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Experiences That Transform

An introduction to Depth-Oriented Brief Therapy

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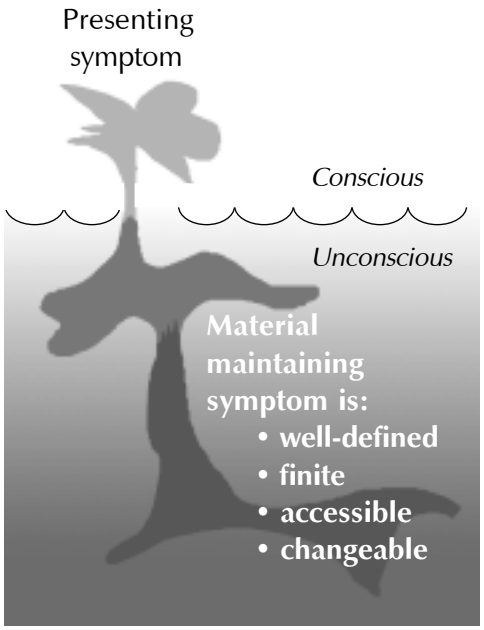
Bruce Ecker, LMFT is co-originator of depth-oriented brief therapy (DOBT). He teaches this modality widely, in professional workshops, conferences, agency staff trainings, and for many years at the graduate level at John F. Kennedy University. He is co-author of *Depth-Oriented Brief Therapy: How To Be Brief When You Were Trained To Be Deep, and Vice Versa*, and of numerous articles and book chapters on DOBT.

The DOBT website (www.dobt.com) provides an introduction to the approach and a range of training resources, including workshop schedule, videotapes of sessions by Bruce Ecker, online training courses, the *DOBT Practice Manual and Training Guide*, and the *DOBT Clinical Notes* series.

CENTRAL PREMISE

The unconscious material maintaining a therapy client's presenting symptom is a specific formation of personal emotional reality in the subcortical brain—the limbic system and/or the brain stem—which proves to be well-defined, finite, directly accessible and changeable.

DOBT guides native mental processes capable of zeroing in on, engaging and transforming only that particular, symptom-requiring section or module of personal reality and no more—the minimum amount of material needed for in-depth dispelling of the presenting symptom.



MAIN TENETS

Symptom coherence*—DOBT's model of symptom production:*

A therapy client's presenting symptom occurs entirely because it is compellingly necessary to *have,* according to at least one of the client's constructions of emotional reality—some unconscious but well-defined formation of personal themes, purposes, constructs.

When there is no longer any construction of reality that necessitates having the symptom, the person ceases producing it, with no other symptom-stopping measures needed.

The emotional truth of the symptom. The client's symptom-requiring theme and purpose, always well-defined though unconscious at the start of therapy.

The immediate accessibility of unconscious constructs is assumed in DOBT—even for those unconscious emotional realities formed in childhood and generating symptoms for decades—through experiential methods that engage the limbic system.

Experiential process of change, essential for effectiveness, does not require clients to have high level of analytical insight or verbal skill. Suitable for wide range of client populations. Therapist guides client into experiences of three types: *discovery* experiences, *integration* experiences, and *transformation* experiences of symptom-requiring emotional schemas.

VIDEO #1. *TEACHER'S IMPOTENT RAGE*

A. Presenting symptom: Woman high school teacher describes many weeks of reactive, impotent rage daily in response to a male student's provocations and thinly veiled threats of violence toward her. "This could give me a heart attack." (For transcript of video see DOBT book, pp. 186-194.)

B. Discovery technique used: *Symptom deprivation*—imaginal experience of being *without* her reactivity in the very situation where she normally produces it. Result: Client's symptom-requiring material begins surfacing into awareness in resistance. She spontaneously feels and hears, "Nn-nn, gotta hang onto that," which opens into her emotional truth of attraction to the boy's challenge to "joust" as a "warrior."

C. In-session integration technique: *Overt statements* of symptom-requiring themes and purposes to therapist and to student, visualized. "I *like* battling with this kid every day." "I want you to know that I look *forward* to coming here every day and wrestling with you. I *love* it. I *don't* want you to leave my class, because then I won't have *this* to look forward to every day. You make my day."

