FOCUSING THERAPY: Theory, Research, Practice, and Training

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For a more thorough introduction to how I practice Focusing Therapy, please see my papers and books listed in the reference section. Focusing Therapy also includes couples and family work, Focusing Therapy groups, and Focusing Support groups. Focusing Therapy also integrates very well with all forms of body work, and the listening/focusing model of consensual decisionmaking provides a cooperative model for organizational development and decisionmaking. This paper will address the particulars of individual therapy and creating a Focusing Therapy movement: theory, research, and training.

My central purpose in wishing to rename Client-Centered/ Experiential Psychotherapy (Gendlin, 1974; Gendlin, 1973) as Experiential Focusing Therapy, or Focusing Therapy, is to point more directly at the operative variable in personality change, client focusing. My primary concern at the present time is that research be able to substantiate that structural change in personality can happen in a cost-effective, relatively brief format. In the United States, structural change in personality is equated with very long-term, psychodynamic therapy. Short-term crisis counseling and symptom management, without resolution of causes, is becoming the normative standard for mental health care.

We must be able to demonstrate that somewhat longer, indepth psychotherapy, which aims at the resolution of causal roots in childhood abuse and neglect, is cost-effective in reducing overall medical costs. We must be able to distinguish, in measurable research terms, when therapy has been "just talking" and when personality change has occurred. Armed with Experiencing (EXP) Scale measures of in-therapy process for both client and therapist (Klein, Mathieu-Coughlin, & Kiesler, 1986) , we can demonstrate that Focusing Therapy is effective in a brief (seven-ten session) therapy context. Then we can demonstrate that somewhat longer therapy (twenty-thirty sessions) can be even more effective in reducing overall medical costs.

THEORY AND RESEARCH

Focusing Therapy grows out of Gendlin's theory of personality change (Gendlin, 1964) and research with the patient Experiencing (EXP) Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969). Both define observable, measurable steps of personality change as it does, or does not, occur within psychotherapy sessions. The EXP Scale measures seven levels of client experiencing. In Stages 1 through 3, talking is objective, intellectualized, and reactive. Stage 4 represents the beginning of "direct reference" to felt experiencing: the client turns inward for subjective self-description. Stage 5 measures "focusing:" the client asks a self-reflective question like "Why do I always respond like that?" and ponders, sitting with preverbal felt experiencing. Stages 6 and 7 measure the "felt shift," the emergence of new meanings basic to structural personality change. The Therapist EXP Scale describes parallel levels of therapist experiencing, Stages 4 - 7 representing varying degrees of empathic involvement.

Although identical therapist and client process behaviors will be found at the crux of any effective psychotherapy, whatever the theoretical persuasion of the therapist (Gendlin, 1974), Focusing Therapy defines the therapist's interventions which optimize such steps of personality change. By explicitly defining the most effective therapist interventions and proving their effectiveness through observable changes in client EXP level, Focusing Therapy allows practitioners to optimize personality change in either short- or long-term frameworks for psychotherapy. This is especially true in a "brief therapy" context, where an understanding of the Focusing process allows therapists to operate with laser-like efficiency. Clients can also be explicitly taught the six step Focusing process. They can then potentiate personality change both in sessions and in home problemsolving during and after the end of psychotherapy.

"Focusing" is the client behavior of sitting with, directly attending to, the felt sense of a problem, allowing new meanings to emerge. When the client is Focusing, the most appropriate therapist interventions are Focusing Invitations ("What's the feel of all of that;" "What's in that for you?"; "What's in that anger?"; "Just sit with it and see what comes.") and Experiential Listening, saying back the person's words with attention to the "feel of it all." The client can check these words against the felt sense and continue to articulate until words or images are found which exactly fit, or "carry forward," the felt sense. At this moment, there is a "felt shift," a change at the level of ways-of-being-in-the-world. New thoughts, behaviors, and actions follow automatically as the person-world interaction is lived differently (Gendlin, 1973).

