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Coherence Therapy

Practice manual & training guide

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Bruce Ecker, MA, LMFT, and Laurel Hulley, MA are the originators of Coherence Therapy (originally named Depth Oriented Brief Therapy).

The Coherence Therapy website, www.CoherenceTherapy.org, provides a wide range of learning resources:

- Free case examples, free downloads of many published articles
- Bibliography of Coherence Therapy and memory reconsolidation
- Videos of real sessions by Bruce Ecker
- Online short courses
- The Clinical Notes series
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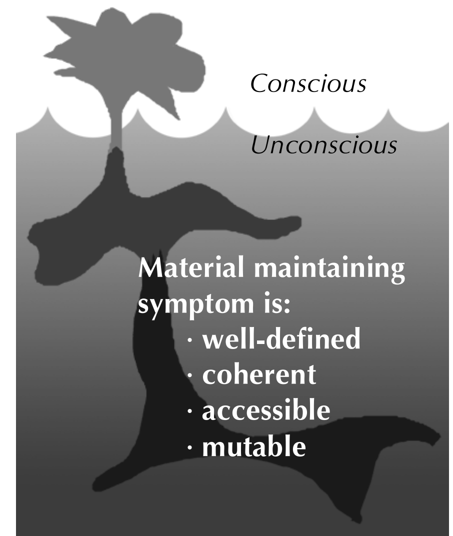
Key Features of Coherence Therapy

Core Concepts



The cause of a therapy client's presenting problem or symptom proves to be non-conscious emotional knowledge requiring it. This material is well-defined, accessible and transformable—a specific construction of personal emotional reality held in subcortical and right-brain implicit memory.

Symptoms are maintained only by presently existing constructions of reality, formed in the past and still held. How a person experiences and responds to a situation is caused not by circumstances, but by viewing circumstances through the lens of unconscious personal constructs—the projection of the past onto the present.

Goal of Coherence Therapy is transformation of the minimum amount of underlying material needed for ending unwanted patterns of mood, thought and behavior ("symptoms").

People have native mental processes for zeroing in on and transforming the symptom-requiring material and its neural pathways, and these processes are available right now, from the first session.

The immediate accessibility of unconscious constructs is always to be assumed. Even unconscious emotional realities first formed in childhood and generating symptoms for decades are readily accessible through experiential, noninterpretive, noncounteractive methods that engage and unpack these schemas held in emotional implicit memory systems.

Change occurs through experiences. Change results from direct experiences of the symptom-requiring material, not from cognitive insights. Cognitive insight follows *from* (rather than leads and produces) such experiences. People do not need analytical insight or verbal skill in order to have such experiences.

Techniques for creating experiences in Coherence Therapy are unlimited. A "basic set" of particularly useful techniques are described in this manual, but the therapist has unlimited leeway in applying any experiential methods to carry out the methodology. Though the methodology is well-defined, Coherence Therapy is not a formulaic, cookie-cutter approach on the concrete level of technique. Rather, the therapist faces a creative task of coming up with a technique that meets the methodological needs moment-to-moment. The basic set of techniques described in this manual is highly versatile, but any other experiential methods known to the therapist can be applied at any time.

Non-counteractive methodology. The paradigmatic difference between Coherence Therapy and most other in-depth therapies—the difference that allows for profound change to become a regular occurrence in a therapist's daily practice—is the use of a thoroughly non-counteractive methodology guided by the central principle of *symptom coherence,* described on the next pages.

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Key Features of Coherence Therapy (CONTINUED)

Symptom Coherence

Symptom coherence is Coherence Therapy's model of symptom production. The principle of symptom coherence guides and informs the entire methodology.

Definition of symptom coherence. A therapy client's presenting symptom occurs entirely because it is compellingly *necessary to have* and fully makes sense to have according to at least one of the person's adaptive schemas or constructions of emotional reality—a non-conscious, nonverbal but well-defined and coherent cluster of personal themes, purposes, knowings, meanings, constructs.

This means: When there is no longer any schema or 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" refers to those coherent, unconscious, symptom-requiring schemas, described above.

Example A. A 40-year-old man's presenting symptom was how "held-back" he is with his wife—his non-initiation of physical affection and his lack of sexual feeling toward her, all of which baffled him and was causing distance and strain in the marriage. In his sessions he experientially discovered *for himself,* with no interpretation given by the therapist, the necessity—the underlying emotional truth—of being so held-back: a fearful expectation that "reaching out physically" toward his wife in any way would bring her into sexual desire and a physicality that would "overwhelm" him. "Overwhelm" meant, it further emerged, making him again feel trapped, violated and used like he always felt from his mother's heavily impinging, sexually-tinged, entrapping physical affection, an ordeal he regularly suffered as a boy. Being held-back was necessary because it successfully prevented that from happening to him again.

Example B. A middle-aged woman's presenting symptom was an intense, pervasive anxiety that had developed in recent years after failing to develop a couple relationship despite getting involved with several worthy prospects. She was now in fear over being "all on my own in the world" as she goes into old age, dreading great physical and emotional hardships and dangers. In her sessions she became directly aware of a previously unrecognized need for the aloneness that was scaring her: it was urgent to make certain she is never, ever again abandoned by anyone close, as she was, repeatedly, until she was 14. She experienced her emotional truth of carrying out this purpose by never allowing profound bonds to form, "because getting close is how it could happen again." Being all on her own was necessary in order to prevent abandonment; and her aloneness brought, in turn, the anxiety-producing prospect of severe hardships and dangers as she ages.

Empathy toward the emotional truth of the symptom, or *coherence empathy,* sets the tone of Coherence Therapy. Through coherence empathy the therapist expresses his or her understanding, acceptance and respect for how the symptom is necessary to have. Coherence empathy is to be distinguished from empathy for the suffering due to the symptom, which the therapist also expresses at times.

Symptom coherence and personal agency. At the start of therapy, the client feels powerless over the presenting symptom, which seems to the client to be something that happens *to* him or her with a life and a power of its own. By bringing to awareness the emotional truth (the coherence) of the symptom, the client experiences, as in the two examples above, that he or she actually has great personal agency in producing the symptom—that the symptom arises from the client's own use of personal power applied to his or her own strategy for solving a particular existential dilemma.

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Key Features of Coherence Therapy (CONTINUED)

Symptom Coherence (CONTINUED)

Meaning of "necessary to have." There are two different, basic ways in which presenting symptoms and problems are found to be coherently necessary to have:

- ***Necessary functionally.*** The presenting symptom is the *very means* of carrying out a crucial personal purpose or meeting a crucial personal need. In other words, the presenting symptom has a definite, crucial function. The symptom is necessary directly.

  Example A on previous page represents this type of "necessary to have": the client's held-back state in his marriage was necessary as his *very means* of making sure he won't suffer again what he suffered with his mother.

- ***Necessary consequentially.*** The presenting symptom is an *inevitable effect or by-product* caused by the specific way in which the person carries out some crucial personal purpose or meets a crucial need. The presenting symptom does not in itself have a function; rather, it is a *necessary consequence* of some other formation held by the individual. The symptom is necessary indirectly.

  Example B on previous page represents this type of "necessary to have": the client's anxiety was necessary as a consequence of her use of aloneness to make sure she wouldn't suffer abandonment ever again. (It was her aloneness, not her resulting presenting symptom of anxiety, that was necessary functionally, as the very means of preventing abandonment.)

The therapist, hearing the client's initial description of the symptom or problem, cannot infer or figure out which type of *necessary* is the case. Rather, the unfolding of the work *shows* which is the case, by revealing the unconscious material necessitating the symptom. The client is then guided into transforming the symptom-requiring material, whichever type it is, ending symptom production.

Verification of symptom coherence. Symptom coherence is not an interpretation imposed on the client or on the client's material. It is manifestly evident from and in the client's own material, understood in its own terms, with no interpreting. The actuality of symptom coherence is empirically confirmed and demonstrated by the revealed psychological material of each client and by the symptom cessation that results from transforming that material, without ever counteracting the symptom itself.

Principle of deep coherence. The mind-body system or psyche can purposefully produce any of its possible conditions or states, including any kind of clinical symptom, in order to carry out any purpose that the mind-body system is capable of having.

"You won't fully grasp Coherence Therapy until you grasp the nimble, active genius of the psyche not only in constructing personal reality, but also in purposefully manifesting any one of its myriad possible states to carry out any of its myriad possible purposes. The client's psyche is always coherent, always in control of producing the symptom—knowing why and when to produce it and when not to produce it."—Bruce Ecker, to a training group

History of coherence. A principle of psychological coherence has appeared in various forms, both explicitly and implicitly, in the writings or clinical methods of Jung, Laing, Bateson, Satir, Dell, Maturana and many others. What is new in Coherence Therapy is (1) the further development of the concept into a central principle of the psyche's activity and self-organization, and (2) the systematic utilization of coherence for swift, accurate retrieval and dissolution of symptom-generating emotional schemas.

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Key Features of Coherence Therapy (CONTINUED)

The "Part" That Has Control Over Symptom Production

In Coherence Therapy, clients are guided into direct, subjective experience of their previously unconscious, symptom-requiring knowledge or schemas—the emotional truth of the symptom.

This is an experience of emotional learnings that have been outside of awareness, unknown to the usual, conscious personality. When the client is subjectively, directly experiencing this schema/subpersonality/part/ego-state/complex/reality-construction, the client is typically in an altered state that consists of:

- being at a particular age or stage (such as being a child of a certain age)
- being in a particular situation that is intensely problematic in a specific way
- having specific emotional and somatic responses to that situation
- having living, personal knowledge of how that situation works, especially how it affects safety, well-being or justice, including—

    living, tactical knowledge of how it is urgently necessary to behave, feel or think in this situation for safety, well-being or justice—and this requires producing the presenting symptom (whether functionally or consequentially)

    living knowledge of an even worse suffering that would result from *not* producing the presenting symptom

To the client, this mode of self-in-situation may feel like a distinct "part" of him- or herself, a part that consists entirely of a certain module of urgent emotional learnings: knowledge of a specific suffering that is urgent to avoid, and knowledge of how to avoid it. The client's presenting symptom is either a response to that knowledge of vulnerability to that suffering, or part of what is necessary for avoiding it.

The symptom-generating schema or module of emotional learnings is the target of change in Coherence Therapy. The schema is sometimes referred to as the client's ***pro-symptom position***. "Pro" denotes that the symptom is *emotionally necessary* according to the knowledge in this self-state or part, and "position" is meant to denote personal agency—an active and self-protective (if initially unconscious) positioning and responding that entails the symptom as a necessary, adaptive feature.

At the start of therapy, the client is unaware of her/his pro-symptom position and consciously feels and expresses only a position that is strongly *against* having the symptom because of the suffering or limitation that it brings. This is referred to as the person's *anti*-symptom position. To sum up:

Emotional reality in the conscious (neocortical) self-state that is *against* having the symptom—client's *anti*-symptom position	**Emotional reality in the unconscious (subcortical) self-state that is *for* having the symptom—client's *pro*-symptom position**
• The problem or symptom is senseless, irrational. • The problem or symptom is totally undesirable; I hate it and want only 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 am [or others are, or the world is] inadequate, defective, damaged, bad, crazy, stupid, selfish, a failure, etc.	• The symptom's existence has deep emotional sense and personal meaning. • The symptom is at times compellingly necessary for me to *have,* because it is part of how I avoid an even worse suffering, and so it must *not* simply be stopped or disallowed. • I myself produce the symptom as part of how I carry out my own urgent purposes.

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Key Features of Coherence Therapy (CONTINUED)

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.
- People are able to change a position they experience having, but are not able to change a position they do not know they have.

Nature of Pro-Symptom Position

Consists of linked, component constructs. For example, the pro-symptom position (psp) of the man who couldn't "reach out" to his wife in any physical way (Example A on p. 2) consisted of linked constructs that could be verbalized as follows after being emotionally and somatically experienced consciously:

ESTO SE PARECE A LOS DILEMAS IMPLICATIVOS DE VILLEGAS

- A woman who desires physical contact with me will do it and use me with no thought at all about me and what I'm feeling.
- I've got to keep that ordeal from happening, by keeping women from feeling any desire for physical contact with me.
- My own feelings of affection or sexual desire toward a woman are a great danger because if I express them physically to her, it will ignite her own desire for physical contact with me.
- I've got to cut off from my own feelings of affection or sexual desire.

Evident in these component constructs are two characteristic features of pro-symptom positions:

- **A model of a problem** (here, the danger of suffering being trapped in a violating physicality)
- **A well-defined solution** necessitating the symptom (here, tactics that avoid that suffering)

Through Coherence Therapy, the client makes conscious and revisits both the core problem as originally construed, and the strategy he/she originally formed as a solution to it—a strategy that entails producing the symptom. The result is a profound unlearning and revision of the nature of the problem, the solution for dealing with it, or both, resulting in symptom cessation.

Held in the brain's emotional implicit memory systems (limbic system and right brain). This means—

- psp consists of non-conscious, nonverbal constructs: perceptual, emotional, somatic and kinesthetic knowings; knowings one doesn't know one knows, until made conscious and verbalized.
- non-conscious psp is unaffected by cognitive (neocortical) insights, reframes, narratives, beliefs.
- psp responds to imaginal experiential work as though it is real, because the emotional brain does not distinguish between imagined and real experience; hence psp can be directly accessed by imaginal experiential methods.
- unconscious psp is separate and insulated from client's other, different knowledges defining self and world, and is therefore timeless, unchanging: past exists now.

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Key Features of Coherence Therapy (CONTINUED)

Nature of Pro-Symptom Position (CONTINUED)

More than one pro-symptom schema can exist. A symptom can be necessary to have in two or more completely different ways simultaneously, each a separate psp. A person ceases producing a symptom only when all of its psp's are transformed and the symptom is no longer necessary in any way.

Pro-symptom positions are made of constructs. "Construct" means any and every representation formed by the mind. Constructs serve as knowings of reality and are experienced *as* reality; they are not recognized as one's own created, changeable models of reality until experientially disconfirmed.

Constructs are formed in several different dimensions including sensory/perceptual knowings; emotional knowings; somatic/kinesthetic knowings; verbal/narrative knowings. A cluster of linked constructs makes up a schema. Coherence Therapy uses the term "position" to denote a relatively more complex schema that defines a particular type of situation, how it works and how to respond to it.

Unconscious constructs constituting people's pro-symptom positions tend to be constructs that define these areas of personal reality and felt meaning:

- The essential nature of self/others/world ***(ontology/identity)***
- The necessary direction or state of affairs to pursue ***(purpose, teleology)***
- What necessarily results in what ***(causality)***
- How to be connected with others; how attachment works ***(attachment/boundaries)***
- How self-expression operates ***(identity/selfhood/boundaries/creativity)***
- Where to place responsibility and blame ***(causality, morality)***
- What is good and what is bad; what is wellness and what is harm; what is safety and what is danger ***(safety/values/morality)***
- How knowing works; how to know something ***(epistemology)***
- The way power operates between people ***(power/autonomy/dominance/survival)***
- What I am owed or what I owe ***(justice/accountability/duty/loyalty/entitlement)***

Examples (verbalizations of unconscious, nonverbal constructs/schemas held in the limbic system and body)

Ontology: "People are attackers. If they see me, they'll try to kill me."

Causality: "If too much is going well for me, that will make a big blow happen to me."

Purpose: "I've *got* to keep Dad from withdrawing his love by never, ever disagreeing with him."

Attachment: "I'll get attention and connection only if I'm visibly unwell, failing, hurting." "You'll reject and disconnect from me if I differ from you in any way."

Values: "It is selfish and bad to pay attention to my own feelings, needs and views; it is unselfish and good to be what others want me to be."

Power: "The one who has the power in a personal relationship is the one who withdraws love; the other is the powerless one."

Duty: "If my mother shows emotional pain, it's my job and my responsibility to get her out of it."

"Memory" in Coherence Therapy refers to the continued holding of previously constructed and learned knowings, such as the unconscious schemas listed above. Schemas are used for knowing what is happening and how to respond. When the client is accessing images, feelings, knowings formed in sufferings in "the past," this is actually the accessing of currently existing constructs and schemas.

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Key Features of Coherence Therapy (CONTINUED)

Methodology of Coherence Therapy

Prerequisite: Empathize accurately with client's *anti*-symptom position—client's suffering of the presenting symptom and the wish to be rid of it. *Then:*

➢ ***Create DISCOVERY EXPERIENCES* of pro-symptom position** (“Radical inquiry” in DOBT book)	· Therapist learns from client what to regard as the symptom(s)—the specific features of experience that constitute the problem. · Therapist experientially prompts emergence of client's pro-symptom position (psp) or core schema of how and why symptom is necessary. · Client's psp becomes apparent to therapist but not to client. · No attempt to change psp or prevent the symptom(s).
➢ ***Create INTEGRATION EXPERIENCES* of pro-symptom position** (“Position work” in DOBT book)	· Experiential shift of psp from unconscious to routinely conscious. · Client relates to problem *from* and *in* psp: client is directly in touch daily with carrying out an urgent, self-protective purpose in a way that entails producing the symptom. · No attempt to change psp or prevent the symptom(s).
➢ ***Create TRANSFORMATION EXPERIENCES* of pro-symptom position**	· Change of psp: schema's key constructs are revised or nullified. · Result: Client no longer has any position or emotional schema in which symptom is necessary to have, so ceases producing symptom. · Transformation of psp occurs through an experiential sequence, corroborated by memory reconsolidation research, that brings about profound unlearning of target schema.

An effective session is one in which a significant further experience of discovery, integration or transformation of a pro-symptom position has occurred. Therapist strives for this in every session. At any point in a session, therapist is working to create an experience of discovery, integration or transformation of a psp. *Perpetual psp focus* is the key to achieving the full effectiveness possible with Coherence Therapy. Mindfully maintaining psp focus throughout entire session is a basic standard of proficiency.

Strategy of Coherence Therapy in context

In most therapies…	In Coherence Therapy…
Focus is on steps designed to get rid of the symptom.	**Focus** is on how symptom is cogently necessary to *have*.
Strategy of change is to *counteract, override, prevent, fix, disengage from* the symptom and its underlying material, by building up needed strengths, resources and skills to prevail over the symptom.	**Shortest path to change** is *profound engaging and embracing* of the underlying emotional truth of the symptom, by ushering client into direct, feeling-level experience of pro-symptom position(s).
Anti-symptom strategy (symptom-opposing, symptom-pathologizing).	**Pro**-symptom strategy (completely non-opposing, non-counteracting, non-pathologizing)

To do Coherence Therapy is to say and do nothing designed to directly counteract, overcome and prevent the symptom, and to do no interpreting. Therapist ushers client into experiencing, owning, embracing, befriending his/her own pro-symptom position(s). Therapist's continuously empathic, validating, accepting attitude toward client's pro-symptom positions is essential (coherence empathy).

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Methodology for Discovery Experiences

Shortest path of discovery: How to utilize symptom coherence

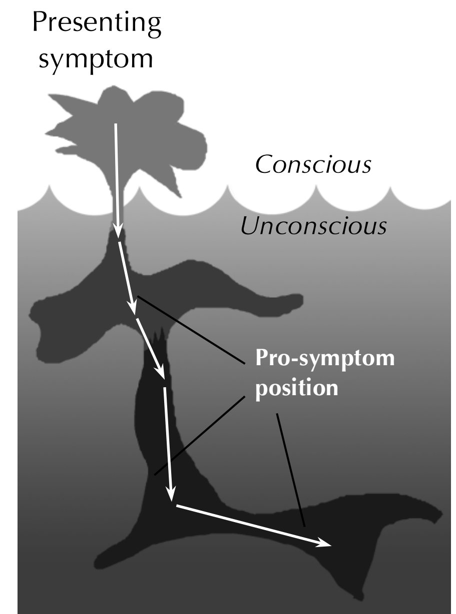
To create discovery experiences is to head directly toward and into live emotional truth of how the symptom is necessary to have.

The most direct path into the emotional truth of the symptom follows the symptom's coherence:

Symptom is directly linked to underlying, coherent material necessitating it—pro-symptom themes, purposes, constructs.

Therapist begins from the presenting symptom and actively applies experiential techniques that usher client's awareness progressively into the coherent material along the linkage.

Client subjectively "bumps into" the underlying pro-symptom material, revealing it to therapist. The therapist must recognize pro-symptom-relevant material as it fleetingly appears. Coherence awareness isn't in the technique, it's in the therapist.



Recognizing pro-symptom relevance is necessary for effective discovery work: Therapist screens literally everything client expresses for pro-symptom relevance—relevance to how and why the symptom is necessary to *have*. This requires *keeping the symptom explicitly in mind at all times*. If the therapist is not staying mindful of what the symptom is, she/he cannot recognize that a bit of newly emerging material reveals something of how that particular symptom is necessary to have. Client's latest communication consists of numerous elements, verbal and nonverbal. *Therapist selects the element that she/he deems most pro-symptom relevant,* and focuses there for a further step of discovery. That is the *selection criterion* that guides the discovery work. (If you habitually use selection criteria that differ from this, you will need to identify and deliberately desist from your usual criteria in order to successfully explore the use of Coherence Therapy's selection criterion.)

Different types of material can be pro-symptom relevant and can serve as the "doorway" that opens directly into the deeper, limbic emotional truth maintaining the symptom. Pro-symptom positions are an amalgam of linked constructs (implicit knowings) of several different types—percepts (images, sounds, etc.) and sequences of percepts; emotions; felt meaning (nonverbal yet well-defined); somatic sensations; kinesthetic sensations; energic sensations. Later, with discovery complete, meaning-plus-emotion usually proves to be the deep core that is most important to fully retrieve, experience and integrate in order for therapeutic change to occur. However, this does not mean that the initial accessing necessarily should occur through a focus on affect or meaning (though it might). The discovery work could, for a particular client, most readily open up through focusing on an image that has arisen, or on a kinesthetic sensation, for example, rather than through an initial focus on an emotion or mood. Then, as discovery and accessing proceed, all other components of the full pro-symptom schema come into being experienced and processed, including the affective dimension. In short, to regard affect as the necessary point of access to the deeper material greatly limits the many ways and many opportunities through which the therapist can usher the client into the material. The core material, too, may or may not be experienced as predominantly emotional. It is experienced by some clients more intensely as a felt meaning than as emotion.

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Methodology for Discovery Experiences (CONTINUED)

How therapist thinks and listens in order to recognize and select for pro-symptom relevance. Therapist's listening is continuously guided by the implicit (unasked) coherence-question: *"What emotional reality exists, that makes the symptom more important to have than not to have?"*

In practice, therapist thinks in terms of these four operational forms or variations on that question: (Note: These are *not* questions to ask client!)

(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) How is the symptom necessary as a by-product of something else? Does the symptom inevitably follow from how the client solves some other problem, from some attribution of meaning or other reality-construct, or from an actual blow or loss suffered?

Scene-specificity and concreteness in discovery: *The engagement condition.* Avoid or minimize generalized, abstract talk *about* the symptom and its causes. Instead, *carry out discovery in a specific scene, brought to mind and visualized by the client, in which the problem or symptom is happening*. In that scene the client's pro-symptom position is *engaged* and is therefore most easily accessed. Perceptions and meanings are in play that link directly into core pro-symptom constructs.

Recognizing pro-symptom relevance often requires recognizing unspoken, passionate meaning implied by a client's ordinary, low-key language. *Example:* A depressed client says offhandedly, "What just came to mind is how as a girl I used to say things to my Dad, and he'd always keep talking as if I hadn't said anything, like I wasn't even there." The therapist, actively remembering that the symptom is depression, recognizes probable pro-symptom relevance in the phrase, "like I wasn't even there," because these words probably indicate a core emotional meaning of, "I don't matter," a construct that almost always generates a great downheartedness or despair that shows up consciously as a depressed mood. Therapist next probes for this material by asking, "Would you imagine being back in one of those moments, right now, where you're little and Dad just keeps going like you're not even there? Good. And just notice: What does it feel like it *means* about you, in your secret heart, that to him you're not even there?" Client soon says: "It means I'm not important; like I don't matter." Tears come, and client names strong feeling of "sadness." This then emerges more fully as "despair" over not mattering to Dad, which client now recognizes to be the emotional truth of her "depression." Note how therapist's inferences may guide the work but are never delivered as interpretations.

Therapist's stance during discovery: *Freedom to clarify.* Therapist is unconcerned with changing the client, fixing the problem or making the symptom stop happening, and during discovery only seeks clarity into the underlying emotional learnings *requiring* the symptom. When an attempted step of discovery doesn't yield significant new material, either modify how you crafted that step and try again, or switch to a different technique of discovery. Persistence is necessary. The pro-symptom schema is there, ready to reveal itself.

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Methodology for Discovery Experiences (CONTINUED)

Like an anthropologist, therapist knows that the real meaning of client's key words—such as "hurt," "unworthy," "failure"—is idiosyncratic, not obvious or inferable, and must be elicited and unpacked.

Therapist does not figure out, diagnose or interpret client's psp from client's presenting symptoms. Therapist's task is to prompt the *experiential* surfacing of unconscious, pro-symptom material. Therapist learns the pro-symptom theme and purpose from the client, not *vice versa*. Therapist is in the dark during discovery and must tolerate not-knowing while prompting experiential steps that surface psp material. Persistence is essential. Not all steps of discovery are fruitful. Therapist sometimes does not know what to do next, then waits for a sense of where to focus for more discovery.

"What's under this?" When an underlying emotional truth comes to light and is experienced, verbalized, and sat-with in the room, therapist soon thinks, *"And what's under this?"* In other words, "Is this in turn arising from a next-deeper layer? What underlying construct or presupposition must be present for the found material even to exist? What next step of discovery might best elicit what's under this?" The goal is to go only deep enough to dispel the presenting symptoms, but it is important to *go* deep enough to accomplish that. *Minimum depth required for effective Coherence Therapy is the governing purpose that necessitates having the symptom.* This purpose will always prove to be well-defined, passionate, and accompanied by a specific way of being carried out. (See complete psp schemas laid out on p. 28.)

Client's state during discovery. Spontaneous experiencing; state-specific awareness (altered state): unintegrated, quickly lost. Significance of emerging pro-symptom material becomes apparent to therapist but may not be grasped by client until subsequent creation of *integration* experiences.

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Starting Point: Identifying the Symptom

Eliciting the experiential particulars of the problem: First critical step

Obtaining from the client an initial clarity about what to regard as the symptom or problem is the first step of Coherence Therapy. The required clarity consists of specificity of description of *what* the client is experiencing as the symptom or problem is happening, and *when* this occurs. This information is elicited best by asking the client to bring to mind a recent incident or situation that is strongly representative.

Therapy clients often use broad abstractions and nominalizations, lacking the *what* and *when*, in describing their problem or symptom, such as “stressed-out,” “anger problem,” “binge eating,” “depressed,” “shut down,” or “communication problem.” This level of description is too blurry for purposes of carrying out Coherence Therapy with consistent effectiveness. Eliciting a specific initial description of *what* and *when* is critical and indispensable for two reasons:

- As shown in the diagram on p. 8, the presenting symptom is, in a very real sense, linked directly to the pro-symptom position (psp) and serves as the portal or trailhead from which a path into the psp will be followed. It is the client’s actual *experience* of the symptom, not the client’s *description* of the symptom, that is the real trailhead. If the description of the symptom does not identify the actual experience of the symptom specifically enough, there is much less likelihood of then finding and following the linkage, the path, that leads into the psp. The work is likely to wander.
- The more specific and complete the initial description of the client’s experience of the symptom, the better can the therapist then recognize, during the discovery work, the emerging, fleetingly present material that reveals how the symptom is necessary to have—material that *is* the path into the psp and *is* the psp. With a too-fuzzy notion of the symptom, the therapist can not reliably recognize pro-symptom material as it emerges, and key bits of material will be passed by, bits that could have been used to advance the work powerfully in minutes if their pro-symptom relevance had been recognized.

How to do it

The following questions are effective for bringing a client’s attention directly onto his or her experience of the symptom or problem, to get the needed initial level of specificity. Persistence is often necessary.

- “I assume you’re here because there is something you experience that you want not to keep experiencing. What’s the problem, as you actually experience it?”
- “Please walk me through a good recent example of it happening.” Elicit specifics of thoughts, feelings, somatics, behaviors, circumstances. “What is it you’re thinking and feeling right then?”
- “How do you know that the problem is happening?”
- (a) “What was the very first moment when the problem started cropping up, in that situation?”
(b) “What had just happened in the preceding moment?”
- (a) “When was the first time you ever experienced this?”
(b) “What happened, or changed, at that time?”
- “How will you know if our sessions have been effective?”
- “If I claimed that I experience exactly the same problem and the same suffering as you do, what specifics would you have to ask me about in order to see if that’s really true?”

