DOWN EVERY YEAR
The Instructor’s Manual accompanies the DVD Down Every Year:
A Demonstration of Depth Oriented Brief Therapy (Coherence Therapy)

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Instructor’s Manual for Down Every Year: A Demonstration of
Depth Oriented Brief Therapy (Coherence Therapy)

with Bruce Ecker, LMFT

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DOWN EVERY YEAR
Instructor’s Manual

DOWN EVERY YEAR
A Demonstration of Depth Oriented Brief Therapy (Coherence Therapy)
with Bruce Ecker, LMFT

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DOWN EVERY YEAR
Tips for Making the Best Use of the DVD

1. GET SOME BACKGROUND
Develop a basic understanding of the guiding principles and structure of the Depth Oriented Brief Therapy (DOBT) approach by reading the Synopsis of Depth Oriented Brief Therapy in this manual. This will help you make the most of the Session Commentary Cues (see below) so you can help viewers gain a more thorough understanding of the process unfolding in the video session. See the Glossary of Techniques for some important technical vocabulary.

2. USE THE TRANSCRIPT AND SESSION COMMENTARY CUES
Make notes in the video Transcript for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during the video and post-viewing.

The transcript contains Session Commentary Cues that explain the methodology and the therapeutic effects along the way. The numbers in the lower right corner of the video screen correspond to the numbered commentaries in the transcript. When the yellow numeral changes to red, you may pause the video and read the commentary. A particularly effective way to use the video is first to view it straight through, taking in the session as a whole, and then view again, pausing for commentaries.

3. GROUP DISCUSSION QUESTIONS
Pause the video at different points to elicit viewers’ observations and reactions to the concepts presented. The Discussion Questions provide ideas about key points that can stimulate rich discussions and learning.

4. LET IT FLOW
Allow the session to play out some so viewers can appreciate the work over time instead of stopping the video too often. It is best to watch the video in its entirety since issues untouched in earlier parts often play out later. Encourage the viewers to voice their opinions; no
therapy is perfect! What do viewers think works and does not work in the sessions? We learn as much from our mistakes as our successes and it is crucial for students and therapists to develop the ability to effectively critique this work as well as their own.

5. SUGGEST READINGS TO ENRICH VIDEO MATERIAL

Assign readings from Suggestions for Further Readings and Websites prior to viewing. You can also time the video to coincide with other course or training materials on related topics.

6. ASSIGN A REACTION PAPER

See suggestions in Reaction Paper section.

7. ROLE-PLAY IDEAS

After watching the video, organize participants into groups of three. Assign each group to role-play a single session of therapy, focusing on eliminating the client’s need to produce the symptom. Each role-play shall consist of one therapist, one client and one observer. After the role-plays, have the groups come together to discuss their experiences. First have the clients share their experiences, then the therapists, and then ask for the comments from the observers. Open up a general discussion on what was learned about going deep in a single session.

An alternative is to do all of this in front of the group with just the therapist and the client; the entire group can observe before discussing the interaction. After a while, another participant may jump in as the therapist if the therapist gets stuck or reaches an impasse. Follow up with a discussion that explores working from a depth oriented brief therapy perspective.

8. PERSPECTIVE ON VIDEOS AND THE PERSONALITY OF THE THERAPIST

Psychotherapy portrayed in videos is less off-the-cuff than therapy in practice. Therapists or clients in videos may be nervous, putting their best foot forward, or trying to show mistakes and how to deal with them. Therapists may also move more quickly than is typical in everyday practice to demonstrate a technique. The personal style
of a therapist is often as important as their techniques and theories. Thus, while we can certainly pick up ideas from master therapists, participants must make the best use of relevant theory, technique and research that fits their own personal style and the needs of their clients.
Synopsis of Depth Oriented Brief Therapy (Coherence Therapy)

by Bruce Ecker, LMFT

Depth Oriented Brief Therapy (DOBT), also known as Coherence Therapy, is a non-pathologizing approach for time-effectively dispensing problems and symptoms at their roots. It is a system of personal construct therapy. Its central principle is *symptom coherence*, the view that a person’s presenting symptom exists because he or she harbors specific but unconscious personal themes, purposes, constructs—some specific version or construction of emotional reality—within which the symptom is compellingly necessary to have, despite the very real suffering or trouble incurred by having it.

These coherent, symptom-necessitating themes and purposes are *the emotional truth of the symptom*—the emotional truth of how, in the client’s world of meaning, the symptom is actually necessary to have.

At the start of therapy the client, unaware of how the symptom is necessary, naturally regards it as a form of irrationality or defectiveness, something involuntary and out of control, something to get rid of. The therapist empathizes genuinely with the client’s pain or hardship, yet assumes that the client’s psyche actually is not out of control in producing the symptom, and sets out to guide the client into discovering the emotional truth maintaining it. The goal is to skillfully prompt the client’s own native capacities to find and to transform the symptom-requiring material. When there no longer exists any construction of personal reality in which the symptom is necessary to have, the person ceases producing the symptom, *with no other symptom-counteracting measures needed*.

As a capsule example to illustrate these ideas, consider the woman who wanted therapy to relieve her ongoing, raw anxiety and almost paralyzing feelings of vulnerability to disaster. She was in the midst of several protracted extra familial battles and legal struggles, each
having potentially dire outcomes for her children, her husband and herself. The therapist, resisting the temptation to view these very real ordeals as “causing” this woman’s anxious and overwhelmed state, searched for specific, personal themes and purposes necessitating that state. By the end of the first session the unconscious emotional truth of her anxiety was discovered and was put into words as follows: “My life was supposed to be the life of a Good Girl. I’m not willing to give that up! I won’t risk seeming like a trouble-maker or crazy—which I would seem if I got fierce, to fight a battle. So I’m not going to get fierce and fight, even if my lack of fierceness leaves me feeling so endangered and so unable to protect my children that I’m full of anxiety.”

This woman’s high-priority purpose of having the identity and the rewards of being a good girl necessitates not fighting or being fierce; then, being a non-fighter necessarily generates feeling extreme vulnerability and anxiety when under attack.

In a very real sense, this woman discovered having a position she didn’t know she had—an initially wordless but nonetheless well-defined and emotionally governing position which, when experientially brought into awareness, found expression in the words quoted above. To call this the client’s “position” is meant to emphasize the client’s discovered agency in relation to the problem. The client directly experiences how the presenting symptom—in this case her anxiety—results directly from how she carries out one of her own ardent purposes.

For a therapy client to “integrate” or make fully conscious such a symptom-generating position often has remarkable and swift therapeutic effects—if the awareness is fully the client’s own direct, unmistakable experience, not merely a cognitive insight or the therapist’s interpretation. Interpretation is avoided in DOBT. The woman in our example had only one session (she lived a very great distance from the therapist), ending with her above-quoted words of emotional truth written on an index card that she was to read and stay in touch with daily. At a six-month follow-up she said her anxiety and the paralyzing sense of vulnerability to disaster had been and still were “hugely eliminated” by the session; and she had immediately taken assertive action on a number of fronts.
Note that the therapist had done nothing to prevent or eliminate the symptoms, other than having her subjectively experience and “own” her powerful position that necessitated them. This illustrates one of this approach’s major principles of change: To best promote change, one should first find and take one’s position in which it is more important to have the symptom than not have it. Change is blocked by unawareness of having that position. People are able to change positions they consciously experience having, but are unable to change positions they do not consciously experience having. The client spontaneously transformed her position of “I won’t be a fighter” once she knew she had that position.

