

Case example of Coherence Therapy for Panic Attacks

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For therapy to be brief, depth must be sacrificed—according to assumptions that have prevailed in the world of psychotherapy for almost a century. Under managed care, on the staff of a counseling center, or in private practice, most brief therapists avoid clients’ deeper, unconscious themes. Consequently many clinicians feel a serious deterioration in both the quality of services rendered and in professional satisfaction.

Swift, focused, *in-depth* therapy with individuals, couples and families turns out to be a very real option, however. The approach described here, Coherence Therapy (formerly known as Depth Oriented Brief Therapy, or DOBT), is a complete, versatile modality in which theory and practice are completely aligned for achieving the new level of effectiveness that is needed if therapy is to be deep *and* brief (Ecker and Hulley, 1996, 2000, 2002). Here are some of Coherence Therapy’s fundamental components, illustrated by how they were applied to dispel a client’s panic attacks and the underlying, lifelong emotional themes driving them.

The emotional truth of the symptom

In carrying out Coherence Therapy, a therapist is guided by a deceptively simple way of thinking that plays out in a rich diversity of ways with different clients: How, in this person’s world of meaning, is the presenting problem cogently and compellingly necessary to *have*, even with the suffering or trouble it brings?

The therapist keeps prompting the client to zero in on *the emotional truth of the symptom*—specific, unconscious personal themes, knowings and purposes that, in one way or another, powerfully and passionately require *having* the presenting symptom, even though consciously the client wants so much *not* to have it.

This basic idea is of course not new in the field of psychotherapy. What is new in Coherence Therapy is the degree to which it is taken seriously, the completeness with which therapy is organized around it, and the remarkable effectiveness of in-depth dispelling of symptoms that often results.

Consider for example the intense, panic attacks described by Adrienne, 34. Her panics began in early adolescence and though eventually she “learned to live with them,” they still plagued and baffled her. “Objects in the room swell and shrink, and get halos around them,” Adrienne explained. Her heart pounds violently, she feels cold and lightheaded, her arms and legs get rubbery, and her breathing becomes rapid and shallow—the classic physical symptoms of a panic attack.

She had come for therapy because after beginning a new job recently, the intensity of her panic had increased and the frequency was now almost daily. She also obsessed all evening about her actions at work, couldn’t sleep, and was living in almost continuous misery.

What was the emotional truth of Adrienne’s panic attacks? What piece of personal reality fully made sense of them and made them necessary to have?

DOBT Discovery: Experiential accessing

Adrienne’s therapist did not try to figure out or interpret the answers to those questions. In Coherence Therapy, the therapist learns the symptom’s emotional truth from the client, not the other way around.

Therapy began by having Adrienne bring to mind any recent moment at her job in which she particularly felt the panic starting up, and to imagine being again in that scene right now. This first step of *engagement* in a concrete scene in which the client’s problem occurs is one of Coherence Therapy’s basic practices for best accessing of the underlying material.

Adrienne closed her eyes and visualized being in a scene of triggered panic. Asked to describe her perceptions, thoughts and feelings, she deepened into the natural trance of the visualization experience and the panicky feeling grew. The therapist then asked her to “take an emotional snapshot of this experience” and a few seconds later to “take a big breath that clears the scene and the feelings all away.” After a pause, the next prompt was “bring to mind now a very different experience: a situation where you were happily free of any panic while at work—at this job or any previous one.” She pictured and described such a scene at a previous

job. Then the therapist asked, “What’s different in how you’re experiencing this situation that allows for no panic, compared to the first one?” Adrienne couldn’t identify such a difference, so the therapist had her close up the non-panicky scene with another breath, guided her back into the scene of her current job with her incipient panic, and persisted by softly saying, “Something in this scene really makes sense of panicking. What is it?”