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Starting Point: Identifying the Symptom (CONTINUED)

Example

Th: What difference do you want our sessions to make for you?
Cl: I need tools for dealing with anger.
Th: Does the anger come up mainly at home or at work or both?
Cl: Both.
Th: Please walk me through a good recent example of it happening.
Cl: Well, just last night's a good example. I asked my daughter—she's 16—how it went at her job. She just started this summer job, first real job she's ever had, so it's a big deal in our family. I asked her how it went—y'know, bein' a Dad, showin' some interest—and she instantly got full of attitude and said, "Can't you just let it alone?" And then I lost it. Bam!
Th: Your anger flared right then?
Cl: Oh yeah. Screamed at her as she walked away. Slammed a wall. And then my wife was upset with me all evening for "fouling our nest" again, as she says.
Th: Mm-hm. Good example. Tell me if I'm understanding it correctly: You reached out, you said something intended as a positive expression of interest and connection and caring, and you weren't received, you were seen as doing something bad and got pushed away. And your anger flared right then. Is that accurate?
Cl: [Pause while thinking.] Yeah, that's pretty accurate. Hnh. I hadn't thought about it like that, but yeah, that's what happened.
Th: Mm-hm. Now, I know how fast that flare of anger can be, but let's see if we can spot what happened for you in the moment before the anger crops up. Could you rewind the tape of last night's incident and freeze-frame at the split second of that first moment of seeing that your daughter is rejecting your positive attempt to connect with her? See if you can notice: What are your private thoughts and feelings, right then—just before the anger floods through?
Cl: Well, something like, that really hurts my feelings. Or like, you don't want me, or like, I don't matter.
Th: I see. You don't want me; I don't matter; and that really hurts your feelings. Just for a split second, and then the anger roars through. Is that right?
Cl: Well, it's not anything I noticed at the time, but if we stop the action like that, then ok, I can see how that was goin' on like, behind the scenes.
Th: I'm wondering whether your anger-incidents *often* involve that same pattern: wanting to connect, expressing something positive, having it rejected or seen as unwelcome or bad, and feeling very hurt, like you don't matter. How about if we look at one or two more incidents?

Contrast the blurry initial definition of the problem—"anger"—with the sharper focus on the *what* and *when* of the symptom now achieved: the client lashes out in anger upon feeling rejected and unimportant. The therapist now knows by assuming symptom coherence that the anger-symptom is necessary to have in the specific personal context of "feeling rejected and unimportant." The discovery work that comes next would create experiences of exactly how and why anger is necessary when feeling rejected and unimportant (the client's pro-symptom position). The discovery techniques on the following pages are ways of doing that.

Time required. With many therapy clients, sufficient initial specificity of symptom definition is achieved within 10 to 15 minutes after the client has introduced a new symptom or problem to work on. However, this step of the work can take longer with clients who have weak verbal skills, a confused or chaotic inner process, and/or a very low level of self-awareness. Even if an entire session or two is necessary, this step must not be skipped, because the unfolding of the subsequent work largely depends on it.

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Techniques for Discovery Experiences

Therapist's broad leeway in use of techniques

This section presents a "basic set" of techniques for creating discovery experiences of pro-symptom positions. The therapist is by no means limited to the particular techniques described here. Any experiential technique can be adapted and tailored to bring clients into direct experiences of their previously unconscious themes and purposes that require having the symptom.

Techniques in the "basic set" are simple, versatile and reliably effective. Experienced Coherence Therapy practitioners find that they use these techniques a majority of the time. Yet even these mainstay techniques are not formulaic. They have a well-defined form, but they have to be tailored to the person and the therapeutic moment. The therapist's skill, judgment and experience are actively involved.

The sequence of techniques in Coherence Therapy likewise is not formulaic. The methodology is well-defined, but the concrete, moment-to-moment implementation of that methodology is a creative process on the part of the therapist, including the choice of technique at each step. Coherence Therapy done properly has an unhurried, natural pace and feeling, yet focus is maintained continuously. (For a detailed map of how the therapist adheres to the methodology throughout a session, see, "The Coherence Therapy Process Pattern: How to Maintain Continual Pro-Symptom Focus" on pp. 61-65.)

Note that techniques for discovery do not, as a rule, consist of the asking of questions. Rather, they consist of *guiding the client into an experience* in which previously unconscious pro-symptom themes and purposes become apparent.

Techniques for Discovery Experiences: Overt Statement

Procedure for overt statement

Invite client to make a succinct I-statement of any element that he/she already knows and feels of the symptom's 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 "limbic" phrasing that is fully candid emotionally and directly names what's at stake (see verbalization guidelines, p. 39)
- rich in personal pronouns—I, me, you

Collaborate with client on the phrasing; freely offer suggestions or even an entire "trial sentence" and explain, "The idea is for you to 'try on' saying these words, even mechanically at first, and just feel whether they have emotional truth for you. If it's off even a little, change the wording in any way to make it more accurate to what's true for you." Invite a second or third repetition until client drops into a feeling-level experience of the verbalized meanings, which is the goal (not necessarily an intense experience of emotion). Additional linked material then surfaces into experience and becomes part of the next overt statement (or some other, further step of discovery or integration). The following example demonstrates this use of overt statements.

Continues…

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Techniques for Discovery Experiences: Overt Statement (CONT'D)

Example (viewable on video in Coherence Therapy Online Course 100, www.coherencetherapy.org)

Client's description of problem: "How afraid I am to be more of who I know I can be..." "...my more brilliant self..." "That's very frightening to me... I spend a great deal of my time in hiding, being safe, being marginal... It doesn't make any sense..."

Th: Perhaps let's start, if you're willing, picture your parents, your family...Picture them all, if you would. Get an image of them there—I don't know if they're sitting or standing or whatever seems right to you—good—and just try out saying to them, "I feel I better not show my brilliant, my really capable self." And you can say it silently to them or out loud, it doesn't matter—whatever feels right to you.

Cl: I feel I better not show you my brilliant, capable self. (*Th:* Good.) I don't feel anything, really.

Th: Mm-hm. You don't feel anything?

Cl: No, not really. I feel frozen, numb.

Th: Ah. Okay...So, tell them the truth of what feeling frozen in saying this to them is. Does it feel dangerous to say this to them?

Cl: I—yeah, somehow. I can't even be that real. I can't even say that, somehow.

Th: Good, good. Maybe try saying to them, "Even telling you *that*, is terrifying to me."

Cl: [Suddenly crying as she speaks.] Even telling you *that*, is terrifying. And I don't know why.

Th: Yes. Mm-hm. All right, let's find out. How about if you continue by saying, "Because, if I tell you this—" And just see what comes to finish that.

Cl: [Crying.] 'Cause if I tell you this—what just is coming is—somehow you'll be hurt, or you'll feel bad, or you'll—I don't know—threatened; uncomfortable. You don't want to hear what I have to say. You don't want to know it! [Cries.] You want me to just be quiet! And good! And hide in my room! [Cries.]

Th: Mm. It sounds like you have a very keen feeling that it'll hurt *them*, in some way. (*Cl:* Yes!) And you're protecting *them* (*Cl:* Yes!) by putting your light under a bushel. (*Cl:* Yes!) Mm-hm. Good, good. Keep going: Tell them more about what you know about *how* it will hurt them. And which ones it will hurt.

Cl: Ahh. That's where it gets tricky, because right now they're all just sort of glommed together.

Th: Mm-hm. All right, then just let it be a glom, and say whatever comes about, "If I let my real brilliance show to you,—" (*Cl:* My *truth*.) "—my *truth* show to you, it'll hurt you because you'll—" Or whatever. Just let that flow about how you know it will hurt them. There's something you know about how it would hurt them.

Cl: The words that are coming are, "You're so *fragile* that—it'll break you. You'll crumble, you'll be devastated by my truth." And I don't know how to *say* it any way that isn't devastating. I'm sure my words will do it. That's it: My words will do it! (*Th:* Your words will do it.) And then you'll go away! [Cries.] And I won't have anybody! [Cries.] (*Th:* I see.) So, I don't want to do that! [*Client's compelling purpose—why symptom of "hiding brilliance" is necessary to have—was just revealed to the therapist. This illustrates the creation of discovery experiences. Client is immersed in the experience and does not grasp it yet. Therapist will next guide client to realize more fully the personal purpose in what she just experienced and voiced.*]

Th: I see. So say to them that. Say, "I'm making sure you don't go away by hiding my truth, my brilliance." [*Therapist now ushers client into "connecting up," a return of attention to the concrete presenting symptom with new awareness of the deeper emotional truth requiring it. Client's own agency and purposefulness in producing the symptom will now be recognized and felt by her—the "pivot into agency"* *(see p. 37)*.]

Cl: Yeah! "I'm making sure you don't go away, so I'm really quiet, and I'm good, and I swallow what I want to say or what I feel or what's real for me or what I see—everything!" [Cries.] *[End of example.]*

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Techniques for Discovery Experiences: Sentence Completion

Procedure for sentence completion

- Provide custom-made first part of sentence designed to pull for completion in terms of pro-symptom themes and purposes—how the symptom is necessary to *have*. (See examples below.)
- Wording is simple, vivid, highly personal (I, me, you), with emotional resonance.
- Tell client, "Say the words and let the sentence finish itself. Don't pre-think the ending, just say the words, reach the blank and it will finish itself." After client does it once, tell client, "Good. Keep going. Say it again and let's see what else wants to finish that sentence." Continue until no new endings come up for 2 or 3 tries.
- Typical process: familiar, anti-symptom endings arise first, then unfamiliar pro-symptom endings emerge. Write down, in your session notes, every pro-symptom ending—every ending relevant in any way to how having the symptom is necessary.

Sentence stem can be designed to elicit either the positive or negative necessity of a symptom.

Positive necessity of having the symptom. Example of a sentence stem designed to elicit the positive purpose of having a presenting symptom of underachieving:

Th: Picture your parents [and/or siblings or spouse] and 'try on' saying to them, **"When you see me as failing to achieve anything, part of me hopes that—**"

Cl: When you see me as failing to achieve anything, part of me hopes—that *I'll* finally get noticed and helped—like Dad got whenever *he'd* have things go wrong.

The pro-symptom emotional reality is now emerging; therapist invites fuller expression and learns: Throughout childhood client felt neglected, alone and un-taken-care-of in his disengaged family. Regularly Dad would lay around, depressed after losing his job or some other defeat, and Mom and two older sisters would then give Dad much care and attention. In client's pro-symptom position his purpose is to get the experience of being taken-care-of that he was deprived of, and his method of getting it is to show unsuccess and defeatedness as Dad did.

Negative necessity of having the symptom. How is *not* having the symptom a *negative?* Example of a sentence stem that elicits the *negative* necessity of underachieving—either how having the symptom avoids something negative, or how *not* having the symptom *brings* something negative:

Th: Picture your parents, siblings, and wife and 'try on' saying to them, **"If I have my own big successes and you see me as really capable and doing well,—**"

Cl: If I have my own big successes and you see me as really capable and doing well— then you'll *never* give me any help or caring, and no one *ever* will.

Same pro-symptom emotional reality as above then emerges. (After discovery of this material, an *integration experience* is needed, typically consisting of an overt statement of it by client, such as: "I didn't get taken care of and that's not ok. I hate achieving so little, but being too messed up to succeed, like Dad, is my only hope of getting you [parents, spouse] to really notice and care about me and take care of me. If I'm strong and successful you'll never want to take care of me.")

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Exercise: Sentence Completion Role-Play

The following two scripts *demonstrate how sentence completion comes into use within the flow of a session, for creating a discovery experience of a pro-symptom position. (Also shown are the use of two techniques for creating integration experiences: the "What's the connection?" technique and the creation of an index card post-session task.)*

These scripts can be read aloud as an action-learning exercise, with a suitable person reading the role of client. Reading these scripts aloud, even mechanically, will help build a working knowledge of Coherence Therapy methods. Segments labeled "Therapist thinks" should be read aloud also, as if thinking aloud.

Part 1. Eliciting the *positive* necessity of the symptom

Therapist: What difference do you want your sessions with me to make for you?

Client [male]: Well I'm 38 and I'm just not getting anywhere with my life. Like I'll change jobs after a year instead of sticking with anything and getting somewhere with it. Even my friends keep saying, "Hey man, how come you always aim so low?" And I have to admit they're right, and I've been like that since I can remember, so I'm thinking hey, if I don't get a grip on this I'll still be getting nowhere when I'm 48 or 58.

Therapist thinks: [The "symptom" seems to be lifelong *underachieving*. For Coherence Therapy, my job here is to bump him into *his own purpose* for underachieving, and to *learn from him* how underachieving is actually very *necessary* in some unrecognized way. It's highly likely that his driving purpose for underachieving is based in family-of-origin relationships, so I'll probe there first.]

Therapist says: Mm-hm, I see. So let's begin to find what's holding this pattern in place. What I'd like you to try out, if you're willing, is to picture your family—your parents and siblings—and then, as you're looking over at them, you'll try out saying out loud to me, **"When they see me always failing to achieve anything, part of me hopes they will—"** You'll just mechanically say those words and then let the sentence finish itself, without pre-thinking it. Willing to try that?

Client: Hey, if it'll help change this, sure.

Therapist: OK, so picture your family—maybe in some familiar room in their house—and it doesn't have to be a vivid picture—maybe see them on a video screen or a movie screen if that helps. Eyes open or eyes closed, whatever works for you. [Pause.] Got 'em there?

Client: [Keeps eyes open.] Yeah.

Therapist: Good. And while you're looking at them, say out loud to me, "When they see me always failing to achieve anything, part of me hopes they will—" and then let it finish itself without pre-thinking it.

Client: When they see me failing to achieve anything, part of me hopes they will— [Pause.] Part of me hopes they'll notice.

Therapist: Good, good. Keep going—say it again and let it finish itself again. Let's see what else wants to finish that sentence. "When they see me always failing to achieve anything, part of me hopes they'll—" Say the whole thing again.

Client: When they see me failing to achieve anything, part of me hopes they'll— [Pause.] Part of me hopes they'll notice and fucking *care*.

Therapist: Good. You're good at this. Keep going—again from the top.

Continued…

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Exercise: Sentence Completion Role-Play (CONT'D)

Client: When they see me failing to achieve anything, part of me hopes they'll—[pause; chin quivers]—damn, all of a sudden I'm like really flashing on this thing that would happen every few months, where my Dad like caves in because he's like, totally defeated or something, and he stays in bed for days and he hardly talks, and the gloom is like, really heavy. And my Mom and sisters are like suddenly all concerned about him and catering to him and trying to help him feel ok again.

Therapist thinks: [He just revealed a powerful purpose for underachieving: He was emotionally neglected and was always starving for attention and being taken-care-of. He saw his father receive big doses of caring attention by "caving in" and being "defeated." In the client's emotional world, to appear to be well is to be neglected and alone. To appear to be seriously collapsed is to get noticed and cared-about. His passionate purpose here is to get caring attention and to matter to his family members; and his blatant underachieving is his very means of appearing collapsed and defeated in order to get that caring attention, like Dad did. Next I've got to usher him into actually experiencing for himself his purpose and his way of trying to carry it out.]

Therapist says: I see. That sounds very important. So tell me: *What's the connection,* if any, between your own very visible underachieving, and how Dad would get all that caring attention in the family?

Client: [Looks confused.] You lost me.

Therapist: How did *Dad* get family members to notice and care about *him*?

Client: By caving in. Like he's going under.

Therapist: So, what's the connection, if any, between Dad getting all that caring attention by being visibly defeated and caved-in; [pause] and your *own* hunger for being noticed and cared-about, and *you* being visibly unsuccessful?

Client: Oh, *man!* I'm trying to get it the way *he* got it! Damn!

Therapist: I see—you're trying to get it the way *he* got it. Do you mean, you're trying to get personal, caring attention by being defeated and caved-in like Dad, because you saw that work for him? Is that it?

Client: That's it, that's it. Damn!

Therapist: How about if I just write that on a 3-by-5 card for you to look at every day, just as a way to stay in touch with this? Because you'll be much more able to change your pattern of "getting nowhere" if you stay in touch with this emotional truth of why you do it. Follow me?

Client: Yeah—that makes sense.

Therapist: Hmm—I wonder if you also feel like some of that personal attention is *owed* to you.

Client: Damn *right* I do!

Therapist: So let's put that on the card too. [Thinks; writes.] How's this: "I hate achieving so little, and it could derail my whole life, but my only hope for getting noticed and taken-care-of is to be defeated and caved-in like Dad. I'm <u>owed</u> being taken-care-of and I <u>insist</u> on getting it! If I seem strong and successful I'll <u>never</u> get it, so I've <u>got</u> to seem unsuccessful and defeated, even if then my life crashes and burns."

Client: Yeah—that's it. Geez.

Therapist: Good. Look at the card every day just to stay in touch with the emotional truth of that. Don't try to change it yet. Just stay in touch with it—just like you are right now. OK?

Client: Got it.

End of Part 1.

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Exercise: Sentence Completion Role-Play (CONT'D)

Part 2. Eliciting the *negative* necessity of the symptom

Therapist: What difference do you want your sessions with me to make for you?

Client [male]: Well I'm 38 and I'm just not getting anywhere with my life. Like I'll change jobs after a year instead of sticking with anything and getting somewhere with it. Even my friends keep saying, "Hey man, how come you always aim so low?" And I have to admit they're right, and I've been like that since I can remember, so I'm thinking hey, if don't get a grip on this I'll still be getting nowhere when I'm 48 and 58.

Therapist thinks: [The "symptom" seems to be lifelong *underachieving*. My job here is to bump him into *his own purpose* for underachieving, and to *learn from him* how underachieving is actually very *necessary* in some unrecognized way. It's highly likely that his driving purpose for underachieving is based in family-of-origin relationships, so I'll probe there first.]

Therapist says: Mm-hm, I see. So let's begin to find what's holding this pattern in place. What I'd like you to try out, if you're willing, is to picture your family—your parents and siblings—and then, as you're looking over at them, you'll try out saying out loud to me, **"If I have my own big successes and they see me as really capable and doing well,—"** You'll just mechanically say those words and then let the sentence finish itself, without pre-thinking it. Willing to try that?

Client: Hey, if it'll help change this, sure.

Therapist: OK, so picture your family—maybe in some familiar room in their house—and it doesn't have to be a vivid picture—maybe see them on a video screen or a movie screen if that helps. Eyes open or eyes closed, whatever works for you. [Pause.] Got 'em there?

Client: [Keeps eyes open.] Yeah.

Therapist: Good. And while you're looking at them, say out loud to me, "If I have my own big successes and they see me as really capable and doing well,—" and then let it finish itself without pre-thinking it.

Client: If I have my own big successes and they see me as really capable and doing well,—[pause]— I won't feel like such a fuck-up around them.

Therapist: Good. Keep going—say it again and let it finish itself again. Let's see what else wants to finish that sentence. "If I have my own big successes and they see me as really capable and doing well,—" Say the whole thing again.

Client: If I have my own big successes and they see me as really capable and doing well—[pause]—my Mom will get off my back.

Therapist: Good. Keep going—again from the top. And this time, see if it's really *all* positive for you if they see you as capable and doing well. See if anything comes up to finish the sentence, that's about it being in some way *not* so great if they see you as having successes and doing well.

Client: If I have my own successes and they see me as capable and doing well,—[pause]— It's kinda like there they are, looking at me and sort of impatiently saying, "Okay, okay." Like, being successful is just what I ought to be doing; like it's *bothering* them to have to pay attention to that or give me some kind of credit or strokes for it or anything.

Therapist: I see. So go ahead and say the sentence again and let the words for *that* finish it.

Client: If I have my own successes and they see me as capable and doing well—it's a big nothing.

Continues…

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Exercise: Sentence Completion Role-Play (CONT'D)

Therapist: Good. Again.

Client: If I have my own successes and they see me as capable and doing well—I might as well be the wallpaper! Or like I'm a plant over in the corner.

Therapist: Like if you're doing well, then you don't get any caring attention; you're taken for granted and forgotten about.

Client: Exactly.

Therapist thinks: [If doing *well* results in *not* getting attention, his purpose for doing *poorly* might be to *get* attention and avoid being neglected—taken for granted like wallpaper. Hmm, how can I probe for *that*?]

Therapist says: That sounds like an important emotional truth—that if the family is there in the room and if you were to say, "I got an A on a spelling test!" or "I got a raise and a promotion!", they'd be sort of bothered by having to pay attention to that.

Client: Right.

Therapist: All children have a deep need to receive caring attention, and I'm learning from you that getting it was a problem for you in your family. Doing *well* at things *didn't* get you any caring attention and worse, it made you fade into the background. So tell me: *What's the connection,* if any, between your pattern of doing *poorly* at things, and your struggle to get caring attention from your family?

Client: Say that again?

Therapist: What's the connection, if any, between your pattern of doing *poorly* at things, and your struggle to get caring attention from your family?

Client: Hmm. All of a sudden I'm like really flashing on this thing that would happen every few months, where my Dad like caves in because he's like, totally defeated or something, and he stays in bed for days and he hardly talks, and the gloom is like, really heavy. And the thing is, my Mom and sisters are like suddenly all concerned about him and catering to him and trying to help him feel ok again.

Therapist: I see. Dad *did* get lots of caring attention when he did very *poorly*—caved in, defeated.

Client: Yeah, right. Man—I never thought about it like that before.

Therapist: Mm-hm. So what's the connection—between Dad getting all that caring attention by being visibly defeated and caved-in; and your *own* hunger for being noticed and cared-about, and *you* being visibly unsuccessful?

Client: Oh, *man!* I'm trying to get it the way *he* got it! Damn!

Therapist: I see—you're trying to get it the way *he* got it. Do you mean, you're trying to get personal, caring attention by being defeated and caved-in like Dad, because you saw that work for him? Is that it?

Client: That's it, that's it. Damn!

Therapist: How about if I just write that on a 3-by-5 card for you to look at every day, just as a way to stay in touch with this? Because you'll be much more able to change your pattern of "getting nowhere" if you stay in touch with this emotional truth of why you do it. Follow me?

Client: Yeah—that makes sense.

Therapist: Hmm—I wonder if you also feel like some of that personal attention is *owed* to you.

Continues…

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Exercise: Sentence Completion Role-Play (CONT'D)

Client: Damn *right* I do!

Therapist: So let's put that on the card too. [Thinks; writes.] How's this: "I hate achieving so little, and it could derail my whole life, but my only hope for getting noticed and taken-care-of is to be defeated and caved-in like Dad. I'm owed being taken-care-of and I insist on getting it! If I seem strong and successful I'll never get it, so I've got to seem unsuccessful and defeated, even if then my life crashes and burns."

Client: Yeah—that's it. Geez.

Therapist: Good. Look at the card every day just to stay in touch with the emotional truth of that. Don't try to change it yet. Just stay in touch with it—just like you are right now. OK?

Client: Got it.

End of Exercise Part 2.

Techniques for Discovery Experiences: Symptom Deprivation

Symptom deprivation is used to discover the unwelcome or dreaded consequences that would result from living without the symptom. The client is guided to imaginally experience being without the symptom in the very circumstance in which normally she or he produces the symptom. Because the symptom is in some way highly important to have, being without it is likely to result in experiencing something distinctly unwelcome, some specific dilemma or distress. This unwelcome experience points directly to the client's pro-symptom position, which consists of knowledge of this dilemma or distress and of how to avoid it by having the symptom.

Symptom deprivation is not to be confused with the "miracle question" that is central to solution-focused brief therapy. Although both techniques prompt the client to construct and sample a symptom-free state, the strategies and goals they serve are paradigmatically different.

For case examples of symptom deprivation, see pp. 21, 22-23, 31, 26, 28 (item B).

Continued...

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Techniques for Discovery Experiences: Symptom Deprivation

Basic procedure for symptom deprivation

1. **Prompt client to experience being in a concrete situation in which the symptom happens distinctly**—either by recalling and imagining being in the midst of such a situation, or by focusing on a real-time occurrence of the symptom during the session. (This is the *engagement* condition. In any situation in which the symptom is happening, the pro-symptom position is engaged and therefore most available for being brought into conscious experience.)

2. **Guide client to be without the symptom in this situation.** Many different styles of prompting can be used. For example, "If you're willing, see what you experience in this situation if you *don't* [feel, think, or do the symptom]. Purely through imagination, see what you experience if [the symptom] isn't happening."

   Use concrete, vivid prompts. "You walk into the room, you see your brother—and if the anxiety just isn't there—hands are staying dry, breathing's staying easy—see what you start to experience."

   If resistance to this exercise arises and blocks it, use the "double dissociated" version: Have client imagine viewing a video or movie screen and seeing him- or herself in that situation but without the symptom. Nearly always this is tolerable for the client and the exercise goes forward.

3. **Guide client's attention to unwelcome effects of being without the symptom.** "And as you look at your brother with this easy breath and dry hands, notice also, right along with how it may feel *better* to be without the anxiety, whether there is also anything *un*comfortable or *un*welcome that crops up for you now, in how your interaction with him goes, or how you feel there with him, with no anxiety happening." Persist! "If you're free of anxiety, and there he is, how do you start to feel instead? Or say, or do?"

4. **If an unwelcome experience arises, invite full articulation of it from client and then mirror back to client.** For example, "So if you do not feel any anxiety, then what comes is this very unwelcome feeling of strong anger at him." This is an initial, partial surfacing and naming of client's pro-symptom emotional reality (client's anxiety is necessary in order not to feel his anger). Further deepening and unpacking is then pursued. What is the anger about? Specifically what makes the anger too uncomfortable or dangerous to feel? What might happen? Etc.

5. **If no unwelcome experience arises** despite full, cooperative, sustained experiential scan by client, take this as an indication that the symptom may be functionless (a coherent by-product of something else; see #4 on p. 9). Move on to pursue the line of discovery effective for functionless symptom, described on p. 25 as the *two-step* technique.

Alternate forms of symptom deprivation

- Assign an anti-symptom measure (such as how to reply constructively to spouse or a plan for not procrastinating a particular task) knowing the client's psp will thwart it, and then use the thwarting event to elicit the operative psp.
- Regard as the symptom the client's adherence to a discovered, longstanding, underlying emotional reality (such as, "I'm unsafe everywhere"). Assume client remains parked in that version of reality for a yet deeper purpose. To discover that purpose, carry out deprivation of that entire version of reality.

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Techniques for Discovery Experiences: Symptom Deprivation

Case example: Symptom deprivation of low self-worth

Client: Woman who recently received new level of professional recognition as a performer, and ever since has an ongoing self-talk accusing herself of being "undeserving" and an "imposter."

Three pro-symptom positions discovered through repeated symptom deprivation

Symptom deprivation #1: Therapist prompts client to imagine "allowing it to be true that you're good enough" to deserve the enhancements that her success is now bringing. Result: Immediate tears and surfacing of sharply painful grief. To elicit further, therapist later asks: "Do you mean, if you're recognized now as being talented, gifted, worthy of all this attention—then it means you *were* that all along?" Client cries in anguish and replies, "Yeah—that's *really painful*. For some reason that really *hurts*... I don't know if it's that I feel like I wasted *time*, or—something just feels very *unfair*." In this discovery experience, two different emotional truths (two pro-symptom positions) have surfaced by being without her self-devaluing: she feels both a deeply painful grief over wasted decades and a deeply disturbing sense of injustice in life for allowing this to happen. Both sufferings disappear by devaluing herself, which is why her self-devaluing is necessary.

Symptom deprivation #2: Therapist: "So, look at your parents, or maybe more at your mother. And, as you look at her, I want you to—get a real sense of what happens to your connection with her, as it is—your sense of relationship to her, as it is—as you become successful, famous, recognized; really convinced yourself that you *are* talented, gifted—"

Cl: It becomes—my connection with her—she becomes *smaller*. [Laughs.] I have a sense her shrinking, like "the incredible shrinking woman."
Th: OK. Keep going with that. See if you can allow that to happen.
Cl: She, she—yeah, she gets very little.
Th: Mm-hm. And—visually, she's getting very little. (Cl: Yeah.) Th: And what about your *feeling* of relationship to her—does that change, along with that?
Cl: Umm—she becomes sort of this peripheral—kind of this adjunct, on the periphery.

This is the discovery of a position in which self-devaluing is needed because it effectively keeps her in shared reality with mother and avoids loss of her original attachment to mother.

Between-session task of integration

Real-time recognition (use of symptom as a signal): "Whenever you notice thoughts of being undeserving or an imposter, they're now your *signal* to remember, right then, and actually feel these two big ways it's important *not* to accept you're talented: *[Written on* ***index card****:]* "It's much too painful to feel the unfairness and the waste of so many years of my life; and I don't want my mother to be small and peripheral in my life. I don't have to feel any of that if I just think I'm *not* talented."

Outcome. Client reported lasting cessation of regarding herself as an undeserving imposter when she receives recognition of being talented.

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Exercise: Symptom Deprivation Role-Play

In the following script, *client and symptom are same as in the previous scripts demonstrating sentence completion (pp. 15-19), but now symptom deprivation is used instead for creating the discovery experiences.*

Therapist: What difference do you want your sessions with me to make for you?

Client [male]: Well I'm 38 and I'm just not getting anywhere with my life. Like I'll change jobs in a year instead of sticking with anything and getting somewhere with it. Even my friends keep saying, "Hey man, how come you always aim so low?" And I have to admit they're right, and I've been like that since I can remember. I'm still living in the same neighborhood where I grew up, where my parents live. I'm thinking hey, if don't get a grip on this I'll still be getting nowhere when I'm 48 and 58.

Therapist thinks: [The "symptom" seems to be lifelong *underachieving*. My job here is to bump him into *his own purpose* for underachieving, and to *learn from him* how underachieving is actually very *necessary* in some unrecognized way. Let's deprive him of this symptom and see if something unwelcome surfaces. His purpose for underachieving is likely to be rooted in family-of-origin relationships, so let's deprive him of it in the presence of his family.]

Therapist says: Mm-hm. OK, let's begin to find what's holding this pattern in place. What I'd like you to try out, if you're willing, is to just imagine something: Imagine you've stayed with your job for 18 months now; and your boss is telling you he's giving you a small raise and a modest promotion, or a modest expansion in what you're responsible for. Willing to just imagine that?

Client: Hey, if it'll help change this, sure.

Therapist: OK, go ahead. Eyes open or eyes closed if that helps imagine it like it's happening. Go ahead and picture your boss calling you in and telling you he's giving you a raise and more responsibility. [15-second pause.] Got that? Good. And that was on a Friday. Now let the scene change. Now it's Sunday, and you're over at your parents' house for a while. [Pause.] Got that?