For convenience of distinguishing a client’s symptom-producing position from many other positions he or she holds, it is often referred to in writings on coherence therapy as the client’s “pro-symptom” position because it is for having the symptom. This contrasts sharply with the position against having the symptom that the client expresses at the start of therapy—his or her anti-symptom position. The recognition that the mind simultaneously harbors widely different positions or contextual versions of reality is fundamental to this therapy.

An assumption dominating the therapy world is the view that unconscious realities formed in the course of development and persisting for decades necessarily require much time to access and change. Coherence therapy challenges this view.

The fact that a potent construction of emotional reality has been fully unconscious for decades means not that it is inaccessible or remote, but only that it habitually goes unattended. The key unconscious emotional theme generating the presenting symptom is actually always very close at hand. After a lifetime of inattention to it, the client’s attention can be brought to it now, in this very session, in minutes. What is required is not time, but a reliable methodology for bringing attention precisely to the parts of the client’s unconscious constructions that govern the production of the presenting symptom.

Coherence therapy’s methodology focuses on very effectively prompting the person(s) in therapy to discover and then to revise
their symptom-requiring themes and purposes. As noted previously, when there is no longer any version of reality necessitating the symptom, the person stops producing it.

Broadly speaking, the methodology has three overlapping processes:

- **Discovering** the unconscious, symptom-generating emotional themes.
- **Integrating** these specific themes and purposes, making them fully and routinely conscious.
- **Transforming** these constructs as needed for resolution (which may occur spontaneously upon integration or, if not, requires additional steps).

Each of these three processes follows well-defined principles. Coherence therapy/DOBT is defined not by a set of techniques, but by this threefold methodology operating experientially within the assumption of symptom coherence. The process is open-ended with respect to the experiential techniques that can be applied or invented to carry out the methodology. The experiential nature of the work is essential, because it is only by subjectively experiencing a construction of emotional reality that it becomes accurately known and actually accessed and made available for immediate change. With the client experiencing the emotional truth of the symptom, change can occur at the root of the problem.

Symptom coherence does not mean that the client *likes* having the symptom. It means she or he unconsciously expects *not* having the symptom to bring an even worse suffering than the familiar suffering *with* the symptom. The person’s psyche, faced with this choice between the suffering *with* the symptom and the suffering expected *without* it, coherently opts for the lesser misery—*having* the symptom!

In our example, the even worse suffering expected from *not* having the paralyzing sense of vulnerability (by at times being a tough fighter) was the loss of the identity and protected, happy life of a good girl.

It is noteworthy that the coherence model of symptom production described above is not an inferential theoretical construct. On the contrary, it is readily verifiable empirically in every therapy session.
by using the phenomenological methodology of coherence therapy/DOBT. That is, the process of therapy itself concretely demonstrates symptom coherence as the essential nature of the production of a vast array of presenting symptoms, including anxiety, panic, depression, attention problems, low self-esteem, procrastination, many sequelae of childhood abuse, and a wide range of couple and family problems.

Applying the Model to the Video Example

The session presented in this video is the client’s first with Bruce Ecker, LMFT, co-originator of coherence therapy/DOBT. The session takes place during a clinical training workshop as a live demonstration. The client is an attendee who volunteered for this session; the therapist had no prior knowledge of what the presenting problem would be.

ANTI-SYMPTOM POSITION

In effect, “I don’t see why, every Fall, I get depressed, and snap at people in anger, and feel like an imposter, and I want to be rid of these feelings.”

PRO-SYMPTOM POSITION

THE EMOTIONAL TRUTH OF THE SYMPTOM

The session accomplished the discovery of a number of unconscious constructs coherently maintaining the three initially presented symptoms of depression, anger and impostering as well as a fourth symptom of self-blame/inadequacy/low self-worth. The following paragraph gives a verbal depiction of these underlying constructs— the client’s pro-symptom position, the emotional reality in which the four symptoms (in italics) were compellingly necessary to have:

“What my parents expected of me and would have valued me for is the ability to have a wonderful experience in Sweden. I completely failed to do that. Their silence about my being miserable instead of having a wonderful experience means they’ve given up on me because my inadequacy is too fundamental to repair by talking about it. I agree with them that I am inadequate—that I should have been able to have
a wonderful experience. I must agree because if I disagree—if I see them as wrong for expecting me at ten to have a wonderful experience on my own in Sweden—my feeling of attachment to them diminishes greatly. I feel hopeless over how they’ve given up on me for being inadequate, and I’m depressed because of how hopeless I feel. Like them, I must not say anything about all this and must instead act as if I was and am adequate. I must keep faking adequacy with them and with everyone, even though I feel like an imposter, so that my inadequacy is never openly apparent, or else their disappointment, criticism and wrath will come to the fore. Then they would overtly give up on me and cut off from me. I feel so angry at them for giving up on me; and staying in anger over it keeps me from feeling how much it hurts. I’m also angry that my endless, tiring effort of faking adequacy can never really get them to think I’m actually adequate, and only maintains a cover-up.”

The foregoing is only one possible verbal rendition of what was a largely nonverbal, unconscious emotional reality driving the four symptoms. There could also be other pro-symptom constructs not yet discovered. Various types of construct are evident as components of this complex construction, including construed meanings about others, definitions of harm and well-being, imperative purposes, strategies for enacting purposes, specific emotions and specific behaviors. The inherent pattern of linkage between these different types of construct is a key feature of coherence therapy’s conceptual framework.
Glossary of Techniques

Below is a list of techniques used in the video. Associated Commentary
Cue numbers (C1, C2, et cetera) are listed following the definition.

**Cycling:** The client in imagination revisits and re-experiences a situation in which the symptom or problem occurred, and is alternately guided to have and not to have the symptom be occurring and to notice the differences in the experience that develops. C10, C11

**Imaginal Interaction:** The client visualizes one or more persons and, with guidance from the therapist, engages in a spoken and/or behavioral interaction as though the person(s) were actually present (as in Gestalt chair work and Jungian active imagination). C4, C5, C12, C14

**Index Card:** The client’s between-session task is written on an index card that the client reads daily. On the card is either a verbalization, in *limbic phrasing*, of key emotional truths found in the session or instructions for an experiential practice. C18

**Limbic Phrasing:** A particular style of verbalizing has been confirmed by research to be necessary for fostering the direct accessing of deeply held, emotional material: phrasing that is present-tense, highly personalized, emotionally naked, perceptually vivid, and vulnerability revealing.

**Overt Statement:** The client is guided by the therapist to speak a sentence that expresses a discovered personal truth, using *limbic phrasing*. Overt statements spoken to a visualized, emotionally significant person or persons tend to be particularly powerful. C4, C5, C14
**Sentence Completion:** The therapist supplies the first part of a sentence, inviting the client to say it out loud and “let it finish itself spontaneously, without pre-thinking it.” In DOBT the supplied wording is crafted so as to elicit unconscious, symptom-requiring material. C16, C17

**Symptom Deprivation:** Client is guided to experience in imagination being symptom-free in a recent situation in which the symptom occurred. Any uncomfortable or unwelcome experience that arises due to being without the symptom begins to reveal why the symptom is necessary to have. C7, C8, C9
Group Discussion Questions

Professors, training directors or facilitators may use a few or all of these discussion questions keyed to certain elements of the video or those issues most relevant to the viewers.

INTRODUCTION

1. **Unlocking Question**: How did the therapist’s questions help the client delve into a time in his life that had been locked away? Did it seem to you that this important material came up quickly in the session? How did that happen and did it work? If you had been the therapist, how might you approach the opening moments differently?