At times in therapy, the client does not have a "felt sense," a direct experiential feel for "all of it" that he or she is talking about. If Focusing Invitations and Experiential Listening are not sufficient to evoke such a "felt sense" of the issue, then the therapist may use other techniques to bring a felt sense into awareness. Such "evocative" techniques can include every modality and skill available to a therapist (dream imagery, Gestalt role play, Freudian interpretation, behavior modification attempts, anger work, eye movement work, body work, drawing, dancing, sound, bioenergetics). As soon as a "felt sense" forms experientially, the therapist turns again to Focusing Invitations and Experiential Listening, helping the client to Focus upon and articulate new meanings from the presently felt experiencing. The explication of new meanings distinguishes Focusing Therapy from purely evocative therapies, in which emotions are evoked, but new meanings are not created through Focusing. Approximately three-fourths of therapist responses will be empathic listening/focusing interventions; only one-fourth other eclectic techniques. The therapist is empowering the client to work with his or her own inner experiencing, even if this is a slow, subtle process.

From moment to moment, the Focusing Therapist follows, not only the content, but also the EXP level of the client's process, in part by paying attention to his or her own inner felt sense of what is happening. If the client is stuck at level 3 EXP, the therapist may use evocative techniques, hoping to move the client to level 4 by bringing a felt sense into awareness. If level 5 focusing is in process, the therapist will sit with the client in silence and use Focusing Questions to deepen direct reference to felt experiencing. During levels 6-7 felt shift process, the therapist helps the client to create new meanings through reflective listening. The Therapist EXP Scale measures the depth of experiencing of particular therapist interventions.

There are times when the therapist is practicing Focusing Therapy (evocative techniques plus listening/focusing to carry forward experiencing, accompanied by the Rogerian attitudes of empathy, congruence, and positive regard) and the client remains at Stage Three or below on EXP Scale. A therapist behavior measure, independent of client EXP level, is needed to establish whether Experiential Focusing Therapy (FT) is being done and the client is remaining too structure-bound to receive the opportunity for focusing upon present experiencing. The Therapist Experiencing Scale or an objective protocol of therapist interventions would be adequate. However, in terms of answering the research question, is FT effective in producing structural change in personality on outcome measures, only those clients who routinely experience Stages 6-7 EXP should be included. Only their sessions exhibit the evidence of in-process personality change which would show up as positive change on outcome measures.

Although Gendlin's process theory of human change is more conceptually in tune with the actual way-of-being of the human organism, Greenberg and Safran's theory of emotion in psychotherapy (1987) provides concepts which may be more easily understood by most academic psychologists. Within this theory, personality change occurs at the level of cognitive/ behavioral/ affective schemata which, as ways of perceiving, generate thoughts, behaviors, and emotions. Greenberg and Safran explore the way in which state-dependent learning of schemata requires that the client return to the affective state of the original learning in order to generate new schemata. Within Gendlin's theory, schemata, which are merely abstract, theoretical concepts, are experienced organismically as a "felt sense" of the whole interaction between organism and environment. For lasting change in thoughts, behaviors, and emotions, new meanings must be generated specifically out of direct reference to the "felt sense" of a situation which underlies symbolizations.

In Gendlin's theory, as in Carl Rogers' description of the "fully functioning" person, there should be a flexible and mutually-informing interaction between symbolizations (ways of being-in-the-world, manifested as behaviors, thoughts, emotions, body posture, interactional patterns, artistic expressions, dream symbols, images, reactions, etc.) and the preverbal, bodily-felt experiencing underlying and giving meaning to symbols (Gendlin, 1962). Any symbol is, by its nature as a symbolization, a making-manifest of the preverbal, a "structure," a "structure-bound" bit of experiencing. Martin Buber, in describing "I-Thou" and "I-It" states of relationship, acknowledges the need of the human organism to spend most of its time in an "I-It," symbolized state in order to move around in the world. However, the term "structure-bound," when used in a clinically diagnostic sense, refers to symbolizations which are so "out of touch" with present felt experiencing that the client cannot easily step out of the symbolization and refer to the felt meaning underlying it (Stage 3 and below EXP).