Client: Mm-hm. [Pause.] We're watchin' a game on TV. My brother's there too. Mom's around.

Therapist: OK. You're watching the game, and then there's a commercial; and you say, "Hey, my boss called me in on Friday, gave me a raise and some new responsibilities."

Client: [Silent; now has an impassive, stiff look.]

Therapist: How is it to say that to them?

Client: [Pause.] I haven't yet.

Therapist: [Gently.] How come?

Client: Dunno. Can't even remember what you asked me to say.

Therapist thinks: [Excellent: He's in strong resistance to being without his underachieving. *Having* his underachieving is so important to his pro-symptom position that it won't even let him sample the experience of coming across to family members as achieving instead of underachieving. I can draw out his psp by welcoming and empathizing with its resistance.]

Therapist says: I was asking you to just mention about getting a raise and a promotion. Is it comfortable or somehow not so comfortable to do that?

Client: Seems not so comfortable! It's weird—I keep just totally tuning out.

Continues…

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Exercise: Symptom Deprivation Role-Play (CONTINUED)

Therapist: OK, let's respect that: Some part of you seems to be not ok with saying you got a raise and a promotion, so let's take a step back.

Therapist thinks: [How can I usher him to get more in touch with this resistance as his own self-protection? Ah yes, a simple *overt statement* of the resistance could do it.]

Therapist says: How about if you just try out saying to *me,* "I better not tell them I got a raise and a promotion"? See if that fits for you: "I better not tell them I got a raise and a promotion."

Client: I better not tell them I got a raise and a promotion. [Slightly squirms in his chair.]

Therapist: Does that fit?

Client: Yeah, yeah, but—it's like it's making my palms sweat to say it.

Therapist: I see. Something seems pretty uncomfortable about you doing well and feeling you better keep it hidden.

Client: I'll say.

Therapist: I wonder what makes it so uncomfortable to do well and then feel you better keep it hidden. Any inkling? [Pause.] Some part of you knows something about doing poorly and doing well, and how that plays out in your family.

Client: When you said that—I'm just flashing on 3rd grade all of a sudden. Up til then I was this good student, y'know? Good kid. My brother—he's two years older—he was always in trouble and screwing up, and my parents were always all involved with him over it. Well I got like a 94 on some exam and I came home and tried to show it to my folks but they were totally wrapped up in dealing with some worst-yet thing my brother was just caught at, and my Dad just turned to me and said, "Not now!" And later that night my brother pinned me down and made his drool hang down right near my face and called me "teacher's pet" and "total wimp" and shit like that.

Therapist: Let me see if I really get it: Doing well at things makes you sort of fade into the background in your family—you don't get much personal attention at all. And there's your brother doing really *poorly* and getting *loads* of personal attention for it. And you might even get sort of tortured for doing well.

Client: I never thought about it like that before, but yeah, I couldn't have put it better myself.

Therapist: So let's bring that back into that scene you were imagining before—in front of the TV on Sunday at your folks' house. OK? And in that scene, just privately think to yourself what we just acknowledged—something like, *"Better not say anything about my raise and promotion, or my 94. That's not how to get caring attention in our family. Personal attention in our family goes to whoever's doing really poorly. My only chance for any special attention is if I seem to be doing really poorly."* [Later in session, these words go onto index card for daily reading.]

Client: [Pause.] Oh, man—it's so true but it's not new, it's *old,* really *old,* but it feels so new to, like, face it or say it like that. [Pause.] Y'know, now I'm flashing on this thing that would happen every few months, where my Dad like caves in because he's like, totally defeated or something, and he stays in bed for days and he hardly talks, and the gloom is like, really heavy. And the thing is, my Mom and sisters are like suddenly all concerned about him and catering to him and trying to help him feel ok again. It's the *same thing.* Man—I never thought about it like that before.

End of exercise

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Techniques for Discovery Experiences: Two-Step

Two-step is effective if symptom is a by-product (functionless), which therapist cannot know in advance.

Procedure of two-step technique

1. Ask client, "What shift of any kind would you have to make, so that [the symptom] would really diminish or even stop? What change in your perspective, or attitude, or behavior?"

   If necessary, (a) tell client you are asking him/her to scan the possibilities by imagining trying them out, not by speculating intellectually, (b) toss out various possible shifts of different types. Persist.

2. Discover how it is important *not* to make the shift that client has found would dispel the symptom: Invite client to imagine *making* this shift in a relevant situation, and guide client to bump into the unwelcome consequence of making that change. (Same process as symptom deprivation technique.)

   This surfaces a theme and purpose for not doing what would eliminate the symptom. This theme and purpose is the pro-symptom position: The presented symptom is a necessary by-product of this theme and purpose for not doing what would eliminate it.

   Stay right there and integrate: For example, ask client, "Which is worse: Having [the symptom], or doing [the shift] to be free of it and living with [the unwelcome effect]?" Client will find that worse is doing the shift to be free of the symptom. Then, collaboratively shape and have client speak an overt statement that captures this finding—something of the form, "It's so important to me to avoid [the unwelcome effect] that comes with doing [the shift] to dispel [the symptom], that it's worth enduring [the symptom]." Preface if necessary with, "I hate to admit this, but—" if this helps client.

Example of two-step technique: Woman with paralyzing anxiety

A female client described ongoing, "paralyzing" anxiety and feeling intensely vulnerable to disaster. She also described several concurrent assaults endangering her family—legal, financial and social attacks that were understandably frightening. After several unsuccessful attempts at surfacing a position or emotional truth necessitating her particular experience of intense, debilitating anxiety, the therapist asked the question that begins the two-step.

After an extended reflection in silence, the woman said that what would diminish her anxiety was "fighting back." The therapist, who had no idea she was not fighting back, next guided her to imagine fighting back in specific ways visible to all concerned. This brought distinct discomfort: to fight back is to be seen as a "troublemaker" and as "crazy." It then emerged that being a Good Girl was her lifelong identity in her strict Catholic family and that such unalloyed goodness was to bring her a good life with protection from bad things happening, as well as a heavenly hereafter. The urgent purpose in her pro-symptom position was to preserve her status as a Good Girl, which requires not fighting back even though under attack, and this in turn, as a by-product, necessarily results in her feeling utterly open to disaster and overwhelmed by anxiety—her presenting symptoms.

Sentences capturing this emotional truth were formed and written on an index card for daily reading: "My life is supposed to be the life of a Good Girl. I'm not willing to give that up! If I get fierce, to fight a battle, I'd seem like a troublemaker and crazy and no longer *be* a Good Girl. So, I'm *not* going to be a fighter and get fierce, even though that leaves me so endangered and so unable to protect us that I'm full of anxiety." She reported several months after this session that, feeling and owning this previously unconscious position, she immediately found her anxiety "hugely eliminated" and very soon began fighting back actively.

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Techniques for Discovery Experiences: Direct empathic eliciting

Direct empathic eliciting is a straightforward and transparent guiding of the client into experiencing the underlying emotional basis of the symptom. An overt expression of coherence empathy, direct empathic eliciting is useful in two ways, described below: for accessing childhood experiences in which a pro-symptom position was first formed; and for further accessing of newly emerging pro-symptom material.

Accessing childhood experiences in which pro-symptom position was formed

The therapist focuses the work on childhood experiences in Coherence Therapy only if that helps to access underlying pro-symptom emotional themes and purposes driving symptoms. (Frequently, pro-symptom positions are fully accessed and transformed without any reference to the past at all.)

Focusing on childhood experiences is not actually a search for causes in the past. Rather, it is a search for a cause in the present—a cause in the form of an emotional reality-construction which, though formed in the past, is now still carried in the present and requires the client's symptom(s). The client thinks, "we're going into the past," but a Coherence Therapy practitioner understands that present symptoms are maintained only by reality-constructs existing in the present, even if formed in the past. The past literally exists in the present, in and as those constructs.

Below are useful forms of direct empathic eliciting of early experience. Speak relatively slowly (but not too slowly), with an empathic tone (but not too empathic). Underlining indicates key phrases:

- "What in your life might make sense of [feeling so afraid of being alone]? Some part of you knows something about [being alone]. What have you experienced of [being alone] that may have led you to form such a strong [avoidance of it]? [Pause.] Take a guess."
- "Is there something familiar to you about that experience of [feeling both trapped and humiliated]? Is that familiar in some way, in your life?"
- "Did someone in the past behave in the way that you now expect others to do, [attacking you for the slightest thing that isn't perfect]?"

These questions can be used either right after the client has newly presented a symptom or problem, or later on, whenever material has emerged that strikes you as suitable for this step. Not all symptoms readily link to original experiences in this way, even if arising from emotional schemas first created in childhood. If nothing emerges from using these questions, stop fishing for childhood experience and switch to another way of creating a discovery experience.

If these questions do put the client in touch with early scenes and experiences, she/he will probably describe them in talk-about mode (factual account of what happened). As a rule you should then—quite soon, within minutes—invite a shift into experiential mode (client subjectively inhabits those scenes and experiences, talking now *from* and *in* them) by applying any of the techniques described in these pages, or others you may know, for creating further steps of discovery or integration. As always, each step should be designed so that it does not bring more emotional intensity than is workable for the client.

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Discovery Experiences: Rapid Surfacing of Emotional Schemas

Techniques for Discovery Experiences: Direct empathic eliciting

Further accessing of newly emerging pro-symptom material

When for the first time the client has just expressed something verbally or nonverbally that the therapist recognizes as being a pro-symptom position's viewpoint or feeling, immediate use of direct empathic eliciting can be an effective way to deepen into this material and bring the pro-symptom theme and purpose more fully into conscious experience.

Example: Client feels non-competent, non-confident, and therefore anxious at work, despite being in fact highly competent and having an impressive track record. Therapist creates a symptom deprivation experience by guiding client to imagine attending a daily company meeting, making a few brief comments, and feeling confident in his knowledge while doing so. Imagining this, client starts to feel an unwelcome result, which begins to reveal a pro-symptom position:

Cl: Now I'm feeling really uncomfortable, but—in a different way. A new way.

Th: [Direct empathic eliciting:] OK, let yourself feel it—this new discomfort. See if any words come along with this uncomfortable feeling.

Cl: [Pause.] Now they hate me.

Th: [Direct empathic eliciting:] Now they hate me. Good; keep going: See if this really uncomfortable feeling also knows *why* they hate you now.

Cl: [Pause.] Huh. Wow. It's because—now I'm—an arrogant asshole—like my father—a totally self-centered, totally insensitive know-it-all.

Th: Having a feeling of confidence as you spoke turned you into an arrogant asshole, like Dad?

Cl: Yeah, exactly. Wow.

Th: And how do feel about being like him?

Cl: It's horrible! It's what I've always vowed *not* to be!

Th: [Overt statement technique:] So, would you try out saying to me, "Feeling *any* confidence means I'm arrogant and self-centered like Dad, so I've got to *never* feel confident, ever."

Imaginal interaction techniques

A wide range of guided experiential techniques can be applied in service of Coherence Therapy methodology:

- Gestalt-type imaginal dialogues with others or between "parts"
- Jungian active imagination
- Experiential dreamwork
- Guided visualization
- Sandtray
- Inner child work
- Mind-body communication
- Psychodrama techniques

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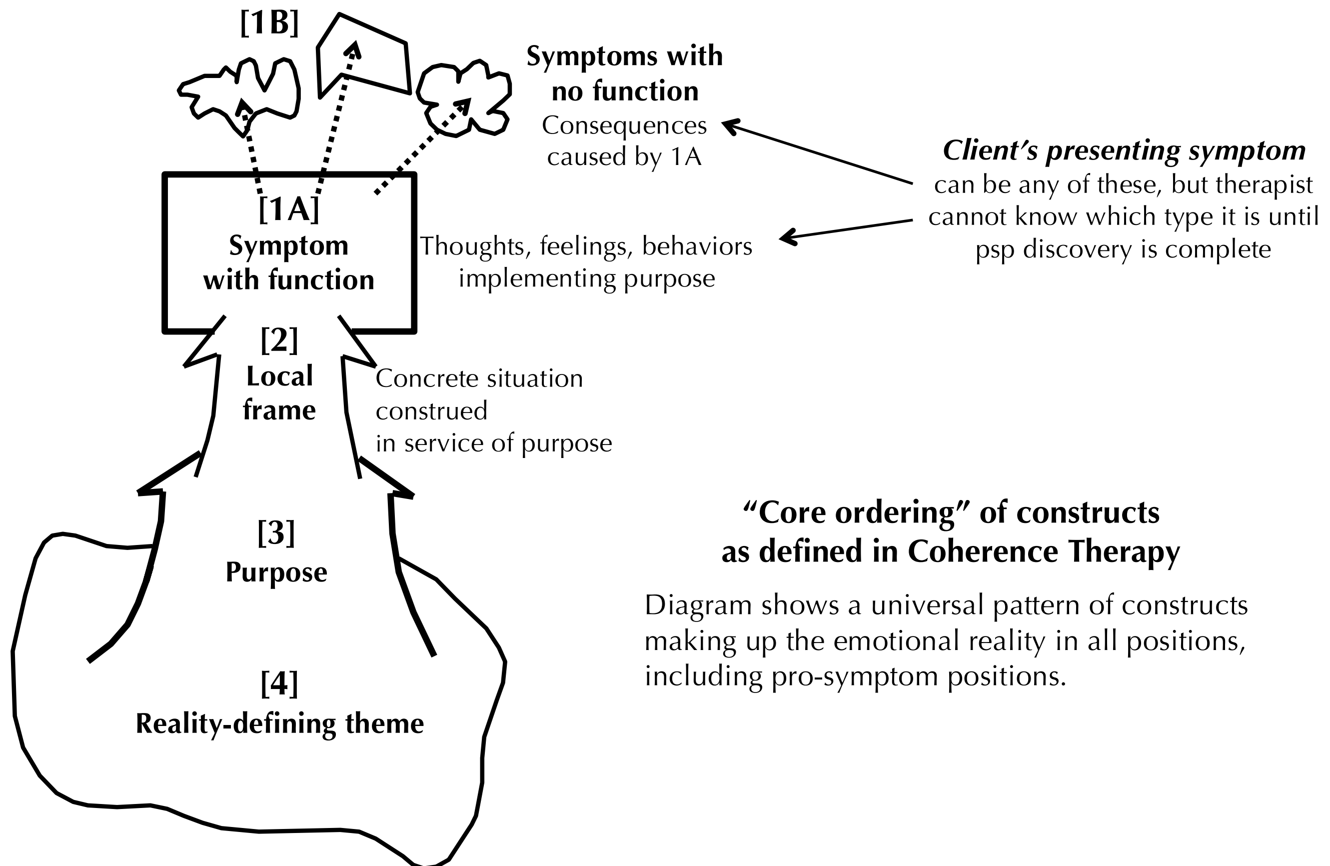
How Emotional Schemas Are Organized

Anatomy Diagram of Pro-Symptom Position



Case Example	**[4] Theme** (UNCONSCIOUS*)	**[3] Purpose** (UNCONSCIOUS*)	**[2] Situation construed** (UNCONSCIOUS*)	**[1A] Symptom with function**	**[1B] Symptom without function**
Always hiding her truth (p. 14)	Others are fragile and my truth is too much for them, devastates them and drives them away. I plunge into aloneness and guilt that I cannot bear.	Never say the words of my truth or knowledge to others, so they won't crumble and go away.	I'll get to stay in this case consultation group only if I'm quiet and go along with whatever is said.	Is unassertive, compliant, avoidant of interaction and attention. Hides her truth. *(Functional symptoms)*	Negative judgments toward self for being an outsider, socially marginal, isolated. *(Functionless presenting symptom)*
"Black cloud" of depression (p. 32)	Everything I know, do or care about is wide open to being taken over by Mom and others; I have no walls and no walls are allowed; I can never safely have my own life inside or outside.	I've got to be blank, all erased, to be safe from being robbed painfully of anything I feel, know or do.	Writing grant proposals for nonprofits is the right job for me because I have no interest or motivation for it at all—I can stay blank and safe.	Feels no motivation or interest at all in anything. *(Functional presenting symptom)*	Feels "black cloud" of depression, hopelessness about herself and her future. Low self-worth: negative judgments toward self for being a "vegetable." *(Functionless presenting symptoms)*
"Paralyzing" anxiety & vulnerability (pp. 24, 53)	A Good Girl is protected and has a good life; bad things will not happen to her.	Never make trouble or I won't be that Good Girl and have that protected, good life.	These bad things happening means I haven't been Good enough. I'm unprotected! I've got to be even more Good and make *no* trouble, to get the bad things to stop.	Doesn't fight back even while under attack. *(Functional but unpresented, unconscious symptom)*	Feels wide open to disaster and intense anxiety. *(Functionless presenting symptom)*

*Unconscious constructs are emotional/perceptual knowings that do not exist in verbal form prior to becoming conscious and verbalized.

Symptoms with and without functions: How to distinguish

After full discovery of client's pro-symptom position, including the pro-symptom *purpose* and the client's specific way of carrying out that purpose, it becomes clear to the therapist whether the presenting symptom is itself the *very means* of carrying out that purpose. If it is, the symptom has the function of carrying out that purpose (symptom is 1A in anatomy diagram above). If not, the presenting symptom is a *by-product* or *derivative effect* (1B in anatomy diagram) caused in turn by whatever is the client's means of carrying out the pro-symptom purpose.

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How Emotional Schemas Are Organized (CONTINUED)

The Four Forms of Symptom Coherence

Emotional truths:
Four different ways in which symptoms are coherently "necessary" to have

A symptom is produced by a person because he or she is currently harboring at least one of the following four types of unconscious emotional reality (personal schema) within which the symptom is necessary to have. The mind has native capacities to access and to transform all four types of emotional reality.

Through the discovery work, the therapist *learns from the client* which of these four types of emotional truth or pro-symptom position is the case. As a rule the therapist does not and cannot infer and diagnose the correct type from the client's presenting symptoms. Understanding the various possible types of emotional truth helps the therapist recognize which type the client's emerging material is revealing.

A. A pro-symptom position in which the presenting symptom is necessary because it is the *very means* of carrying out a compelling purpose or function.

Within this pro-symptom position:

- Having the symptom is in some specific way very needed and desirable, and/or…
- Not having the symptom is in some specific way very undesirable

The symptom is element 1A in psp anatomy diagram, p. 28.
Case examples: pp. 22, 32, 55, 56, 61.

B. A pro-symptom position in which the presenting symptom has no function but is an inevitable (necessary) by-product of some relied-upon way of carrying out a compelling purpose.

In other words, the presenting symptom is a merely derivative effect necessitated by some other symptom, possibly unpresented or unconscious, which does have a function (the function being to carry out the vital purpose that exists in this position).

The presenting symptom is element 1B in psp anatomy diagram, p. 28.
Case examples: pp. 25, 32 (example B), 57, 82.

C. A pro-symptom position in which an existentially valid and unavoidable feeling, desire or need is necessary not to have or acknowledge because it brings negative meanings and/or dangers.

This type of psp can be considered a variation of type A above.
Case examples: pp. 32 (example C), 48 (example C).

D. A pro-symptom position consisting of a traumatic memory that breaks into awareness.

The presenting symptom is some part of an earlier traumatic experience reoccurring as a flashback, though it may not initially be apparent to client or therapist that the symptom is a flashback.

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How Emotional Schemas Are Organized (CONTINUED)

Layer-cake view of psp shows the same stack of constructs as in the anatomy diagram, listed as a table.

Example: Woman with "black cloud" of depression (Example B on p. 32).

Pro-symptom position as verbalized in session: "My mother takes everything! She 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? So I erased myself, so she couldn't keep doing that to me."
Layer-cake view of how the constructs making up this psp are organized:

ORDER OF CONSTRUCT	CONSTRUCT (nonverbal knowledge as verbalized after becoming conscious)
1st Order ***Concrete response: Overt thoughts, feelings, behaviors***	**A. Feels no motivation or interest in anything** **B1. Feels a "black cloud" of depression, a hopelessness about herself and her future** **B2. Has negative judgments toward herself for being a "vegetable."**
2nd Order (UNCONSCIOUS) ***Meaning of the concrete situation***	**Writing grant proposals for nonprofits is the right job for me because I have no interest or motivation for it at all—I can stay blank and safe.**
3rd Order (UNCONSCIOUS) ***Broad purposes and strategies***	**I've got to be blank, all erased, to be safe from being robbed painfully of anything I feel, know or do.**
4th Order (UNCONSCIOUS) ***Nature of self/others/ world (ontology)***	**Everything I am, have or do is wide open to Mom and others; I have no walls and no walls are allowed; I can never safely be my own person and have my own life.**

· Each construct (and the emotional reality it creates) arises out of the one below it in the table, and in turn gives rise to (is the basis of) the one above it. In this hierarchy of constructs, each construct is *subordinate* to the one below it and *superordinate* to the one above it.

· As a rule, at start of therapy the only conscious parts of a psp are some 1st-order constructs (some of its overt manifestations or "symptoms").

· 3rd- and 4th-order constructs are the core emotional truth of the symptom.

· Constructs lower in the table are more unconscious, more removed from awareness. This hierarchical map defines a four-level scale or metric for the degree of unconsciousness of a given construct.

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Coherence Therapy for Depression

Underlying emotional truth of depression: Three types

A. Depression that directly carries out an unconscious purpose/function

B. Depression that is a by-product of how an unconscious purpose is carried out

C. Depression expressing unconscious despair/grief/hopelessness

A. Depression that carries out an unconscious purpose

Client: Mother who is still in pained, debilitating depression 8 years after her 5-year-old son died after being hit by a car. (To view entire session see video 1096T, *Stuck in Depression*.) The following excerpt shows the creation of discovery experiences that reveal the powerful purpose of staying in depression (a purpose often encountered with clients in the bereavement process).

Th: I want you to look and see if there's some other side of you, some area in your feelings where you feel you *don't* deserve to be happy again.
Cl: Probably the guilt.
Th: The guilt. So what are the words of the guilt?
Cl: That I wasn't outside when he was hit (to prevent it).
Th: I should have been outside.
Cl: I should have been outside.
Th: It's my fault.
Cl: It's my fault.

(About two minutes later:)

Th: Would you try to talk to me from the part of you that feels the guilt. Just from that side. I know there are these other sides. But from the place in you where you feel guilty, where you feel it was your fault that your dear little boy got hit by a truck, from that place, what's the emotional truth for you — from that place — about whether it's OK to feel happy again?
Cl: ...I don't allow myself to be happy.
Th: [Very softly:] How come? How come?
Cl: How come?
Th: Because if you were happy—would you complete that sentence? "I don't allow myself to be happy because if I were happy—"
Cl: I would have to forgive myself. [Pause.] And I've been unwilling to do that.
Th: Good. So keep going. "I'm unwilling to forgive myself because—"
Cl: You know there are parts of me that I think it's about not wanting to go on myself without him. And if I keep this going then I don't have to do that.
Th: I see. So would you see him again? Picture Billy? And just try saying that to Billy. Try saying to him, "I'm afraid that if I forgive myself I'll lose connection with you and I'll go on without you."
Cl: [With much feeling:] Billy, even though I can picture you as a little angel I'm afraid to forgive myself—that you'll go away and I don't want you to go away.
Th: Yeah. And see if it's true to say to him, "It's so important for me to stay connected to you that I'm willing to not forgive myself forever. I'd rather be feeling guilty and not forgiving myself than lose contact with you and move on without you." Try saying that. See if that feels true.
Cl: [Sighs. With much feeling:] Billy, I just feel like I would do anything to keep this connection with you including staying miserable and not forgiving myself for the rest of my life. And you know that's true. [Her purpose for staying in depression is now explicit and directly experienced.]

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Coherence Therapy for Depression (CONTINUED)

B. Depression that is a by-product of how an unconscious purpose is carried out

Client: Lethargic woman, 33, says, "I've been feeling depressed and lousy for years… I have a black cloud around me all the time." She describes herself as having absolutely no interests and as caring about nothing whatsoever, and expresses strong negative judgments toward herself for being a "vegetable." [Details of this example are in the 2002 publication cited in bibliography on p. 85. Several pro-symptom positions for depression were found and dissolved. The following account is from her sixth and final session.]

Discovery via symptom deprivation: Therapist prompts her to imagine having real interests; unhurriedly persists with this imaginal focus. Client suddenly exclaims, "I erased myself!" and describes how "my mother 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? So I erased myself, so she couldn't keep doing that to me." Client now experiences her blankness as her own solution to her problem of psychological robbery, and recognizes her depression to be an inevitable by-product of living in the blankness that is crucial for safety but makes her future hopelessly empty.

Therapist then continues discovery into why "erasing" herself is the necessary way to be safe: Client brings to light a core presupposition of having no boundaries with mother, a "no walls rule." With this awareness dawns the possibility of *having* "walls" so that what she thinks, feels or does remains private and cannot be stolen. She could then safely have interests and accomplishments. This new possibility immediately creates for client the tangible prospect of an appealing future, and she congruently describes rich feelings of excitement and energy.

Outcome: In response to follow-up query two months later, client reported, "It felt like a major breakthrough...this major rage got lifted" and said she had maintained privacy from mother around all significant personal matters. After two years she confirmed that the "black cloud" was gone, she was enthusiastically pursuing a new career, was off antidepressants, and said, "Things are good, in many ways. Things are very good."

C. Depression expressing unconscious despair, grief, hopelessness

Client: Man with long history of a "drop" into depression every Fall. [This one-session example is video 1097SP, *Down Every Year*, available online at coherencetherapy.org. For a multi-session example of working with this type of depression, see "Unhappy No Matter What" in DOBT book, pp. 63-90.]

Surfaced emotional reality: At 10 he formed a belief that he failed parents' expectations so severely that they forever "gave up on me" (he was sent in the Fall from USA to boarding school in Europe, was utterly miserable and begged to come home). Has been in despair ever since, unconsciously.

Outcome: Client subsequently initiated talk with parents about the incident 30 years ago; not once had it been discussed. In this conversation it became real to him that their behavior did not mean they gave up on him, and five months after session reported continuing relief from feeling depressed and inadequate.

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Constructivism in Coherence Therapy

Mind's enormous agency over, and capacity for change in, experiential reality.
Unconscious mind is active, potent organizer/reorganizer of experiential reality.

Present symptoms are produced entirely as an expression or result of constructions of reality presently held and applied. Consistent with developmental views of how and when these constructions were first formed. In Coherence Therapy, the power of the symptom to persist is found by the client to be his or her own power to persist in viewing and responding to the world according to specific emotional learnings.

Unconscious emotional learnings are schemas or models that are directly accessible and changeable in the present, even though first formed in childhood and held for decades. The mind has native processes for both creating and uncreating its renditions of reality.

Recommended readings on the constructivist paradigm of psychotherapy

Greenberg, L. & Pascual-Leone, J. (1995). A dialectical constructivist approach to experiential change. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp.169-191). Washington, DC: American Psychological Assn.

Guidano, V. F. (1995). A constructivist outline of human knowing processes. In M. J. Mahoney (Ed.), *Cognitive and constructive psychotherapies* (pp. 89-102). New York: Springer.

Guidano, V. F. (1995). Constructivist psychotherapy: A theoretical framework. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 93-108). Washington, DC: American Psychological Association.

Lyddon, W. J. (1995). Forms and facets of constructivist psychology. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 69-92). Washington, DC: American Psychological Association.

Mahoney, M. J. (1995). Continuing evolution of the cognitive sciences and psychotherapies. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 39-68). Washington, DC: American Psychological Assn.

Mahoney, M. J. (1995). Theoretical developments in the cognitive and constructive psychotherapies. In M. J. Mahoney (Ed.), *Cognitive and constructive psychotherapies* (pp. 3-19). New York: Springer.

Mahoney, M. J., Miller, H. M. & Arciero, G. (1995). Constructive metatheory and the nature of mental representations. In M. J. Mahoney (Ed.), *Cognitive and constructive psychotherapies* (pp. 103-120). New York: Springer.

Neimeyer, R. A. (1995). An appraisal of constructivist psychotherapies: Contexts and challenges. In M. J. Mahoney (Ed.), *Cognitive and constructive psychotherapies* (pp. 163-194). New York: Springer.

Neimeyer, R. A. (1995). Constructivist psychotherapies: Features, foundations, and future directions. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 11-38). Washington, DC: American Psychological Assn.

Neimeyer, R. A. (1997). Problems and prospects in constructivist psychotherapy. *Journal of Constructivist Psychology, 10,* 51-74.

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Constructivism in Coherence Therapy (CONTINUED)

Constructivism — Definitions & Descriptions

Psychologists . . . use the term "constructivist" to . . . underscore individuals' active participation in reality-making. . . . As an epistemological perspective, constructivism is based on the assertion that humans actively create their personal and social realities.

—Lyddon, W. and McLaughlin, J. (1992). Constructivist psychology: a heuristic framework. *Journal of Mind and Behavior, 13,* 89-107.

* * *

[T]wo basic principles ...:

1) Knowledge is not passively received either through the senses or by way of communication, but it is actively built up by the cognizing subject.
2) The function of cognition is adaptive and serves the subject's organization of the experiential world, not the discovery of an objective ontological reality.

—Glasersfeld, E. von (1988). The reluctance to change a way of thinking. *Irish Journal of Psychology*, *9* (1), 83-90.

* * *

Both verbal and nonverbal information are organized or reorganized actively (constructively) in individuals. This proposition implies that clients in psychotherapy are active, intentional agents capable, under certain supportive conditions, of reorganizing and revising their memories and experiential knowledge structures.

—Martin, J. (1991). The social-cognitive construction of therapeutic change: A dual-coding analysis. *Journal of Social and Clinical Psychology*, *10* (3), 305-321.