2. **The Association**: The client says he’d never previously associated his experience of going to boarding school in Sweden with his end-of-summer drop in mood. What if the therapy session had ended right there? Might the association have been enough to create some shifts, or do you think it needed to be flushed out and worked together with the therapist? If you had been the therapist in this session, would you have stuck with this particular memory as the key to the drop in mood, or would you have explored elsewhere?

3. **Talking with Parents**: What do you think of the client’s visualizing his parents and talking to them with the therapist coaching him along? Is this something you can imagine yourself doing? Does anything about this approach feel awkward, uncomfortable or unappealing to you? If so, how?

GOING DEEPER

4. **Connecting with Current Experience**: The therapist shifted the client’s focus from his dialogue with his parents to his current drop in mood. What did you notice about the therapist’s technique and style here? Do you think this intervention was effective? What about it did you like or not like?
5. **Silence:** How comfortable were you with the periods of silence in the video session? Would it be difficult for you to sit together in silence with this client or would you try another tact? What comes up for you when there is silence in a session?

**EXPERIENCING EMOTIONAL TRUTH**

6. **No Differentiation:** Does the client’s recognition that he does not differentiate between small disappointments and crises of abandonment seem like a major moment in the therapy? Would you have stayed longer with this new awareness or moved on as Ecker did and why?

7. **Index Card:** How did you feel about the index card intervention at the end of the session? What impact do you think it had on the client that the therapist chose what would be written on the take-away card? Can you imagine using this kind of intervention with clients? If you had been the therapist, would you have written down what Ecker did, or was there a different statement that would have been more significant for you?

**CONCLUSION**

8. **The DOBT Model:** Does this model make sense to you? Do you see using it with your clients? Why or why not? What changes would you make in the model, if any, to suit your own style better?

9. **Ecker’s Style:** What about Ecker allowed this client to feel comfortable enough to engage in such deep work in front of a room full of people? What did you notice about how he joined with the client and brought him into the therapy?

10. **Personal Reaction:** How would you feel about being a client of Ecker’s? Do you feel an alliance could be made, and that he would be effective with you? Why or why not?
Reaction Paper for Classrooms and Training

Video: Down Every Year

Assignment: Complete this reaction paper and return it by the date noted by the facilitator.

• Suggestions for Viewers: Take notes on these questions while viewing the video and complete the reaction paper afterwards, or use the questions as a way to approach discussion. Respond to each question below.

• Length and Style: 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

What to Write: Respond to the following questions in your reaction paper:

1. Key Points: What important points did you learn about psychotherapy in general, and Depth Oriented Brief Therapy (DOBT) specifically? What stands out in how Ecker works?

2. Buttons Pushed: What issues/principles/strategies did you find yourself having resistance to, or what approaches made you feel uncomfortable? Did any techniques or interactions push your buttons? What interventions would you be least likely to apply in your work? Explore these questions.

3. Most Helpful: What was most beneficial to you as a therapist about the DOBT model presented? What tools or perspectives did you find helpful and might you use in your own work?

4. Doing it Differently: What might you have done differently than Ecker did in the video? Be specific in what different approaches, strategies and techniques you might have applied.

5. Other Questions/Reactions: What questions or reactions did you have as you viewed the therapy in the video? Other comments, thoughts or feelings?
DOWN EVERY YEAR
Suggestions for Further Readings, Websites and Videos

BOOKS


WEB RESOURCES

www.dobt.com  Depth Orient Brief Therapy website

www.constructivistpsych.org  The Constructivist Psychology Network

www.tandf.co.uk/journals/tf/10720537.html  The Journal of Constructivist Psychology

www.brieftherapynetwork.com  The Brief & Narrative Therapy Network

www.brief-therapy.org  The Brief Family Therapy Center, home of Solution-Focused Brief Therapy

RELATED VIDEOS AVAILABLE AT WWW. PSYCHOTHERAPY.NET

Existential-Humanistic Psychotherapy in Action  – James F. T. Bugental, PhD

Existential-Humanistic Therapy with James Bugental, PhD

Object Relations Therapy with Jill Savege Scharff, MD

Time Limited Dynamic Psychotherapy  – Hanna Levenson, PhD

Transactional Analysis with Mary Goulding, MSW
INTRODUCTION

Psychotherapist—Bruce Ecker: What’s the problem as you experience it?

COMMENTARY 1: These opening words begin to suggest to the client the direction the work will take: the therapist will be more interested in learning how the client constructs the problem, than how the problem happens to the client. The client relates to the problem situation using a uniquely personal construction of reality. This construction has enormous influence on how the problem is experienced and how this experience can be changed.

Client: Well, I, ah, over the last four years or so have, um, really, um, become aware of a drop in my mood, um, getting into a, a pretty—what I’d call a kind of a depressed place, that happens every year, late summer, um, and carries over, um, until I quit thinking about it basically. I mean it, ah—And in and of itself it, it—I’ve known it in some way, shape or form most of my life but wasn’t as aware of it.

Ecker: Hm. How far back? Most of your life means how far back?

Client: Well, I don’t know that I ever—Four years ago I went to a therapist, um, to talk about it and what was going on for me. That’s the first time I really said, hey, wait a minute, this is not okay, I’m not comfortable right now. And I didn’t know at that time that there was a, a, that there was some kind of a pattern to it, or at least I didn’t think that way.

Ecker: So, at least four years ago.
Client: Correct.

Ecker: And—

Client: My wife has told me—and we’ve been together for longer than that—and she, when I did that she—in somewhere in that time frame—um, admitted to me that she had noticed that before.

Ecker: Okay.

Client: Um, and then I starting putting together other things, of course, about it. Um, looking back and saying, you know, I always thought of Fall as my favorite time, and then trying to make sense out of that. And, ah, so I think there’s been some element of it going on for probably quite a long time.

Ecker: Mm-hm.

Client: Um, and in and of itself it, it—I don’t know that it was all that, um, problematic for me. What, what became problematic was some of the symptoms of it, some of what happened in conjunction with it, or whatever. I, ah, when I first went to the therapist it was because, um, I was in a job situation and I, and I found myself feeling so insecure in that, and questioning everything I was doing and becoming, um, very, um, engaging in a lot of power plays with my, with the people I supervised and, um, being very short and impatient and, um, snapping and, uh—I mean, it was uncomfortable for them, it was uncomfortable for me. Um, I, I mean, I was angry, I was—I didn’t want to be there and I wanted to be there. I mean, it was just very uncomfortable and—

Ecker: And this is associated with this drop in your mood at the end of summer.

Client: Yeah, yeah…

Client: Well, and I end up very—I mean, at the same time, I mean, there are other elements of it. I mean, I’m very, I get the typical kind of imposter kinds of thoughts. I mean, I, I get worried that I’m going to get found out; um, that I don’t know diddly squat; that I’m a, what am I doin’?

Ecker: So, what, what, what is the end of summer, in your life? What,
ah, in your current actual circumstances? Do you have a teaching job? Is summer the beginning, ah, the—

Client: No.

Ecker: No.

Client: No, it really doesn’t mean anything in my current—well, of course it means something, but, um, not associated with my job, per se. Um—

Ecker: Has there ever been any major event in your life at the end of summer? Ah, upheaval, or—

COMMENTARY 2: The client has described a cluster of longstanding symptoms—depression, anger, and imposter feelings—that occur together regularly at the end of summer. In relation to this he has also indicated a considerable degree of unconsciousness: until four years ago he was unaware of these symptoms, then noticed the anger component first because of the interpersonal trouble it caused him, then gradually realized the annual recurrence of the whole cluster; he describes the “drop” in his mood as something that happens to him involuntarily; and he has not been able to make sense of having such symptoms during what he thought was his favorite time of year, Fall.

