EXPERIENTIAL FOCUSING AS A BRIEF THERAPY INTERVENTION

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Summary: "Managed mental health care" by insurance companies has pushed psychologists in the United States to develop brief therapy techniques and research methods which can demonstrate positive outcome in an average of seven psychotherapy sessions. This chapter introduces Experiential Focusing as a brief therapy intervention, outlines a program for outcome research based upon the protocol method, and includes a case presentation of a four-session brief Experiential Focusing Therapy.

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Experiential Focusing (Gendlin, 1981; 1996) [1] is a highly specific intervention which produces measurable results that are immediately evident within a single therapy session. It therefore is an excellent candidate for inclusion as a brief therapy modality.

Experiential Focusing is an outgrowth of a large, highly-regarded psychotherapy research project (Rogers, 1967) where Rogers, Gendlin, and others set out to test the assumptions of client-centered therapy against long-term outcome measures with the population of patients at a state mental hospital.

The surprising finding of this study was that success in long-term therapy was already predictable by the fourth session and that the variable was, not so much what the therapist was doing, but **what the client was doing**. Clients who came into therapy able to refer to and speak from the fresh, present, bodily-feel of issues and symptoms profited from therapy, almost regardless of what the therapists did. Clients who lacked this capacity for "direct reference" to felt experiencing did not change over time.

Gendlin decided that he needed to learn how to teach people the capacity for "direct reference to felt experiencing," and the six-step Experiential Focusing process (Gendlin, 1981), as well as Focusing-Oriented Therapy (Gendlin, 1996) are the products of his efforts . Research has shown that clients who naturally used Experiential Focusing during sessions profited most from therapy (Gendlin, Beebe, Cassens, Klein, & Oberlander,

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[1] I am choosing to use the complete term Experiential Focusing, rather than the shortened term Focusing often used by Gendlin and others. I wish to delineate Experiential Focusing as a specific, researchable technique. I will therefore use the term as a proper noun and not as a verb and say, "The client uses Experiential Focusing..." rather than "The client focuses...". I also wish to differentiate it from the layman's understanding of the term "focusing" as applying to a form of cognitive concentration, rather than a body-centered, experiential sensing.

1968; Seeman, 1996) and that teaching clients Experiential Focusing increased their Experiencing Level during therapy (Durak, Bernstein, & Gendlin, 1996; Leijssen, 1996).

Experiential Focusing is the client behavior of directly attending to the bodily felt sense of an issue, memory, or symptom, allowing new meanings to emerge (Gendlin, 1962;1964; 1973;1974;1996). When the client is doing Experiential Focusing, the most appropriate therapist interventions are (a) Experiential Focusing Suggestions, encouraging the client to stop talking and to sit quietly with the bodily felt sense ("Notice the feel of all of that;" "Notice what that is for you"; "Notice what's in that anger... Just sit with it and see what comes.") and (b) Experiential Listening Responses, reflecting the client's words with attention to the "feel of it all" (Gendlin, 1968,1990). 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,"(Gendlin, 1964), a change at the level of cognitive/affective/behavioral schemata (Greenberg & Safran, 1987). New thoughts, behaviors, and actions follow automatically as the person-world interaction is lived differently (Gendlin, 1973).

Experiential Focusing is ideally suited as a brief therapy approach because:

(1) Experiential Focusing is a teachable skill clients can practice at home and in support groups and take with them for life-long problem solving (McGuire, 1981, Gendlin, 1981, Cornell,1996).

(2) Experiential Focusing empowers clients to find their own solutions to life's problems.

(3) Experiential Focusing works directly at the mind/body interface, resolving physical as well as psychological symptoms, thereby having the potential to decrease overall medical costs.

(4) Experiential Focusing keeps humanistic values and the development of each client's unique inner meanings and life direction at the core, even in a brief therapy setting.

(5) Experiential Focusing can be defined as a specific intervention for specific client

diagnoses and adapted to the research protocol method of brief therapy research.