* * *

Perhaps the core of postmodern consciousness is the increasingly widespread awareness that the belief systems and apparent "realities" one indwells are socially constituted rather than "given," and hence can be constituted very differently in various cultures (or subcultures), times, and circumstances, although they might appear to carry the force of necessity to those who inhabit them. . . . Constructivist therapies are united in their rejection of a correspondence theory of truth and its corollary assumption that any beliefs that fail to corrrespond to objective reality are, by definition, dysfunctional. Instead, they hold that the viability of any given construction is a function of its consequences for the individual or group that provisionally adopts it, as well as its overall coherence with the larger system of personally or socially held beliefs into which it is incorporated.

At the core of constructivist theory is a view of human beings as active agents who, individually and collectively, co-constitute the meaning of their experiential world. . . with no simple prospect of validation against an objective reality beyond people's constructions.

—Neimeyer, R. A. (1993). An appraisal of constructivist psychotherapies. *Journal of Consulting and Clinical Psychology, 61 (2),* 221-234.

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Constructivism in Coherence Therapy (CONTINUED)

Constructivism — Definitions & Descriptions (CONTINUED)

Constructivism...means that all knowledge of the world is the result of our own constructing, ordering, inventing, languaging, constituting, creating (and so forth) processes, and not the result of our discovery of how the world really *is*. ...'[C]onstructivist therapy' differs, at least in one fundamental sense, from 'non-constructivist therapy' in that the latter may be said to 'impose' the correct view of the problem on the client in order to fix his or her objectively-defined (psychological) defect, while the former admits to no such true view. ...[W]hat is shared [among constructivists] is the notion that no meaning (or what I have elsewhere called 'predetermined explanatory content')...is imposed upon the client.

—Held, B. (1990). What's in a name? Some confusions and concerns about constructivism. *Journal of Marital and Family Therapy, 16,* 179-186.

* * *

Nonconstructivist theories that address the human mind and mentation generally portray them as passive, receptive, and "retentive" (capable of "storage"). Constructivists view mentation as active . . . as well as generative. For the constructivist, "retention" is an active maintenance and elaboration *process* rather than a metaphorical "storage" of copies, bits, and pieces of prepackaged information. In constructivist theories, *information* is not transferred from the environment to the organism via the senses. Rather, true to the etymology of the term, "information" (*in formare*) is that which is formed from within. . . .

[A] basic feature of constructivism. . . [is] the assertion that human systems are organized such that (a) central, core, or nuclear processes dictate and constrain the contents of and particulars of ongoing activity, and (b) core ordering processes operate at predominantly tacit (unconscious) levels and are less accessible and less amenable to change than are more peripheral activities. In other words, the "surface structures" of everyday life and momentary experience are projected from and selectively biased by the elusive "deep structures" that constitute the core ordering processes of that individual. Human activity and over time, psychological development thus reflect deep and powerful *self-organizing processes*. . .

. . . [S]elf-organizing systems with deep/surface structuring actively resist change in their central or core constructs. This is called the *self-protective theory of resistance* because it emphasizes the fact that resistance to change serves a natural and often healthy function in protecting core organizing processes (and hence systemic integrity) from rapid or sweeping reconstructive assault. Processes bearing on the individual's sense of (1) reality, (2) identity, (3) power/control, or (4) values are particularly resistant to change.

—Mahoney, M. J. (1988). Constructivist metatheory: II. Implications for psychotherapy. *International Journal of Personal Construct Psychology, 1,* 299-315.

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Integration Experiences: Inhabiting Emotional Truth

Meaning & Purpose of Integration in Coherence Therapy

Integration = Direct, subjective experience of pro-symptom emotional truth, routinely sustained during daily life, particularly whenever the problem or symptom occurs. Client relates to the problem or symptom *from* and *in* the pro-symptom emotional reality.

Purpose of integration: Subjectively experiencing psp = Accessing psp = psp directly available for change

Principle of accessing: *Unconscious emotional realities are directly accessed only by experiencing them consciously—an immersion in the subjective "reality" of the constructs being accessed while also verbally cognizing the content of these constructs.* (Not to be equated with dramatic emotionality, catharsis, or abreaction. These may or may not occur and are not intrinsically required in Coherence Therapy.)

Client's experience of integration

· **Immersion.** Relates to the problem or symptom *from* and *in* the pro-symptom emotional reality, rather than from the anti-symptom position originally expressed.

· **Profound connection-with-self and authenticity.** Experiences the pro-symptom theme and purpose as her own view of reality, her own passionate purpose, and her own way of carrying out that purpose.

· **Agency.** Experiences the symptom as being either her *very means* of carrying out that crucial purpose (functional symptom), or as an *inevitable by-product* caused by how she carries out that purpose (functionless symptom).

· **Agency.** Symptom's mysterious power to persist is experienced by client as his/her 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).

· **Awareness of the "two sufferings."** Experiences the suffering due to having the symptom as being worth enduring in order to avoid an even worse suffering expected from being without the symptom.

· **Existential illumination.** Recognizes, feels and engages the core existential dilemma—the "real" problem—that until now had been unconscious and had been solved by producing the symptom.

Integration mottos. 1. *The pace should be set by the client's capacities, not the therapist's assumptions.*
2. *Empathize with, validate, honor* the client's psp and draw client into same attitude of self-compassion.
3. Once the client has been ushered into inhabiting—subjectively experiencing—the emotional reality in his/her psp, then: *Pitch a tent. Set up camp right there. Go nowhere else.* (Exception: traumatic memory.)

Successful integration is indicated by client subsequently referring congruently to the pro-symptom theme and purpose *on his/her own initiative*. For example, after a between-session task of integration (p. 41) has been given, always follow up at start of next session by asking, "How did that task go?" or "How was it to stay in touch with what we wrote on that card?" These questions deliberately do not remind client of the specific content of task material. Observe whether client's response refers explicitly to pro-symptom themes and purposes that were in the task. If necessary, probe by asking, "And how was it to be in touch with the specific parts of it?" If this reveals resistance to integration, apply Coherence Therapy to the resistance (see pp. 48-49).

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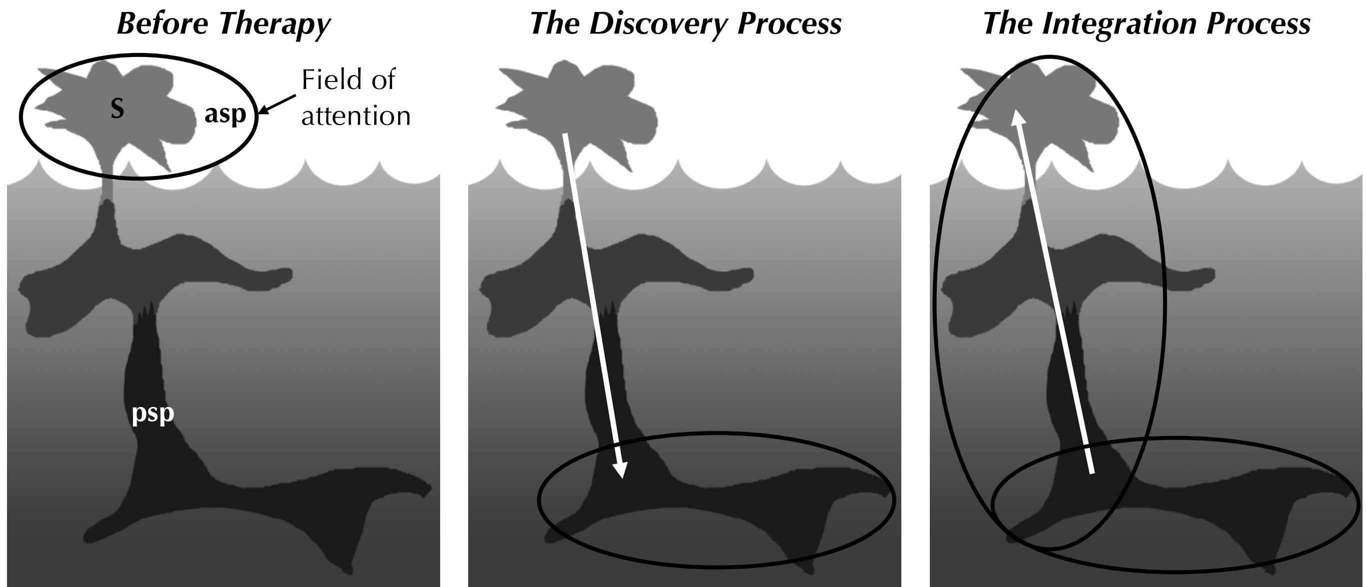
Integration Experiences: Inhabiting Emotional Truth (CONTINUED)

"Connecting up" and the Pivot into Agency



Client is aware of symptom (S) and anti-symptom position (asp) but unaware of pro-symptom position (psp) underlying and requiring S.

Guided connecting "down" brings attention off of S and asp and onto a major personal theme and purpose in psp. Core psp content does not refer to S.

Guided connecting "up" returns attention back up to S *with* awareness of the personal purpose (psp) necessitating S.

Example: Intense, chronic anxiety is a 28-year-old woman's longstanding presenting symptom. Currently her anxiety has for many months been focused on her baby daughter's health problem. Initially her anxiety was justified by the life-threatening seriousness of the infant's condition, but now it has been months since the doctors said the danger is over, yet the anxiety is undiminished.

Her discovered pro-symptom position: If anxiety recedes, what comes up instead is for her a much worse experience: her never-dealt-with raw pain and rage over severe emotional abuse by her father throughout childhood—feelings that quickly start to feel unbearable if allowed to arise, hence the continual need for the anxiety. The core of her psp is the dilemma of carrying these father-related feelings and the urgent need not to feel them. Upon entering into the massive, compelling father-material, both client and therapist can easily forget all about the presenting symptom that was the starting point of the discovery work: the anxiety she generates to block the unbearable father-material.

"Connecting-up" means deliberately guiding the client's attention back to the presenting symptom, but now *with* awareness of the discovered core purpose that necessitates having that symptom. Doing this, she now experiences her anxiety over her baby as something she herself whips up to protect herself from feeling her feelings about father and childhood. The client is now consciously in front of "the two sufferings" and recognizes that having the symptom is how she avoids an even worse suffering. The symptom has now transformed from something that mysteriously "happens *to* me" into an obvious feature of the client's own way of carrying out her own passionate purpose. This is referred to as the client's *pivot into agency.* An involuntary muscle has become a voluntary muscle. Connecting-up is an essential step of integration in Coherence Therapy and the pivot into agency is a major milestone with each client.

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Integration Experiences: Inhabiting Emotional Truth (CONTINUED)

Pro/Anti Synthesis

Optimal final form of integration: Pro/anti synthesis

Initially the client's anti-symptom position (asp) and pro-symptom position (psp) are completely unconnected or split, and the psp is unconscious. In the course of the discovery and integration work, the psp becomes conscious and emotionally real to the client, who now recognizes how the symptom is necessary to have.

Integration is not complete, however, until the client is further guided to unsplit and join the asp and psp views of the symptom. This joining consists simply of including, along with the new recognition of how the symptom is necessary to have, an explicit recognition and inclusion of the suffering or cost that the symptom brings.

Example*:* The underachieving man in the script on pp. 15-17. The verbalization created at the end of the session, and written on an index card for his between-session task, was, "I hate achieving so little, and it could derail my whole life, but my only hope for getting noticed and taken-care-of is to be defeated and caved-in like Dad. I'm owed being taken-care-of and I insist on getting it! If I seem strong and successful I'll never get it, so I've got to seem unsuccessful and defeated, even if my life then crashes and burns." This achieves a pro/anti synthesis with its opening and closing phrases, which explicitly recognize the cost of the underachieving.

Example*:* The woman whose young son died (p. 31). Her pro/anti synthesis could be verbalized as: "Staying depressed and guilty over Billy really feels awful, and my children need their Mom back, but only my misery is keeping Billy with me, so it's worth it. No way am I willing to let go of him."

In the pro/anti synthesis, both the compelling necessity of having the symptom (the psp view) *and* the unwanted suffering due to having it (the asp view) are experienced together in one unified awareness: the client apprehends that the necessity of the symptom emotionally outweighs the suffering it brings; that the suffering is a disliked but acceptable cost of the benefit gained by having the symptom; that *not* having the symptom brings a different suffering (the "real" problem) that is even worse than the suffering from the symptom.

These "two sufferings" and the dilemma of having to choose between them (and opting for the symptom as the lesser suffering) had been unconscious. At the moment that the pro/anti synthesis is experienced, the two sufferings begin to be faced consciously by the client for the first time. The dilemma of choosing between them is then being consciously revisited by the client, and will be transformed as a result.

Importance of pro/anti synthesis in stabilizing integration of psp

In moments when the client is again suffering an occurrence of the symptom, she or he is likely to go into the asp view of having the symptom—the view of wanting only to get rid of the symptom as a purely negative experience. Without a pro/anti synthesis, this re-immersion in the asp's version of emotional reality causes the client to lose awareness of his or her psp, a setback in the process of integrating the psp.

After establishing a pro/anti synthesis, an experience of suffering the symptom does not cause the client to lose sight of the psp view, because now the suffering brought by the symptom is part of a unified view that includes the psp.

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Integration Experiences: Inhabiting Emotional Truth (CONTINUED)

Techniques for Integration Experiences

IN-SESSION TECHNIQUES

Verbalizing emotional truths: Guidelines for “limbic language”

Aim for highly succinct, present-tense, live-wire phrasing in maximally personal terms (I, me, you), with client speaking *from* and *in* the subjective experience of the ardent, pro-symptom emotional reality. When possible, phrase so that client is speaking directly to the emotionally relevant person(s). Make phrasing utterly candid emotionally—unflinchingly naming what’s at stake with words vivid enough to do justice to the passionate themes and purposes involved. Edgy, gut-level language of purposefulness and agency, rather than language of victimhood, depersonalization, or factuality.

Effective phrasing	Ineffective phrasing
I am madder than hell at you, Bill, for always bullying me.	It makes me angry that my older brother was always a bully.
I hate how it feels to be so blank, a vegetable, but if I have anything going, Mom will take all credit for it! That’s even worse! Gotta stay blank!	It’s more important to be a blank, a vegetable, than to have anything going that Mom could take credit for.
Being this depressed feels awful, but if I felt ok and if I forgave myself, I’d have to go on myself, without Billy. No way. Billy, I can’t bear to let go of you.	I’d rather stay depressed so I won’t have to go on without Billy. I choose not to forgive myself.

Overt statement

See p. 13 for description and p. 14 for example. Simple technique that is highly effective for emotionally deepening clients into their material. Useful for both discovery and integration of psp. An overt statement can be offered by the therapist as a *trial sentence*: Therapist forms a sentence articulating pro-symptom material that has surfaced, with zero interpretation added, and asks client to “try on” saying it, see how true it feels to say it, and revise wording as needed for better accuracy.

“What’s the connection, if any, between D, and S?”

D is some discovered feature(s) that seems likely to be important pro-symptom material. S is the symptom. This question guides conscious attention to illuminate and recognize pro-symptom material and its coherence. An example is in the transcript on p. 17: Therapist asks the underachieving man, “So, what’s the connection, if any, between Dad getting all that caring attention by being visibly defeated and caved-in [D]; and your *own* hunger for being noticed and cared-about, and *you* being visibly unsuccessful? [S]” This results immediately in a major integration experience: client recognizes and experiences his purposeful use of underachieving as his way to try to attract loving care. “What’s the connection?” is useful as a “blind” technique: therapist asks without knowing the answer.

Cycling (between having and not having the symptom)

1. Following symptom deprivation and the surfacing of an unwelcome consequence of being *without* the symptom, guide client to replay the scene *with* the symptom once again.
2. Ask client if that unwelcome consequence is present now *with* symptom. Client finds it is gone.

Continues…

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Integration Experiences: Inhabiting Emotional Truth (CONTINUED)

Techniques for Integration Experiences (CONTINUED)

3. Verbally review the client's phenomenology. For example, with the woman whose little boy died: "So, what I'm learning from you is this: If you stay in this painful grieving, then you feel him still with you and emotionally close by; but if you come out of the pain and despair, and into feeling regular and ok again, then you feel he *moves on without you,* and you lose that closer contact with him. Is that right?" Client's pivot into agency is likely to begin at this point.
4. Ask client to make own overt statement of what therapist summarized in step 3, to relevant person.
5. If client does not yet become aware of his/her own purpose and agency in producing the symptom in order to avoid the unwelcome consequence, repeat cycling.

Integrative mirroring

Therapist offers a non-interpretive summary of key elements of client's phenomenology, bringing these together for the first time in a single unified picture so that client makes and feels connections, leading to experiencing his/her own purpose and agency in producing the symptom. Example: Step 3 above.

BETWEEN-SESSION INTEGRATION TASKS

Necessity of between-session tasks of integration. Integration is not occurring until client is relating to the occurrence of the problem or symptom *from* and *in* his/her pro-symptom position during daily life between sessions. In other words, client stays in touch with the emotional truth of how the symptom is necessary to have. Between-session tasks establish this.

Index card reading of pro-symptom emotional truths found in session

- **Therapist and client collaborate** on forming the card's sentences, either by (a) working together from the start, or (b) therapist writes a first draft based on what therapist sees as key material for card and then says, "I'll read what I've come up with. Tell me if it really captures what we've gotten in touch with. If the wording is off in some way we'll correct it to feel really true for you."
- **Therapist writes** the card. Client sees you write a copy first in your own notes, then on card.
- **Tell client,** "Best would be to read the card every day, morning and evening. The purpose is just to stay in touch on a feeling level with what you've gotten in touch with here during the session."
- **Follow up** at start of next session (see p. 65): "How was it for you to stay in touch with what we put on that card?"

Real-time recognition: Use of symptom as signal to access the pro-symptom position
Whenever the symptom occurs, client is to use it as a signal to get in touch with the emotional truth of how the symptom is needed in the current situation. This task is used only after in-session integration is well established—the client readily getting in touch with pro-symptom position during session. For an example, see p. 22.

Hindsight recognition. Same as real-time recognition, but carried out in hindsight, after the symptom has occurred, in an imaginal replay of the moments when the symptom was happening. Hindsight recognition builds up the awareness needed for real-time recognition.

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Transformation Experiences: Dissolving Emotional Schemas

Transformation Concepts and Methodology

Transformation of symptom-requiring schemas is the goal in Coherence Therapy because a person ceases producing a symptom as soon as there no longer exists any emotional schema (learned model or construction of reality) making that symptom necessary to have.

Coherence Therapy utilizes the innate process of memory reconsolidation to unlearn, nullify and dissolve emotional implicit schemas formed previously in the course of experience and development. The experiential process of change is suitable for wide range of client populations because it does not require high levels of analytical insight or verbal skill.

Why integration into conscious awareness is the crucial pre-condition for transformation

- An unintegrated/unconscious emotional learning or schema is extremely durable over time because it is isolated and insulated from contact with other, sharply different knowledges/realities/identities that could disconfirm, unlearn and nullify it.
- Integration of a pro-symptom schema into direct, daily awareness opens it to contact with other knowings that can disconfirm and nullify it through the natural process of memory reconsolidation.
- Conscious awareness is the “workbench of the psyche” (Robert Neimeyer)

Basis of transformation methodology: *Innate rules for coexisting models of reality*

- The brain and mind allows coexistence of any number of contradictory, incompatible constructs/schemas/knowings, as long as the contradictory knowings are held separately, never come into mutual contact, never enter the same field of awareness, never are experienced together.
- However, the brain and mind do *not* tolerate an incompatibility or contradiction between constructs that are co-present in the same field of awareness, juxtaposed and experienced together. When a 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 quickly 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 of juxtaposed constructs, it then fundamentally transforms (unlearns, revises or dissolves) the more limiting construct because its perceived realness or truth has been disconfirmed by the other. (Piaget: accommodation.)

Coherence Therapy's model of transformational change: *Disconfirmation by juxtaposition*

A symptom-generating schema is unlearned and nullified when it and some other, fundamentally incompatible living knowledge are *subjectively experienced together—juxtaposed—in the same field of awareness*. The capacity of this *juxtaposition experience* to dissolve an ingrained emotional schema was discovered clinically by Ecker and Hulley and first described in their 1996 book *Depth Oriented Brief Therapy*. Rigorous empirical confirmation that schemas can be nullified through juxtaposition came in 2004 from neuroscientists' research on memory reconsolidation (with many later confirmations; see list at http://bit.ly/2b8IbJH); what Coherence Therapy terms a juxtaposition experience is called by reconsolidation researchers a *memory mismatch* or *prediction error* experience).

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Transformation Experiences: Dissolving Emotional Schemas

Transformation Concepts and Methodology (CONTINUED)

Methodology for transformation of symptom-requiring schema (pro-symptom position)

Once a pro-symptom schema is well integrated into awareness, the transformation phase of Coherence Therapy begins with a search for a fully real-feeling personal knowledge that the client experiences as being a sharp contradiction of that symptom-requiring schema. Finding such a contrary knowing is the first step of the transformation phase.

The second step is guiding the client to experience the target schema and the contrary knowing concurrently, side by side, in the same field of awareness. This is the *juxtaposition experience* that Coherence Therapy defines as the critical condition for transformational change to take place. The client's first experience of the juxtaposition is a strong mismatch or prediction error experience, which extensive research has shown to immediately unlock the neural encoding of the target learning. The target learning is now available for fundamental unlearning and nullification.

The third and final step consists of guiding just a few repetitions of the juxtaposition experience, which brings about the unlearning and nullification of the target schema. (See below for detailed guidelines for these steps.)

Subsequently, the markers of transformational change appear and are verified: the schema is devoid of its former compelling emotional realness, it no longer triggers in response to its former cues, and it no longer generates the symptoms it had been driving, with no effort required to maintain this liberating shift.

Finding contrary knowledge that will disconfirm the target schema

The most important condition for successfully finding contrary knowledge in Coherence Therapy is a thorough completion of the preceding steps of discovering and integrating the symptom-generating schema. Here's why:

- The process of finding contradictory knowledge is completely guided by and based on knowing specifically *what* needs to be disconfirmed—the schema previously revealed.
- If you are not yet closely familiar with the specific make-up of the target schema— core beliefs, meanings, models and expectations defining a dire problem (a suffering that is urgent to avoid) and the necessary solution (how to avoid it)—you cannot efficiently find contrary knowledge that will specifically disconfirm those well-defined components. *Disconfirmation must be very specific.*
- Therefore, slower is faster: dwell with schema discovery and integration and do a thorough job there before trying to head for a juxtaposition experience.

When the time is right to begin the search for contradictory knowledge, the following map of its possible sources will equip you to conduct the search efficiently.

Sources of contrary knowings

The needed contrary knowing will either be found in the client's **already-existing knowledge** or it will be created by a **new experience** that occurs during or between therapy sessions.

Both sources—already-existing knowledge and new experiences—can be accessed through a wide variety of techniques. The techniques listed below are a basic set that will equip you for versatile, effective work with nearly all clients. A list of published examples of these techniques is provided at the end of this section.

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Transformation Experiences: Dissolving Emotional Schemas

Techniques for Finding Contrary Knowledge

Already existing knowledge is searched to find contrary knowledge in two main ways: *mismatch detection* and *past opposite experiences*.

Mismatch detection. This, as a rule, is the first approach for finding contrary knowledge. It is carried out simply by guiding the client to make declarative assertions of the discovered pro-symptom schema. Such *overt statements* are a standard part of completing Coherence Therapy's integration phase. Overt statements of the target schema engage the brain's own mismatch detection system. In a sizable fraction of cases, the mismatch detector finds contradictory knowledge that the client already possesses but has never experienced in juxtaposition with the pro-symptom schema, and automatically brings it forward into awareness and directly into that juxtaposition. The client, in the midst of asserting the schema's knowings and expectations, suddenly experiences a distinctive "Hey, wait a minute!" sensation, followed by the contrary knowledge coming into focus and articulation.

Through mismatch detection, the integration work can spontaneously cascade into finding contrary knowledge and creating a juxtaposition experience. The importance of thoroughly carrying out theintegration phase by dwelling in the discovered schema and guiding overt statements of it is again apparent here.

Mismatch detection often occurs and produces a juxtaposition experience during widely used systems of trauma therapy (such as EMDR, Progressive Counting, TIR, Sensorimotor Psychotherapy, Somatic Experiencing, and tapping techniques) as well as in experiential therapies such as AEDP, Emotion-Focused Therapy, Focusing, Hakomi, Internal Family Systems, IPNB, Pesso Boyden Therapy, and others.

Past opposite experiences. When overt statements do not elicit juxtaposition in the spontaneous manner described above, the target schema remains in force, even though it is now fully revealed and well integrated into awareness. The next option for finding contrary knowledge is to ask the client whether she or he has ever had any past experiences in which life did *not* behave according to the specific expectations or beliefs of the target schema.

If the client remembers any such experiences, guide an imaginal, experiential revisiting of the strongest one or two of them. Focus the client on mindfully recognizing the divergence from what the target schema expects. That accomplishes finding contradictory knowledge and creating a juxtaposition experience.

New experiences can be created to generate the needed contradictory knowledge if it is not found in existing knowledge. Such new experiences can be created in several ways: *daily life, structured revisiting, the client-therapist relationship, self-revelation by others*, and *experiential psychoeducation*.

Daily life fairly often produces situations that differ sharply from the expectations in people's schemas. However, it is only after a schema is integrated into ongoing awareness that the client notices such an experience as being curiously at odds with a core belief or expectation. The client then mentions the unusual experience and the therapist utilizes it to create an explicit juxtaposition experience.

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Transformation Experiences: Dissolving Emotional Schemas

Techniques for Finding Contrary Knowledge (CONTINUED)

Structured revisiting is a guided experience of re-encountering the original scene or situation in which the target schema's component meanings and models were formed, and now having a very different experience of that scene and reconstruing it, that is, forming new meanings and models that juxtapose with, disconfirm and nullify the original ones. This can be accomplished using many well-known techniques of psychotherapy, such as:

Empowered reenactment of a traumatic incident. The therapist closely accompanies and guides client to revisit the incident, move through it and respond differently than in the original case, now forcefully enacting the natural, self-protective behavior that was originally blocked. This creates a new experience of preventing harm, which contradicts and disconfirms the helpless vulnerability that was learned in the original incident and became the client's ongoing, implicit expectation. This expectation of being helplessly vulnerable is usually responsible for the ongoing, traumatic quality of the memory and is often the root and driver of ongoing PTSD symptoms. The disappearance of helplessness in the very scene that had produced it is a built-in juxtaposition experience that de-traumatizes the memory.

Inner child work. In a scene of mistreatment in childhood, the adult client or the therapist observes and interacts with the client's child self and guides the child into experiencing new meanings and construals of what is happening that differ from and dispel the child's original meanings, which have been generating low-self-worth, depression, anxiety and/or body symptoms.

EMDR, NLP, Progressive Counting, TIR, Tapping. These therapy systems consist mainly of structured revisiting and can be applied to specific target schemas in Coherence Therapy. These therapies set up some special internal condition, such as dual focus, that allows the mind to freshly revisit and reconstrue an original traumatic incident from a viewpoint outside the schema (the construal) that was formed in that incident and that normally rules the client's response to the incident's component cues.

De-suppression of traumatic memory. Traumatic memory is held in a state of suppression that keeps the original suffering out of awareness. Though such suppression entails costly symptoms (including emotional dissociation, somatic tightness, psychogenic physical pain, and hypervigilant avoidance of reminders), it exists as the client's necessary solution to the problem of having living knowledge of extreme suffering that is expected to be overwhelming and beyond the client's capacity to experience consciously. That implicit model of the client's emotional incapacity encounters a contrary knowing when the client, guided and accompanied empathetically by the therapist, revisits traumatic experience, opens to it and feels it without being overwhelmed or shattered by it. That juxtaposition dissolves both the client's view of emotion as a great danger and also the need for the suppression solution, so the various symptoms entailed by suppression disappear. Of course, de-suppression must be carried out in small enough steps to be bearable and workable for the client at every step. The point here is that the process of de-suppression of traumatic memory is itself a source of contrary knowledge that creates a juxtaposition and dispels an array of significant PTSD symptoms.

The client-therapist relationship can create a new relational experience that contradicts and transforms the client's negative relational expectations, also known as insecure attachment and low self-esteem. This use of the client-therapist relationship is capable of nullifying some schemas of insecure attachment, but not others; and not all clients' presenting problems are based in insecure attachment in the first place. (For a detailed examination of these important matters, see chapter 5 of *Unlocking the Emotional Brain*.)

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Transformation Experiences: Dissolving Emotional Schemas

Techniques for Finding Contrary Knowledge (CONTINUED)

Self-revelation by others occurs typically in couple and family therapy when one person shares the inner true meaning of his or her behavior, and this revealed meaning is for others a new experience that juxtaposes with and dispels the problematic meanings they had been attributing to that behavior.

Example from family therapy. A father has been criticizing his teenage son as a lazy goof-off for spending so much time on social media, and the boy has felt hurt and alienated by his father's negative judgment of him. Then, in a family therapy session, the boy vulnerably and tearfully reveals that he feels deeply lonely and isolated in his peer life at school and that social media gives him some relief from that aloneness by connecting him to "friends" all over the world. This new meaning of the behavior dispels the father's prior disparaging meaning of it.

Example from couple therapy. Susan defined her problem as Luke's behavior of "shutting down, withdrawing and not talking to me whenever I get the least bit upset with him." Therapist further drew out that she construed this behavior to mean, "He doesn't really love me. If you love someone, you want to know what's upsetting them." Giving his behavior the meaning "He doesn't really love me" was what was generating her intense pain, despair and anger in response.