In the first stage of coherence therapy/DOBT, the therapist works to discover the client’s unconscious but coherent context, or construction of emotional reality, within which the presenting symptoms are compelling to have and fully make sense to have. In what the client has revealed so far, the “end of summer” is very likely an element of just such a pro-symptom emotional reality and can serve as a point of departure for further accessing of that unconscious construction. To do this, the therapist is bringing the client’s attention to “end of summer” and is prompting him to access subjectively whatever personal meaning then stirs into awareness.

Note that the therapist probed first for how the emotional significance of “end of summer” might be apparent in current life circumstances, found no resonance, and only then directed the client’s attention to the past. As a constructivist, the therapist is not really asking about the factual past
even though he necessarily uses conventional language that sounds as though he is; nor is he, in bringing attention to “the past,” searching for causes in the past. Present symptoms are produced entirely on the basis of presently held constructs of reality, but it is often the case that these symptom-producing constructs were formed in the past and depict an emotional reality first experienced in the past. The client still holds and applies these constructs unconsciously in the present, making the past reality truly exist in the present.

Client: Oh yeah, I think, I think there probably was, ah, every year, going back to school. Um, and, and there was at least one year when I was really, um, I was ten years old and my, um—I’m the oldest of six kids and my parents are both physicians and, and, eh, my Mom’s a Swedish citizen so my father thought it would be a wonderful idea, all of our lives, for us to, to take advantage of her being from another culture, another language. And, when I was ten, um, somewhere in the middle of summer I flew off with a friend of our family to Europe, and spent time with this adult and his adult family, and then was put on a plane and, ah, shipped up to Sweden to connect briefly with my aunt and my cousins, and driven out into the middle of Sweden to a boarding school and dropped off and good-bye and now I’m supposed to be here for the year at this boarding school, and I was ten. And it was traumatic as hell. Um, I did not stay, ah, to make a long story relatively short, but it was very painful.

Ecker: And that was at the end of summer.

Client: Yeah, well, yeah.

Ecker: Yeah. And you knew that was coming.

Client: You know, it’s very interesting, I’ve never associated this with it, yeah. I—I didn’t know it was going to be that painful because it was supposed—I was supposed to have a stiff upper lip, it was supposed to be an opportunity. It was, ah, I mean, that, that was the language of the adults, the “wonderful experience.”

Ecker: Yes, yes.

Client: Ah, but, emotionally for me, it was, um, extremely traumatic. I mean, I, it was very painful.
Ecker: Sounds really intense.

Client: It was.

**COMMENTARY 3:** A childhood, end-of-summer “trauma” that he has never consciously associated with his symptoms has surfaced. It is now time to stop talking about this and begin a fully experiential process of finding how his construction of that trauma leads him to produce his presenting symptoms.

For this purpose the therapist will next repeatedly use the technique of overt statement, in which the client verbally expresses disowned emotional truth directly to the relevant figures (visualized or in person). If the therapist persists in having the client express phrases vividly capturing his emotionally true, symptom-requiring position, that position cannot remain split off and unconscious. The client will feel the emerging emotional themes in the present moment and experience them as present emotional realities. It is only in such direct, subjective experiencing of unconscious constructs that they are truly accessed and made available for swift, lasting change.

**USING OVERT STATEMENTS**

Ecker: I’d like you to try something, if you’re willing. I’d like you to, I’d like you to picture your parents.

Client: Yeah.

Ecker: Get, get a, got an image, an image of them in front of you?

Client: Essentially, yeah.

Ecker: Yeah, okay. That’s good enough to start off. And I’d like you to try out beginning to tell them, in straight terms, what that experience was for you—how that really felt for you.

Client: (Sighs.)

Ecker: And you can do that either out loud or quietly inside. It can be silent. Whatever feels right for you.

Client: (Sighs.) I have told them—
Ecker: You have.

Client: —but not very fully, I don’t think.

Ecker: All right. What’s the part that you haven’t told them yet? What’s the “fully”?

Client: I don’t think I’ve, um, really blamed them. I don’t think I’ve really been angry at them. Ah, I’ve kind of laughed it off.

Ecker: Ah. So, how would you tell them about this without any laughing it off, and showing them what you really feel and how it really affected you?

Client: (Big sigh. Voice slightly quavering.)) I was ten years old. I mean I look at a ten-year-old kid now, and I can’t even imagine—(pause))—what happened.

Ecker: Yeah. Would you try out saying to them, to see if it, to see if it feels true for you, would you try out saying to them: “It was so awful for me that, to this day, I get very unhappy at the end of summer.”

Client: (Big sigh.) It was so awful for me—ah hell, it sucked! I mean it sucked and it sucks every year. (Pause.) And I’ve never put those things together.

COMMENTARY 4: The therapist has prompted an overt statement that links the client’s emerging emotional truth, “It was so awful for me (in Sweden),” to the concrete symptom, “that, to this day, I get very unhappy at the end of summer.” When the client then says, “And I’ve never put those things together,” the sentence has succeeded in fostering an experiential connection between his presenting symptoms and his childhood ordeal in Sweden.

This is an example of how “unconscious” does not mean “inaccessible.” Unconscious, symptom-producing constructs carried for decades can be accessed in minutes if the therapist (a) assumes symptom coherence and, on that basis, initially does nothing but look for how the presenting symptom is necessary to have (rather than trying to get rid of it in any way), and (b) carries out this discovery experientially.
It may seem surprising that such a psychologically aware, high-functioning person could live out decades of adulthood completely unconscious of the direct connection between his symptoms and his experience at ten. Actually, such unconsciousness of salient, pivotal emotional truth is the norm in therapy clients at all levels of psychological sophistication.

At this point the therapist anticipates that the rest of the session will be used to fully unpack the emotional truth now emerging and to achieve as much experiential integration of this specific pro-symptom construction as possible.

**Ecker:** I see. (Pause.) Yeah. Would you try out saying to them—and change the words to make it fit for you just right—ah, “How could you do that to me? Didn’t you know?” What are your words for that?

**Client:** Um, I, I need to—ahh. Who knows what this is, but—

**Ecker:** Yeah.

**Client:**—when you said that, the problem for me has always been is that that’s failure on my part.

**Ecker:** What is failure on your part?

**Client:** Not, not being able to accommodate their expectation.

**Ecker:** I see. Their expectation that you should—?

**Client:** That was my stuff, is that I’m a big boy. (Laughs.) I can handle this. This is, I mean, there’s not a problem here, this is an opportunity.

**Ecker:** Mm-hm.

**Client:** But that’s not how it felt.

**Ecker:** Okay. So, how about telling them, “I know you really wanted me to just handle it, like a big boy, but I was ten, just ten.”

**Client:** (Sighs.) Yeah.

**Ecker:** What do you want to say to them? “I wasn’t a big boy”?

**Client:** I, yeah (laughs)—No, I was telling ’em forwards and backwards, “I am a big boy, I am a big boy” and that fell, that flew in the face of my internal stuff—I hurt like hell. Um, I mean, ahh—I wanted, I guess now I want to tell ’em, despite what I was trying to
show you that I could handle things and that I knew stuff and that I was on top of stuff, I didn’t. I couldn’t. And you needed to see that. You were the adults, for God’s sakes, I was a ten-year-old boy! (Tears.) You were supposed to know. Not just send me off there and look at my smile and say, “Oh, he’ll be fine.” (Cries.) It wasn’t fine.