1. **Brief Therapy Philosophy**

"Brief Therapy" has arisen largely in response to the demand from insurance companies in the United States to cut costs for health care. Mental health care has been a major target of such cost reduction and has been redefined as "short-term, crisis intervention" without the attempt to treat underlying long-term causes.

Although at times a practitioner can request additional sessions, perhaps to a maximum of thirty, in general, the "successful therapist" is expected to be able to average 4-7 sessions per client. Membership on the insurance panels which guarantee payment for mental health services can be terminated if the therapist does not meet this average number of sessions. There are various other controls, like "risk-sharing pools" (if a group of therapists exceeds the average, they all lose a percentage of their payments which has been withheld in a "risk pool") and "capitation" (a group of practitioners contract to treat all mental health needs of a given population of insured for a fixed rate, like $2 per insured per month. If the practitioners spend more than that amount per insured, they are not paid for this excess).

There are many possible negative outcomes of managed mental health care, including excessive reliance on medication, shunting of difficult patients out of "risk pool" practices, and making decisions about treatment based upon insurance company requirements rather than medical necessity. However, a positive outcome is that mental health practitioners have been forced to define **exactly what it is in psychotherapy that works and why and for which specific client diagnoses**. They have had to develop techniques which demonstrate rapid, measurable effects upon client symptoms and research protocols and outcome measures which can capture the effectiveness of psychotherapy in a brief therapy model.

Psychology as a field has risen to the demand from insurance companies and created many new models of therapy which promise maximum, measurable results in 3 to 12 sessions. An American Psychological Association Task Force is at work creating a list of those psychotherapy procedures which have been proven effective through research. Purportedly, insurance companies could then refuse payment for treatment modalities not on that list. To remain a treatment of choice in the United States, Experiential Focusing must be operationalized in a simplified research protocol. Data must be gathered on its effectiveness for the treatment of specific diagnoses in the brief therapy format.

Francine Shapiro's (1995) Eye Movement Desensitization and Reprocessing (EMDR), a therapeutic technique with proven effectiveness in working with the diagnosis Post-Traumatic Stress Disorder (PTSD), is a representative example of a brief therapy technique and the use of a simplified research protocol in gathering data of effectiveness. While EMDR can be used with many types of client problems, research endeavors were initially targeted at proving its efficacy with one specific diagnosis, PTSD. Experiential Focusing should also be initially researched in treatment of the diagnosis for which the largest treatment effect could be predicted to occur.

When used for work with traumatic memories, EMDR stimulates the same kind of felt-shifting, transformative healing process which Eugene Gendlin, creator of Experiential Focusing, has studied as basic to personality change since the 1960's (Gendlin, 1962; 1964; 1973; 1974; 1991; 1996; McGuire, 1991, 1993). EMDR research strategies could be used as one model for successful research on Experiential Focusing.

In EMDR, after choosing a traumatic memory to work on, the client is instructed to find a strong visual image of the trauma, as well as present negative cognitions, emotions, and a "body location for the emotions" associated with the image. Then, the therapist moves his or her fingers back and forth in front of the client's eyes as the client tracks the fingers. The technique stimulates a healing process which goes from negative

associations with a traumatic memory through an affective and cognitive "reprocessing" to a more positive and empowering way of viewing the situation. PTSD symptoms related to the memory, like flashbacks, anxiety, panic attacks, and nightmares, abate.

In Experiential Focusing, after choosing an issue, symptom, or memory to work on, clients close their eyes and pay attention to the bodily "feel" of the issue, symptom, or memory, carefully looking for words or images which exactly fit, or "resonate with", the bodily felt sense. Very similar to the EMDR protocol, the therapist, through Experiential Listening Responses and Experiential Focusing Suggestions, guides the client in the development of "the full felt sense," which includes an image or symbol, the emotional quality, a body sensation, and the life connection or story related to the felt sense (Cornell, 1993). When symbols are found which exactly capture the "feel of it all", the client experiences a "felt shift," a tension-release accompanied by the unfolding of the previously blocked material into the creation of new meanings and action steps.

