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FOCUSING INNER CHILD WORK WITH ABUSED CLIENTS

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Ten years ago I disagreed with those who conducted eyes-closed Focusing therapy sessions. I argued that clients needed to be healed by the interpersonal interaction with the therapist. My manuscript, ***The Experiential Dimension in Psychotherapy***(1984), describes interjecting short Focusing invitations into traditional verbal psychotherapy. Therapist and client use Focusing to explore the felt sense of the "transference" of parent/child dynamics into the present relationship.

This approach is still valid for therapists choosing to work interpersonally and for clients who are not able to work with eyes closed. However, in my own clinical practice, I presently find myself moving away from an emphasis upon "the transference" and toward an eyes-closed Focusing therapy. It is my version of Focusing Inner Child Work. Rather than placing priority upon the relationship between myself and clients, I emphasize the healing relationship between their own Inner Nurturing Adult (or Inner Listener) and their wounded Inner Child.

Traditionally, people using Focusing refer to themselves as non-directive, client-centered, "not ever making the Focuser do anything," "not having any agenda for a Focusing session." While such an approach is sacred to Focusing Training and Listening/Focusing peer counseling, it does not fully describe my work as a Focusing Therapist. Especially with people who have been severely abused in childhood, I work quite directively, taking us back again and again to the felt sense of painful childhood memories. In writing this article, I also want to begin discussion about directiveness in Focusing work.

One factor motivating my change to an eyes-closed Focusing Therapy was burnout from working with sexually and physically abused people. I was doing too much work trying to get them to find a felt sense. I was battered from walking headlong into resistances. I needed a method to overcome the dissociation from the bodily felt sense symptomatic of severe trauma in childhood. I wanted a method that was easier on me, placing more responsibility with clients. Focusing Inner Child Work accomplishes both of these goals.

I have also discovered some difference between myself and Gendlin on the role of catharsis and the reworking of childhood pain in the Focusing process (McGuire, 1991; Gendlin, 1991). Theoretical work on emotion in psychotherapy (Safran and Greenberg, 1991) has sharpened my understanding of my approach. The Inner Child work of Bradshaw (1990) and others in the adult children of dysfunctional family movement (ACOA, etc.) has also provided concepts for aspects of my work. Others within the Focusing tradition have described aspects of Inner Child Work (McGuire, M., 1991; Gendlin, 1984; Armstrong, M., 1988; Caffaro, T., 1992).

Focusing Inner Child Work is also my personal way of attracting those I want to work with at the present time. Individuals are screened out who do not have sufficient ego strength to work with their own Inner Listener and Inner Child. These people need to be worked with in a more interpersonally supportive style.

Dissociation and Childhood Abuse

Focusing grows out of the client-centered tradition (Hart & Tomlinson, 1970). Given facilitative conditions, the body will unfold its own unique next steps. Rogers' client-centered therapy (1951) is "non-directive." The therapist reflects or mirrors clients' words, emphasizing the feeling tone. Clients go deeper by hearing nuances in their own words. Gendlin's client-centered/experiential therapy (1974) allows more direction. The therapist can suggest Focusing: "Would you like to stop and sense into the meaning of those words?"

Focusing Inner Child Work goes further in terms of directiveness. I encourage clients to keep their eyes closed through most of the session (there are, of course, exceptions). I also feel free to direct them to Focus upon specific issues. For instance, I may tell them that I see signs which usually indicate sexual or physical abuse in childhood. I encourage them to accompany me in looking carefully at childhood memories and body senses to see what emerges.

Much of the time, I work with people who cannot get a body sense. They are "dissociated" from their feelings, from the felt senses that would normally come along with their words or images. Dissociation is a protective response to situations that are so physically or psychologically painful that the person must not feel them in order to survive. To preserve the Self, the person leaves the felt sense and goes into a fantasy world, or symbolizes the pain in bodily tensions, or intellectualizes what's happening as if an observer.