D. Between-session integration technique: Task of deliberately staying in touch with her own symptom-requiring position in the problem situation at school.

E. Her presented (anti-symptom) position toward problem: In effect, "I hate my daily encounter with this student who threatens and victimizes me. He keeps me from being an effective teacher and I feel powerless, which infuriates me. This is an ordeal that could give me a heart attack."

F. Her discovered (unconscious, pro-symptom) position toward problem: In effect, "I'm a warrior and a warrior must meet any challenge. I *love* the excitement and the challenge of my daily encounter with this young male. I'm every bit his match and I *want* to joust with him, and to hell with being 'teacher' for the others. What enrages me is that I'm *not* free to joust with him because of having to be 'teacher.'" (Governing emotional truth.)

G. Outcome: One session eliminated client's emotional reactivity to her student and her attachment to him as a jousting partner. Client immediately arranged student's transfer out of her class.

PRINCIPLES OF CHANGE

- Change of a symptom is blocked when a person tries to make the change from a position that does not actually have control of the symptom; a position merely against having the symptom.
- Therefore, for client to achieve rapid change of the symptom, first have client make conscious and truly inhabit his/her symptom-*requiring* position, because that is the position that *does* have control over producing the symptom.
- People are able to change a position they experience having, but are not able to change a position they do not know they have.

CLIENT'S POSITIONS

Conscious Anti-Symptom Position (Neocortex)

—The problem or symptom is senseless, irrational.

—The problem or symptom is totally undesirable, so I hate it and want to get rid of it.

—The problem or symptom is an involuntary experience; I'm powerless to make it stop, I'm an unwilling victim of it.

—The existence of the problem or symptom *means* that I [or others] am [bad, defective, crazy, inadequate, stupid, selfish, a failure, etc.].

Unconscious Pro-Symptom Position (Limbic System)

—The symptom's existence has deep sense and compelling cogency.

—The symptom or problem is at certain times vitally necessary for me to *have,* so it must *not* simply stop or be disallowed.

— I myself produce the symptom by how I carry out my own urgent purposes.

METHODOLOGY OF DOBT

Prerequisite: Empathize accurately with client's anti-symptom position. Then, *create experiences* of:

◆ ***DISCOVERY* of client's pro-symptom position** *("radical inquiry")*

- Therapist learns from client what to regard as the symptom(s)—the specific features of experience that constitute the problem that client wants dispelled.
- Therapist prompts client's first direct experiences of how and why symptom is necessary to have (the emotional truth of the symptom—client's unconscious, pro-symptom position [psp]).
- Client's psp becomes apparent to therapist but not to client.
- No attempt to change psp.

◆ ***INTEGRATION* of pro-symptom position** *("position work")*

- Experiential shift of psp from unconscious to routinely conscious.
- Client relates to problem *from* and *in* psp: client is now directly in touch with carrying out a passionate, powerful personal purpose in a way that entails producing the symptom.
- No attempt to change psp.

◆ ***TRANSFORMATION* of pro-symptom position**

- Change of psp: component constructs are revised or dissolved.
- Result: Client no longer has any position (emotional theme and purpose) in which symptom is necessary to have, so she/he no longer produces symptom.
- Transformation often occurs as spontaneous outcome of integration; or else is deliberately prompted by therapist.

VIDEO #2. *OBSESSION WITH FORMER LOVER*

A. Presenting symptom: Woman describes being in chronic, emotionally painful obsession with her former lover two years after their eight-year relationship ended. Indications of enmeshment/ merging/symbiotic attachment.

B. Discovery technique: Sentence completion: "If I let this end—." Client completes: "If I let this end—I lose *me*." Meaning is initially opaque and requires further unpacking, resulting in step C…

C. In-session integration technique: Overt statement of pro-symptom position, "I want to be you," spoken to image of former lover.

D. Between-session integration technique: Daily experiential focus on psp through reading psp written on 3x5 index card as, "An important part of me wants to be you."

E. Session #2: Client reports potent realization, "an epiphany for me: …No boundaries equals death." Integration of the psp has led spontaneously to its transformation (dissolution in this case).

F. Outcome: Ten sessions resulted in discovery and dissolution of two more pro-symptom positions. In session 10 client reported: no longer obsessing, comfortable ending all contact with former lover.