In both EMDR and Experiential Focusing, clients change the cognitive/ behavioral/ affective schemata (Greenberg and Safran, 1987) which form the phenomenological base leading to thoughts, behaviors, emotions, and other symbolizations (Gendlin, 1962, 1964, 1996). The same basic personality change process is described and researched through two different windows, cognitive/behavioral and humanistic/phenomenological. Research on EMDR may apply to Experiential Focusing; looking at EMDR through Gendlin's theory of the creation of meaning may broaden the understanding of how people change in EMDR treatment.

Experiential Focusing theory also informs the application of other brief therapy techniques. For instance, Solution-Oriented Therapy (deShazer, 1985; 1988; O'Hanlon &Weiner-Davis, 1989) takes the client's emphasis off the problem and directs attention to possible solutions. Clients are also helped to look at ways problems were solved in the past, emphasizing the positive skills they can build on in the present. Among other

techniques, clients are asked the "miracle question": "If you woke up tomorrow and the problem was gone, what would it be like? What would people see you doing that you're not doing now?"

Experiential Focusing has always had a similar question. Toward the end of an inner exploration of "What's stuck?" or "What's in the way of this being okay?," the Experiential Focusing Suggestions then are: "Can you get an image of how this situation would be if it were all okay?...Now, can you find one small step in that direction which feels okay?...Check with your body until you find something that feels really doable." Solution action-steps derived cognitively without the cooperation of the body's motivation are not likely to be carried out. Grounding the "miracle question" in body-centered Experiential Focusing increases the likelihood of solution-oriented action (See Fleisch, Chapter ___in this book).

2. The Experiential Focusing Protocol

Part of EMDR's success in quickly collecting research data is the use of a specific EMDR Protocol which specifies the exact steps of the therapist's intervention and can be replicated from one therapist to another.

Experiential Focusing can also be operationalized as a series of specific steps. As in EMDR, a research protocol can be written from these steps which specifies what the therapist says and what the client does at each step clearly enough so that controlled outcome studies can be done with assurance that the treatment protocol has been carried out by the therapists. Here is an initial attempt at an Experiential Focusing Protocol based on Gendlin's (1981) breakdown of the naturally occurring process into teachable steps. Greenberg, Rice, and Elliott (1993) come up with a similar protocol in their "task analysis" of Experiential Focusing as an emotional change event in therapy:

Step One: Clearing a Space. The client is helped to take an "inventory" of the various issues being carried in the body that day, not going into any one but simply

noticing and listing what comes up in response to the Experiential Focusing Suggestion: "Notice what you are carrying today."

Step Two: Getting a Felt Sense. The client is helped to choose one issue to work on and to get a "bodily feel" for the whole of it with the Experiential Focusing Suggestion: "Notice what this_____is all about. Wait for a feel of the whole thing to form in the center of your body, between the throat and the stomach."

Step Three: Getting a handle. The client is helped to find some words or an image that are just right in capturing the "feel of it all": "It's something about..." or "I get a picture of..." or "I feel (description of a body sensation)." The therapist guides the client in developing the "full felt sense" (image, emotion, body-sensation, and story) (Cornell, 1993; Leijssen, 1995), using Experiential Focusing Suggestions and Experiential Listening Responses.

Step Four: Checking or resonating. The client is helped to take any words or images which have come and to check them against the body-feel of "it all," refining the words or images until they are "just right," experienced as a tension release or body-response of "Yes. That fits."

Step Five: Asking an open-ended question. The client is helped to ask a question of the body-feel, like "What would it take for this to be all okay?" or "What does this stuckness need?" or "What's so hard about this issue for me?" and, instead of answering immediately from the head, to wait quietly and pay attention to the bodily-feel which comes in the center of the body in response to the question. As in Steps Three and Four, the client again carefully looks for words or an image to capture "the feel of it all," checking and resonating words or images against the body-feel and fine-tuning until the words or image are "just right," again experienced as a bodily tension-release of "Yes. That fits."