Many symptoms attributed to depression or anxiety neuroses are caused by forgotten sexual, physical, or emotional abuse in childhood. When a therapist sees signs of dissociation, the question becomes, "What could have happened to this person that was serious enough to cause dissociation?" Particularly in cases of severe physical, sexual, and emotional abuse in childhood, the body process may *not* get to dissociated memories on its own. The therapist must intervene to connect the person with bodily experiencing.

Focusing is an ideal method for overcoming dissociation. Focusing emphasizes staying with and trusting vague, preverbal bodily senses. A relationship with the felt sense is seen as necessary for lasting change. Many techniques deal with the problems that get in the way of experiencing the felt sense (the Critic, being Too Close or Too Distant, etc.).

All of us dissociate to some degree and use Focusing to bring us back to the felt senses. However, the more severe the physical or emotional pain, the more severe the dissociation. In extreme cases, the Self splits into multiple personalities who are not even aware of each other.

The dynamics of incest set up ideal conditions for dissociation:

1) Often, the abuse happens to an infant or toddler who does not have words or concepts for what is happening. The person is left only with vague feelings that something happened.

(2) The abuser, especially if the father, is loved by the child. The abuse may be mixed with affection. It's impossible to keep loving the father and remember the abuse. The abuse is forgotten.

(3) The abuse may be physically painful enough to cause bodily dissociation for survival.

(4) The child has no choice but to stay in the situation so must construct a cognitive framework that makes this tolerable: "It couldn't be happening. I made it up." This becomes more likely as the child tries to tell other family members and is met with denial. The abuser may also say: "This did not happen."

(5) The abuser may tell the child, "You made this happen. You are bad. If anyone finds out, you'll be in trouble." Or the child senses that what is happening is "bad" and blames him- or herself for participating. The child forgets the abuse, remembering only "I am bad."

(6) The child may have experienced some pleasant sexual sensations during the abuse. S/he then thinks s/he has chosen to participate and is the guilty party. The conflict with simultaneous feelings of violation causes forgetting of the unresolvable confusion.

Sexual abuse is not a minor exception in the work of Focusing therapists. Since I have become attuned to the signs of incest, I find it or suspect it in at least seventy-five percent of the clients, male and female, coming to me for generic psychotherapy. The frequency is so great that I find myself tending to agree with Freud. He initially stated that in every case of neurosis the cause was to be found in disturbances related to childhood sexuality. Using abreactive and hypnotic techniques, he found that recovering memories of sexual abuse was the turning point in cases of hysteria and conversion reactions. Only later, after harsh criticisms, did he develop an alternative theory that these were *imaginary* instances, dreamed up by children under the intrapsychic sexual pressures of the Oedipal situation.

Analyst Alice Miller (1983; 1981) shows how the latter version of Freudian theory and authoritarian systems of child rearing have conspired to draw a veil over the tremendous actuality of severe physical and sexual abuse during childhood. Given what I know now, I can look back over many past clients and see symptoms of sexual abuse. Yet we did not uncover incest as the root of problems because I was not aware enough of the signs and did not point us explicitly toward the issue.

The degree to which memories of physical and sexual abuse can be forgotten is startling. It was only the difficulty of my own journey of discovery which encouraged me to undertake the deep pursuit necessary for recovery by clients. In my own case, I practiced Focusing and/or received experiential psychotherapy at least once a week for twenty years without becoming aware of sexual abuse in my childhood. I had painful physical and emotional symptoms and pursued medical and psychological treatment

possibility of abuse, saying, "Are you aware that what you just said implied that you were hurt in a sexual way?" Only then did I become able to unravel that piece in a Focusing way.