Adrienne, eyes still closed, was suddenly very still. In a low, even tone she said, “It’s that if I do the wrong thing it will hurt them in some way. [Pause.] On this job I’m responsible for making decisions that directly affect them—that’s what’s different about it. That’s new. [Pause.] And if I do something wrong—how damaged they’ll be, how awful it will be—and it’ll be my fault.” The therapist replied gently, “The way you said, ‘my fault’—it sounded pretty somber, like the ‘damage’ you’d cause would be really serious, or criminal.” “Exactly,” Adrienne replied, still absorbed in the experience. “That’s how it feels.”

The unconscious emotional truth of Adrienne’s panic had begun to surface into awareness not through talking “about” the problem, but through focused experiential work. It involved a powerful theme of being to blame for doing something wrong that gravely harms others. This was just the first, most accessible layer of the personal reality-schema maintaining her panic.

Symptom coherence

A primary feature of Coherence Therapy is apparent in Adrienne’s first session: the therapist has said or done absolutely nothing aimed at counteracting, overriding or preventing the symptom or its underlying material. This noncounteractive approach is based on the pragmatic principle that the shortest path to change is the profound recognition and acceptance of what *is*.

This principle results in effective therapy because there is an unconscious cogency underlying the client’s problem or symptom. Coherence Therapy’s model of symptom production is *symptom coherence*: A symptom or problem is produced by a person because he or she harbors at least one unconscious schema of emotional reality—one set of reality-defining themes, purposes, constructs, meanings, frames—in which the symptom is compellingly and coherently necessary to *have*, despite the suffering incurred by having it.

Conversely, when there is no longer any formation of personal reality within which the presenting symptom is necessary to have, the person ceases producing it, *with no other symptom-stopping measures needed*.

The therapy world has many different terms for such psychological modules: subpersonality, part, ego-state, schema, complex, and so on. Whatever we term them, Coherence Therapy is designed from the ground up for rapidly finding the client's specific symptom-requiring reality-construction, rendering it routinely conscious and then prompting the client's native capacity to revise or dissolve this particular construction—and, as the example of Adrienne will show, all without resorting to methods of counteracting or opposing the symptom. This approach proves effective for a wide range of symptoms and problems with individuals, couples and families.

The immediate accessibility of unconscious constructs

A core tenet of Coherence Therapy is the immediate accessibility of unconscious emotional realities. Any current symptom is produced on the basis of reality-constructs currently in play. Even if they have been unconscious for decades, those constructs are right here in the consulting room, and the client's experiential attention can be guided to them far more efficiently than is widely believed in our field.

In this regard, recent psychobiological research has provided hard scientific knowledge that is of fundamental importance to all therapists: Emotionally intense reality-schemas are formed by and stored in the brain's limbic system, and experiential process is required to reach and access this emotional material directly. Non-experiential, conceptual insights and interpretations are, in themselves, ineffective for true accessing because they take place in a very different brain system, the neocortex, which cannot control, override or even access the limbic system's networks of emotional reality.

Coherence Therapy's experiential methods, by always approaching the symptom empathically as coherently necessary to have, particularly match the nature of the unconscious limbic material at the heart of the problem.

Welcoming resistance

The work in Adrienne's third session illustrates both immediate accessibility and how the client's resistance often serves in Coherence Therapy as a therapeutic goldmine.

Adrienne began by describing the latest panic-inducing moments at work. The therapist then asked her to visualize that scene and said, "Let's see if what we already found fits for you here. Would you try out saying out loud within this scene, 'I'm so afraid I'll do something wrong that causes serious damage to people'? See if that fits for you."

What Adrienne said instead was, "It's so possible that a mistake could cause serious damage for people." The therapist had very deliberately provided an I-statement because highly personalized, concrete, vivid phrasing is necessary for effective accessing of unconscious emotional realities. But Adrienne had filtered herself out of the sentence, depersonalizing it into an abstract truism. She then added, "Isn't that how many people feel?" which again removes Adrienne, the individual, from the picture. There had already been moments in the first two sessions when she had shut down her experiential process with exactly the same kind of depersonalization. It was now clear that Adrienne was resisting contact with the emerging material and that her resistance had the consistent, distinctive feature of removing herself from the picture.