When Luke subsequently went into that shut-down state during session, the therapist guided his attention to his in-the-moment feelings, then helped him verbalize them for the first time; soon Luke poignantly said to Susan with chin quivering, "I'm shut down like this because I'm *really scared:* When you're upset with me I think you really don't want me around any more."

The therapist, recognizing that a potently disconfirming, contradictory construct had now been supplied by Luke, immediately turned to Susan and gently guided a juxtaposition experience by asking her, "Did you let that in? All along you thought his shutdown meant, 'He doesn't love me,' and now you're seeing and hearing how real it is that inside of Luke it actually means, 'I'm so scared because Susan's displeasure means she doesn't want me.' What a different meaning of being shut down and quiet. Did you let it in?"

Note the non-counteractive nature of the process: Therapist was deliberately guiding Susan to *stay* in touch with her pro-symptom construct, "It means he doesn't love me," *and* to experience as real the disconfirming new knowledge, "It means he's scared of losing my love," in the *same field of awareness*. The therapist transparently invited her to "let in" the new construct while also keeping her in touch with the old one, so that she would experience the juxtaposition of the two incompatible constructs. The problematic meaning was unlearned and dissolved by this juxtaposition experience, ending the distress it was contributing. (Suppose as before the therapist hears from Susan, "He doesn't really love me," but now follows this by pointing out to her all the evidence that Luke *does* indeed truly love her. That would be a *counteractive* approach, an attempt to build up preferred cognitive knowings, but they would not feel real enough to disconfirm the target meaning, which would remain intact.) Further work focused on Luke's fearful expectation of abandonment.

Experiential psychoeducation occurs when the therapist imparts new information that immediately lights up and is experienced by the client as a felt reality, not merely dry facts. After the therapist has become familiar with the make-up of the client's symptom-requiring schema, the therapist may be able to provide information that the client experiences as new, lucid knowing that juxtaposes with the schema, disconfirming and nullifying some key part of it.

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Transformation Experiences: Dissolving Emotional Schemas

Techniques for Finding Contrary Knowledge (CONTINUED)

Example of experiential psychoeducation. A woman client was stuck in the distress of feeling deeply hurt, rejected and unloved by her husband because he had repeatedly disregarded all of her helpful, caring suggestions regarding his serious health problem that had developed. "I don't matter" were the words that captured her core despair, an ego-state that was a primary wound from her childhood. After empathizing with her experience, the therapist soon commented, "I remember that you once told me that your husband suffered throughout his childhood from feeling massively dominated and controlled by his mother." Suddenly the client said with great energy, "Oh! That's right! *That's* why he isn't listening to me—he's so afraid of being controlled by me like he was by her! It's not that I don't matter and he doesn't respect my knowledge!" Her previous distress vanished with this change in the meaning she attributed to her husband's behavior, brought about by one bit of skillfully delivered information about her husband that was real to her. The therapist, seeing the opportunity for generalizing this shift into a more broad-ranging disconfirmation, then said, "What if it was the same with your parents? What if their disregard of you really meant something about *their* emotional baggage, instead of meaning that you don't matter? And what if *anyone's* disregard of you is the same?" This had strong impact and the learned identity or ego-state of "I don't matter" no longer flared up after this.

Guiding Juxtaposition Experiences

From contrary knowing to juxtaposition: The importance of making the juxtaposition explicit

For maximum consistency of producing transformational change with clients, do not assume that the client, in having the contradictory knowledge, is also having the juxtaposition experience. The client may have disconnected from the experience of the pro-symptom schema in attending to the contrary knowledge. Always guide the both-at-once juxtaposition experience explicitly. That is done by verbally cueing the client to mindfully feel both the target schema's version of reality and the contrary knowing or experience. Below are additional guidelines.

Guiding the first juxtaposition experience

It may take any number of sessions to retrieve the symptom-necessitating schema into integrated awareness and then find a contrary knowledge, but then the juxtaposition experience is simple to guide and typically requires just minutes.

In a juxtaposition experience, you are cueing the client to subjectively feel two different knowings concurrently, and both feel real, yet both cannot possibly be true.

This template is often useful: "Let's go over two things that seem to feel true for you. It would be good if you picture and *feel* these things as much as possible as we review them. First, what you learned in life very deeply is that [core belief/mental model that is the target of change]. And second, you've had experiences, such as _________, that have shown you that [contradictory knowing]."

As you cue the two knowings, you empathize equally with each, indicating no favoring or disfavoring of either. Any favoring or disfavoring cues the client to re-suppress and disown the target emotional learning (schema), which switches the process into being counteractive and suppressive rather than transformational and nullifying. You are trusting the client's mind and brain to register the disconfirmation and unlearn and nullify the target schema. So you ask simply, "How is it to be in touch with both of those?"

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Transformation Experiences: Dissolving Emotional Schemas

Guiding Juxtaposition Experiences (CONTINUED)

Guiding a few repetitions of the juxtaposition experience

A juxtaposition experience is an oddly surprising, edgy experience for the client, so it is natural to dwell with it and review it a few times during the remainder of the session, creating repetitions.

The first repetition comes from asking "How is it to be in touch with both of those?" after initially guiding the juxtaposition. Two more repetitions can usually be created in a natural manner simply by empathetically reviewing what the client has recognized and experienced on both sides of the juxtaposition. A total of three such in-session repetitions is usually sufficient.

In reviewing the two sides of the juxtaposition, very specifically name the disconfirmed and disconfirming knowings, in order to re-cue them. In that way, the client re-encounters the juxtaposition afresh. For example, the therapist says, "All along, it just seemed so true that ______________ . And now it's something of a surprise to recognize that ____________________ ." Then further discussion will afford additional opportunites to again refer specifically to both knowings, for another repetition.

Once a juxtaposition experience has occurred, the best post-session task for the client is to revisit the experience for several days, for additional repetitions. To that end, write the juxtaposition on a (paper or email) card for the client to read daily between sessions. The phrasing given just above is useful in most cases.

Verifying Transformational Change

In the course of guide a set of juxtaposition experiences, asking the client, "How is it to be in touch with both of those?" not only repeats the juxtaposition but also, by prompting the client to re-sample both sides of the juxtaposition, that question probes for whether the target learning is continuing or ceasing to feel real. The therapist can also guide the client to focus imaginally on the cues that are well known to have always triggered unmistakable activation of the pro-symptom schema,inorder to see whether such activation still occurs. This begins the verification phase.

If the juxtaposition is successfully disconfirming and dissolving the target schema, the client will respond to the above question or to the re-cueing of the schema by expressing either gleeful laughter, or a sense that the schema now seems silly or absurd, or, conversely, by expressing some form of distress, such as a pained grimace or tears over recognizing that so much of his or her life was shaped by beliefs now recognized to be false. All of those are initial markers of schema nullification.

Thorough verification requires observing that the full set of markers mentioned earlier persists over time: the schema is devoid of its former compelling emotional realness and no longer triggers in response to its former cues, and it no longer generates the symptoms it had been driving, with no ongoing effort required for preventing the activation or the symptoms.

If the target schema remains real-feeling and triggerable after a set of well-crafted (highly specific and richly experiential) juxtaposition experiences, the therapist should begin to consider that resistance to transformation may be occurring. The methodology of Coherence Therapy for dispelling resistance to transformation is described later in this manual.

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Transformation Experiences: Dissolving Emotional Schemas

Case Examples: Sources Of Contrary Knowing

Where to find case examples illustrating sources of contrary knowing

UEB = *Unlocking the Emotional Brain* (view on amazon: http://amzn.to/2gFro38)
MRP = *Memory Reconsolidation in Psychotherapy* (view on amazon: http://amzn.to/2gFQ5gS)
DOBT = *Depth Oriented Brief Therapy* (view on amazon: http://amzn.to/2gUPY02)

Source of contrary knowledge	Published case examples
Existing knowledge	
• Mismatch detection	UEB pp. 71–77; UEB pp. 77–86; UEB pp. 120–123; DOBT pp. 184–185; online videos at http://bit.ly/2gDBpkP: "Compulsive Underachieving," "Down Every Year," and "Stuck in Depression"
• Past opposite experiences	*Psychotherapy Networker* articles: http://bit.ly/2gg9U07 and http://bit.ly/1We4HDZ
New experiences	
• Daily life	UEB pp. 43–61; *Psychotherapy Networker* article: http://bit.ly/1We4HDZ; *Therapy Today* article: http://bit.ly/2gGWd7G
• Structured revisiting	UEB pp. 86–91; MRP pp. 69–78; *New Therapist* article: http://bit.ly/2g3pCZG
• Client-therapist relationship	UEB pp. 106–109; UEB pp. 130–136; MRP pp. 29–35
• Self-revelation by others	DOBT pp. 22–24; DOBT pp. 221–230; DOBT pp. 240–256
• Experiential psychoeducation	*Psychotherapy Networker* article: http://bit.ly/2guAAbe

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Levels of Change, Types of Therapy

1st-order change therapies

- Change efforts focus on 1st-order constructs: the symptoms themselves.
- Strategy: Prevent symptoms from occurring by teaching the client alternative, desirable responses (such as relaxation techniques, communication skills, positive beliefs, etc.).
- No work on underlying emotional realities that make symptoms necessary to have; pro-symptom schema remains intact.
- In effect, 1st-order change strategy is to empower the client's conscious, anti-symptom position to counteract and override her/his unconscious, pro-symptom position. Ineffectual strategy highly susceptible to relapse and symptom substitution.

2nd-order change therapies

- Focus is on changing 2nd-order constructs: the construed meaning of the concrete situation.
- Strategies:

  (a) Prevent symptoms from occurring by developing client's insight into the unresolved life issue that gets activated, so that client can rationally separate past from present, override the reactive tendency stemming from that life issue, and choose instead a more constructive and appropriate response.

  (b) Prevent symptoms from occurring by *reframing* the problem situation—getting the client to view the situation in a new way, in an altered context, so that the situation has an altered meaning that elicits a different, nonsymptomatic response from the client. The new frame must hold strongly enough to override the unconscious, pro-symptom meaning necessitating the client's symptomatic response.

- No transformation of the underlying material driving and maintaining symptoms; pro-symptom schema remains intact.

3rd- and 4th-order change in Coherence Therapy

- Change efforts focus on 3rd- and 4th-order constructs: core, unconscious, learned emotional schema necessitating the symptom adaptively
- Strategy: Dissolve the very basis of the symptom's existence by prompting client's use of his or her native capabilities to locate, access and unlearn (nullify) symptom-necessitating constructs formed (learned) previously in the course of development.
- Fully non-counteractive process: no attempts to avoid, prevent, override or oppose pro-symptom schemas.

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Dispelling Client Resistance in Coherence Therapy

Working with resistance: Overview

The therapist responds to resistance by applying the usual Coherence Therapy methodology to it: Temporarily the therapist regards the resistance as the "symptom" and accords it the same empathy, acceptance, and respectful assumption of cogency that all symptoms receive in Coherence Therapy. Therapist then works to discover the emotional truth of the resistance—how and why, for the client, the resistance is necessary to have at this moment. When the concerns driving the resistance are brought to light and respected, either client and therapist then find a way to honor those concerns that allows resumption of the work, or the driving concerns dissolve as a result of becoming conscious, ending the resistance.

Resistance of two main types occurs in response to creating experiences of discovery, integration, and transformation of pro-symptom positions:

Conscious resistance. The client readily has some awareness of why it feels necessary to resist the experience that the therapist is prompting, and can express feeling threatened or distressed by the emerging pro-symptom material. For example, client expresses fear of being overwhelmed emotionally, or negative judgments of the emerging material, or a disorienting departure from familiar self-image.

Unconscious resistance. The client has no awareness at all as to why resistance is occurring and is baffled by it. Examples are a sudden blankness, fogging-over or heavy fatigue, a sudden loss of all feeling-level engagement in the material, or a sudden inability to get the mind to do the simple step invited by the therapist. Such resistance comes either directly from the client's unconscious, pro-symptom position (and so provides a therapeutic opportunity for immediate further discovery work) or from a different but closely associated position of purposefully keeping the pro-symptom material unconscious.

Working with conscious resistance: Techniques

Conscious resistance usually can be cleared relatively quickly, with little or no in-depth work, using any of the following five techniques:

Just a part of you. Some clients become willing to open up to feeling and owning their pro-symptom emotional truth only after hearing the therapist say, "I know this is only a *part* of you, and I know that *other* parts of you have a very, very *different* view and feeling about this. But even if other parts really disapprove or think it's 'irrational' [or 'selfish,' 'childish,' etc.], we need to hear how *that* part [psp] sees this and feels about it, because *that* part seems to be in control."

"I hate to admit it, but…" In a similar vein, some clients become willing to open up to feeling and verbalizing their pro-symptom emotional truth only if the verbalization begins with, "I hate to admit it, but…" The conscious personality needs its disapproval of the material made explicit so that there is no appearance of approving.

Cognitive map. Some clients need first to know *why* it is necessary to head *toward* and get *in* touch with material they (consciously) hate and want to get rid of. Providing such clients with a non-jargony, capsule explanation of Coherence Therapy's rationale usually clears away this obstacle. For example, "You've been trying for years, in all kinds of ways, to make X stop happening. There's a part of you that *keeps* X happening, and that part apparently is stronger than all the ways you've tried to override it and counteract it. So let's not try more of what doesn't work. Let's instead get to know that part really well. This will reveal pathways of real change that we cannot know until we're there."

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Dispelling Client Resistance in Coherence Therapy (CONTINUED)

Working with conscious resistance: Techniques — *continued*

Small enough steps. This simple technique applies when client indicates in any way that the incipiently emergent pro-symptom material seems overwhelming.

Therapist then elicits what client glimpses of the incipient material (content, type of emotion involved, and specifically *how* it would go unworkably badly to open up to it). A sentence completion can be useful: "If I opened up to this, …" Therapist then mirrors back an accurate understanding of what client has explained.

Therapist next communicates the following content in an empathic, authentic manner: "I am taking seriously your sense that what we're getting into could be too intense (or too big, or whatever word the client used) to open up to all at once. It is clear to me that we can go into this crucial area only if at every point we take a *small enough step* for it to feel really workable for you. This is often how it is and I am completely ready to parse down to a truly small enough step at every point. I will actively be checking with you about whether a particular step I am suggesting feels ok to you; and I hope you will feel free to let me know if and when any step does *not* feel ok to you. I want you to feel that *you* can control the pace. How do feel about this approach?" Resistance usually begins to relax at this point.

Finally, therapist stays mindful of this agreement and not only puts real thought into how to carve down all steps of discovery and integration into mini-steps (which is always possible with some thought and ingenuity), but also therapist proactively and transparently comments to client about the need for a small-enough step, and regularly asks, "Is what I just asked you to do a small-enough step?"

Create juxtaposition. The client's first lucid awareness of the pro-symptom position (psp), including its solution and the high costs of that solution (namely, the symptom), may bring a knee-jerk protest, "No way! That's *not* worth it!" This resistance to integration and ownership of the psp arises because the psp is coming into the same field of awareness with a conscious knowledge that is sharply at odds with the psp's model of the necessary solution. The conscious knowledge showing up spontaneously as resistance to integration is the very material which, if brought fully into juxtaposition with the psp, could transform the psp's solution and end symptom production. Therefore, therapist invites client to explicitly articulate the knowledge behind the protest—exactly how and why the psp-solution is unacceptable—and then prompts an experiential juxtaposition of this knowledge alongside the psp solution-knowledge.

Working with unconscious resistance

Each of Coherence Therapy's three main phases can encounter unconscious resistance:

1. Resistance to discovery experiences. Consciously the client is willing and trying to cooperate, but resistance in some form blocks the new experience of pro-symptom emotional reality that the therapist has guided the client to have.

Unconscious resistance to discovery experiences is a "no" toward allowing the pro-symptom emotional reality to become conscious. This "no" often proves to be coming directly from the pro-symptom position (psp) itself, which makes the resistant response an excellent opportunity for engaging the psp directly and drawing it out into explicit expression. As the following example shows, this is done by first receiving and acknowledging the psp's "no" with empathy and respect.

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Dispelling Client Resistance in Coherence Therapy (CONTINUED)

Working with unconscious resistance — *continued*

Example of carrying out Coherence Therapy on unconscious resistance to psp discovery: Client's presenting symptom is his reactive anger, which is creating serious trouble at home and work. Therapist wants to probe for whether a central, underlying, unresolved anger is involved:

Th: In your whole life, who is it that you'd say you might have the most anger towards?
Cl: Maybe my older brother.
Th: Would you be willing to picture him right now? Good. And if it feels ok to you, try out saying to him, "I'm angry at you, and I want you to hear why."
Cl: OK. [Pause. To the therapist:] Well, y'know, there's actually *lots* of things I'm mad about. I mean, like, why am I the last guy in the shop that the boss gets a new toolbox for?

Therapist here recognizes resistance to the requested experience of deepening into his anger at his brother, and next begins to apply Coherence Therapy to the resistance itself:

a. Comment neutrally upon the specific form of the resistance:

Th: I notice that we headed away from that anger at your brother pretty fast. Did you notice that?

b. Carry out discovery gently but persistently into the emotional truth of why it was necessary just then to avoid what was avoided:

Th: I wonder if there's a way it's important *not* to reveal or even feel your anger at him. Could we look at that—at why it might be important not to reveal or feel anger at him? What might you guess?

c. Discovery culminates soon in client's overt statement of the emotional truth of the resistance:

Cl: If I show any of my anger at him, he'll be crushed, and he'll start drinking again, and it'll be my fault. So I've *got* to keep my anger at him hidden, a whole lifetime of anger bottled up inside me.

This newly conscious position—the emotional truth of the client's resistance to psp discovery—proves to be itself a psp maintaining his symptom of reactive anger. This illustrates that resistance to discovery often provides direct access to the psp, because it is arising from the psp.

Double dissociation technique is another reliable method for working with resistance to discovery experiences. Double dissociation is a specific way of pursuing the same direction of discovery, but through a smaller, small-enough step that no longer gets resistance. In the example above, the therapist could have used it by saying: "Maybe I created too big a step, in imagining telling your brother you're angry at him. So instead, just imagine a big video screen, and on that screen there's you, and there's your brother; and watch yourself there on the screen saying to him, 'I'm angry at you.' And on that screen, see how that goes between you. [Pause.] And, notice also why it's important *not* to let that actually happen." Double-dissociated accessing is usually workable when direct accessing wasn't.

2. Resistance to integration experiences. The client allows discovery and has a direct, feeling-level experience of the pro-symptom emotional schema, but this soon cuts off during or soon after the session. This resistance arises from an unconscious knowing or position that maintaining awareness of the pro-symptom emotional reality would bring unworkable costs or distress. As the following example shows, this anti-integration position exists alongside the psp, closely related to it but distinct from it.

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Dispelling Client Resistance in Coherence Therapy (CONTINUED)

Example of Coherence Therapy applied to unconscious resistance to psp integration. An underachieving man's psp, after being discovered and verbalized, is, "I better *not* have any real achievements, because if I did, Dad will feel hurt and inferior and worthless and sink into depression." His experience of the emotional realness of this position, vivid during discovery, then shuts down. His anti-integration position is then discovered and verbalized as, "If I'm in touch with that, then I can't bear how *unfair* it feels that my possibilities don't matter and my life goes down the toilet to protect Dad!" The anti-integration position itself must first be addressed (discovered, integrated and transformed) before the client will allow sustained integration of the psp proper. That may require three minutes or three sessions.

3. Resistance to transformation experiences: If the target schema remains real-feeling and triggerable after a set of well-crafted (highly specific and richly experiential) juxtaposition experiences, the therapist should begin to consider that resistance to transformation may be occurring.

Such resistance is not conscious. It occurs if disconfirmation of the target schema (recognition of it as being untrue) would bring some knowing, feeling or consequence that is too distressing to allow, so schema nullification is blocked and the schema remains in force. Even though the target schema is itself a source of suffering, its nullification can bring significant distress in various ways.

So, when a schema remains in force after a well guided set of juxtaposition experiences, the therapist regards the resistance to transformation to be the current symptom and carries out Coherence Therapy on it: The therapist gently begins looking for the specific distress that the schema's nullification would bring. The client is guided in small, tolerable steps to face that distress and to render it workable. As soon as it feels workable, the therapist repeats the juxtaposition experience, and now the schema dissolves.

Example of Coherence Therapy applied to unconscious resistance to psp transformation. John was a father who described an array of emotional and behavioral problems that developed after his daughter Ann's illness resulted in one of her legs being amputated. His Coherence Therapy sessions revealed that at the root of all those problem patterns was John's intense self-blame and guilt for failing to prevent what happened to Ann. The therapist then set up a juxtaposition experience in which John lucidly recognized the truth of his helplessness over her illness. For some minutes John allowed himself to experience that knowledge of helplessness, which could have dissolved his self-blame and guilt. Soon, however, he snapped back into the position that there must have been something he could have done to prevent what happened, and that in some way he was to blame. This was a clear indication that resistance to transformation was occurring. In the next session, the therapist focused discovery work on finding the unacceptable consequence of John knowing he was helpless and not at fault. What emerged was John's lifelong, cherished belief about life: "If you do everything right, bad things don't happen." This fundamental model of the world would be contradicted and shattered if John faced and accepted that he had been helpless to prevent the loss of Ann's leg. It was now clear that protecting that worldview was the coherent purpose of his resistance. And within that worldview, it was actually impossible for what happened to Ann to have happened without it having been his fault. Gently the therapist guided John to face that his cherished belief was being challenged by what happened to Ann. His between-session task was to maintain that awareness. At the start of his next session, John said, "It's a tragedy but it wasn't my fault…" John was now allowing his belief to be modified, so his resistance had cleared and the transformational shift was now occurring. (For full details of this case, see chapter 7 of *Unlocking the Emotional Brain*.)

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Coherence Therapy for Anxiety, Panic and Phobia

Underlying emotional truth of anxiety, panic and phobia: Four types

The four types of symptom coherence defined in general on p. 29 apply as follows to clients who present symptoms of anxiety, panic or phobia (for a more complete account see Bibliography 2000b and 2003).

A. Anxiety/panic/phobia that directly carries out an unconscious purpose/function

Example A1. Chronic anxiety over baby's illness (p. 55)
Example A2. Panic attacks from imagining harm befalling loved ones (p. 56)

B. Anxiety/panic/phobia that is a by-product of how an unconscious purpose is carried out

Example B1. 20 years of panic attacks (p. 57)
Example B2. Paralyzing anxiety over multiple adversities (p. 58)

C. Anxiety expressing unconscious but existentially real vulnerability and uncertainty

When valid anxieties are suppressed and unconscious, a wide range of symptoms can result. Coherence Therapy is applied to make conscious the client's purpose(s) for suppressing awareness that he/she is in anxiety over certain conditions. This in turn leads to awareness of both the anxious/fearful feelings and the anxiety-producing, existential conditions currently occurring in the client's life. The process normalizes the anxiety for the client.

Example C. A male client's father regularly berated him in childhood for feeling any fear or other "weaknesses." To avoid such humiliation and loss of father's love, client represses all awareness of experiencing anything as frightening. When frightening conditions arise he registers bodily feelings of tenseness with no awareness of fear and no recognition of danger. As a result of Coherence Therapy, he experiences the true nature of his dilemma—"Dad puts me down for feeling how scary life sometimes really gets"—and instead of trying to solve this dilemma by repressing his fears, he now solves it instead by feeling and recognizing his fears, while knowingly keeping them completely private from Dad and accepting his own sadness over Dad's limitations as a dad.

D. Anxiety/panic/phobia that is a flashback of original trauma

The fear state in this case is the emotional-somatic component of an original trauma and is a flashback. The flashback does not include the *perceptual* memory-elements of the trauma, so it is not at first apparent that the fear is a flashback.

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Coherence Therapy for Anxiety, Panic and Phobia (CONTINUED)

A. Anxiety/panic/phobia that carries out an unconscious purpose

Example A1. Chronic Anxiety Over Baby's Illness

Symptoms. Continual, intensely anxious preoccupation with health of 20-month-old baby daughter, whose medical condition at birth was life-threatening, but no longer is.

Symptom-positive context discovered: Client was agonizingly unhappy throughout childhood due to continually "cruel," rageful, critical father who "never" expressed warmth or positive regard of any kind.

Discovered psp verbalized in session: "It just hurts 'way too much, it's overwhelming, to feel any of my feelings about my father. And it's gone if I'm all worried about my baby."

The symptom has a function: Her anxiety is a highly effective screen state that is itself the very means of carrying out her purpose of avoiding all awareness of painful father-related feelings.

ORDER OF CONSTRUCT	CONSTRUCT (nonverbal knowledge as verbalized after becoming conscious)
1st Order *Concrete response: Overt thoughts, feelings, behaviors*	**Continuous anxiety over baby daughter's health (presenting symptom)**
2nd Order (UNCONSCIOUS) *Meaning of the concrete situation*	**My baby's illness is something I can worry about constantly and totally occupy my attention.**
3rd Order (UNCONSCIOUS) *Broad purposes and strategies*	**Always keep away from my overwhelmingly painful feelings about daddy.**
4th Order (UNCONSCIOUS) *Nature of self/others/ world (ontology)*	**I cannot survive feeling my hurt, grief and anger over how cruel and unloving daddy is.**

Outcome: Client found that when she chooses not to suppress her emotional pain and grief over father, she is then anxiety-free. (Client ceases to produce symptom when she no longer needs it.) Client then moved forward with long-stuck grief process.

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Coherence Therapy for Anxiety, Panic and Phobia (CONTINUED)

A. Anxiety/panic/phobia that carries out an unconscious purpose

Example A2. Panic From Imagining Harm Befalling Loved Ones

Symptoms: Daily panic attacks triggered for example by knowing that her husband is driving home and is slightly late in arriving: Thinks of him having an accident and panic rapidly builds. Similarly panics over other loved ones. Always feels "strong sense of danger." Staving off the dangers is "like a war." Panic attacks began five years ago. They "replaced depressions" that lasted weeks and they intensified after an earthquake.

Symptom-positive context discovered: Parents were "very religious" Christians. Since childhood feels "very turned-off to religion." Regards self as staunch agnostic and experiences this as difficult because "it makes the world seem chaotic. If you don't have a belief in God, you don't know what's controlling things."

Discovered psp verbalized in session. "If I don't worry, I feel it means I believe we'll live forever and nothing bad will happen—and having *that* belief *will* make bad things happen. I really feel that if I panic, it keeps it from happening. I feel I believe I can get away with nothing happening if I just suffer."

The symptom has a function: Her suffering of panic is itself the very means of carrying out her purpose of protecting the family from uncontrollable harm.

ORDER OF CONSTRUCT	CONSTRUCT (nonverbal knowledge as verbalized after becoming conscious)
1st Order *Concrete response: Overt thoughts, feelings, behaviors*	**Panic attacks (presenting symptom)**
2nd Order (UNCONSCIOUS) *Meaning of the concrete situation*	**My husband driving home is a prime moment of vulnerability, so I must quickly suffer enough to make calamity unnecessary.**
3rd Order (UNCONSCIOUS) *Broad purposes and strategies*	**Always deliberately suffer enough so the universe won't uncontrollably inflict harm on our family.**
4th Order (UNCONSCIOUS) *Nature of self/others/ world (ontology)*	**The universe requires intense suffering in every house and it will actively inflict it if not enough suffering is occurring. If one of us suffers enough, the others won't have to.**

Outcome. Major reduction in frequency and intensity of panic attacks.

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Coherence Therapy for Anxiety, Panic and Phobia (CONTINUED)

B. Anxiety/panic/phobia that is a by-product of how an unconscious purpose is carried out

Example B1. 20 Years of Panic Attacks

Symptoms: "Objects in the room swell and shrink, and get halos around them." Limbs get rubbery, heart pounds violently, feels cold and lightheaded, rapid and shallow breathing. Onset in adolescence or earlier; age 34 now. Intensity and frequency sharply increased with new job entailing responsibility for decisions that affect others.

Symptom-positive context discovered: Family of origin was organized largely around continuous anxious preoccupation with mother's physical and emotional fragility: As a girl, client was reminded frequently that causing mother any trouble or stress could make her health collapse fatally. Several incidents appeared to confirm this vividly and terrifyingly.

Discovered psp verbalized in session: "If I somehow do the wrong thing that upsets you, it could kill you, and it would be all my fault, so I've got to stay unnoticed, out of the picture." From this position, the opposite situation at her new job—visibly having a major influence upon others—is so dangerous and terrifying as to warrant panic.

The presenting symptom is functionless: Her panic is not in itself the very means of carrying out her purpose of keeping herself from harming others. Her unconscious, unpresented symptom of avoiding attention and influence has that function, and her panic is a by-product of *failing* to avoid attention and influence.

ORDER OF CONSTRUCT	CONSTRUCT (nonverbal knowledge as verbalized after becoming conscious)
1st Order *Concrete response: Overt thoughts, feelings, behaviors*	**A. Avoids attention and influence (unpresented, unconscious symptom)** **B. Panic attacks (presenting symptom) (when failing to remain unnoticed and unimpinging)**
2nd Order (UNCONSCIOUS) *Meaning of the concrete situation*	**At this job I am completely visible in directly affecting others, so my lethality could cause grave harm at any moment!**
3rd Order (UNCONSCIOUS) *Broad purposes and strategies*	**I've got to avoid being the focus of others' attention in order to keep my lethality from harming anyone.**
4th Order (UNCONSCIOUS) *Nature of self/others/ world (ontology)*	**I am a dangerously harmful, even lethal presence. My harmfulness can come out without my knowing or controlling it.**

Outcome: Permanent cessation of panic attacks after fourth session; five sessions total.