Here are some of the red flags that raise suspicions of incest. The therapist operates as a detective, piecing together clues that lead to a hypothesis which can be offered to the client:

- The client is the child of an alcoholic family.
- S/he can't remember portions of childhood.
- There were stepfathers or mother's boyfriends in and out of the home, plus alcohol.
- The mother was severely mentally ill or abused as a child herself.
- The client shows excessive guilt, shame, self-punishment: "It's all my fault. I'm bad, lazy. I've disappointed my family. I'm nothing."
- S/he has an extreme need to control the therapy session, is distrustful of the therapist, and is especially sensitive to any questioning of his/her perceptions.
- S/he is in an abusive relationship and unable to get out. There may have been a series of abusive relationships.
- S/he shows signs of dissociation: Low Experiencing on the Experiencing Scale (Klein, Matthieu et al., 1970); s/he does not seem present behind the eyes; s/he seems to be covered by a "glass shell," a fragile rigidity; s/he is afraid to close his or her eyes; s/he talks about traumatic events with no emotion, saying, "It's as if it's happening to someone else;" "It's as if I'm watching a movie;" "I'm on the ceiling looking down at myself;" s/he keeps the therapists's comments out with a wall of words, protecting.
- The client's jaw is tight, angry-looking.
- S/he has an eating disorder (overweight, bulimic, anorexic).
- S/he is abusive to others.
- S/he has panic attacks, agoraphobia, other phobias.
- S/he is obsessed with death or wanted to die as a child.
- S/he was happiest in a fantasy world in childhood.
- S/he is self-destructive, self-mutilating.

DSM-III symptoms of Post-Traumatic Stress Disorder, Borderline Personality Disorder, and Multiple Personality Disorder all can apply to incest survivors.

It is my responsibility as the therapist to keep taking clients back to painful material: "I know you're afraid of this; you're maybe even afraid that you'll die if you let yourself be here, but this is your Magical Inner Child. This is the place from which creativity and new energy will arise."

When I suspect a client is an incest survivor, I may make an even stronger intervention. The material is so dissociated that it may never come up in Focusing, yet the person will continue to suffer symptoms caused by the forgotten events. I must make judgments about timing: how much individuals can handle, how likely it is that they will discover the abuse themselves, whether they are working successfully on other material at the time, whether work on the incest is essential to our work together and within the therapeutic contract, etc. But in many cases, although the client has not brought up the issue, I will say, "I think that you were sexually abused as a child, and here is why..."

Sometimes the person will immediately see incest as a possibility and start working on pieces of information that have suddenly fallen together. Sometimes clients need to think, read, talk to other survivors. Often they need time for the incest possibility to sink in cognitively before it can be worked on emotionally. They need to rethink and reorient their whole lives in terms of this new framework. Sometimes a client says, "No way. Not possible." However, if I keep seeing the signs and progress blocked by the lack of the information, I will keep bringing up the possibility, with more reports of what I am seeing.

Sometimes there are "screen memories." A client remembers an incident of abuse by a neighbor or a stranger and keeps attention upon this event. The therapist thinks, "It's unlikely that event would cause the degree of dissociation and other signs of the incest pattern I am seeing. Why the intense guilt and shame? Why couldn't the child tell her parents? Is there also incest here?"

Focusing Upon Childhood Memories

Many theorists now believe the deepest level of personality change cannot occur unless clients access and change core organizing schemata that are cognitive *and* emotional. These schemata can only be changed by returning to the emotional state of their creation (Safran and Greenberg, 1991, p. 11). Harvey Jackins (1962), in his reevaluation co-counseling, knew that emotional work was necessary to change thinking. John Bradshaw (1990) describes "original pain" work:

> What I didn't know was that I needed to embrace my heartbroken little boy's loneliness and unresolved grief about his lost father, his lost family, and his lost childhood. I had to embrace my original pain. p. 76.

Ron Kurtz (1990) in his Hakomi therapy, refers to "the core material":

> Such information has been called by many names. Karl Popper calls it intuitive belief. Joseph Campbell's mythic images is another phrase... Intuitive beliefs suggests the non-verbal, non-objectified state of this information. It is intuitive, non-verbal; it is felt or sensed, rather than thought. Yet, at the same time, it is acted on; it guides actions (p. 116).