In DOBT the therapist accepts and welcomes resistance and temporarily shifts the focus of the discovery work onto the resistance itself, bringing to light how and why it is right now necessary not to get in touch, or stay in touch, with certain material. The therapist did this with a simple, transparent comment to Adrienne: "I'd like to check something out with you. As we get in touch with this area and describe it, I get the impression that it's more comfortable for you if you stay out of the picture. I keep noticing that in what you say, you're not in the picture anymore. Have you noticed that?" Recognizing herself in this description, Adrienne gave an ironic laugh and said, "No, I didn't notice it, but—well, that's how I was brought up."

The therapist asked her to explain what she meant. In a chipper, offhand manner she explained that throughout her childhood, the family revolved around her mother's physical and emotional fragility. There was always a tremendous emphasis on great carefulness to avoid causing mother any trouble or stress because it could make her health collapse catastrophically. Several harrowing incidents appeared to prove this. For example, when Adrienne was 15 she

“lost control” one day and had an intense argument with her mother. The very next day she found mother curled up on the floor in excruciating pain (which turned out to be appendicitis).

In one more step the therapist ushered Adrienne into experiencing her own emotional truth of her resistance by saying, “So would you look for this: *what’s the connection* between—how crucial it always was to make sure you don’t cause Mom’s collapse—and how automatically you remove yourself from the picture?” The connection was obvious to the therapist and could easily have been put to Adrienne as an interpretation, but in Coherence Therapy the goal is to have the client feel and experience the connection for herself. Interpretations are avoided. A few moments passed before she said, “Yeah, to keep from upsetting her I was always trying to make sure that I didn’t come right into her field of view. But it was automatic. I didn’t think about it.” “And we’re seeing it *still is* automatic,” the therapist replied, “because even here with me, part of you keeps deleting yourself from the picture. But now you *are* starting to think about it.”

Adrienne’s resistance, far from being an obstacle to the Coherence Therapy methodology, had served as a further opening into the deeper emotional truth of her panic.

And what’s under this? Getting to the “real” problem

The therapist had now learned from Adrienne that (a) she carries an urgent purpose of keeping herself from causing mortal harm to her mother or anyone, and (b) her means of carrying out that purpose is by keeping herself peripheral and avoiding having any direct, personal influence on others.

This until-now unconscious emotional schema fully made sense of her recently intensified panic: At her new job she could not carry out that urgent purpose because, much to the contrary and to her terror, “I’m responsible for making decisions that directly affect them.” Her direct, personal influence was blatant, and the danger of severely harming others seemed so intense as to be panic-inducing.

This was substantial progress in in-depth discovery. Nevertheless the therapist now went further, bringing to bear a key practice of Coherence Therapy discovery by thinking, “And what’s under this? What’s the next layer of personal reality that is in turn the very basis of this one?” The goal is to go only deep enough to dispel the presenting symptoms, but it is important to *go* deep enough to accomplish that. The therapist therefore said, “What I’ve been learning

from you is that you feel you always have to protect and prevent others from being destroyed by you. So now tell me this: What kind of person must you be, if you always have to protect others from being seriously damaged by you?” Here again the therapist resisted the temptation to verbalize the next piece of emotional truth ready to surface, and instead aimed to have Adrienne “bump into” it herself.

She instantly teared up and seemed to wince in emotional pain as she silently cried. When she could speak she answered. “A—very—harmful—dangerous—person,” she said between uneven, gasping breaths. Unconscious since childhood, this view of her own being as intrinsically harmful and dangerous was the inner core of the emotional truth of panicking. From the therapist’s point of view now, the *real* problem was Adrienne’s harboring of this potent construal of her self, not her panic attacks that derived from this construal. As a client’s underlying material progressively comes to light, what the therapist regards as the “real” symptom or problem shifts to more fundamental features of the symptom-requiring schema, until arriving at a core, reality-defining construct.