In order for symbolizations to change, the client must be able to create new symbolizations directly from present felt experiencing. Where symbolizations are "structure-bound," direct reference does not happen, and the client cannot change. So, of course, structure-bound symbolizations are the main area of work for the Focusing Therapist. They are the "repetition compulsions" of the Freudian, the maladaptive behavioral patterns of the behavior modifier, the problematic thoughts of the cognitive therapist, the physical "character armor" of the Reichian, Lowenian, and other bodyworkers. Even dream symbols and the drawings/ paintings/dances of art or movement therapy can be structure-bound, if the client is not able to go flexibly between the symbol and underlying felt meaning.

Structure-bound" is another term for "dissociated" -- a symbolization is dissociated from the felt experiencing which is its ground in terms of meaning. The EXP Scale is a measure of dissociation, the degree to which a client is separate from present felt experiencing. Healing involves overcoming dissociation. Stages One through Seven measure varying degrees of dissociation and help integrate varying theories about recovery from childhood trauma. Dissociation lies at the base of not only the so-called "dissociative disorders" (including multiple personality) but of many other psychopathologies: anxiety disorders such as phobias and obsessive/compulsive rituals; reactive emotionality, be it hysteria, angry acting out, or the borderline flip from intimacy to anger.

Personality disorders, defined by their inaccessibility to change, are cases where structure-bound ways of being completely fend off any attempts to reconnect with felt experiencing. Even depression is a dissociation from felt experiencing, which usually becomes grief and anger, an active change process, if focused upon. Psychosomatic physical illnesses are also structure-bound symbolizations dissociated from present felt experiencing. Focusing Therapy is a premiere technique for overcoming dissociation from childhood memories of physical, sexual, and verbal abuse.

Within experiential theory, much of what is considered "normal" functioning in society is at Stage Three or less on the EXP Scale -- intellectualized, reactive, structure-bound. Many people who are not in therapy, including many therapists and academics, operate continuously out of a structure-bound state. If we are serious in defining mental health as fluidity between symbols and felt experiencing as measured by Stage 4 and above EXP, many interesting research questions are raised. For example, one could develop a continuum of diagnoses correlated with EXP level. One could test the hypothesis that increased EXP level equals less dissociation equals mental health. One could also measure the EXP level of various kinds of academic writing about personality and psychotherapy, as well as of actual therapy sessions using various modalities.

RECOMMENDATION: We must collaborate with the Psychotherapy Process Research Group of the Society for Psychotherapy Research in setting up an organized program of research which will establish the experiential approach, and Focusing Therapy, on equal grounds with cognitive and behavioral therapies in academic training programs.

PRACTICE

The skill of the Focusing Therapist lies exactly in the ability to allow clients to experience the bodily-felt sense, the felt meaning underlying structure-bound symbolizations. The majority of the Focusing Therapist's work happens exactly at the edge between a symbol and the felt meaning underlying it. The Focusing Therapist uses many tactics in order to allow the client to become dis-identified enough with the symbol to be able to interact with it, to go between symbolizing and felt meaning until new symbols are created. EXP level will go from Stages1-3 (structure-bound) to Stages 4-7 (focusing and articulation of new meanings). The new symbolization will be more accurately in tune with today's present felt experiencing, which includes the nurturing presence of the therapist and the client's own more adult capacity for understanding an earlier experience. Personality change needs a re-symbolization, not simply a re-experiencing, of emotion.

An example of working with structure-bound symbolization: A woman does eyes-closed focusing. She talks about needing to keep people out, needing to protect, having her own boundaries, being in control, all the time making "keeping out" gestures with her hands. The therapist reflects, then uses a Gestalt intervention: "Can you notice what your hands are doing, your gesture...Can you accentuate it?" She follows up with Focusing Invitations: "How does it feel inside when you make that gesture?...What are the words or images which come from it?...What is it saying?" If successful, the client will be able to connect with the preverbal bodily felt experiencing symbolized in the gesture (perhaps including childhood experiences of being invaded) and to make new words and images ("I am bigger now; I can choose what to let in, what to keep out") more accurate to present experiencing. Once the felt sense beneath the symbolization has been evoked, the therapist turns to Experiential Listening and Focusing Invitations to "carry forward" experiencing and create structural change through the creation of new, more accurate symbolizations.