Note the similarity in his description to a "felt sense," in Gendlin's terminology. Gendlin also uses the term "frozen wholes" to refer to these cut off aspects of experiencing.

I make the assumption that troublesome situations are those in which a person is operating out of preverbal "rules" which were formed in childhood and have remained unchanged by further experiences. If the client is in an abusive relationship, I find myself asking: "Where did she learn to take abuse without leaving? When was it necessary for

survival to do so?" A grown woman, unentangled by the past, would not allow herself to be beaten repeatedly. A belief system keeps the abused woman there: "I'm doing something to deserve this." Shame, guilt, and self-blame are predominant emotional features: "I want him back...If I'd only done things differently...I can see why he's angry, and I'm willing to change...I do make him angry. I nag him...What's wrong with me? My last husband said I was crazy..."

Bradshaw (1990) describes "toxic shame:"

> ...the internalized feeling of being flawed and defective as a human being. In the internalization process, shame, which should be a healthy signal of limits, becomes an overwhelming state of being, an identity if you will. Once toxically shamed, a person loses contact with his authentic self. What follows is a chronic mourning for the lost self. The clinical description of this state of affairs is dysthymia or low-grade chronic depression (p. 66).

Often, when Focusing upon a problematic reaction in the present, clients will go back to childhood connections: "Oh, and this reminds me of..." But if they don't, I will ask, "Is this feeling familiar from your childhood? Did someone there treat you like this?...Can you sense into the feeling and see if there's something similar?"

Notice that I am asking clients to Focus, but I am directing what they will Focus upon. Sometimes the client will connect: "Yes...my father treated me this way," and the Focusing process can be used to unravel the felt sense of that interaction. But sometimes s/he will say tearfully, "No, my parents were very kind to me. They sacrificed everything for me."

Alice Miller talks about this tendency for the abused child to idealize the abuser, so that the child can stay in the situation and survive. The giveaway here: "They sacrificed everything for me..." Again, the keynote: the parents are the good and worthy ones, the client the undeserving one: "They sacrificed...I didn't deserve it...I disappointed them." Parents who were truly caring would leave behind self-esteem: "My parents gave us everything they could; I'm grateful." In the abusive family, the child got the message: "We are sacrificing for you. Make sure you deserve it." The Focusing question: "How did they sacrifice for you? Can you go back to the specific memories?"

Often the person will say, "I don't remember my childhood very well." Again, a give-away: "Why not?" If we do not get to specific childhood memories from the client's felt sense of present situations, then I may take us back into childhood directly: "Let's just look for any memories. We can slowly reconstruct your childhood by telling over and over, with as much detail as possible, whatever incidents you do remember...You can start with birthdays or holidays, with good times, close times you remember...How was it at the dinner table?...Tell that story about your parents' fighting again, but with every specific detail you can remember." We continue in this way until the client hits upon an emotional reaction or a felt sense about something, or until I hear a pattern, in which case I will name it and ask the client to Focus into it: "That sounds the same as what's happening with your boyfriend now...that you asked for your father's attention and he ignored you. Can you try to sense into the feel of that?"

Here the work often moves naturally into the Inner Child metaphor. I may say, "Can you imagine that you're a little girl and your father is talking to you in that way?" or "Can you get a picture of how old you were, how you looked at that age?"

The Inner Adult/Inner Child and Self-Compassion

Moments of "self-compassion" or "self-empathy" are the essence of change in psychotherapy. In metaphorical language, people are able to turn around and to embrace the parts of themselves which have been disowned. In theoretical terms, they are able to touch with their attention the preverbal experiencing underlying a frozen, static symbolization. This moment of direct reference to felt experiencing allows new symbolizations to arise. Static symbolizations change into something new and more inclusive of present as well as past experiencing. Gendlin's term is "content mutation."

It is exactly these cut-off "frozen wholes" which must be related to in an empathic way if people are to heal--and it is exactly these wounds which they avoid with every tactic at their disposal. They don't like these parts of themselves. In fact, they survived childhood only because they were able to make this part go away. Clients, unless they are experienced at and self-responsible for Focusing, are not going to return to this wound again and again and patiently make words and images for it, feeling the emotions which arise. Yet it is exactly the reintegration of these parts of experiencing which will allow them to be whole.