Step Six: Receiving and nurturing whatever has come. The client is encouraged to sit for a moment with whatever new information has emerged, thanking the body for its cooperation, and gently being with whatever has come without judging it.

Step Seven: Another round. Client and therapist decide whether they want to begin another cycle of Experiential Focusing upon whatever has come, going back to Step Five through Step Six as often as desired or needed until the issue is resolved.

While other Experiential Focusing theorists (Cornell, 1996; Leijssen, 1990) have legitimately argued against breaking the natural process down into rigid "steps" or have developed somewhat different step-wise approaches to teaching Experiential Focusing, Gendlin's steps form a good beginning basis for adaptation of the technique to a research protocol. The Protocol should be refined in pilot studies until it more clearly reflects what the therapist does to aid in the development of the "full felt sense" (Cornell, 1993; Leijssen, 1995) and until its use can be reliably replicated by various therapists.

3. Research Support for Experiential Focusing as a Therapy Technique

Gendlin's Experiential Focusing grows out of the client-centered tradition's long-term interest in psychotherapy process research. Carl Rogers and his colleagues, Gendlin among them, were the first who actually listened to audio tapes and tried to analyze and measure psychotherapy process. They were looking for exactly what interventions allow personality change during psychotherapy sessions.

The Experiencing (EXP)Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969; Gendlin & Tomlinson, 1967) is the measure the researchers developed to distinguish when therapy is "just talking" and when personality change is occurring . The Experiencing Scale predicts success on long-term measures of psychotherapy outcome, has strong validity and reliability credentials, and has been widely used to measure the effects of various interventions upon in-session client process (Gendlin, Beebe, Cassens, Klein, & Oberlander, 1968; Rogers, 1967; Klein, Mathieu, Gendlin, & Kiesler, 1969; Mathieu-

Coughlin & Klein, 1984; Klein, Mathieu-Coughlin, & Kiesler, 1986; Seeman, 1996; Leijssen, 1996).

The Experiencing (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 behavior necessary for success in therapy: the client turns inward for subjective self-description. Stage 5 measures Experiential Focusing: the client asks a self-reflective question like "Why do I always respond like that?" and ponders, sitting in silence with preverbal felt experiencing for at least a few seconds. Stages 6 and 7 measure the "felt shift," the emergence of new meanings which is facilitated by Experiential Focusing and which is basic to structural personality change. Hendricks (1986) divides the EXP Scale into Low, Middle, and High EXP and gives examples of therapist responses which facilitate or flatten forward movement. McGuire's *The Experiential Dimension In Psychotherapy* (1984) includes an analysis of psychotherapy transcripts according to Experiencing Scale ratings. Leijssen (1996) outlines fifteen years of case studies based upon Experiencing Scale ratings.

The EXP Scale is a highly reliable and valid measure of client experiencing level in psychotherapy. However, the Scale is cumbersome to use because ratings are made from audio tapes or transcripts of therapy sessions, and raters must be rigorously trained to achieve inter-rater reliability. Jim Iberg (see Chapter __ in this book) is working on paper-and-pencil measures of depth of experiencing during sessions which can be filled out immediately after a session by both therapist and client. Such paper-and-pencil measures would greatly increase the ease of doing research to substantiate the validity of Experiential Focusing in a brief therapy context.

The in-session measures used in the EMDR research *(*Shapiro, 1995), are even easier to use and, along with the carefully delineated research protocol of therapist responses, have allowed EMDR researchers to carry out a large number of studies (Shapiro,1995,

pp.328-332) establishing validity of the procedure within the framework of these short-term, in-session measures of efficacy. The Subjective Units of Discomfort Scale (SUDS) measures subjective discomfort by client verbal self-report on a scale from 0-10. The therapist/researcher says, "On a Scale from 0 to 10, how disturbing is that memory to you now?" at various points in the session, looking for a significant reduction in SUDS as evidence of successful intervention. The Validity of Cognition Scale (VOC) measures the validity of the positive cognition being installed. The therapist/researcher says, "How true is that positive cognition to you now, on a scale from 1 to 7, where 1 is 'completely false' and 7 is 'completely true'?" at various points in the session, looking for a significant increase in VOC as an indication of success. Although more traditional therapy researchers question the validity of the EMDR studies, the existence of such specific data has influenced insurance companies to include EMDR as a legitimate treatment modality.