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B. Anxiety/panic/phobia that is a by-product of how an unconscious purpose is carried out

Example B2. Paralyzing Anxiety Over Multiple Adversities

Symptoms: "Paralyzing" anxiety and overwhelming sense of vulnerability to disaster, in response to major financial and legal jeopardies facing her family, her parents' health crises, conflict with another child's parents, etc. (Same example as on p. 25 illustrating use of two-step technique.)

Symptom-positive context discovered: Client's strict religious upbringing with narrow gender roles and black-and-white definitions of goodness, badness and their predictable, enormous consequences.

Discovered psp verbalized in session. "My life is supposed to be the life of a Good Girl. I'm not willing to give that up! If I get fierce, to fight a battle, I'd seem like a trouble maker or crazy and no longer *be* a Good Girl. So, I'm *not* going to be a fighter and get fierce, even though that leaves me so endangered and so unable to protect us that I'm full of anxiety."

The presenting symptom is functionless: Her anxiety is not in itself the very means of carrying out her purpose of being a Good Girl and having the protected life of a Good Girl. Her unconscious, unpresented symptom of not fighting back even when under attack has that function, and her anxiety is a by-product of this defenselessness.

ORDER OF CONSTRUCT	CONSTRUCT (nonverbal knowledge as verbalized after becoming conscious)
1st Order *Concrete response: Overt thoughts, feelings, behaviors*	**A. Doesn't fight back while under attack (unpresented, unconscious symptom); consequently:** **B. Feels wide open to disaster, utterly vulnerable, and paralyzed by anxiety (presenting symptoms)**
2nd Order (UNCONSCIOUS) *Meaning of the concrete situation*	**These bad things happening to us means I haven't been good enough. I'm unprotected! I've got to try even harder to be good and make no trouble whatsoever, to get the bad things to stop.**
3rd Order (UNCONSCIOUS) *Broad purposes and strategies*	**Never ever make trouble or I won't be that Good Girl and have that protected, good life.**
4th Order (UNCONSCIOUS) *Nature of self/others/ world (ontology)*	**A Good Girl has a good life; bad things will not happen to her.**

Outcome. At six-month follow-up client reported that after her single session she immediately began fighting back by taking assertive actions, and immediately her intense feelings of anxiety and vulnerability had been and still were "hugely eliminated."

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Coherence Therapy for Low Self-Worth

Symptom Coherence in Low Self-Worth

In childhood, to receive mistreatment is to perceive one's abuser as sending a sharply negative message about oneself (unlovable, bad, unworthy, inadequate, stupid, etc.). To accept and believe that negative message is to form negative self-regard (low self-esteem) and to blame oneself for the abuse received, rather than see the abuser as the one who did wrong and failed to be loving.

This self-blaming agreement with the received negative message about oneself is done for a fully coherent, unconscious purpose: agreeing avoids even worse emotional ordeals that would be experienced as a result of not agreeing and not going into negative self-regard. Negative self-regard very effectively avoids all experience of these worse ordeals, which are listed below.

Passage of time does not alter this configuration: Even decades later, the avoided ordeals arise in experience immediately when the person ceases invoking negative self-regard. That is why low self-worth is an especially tenacious symptom: particularly distressing and numerous sufferings arise without it.

Unconscious purpose for creating and maintaining negative self-regard	Ordeal avoided by negative self-regard and immediately encountered without it
1. **Maintain connection with parents** by sharing their definition of reality—agreeing with their negative definition of me	Frightening loss of common ground and emotional connection with parents; painful realization of not being seen or known by parents
2. **Maintain feeling of having power** to stop the abuse (if it is my fault, I could stop it by becoming good enough to deserve love instead)	Frightening powerlessness over stopping the abuse
3. **Preserve safety** by disentitling self from protest or anger that would trigger greater abuse or abandonment (if I agree I am unworthy/inadequate/stupid/etc., then I feel no protest: I deserved how they treated me)	Intensely felt anger and sense of injustice with strong need to express it
4. **Avoid all awareness of betrayal by parents** (if I agree I am unworthy/inadequate/stupid/etc., then no betrayal occurred: I deserved how they treated me)	Vivid feeling of betrayal by parents in their hurtfulness and in imparting a negative view of myself; shattering of my "good" image of my parents
5. **Avoid awareness of living out only a small part of my potential** (if I agree I am unworthy/inadequate/ stupid/etc., then no potential was unrealized)	Intensely painful grief over having lost so much of what my life could have been because I was led to live in a false negative view of myself
6. **Maintain safety from further blows**, attacks, failures (if I agree I am incompetent/stupid/etc., then I will not express myself or try for anything, keeping me safe)	Strong awareness of heightened risks of failure, criticism, and rejection and intense feelings of vulnerability to such blows.
7. **Avoid existential weight of self-responsibility** for how my life goes (success and excellence are not expected of a fundamentally deficient self)	Vivid awareness of heavy weight of existential self-responsibility *List continues…*

Coherence Therapy for Low Self-Worth (CONTINUED)

Symptom Coherence in Low Self-Worth (CONTINUED)

Unconscious purpose for creating and maintaining negative self-regard	Ordeal avoided by negative self-regard and immediately encountered without it
8. **Maintain a view of the world, human nature and/or God** as being fair, sensible, good, orderly (which they are if I agree that how I was treated was due to my own unworthiness).	Crisis of meaning about the kind of world it is that can allow a good, worthy self to be so abused; or a crisis of faith in human nature or God.
9. **Quest for accountability**, apology, remorse from parents by forcing them to see the damage they did to me.	Galling lack of any way to make parents accountable. Acceptance of moving on into wellness without getting acknowledgement of being harmed and wronged.
10. **Quest to collect owed caring attention and nurturance** that others should supply in response to seeing my woundedness and poor functioning.	Grieving of the lack of caring attention received in childhood; letting go of the impossible quest to have a child's proper experience of being taken care of
11. **Quest for owed childhood**: If I believe I'm not capable of much, I'm free of demands and pressures and get to have the carefree childhood I was robbed of.	Grieving of the deprivation of a carefree childhood; letting go of the impossible quest to have a child's proper experience of being carefree
12. **Pseudo-penitence**: I view myself as unworthy or bad in order to do the bad things I want to do and still feel I'm a good person; a bad person wouldn't even feel bad about it.	Authentic self-honesty and struggle with conscience, integrity, values
13. **Disidentification.** By feeling incapable, unconfident, and bad about myself, I make sure I'm not an arrogant, insensitive monster like [Dad, Mom, sibling].	Shadow struggle: Shame and/or self-hatred due to seeing self as having the horrible qualities of the abusive parent or sibling.
14. **Preserve familiar, lifelong identity, roles and patterns of relating to others and to life.**	Sweeping loss of familiar sense of self and familiar roles and patterns

Strategy of Coherence Therapy for low self-worth

- Therapist guides client into *experientially* discovering his/her unconscious purposes for self-devaluing (see procedure on p. 56). (Therapist does *not* introduce purposes through interpretation or explanation.)
- For each unconscious purpose for self-devaluing that becomes experientially conscious, client recognizes an existential dilemma that he/she has been solving by going into low self-worth.
- Client is then guided into engaging each such dilemma explicitly and finding a different solution for it.
- When thoughts and feelings of low self-worth are no longer needed as a solution for each dilemma, client ceases to produce such thoughts and feelings.
- Often this process requires many small steps over a series of sessions because, as the right-hand column in the list above shows, the full, direct experience of each dilemma can be quite arduous. (For examples of Coherence Therapy for low self-worth, see bibliography entry 2000a and the DOBT book, pp. 42-63.)

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Coherence Therapy for Low Self-Worth (CONTINUED)

Case Example: Shame-Based Man in Men's Group

Client: "Jeff," 31, in childhood was regularly criticized and demeaned harshly by his father. He now often plunges into shame and carries an overriding sense of personal deficiency and unworthiness. For example, he feels undeserving of attention in the men's therapy group that he attends.

In the transcript below, a discovery experience reveals one of Jeff's purposes for having negative self-regard. The discovery technique used is symptom deprivation.

Transcript from men's group

"Jeff": Just when you said that, when you said, "Yeah, it's OK" just [for me] to have that piece of time, that just felt really good, you know? Just like, *wow*, you know? Someone values what I'm saying. It's like I'm just — I'm shaking because it's just like, ahhh — it's like accepting responsibility, you know? It's like accepting the responsibility of taking care of myself, you know.

Th: As if you count. **Jeff:** Mm-hm. **Th:** Knowing you count too. **Jeff:** Mm-hm.

Th: *You're* valid, too — all the stuff you *didn't* get from your father.

Other man #1: I really feel like you count. You really matter. You're important to me. I really care about you. I *fully* accept you in the group.

Other man #2: I'm *very* comfortable with you. I *like* you in the group.

Other man #1: I really like having you here in the group. I look forward to seeing you.

Th: Can you handle this?

Jeff: No. There's **half of me that, that brushes it aside**, you know, and half that really wants it and really takes it in, you know?

Th: What would happen if you let it in? *[Symptom deprivation.]*

Jeff: I would be a more whole person. I would be more connected. I would —

Th: But it's brushed aside because of some threatening quality, or problem, so, **what's the unworkable or bad thing that would happen if you really let it all in, deeply?**

Jeff: God, I'm not sure, I don't know. [Long silence.] **You know, what I keep seeing in my head though, is like — I don't know if this is — if I'm imaging, if I'm — I don't know, but, I keep seeing, like, my father being pushed away**, in my head.

Other man #1: [Laughs knowingly.]

Jeff: Like if I do accept this from you guys, then somehow, my dad's gonna go away, you know? And I'm pushing him away.

Summary: Symptom deprivation yielded direct visual and kinesthetic experience of losing familiar connection with father when in a positive self-worth position. Low self-esteem position is necessary for preserving his original bond with father.

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Coherence Therapy for Low Self-Worth (CONTINUED)

Basic Procedure of Coherence Therapy for Low Self-Worth

This is not a rigid protocol but rather a flexible sequence of steps that can be varied to fit for each client.

Step 1. Orientation. Tell client, "In a few minutes you will begin to see for yourself that whenever you, or anyone, go into negative thoughts and feelings about yourself, you're doing it because staying ok about yourself would make something much worse crop up. That understanding is the *key* we will use again and again to create experiences that change this pattern."

Step 2. Specifics. Have client bring to mind a representative, concrete incident of experiencing his/her low self-worth, as though it is happening now, and describe in specifics the externals and internals of what is happening. Elicit self-judgments such as "unworthy," "dumb," "imposter," "inadequate," etc.

Step 3. Received message. Ask client, "When you were growing up, what specific behaviors did your parents or others do, that for *you*, really sent you the message that you're 'unworthy'? Would you describe it to me as though you're watching the scene happening now?"

Step 4. Owning the agreeing. Invite client to visualize parents (and/or others who mistreated client significantly in childhood) and while looking them, to "try out" thinking privately, "*You* think I'm unworthy [or dumb, etc.], so I do, too. I *agree with you* that I'm unworthy. I agree with you about me." Have client repeat these overt thoughts a second time.

Then ask client, "Does it fit? Does it feel true?" If client goes into resistance, suggest he/she try out the variation, "I hate to admit it, but I agree with you about me"; or, "Even though I know better intellectually, in my feelings I agree with you about me—I agree I'm unworthy."

Step 5. Symptom deprivation. "Ok, take a big breath and clear all that away… Let's see what happens if privately you *don't* agree with their negative view of you. Just for a minute or two, see what it's like to look over at them, and see them from a position of just knowing that you're fine; that you're basically adequate and worthy, with a normal balance of strengths and weaknesses like we all have. No evidence needed; you just know you're an ok human being, as you look at them. See what you experience if you look over at them knowing you're ok, privately not agreeing with their negative view of you—knowing they're wrong about you. See if you can get a glimpse of that." Persist.

Client experiences and describes some form of loss or distress (for example, a visual or kinesthetic sense of greatly diminished connection or a stab of grief) that comes with relating to parents from position of positive self-worth. This is the initial surfacing of an unconscious, dire existential dilemma that client avoids by maintaining negative self-regard. In the client's pro-symptom position, the unconscious purpose for self-devaluing is the avoidance of the loss or distress now surfacing.

Complete symptom deprivation by mirroring client's experience back to her/him. For example, "OK, you just tried out *letting yourself feel worthy*, and then immediately what you experienced is that letting yourself feel worthy brings this [loss of connection, painful grief, etc.]."

Continues…

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Coherence Therapy for Low Self-Worth (CONTINUED)

Basic Procedure of Coherence Therapy for Low Self-Worth (CONT'D)

Step 6. Cycling. Prompt client to again take a clearing breath, then resume looking at parent(s) while again *having* the usual thoughts and feelings of low self-worth. Then ask client if the specific loss or distress that arose in Step 5 is still present. Client reports that it is not present. Verbally recapitulate client's descriptions succinctly—for example, "What I'm hearing from you is that, if you *stay* in feeling you're *un*worthy, then in your image Dad is up close and is pretty big, and your sense of connection with him is fully there. But if you step *out* of feeling unworthy and know you're ok, then he's *not* close any more; he's receding or shrinking, and your sense of connection feels diminished; there's much more distance. Is that right?"

Step 7. Overt statement for integration. Ask client to say out loud his/her own overt statement of the emotional truth found in previous steps, while visualizing parent(s) at a moderate distance so they cannot hear. Collaboratively craft the phrases to capture adequately the direness and passion in what is at stake for client. For example, "Dad, if I know I'm ok, then it feels like you don't know me at all and never did, and I feel so disconnected from you, and that's so scary [or so sad, or whatever is accurate for client] that it's worth feeling I'm unworthy to stay connected with you. Then we're still in the same reality—we both see me the same way." In integrating this emotional truth, the client apprehends that for him to step out of low self-worth is to step into a great dilemma of separation-individuation, so he resorts to thoughts and feelings of unworthiness not because they are true, but to avoid a rupture of felt connection with his father that would make client feel much more on his own in the world.

Step 8. Between-session tasks of integration. Write overt statement from Step 7 on index card for daily reading; this is the initial between-session task. After some progress with integration, assign real-time recognition (use of the symptom as a signal): "Whenever you notice yourself going into thoughts or feelings of being unworthy, these thoughts or feelings right then are your *signal* to remember what's on the card—how feeling unworthy keeps you feeling connected with Dad, because then you're still the son he knows. So it's a *signal* for you to ask yourself: 'What was happening for me just then, that I needed a fresh sense of being the son Dad knows, instead of the son he doesn't know?' I'll write that question on a card for you too. See what comes with trying that, and we'll see how it went at our next meeting." Integration tasks must be sustained with persistence from session to session.

Step 9. Transformation. With ongoing integration it becomes more and more clear and real to client that he/she goes into thoughts and feelings of self-devaluing not because they are true, but because they completely block any awareness of some extremely painful, existential dilemmas (see accompanying list). Early in the discovery process these dilemmas may be too painful and disturbing to allow into awareness for more than a glimpse at a time, but they become more tolerable to experience. Finally, when the client no longer needs to avoid experiencing them and is grappling directly with them, he or she no longer goes into self-devaluing because the only purpose for that—avoidance—no longer exists.

NOTE: This procedure must be carried out for each of client's several operative, unconscious purposes for self-devaluing (see list). The session-to-session process of working with these several distinct purposes typically is highly nonlinear. Therapist must carefully keep track of the various co-present themes and purposes that have emerged and are in different stages of discovery/integration/transformation.

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Coherence Therapy for Low Self-Worth (CONTINUED)

Hierarchy of Unconscious Constructs in Low Self-Worth

Example

Each of the purposes for self-devaluing (see list, pp. 53-54) represents a separate pro-symptom position. Below is the hierarchy of constructs for the pro-symptom position in which the purpose is preserving connection with parents.

ORDER OF CONSTRUCT	CONSTRUCT (nonverbal knowledge as verbalized after becoming conscious)
1st Order *Concrete response: Overt thoughts, feelings, behaviors*	**Thoughts and feelings of being deficient/unlovable/unworthy; feelings of shame; perfectionism; compulsive pleasing; etc. *(presenting symptoms)***
2nd Order (UNCONSCIOUS) *Meaning of the concrete situation*	**I'm being [neglected; beaten; denigrated; molested; etc.] by Daddy because I'm unworthy of good treatment and love. It's my fault. Daddy's right about me.**
3rd Order (UNCONSCIOUS) *Broad purposes and strategies*	**At all cost I've *got* to stay connected with Daddy: I've got to feel, think and act in whatever way keeps me in shared emotional reality with him; I've got to agree with his view of me.**
4th Order (UNCONSCIOUS) *Nature of self/others/ world (ontology)*	**My survival is totally dependent on my connection with my parents. Disconnection is horror and death.**

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Use of Client-Therapist Relationship in Coherence Therapy

Therapeutic effects of the client's relational experience of the therapist

1. Calming accompaniment. For many clients, to approach their pro-symptom material on their own would bring feelings of aloneness and/or fear that are unbearable. Feeling accompanied by the therapist greatly reduces these daunting feelings, making it workable to go into the material.

2. Fostering alignment of neocortex and limbic system. Going into unconscious emotional material alone (without the therapist being present) would, for many clients, result in merely merging into the troubled material and re-suffering it helplessly in its original intensity, a plunge into the limbic system without retaining the neocortical, adult, observing self. In contrast, being in empathic interaction with the therapist while going into the troubled, pro-symptom material helps anchor the client in his or her adult, observing self, which has two crucial effects:

(a) As experienced by the client's full adult self, the material is now tolerable (whereas it is intolerable if merely merged into) and the client can open to it and allow integration of it.

(b) Encountering the material from the perspective of the adult state allows the client to recognize metacognitively the symptom-generating meanings (the pro-symptom constructs) she or he originally formed, which sets the stage for transforming them.

3. Utilizing transference. Working with client transference is with certain clients an effective way to access and transform pro-symptom positions (see pp. 60-61).

4. Creating the experience of neuro-affective well-being. In fully integrating a pro-symptom position, whatever its specific content, Coherence Therapy clients experience:

- a deep connection-with-self
- the actual coherence of self
- a profound authenticity of self
- being seen, heard, intimately understood, honored and affirmed at this same, vulnerable level of depth by another human being (the therapist)

While in this state of both connection-with-self and connection-with-other, the client's limbic system and right brain are to a significant degree restored to their native state of well-being—calm, undefensive, a full member of the human family. The experience of this state, which is an inherent result of Coherence Therapy methodology, is an important goal of therapies having a neurobiological orientation to attachment theory (as advocated for example by Diana Fosha, Allan Schore and Daniel Siegel).

While utilizing the client-therapist relationship is always an option in Coherence Therapy (see next page, "Client transference: When to focus the work on it"), the methodology does not in general require working with, or calling attention to, the client-therapist relationship or client transference. With a majority of clients, neither the presenting symptom nor the underlying material driving it (the pro-symptom position) becomes involved at all in the client's relational experience of the therapist. With such clients, it can border on the absurd to try to resolve the presenting problem by focusing on the client-therapist relationship. Coherence Therapy ushers the client into neuro-affective well-being with or without a focus on the client-therapist relationship, as appropriate for dispelling the presenting problem.

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Use of Client-Therapist Relationship (CONTINUED)

Client transference: When to focus the work on it

The client-therapist relationship becomes the focus of Coherence Therapy in two situations:

Transference "A": Client produces his/her presenting symptom during sessions in reaction to therapist. A transferential occurrence of the presenting symptom, like any real-time occurrence of the presenting symptom during a session, is the most opportune condition for engagement of the pro-symptom position, even more so than having client imaginally experience an incident of the symptom happening (the usual method).

Transference "B": Client develops a transference reaction to therapist that is different than presenting symptom and thwarts work on presenting symptom.

The following two methods apply to both types of transference.

Method #1 for utilizing transference: Coherence Therapy as usual

Regard a particular manifestation of transference as the "symptom." Conduct Coherence Therapy as usual, surfacing and integrating the emotional reality necessitating this symptom. Therapist is now the emotionally relevant person addressed by client in experiential process of discovery and integration of pro-symptom positions.

Method #2 for utilizing transference: "Who else?"

Step 1. Transference cues. Notice client's behaviors that possibly indicate an unacknowledged emotional reality is currently activated in relation to you. For example, client seems unusually quiet and is making less eye contact than usual.

Step 2. Mirror transference cues and invite verbalization. For example, "I just want to mention that you seem kind of quiet today; and also looking at me less than usual. Maybe it's nothing, but I'm wondering if there's anything to it." Offer no interpretation.

Persist if client is not readily forthcoming: "If it's nothing, or if it's something you really don't want us to get into, ok—but I hope you feel free to say what it is, if there *is* something to it. Maybe it's something you want or need to say to *me*."

Client reveals, for example, that what therapist said near end of last session meant therapist does not want to see him any more and will abandon him, and client is now in fear and anger over this.

Step 3. Accurate empathy and verbal mirroring. Therapist responds, "I *see*—when I said [such-and-such] last time, that really sounded to you like it meant I don't want you as a client and that I'd probably stop seeing you—that I'd abandon you. And then naturally you're feeling fear about that and angry at me for it. Well I'm really glad you told me—I appreciate it."

Step 4. Invite overt statement. Therapist continues, "Well, I'd like you to have the satisfaction of really saying the full emotional truth of this to me. Maybe something like, 'Bruce, what you said means you want to abandon me, and now I'm scared you might, and I'm really mad at you over it.' Or whatever words really fit for you." Therapist receives client's overt statement with empathic understanding.

Continues...

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Use of Client-Therapist Relationship (CONTINUED)

Method #2 for utilizing transference: "Who else?" — *continued*

Step 5. Taking the blame. Therapist apologizes for either not realizing that how she/he spoke would seem to mean "abandonment" and cause distress; or, for actual insensitivity or error identified by client. Process with client until she/he feels heard, validated, and reassured.

Step 6. Ask "Who else?" Tell client, "You know, right along with this process between us over this, I'm also wondering if there's anyone else in your life, to whom it also feels true, or felt true, to say the same thing you said to me: 'You want to abandon me, and now I'm scared you will, and I'm really mad at you over it.' Does saying that feel familiar toward anyone important in your life?" Client identifies parent(s), older sibling, or other key figure.

Step 7. Invite overt statement. Ask client, "I wonder if you'd be willing to picture him/her/them, and try out saying those words right to him/her/them." Client does so and immediately deepens into direct experience of underlying interpersonal themes that were being projected onto the therapist. Next:

(a) If the transference included producing the presenting symptom, this material is the client's pro-symptom position; continue to discover, integrate and transform it.
(b) If the transference did not entail the presenting symptom, client and therapist now decide whether to make this material an additional focus for therapy.

Note: The "Who else?" technique can be used as a technique of psp discovery and initial integration whenever a client's presenting symptom is a current reaction to spouse, boss, etc. Usher client into an overt statement of the current reaction, as in step 4, then carry out "Who else?" as in steps 6 and 7.

The Coherence Therapy Process Pattern: How to Maintain Continual Pro-Symptom Focus

The process used by the therapist for carrying out Coherence Therapy methodology throughout an entire session is described step-by-step on the following pages. Through this procedure your sessions will naturally zero in swiftly on the underlying, symptom-necessitating material.

Whole-session training exercise. A major step in training consists of conducting practice sessions by following this process pattern for the entire session. The client should be a therapist colleague who presents either an actual (but mild) current problem of their own or role-plays one of their own clients.

Refer freely to the following two pages of instructions throughout the session. Most centrally remember:

- This is an exercise firstly in *maintaining the coherence-minded, pro-symptom focus for an entire session,* continuously—finding and embracing how the symptom is necessary to *have*.

  This means, *do not say or do anything designed to counteract, fix or prevent the symptom*—
  do not give alternative behaviors or beliefs, communication tools, how to calm down, etc.
  In Coherence Therapy it should never feel to you that you are trying to make clients *stop* being how they are, or trying to make them *be* how they aren't.

- This is also an exercise in *creating experiences of discovery and of integration* of client's pro-symptom position(s) (psp's). This means, do not *explain* or *interpret* any psp to client. Your task is to usher client into her/his own direct, subjective *experience* of psp(s), using basic techniques.

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The Coherence Therapy Process Pattern: How to Maintain Continual Pro-Symptom Focus

This is the process pattern for the first session of therapy for a newly presented problem or symptom, whether with a new or ongoing client. (Second and subsequent sessions begin differently than steps 1 and 2 below, but steps 3-7 apply. See p. 65.)

1. Learn from client what to regard as the presenting symptom

- Empathize initially with client's anti-symptom position but do not keep following client's focus there.
- Ask client to bring to mind a good recent example of the symptom or problem happening.
- Use queries on p. 11 for eliciting the concrete *what* and *when* of the symptom in that scene.
- Do not proceed further until you get a concrete description that is clear to you. Do not stop with blurry abstractions such as "depressed" or "anxious." Elicit specific thoughts, emotions, bodily sensations, behaviors and sequences. Do these elements reveal the symptom-positive context? Choose specific feature to use initially as point of departure for discovering a psp.
- Bear in mind that as discovery proceeds and you learn of other features that constitute and maintain the problem, you might change what you regard as the symptom to a deeper, more causal element.

---

2. Begin discovery process: Create a discovery experience

Apply any one of the experiential techniques below. Do this soon, while you are still in the dark. Do not wait until you have *talked-about* long enough to *figure out* client's pro-symptom theme and purpose.

- Overt statement (to the emotionally relevant person[s]) (p. 13)
- Sentence completion (worded to elicit the necessity of the symptom) (p. 15)
- Symptom deprivation (imaginal replay of recent instance but *without* the symptom) (p. 20)
- Two-step (What shift would eliminate the symptom? How is it important *not* to make that shift?) (p. 25)

Persist. If the technique you're using yields nothing of pro-symptom relevance, try next another technique or a variation in the first one.

---

3. Screen client's response and select elements with pro-symptom relevance

Digest client's response to the previous step in this way:

a. Stop. Actually stop. If needed say, "Let's pause."

b. Remind yourself of what the concrete symptom is (whether the feature you first identified, or a feature you switched to, or current client resistance). *Proceed only with the symptom clearly in mind!*

c. Mentally review every part of what client has just expressed. Look at each element for how it might be tipping you off to any way that the symptom could be necessary to have or makes sense to have. (See p. 8.) Select the element that seems to you to have such pro-symptom relevance.

(If there is more than one, select for strongest pro-symptom relevance. If there are none, carry out another step or variation of the technique used in step 2 above, and then do step 3 again.)

---

4. Choose the *type* of experience to create next: discovery, integration or transformation

You are going to focus the client's attention on the element you selected in step 3, and use that element as the starting point for a new experience of either discovery, integration or transformation. You will now decide, based on the selected element, which of these three types of experience to create next. The choice may be intuitively apparent to you, or you can use the following criteria to make the choice:

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The Coherence Therapy Process Pattern: How to Maintain Continual Pro-Symptom Focus (CONTINUED)

Choose *discovery* if the element selected in step 3—

- is not strongly disturbing or disorienting to client, so going deeper is workable and safe, and
- is not yet deep enough to include the psp *purpose,* so going deeper is needed

Choose *integration* if the selected element—

- is newly-surfaced, significant pro-symptom meaning that warrants apprehending in itself (consider using for this, in Step 5, a simple overt statement of the element)
- has significant emotional charge for client that requires processing and stabilizing (to check for this, ask client, "How is it for you to be in touch with this?"; watch for resistance to the experience)
- explicitly reveals pro-symptom *purpose*, allowing next an integrative step of *connecting-up* (see p. 37)
- explicitly reveals the *two sufferings*, allowing next an integrative step of *pro/anti synthesis* (see p. 38)

Choose *transformation* if the selected element—

- is a key construct within client's psp and you want to put this element in living juxtaposition with some other, incompatible piece of reality that disconfirms it experientially—

  but beware your own counteractive reflex, which would make you try for transformation too soon, in an attempt to get *rid* of pro-symptom material rather than have the client first embrace it, own it, live with it, *integrate* it. Even if psp seems to be transforming spontaneously, as a rule it is best to continue creating integration experiences of psp, which enhance thoroughness of transformation.

---

5. Design *how* to create the type of experience you chose in step 4 to create next—

—by letting yourself *feel* for your own natural way to do so: Sit still, hold the intention to create the type of experience you chose in step 4, and let the knowingness of *how* to do it arise for you in the same way you know which arm to use to open a door. Trust what comes.

If you need to look at a list of techniques to choose from, do so (p. 66 or cue-card), but do so only as an aid to selecting a technique by *feel* in this way, not by going up into your head and intellectually figuring out which is the "right" one to use.

Then carry out the technique you've picked for creating the type of experience you chose in step 4.

---

6. Repeat steps 3, 4 and 5 (over and over, until 10 minutes remain in session)

Goal of discovery and integration work is the well-defined *purpose* in client's pro-symptom position.

---

7. Create post-session task of integration during final 10 minutes

Together with client create succinct sentences in limbic phrasing that vividly captures the most important pro-symptom material accessed during session (see p. 39 for phrasing guidelines). Write these on an index card, give to client and recommend reading every day, morning and evening.

Optionally, also assign post-session task of real-time recognition and/or hindsight recognition.

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The Coherence Therapy Process Pattern: How to Maintain Continual Pro-Symptom Focus (CONTINUED)

Process pattern for second and subsequent sessions

1. Follow up on between-session task from previous session

Begin session by following up on the between-session task. Determining the client's relationship to the material in the task, including whether resistance arose, is absolutely necessary in order to know what to do next in the process of discovering and integrating the pro-symptom position involved in the task.

Most between-session tasks are designed as integration experiences for forwarding integration of pro-symptom material so far discovered. The main way to know whether further integration actually occurred —whether client is now routinely in touch with the pro-symptom material targeted in the task—is to see if the client now refers specifically and with feeling to that material *on his/her own initiative*. Therefore the following questions deliberately do not remind client of the specific content of task material.