The Inner Child metaphor is one of the most powerful ways of allowing people to connect with the feel of cut-off aspects of childhood experiencing. The Inner Adult/Inner Child metaphor concretizes the dialogue between the empathic Inner Listener and the felt sense necessary for successful Focusing (Gendlin, The Client's Client, 1984; Cornell, 1991, ***The Folio***, Summer 1991; others--McGuire, M., 1991; Armstrong, 1988; Coffeng, 1992). The embracing of the wounded Inner Child by the Inner Nurturing Adult brings about the moment of self-compassion necessary to reintegrate rejected aspects of the Self into the total personality.

In ***Healing Your Aloneness***, Chopich and Paul coin the term Inner Child Bonding for their approach to healing:

> *Becoming aware of the unloving way in which we are parenting ourselves and what it means to be a loving Adult to our Inner Child is the most important thing we can each do for ourselves.* The way we each treat our Inner Child causes everything else in our lives. Treating our Inner Child unlovingly results in substance and process addictions and creates fear, anxiety, depression, pain, emptiness, neediness, low self-esteem, and an unbearable sense of aloneness, as well as physical and mental illness. The severity of mental illness from which a person suffers is directly related to the degree of internal disconnection between the Inner Adult and the Inner Child. Craziness results when we avoid facing and feeling the deep aloneness and pain of the Inner Child.
>
> Treating our Inner Child lovingly creates the inner connection that fills the emptiness from within rather than needing to fill it externally with addictions. The more we learn to treat our Inner Child lovingly, the more solid and full the internal connection becomes, leading to peace, joy, power, and wholeness, erasing the need to give ourselves up to be loved by others (pp. 25-27).

Chopich and Paul (1990) also distinguish the Inner Loving Adult from the Inner Unloving Adult (the many faces of the Critic); the Inner Loved Child from the Inner Unloved Abandoned Child.

Stone and Winkelman, in ***Embracing Ourselves; The Voice Dialogue Manual*** (1989) provide a wealth of metaphorical language for noticing and creating dialogue between parts of ourselves: The Protector/Controller, The Heavyweights (The Pusher, The Critic, The Perfectionist, The Power Broker, and The Pleaser), Disowned Instinctual Energies (The Demonic), The Inner Child (The Vulnerable Child, The Playful Child, The Magical Child), The Parental Selves (The Good Mother, The Good Father, The Negative Father, The Negative Mother, The Rational Parent), The Spiritual Dimension.

The Inner Child is only one of many metaphors which arise as people attempt to express aspects of experiencing. A therapist caught in the Inner Child metaphor can miss more individually powerful metaphors which arise from a client's own unique process: "It's like the gollum from 'Lord of the Rings'...it's been underground for so long that it's colorless and it cannot see;" "I'm like a butterfly with one bent wing...I can't allow that wing to unfurl;" "It's like a wounded animal...It just wants to go and be alone;" "It's like a gangrenous leg...I just want to cut it off!"

Working toward Inner Adult/Inner Child bonding is not simple. The Inner Child is not necessarily going to be friendly or pretty. Cut off and ignored for thirty years or so, s/he's likely to be dirty or disfigured or ugly. S/he's likely to be in a rage, too hurt to talk, untrusting. And the client may not be aware of her own Nurturing Adult.

I may say: "Imagine that part of you (that felt sense) as a little, hurt child...you want to find some way to approach her." All sorts of things may happen. The client may say: "I *have* no adult; I don't know how to take care of her; I'm afraid of her--she's so angry." In Ann Weiser Cornell's terminology (***The Folio***, Summer, 1991), the client is Too Close, overwhelmed, and needs help finding an appropriate distance from the felt sense/ Inner Child: "Is there a nurturing adult you know who you could take with you?;" "Can you remember how you are a nurturing adult for your own real children?" The client may say: "I hate that little girl; she's so ugly and dirty." Therapist: "Can you imagine that it's not you but another little child that you know who looks like that? How would you feel about that child?" Often, people who cannot cry for themselves can feel sympathy/ empathy for "some other little child."