**Ecker:** Yeah. (Pause.) Good, keep, keep going. Tell them, tell them more of what, what the experience really was for you, some of the details. What was the worst of it for you? Tell them.

**Client:** I don’t know what the worst was, I just remember it was really painful, it was scary, I was very homesick. I, ah—I mean there were really, there were a lot of good things, too, but, ah, and I remember them. You know, funny, you ask me, “Tell ’em how bad it was” and what comes to my mind is the fun stuff. I mean, um, but I didn’t know the language, I didn’t know anything.

**Ecker:** Are you willing to tell them, “I was so homesick, it was so painful.”

**Client:** Yeah, that’s the stuff they did hear.

**Ecker:** They did hear that.

**Client:** Well, (laughs) um, oh hell, it was 1960—I don’t know, four or something like that, ’63—and I can remember that, it was, there was a transatlantic cable then, there were no satellites, so the telephone calls took forever to connect and, and you’d get called back by the operator. And I was a ten-year-old kid so I’d get this call and I’d go running for it, and I would try and diplomatically tell, talk them into taking, letting me come home. And let it be reasonable, intellectually. (Laughs.)

**Ecker:** In other words, by not, not showing what was really going on.

**Client:** Yeah, except for I couldn’t do that. I mean, I would break into tears, and plead and beg and, and they’d keep trying to shore that up, so it would be okay.

**Ecker:** So, what do you need to say to them now about that? “Couldn’t you see what was happening to me?” What, what do you, what do you want to say to them about that?

**Client:** I don’t know, I don’t know. I, um—
GOING DEEPER

Client: I mean, I buy into a lot of what, of the other side of it, which is, ah, you know, I—Yeah, well, but I think that, I think that they thought that, you know, if I could just get by the initial insecurity then it would be a wonderful experience.

Ecker: All right. Try this, if you would. Try saying to them, “I agree with you that I should have been able to handle it well.” How ’bout giving voice to that side of your own feelings?

Client: Yeah, well, part of me at least does agree with that. That I, I, I, I should have been able to get through with it, um, to get to a place that was more comfortable. Um—

Ecker: Mm-hm. Okay. And now, would you let yourself, to whatever degree is there for you right now, let yourself feel or connect with that particular kind of feeling that develops at the end of summer, now in your life? I think you said a drop, a drop in your feelings happens. Let yourself feel that. Let yourself speak to them, your parents, from that drop. What needs to be said, to them, from that drop in your feelings?

COMMENTARY 5: When first asked to tell his parents “in straight terms, what that experience was for you—how that really felt for you,” the client equivocated and then said, “I don’t think I’ve, um, really blamed them. I don’t think I’ve really been angry at them. Ah, I’ve kind of laughed it off.” This indicates extensive suppression of the emotional truth of his experience in Sweden and of the associated unresolved themes and meanings in relation to his parents. Heading directly for this material, the therapist has twice invited him to tell his parents imaginally of the emotional suffering their choices caused him, and to ask for some accounting for this from them. He managed to do some of this but each time soon cut off the process by shifting into self-blame, the view that his ordeal in Sweden was due to his own inadequacy.

The therapist sees this self-blame or low self-worth as a distinct symptom in itself, and has responded to it in the manner characteristic of coherence therapy/DOBT: he accepts the symptom of self-blame as being what’s so for the client and, in order to discover how it is more important to have than not to have, invited fuller expression
of the client’s powerful position of producing it. The client engaged this to a degree but remained at too cognitive a level for the work to advance usefully. The therapist therefore decided to focus where deeper experiential accessing would be more likely to occur—the subjective state of the drop in feelings. In going into his state of producing the symptom, the client is activating and occupying his pro-symptom position.

**Client:** (Long pause. Sighs.) The only thing that comes to my mind is that no, I’m really not what you think I am.

**Ecker:** Good. Keep going with that.

**Client:** I, I’m, yeah, boy, I’m really not, ah, as secure or as comfortable in things. (Pause.) I’m really quite frightened. (Sighs.) Huh.

**Ecker:** Tell them, of what.

**Client:** (Sighs.) I’m frightened of being found out, I’m frightened of being, ah, of being inadequate, of being, um, not able to meet up to the expectations.

**Ecker:** Your expectations? Their expectations, I mean?

**Client:** (Laughs.) Is there a difference? (Laughs.)

**Ecker:** Yeah, exactly. So, then, is what you’re getting at something like, “I’m really frightened”—Well, it’s the first thing you said, “I’m really not what you think I am, and I’m really frightened that you’ll find that out, and you’ll see I’m, I, I don’t live up to your expectations. And every Fall I get troubled and depressed about that.” Is that what this is leading to?

**Client:** Yeah, it’s, it’s become the parents in general—the world around me, my own parent, everything.

**Ecker:** Mm-hm.

**Client:** I get really frightened that I’m going to get found out, that I’m, that I’m not okay, that I’m not capable, that—and I, and I get really pissed ’cause I don’t like the pressure of having to keep proving that I am.

**Ecker:** Ah—so there’s the anger part of it there.
Client: Yeah.

Ecker: Mm-hm.

Client: I mean it takes a, for me it takes an awful lot of effort, it feels like, to keep proving that I’m worthy…

Ecker: So, picture your parents again, and just try out saying directly to them, just what you were getting in touch with and putting words on—ah, “I’m not what you think I am, and I’m really frightened you’ll find out that I, I don’t live up to your expectations.” Would you try out just direct to them, saying that.

Client: I’m not what you think I am. Heck, I’m afraid that you do think right of what I am and that I’m not okay, and you don’t think I’m okay. That’s what I really think. I’m not afraid that they—I’m afraid that they already know that I’m not okay.

Ecker: I see. I see.

Client: That’s what I, that, that’s the real stuff, is that we can all keep up the act, but, underneath all that, they, supervisors, authority figures, whatever, already know that somehow I’m not okay.

Ecker: Mm-hm.

Client: No wonder I get angry. (laughs.)

Ecker: No wonder you get angry?

Client: Yeah. (laughs.)

Ecker: What do you mean?

Client: Well, (laughs) I’m thinking that, you know, I work really hard to prove I’m okay all that time, and, at a certain point I get really tired of it. And I just want to tell them to fuck off, you know, just, give it up, already, you know?

COMMENTARY 6: The coherent basis of the client’s anger, one of his presenting symptoms, is beginning to emerge: He carries the construction that all authority figures already see him as he sees himself, fundamentally inadequate, and only act as though he might be adequate. He is angry over this falseness that endlessly leads him on to make futile
efforts in hope of getting them to think he is adequate, and he is angry over the impossibility of ever changing their unspoken view of him. These themes are a direct generalization of the construals he formed in relation to his parents after his stay in Sweden.

**Ecker:** Go ahead. Who’d you like to picture—

**Client:** (Laughs.)

**Ecker:**—to say that to?

**Client:** (Laughs.)

**Ecker:** Who’s top on the list?

**Client:** (Laughs.) Boy, I don’t know.

**Ecker:** Who would you *most* like to say, “I’m *really* tired of trying to convince you I’m okay, when I think you already think I’m not, and it’s an impossible task.”