Structure-bound symbolizations (the Critic, the "chit-chat" defensive style, etc.) all have felt senses underlying them which can be experienced. Sometimes the therapist may ask a client to see if he or she can step around a structure to experience another quality of experience. However, at other times, the therapist will "ally with the defense" (in Freudian terms), will ask the client to sit with the Critic or other defensive structure and ask "What's the feel of all of this?" or "What does the Critic want to say?...Check inside...in the center of your body."

Focusing therapy includes a continuum from eyes-open, relationship-based, interpersonal therapy, where small pieces of focusing are encouraged through the asking of Focusing Questions ("What's the feel of that anger?," "Can you stop talking and just pay attention to the feel of it all in the center of your body?") to more intentional, eyes-closed focusing work, where emphasis is upon the relationship between the Inner Listener (Nurturing Adult), the Felt Sense (Vulnerable Inner Child), and the Critic (Negative Parent). With some clients (who start at Stages 1-3 EXP), therapy may proceed for many sessions without the client being willing to close eyes and go inside. With other clients (those who begin at Stage 4 or above EXP), it can established in the first session that the majority of the session will be spent doing an eyes-closed focusing process, combined with Inner Child work and evocative techniques when needed.

An eyes-open, conversational style is one of the most widely occurring structure-bound defenses against noticing what is happening inside. As in regular focusing practice, so in Focusing Therapy: eyes-closed work teaches the inner-directed awareness essential to life-long self-healing. The argument for a norm of eyes-open work in Focusing Therapy comes from the assumption that interpretation of the relationship between client and therapist is the main way of working with structure-bound patterns. In fact, patterns of relating are only one of many ways in which structure-bound ways of being become manifest.

Clients with sufficient ego-strength (Inner Relationship capability) to work with eyes closed can experience such structurebound patterns internally, as directly between the Inner Critic and the vulnerable felt sense, for instance. They do not need to act them out in the relationship with the therapist and have the therapist interpret them. Such eyes-closed work especially speeds the process of healing in a brief therapy context. Research hypothesis: the degree to which eyes-closed focusing is possible within therapy sessions will correlate with measures of client ego-

strength and the observing ego, the degree to which the client has the capacity to maintain a relationship between an Inner Listener and the Felt Sense.

Although the process of Focusing Therapy can be objectively measured and researched, the metaphors used in describing the process to clients and to therapy trainees are very soft. Clients may generate any metaphor to describe a felt sense ("It's like a wounded animal..." "...a gangrenous leg. I want to cut it off!" "Like the Golum in Lord of the Rings. It has been in the dark so long it can no longer see."). The metaphor of the Inner Child/Inner Nurturing Adult/Inner Critic is a universal one which arises when approaching the vulnerable life experiencing which is the felt sense. Clients are encouraged to take a gentle, nurturing attitude toward emergent experiencing ("Be with it the way you would be with a hurt child, or a wounded animal"). Therapists use the same gentle, nurturing attitude in encouraging the deeper levels of experiencing to come forward ("It looks like there are some tears there. Can you imagine putting your arms around that part of yourself that wants to cry, just being with it in a nurturing way").

The crux moment of change in psychotherapy is when, metaphorically, the client is able to turn around and embrace a part of the Self which has previously not been allowed to be experienced . The client becomes larger, able to integrate more polar opposites, less reactive (structure-bound), more open in newly experiencing present situations. Thoughts, behaviors, and emotions reflect this broader frame for experiencing.