METHODOLOGY, PART 1: DISCOVERY EXPERIENCES

Most direct path into the emotional truth of the symptom

- Follows the coherent linkage of the symptom to the underlying constructs necessitating it.
- Therapist has array of specialized techniques of discovery, tailors them into experiential steps.
- Client "bumps into" unconscious, pro-symptom themes and purposes, which become apparent through direct experience, accurately and nonspeculatively. Therapist *learns from client* how symptom is necessary to have.

Central logic of discovery: Elicit client's personal themes, purposes, and models of reality that make the symptom more important to have than not to have.

Searching for coherence: How therapist thinks and listens in order to seek out and then recognize pro-symptom material as it emerges (*not* questions for client or interpretations to make!)

(1) What does the symptom do for the client that is valued or needed in the client's world? How, and in what context, does the symptom express or pursue a valid, important need?

(2) How is the symptom an actual success for the client, rather than a failure? To what problem is the symptom a solution, or an attempt at a solution?

(3) What are the unwelcome or dreaded consequences that would result from living *without* the symptom? What happens if the symptom doesn't?

(4) a. What would the client have to change so that the symptom would cease to occur?
b. How is it important *not* to make that change? [Functionless symptom.]

PRINCIPLE OF ACCESSING

Personal constructs are directly accessed only by inhabiting them experientially—
a subjective immersion in the felt "reality" that the constructs create, while also verbally cognizing the content of this "reality."

VIDEO #3. *FAMILY with ACTING-OUT 10-YEAR-OLD SON*

A. Presenting symptom: 10-year-old son's hitting other children at school several times each week. Parents describe boy's life history of physical aggressiveness, even as a toddler readily hitting, biting, scratching. HMO psychologist recently diagnosed A.D.D. and recommended Ritalin.

B. Discovery technique: Circular questioning. Son's comment here in session #8 tips off therapist to father's pro-symptom position.

C. In-session integration technique: (1) Father is invited repeatedly by therapist to make overt statements of his pro-symptom position directly to son: "Part of me is very pleased that you don't get pushed around [like I was as a boy]." "I wish I could have gotten into as much trouble as you—*darn* right—wish I could have." "Even though it's a lot of trouble for me, I'm *glad* you take care of yourself when you feel it's necessary. I'm glad that you can hit back." Therapist persistently maintains focus of session on father's pro-symptom position once discovered.

(2) Therapist guides son to integrate father's revealed emotional truth. "How is it for you to hear this from your Dad?" etc.

D. Between-session integration technique: Real-time recognition (use of symptom as signal): father to find, feel and overtly take his pro-symptom position in response to each incident of son hitting.

E. Outcome: After this session (#8) came one more family session and four couple sessions. Six months after session 8, follow-up query to father found that the boy's hitting abruptly ceased after session 8: no further hitting had occurred and school grades had improved.
(Video transcript is in DOBT book, pp. 222-229.)

METHODOLOGY, PART 2: INTEGRATION EXPERIENCES

Integration techniques repeatedly prompt client to experience the problem situation *from* and *in* psp.

Integration mottos. Pitch a tent • Set up camp right there (in psp) • Go nowhere else. (Exception: trauma)

State-specific awareness (altered state) vs integrated, lasting awareness

Integration = Client directly experiencing emotional truth of how/why symptom is necessary to have, routinely, daily, especially whenever the problem or symptom occurs.
Client relates to problem or symptom *from* and *in* the pro-symptom emotional reality requiring it, rather than from the anti-symptom position initially expressed.

Successful integration is indicated by client referring congruently and explicitly to the pro-symptom theme and purpose *on his/her own initiative,* especially at start of session.

Realization of agency. With integration of psp, the symptom's mysterious power to persist changes into client's own power to persist in carrying out a vitally important purpose. Experience of being a powerless victim (view of symptom as "happening *to* me") is replaced by experience of agency (one's own use of power and choice). Pivot into agency = "empowerment" in DOBT.

Basic in-session technique of integration: Overt statement. Invite client to make a succinct I-statement of any element of the symptom's emerging emotional truth—in present tense; spoken directly to the emotionally relevant person(s), visualized or in the flesh (if visualized, then also in the emotionally relevant scene); using phrasing that is fully candid emotionally—directly names what's at stake; rich in personal pronouns (I, me, you). Collaborate with client on wording.

