things are very good."

Listening for Coherence

In her six carefully focused and intense sessions, Tina had experienced breakthroughs with a depth unlikely in a brief therapy, and with a swiftness almost unheard of in traditional long-term therapy. What had worked for Tina was what we find works for a wide range of clients--a systematic and experiential approach that allows deep therapy to be brief, and brief therapy to be deep. We had not tricked or driven away the demon of her symptom, nor had we subdued it with intellectual insights or ingenious reframes. We had simply listened to what Tina's symptoms were telling us and helped her grasp her own most deeply held and long-unspoken constructions about the nature of reality.

Once she brought these unconscious constructs to light, other ways of dealing with the world and of solving her emotional dilemmas became possible. She could now safely let her personal world develop while consciously deciding how much of herself to share with her mother and others. In this new landscape, she found that the depression that had once protected her was no longer necessary and it fell away, replaced by a new sense of well-being and self-worth.

Resources

Literature, training videos, and other Coherence Therapy resources are available online at www.coherencetherapy.org.

Coherence Therapy Basics

Coherence Therapy is a practical approach to identifying and dissolving the unconscious constructs or “emotional truth” underlying a client’s symptoms in just a few sessions. The key to this approach is the use of experiential methods that create everyday awareness of how the symptom is a cogent part of the client’s existing, much-needed solution to a specific, passionate dilemma of safety, well-being or justice.

Focus

In Coherence Therapy, the therapist begins by learning what to regard as the "symptom"--the specific, concrete features of experience that the client wants changed. To get beneath abstract labels, use questions and prompts such as, "Walk me through a recent situation where the problem happened strongly. What is it you're thinking and feeling right then?"

Discovery

Once you've identified what to regard as the symptom, begin to elicit the full emotional truth of the symptom. Use experiential questions and cues—"What would you say to your brother if it were safe to tell him?" "What should your parents realize from seeing how your life is 'going nowhere'?" Have the client talk *from* the evoked emotional reality requiring the symptom, not *about* it.

Integration

The client's experience of newly surfacing material is still split off from the rest of conscious knowledge. Integrative methods are necessary to develop routine, daily awareness of the previously unrecognized themes, dilemmas and solutions. Basic techniques include:

Overt Statement. Invite the client to speak a discovered emotional truth as a first-person, present-tense assertion to the emotionally relevant person.

Index Card. After the client has experienced the underlying purpose maintaining the symptom, help the client form a succinct, vivid verbalization of that purpose and write these words on an index card for daily reading.

Real-Time Recognition. Coach the client to use symptom's occurrence between sessions as a signal to recognize and feel how the symptom is necessary in the situation.

Transformation

Full integration of the underlying emotional truth of the symptom often spontaneously yields a transformation, but if not, another step is needed. This involves prompting clients to juxtapose an old, symptom-requiring construct (now conscious and integrated) with another, incompatible construct that disconfirms and dissolves the old one. An example would be guiding Tina to experience herself as having "no walls" with her family—her lifelong construct of having no personal boundaries—and simultaneously to experience a new, opposite but compellingly real construct of "having walls."