It is just at such moments of self-compassion, when the client is able to embrace a part of the Self previously pushed away, that Stage 6-7 EXP occurs, indicating the shifting of meanings that makes personality change. Tears of being touched and moved are often the physical accompaniment of this reunion with and carrying forward of previously structure-bound experiencing. There is a spiritual quality to the felt shift, a sense of participation in something larger than the ego, experienced by both therapist and client (Campbell & McMahon, 1985; Hinterkopf, 1995).

While there is a tendency in describing therapy process to talk about working with problems, with stuck places, there are also times in Focusing Therapy when it is most appropriate to use the focusing technique to sit with and to articulate meanings from a positive experience. For instance, if a client who is always sad, comes in saying, "I had a moment this week when I felt absolutely newborn!," the therapist would be wise to ask the client to sit with the feel of all of that, the sense of being "newborn," and to articulate new symbolizations from that positive feeling. Gendlin describes always looking for the "growing edge," the fresh, green shoots trying to come up, the breath of new air. At one time, the "new air" may be allowing oneself to feel compassion for a five-year old self who was told to be tough, that tears don't matter. At another time, the "new air" may be saying "I don't need to cry anymore. I'm free of those people!" For the person who is habitually sad, perhaps in a structure-bound way, anger may be the new air; for the person structure-bound in anger, the new air may be sadness; for a person who dissociates from felt experiencing by always looking at the bright side, sadness may be the new air.

Some feel that the essence of Focusing Therapy should be defined as attitudes, rather than techniques. I like to define it in terms of the emergence of the "felt sense." Focusing Therapy is happening whenever Stage 5 and above EXP is occurring. The felt sense will not emerge unless

both therapist and client are taking a genuinely empathic attitude toward the vulnerable experiencing which is emerging. . If therapist or client is not genuinely empathic with the felt sense, new meanings will not emerge, Stages 6-7 on the EXP Scale will not occur, and Focusing Therapy has not happened.

META-ISSUES

There may be meta-issues in the way of the experiential strand taking its proper place in both academia and clinical practice. The research (Rogers, 1967) establishing EXP level as the crux variable affecting positive outcome in psychotherapy has been available since the early 1960's, yet psychotherapy is more and more dominated by cognitive and behavioral strategies. It would seem quite easy to have part of psychotherapist training include an objective audiotape rating of therapist and client EXP levels, yet observation of therapists' actual in-session behavior is almost non-existent during or after psychotherapy training.

Experiential training is also almost absent from academic psychology training programs, except those specifically marked as Humanistic. Is there a suppression of the experiential strand? If so, is the motivation political? Economical? Is it based upon a conscious manipulation of power? Or is it perhaps also based upon more unconscious factors having to do with the way in which academics and therapists live-in-the-world? Hoping that others will address the political and economic forces, I will offer some thinking about the being-in-the world variable.

In my experience, the resistance to the experiential strand in academia and among cognitive/behavioral therapists feels similar to the resistance one comes up against in psychotherapy when suggesting to clients that they check with the body, that they "sit with" whatever they feel in the center of their body, that they embrace their long-forgotten Inner Child and its painful stories. The body-centered psychotherapies (for instance, the experiential unfoldings in therapy sessions included in John Bradshaw's PBS videos called "Homecoming;" the body-centered Hakomi therapy of Ron Kurtz (1990), which borrows heavily upon Focusing theory), while widely embraced by clients seeking healing, happen completely outside the frame of academic research and training.

Masters-level counselors seem more open to experiential, body-centered approaches than Ph.D.'s (an easily researchable hypothesis). Research hypothesis: EXP level of academics/therapists will correlate with their choice of school of therapy, with Stage 1-3 EXP related to a cognitive/behavioral viewpoint, Stage 4 and above to experiential therapy research and practice. Remember, Stages 1-3 EXP represent structure-bound being, hardly the most optimal state out of which to generate theory, research, and practice in psychotherapy.