4. Experiential Focusing Therapy

Although for research purposes, the step-by-step protocols for the interventions must be adhered to, in actual practice, both with EMDR and with Experiential Focusing, moments of EMDR or Experiential Focusing are mixed with many other therapist interventions in the ongoing flow of a psychotherapy session (Gendlin, 1996; McGuire, 1984, 1991, 1996).

Experiential Focusing Therapy includes a continuum from eyes-open, relationship-based, interpersonal therapy, where small moments of Experiential Focusing are encouraged through Experiential Focusing Suggestions ("Notice 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 Experiential Focusing work, where emphasis is upon helping the client to notice and consciously work with the relationship among the client's own Self as inner listener, the vulnerable bodily-felt sense, and

internalized critical messages (Gendlin, 1974 ; Cornell, 1996; Leijssen, 1995; McGuire, 1984, 1991,1993, 1996). With 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 for intentional Experiential Focusing. Instead, the therapist gradually introduces and teaches Experiential Focusing through Experiential Focusing Suggestions interspersed throughout many other interventions during the session. With clients who begin at Stage 4 or above EXP, it can be established in the first session that a good part of each session will be spent doing eyes-closed Experiential Focusing as appropriate.

From moment to moment, the Experiential Focusing Therapist follows, not only the content, but also the EXP level of the client's process. 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 EXP Experiential Focusing is in process, the therapist will sit with the client in silence and use occasional Experiential Focusing Suggestions and Experiential Listening Responses to deepen direct reference to felt experiencing. During levels 6-7 "felt shift" process, the therapist will help the client to create new meanings through Experiential Listening Responses.

Here is an example of a four-session, Brief Experiential Focusing Therapy:

> The client is a 40-year old male. His presenting complaint is an overwhelming attraction for a woman who is not his wife. He also has rage attacks at his teenage children. From the beginning of therapy, the client is easily able to engage in Stage 4 EXP "direct reference" to felt experiencing and is comfortable with moments of eyes-closed Experiential Focusing.

> In the first session, the therapist asks him to close his eyes and sense into the whole "felt sense" of the attraction for the other woman: "Notice what that is for you. What does she represent or touch?" After sitting quietly for a moment, eyes closed, the client has a sheen of tears in his eyes and says, tentatively, that she touches a terrible loneliness in him, a place no one else has ever seen, a "vulnerability." The therapist helps him to explore this felt sense through Experiential Listening Responses and Experiential Focusing Suggestions. Toward the end of the session, she

also suggests that one step forward would be to share this sense of loneliness with his wife, to see if she can connect with it in him, to show this vulnerability to her. The therapist also suggests that the client keep exploring the feeling about the other woman to see what he learns, neither acting out nor repressing it.

In Session two, therapist and client talk about the angry outbursts (including some physical violence) with his children. The therapist asks him to use eyes-closed Experiential Focusing again: "Notice where in your life you have seen such anger... Notice where you have learned that response...Ask yourself, ' What is it I am so angry about?,' and wait and see what comes." The client goes into deep feelings and memories of physical and verbal abuse by his father, accompanied by the therapist's Experiential Listening Responses. He has lots of tears around the words: "How could you? Why couldn't you love me?." There is also a lot of anger. The therapist encourages him to role-play standing up to his father, to yell:" That is not okay with me. You cannot treat me that way." She refers him to a low-cost anger management class in town.