Or the therapist may need to side with the resisting part: "It was really important to your survival that you turn away from that little child's feelings. Let's take some time to validate and to hear from the 'coper' who's been doing such a good job keeping you away. Then maybe we can show her that you're bigger now, things have changed, and you can afford to have a relationship with that part."

It's just as likely that the Inner Child will refuse to talk: "You've been ignoring me all these years. Why should I talk to you now? Why should I trust you? Why should I want to help you? I hate you!" In this case, the Inner Listener needs to sit down at a comfortable distance, try to find out from the Child what might be okay, and be willing to stay for a long time, demonstrating gentleness, acceptance, and trust.

Using the Inner Child metaphor in a rote way, or walking large audiences through fixed guided fantasies about finding and reuniting with their Inner Child, can stay at the surface level if attention is not directed to the felt senses which arise. The therapist must help the client to "sit with" the felt senses which arise. Gendlin tells the Focuser to set up a tent and tell the felt sense, or the Inner Child, that you will stay as long as it needs, that you'll be as near or as far as it can tolerate, that you won't give up on it or force it, that you will just be there. Two seconds of being with, contacting this "frozen whole," can be the most curative moment of an hour of therapy. By being contacted, it can begin to melt and to change.

I often use imagery like "Can you just put your hands around the felt sense, as if you were going to warm it?;" "Can you just warm the felt sense with your attention, just touch it gently with your attention?" The touching is all that is needed; the newly wakened experiencing will then take care of its own unfolding.

Introducing Eyes-Closed Focusing Therapy

Beginning with the first telephone contact with potential clients, I say that

(a) I use a technique called "Focusing;"

(b) there's a book they can read (Gendlin, ***Focusing***, 1981);

(c) Focusing involves being willing to spend most of the session with their eyes closed, going quietly inside;

(d) I will teach them how to do this and help them with being scared, if they are;

(e) Focusing is a way of contacting and healing the Inner Child.

When they come for a first session, I say that we can spend some time talking, but that I want to be sure to save time at the end to demonstrate Focusing so that they can see if they are comfortable with it. We spend up to twenty minutes talking about their reasons for coming to therapy, their family of origin, their symptoms. I answer any questions about my training, my approach.

If they hit upon a Focusing place (tears or a vague sense) while talking, I will either label this ("If we were doing Focusing now, I would stop and ask you to go inside quietly to see what that's about") or, if timing and readiness are right, I say, "This would be a good time to try Focusing. Are you willing?" If not right then, I introduce Focusing in the last half hour of the session.

I say that Focusing involves going quietly inside, setting aside intellectual assumptions, and trying to get the feel of "the whole thing" in the center of the body: "Letting the body tell you what it knows;" "consulting the body's wisdom;" "giving the feeling a chance to speak;" "finding your Inner Child." I say that we will start with simple relaxation instructions to help them turn toward the body; that after that sometimes it helps to make a list of all the things jumbled up inside; sometimes it works just to sit quietly and see if a sense of one particular thing that wants attention will come inside.

I say, "I'll ask at that point and let you say whether you need to make a list or whether there's already a strong feeling wanting attention." I say, "Let me know if you are having

trouble anywhere along the way; if you're quiet, I'll assume that you're okay unless you tell me otherwise. Of course, if you need to, you can open your eyes, but I find that the best work gets done with eyes closed, that talking can be a distraction away from feeling." I say that while this way of therapy may seem strange at first, most clients find a great sense of ownership in finding solutions themselves. I answer questions if there are any.