**Client:** Hm. Probably myself. (Pause.) Probably myself.

**Ecker:** You’re tired of trying to convince *yourself* you’re okay.

**Client:** That sounds horrible. (Laughs.)

**Ecker:** What’s horrible about that?

**Client:** I shouldn’t *have* to convince myself that I’m okay. I mean I shouldn’t have to. But I do, *all* the time…

**COMMENTARY 7:** In acknowledging his endless efforts to convince himself he is “okay,” adequate, he plainly sees his “horrible” emotional truth of feeling inadequate. The therapist now wants to discover the coherence of this low self-worth, that is, the unconscious themes and purposes within which low self-worth is necessary to maintain. For this purpose the therapist is next going to apply the technique of symptom deprivation, or viewing from a symptom-free position. Having a client experientially sample being without the symptom in the very situation where the symptom happens strongly is likely to surface the unconscious theme or purpose making the symptom necessary to have—the emotional truth of the symptom. The aim of the technique is the discovery of that specific theme or purpose, not a permanent change to a symptom-free state.
USING SYMPTOM DEPRIVATION

Ecker: Yeah. All right then, then I have an idea of something I’d like you to, to do next.

Client: Okay.

Ecker: Again, picturing your parents. And now, I’d like you to try out seeing what happens for you if, if you look at them, knowing you’re okay. Not, not trying to convince yourself you’re okay. And it’s not, I’m not aiming for, that by the end of session you’ll stay there and always feel okay. Just for a minute or two, here, I’d like you to see what it’s like for you, what starts to happen, if you look at them, seeing them as putting these, these expectations on you that don’t match who you are. And seeing that as a kind of, probably a very well intentioned, misattunement with you. They’re failing to see you and accept you—again, with the best of intentions. But I would just like you to look at them from a place of knowing you’re sufficient, you’re fine, but you’re suffering this, this misattunement that they carry out. Just see what, what that feels like, and what, what they seem like, what changes you notice.

Client: (Laughs.)

Ecker: What’s that?

Client: Ah, it’s a really different picture. (Laughs.)

Ecker: What is it?

Client: Well, for one, they’re really small. Um, and there’s a distance. And I feel pretty stable and constant, but, they’re, that, and—it’s kind of fuzzy.

COMMENTARY 8: Symptom deprivation is working. In holding a position of regarding himself as adequate, the client reports a loss of attachment, a considerable new degree of separateness and emotional distance from his parents. This is not an interpretation coming from the therapist but an experience he is having for himself, directly. (This “incredible shrinking parent” experience is a quite common result of guiding a client to sample being free of low self-worth while imaginally in the company of parents.)
The therapist has learned now that in this man’s unconscious emotional world, maintaining his original attachment with parents is a top priority that necessitates construing the suffering he experienced in Sweden as due to his own inadequacy, rather than due to his parents’ making inappropriate choices that hurt him. When invited by the therapist to inhabit the latter view, he has managed briefly to experience it but has quickly reverted to self-blame.

**Ecker:** Mm-hm, that’s okay. That’s fine. So, just, I want you to stay with that just another minute or so, as I ask you to just **consider**, consider whether—Let me put it this way as you stay with that. Notice how much willingness or unwillingness you have over the prospect of having it stay this way forever. As if the price of getting your own sense of sufficiency and stableness, as you now fuzzily feel it, if the price is that they become small and distant. Just see how much willingness or unwillingness you feel, to have it stay just this way. (Pause.) What is it you notice?

**COMMENTARY 9:** The therapist’s purpose here is (a) to prompt client’s discovery of what for him are unwelcome consequences of shifting into positive self-worth, and (b) to prompt him to begin to realize his agency in staying in low self-worth, by speaking to him as though it is only his unwillingness to accept those unwelcome consequences that stops him from stepping out of low self-worth.

The client enters therapy having already chosen powerfully though unconsciously to live with the suffering that comes from having the symptom, in order to avoid the much worse suffering unconsciously expected from not having it. The therapist is attempting to prompt a conscious, experiential reassessing of this choice.

**Client:** Um, I think I’m, I’m, ah, real **willing** to have that. I don’t feel as secure in, in my capacity to maintain a **hold** on that.

**Ecker:** I understand. In fact, what I’d like you to do now is sort of take a breath and drop that, and go back to **agreeing** that you’re insufficient, you failed to live up to expectations you should, and look at them again from that **position**. (Pause.) Being in **agreement** now, with them, about this. (Pause.)
COMMENTARY 10: The therapist is now using the integration technique of cycling in and out of a symptom-free position. This begins with the symptom deprivation already carried out: the client, who as a result of not having the symptom is experiencing something unwelcome (loss of attachment in this case), is asked to deliberately resume having the symptom. The client will then experience that in having the symptom, the unwelcome feature disappears. The whole cycle can then be repeated if necessary until the client experientially realizes his own purposefulness and agency in producing the symptom in order to keep that unwelcome con-sequence from occurring.

Ecker: How’s that for you?

Client: Well, it’s harder to do, I’ll tell you that. (Chuckling.)

Ecker: Harder? In what sense? You’ve been doing it a long time, how come it’s hard to do?

Client: Yeah, but I like the other—(laughs)—I like the other place. (Laughs.)

Ecker: What did they look like from this place, though, now?

Client: They got bigger right away.

Ecker: They got bigger. And how about the distance?

Client: Ah, right there.

Ecker: They’re right up close again. So it restores—

Client: They get clear, I get fuzzy.

Ecker: Okay. So if you agree that you’re not living up to things you should, it restores them being big and close up.

COMMENTARY 11.

: In returning to having the symptom of regarding himself as inadequate, the client now reports regaining his original, much closer sense of attachment with his parents. The cycling technique is providing direct, experiential evidence that construing himself as inadequate is necessary in order to feel securely attached. In other words, a pro-symptom position for low self-esteem has emerged, a position in which the client’s ardent
purpose is to preserve his original emotional connection with parents. This purpose necessitates being in agreement with their version of reality, and in particular, being in agreement with (what he construes to be) their view of him as inadequate for being incapable of having a positive experience on his own at ten in Sweden. This of course precludes feeling any anger at his parents for sending him, since any such anger can arise only on the basis of construing them as being at fault, rather than himself. Conversely, avoiding such attachment-threatening anger may be an unconscious purpose for construing the fault as his own.

The therapist, in response to the client describing restoration of his sense of attachment, simply verbalizes the phenomenology that the client has just reported, taking care not to add any interpreting at all. This non-interpretive verbalizing is important for prompting the client to integrate what he has just experienced. Otherwise, the experience would remain a state-specific one (an altered state) and be quickly lost. Additional steps of integration will be needed, such as another round of the same cycling process, which the therapist will begin next.

**Ecker:** Okay. All right. So let’s try again the other side. Take a breath and drop this. And again now, see them from that other position of knowing that you’re okay, you’re sufficient, but they’re laying expectations on you that they shouldn’t be. Doesn’t fit who you are. And they’re your parents and they should adjust to who you are. (Pause.) And knowingly suffer the loss of them becoming small and distant, as the result of not agreeing with them now about this. (Pause.) And how is that for you this time?

**Client:** I find myself thinking that they, they, that they don’t think that way. (laughs.)

**Ecker:** …So, as you think—Go ahead, let that thought be there—they don’t think that way. They don’t see me as insufficient or inadequate, and then how does your, how do they appear, as you look from that thought?

**Client:** (Long pause.) They’re just there…
REVISING CORE EMOTIONAL REALITY

Client: Hm. It’s odd because I’m thinking that they may have changed but I haven’t. (Chuckles.)

Ecker: Hm. Is that a new idea? For you?

Client: No, actually in a way it’s the same idea—it’s that I’m not okay, (laughs) you know, it’s that I, I have not grown out of that. They have. They think I’m okay; I don’t think I’m okay.