There are other variables which tap this dimension where theory, research, and practice are expressions of ways of perceiving the world. Gender is one; masculine/feminine as defined by Jung, regardless of sex; the Myers-Briggs (1980) Jungian personality measure (Focusing Trainers include an extremely high percentage of Introverted Intuitives, especially Introverted Intuitive Feelers; cognitive/behavioral therapists should score high on Extraverted Sensing, etc.). Research on the world-views preconditioning psychotherapy research and practice may be a valuable tactic for establishing a place for the experiential strand in mainstream research and training, e.g., why is

that academia does not want to deal with bodily felt experiencing? The prevailing argument is that subjective experiencing is not researchable. Yet the EXP Scale measures exactly this variable with great validity and reliability. Let the show begin!

TRAINING

Focusing Therapy trainees must be helped to change their own structure-boundness (Stage 1-3 EXP Scale) in order to facilitate personality change process (Stages 6-7 EXP) in clients. Stage Three Therapist behavior generates Stage Three Client behavior, blocking personality change process. Trainees must spend equal time as Focusers, working on freeing up their own experiencing, as upon skills for freeing client experiencing. The larger the therapist's self (the less structure-bound), the greater the resonating board for client experiencing. Training programs must be experiential, therapist personal growth being directly related, in a research way, to their capacity to engender personality change process in clients. Research hypothesis: EXP level in therapist's own focusing turn will be predictive of the EXP level they will be able to generate in clients and of therapist scores on measures of empathy.

The most basic component of a therapist training program is the mutual exchange of listening/focusing turns with other trainees, under the supervision and feedback of an expert teacher. Focusing Therapy differs from peer counseling or guided focusing in that the therapist uses more evocative techniques to stir a felt sense to be focused upon, and therefore must have additional training in recognizing transference and countertransference issues, e.g., when is my intervention about the client, when about my own reactivity and structure-boundness?

A second stage of training includes practice clients who are not themselves already trained focusers. Ancillary training includes didactic materials equivalent to an academic Master's degree in clinical or counseling psychology: course work or self-guided reading in major diagnostic categories, organic dysfunctions, psychopharmacology, developmental theory, major personality and psychotherapy theories, and, especially, ethics.

I recommend that we fix a certain number of hours of training within a peer training group with an expert trainer, additional hours which can be acquired from exposure to a variety of trainers, and reading lists, both within the experiential focusing literature and in traditional psychology. Trainees could keep a journal to document their focusing experiences as well as training experiences and readings, which could be used as part of their evaluation for certification.

If we want objective criteria for certifying, or objective reasons for refusing certification, we could use the trainee's EXP level during own focusing turns, the Therapist EXP Scale, and other measures of empathy.

Trainees should learn, not only individual therapy, but couples and family therapy, organizational development, conflict resolution, consensual decisionmaking, and starting focusing support groups for peer counseling.

I like Mary Lawlor's suggestions about rostering (a listing of Focusing Therapist with the requirement that each therapist present clients with a statement disclosing his or her training and a way in which clients may lodge complaints with the rostering board) as well as certification.

I believe that we must have ways to value life experience as well as academic learning. In terms of whether Focusing Therapists should be required to have a Master's or better degree in counseling or psychology, I say "No," that if a person can demonstrate an equivalency of self-directed learning, we should honor that, as long as the person knows that the laws of their state will govern whether they can practice as "therapists" without academic credentials.

In general, in terms of certification, I would like to keep the process person-centered, and I think there is value and safety in a trainee being able to go to persons other than their own trainer for help and evaluation along the path to certification. We might have a model where Coordinators in a region cooperate on certifying, and then a trainee can choose to come to an International workshop, exchange listening/focusing turns with three other Coordinators, and either receive International certification or specific advice on what areas to strengthen and perhaps suggestions to experience workshops by other trainers.

I tend toward a model which fixes the number of hours of training while leaving trainees free to experience several different trainers, with perhaps a portion of the hours spent in a fixed supervision group for deeper work on the trainees own structure-bound issues. I also believe that, as part of training, trainees should start and maintain a focusing support group (a "Changes" group), both as a training ground and as a service to the community.

Update, 2007: Dr. McGuire offers a certification program for Experiential Focusing Professionals, open to all helping professionals, through Creative Edge Focusing ™, www.cefocusing.com

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