Integration: Overt statements and index cards

Adrienne was now not just “in touch with” or “aware of” the full emotional truth of her panic attacks, she was *inhabiting* this emotional reality, subjectively immersed in it and at the same time verbalizing it as a living knowledge of being “a very harmful, dangerous person” who urgently must avoid criminally harming others by always keeping herself from being a direct, visible influence on them. It is this degree of indwelling the material that defines what we mean by “experiential” work in Coherence Therapy, and that constitutes the true accessing that renders the material available for rapid change. The client must be speaking *in* and *from* the emotional truth of the symptom, not merely *about* it.

However, this initial, lucid experience of a long-unconscious emotional schema is a kind of altered state that will quickly disappear without a trace. Lucidity must not be mistaken for integration. Deliberate, carefully shaped steps of sustained integration are the next main aspect of Coherence Therapy’s methodology.

To that end, and with the session almost over, the therapist asked Adrienne to picture Mom. As the home context for the ruling, panic-inducing schema, her interactions with Mom provided the fullest, strongest engagement of that schema. The therapist said, “Straightforwardly

tell *her* what you've been telling me. This isn't a rehearsal for actually saying any of this to her; it's just an exercise here in our session."

She said to her image of Mom, "You know, I'm always afraid to mention any of my problems because I'm afraid I'll make your health fall apart." This *overt statement* technique, in which the client makes a present-tense I-statement of the symptom's emotional truth to the relevant person, is a very simple but effective experiential step of in-session integration.

The therapist then wrote those words on an index card: "Mom, I'm always afraid to mention any of my problems because I'm afraid I'll make your health fall apart." Handing the card to Adrienne, the therapist suggested two simple between-session tasks of integration. First, she would simply read the card daily, morning and evening, in order to develop routine, everyday awareness of this emotional truth. Use of index cards in this way is a mainstay between-session technique.

Second, Adrienne would make her usual weekly telephone call to her mother and while talking would have the card in front of her. For this technique of *real-time recognition*, the therapist emphasized that the purpose was not to confront, challenge or blame Mom in any way, or even say anything at all about this theme, but only to consciously feel and be aware of her emotional truth right in the moment when it is actually in play, while interacting with Mom.

Note that so far, in all of this discovery and integration work, the therapist still had said or done nothing that came across to Adrienne as an attempt to counteract, oppose or prevent her panic or the underlying emotional reality maintaining it.

Transformation through experiential disconfirmation

Yet real change certainly is the goal of Coherence Therapy. Let's see how integration—the *acceptance* of a symptom-requiring emotional reality—is the very condition for its transformation.

At her fourth session Adrienne reported that she phoned her mother and after a few minutes actually said the words on the card in a subdued voice. Mom gave a very quick, tight denial ("Oh, that's nonsense!") and abruptly changed the subject to superficial matters. Several minutes later Adrienne mentioned that she was seeing a therapist. Mom responded tensely, "Why are you doing *that!* There's nothing *wrong* with you!"

Adrienne explained what she then experienced. Her mother's voice tones were an all-too-familiar signal that she was now doing something exceedingly bad that was threatening to Mom. But because of keeping her eyes on the card as this developed, she experienced something unprecedented, a kind of double awareness of in fact being very gentle and caring in how she was speaking to Mom, and yet simultaneously going into agreement with Mom's message that she was being dangerously harmful. She said it felt very peculiar to suddenly see this big discrepancy and added, "I realized it's that I've simply always been *given the message* I'm dangerous."

As a result of integrating her panic-inducing emotional construction, "I am dangerous and could gravely harm Mom at any time," this schema was now in her conscious field of awareness and, as a result, had spontaneously become juxtaposed alongside the incompatible knowledge that "I am being caring and gentle with Mom." This simultaneous experiencing of incompatible reality-constructs is an *experiential disconfirmation*, which is exactly the condition under which the mind opts to dissolve an old construct in favor of a new one. The mind, as Piaget recognized, natively abhors incompatible constructs held in the same field of awareness. Experiential disconfirmation—the juxtaposition of incompatible constructs—is how transformation is carried out in Coherence Therapy. With many clients this occurs spontaneously as a result of integration, as it did here for Adrienne, but if necessary the therapist deliberately works to set up the disconfirming juxtaposition experience.