COMMENTARY 12: At ten, when he failed to be a big boy who could have a wonderful experience on his own in Sweden, he construed his parents (accurately or inaccurately) as regarding him as inadequate. He has held this construal and unconsciously agreed with it and applied it in various situations for thirty years. In the cycling process, he has for the first time consciously experienced these previously unconscious construals of his inadequacy. Then, spontaneously, he reports a transformation: “I find myself thinking that they, they, that they don’t think that way,” “It’s odd because I’m thinking that they may have changed but I haven’t,” and “it’s that I, I have not grown out of that. They have. They think I’m okay; I don’t think I’m okay.”

This revising of a core, symptom-generating emotional reality by the client is the very essence of in-depth resolution. How can we understand its occurrence here? DOBT provides well-defined principles describing how this transformation of constructs takes place. In the present case:

- The client made experientially conscious his construction of his parents as seeing him as inadequate, a construction formed at ten.
- He then integrated that construction: for the first time he brought it into contact with, and experienced it within, his adult identity-position and associated constructions he consciously applies for organizing reality from that position.
- He then reported that the view from ten—his construal of his parents as deeming him inadequate—did not survive this new contact with the view from forty. The two versions of reality evidently were incompatible, because the view from ten was dissolved into knowing that it is only he himself, not they, who deems him inadequate.
Integration produced a condition of having two incompatible versions of reality experienced simultaneously in the same field of awareness. It is precisely this condition that prompts the psyche to dissolve some constructs in favor of others, in order to maintain a coherent depiction of reality within any one set of connected constructs. Such sudden, significant transformation of longstanding emotional reality typically does feel “odd,” as he says. The client’s follow-up report confirms the importance of this change in how he construes his parents’ view of him.

This transformation illustrates the principle that people can change a position they experientially know they have, but cannot change a position they do not know they have.

(It should be noted for completeness of this discussion that integration does not always or automatically have this effect of bringing the pro-symptom emotional reality into direct contact with incompatible constructs, thereby triggering spontaneous transformation. When transformation does not spontaneously follow integration, the therapist can then deliberately arrange for the client to experience the pro-symptom construction together with other constructs incompatible with them. For further description of principles and techniques see Ecker & Hulley, 1996, Chapter 6.)

**Client:** …And it’s interesting ’cause it—In going back to the story from when I was ten, when I finally came back to the United States—found, kind of finagled my way back—nobody ever talked, we never talked about my failure. We never talked about the fact that I did not stick it out.

**Ecker:** Mm-hm.

**Client:** That was never, ever addressed. I just knew, on some deeper level, that I had not accomplished what it was all about.

**Ecker:** Mm-hm. Okay. So—

**Client:** I guess I’m really pissed that that didn’t happen.

**Ecker:** Ah.

**Client:** I guess I’m really angry that somebody didn’t—that I have to keep calling myself on the act. That they don’t call me on the act. That
somebody doesn’t step up and say, “You know what? This part is fakey. You know, this is the truth: you did not accomplish this. And, and on that level, we’re disappointed.” But nobody ever says that.

**COMMENTARY 13:** At this point there is further clarity into the coherent emotional truth of his symptoms of anger and of feeling like an “imposter.” He has suffered at least as much harm from his parents’ complete silence after the trip to Sweden as from the ordeal of the trip itself. He has anger over their failure to emotionally debrief the experience with him, which has left him imprisoned in his private construal of being gravely and irreparably inadequate. His “faking” of adequacy—being an “imposter”—is completely cogent within this revealed context. Going along with pretending everything is fine, though distressingly “fakey,” has been far more bearable for him than what he anticipates would result from not faking.

When in this session he does express anger at his parents, it is only for failing to talk about their feelings of disappointment. It is striking that there is no sign of anger over their terrible error and misattunement in sending him alone to the school in Sweden in the first place, expecting a 10-year-old boy to cope well with that experience. As noted previously, he consistently avoids these most central aspects of his parents’ accountability for not taking care of him emotionally and reverts to self-blame.

**Ecker:** …So would you try—Here’s what I’d like you to try next. I’d like you to see them, and along with them, a crowd, everybody with whom you’re doing this.

**Client:** Mm-hm.

**Ecker:** And I’d like you to try out saying to all of them, “I hate faking it, but it’s worth doing to avoid getting your disappointment.”

**Client:** Ooooo (chuckles). I hate faking this. I hate acting this out and hiding this stuff, but that’s better than facing your disappointment, your wrath, your criticism. (Pause.) Hnh.

**Ecker:** What’s happening?

**Client:** Well, it feels better to have a crowd.

**Ecker:** How? How is that better for you?
Client: Because there is a crowd.

Ecker: Oh okay. It’s truer.

Client: Mm-hm.

Ecker: It fits.

Client: Mm-hm.

COMMENTARY 14: The client seems to have had an immediate and strong encounter with his own emotional truth when he takes up the sentence offered by the therapist and says it as his own overt statement, elaborating it by identifying “wrath” and “criticism” as responses he expects and strives to avoid in others, in addition to “disappointment.”

Note that this overt statement fully acknowledges his dislike of having the symptom of faking (“I hate faking it,” an anti-symptom position) while also acknowledging how that symptom is nevertheless necessary to have (“but it’s worth doing to avoid getting your disappointment,” a pro-symptom position). In experiencing how the necessity of having the symptom actually outweighs the wish to be rid of it, integration is reaching its fullest form, a pro/anti synthesis or unification of his previously disconnected anti-symptom and pro-symptom positions.

The therapist invoked the image of the “crowd” in order to prompt him to access his present-day position in relation to everyone with whom he has generalized his childhood position of finding it necessary to “fake it.”

Ecker: Good. And how is it to, to let yourself acknowledge to yourself and to all of them, “I resort to faking it to avoid facing your disappointment and your wrath and your criticism. I don’t like faking it. It feels horrible. I get angry over it. But it’s worth, it’s worth it to avoid your disappointment and anger.” How is it to acknowledge that?

Client: (Pause.) As soon as, as soon as I say that I own that, I, I really want to step into the battle with them. I want to just be me and I want to bring what I have, which I think has validity, and just do battle with their criticism.

Ecker: Yeah? You feel ready to face the disappointment and criticism that might arise?
Client: Well, that’s a—I don’t know that I feel all that secure in that, and I don’t how much of the criticism I could face directly before I started questioning my own capacity, my own ability…

Ecker: Mm-hm. In other words, facing whatever criticism or disappointment is there, you’ll, you’ll, you’ll—

Client: I’ll crumble.

Ecker: Crumble.

Client: Yeah.

Ecker: Go into agreement that you’re not okay.

Client: Yeah. And have to face the consequences of it—that I’m not okay.

COMMENTARY 15: The therapist deliberately recasts “I’ll crumble” as “Go into agreement that you’re not okay” in order to continue fostering recognition of his own agency in “crumbling,” that is, in taking a low self-worth position at any given time.

Ecker: Mm-hm. So, would you, would you imagine that? Would you imagine being at that point? Where there’s been so many instances of that—battles, criticism, negative responses. And a point comes when it’s the moment when you would crumble. (Pause.) And I want you to imagine that you’re at a fork in the road there. What was that?

Client: I don’t crumble, they crumble. That’s what happens.

Ecker: They crumble!

Client: Yeah.

Ecker: So are you saying—

Client: They give up on me.

Ecker: Oh, they give up on you.

Client: …(Sighs.) I don’t know. I guess that’s my fear, is that in order to have them, I have to keep working on it in order to have them not give up on me.

Ecker: And what’s “working on it” mean?
Client: Um, being really careful not to disappoint them.