Between-session tasks of integration are a necessity. Mainstays: index card; real-time recognition

Integration as crucial pre-condition for transformation.

Unconscious psp persists endlessly because insulated/isolated from all other material.

Integrated, subjective experience of psp—true (limbic) accessing of psp—ends insulation of psp, exposes psp to other, disconfirming constructs, knowledges, parts, ego-states, so psp is directly available for change.

METHODOLOGY, PART 3: TRANSFORMATION EXPERIENCES

Transformation of pro-symptom positions is the goal in DOBT because a person ceases producing a symptom as soon as there is no longer any position (personal schema or construction of reality) making that symptom necessary to have.

DOBT utilizes native abilities and processes of the mind to revise or dissolve constructions of reality formed previously in the course of experience and development.

Basis of transformation methodology: Principle of organization of realities

- The mind fully allows inconsistency between constructs that never come into mutual contact or enter the same field of awareness.

- However, the mind does *not* tolerate an incompatibility or contradiction between constructs that are co-present in the same field of awareness, juxtaposed and experienced together.

- When juxtaposition of incompatible constructs occurs, the mind has three ways of dispelling it:

  Loose construing: The mind tampers with the perception or meaning of one or both constructs so as to make them seem mutually compatible. (Piaget: assimilation.)

  Splitting: The mind rigidly re-compartmentalizes reality so that the incompatible constructs remain entirely separate and are never experienced together, allowing both to exist.

  Transformation: If the mind faces and accepts the incompatibility, it then fundamentally transforms (revises or dissolves) one of the constructs because the realness or truth of that construct has been disconfirmed by the other. (Piaget: accommodation.)

Condition for transformation of pro-symptom position: *Experiential disconfirmation*

A psp gets revised or dissolved when it and some other, incompatible living knowledge or version of reality are *subjectively experienced together—juxtaposed—in the same field of awareness.*

Methodology for transformation of pro-symptom position

This procedure sets up the experiential disconfirmation that prompts client's mind to use its native ability to change or dissolve pro-symptom constructs:

(1) Have client access the emotional reality of the psp by vivifying and experiencing it. Then, in the *same field of awareness—*

(2) Prompt client also to access and experience as real a different version or knowledge of reality, sharply inconsistent with key features of the psp version, juxtaposed with the psp version.

Transformation versus merely counteractive interventions

CONCLUSION

- **Effectiveness with DOBT results** from maintaining focus persistently on client's pro-symptom position (psp)—persistent steps of discovering, integrating and transforming the symptom-requiring emotional realities.

- **Therapist weaves recursively** back and forth between discovery, integration, and transformation—not a linear sequence of these three activities.

- **Strategy of most therapies** is to oppose, counteract and prevent the symptom by empowering client's *anti*-symptom position—building up strengths or resources to prevail over the symptom. However, the unconscious, *pro*-symptom position contains knowledge held as crucial for survival and is passionate, urgent, powerful, and usually immune to counteractive measures.

- **DOBT's strategy** is not counteractive. To do DOBT is to say and do *nothing* intended to overcome or prevent the symptom, and to do no interpreting. Therapist ushers client into experiencing, owning, befriending his/her own pro-symptom position(s). Therapist's empathic, validating, accepting attitude toward client's pro-symptom positions is crucial. This total commitment to the pro-symptom focus is counterintuitive for many therapists.

- **Beyond symptom relief:** Depathologizing of self; recognition of coherence of self.

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***Depth oriented brief therapy: How to be brief when you were trained to be deep, and vice versa.* San Francisco: Jossey-Bass (1996).** A complete guide to DOBT with many case examples illustrating the specific techniques, the methodological principles, and the constructivist conceptual framework of this approach.

VIDEOTAPES

Videos of therapy sessions conducted by Bruce Ecker, accompanied by transcript with commentaries explaining how the methodology of DOBT is carried out in the session. For descriptions and for ordering online, visit: www.dobt.com/video.htm

Compulsive Underachieving: Video and viewer's manual. *Depth Oriented Brief Therapy Video Demonstration & Training Series, 497E.* Oakland, CA: Pacific Seminars.

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