It is important for integration to be thorough so that all parts of the symptom-generating emotional reality are accessed and subjected to transformation. The therapist therefore persisted in prompting Adrienne to keep inhabiting that emotional reality (which is opposite the reflex of most therapists to usher her as quickly as possible *out* of that emotional reality). The therapist said, "Would you be willing, just as an experiment, to try out saying to me, 'It has always seemed to me that I am a lethal person'? See whether or not that feels true when you say it." The use of the word "lethal" in this *trial sentence* was very deliberate. For effective experiential (limbic) process, it is essential for the verbalization to be vivid enough to capture fully the passionate emotional truths and high stakes involved (for research on use of vivid language see Martin, 1991 and Watson, 1996).

Adrienne became teary in voicing the trial sentence. She then said, "Yes, that's what I felt I was, but I didn't actually *think* it. I always *felt* I was lethal and had to struggle to keep it from

actually coming out and hurting her.” With Adrienne now in touch with her construct of herself as lethal, the therapist deliberately set up another disconfirming juxtaposition, similar to what had occurred on the phone with Mom, by saying empathically, “And now you’ve realized that you’ve actually been very gentle and caring with Mom. [Pause.] What’s it like to know this and look back now, and see all those years of growing up feeling you’re lethal?”

She said after a silence, “I just see this child who’s always trying so hard to do the right thing. Who’s really always very caring and helpful and trying so hard *not* to cause any trouble for anyone.” The therapist, still working to set up the disconfirming juxtaposition, responded, “Mm-hm. [Pause.] And see her also as *thinking* of herself as harmful and lethal.” After a short silence she said with tears, “It’s so sad to see that. Really, really sad that all those years that’s how I felt I was.”

Beyond symptom relief

In the next session, the fifth, Adrienne reported that at work she had felt no panic or anxiety at all in the week since the last session. She said she had felt evenly confident as she negotiated with board members to define her responsibilities in her job description. She indicated the degree of her change in mood by pointing out that she had to readjust her car’s rear-view mirror because her posture and walk had changed and become more upright. A friend was struck by the new look of vitality she saw in Adrienne’s face. This kind of neuromuscular release in the body is an important indicator of the real depth of the psychological work.

The therapist asked her how she made sense of her panic attacks ending. She said, “Now I can admit to myself how much I care about things going well; and I feel I’ll be able to make decisions so they *will* go well.” Asked what she meant by that, she explained that previously, feeling an anxious moment meant to her that she is harmful and will probably do the *wrong* thing, bringing an immediate collapse of confidence and panic. But now an anxious moment means she cares greatly about how she affects others, which makes her feel confident she will do the *right* thing.

By mutual agreement, this fifth session was the last. The therapist made sure Adrienne knew she could have more sessions if and when needed. Six months later, on her own initiative she sent a letter that opens, “Before I become so used to it that I forget I was ever any different, I want to tell you that the narrowly focused change I thought I was seeking [eliminating panic

attacks] has ended up affecting my whole life in ways I never expected! I've become more comfortably gregarious [she had always been very "shy," a manifestation of her unconscious safety-strategy of avoiding attention], but also more comfortable with the fact that I truly enjoy doing many things alone. I've lost 25 pounds, and even my handwriting has changed. And perhaps more important, I find I am now basically an optimist, and tend to assume all problems can be solved somehow..." Two years after these sessions, she sent a holiday greeting card in which she indicated that the changes had held well.

Conclusion

Panic attacks lasting over two decades came to a lasting end in a few sessions by focusing therapy entirely on the threefold, experiential process of discovering, integrating and transforming the specific, unconscious emotional reality necessitating the panic. That strategy and that process define depth-oriented brief therapy. At no point was there any attempt to give the client tools, techniques, beliefs or interpretations designed to override, interrupt or counteract the panic.

Coherence Therapy challenges the long dominant view that unconscious emotional realities formed in childhood and maintaining symptoms for decades require many sessions and much time to reach and revise. It shows that clinicians can work time-effectively and still fully engage the deep-rooted, passionate themes and purposes most important in people's lives.

Resources

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

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