- "How'd it go with your homework?"
- "How was it for you to stay in touch with what we put on that card?"
- "What did you experience in doing that practice that we set up?"

If client wants to focus on a different problem in this session, ask client to report on the task first. That done, probe for resistance: "Can we first look briefly at whether some part of you might be not so keen about where we were heading?" If no resistance is found, ask, "Will we resume that work in next session?"

2. Observe whether client's response refers explicitly to the task's specific material

If client initially responds to step 1 above with a general, ambiguous answer—such as, "It went well"—persistently probe further for integrated awareness of the material by asking questions such as these:

- "How was it to be in touch with the specific parts of it?"
- "Do you now feel you're steadily in touch with the specific parts of it?"
- "What part of it felt most alive or important to you?"
- "Did all of it continue to ring true, like it seemed to in our last session?"

This task assessment process will reveal one of the following five outcomes of the task.

TASK OUTCOME	THERAPIST'S RESPONSE
(a) Task material stayed emotionally alive and true, and client stayed in touch with it and still is.	Integration was successful. Next, carry out steps 3–6 of Coherence Therapy process pattern (on previous two pages).
(b) Same as (a), and in addition the task led to a further awareness and/or a shift in view, mood and/or behavior.	Integration was successful. Next, carry out steps 3–6 of process pattern on previous two pages.
(c) Task material stopped feeling true as client worked with it, so client disengaged from task.	Ask client, "Was the wording inaccurate in some way?" "How would you revise the wording to have it feel true?" If necessary, review the work in the previous session that led to the task material. Persist in re-truing until the material again resonates emotionally for client. Then carry out steps 3–6 of process pattern on previous two pages. *Continued...*

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The Coherence Therapy Process Pattern: How to Maintain Continual Pro-Symptom Focus (CONTINUED)

TASK OUTCOME	THERAPIST'S RESPONSE
(d) Task material continued to seem fully true factually, but stopped feeling emotionally alive and real. Went flat. (e) Client did task little or not at all, with or without knowing why; or client "forgot" about it.	Resistance to integration is indicated; an unrecognized position exists, in which it is necessary not to be emotionally in touch with the task material. Tell client, "Let's see if some part of this task was too big a step in some way we didn't realize, or was heading toward something too unwelcome." Then, temporarily viewing the resistance as the symptom, carry out Coherence Therapy on the resistance until the emotional truth of the resistance—why it is necessary to have—is found and transformed. (See pp. 47-48.) This could take 3 minutes or 3 sessions. Then bring focus back to the task material and resume the work on it.

List of Techniques

This is an open-ended, non-exhaustive list of techniques useful for carrying out Coherence Therapy. Coherence Therapy is defined not by specific techniques, but by its coherence model of symptom production and its tripartite methodology of discovering, integrating, and transforming symptom-requiring emotional schemas, using any suitable experiential techniques for doing so.

TECHNIQUES OF DISCOVERY

—Engagement condition
—Overt statement
—Sentence completion
—Symptom deprivation
—Two-step
—Imaginal interaction
—First time
—Mind-body communication
—Who else?

TECHNIQUES OF INTEGRATION

In-Session

—Overt statement
—What's the connection?
—Cycling
—Pro/anti synthesis
—Connecting-up

Between-Session

—Index card reading
—Real-time recognition (use of symptom as signal to feel pro-symptom position)
—Hindsight recognition (delayed replay with real-time recognition)

TECHNIQUES OF TRANSFORMATION

Experiential disconfirmation: juxtaposition of pro-symptom schema and incompatible living knowledge found via:

—Overt statement
—New meaning revelation
—Guided reenactment
—Opposite current experience
—Opposite past experience

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Training Guide for the Coherence Therapy Learning Curve

Guidelines for Skill-Building and Troubleshooting

Learning an unfamiliar modality of therapy is challenging and requires real determination, even if the new approach has strong appeal. The guidelines below for Coherence Therapy skill-building and troubleshooting assume familiarity with the methodology and its principles. Guidelines are grouped under these headings:

- **Carrying out the whole methodology**
- **Embracing "immediate accessibility"**
- **Maintaining pro-symptom, noncounteractive focus for whole sessions**
- **Working experientially**
- **Don't know what to do next!**
- **What it means if the symptom keeps happening**
- **Other blocks to learning and applying Coherence Therapy**
- **Defining features of an exemplary Coherence Therapy session**

Carrying out the whole methodology

- **Fragmentary use of Coherence Therapy.** Spotty use of this or that piece of Coherence Therapy mixed in with your more familiar ways of working is the natural tendency because it is the lowest-anxiety way to try it out while learning it.

Suggestion. Spotty use will not yield Coherence Therapy's therapeutic effectiveness or effective learning. Sticking with and carrying out the full methodology with a particular client, even if done falteringly and unartfully, is what will best ground you in Coherence Therapy and get the kind of results that motivate you to stick with it.

Suggestion. For successful learning, do not select the most challenging sort of client with whom to do only Coherence Therapy. Start rather with someone who presents a readily well-defined symptom or problem, such as anxiety attacks, depressed mood or procrastination, and require yourself to do *nothing but* Coherence Therapy with this person, tolerating the unsureness you will feel at times.

Suggestion. If you want to switch to Coherence Therapy with a client you've been seeing for some time, the transition is easiest if negotiated transparently. For example, you might say, "I've been thinking about you in connection with some other, rather different ways we could work. Is it ok with you if we try out something that will feel different?"

- **One-song band.** Some therapists form an oversimplified, narrow version of Coherence Therapy—for example, locking onto symptom deprivation or sentence completion and doing nothing but that, over and over, in each session.

Suggestion. Coherence Therapy's methodology is the experiential discovery, integration and transformation of pro-symptom emotional schemas or positions. For carrying out each of those three activities there exists a very wide range of techniques. Any experiential techniques you know can be applied to this methodology. The work looks, feels and sounds very different with different clients. There should be nothing mechanical or rubber-stamped about it. Study published case vignettes or videos to broaden your view of how organically and diversely the methodology plays out.

- **Inconsistent use of between-session tasks,** as though they are optional parts of Coherence Therapy.

Suggestion. Creating a between-session task of integration at the end of every session is mandatory, not optional. This too should not be a spotty practice with your Coherence Therapy client(s). Plan for the last 5 or 10 minutes of each session to be a review of the key emotional truths or positions experienced in the session. Then create a between-session task to further the client's integration of this material—at least an index card.

- **Fading out on Coherence Therapy**—sliding off the learning curve.

Suggestion. Some form of fresh exposure every week or two is typically needed for maintaining focus and staying in touch with your attraction and your motivation to keep learning. You can watch a training video; rethink one of your other clients in terms of Coherence Therapy; do a practice session with a colleague; meet with a small group of colleagues interested in Coherence Therapy for discussion or case consultation; or read a published case example.

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Training Guide for the Coherence Therapy Learning Curve

Guidelines for Skill-Building and Troubleshooting

Embracing "immediate accessibility"

- **Blocked by notions of deep, early material as structural and inaccessible.** Belief that unconscious patterns of cognition, emotion and behavior that were formed and held over many years of developmental history are inaccessible or structural and therefore must take years to access and revise.

Suggestion. This is perhaps the single most dominant belief in the field, for a century. However, "unconscious" at bottom means nothing more than "unattended," not "inaccessible." There is nothing fundamental preventing the client's attention from going right now into parts of her or his world of meaning where it has not gone for decades, or ever. Yes, the client may have potent reasons not to attend to certain material ("defenses," "resistance"), but this too is accessible and transformable in the present session and does not actually amount to inaccessibility, as many published case studies of Coherence Therapy demonstrate. Whole paradigms hinge on this belief. To let go of it can be a difficult and courageous reorientation.

- **Blocked around trust-building.** Belief that it necessarily takes much time for a therapy client to develop sufficient trust in, and alliance with, the therapist as required for in-depth work in vulnerable areas.

Suggestion. Yes, the client must develop adequate trust in the therapist, but adequate trust can develop very quickly for most clients for this reason: trust develops not from time, per se, but from the therapist having an emotionally safe presence. To put it bluntly: How much time will it take to develop trust if the therapist does *not* have an emotionally safe presence? A therapist has an emotionally safe presence if he or she is unafraid of the client's emotions and emotional truths, is empathically highly attuned, is relaxed and authentic, does not impose interpretations, has no need for the client's dependency, and actively seeks to meet and understand the client's emotional truth in relation to the presenting problem. A majority of clients immediately feel enough trust in such a therapist for deep work to begin in the first or second session.

- **Blocked around clients' fragility.** Belief that people do not have the inner skills, ego strength and courage needed for working with their unresolved emotional material immediately and directly; therefore using methods that bring clients into this material will be harmful, not therapeutic.

Suggestion. The aim in Coherence Therapy is for the pace of getting in touch with unconscious, underlying emotional truths to be set by the client's actual capacities, rather than by the therapist's theoretical assumptions or fears of fragility. A well-attuned therapist quickly learns whether a particular client needs each step of discovery or integration to be very small, and if so, parses down the process accordingly. With skillful guidance from a therapist who is unafraid of emotional process, most clients are quite capable of opening up to their underlying material at a pace far greater than is expected by "fragilists." Assumptions of client fragility are sometimes part of a therapist's attachment to being seen and needed as a savior or guru.

- **Blocked around transference.** Belief that the gradual arising of transference is the only reliable way to access directly the client's real issues.

Suggestion. Besides working with client transference, there are many possible ways of accessing underlying emotional themes, as demonstrated in published case examples and videos of Coherence Therapy. With certain clients transference is the best avenue, but with most clients it is not because the emotional issues underlying the presenting symptom do not come into play in relation to the therapist.

- **Blocked around DSM Axis II.** Belief that character disorder has an unconscious basis that is *not* readily accessible.

Suggestion. True, at the severe end of the spectrum of character disorder, the underlying emotional themes and purposes are not likely to be immediately accessible. However, this is a small fraction of clients. Many clients who manifest clear traits of character disorder nevertheless are Coherence Therapy successes. Again, the therapist should not foreclose on the possibility of a given client doing rapid, deep work. Learn what each client is capable of.

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Training Guide for the Coherence Therapy Learning Curve

Guidelines for Skill-Building and Troubleshooting

Maintaining pro-symptom, noncounteractive focus for whole sessions

- **Loss of pro-symptom focus: Anti-symptom departures from Coherence Therapy.** Having the mindfulness and the ability to keep the work focused on pro-symptom positions for whole sessions is a major aspect of proficiency in Coherence Therapy. However, it can at first be elusive or counterintuitive to hold to the pro-symptom focus and to desist completely from the deep habit of making anti-symptom, counteractive interventions—even when your conscious intention at the start of a session is to stay on the coherence or pro-symptom track. This abandonment of the pro-symptom focus is itself coherent and is due to one or more of these four blocks:

  A. Performance anxiety over being perceived by client as ineffective or inept.

  B. Beliefs that the pro-symptom focus will be harmful, counter-therapeutic, or less effective than anti-symptom methods.

  C. Beliefs that no pro-symptom position exists; that this client's problem is outside Coherence Therapy's model.

  D. Therapist's unresolved, unconscious personal issues.

Each of these blocks has several particular forms, as itemized below. First, an overall guideline:

Suggestion. **How to put your anti-symptom departures in service of learning Coherence Therapy.** When for any reason you switch over to anti-symptom interventions (such as teaching a relaxation technique to counteract anxiety, or setting up action plans to counteract procrastination), there is a natural way for this to feed back into and foster your learning: Whenever you subsequently learn from the client that the anti-symptom intervention didn't work—didn't prevent or override the symptom or wasn't used by the client—this failing of the intervention is now your *signal* to:

1. Think, "Ah, yes: this means the symptom was in some way more important to have, than not to have, in that situation. Let's find the emotional truth of *that*." Thinking this way returns you to Coherence Therapy.

2. Carry out steps of discovery into how the symptom was necessary in that situation, until client bumps into the emotional truth of it. (This must be truly experiential work. If working experientially is new to you, at first keep using simple, basic techniques of discovery: overt statements, sentence completion or symptom deprivation.)

3. Create steps of integration of the discovered pro-symptom position both during and between sessions.

Loss of pro-symptom focus due to:

- **A. Performance anxiety over being perceived by client as ineffective or inept.** While learning an unfamiliar system of therapy and still faltering along the learning curve, at times during sessions you might feel intense anxiety over the danger of being seen as inept by your client. To quickly dispel both the anxiety and the danger, you might involuntarily drop the unfamiliar, pro-symptom focus of Coherence Therapy and switch back to familiar methods.

Suggestion. To some degree this pattern is natural and unavoidable. After any session in which this occurred, identify in hindsight the specific dilemma you were having in carrying out Coherence Therapy when your anxiety became too intense to endure. For example, did you get lost or not know what to do next? Did you have worries about experiential steps fizzling? Were you daunted by the emerging pro-symptom material or by the client's discomfort with it? When you have identified your anxiety-producing concern, look it up in these guidelines and focus your learning there for the time being.

Suggestion. The type of role you inhabit as therapist has an enormous influence on the level of anxiety you feel in learning and applying Coherence Therapy. Maximum image anxiety is generated by wanting to be seen by clients as a wise doctor-authority or healer-savior who understands the client's mind and problem better than the client does. Such roles are largely incompatible with Coherence Therapy. The therapist's optimal role in Coherence Therapy is a combination of spelunking guide, bloodhound, anthropologist and process coach who prompts step after step of creative pathfinding into the client's network of personal constructs.

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Training Guide for the Coherence Therapy Learning Curve

Guidelines for Skill-Building and Troubleshooting

Maintaining pro-symptom, noncounteractive focus for whole sessions (CONTINUED)

Loss of pro-symptom focus due to:

B. Beliefs that a pro-symptom focus will be harmful, counter-therapeutic, or ineffective.

- **Let's split.** The pervasive belief that counteracting and opposing is effective for change is deeply ingrained. The corresponding automatic tendency of therapists is to make anti-symptom interventions.

  Beyond this habitual inclination, many therapists have explicit or implicit beliefs that the therapy or the client would be harmed by opening up to the emotional schema underlying and requiring their symptom. Such beliefs are accompanied by an automatic reflex-urge to get the client *away* from and *out* of the pro-symptom emotional reality as quickly as possible, rather than *into* it, as Coherence Therapy would have you do. Doing Coherence Therapy heads straight toward the very material causing all the trouble and pain, and can seem like running *into* a burning house instead of out of it. Various such beliefs contrary to a pro-symptom focus are addressed throughout these guidelines (such as beliefs in client fragility, in the structural nature of the underlying material, in an inherently lengthy timescale for change, etc.).

Suggestion. To do Coherence Therapy requires a fundamental conviction that bringing the client *into* his/her pro-symptom position consciously, at the pace he or she is capable of handling, is the most potent way to dispel that position's autonomous power and the shortest path to its transformation. Remember (a) the client's pro-symptom position is the position, or part, that actually has control over producing the symptom, and (b) people are able to change a position they experience having, but are not able to change a position they do not know they have.

- **Coherence Therapy just for openers.** Some therapists intending to do Coherence Therapy proceed with the discovery work but then automatically revert to anti-symptom methods at the point when steps of discovery have succeeded and the client's pro-symptom theme and purpose have just become clear. The therapist's anti-symptom reflex now jumps in eagerly because exactly *what* to counteract has come into view—gotcha! The therapist is in effect using only the discovery part of the Coherence Therapy methodology in order to find *what* to counteract more swiftly and accurately than ever before. To instead stick with Coherence Therapy at this point would be to immediately carry out steps of integration—heading straight toward and into, rather than away from, the pro-symptom material, ushering the client to feel, inhabit, embrace, and own it.

Suggestion. Focus on a specific moment with a specific client when you followed this pattern and bring to light your own emotional truth of why proceeding with integration was important *not* to do just then. Perhaps replay the scene, this time guiding the client right into the pro-symptom material, and if any uneasiness crops up for you, feel and verbalize it fully, until you are fully in touch with what you were avoiding or protecting by not pursuing integration.

Loss of pro-symptom focus due to:

C. Beliefs that no pro-symptom position exists; that this client's problem is outside Coherence Therapy's model.
If you think the client's symptoms or issues are outside Coherence Therapy's model of coherence and agency—if you don't believe a pro-symptom position could be the symptom's underlying cause—you will drop Coherence Therapy and switch to other, familiar models and methods. Some forms of this block:

I believe there is no pro-symptom position for this, because...

- **I can't imagine that a symptom so distressing and unwanted could be "necessary to have" in any way.**

Suggestion. Study published case examples of Coherence Therapy with similar symptomology in order to see that a psp indeed exists even for such symptoms.

Suggestion. Do not equate existence of psp with "function of the symptom"; remember that symptoms can be functionless yet still coherently necessitated by a psp. (See p. 3 and pp. 28-29.)

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Guidelines for Skill-Building and Troubleshooting

Maintaining pro-symptom, noncounteractive focus for whole sessions (CONTINUED)

I believe there is no pro-symptom position for this, because…

- **The presenting symptom is too diffuse and pervasive**, has too many aspects, and is too difficult for client to describe. There is none of the well-defined thematic structure that pro-symptom positions have.

Suggestion. Do not endure unclarity as to what to consider the symptom(s). Work persistently with client to identify the specific features of experience that the client regards as the problem. See "Starting point: Identifying the symptom" on p. 11. Focus on specific, concrete instances. Symptoms and underlying themes will prove to be well-defined despite client's initial difficulty articulating them.

I believe there is no pro-symptom position for this, because…

- **This is character disorder**, which has an unconscious basis that does not consist of pro-symptom positions.

Suggestion. Consider that a pro-symptom position is simply an unconscious theme, purpose and way of carrying out that purpose. The underlying basis of each type of character disorder has the same make-up (though the all-pervasive, rigid quality of the position is extreme). This is particularly clear in Stephen Johnson's excellent books on psychotherapy for character disorder.

Loss of pro-symptom focus due to:

D. Therapist's unresolved, unconscious personal issues

- **A particular client's pro-symptom material is too similar to material you are still avoiding, so you divert.**

Suggestion. If it is just one particular client with whom you mysteriously keep sliding away from a pro-symptom focus, shared avoidance of similar issues and feelings may be what is occurring and should be looked for. If that proves to be the case, a session of consultation or therapy may be necessary if you are unable to open up to this area on your own.

- **Your unconscious obedience to (or rebellion against) your own family-of-origin rules and roles cuts off your pro-symptom focus with clients.**

Suggestion. Obviously there are many possible forms of this block. One common form is a therapist's residual codependency—a strict avoidance of, and strong discomfort over, causing anyone any displeasure at all. Ushering clients into their pro-symptom positions is often noticeably distressing for them, and a codependent therapist will be too uncomfortable with this to maintain the pro-symptom focus. "I'll fix it *for* you and then you'll like me, need me, and stay attached to me" is the unquestioned assumption of the codependent therapist regarding his or her role.

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Training Guide for the Coherence Therapy Learning Curve

Guidelines for Skill-Building and Troubleshooting

Working experientially

- **Reliance on talking-*about* psp or *explaining* psp.** A block against working experientially tends to show up in therapist's reliance on talking-*about* or *explaining* psp to client with great lucidity and empathy in an attempt to draw client into experiencing psp. This is ineffective and proves draining for therapist.

Suggestion. With your selected Coherence Therapy client, follow a discipline of using your insights into client's pro-symptom position *only* to form experiential steps of discovery or integration. For example, suppose you are inferring or hypothesizing that the client is acting out sibling rivalry with coworkers. Rather than imposing this notion as an explanation or interpretation, use a technique of discovery that has the client experientially "bump into" this emotional truth, if indeed it exists. For example, first guide client into crafting an overt statement to the visualized coworkers—such as, "I feel all of you are trying to defeat me and I *have* to fight back," or "It always feels like you're trying to push me out." Then use the "Who else?" technique: Ask client, "Is there anyone else in your life, to whom you could also really say that?" Client names siblings. You then ask client to visualize siblings along with coworkers and to say the statement out loud to all of them. Then to deepen further into this material, you could invite a sentence completion that client says to all of them: "If I let you win, ..." or "I *have* to outshine you because if I don't, ..."

Suggestion. Reliance on explaining and interpreting psp to client, rather than ushering client experientially into his/her own direct experience of psp, is for some therapists driven by a hidden agenda of demonstrating expert knowledge to the client—an agenda of showing client that therapist understands client's mind better than client does. Attachment to this type of role, image and power as therapist is fundamentally incompatible with carrying out Coherence Therapy properly.

- **Confusion about the difference** between work that is genuinely experiential and work that is not.

Suggestion: In Coherence Therapy, "experiential" means the client is subjectively *in,* and speaking *from,* the emotional reality of his or her pro-symptom position—not merely talking to you *about* that emotional reality or that "part." Client is subjectively in the emotional reality of his or her pro-symptom position as a present-tense, first-person experience.

To this end, as a rule it is important first to have client imaginally place him- or herself *in a scene of the symptom's occurrence* (the condition of *engagement*) and speak to you from and in that recreated experience as you then carry out steps of discovery, integration, or transformation of the pro-symptom position. Keep the experience as vivid as possible and keep the client there, directly expressing the pro-symptom emotional meanings and feelings in that scene, not just talking *about* that situation.

Therapists new to experiential work should stick to the three or four basic techniques recommended for discovery: overt statement, sentence completion, symptom deprivation, and the two-step. Regularly apply one of those techniques. Segments of talking *about* should always serve to set up the next piece of experiential work and should not last very long (usually 5-10 minutes).

Suggestion: Some clients will subjectively inhabit their pro-symptom position in the course of the discovery or integration work, but then quickly step out of it and talk with the therapist *about* it. This talk might *seem* "experiential" because it so directly acknowledges and refers to the emotional reality in that "part" or position, but actually the client is now standing outside of it and speaking *about* it rather than speaking *from* and *in* that emotional reality. Your job as therapist is to again and again spot the difference and ask the client if he/she is willing to go back into that place and talk to you *from* and *in* it.

For example, the client says, "Yeah, that part of me really doesn't want me to feel like anything matters, because if things matter, then you're real vulnerable, you know? You can get really hurt." You respond by saying, "I see; and I wonder if you'd be willing to again *go into* and *be* that part of you right now, and try out saying to me something like, 'I feel I better not let anything matter, because I don't want to get hurt.'"

If a client repeatedly steps out and will not stay in their pro-symptom position, comment on this, express acceptance of it, and then guide client into experiencing the emotional truth of this resistance (for example, a sentence completion: "If I stayed right in that part of me,..."). Discovering and integrating this position of resisting dispels the resistance in nearly all cases.

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Working experientially (CONTINUED)

- **Fear that the emotions underlying the symptom will be uncontainable, overwhelming, and harmful for client, and render your therapy ineffectual.**

Suggestion. Remember that in Coherence Therapy, "experiential" does not necessarily mean a release of intense emotion or "catharsis." Such intensity is not in itself a goal and may or may not be part of the client's retrieval and subjective inhabiting of pro-symptom positions.

Suggestion. Some clients do feel significant discomfort or emotional intensity in experiencing their pro-symptom position. It nevertheless still proves profoundly therapeutic to "go there" with nearly all clients (no faster than the client can handle, of course). The reason is this: In experiencing her or his pro-symptom position, the client experiences not only emotions but new *meaning*—an empowering retrieval of personal themes and purposes, an intrinsic self-validation, a recognition of the authentic dilemma or suffering for which the symptom is actually a cogent response. In this meaningful context the emotions are cogent and workable, but they become unworkable if the *therapist* panics. People are able to grapple with their real issues once they recognize what they are. One of the best examples, and a common one, is unconscious grief. In opening up to unconscious but intensely painful feelings of grief, clients describe a profoundly positive experience of restored wholeness, connection with self, and new coherence of personal history—even when the initial steps of opening were sharply painful and even blocked by resistance. (For a clear demonstration of this see the video *Compulsive Underachieving*.)

- **Verbalization of emotional truth.** For effective experiential accessing, the client must immerse subjectively into the pro-symptom emotional reality and, while in this experience, cognize and verbalize the themes and purposes that constitute it. A concentrated, "limbic" style of wording and phrasing is required. Limbic language sounds utterly natural and simple, yet getting the knack can take some practice. This is a key skill to develop for successful Coherence Therapy.

Suggestion. See verbalization guidelines on p. 39. Verbalizations must capture the passion and direness in client's pro-symptom position—the magnitude and meaning of what's at stake—in intensely personal, vividly concrete terms. The words' fit and emotional resonance as felt by client should be unmistakable. If not, the words are somehow off in style and/or substance. Elicit client's active collaboration to get the wording ringing with limbic emotional truth.

- **Fear of "blind" process of experiential discovery**. Therapist's experience of not-knowing and searching in the dark experientially for an unknown emotional reality can bring sharp anxiety over client seeing your not-knowing and viewing you as inept.

Suggestion. It is normal for the process of discovering a client's pro-symptom position to be experienced by the therapist as a groping in the dark. This is an inherent aspect of authentic discovery; nothing is going wrong when the process feels this way or when the therapist's not-knowing is apparent to the client. Whether this is anxiety-producing for the therapist depends on the type of therapist role and image she/he occupies.

Not-knowing is maximally anxiety-producing for therapists whose stance and image toward the client can be characterized as, "The knowledge of the underlying cause of your symptom is in *me,* and my expertise is my possession of this wise knowledge and my ability to cure you with it."

A therapist is relaxed about not-knowing if the stance and image toward the client can be characterized as, "The knowledge of the underlying cause of your symptom is in *you,* as is the ability to transform it, and my expertise is in my ability to guide you to search for it and find it."

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Working experientially (CONTINUED)

- **Fear of fizzles of experiential techniques.** Fear of appearing inept if an experiential technique doesn't work for any reason; and/or fear of not knowing what to do next or how to recover credibility if that happens.

Suggestion. Yes, the fizzle of an experiential technique is glaringly obvious to the client. Fizzles are image-shattering only for therapists invested in an image of possessing superior wisdom. For a therapist with a stance of "search and discovery guide," fizzles are not a problem and do not come across as ineptness.

Suggestion. A general rule of thumb whenever the trail cools and the emotional realness of the material fades out: Simply return to the last material that was emotionally alive and real in the room. Ask client, "Could we go back to…" Resume further steps of discovery and/or integration from there.

Suggestion. Here is how to proceed when an experiential step or technique fizzles: Transparently look closely with client at why it fizzled. Find exactly what happened in client's subjective process.

- Some fizzles are due to a misunderstanding by client of the instructions for the exercise; if so, simply clarify and take it from the top again.
- Some fizzles won't be fizzles if, as is often necessary, you doggedly persist in prompting client to do the exercise; for example, the symptom deprivation technique often requires dogged persistence and some ingenuity of prompting before the client bumps into an unwelcome result of being without the symptom.
- Some fizzles are due to client resistance to the exercise. If that is what you find, carry out Coherence Therapy on the resistance: first show your acceptance of it and then draw out the emotional truth of why resisting the exercise is necessary (see pp. 45-48). This process often provides a direct line of access to the client's pro-symptom position or to a closely related "lid" position that will be necessary to integrate and transform in any case.
- Some fizzles simply mean there is nothing relevant right there to any pro-symptom position. If so, sit back, relax, and come up with some other way to try for the further discovery or integration you were seeking.

Don't know what to do next!

- **In learning any unfamiliar modality**, moments come during a session when you don't know what to do next. This is natural and unavoidable, but it can be stressful and anxiety-producing. The strong tendency at that point is to drop Coherence Therapy and switch to familiar ways of working, so that the client never notices that you were at a loss. That is for you a negative learning experience. It not only cuts short your Coherence Therapy practice in that session, but also discourages you from doing Coherence Therapy sessions. It is important therefore to prepare in advance for those expectable moments of not knowing what to do next.

Suggestion. Every time you drop Coherence Therapy because you didn't know what to do next, after the session identify specifically at what point you lost your way. What was your dilemma at that moment? Then identify how to be ready for that point in the process. Find guidance in the manual or from other Coherence Therapy practitioners. On an index card write a reminder and instructions to yourself and keep in view in every session.

- **I didn't know what to do next because**…I wasn't clear or lost track of what the client's symptom is.

Suggestion. If you don't have the client's concrete presenting symptom continually in mind, you cannot recognize which bits of emerging material are relevant to how the symptom is necessary to have. In doing Coherence Therapy the therapist is always, *always* listening for pro-symptom relevance. It is your continual mindfulness of the symptom that enables you to recognize emerging pro-symptom elements immediately. As soon as you forget the symptom it becomes impossible to recognize pro-symptom meanings or links, and you feel immediately lost.

Write down the symptom where you can keep reading and remembering it during the session. Whenever you feel unclear about what to consider the symptom, do nothing but work on getting the clarity you need. Be transparent about it. On p. 13 are many questions useful for this purpose; make a copy of them and keep at hand. What you regard as the symptom shifts as the work progresses, but at any given moment you should have a clear notion.

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Don’t know what to do next! (CONTINUED)

- **I didn’t know what to do next because**…I had no idea what the client’s pro-symptom position is about; I was really in the dark.

Suggestion. You’re *supposed* to do experiential steps of discovery “blind,” without any prior knowledge or hypothesis about the client’s pro-symptom position. You’re *not* supposed to first figure out what the client’s pro-symptom position is. You’re working to get the client to bump into that position and *reveal it to you,* so that you *learn from the client* what it is. If you are at a loss during discovery, just keep trying overt statements, or sentence completions, or symptom deprivation, until a thread of pro-symptom significance emerges. Then keep following that thread with further steps of those basic techniques.

- **I didn’t know what to do next because**…the client went into content that wasn’t clearly related to the symptom or the emotional truths so far discovered. I didn’t know where we were any more.