Ecker: Mm-hm. (Long pause.) So would you try saying to them right now, “Keeping you from giving up on me is so important to me, that I’m willing to keep faking it.”

Client: Mm-hm. Keeping you from giving up on me is so important that I’m willing to do anything, including faking it, being something I’m not at the moment, knowing something I don’t know, whatever. I could say that to the crowd.

Ecker: Good. Go ahead.

Client: Yeah, I just did. (Laughs.)

EXPERIENCING EMOTIONAL TRUTH

Ecker: Good. Mm-hm. Well, I, to me right now, that seems really like a big thing here, really central, this, this *dread*.

Client: It’s really disquieting.

Ecker: Disquieting?

Client: Yeah.

Ecker: What, what is—

Client: Well, it’s a little embarrassing to think about it that way. That I’m willing to fake anything in order to keep someone else from givin’ up on me.

Ecker: Well, then, then you, then you are, or that *part* of you is willing to fake anything to keep others from giving up on you tells *me* that the experience, or at least the perception that someone’s giving up on you is an *extremely* painful and large impact or blow or hurt for you in your life.

Client: Yeah.

Ecker: That’s what it tells me. That it’s, it’s that important.

Client: Mm-hm. ok, when this is done,

Ecker: And I hear that it’s disquieting to you, disturbing to face that, acknowledge that.
Client: Frightening.

Ecker: Frightening!

Client: That “disquieting” is a (laughs) bit of a minimization. (Laughs.)

Ecker: Mm-hm. Frightening to see yourself as willing to, to be that fake, in your life, to, to avoid someone giving up on you.

Client: In some ways that’s true. Mm-hm.

Ecker: Hm. So would you again see the crowd? And would you try out saying to them, “If you give up on me—” and just see what comes to finish that sentence?

COMMENTARY 16: The therapist is working to have the client experience consciously the complete emotional truth of the necessity of faking. What has emerged so far is that faking is necessary as the way to keep others from giving up on him. However, exactly how he construes and experiences being given up on, that makes this something to avoid at all cost, still needs to be accessed. The therapist must continue to elicit the client’s construction of this. To do this the therapist is now using another phenomenological technique, sentence completion.

Client: Well, the first thought is, if you give up on me I’ll be alone.

Ecker: I couldn’t hear you.

Client: I’ll be alone.

Ecker: I’ll be alone. If you give up on me, I’ll be alone. Good. Keep going. See what comes up next when you say it.

Client: If you give up on me it means I’m not worthwhile. If you give up on me—(pause)—I don’t know.

Ecker: Nothing else comes?

Client: Not other than anger.

Ecker: Anger?

Client: Well, (laughs) there’s a part of me that says, “If you give up on me, ah the hell with it!”
**Ecker:** Mm-hm. Yeah, there’s that part of you, it keeps popping up as we go. Gets really angry. Knows it’s unfair. Is that right?

**Client:** I think that’s just what I do with the hurt.

**Ecker:** I see. Got it. Yeah, it takes you out of the hurt. Mm-hm. So would you again acknowledge to all of them, “I’m living in dread of you giving up on me.”

**Client:** I’m really frightened that, that you’ll give up on me. (Pause.) That you’ll think I’m worthless. (Laughs.) Or not worthy.

**Ecker:** Not worthy. And that I’ll agree with you?

**Client:** I guess I am really frightened that I’d agree. Because that’s where I want to fight.

**COMMENTARY 17:** Since doing the sentence completion task, the client has twice escaped emerging feelings of aloneness, hurt, worthlessness and fear by going into anger. Anger is one of his presenting symptoms, and this use of anger to avoid other feelings is clearly one way anger is for him necessary to have. The therapist judged, however, that with the other pro-symptom themes and purposes already found, it would be too much in this one session to include either this purposeful use of anger, or his purposeful suppression of anger in other contexts, as an additional focus of integration.

**Ecker:** Reminds me of what happened when you looked at your parents not agreeing. They got small and distant. And you’re alone. Even that way.

**Client:** Yeah but, you know, I can be compassionately alone. I can, I can see them from a distance and say, hey, they’re my parents. I mean, they’re not going to like everything about me, I can’t meet up to all their expectations, it’s not supposed to be that way.

**Ecker:** All right then, keep going with that. Would you try out saying to them, ah, “Okay, you have some expectations of your children, of your son, of your first born, and, I’m not living up to all of them, ’cause I’m me, and you have every right to be disappointed over some of that.”
Client: Yeah, that fits really nicely. I’m, I, I feel overwhelmed by your expectations of me. I, you know, I don’t want to have to (laughs) live up to them all. And I’m really afraid that if I don’t live up to ’em all you’re gonna, you’re gonna think poorly of me and just, kinda, leave me be. But I’m still not going to meet up to ’em all.

Ecker: Mm-hm. And how about the part of, “You have every right to feel disappointment where I don’t live up to your expectations”?

Client: Yeah, you have every right to, to be disappointed with me when I don’t. Just don’t leave. Don’t give up.

Ecker: Ah. Mm-hm. (Pause.) Please don’t leave. Please don’t leave. Please don’t give up on me.

Client: (Sighs.) Every little disappointment is a possible travesty. And that’s ridiculous.

Ecker: I see, I think I see what you mean. It’s like, this whole thing, them, them leaving or not, is at stake, for you, in every, in every little disappointment?

Client: Every last little disappointment. And this is the crowd. I’m so frightened of stuff, I got no, I got no differentiation between someone not agreeing with a point I have and, and them telling me that I’m fired. (Laughs.)

Ecker: Mm-hm. Totally giving up on you.

Client: Yeah.

Ecker: Severing. Mm-hm.

Client: At least sometimes I have no differentiation.

Ecker: Mm-hm. Yeah. Mm-hm. So—
CONCLUSION

Client: You’ve got an awful lot of cards written.

Ecker: Oh, I’ve been just jotting key parts of what we’ve been contacting, and I think I’d like to talk with you about what, what key parts we, we might put on a card for you to really stay in touch with, over this…

Ecker: I’m thinking of, of—tell me what you think but I, I, I’m leaning toward a card that says something like, “I’m not really what you think I am, and I’m really frightened that you’ll find out and become really disappointed and completely cut off from me. So I’m willing to fake it—”

Client: That’s the part.

Ecker: “—to keep that from happening.”

Client: Mm-hm!

Ecker: (Sneezes.) …I managed to funnel the sneeze right into the microphone.

Client: Right into the mike. (Laughs.) Megaphone.

Ecker: Yeah. Okay. So that’s what I’ll, I’ll write on a card for you after we finish. Does that, does that feel like the key piece?

Client: Yeah. Yeah I do. I think that’s the key…

Ecker: Good. Well, thank you very much.

Client: Thank you. Appreciate it.

Ecker: Okay. I’ll write out the card and get it to you a little later.

Client: Okay.

Ecker: Good.

COMMENTARY 18: The therapist gave him an index card with these words:
I’m really not what you think I am, and I dread that you’ll find out, be disappointed in me, give up on me and cut off from me. To keep that from happening I’m willing to do anything, including faking it, even though being a fake feels so bad and I’m so angry over it.
On the other side of the card:

When I don’t agree with you that I’m inadequate, you become small and far away, so I agree I’m inadequate to keep from losing you.

The therapist chose these revealed elements or themes for the card, and not others, because these involve the client’s own compelling purposes for producing his symptoms of faking (impostering) and of regarding himself as inadequate. It is by integrating the unconscious purpose for producing the symptom that the client experiences his agency over producing it, his capacity to produce or not produce it.
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