In the third session, the client reports more intimacy with his wife. He is sharing about the therapy sessions with her and feeling less lonely. The therapist suggests they explore the anger some more, the other presenting symptom. He tells her that it happens when he wakes up from his sleep in the middle of the night. He wakes up in a rage and goes and strikes his daughter. This sounds like post-traumatic stress disorder (PTSD) to the therapist. She inquires and discovers that the client was in Vietnam during the war. She suggests they use Experiential Focusing to explore his Vietnam experience, describing to him the flashback experience and possible connection to his rage. Through closed-eyed Experiential Focusing, he explores many frightening memories of being under constant threat of death in the war, and the rage reaction that went with that. He shakes with fear, says he is amazed at the strength of his feeling, that he has never talked about his war experience before. Among many other memories of ghastly experiences as a medic dealing with the wounded, he expresses that he is remembering something shameful, something too horrible to express, something involving an unconscious teenaged woman. The therapist tells him he need not describe the memory outloud unless he wants to, that it is enough that he forgive himself, that it was wartime, that he was not his normal self (he spent the war drunk and drugged, as did many soldiers). She recommends a Vietnam Vets support group and again continued sharing with his wife.

In the fourth session, the client says he is doing much better. He is no longer afraid he will destroy his marriage. He is renewing connection with his wife through a weekend away. He and his wife have signed up for a

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class on parenting teenagers. He is ready to stop therapy. The therapist is concerned that he may be dropping out because of shame around the Vietnam memory and mentions that. He says, again, that he was amazed at the strength of his feelings, that it was good to talk about it, that he may explore the Vets group./END INDENTATION AND SINGLE SPACING/

The client's presenting problems (the extra-marital attraction and the rage attacks) have been dealt with. In a brief therapy model, short-term crisis-resolution has been successful. The client has some new awareness, some new tools, and access to low-cost community support systems. Therapy can stop. If there is a new crisis, the client can return to therapy for another brief intervention.

5. CALL FOR PROGRAMMATIC RESEARCH

Although Gendlin has shown that 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), Experiential Focusing Therapy (Gendlin,1996; McGuire, 1996) 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, Experiential Focusing Therapy allows practitioners to optimize personality change in either short- or long-term frameworks for psychotherapy. Instead of waiting for clients to stumble into the deep experiential "felt shift" process captured by Stage 6-7 EXP and necessary for personality change, the therapist can help the client to use Experiential Focusing (Stage 5 EXP) to deepen experiencing at many points in the session, thereby potentiating the Stage 6-7 felt-shifting change process.

This is especially needed in a "brief therapy" context, where an understanding of Experiential Focusing allows therapists to operate with laser-like efficiency. Clients can also be explicitly taught the steps of Experiential Focusing. They can then themselves potentiate personality change both in sessions and in home problem-solving during and

after the end of psychotherapy by actively choosing to close their eyes and spend some silent time paying attention to the bodily-feel of an issue or symptom.

Given that research (Rogers, 1967; Seeman, 1996) has already shown that EXP level of 4 and above is the crux variable associated with personality change as measured by long-term outcome measures, research with the Experiential Focusing Protocol need only show that EXP level of 4 and above is predictably caused by the Experiential Focusing intervention in order to prove the effectiveness of the intervention for long-term personality change (e.g., according to logic, if A = B and B = C, then A = C). Durak et al.'s (1996) study, which showed that EXP level during therapy sessions was increased after two outside training sessions in Experiential Focusing, could be used as a starting model for research. Use of Iberg's paper-and-pencil measures of depth of experiencing, if they are found to correlate with EXP Scale levels, would provide an even more efficient measure. And Shapiro's SUDS and VOC could be used as further measures making the research results comparable with those of other brief therapy modalities like EMDR.

Psychotherapy research would be aided if there were an international center where researchers could send audio tapes for Experiencing Scale ratings by trained raters, thereby making the Experiencing Scale available for widespread use in psychotherapy research.

Rather than piece-meal research, collaboration of university- and clinic-based researchers with The Focusing Institute in New York should be directed toward producing ten to fifteen studies using the same Experiential Focusing Protocol, agreed-upon, easily-administered short- and long-term outcome measures, and targetting a specific DSM-IV diagnosis. Experiential Focusing, with its solid base in over thirty-five years of client-centered research and theory, could then be firmly placed on the list of effective brief therapy interventions.

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