Suggestion. Simply return to the last place where you had your bearings—the last piece of material where you knew where you were in the process of discovery or integration. Ask client, “Could we go back to…” Resume further steps of discovery and/or integration from there. Remember, it’s up to you to keep the work focused on pro-symptom positions. This includes recognizing which elements of emerging material have likely pro-symptom significance and then ushering the client’s experience more deeply into those elements.

Suggestion. If a client has multiple pro-symptom positions, comb through your notes from all sessions and compile a distilled list of pro-symptom themes and purposes discovered so far. Keep this in front of you during sessions so that you can astutely link current developments to the relevant psp and go further with discovery or integration.

Suggestion. In doing Coherence Therapy you are empathically going over into a room in the client’s psyche furnished with a particular, pro-symptom emotional reality, while simultaneously staying in your chair and maintaining a clear cognitive map of Coherence Therapy’s methodology and where you are in it. This dual mode of operation is an invaluable knack to develop if you do not already have it.

If you’re getting lost among the trees, zoom back to a wide-angle view of the whole forest. Experienced Coherence Therapy practitioners shift back and forth several times in each session between a wide-angle view of the major, basic features of the client’s material, and a close-up, detailed view of constructs, process sequences or behavioral sequences. In other words, you can keep your bearings by deliberately sitting back and asking yourself:

- What is the problem or symptom we’re working on, as I understand it?
- What is the gist of the emotional truth of how that symptom is necessary to have, as I understand it so far?
- Where am I in the Coherence Therapy process? Do I need to do more discovery, because for me there is still some mystery about how the symptom is necessary to have? Do I need to do more integration, because the client is not yet feeling, owning and verbalizing the pro-symptom position we found?

Suggestion. If client is actively introducing the new, confusing content with real energy, ask client (tactfully interrupting if necessary), “What’s the connection between what you’ve been telling me, and [the symptom or the emotional truth of the symptom as understood so far]? I need you to help me see the connection so I will know where all this fits in.” In other words, rely on transparency: rather than privately struggling to make sense of the material, get the client to make sense of it for you. If it emerges that the confusing content is *not* related to the problem or symptom you were working on, ask client to clarify what client’s intention is in talking about it. If it emerges that client is introducing a new problem or symptom, ask if client wants to use today’s session on this new problem instead of the other one. If yes, check for resistance to staying with the first problem by asking, “Is staying with what we were working on in some way difficult or uncomfortable? Could that be part of why we’re switching to something else?” If yes, do Coherence Therapy on the resistance and bring client in touch with the emotional truth of it—some dilemma that for now becomes the focus of the work.

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Don't know what to do next! (CONTINUED)

- **I didn't know what to do next because**…we got down to an emotional truth, and it feels true to the client—but nothing changed or transformed, including the symptom. So, *now* what?

Suggestion. First, consider whether you *have* brought the client sufficiently into the emotional truth of the symptom. Remember, the minimal level of depth required in Coherence Therapy is the unconscious *purpose* requiring the symptom. For client to experience the emotional truth of the symptom means that a previously unconscious, compelling purpose that necessitates having the symptom has become directly conscious as a personal emotional reality. Is there still any blurriness or mystery to this purpose? If so, further discovery and integration are needed.

With deep-enough awareness of the emotional truth of the symptom, client is sharply aware of a standing choice between two forms of suffering: the suffering that results from *having* the symptom, and the suffering that results from *not* having the symptom. And you, the therapist, are explicitly empathizing with *both* forms of suffering and with the client's emotional truth that *having* the symptom is necessary because that is actually the lesser, more tolerable form of suffering.

Once you *have* brought the client experientially into the full emotional truth of the symptom, *stay there.** Do nothing else at this point other than the integration process of having the client routinely know and feel his/her own compelling purpose necessitating the symptom on a daily basis. Make sure client is "connecting *up*": experiencing the concrete symptom as part of how he/she carries out that compelling purpose. This should completely transform the meaning of having the symptom, and in most cases it will also dissolve the client's illusion of having no control over the symptom, replacing that illusion with awareness of agency.

It sometimes happens that all of this is in place but still nothing transforms. Transformation does not always follow spontaneously and automatically from integration. Deliberate steps of transformation may be necessary; see pp. 40-42.

* There is one major exception to this guideline of *stay there:* When the emotional truth of the symptom involves trauma and PTSD.

What it means if the symptom keeps happening

- **If the symptom continues or reoccurs** even though you believe the client has gotten in touch with underlying, pro-symptom emotional truths, several different possible reasons must be considered:

Reason 1. **The work has not been truly or sufficiently experiential.** Check the guidelines above and throughout this manual for the defining features of experiential work in Coherence Therapy.

Reason 2. **Integration of the pro-symptom position has not reached the needed degree** of routine, daily, feeling-level awareness, because (a) you didn't *stay there* long enough or in relation to all relevant situations, or (b) client resistance to integration is unresolved or undetected. Main indicator of adequate integration: Client relates to all occurrences of the problem or symptom from and in pro-symptom position, and describes these experiences accordingly on own initiative in sessions, without being again guided to do so by therapist.

Reason 3. **The work has not gone deep enough**—to the core constructs at the heart of the pro-symptom position, especially the unconscious, urgent *purpose* (3rd-order construct) necessitating the symptom, which is the minimum level of depth required.

Reason 4. **There exists another, undiscovered pro-symptom position** maintaining the symptom. This is a likely possibility if the previous three reasons do not apply and successful transformation of the already-discovered psp is indicated: that psp no longer has compelling realness or influence for the client, even when guided imaginally by the therapist to reinhabit it in circumstances that formerly triggered it. If an undiscovered psp is suspected, the therapist simply begins discovery anew. The presence of more than one psp is common.

Reason 5. **The pro-symptom position contains trauma** in the strict, neuropsychological sense of the term. For transformation of such material, ordinary experiential work is ineffective; specialized trauma techniques such as EMDR or TIR are required. Symptoms of PTSD as listed in the DSM are reasonably good indicators of trauma.

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Other blocks to learning and applying Coherence Therapy

- **Therapist too exposed.** (a) Coherence Therapy raises the standards of therapeutic effectiveness to such a degree that there is great visibility of therapist's skill or lack of skill in assisting client to alleviate the presenting symptom(s). (b) One's opinion of one's past work can take a disturbing nosedive due to contrast with the effectiveness now seen as possible.

  Suggestion. (a) See guideline above for "Loss of pro-symptom focus due to: A. Performance anxiety over being perceived by client as ineffective or inept." (b) Recognize that in any field, the good fortune of achieving new levels of ability necessarily makes one's past work appear sharply less impressive.

- **Client needed and used by therapist to meet therapist's emotional needs.** Many unresolved needs of therapists block use of methods designed for brevity: therapist's need to be needed; therapist's fondness of client; therapist's desire to know the client's whole story; therapist's perfectionistic need to "finish" the work or effect full characterological change; therapist's fear of being seen as rejecting; etc.

  Suggestion. Considerable self-honesty, inner strength and commitment to ongoing emotional growth is needed for recognizing and letting go of such attachment schemas.

- **Attachment to client for income** tilts one away from any form of briefer therapy.

  Suggestion. Immunizing oneself against this tendency can require a conscious heightening of integrity and courage.

- **Concerns over interacting with third-party payers.** To some therapists it is not clear how to participate successfully in third-party payer systems requiring DSM diagnoses and treatment plan formulation while utilizing a nonpathologizing therapy modality that these systems do not recognize.

  Suggestion. If you relate to your office temperature in terms of Centigrade, but your landlord asks you for the temperature in Fahrenheit, it's a simple matter to provide the information in the requested form. Insurance companies don't want to hear about pro-symptom positions, so simply map your client onto DSM categories for them and similarly translate your Coherence Therapy strategy into the third-party payer's conventional terms.

- **Fear of professional marginalization or ostracism.** Risk of losing credibility in one's professional circles by adopting a therapeutic system that is unfamiliar to, and diverges from, the mainstream.

  Suggestion. Progressives and early adopters in any field face this risk to varying degrees. Don't take up Coherence Therapy if this risk is intolerable for you. Bear in mind too that highly respected, prominent psychologists have gone on the record with strongly positive opinions of Coherence Therapy, and that invited chapters on Coherence Therapy have appeared in academic texts, and that peer-reviewed journal articles on Coherence Therapy have been published.

- **Therapist too taxed.** Unwillingness to make the greater effort of therapist activity and focus required in Coherence Therapy.

  Suggestion. The greater effort and focus is rewarded richly by (a) how interesting and unique the Coherence Therapy process is with each client, and (b) how satisfying and meaningful the enhanced effectiveness is for the therapist.

- **Therapist too leading.** Belief that being active and directive results only in transferential compliance or resistance.

  Suggestion. Experience shows that this concern is relevant only with a small minority of clients, and even then is not usually a fundamental obstacle to carrying out Coherence Therapy.

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Other blocks to learning and applying Coherence Therapy (CONTINUED)

- **More is better.** Belief that brief therapy is necessarily superficial.

  Suggestion. This view may be true of most brief therapies, but not of Coherence Therapy, as any real consideration of it makes plain.

- **Paradigm allegiance.** Loyalty to mentors and training experiences in a different paradigm of psychotherapy. Protection of years or decades of investment in a different paradigm.

  Suggestion. Facing this potent and deep issue can require much courage and strength if it is not to block the biggest opportunities for professional growth.

- **Attachment to role power and mystique.** Unwillingness to lose the power and stature conferred upon the long-term therapist healer/doctor who knows how to diagnose and cure psychological "disorders."

  Suggestion. If having such a role and self-image has been important, letting go of it is a daunting step of personal and professional growth, but it is doable and immensely freeing.

Defining features of an exemplary Coherence Therapy session

- **Maintained pro-symptom focus throughout—made no anti-symptom, counteractive interventions**
- **Prompted two or more segments of fully experiential work with client subjectively in pro-symptom position**
- **Made significant further progress in discovery, integration or transformation of a pro-symptom position**

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Coherence Therapy with Couples and Families

The methods and concepts of Coherence Therapy apply very naturally to family systems.

The couple or family system is viewed in Coherence Therapy as consisting of the interaction among the conscious and unconscious constructions of reality (positions) held by family members individually. Typically this interaction is complex, yet in principle, all properties of the system result from the interaction among positions held by individuals. Since unconscious positions are discoverable and verifiable, all workings of the system likewise are accessible and knowable. For example, any actual "function of the symptom" exists as a definite, third-order construct of purpose in one or more family members' pro-symptom positions, and so is experientially discoverable and verifiable. If the family's presenting symptom is protective in some way, this protective purpose and function *cannot exist independently of the discoverable positions of individuals in the family*.

This view has most affinity with the "ecology of ideas" approach of Gregory Bateson[1] and the "perspective, metaperspective, and meta-metaperspective" approach of R. D. Laing[2]. In the conceptualizations of Bateson and Laing, the way any one family member currently understands the others' behaviors appears to that family member to be confirmed by the others' behaviors. This locks the system into its current, symptom-generating, mutually adversarial, reactive or alienated configuration. The emphasis that Coherence Therapy adds to this view is the fact that the "understanding" one family member has of another is often largely unconscious — an unconscious construal of the meaning of the others' behaviors, triggering an unconsciously generated behavioral response. The others then construe this behavior according to their *own* private and largely unconscious worlds of meaning, and respond accordingly, possibly in ways that inflame the problem further, and the cycle of adversarial reactivity and miscommunication grows.

On the whole, the field of systemic family therapy from its beginnings strongly shunned the emotional and unconscious processes of individuals as a focus of therapeutic attention. This unfortunate bias (a reaction to Freudian orthodoxy) resulted in family therapy neglecting to develop in-depth therapeutic methods for reliably and rapidly accessing and transforming the family's largely unconscious ecology of meanings. The methodology of Coherence Therapy, being designed specifically for the purpose of swiftly discovering and reprocessing unconscious emotional constructions, is well suited for accessing and unlocking the family's troubled ecology of meanings and dispelling the features of that ecology presented as symptoms.

The therapist seeks to identify family members' pro-symptom positions. Radical discovery and integration are carried out with various family members in the presence of the others and often through interaction with the others. The therapeutic potency of family members accessing and revealing their symptom-maintaining emotional truths in the presence of each other cannot be overestimated. The perceived offensiveness or hurtfulness of behaviors, being based upon the perceiver's attributions of meaning, can be significantly diminished or dissolved by witnessing the personal meaning and feeling actually behind the other's behavior. Typically that unexpressed personal meaning and feeling has been largely unconscious, but when it is brought to light and then integrated into the system — into the positions of others — the ecology of meanings rapidly undergoes substantial change and harmonization.

In relation to a given symptom, not all family members necessarily harbor a pro-symptom position. When the symptom-bearer is a child, even more important than this child's own pro-symptom position are those held by one or more of the child's elders—parents or older siblings. An example is the case of a child's longstanding behavior symptoms ceasing after the father's pro-symptom position was found and integrated into the system in the eighth session of family therapy. Whatever pro-symptom positions may have been held by mother or older sister, father's was the key in this case.

For case examples of Coherence Therapy with couples and families, see Ecker and Hulley, 1996, 1998, 1999 and 2000a in the bibliography on pp. 84-85.

[1]Bateson, G. (1972). *Steps to an ecology of mind.* New York: Ballantine. See also Bogdan, J. (1984). Family organization as an ecology of ideas: An alternative to the reification of family systems. *Family Process, 23,* 375-388.
[2]Laing, R. D., Phillipson, H. & Lee, A. (1966). *Interpersonal perception.* New York: Perennial Library.

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What Limits the Rate of Change in Coherence Therapy?

If a person were to abruptly dissolve a pro-symptom position along with the particular area of personal reality it defines, how much of this person's whole world of meaning would be altered? Would the change in experiential reality be all-pervasive, or felt only within a specific, limited area of personal meaning?

The extensiveness of the pro-symptom position's influence is directly related to the rate of change likely to be possible in therapy. The greater the role of the pro-symptom position in structuring the client's overall world of meaning, the more unwilling is the psyche to allow this position to be changed. Sweeping changes in experiential reality tend to be accompanied by extreme disorientation, a sense of disconnection from all moorings, profound lack of control, and existential terror, and so are tenaciously avoided.

In contrast, there is far less difficulty incurred by allowing change in a pro-symptom position that has influence over only a limited area of personal meaning. Correspondingly there tends to be much more psychic willingness to allow change in such a position.

To achieve a durable, in-depth resolution requires transforming or dissolving the pro-symptom position, but if the presenting symptom is produced by a pro-symptom position that has a major, global role in the client's overall construction of experiential reality, change will be acceptable by the person only in steps made small enough, and paced slowly enough, to be tolerable.

The global nature of a pro-symptom position is apparent in its third- and fourth-order constructs. Low self-esteem, for example, typically involves a pro-symptom position that has global third- and fourth-order constructs (see the list of unconscious purposes found in low self-esteem and note the global character of these constructs).

Some clients have *several* global pro-symptom positions co-maintaining the same symptom(s). These *multiglobal* situations are the most challenging to resolve time-effectively. However, even the multiglobal cases as a rule will be resolved in Coherence Therapy in far fewer sessions than in traditional in-depth therapies. A multiglobal configuration is encountered most commonly with clients who in childhood suffered severe, sustained abuse (emotional, physical or sexual). Unconscious constructs formed to cope with abuse tend to be global ones coloring the whole of experiential reality, as noted above in connection with low self-esteem.

Still the therapist should never stereotype any one client as a "long-term client," which would dull the therapist's intentionality, inevitably making therapy longer than it need be. No matter how many sessions are required, *every session* is approached by the therapist as one in which a pivotal breakthrough could occur. It is the client's tolerance for change that should always limit the pace of the work, not the therapist's assumptions or methods.

In addition to adults abused as children, multiglobal clients include those who would be described psychodynamically as having severe character disorder. All of the methodology of Coherence Therapy still applies— discovering, integrating and transforming the client's core pro-symptom constructs in every session.

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Corroborating Research

Research in cognitive science, neurobiology, cognitive neuroscience (neuropsychology), and trauma studies lend strong support to the methodology and conceptual framework of Coherence Therapy. Fundamental aspects that are scientifically upheld include:

(a) The existence of pro-symptom positions, that is, unconscious, compartmentally separate, state-specific modules or schemas of personal knowledge that autonomously generate thoughts, feelings and behavior.

(b) The nonverbal, emotional constitution of unconscious modules or schemas of personal reality.

(c) The necessity for experiential rather than cognitive methods for achieving change in these formations of personal reality.

In cognitive science, the modularity of mental funct-ioning has been well established. The mind self-organizes into many distinct processing modules operating uncon- sciously and simultaneously, each handling a particular, relatively narrow area of experience.[3,4] This system is highly advantageous for the psychic economy as the number of activities supportable by conscious attention is severely limited. Both present-time experiencing and memory are organized in this manner. (The term *memory* refers in cognitive science to the maintenance and retrieval of all forms of knowledge, a broader meaning than the vernacular connotation of "memory" as meaning recall of the past or of facts.) *Explicit* memory (also termed *declarative* memory) consists of the individual's readily conscious, verbal representations of his or her knowledge and experience. *Implicit* memory (also termed *procedural* memory) includes all experiential, nonverbal knowledge, such as use of grammar to form sentences while speaking; how to walk; how to tell a story suspensefully; and all instinctual or reflexive actions. Memory researchers have found that different types of implicit memory are subserved by different areas in the subcortical brain.[5]

Trauma studies too have encountered modularity, finding that the unique symptomatology of post-traumatic stress is due to the fact that traumatic experience is held in memory both separately and differently from nontraumatic experience.[6]

Studies of "deep cognitive activation"[7] also put coherence therapy on firm scientific ground. Historically the very existence of the unconscious and of unconscious mental contents has been largely inferential and concept-ually vulnerable. Deep cognitive activation research applies new methods for a more direct detection of unconscious mental contents, their activation, and their production of surface behaviors, moods and thoughts.

The support for Coherence Therapy from cognitive neuroscience is perhaps most striking. The correspondence of specific psychological activities with the activation of localized regions of the brain is by now well estab-lished. Early work by Michael Gazzaniga in the 1950s and '60s revealed differences in functions carried out by left and right hemispheres. His subsequent findings evolved this initial, simplistic left/right model much further. Gaz-zaniga reviewed the extraordinary results of many of his studies in his 1985 book, *The Social Brain*.[8] He explains:

> Interpreting our behaviors would be a trivial matter if all behaviors we engaged in were the product of ver-bal conscious action. In that case, the source of the behavior is known before the action occurs. If all our actions consisted of only these kinds of events, there would be nothing to explain…*[T]he normal person does not possess a unitary conscious mechanism in which the conscious system is privy to the sources of all his or her actions*…[T]he normal brain is organized into modules and…*most of these modules are capable of actions, moods, and responses. All except one work in nonverbal ways* such that their modes of expression are solely through overt behaviors or more covert actions.[9] (Italics added.)

The picture that emerges from cognitive neuroscience has any number of largely autonomous brain modules—each a network of neurons—operating outside of conscious awareness, and each "can compute, remember, feel emotion, and act"[10]—which is exactly the phenomenology of unconscious, pro-symptom positions.[11]

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[3] Rumelhart, D. E. & McClelland, J. L. (1986). *Parallel distributed processing: Explorations in the microstructure of cognition* (2 vols.). Cambridge, MA: MIT Press.

[4] Fodor, J. A. (1983). *The modularity of mind.* Cambridge, MA: MIT/Bradford Books.

[5] Squire, L. R. (1994). Declarative and nondeclarative memory: Multiple brain systems supporting learning and memory. In D. L. Schacter & E. Tulving (Eds.), *Memory systems* (pp. 203-231). Cambridge, MA: MIT Press.

[5] van der Kolk, B. A. & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress, 8* (4), 505-525.

[7] Wegner, D. M., & Smart, L. (1997). Deep cognitive activation: A new approach to the unconscious. *Journal of Consulting and Clinical Psychology, 65* (6), 984-995.

[8] Gazzaniga, M. (1985). *The Social Brain.* New York: Basic Books.

[9] Ibid., p. 74.

[10] Ibid., p. 86.

[11] For a review of recent, extensive evidence from brain science supporting the existence of pro-symptom positions see Toomey, B. & Ecker, B. (2007). Of neurons and knowings: Constructivism, coherence psychology and their neurodynamic substrates. *Journal of Constructivist Psychology, 20,* 201-245.

Corroborating Research (CONTINUED)

The brain's single verbal module is a key component of the conscious self and "is committed to the task of interpreting our overt behaviors as well as the more covert emotional responses produced by these separate mental modules of our brain. It constructs theories of why these behaviors occurred and does so because of that brain system's need to maintain a sense of consistency for all of our behaviors. It is a uniquely human endeavor…"[12] The verbal module's concoction of conscious explana-tions in its effort to make sense of behaviors generated by nonverbal modules operating out of awareness corresponds to a therapy client's conscious, anti-symptom position in the parlance of Coherence Therapy.

Gazzaniga emphasizes that "Brain modularity is not just a psychological concept…Through [experimental] studies…, it becomes clear that modularity has a real anatomical basis."[13] In more recent studies by other researchers[14] using newer technologies for high-resolution, real-time imaging of brain activity, specific psychological tasks have been found to involve highly localized regions of the brain, corroborating Gazzaniga's model.

In particular, neurobiologists have established that the brain's limbic system stores and controls the activation of all schemas involving emotions of distress, such as fear and anger, along with knowledge of how to be safe and self-protective.[15] Within the limbic brain (also termed the medial temporal lobe), it is the amygdala that compares current perceptions to these emotionally dire schemas. If any feature of current perceptions seems to match some feature of any of these intense emotional realities, the amygdala implements the self-protective response pre-defined by the activated schema.

Of special relevance to Coherence Therapy is that fact that the amygdala distinguishes weakly between percep-tions coming from the external physical senses and those arising in imagination. It is for this reason that imaginal experiential techniques effectively trigger and gain access to the emotional realities (pro-symptom positions) held in the limbic brain. When a situation having negative emotional significance is imagined vividly, to the amygdala that situation is actually occurring.

Further, due to the entirely nonverbal nature of the limbic brain, experiential rather than cognitive methods are required for successfully engaging and changing its schemas. Cognitive methods engage the neocortex, which neither contains nor has direct access to the subcortical, symptom-producing material. In talk therapy, research has shown that language must be used in specialized ways in order to serve this experiential accessing.[16,17] Coherence Therapy accordingly utilizes the highly personal, concrete, vivid, present-tense styles of phrasing that foster a direct engagement with limbic material.

A particularly important corroboration of Coherence Therapy is the recent discovery of a type of synapse change in the brain that can actually erase ingrained emotional learnings held in implicit memory—the type of learning and memory underlying the great majority of clinical symptoms. For nearly a century it was believed by neuroscientists that the neural circuits storing emotional implicit memory and associated responses were indelible and permanent once established in long-term memory by a process of *consolidation*. Research published from 1997 to 2000 toppled that tenet.[18] A dynamic neural process now known as *reconsolidation* can actually unlock the synapses maintaining implicit emotional learnings.

Reconsolidation research then developed rapidly. The sequence of experiences required by the brain for synaptic unlocking and erasure was identified in 2004.[19] As detailed by Ecker and Toomey,[20] the process of change in Coherence Therapy matches, in detail, the steps required for erasure of an emotional learning through reconsolidation and achieves the same result: A symptom-generating emotional response is no longer evocable by cues andcontexts that had strongly evoked previously. This tentatively supplies an established neural mechanism in support of the anecdotal, clinical observations of profound change observed by practitioners of Coherence Therapy.

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[12] Ibid., p. 80.

[13] Ibid., p. 128.

[14] See for example (a) Posner, M. I. & Raichle, M. E. (1994). *Images of mind.* San Francisco: W. H. Freeman and Co. (b) Raichle, M. E. (1994). Visualizing the mind. *Scientific American, 240* (4), 58-64.

[15] Panskepp, J. (1998). *Affective neuroscience: The foundations of human and animal emotions*. Oxford: Oxford University Press.

[16] Watson, J. C. (1996). The relationship between vivid description, emotional arousal, and in-session resolution of problematic reactions. *Journal of Consulting and Clinical Psychology, 64* (3), 459-464.

[17] Martin, J. (1991). The social-cognitive construction of therapeutic change: A dual coding analysis. *Journal of Social and Clinical Psychology*, *10* (3), 305-321.

[18] For example: Nader, K., Schafe, G. E., & LeDoux, J. E. (2000). Fear memories require protein synthesis in the amygdala for reconsolidation after retrieval. *Nature, 406*, 722-726.

[19] Pedreira, M. E., Pérez-Cuesta, L. M., & Maldonado, H. (2004). Mismatch between what is expected and what actually occurs triggers memory reconsolidation or extinction. *Learning & Memory, 11*, 579–585.

[20] Ecker, B. & Toomey, B. (2008). Depotentiation of symptom-producing implicit memory in coherence therapy. *Journal of Constructivist Psychology, 21,* 87-150.

Coherence Therapy

Glossary of Terms

Anti-symptom position: The client's initial, conscious view and stance regarding the presenting symptom, consisting of constructs that depict the symptom as senseless, completely undesirable, involuntary, and evidence of deficiency, illness or badness.

Construct: Any internal representation of self or world, in any mode of experiencing: sensory/perceptual; narrative/linguistic/conceptual; emotional; kine/somesthetic. A construct is a model of reality that operates as a unit of knowing; when applied, its representation seems real. A cluster of linked constructs form a *schema*, a mental model more elaborate than that of a single construct.

Counteractive change: The cultivation of preferred behaviors or states of mind through new learning that is intended to suppress and override unwanted behaviors or states of mind but does not dissolve or nullify the underlying learning that generates the unwanted pattern, so symptom relief tends to be partial and is prone to relapse; as distinct from *transformational change*.

Experiential shift: (Phrase used in the *Depth Oriented Brief Therapy* book.) Change in how the client holds her/his pro-symptom position—either the *integration* (making-conscious) or *transformation* (revision or dissolution) of it.

Experiential work: Any step of work during a therapy session in which the client's attention is mainly or wholly on nonverbal, non-intellectual material; not to be equated narrowly with catharsis or highly intense or dramatic techniques. In Coherence Therapy, "experiential" means the client is subjectively in, and speaking from, the emotional reality of his or her symptom-generating emotional schema as a present-tense, first-person experience.

Implicit knowledge/implicit memory: Acquired knowledge that the individual is unaware of possessing or having learned, even as such learnings respond and drive responses of behavior, mood, emotion, thought.

Integration experience (or position work): The process of prompting the client to make his or her pro-symptom position routinely conscious instead of unconscious, with no attempt to change the content or emotional truth of that position. The client subjectively inhabits that position, feels its emotional truth and consciously, daily relates to the problem from that position. Integration, the first form of change or experiential shift in Coherence Therapy, in many cases spontaneously triggers a transformation and resolution.

Juxtaposition experience: Simultaneous experiencing, in the same field of awareness, of two sharply incompatible personal knowledges, each of which feels umistakably real, and one of which is symptom-generating knowledge that has been retrieved into direct awareness; the core process of change in Coherence Therapy's transformation phase.

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Coherence Therapy

Glossary of Terms (CONTINUED)

Position: A set of constructs that insistently maintains a particular, unquestioned version of reality as well as a particular attitude or action in response to any situation relevant to that version of reality. Roughly equivalent terms are schema, subpersonality, part, ego state, complex. The linked constructs comprising a position activate together when current perceptions appear relevant to any of them. These constructs may be conscious or unconscious and may include specific feelings, beliefs, perceptual representations (images, sounds, smells, etc.), somatic and kinesthetic sensations, values, and presuppositions.

Presupposition: Any unquestioned, unconsciously held construct or belief defining what means what, what causes what, what necessitates what, what the rules of acceptance/rejection are, how power operates, how to be safe, what is good and what is bad, and so on. (See p. 6.) Presuppositions are usually not held in a linguistic/narrative/cognitive representation.

Pro/anti synthesis: The client's direct, subjective awareness that the value or necessity of *having* the symptom (pro-symptom position) actually outweighs the pain or costs of having it (anti-symptom position). The client is aware of both the suffering that comes from having the symptom *and* the suffering expected from *not* having the symptom; and is aware of the emotional truth that the lesser, preferable suffering is that which comes from *having* the symptom. This conscious pro/anti synthesis is the goal of integration.

Pro-symptom position (the emotional truth of the symptom): The client's unconscious emotional knowledge, learned in life experiences, according to which the presenting symptom is compellingly necessary to have, either for avoiding or in response to a particular suffering.

Radical inquiry: (Phrase used in the *Depth Oriented Brief Therapy* book.) The discovery process in Coherence Therapy—the therapist's active, experiential, noninterpretive seeking of clarity into the emotional truth of the symptom (the client's pro-symptom position). "Radical discovery" or simply "discovery" are equivalent terms. A successful step of discovery brings the client into direct experience of pro-symptom themes and purposes, and the therapist learns from the client what these themes and purposes are. The first phase of Coherence Therapy's methodology.

Symptom coherence: The core principle of symptom production and symptom cessation in Coherence Therapy; the view that a therapy client's presenting symptom occurs entirely because it is compellingly necessary according to at least one of the client's non-conscious, adaptive *emotional learnings* or *schemas*, and that a symptom ceases to occur when there is no longer any emotional schema that necessitates it, with no other symptom-stopping measures needed.

Transformational change: Experiential unlearning, revision or dissolution of the constructs and learnings comprising the client's symptom-generating schemas, so that there no longer exists an emotional reality in which the symptom seems necessary to have. Transformation is carried out using well-defined methodological principles of *experiential disconfirmation*—the conscious *juxtaposition* of pro-symptom constructs with other, incompatible constructs.

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