I say that I am going to take notes that will show the steps of their process, that there is nothing secret about these notes, that one copy is for them to take home, one copy is for my files. I say that sometimes looking at the notes can help them get back to the feel of the whole thing if they decide to Focus on it again at home. I get a clipboard with carbon paper. I make three columns: one for major Therapist interventions, one for major Client steps, and one for The Critic. (Table One: example of notes).

TABLE ONE

Example of process notes taken by therapist (if needed) and given to client.

Clearing a Space

Relationship	**Money**	**Work**	**Spring**
Stomach: Anxiety	**Chest: Tightness**	**Sholders: Responsibility**	**Heart: Happy**

Choose One

GUIDE	**SELF**	**CRITIC**
	Work: Responsibility	
	Just want to rest	"Whining again. Who gets to rest?"
	(tearful) I'm so tired, and it's Spring.	
Tears there: "And it's Spring." Want to sense into that?	I love the Spring—it makes my heart swell—it's so beautiful and growing. (tearful)	
	And not like responsibility: "The lilies of the field..."	
The lilies of the field didn't have to work and could be okay.	Yes I want to trust more—trust the Universe—trust the Universe—then I get afraid.	
So as soon as you start to relax, your Critic comes and syas, "Not safe to rest!"		"You fool! Don't trust. No one will take care of you."

Then, clients close their eyes and I give initial Relaxation/Focusing Instructions:

> Just notice your breathing, as a way of turning gently toward your body...Don't try to change it; just notice the breath going in...and out...Loosen your clothing if it's too tight, or, if you notice a tense part of your body, feel free to move it around or massage it...Do whatever you can to make your body feel welcome...
>
> Now, imagine that there is a ladder going from the top of your head down through the center of your body all the way to your stomach. You're at the top of the ladder, where you do all your thinking and analyzing. You're going to gently say 'Goodbye' to this part of yourself and slowly let yourself down the rungs of the ladder...going down behind your eyes...you might breathe into the energy there...in and out...now down, down to your throat...again, you can stop and breathe into the energy there...in and out...now down, down into your chest...again, breathe into the energy there...in and out...now, down into your stomach...and breathe...in and out...Notice that there is that channel of energy down the center of your body and that it's a place where you can look for information during Focusing...
>
> Okay, now check and see if you need help making a list, or if you just want to sit and see what comes in the center of your body (or, if we've already chosen an issue to Focus upon before starting, I'll say, 'Now turn your attention toward that feeling about....just sit with it and see if you can get the feel of the whole thing in the center of your body' (adapted from Bala Jaison's Focusing Training tape, *A Guided Experience Through the Six Steps of Focusing*).

From there we go on with all the normal steps of Focusing: finding words or an image that are just right, checking them against the felt sense, looking for more words or images as they arise, noticing and setting aside the Critic if it arises. In later sessions, I ask them to let me know if they want relaxation instructions, or help making a list, or if they just want to sit quietly and get in touch with what comes in the center of their body.

At the end of the time, I ask potential clients how that was for them, say that they can decide to set up another appointment now or call me after they think about it and that, if they decide to continue, I will give them a copy of my manual, ***Building Supportive Community***, with Chapter Four on Focusing alone, and my two Focusing training tapes for practice at home.

In future sessions, clients can spend about ten minutes catching me up on events from the week if they wish (this often serves the same function as "Clearing a Space"), and then I have them close their eyes and go inside, me taking notes.

Directive Interventions

So, what's different from regular Focusing sessions? The degree to which I am willing to direct clients toward the material to Focus upon, sometimes arguing quite strongly that they try out my suggestion even if they are afraid to do so or don't think it is valid.

As a licensed psychologist, I operate under particular constraints. Where I live, most people have health insurance which allows approximately thirty one-hour sessions of psychotherapy. I would feel irresponsible if I did not alert them to the possibility of forgotten sexual or physical abuse in childhood as an underlying problem causing symptoms of distress, even if they came to me for some other reason. I don't always have time to wait for the body process to get to problematic material on its own.

Here are some situations where I am directive:

(1) A client says, "I don't need to close my eyes. I just want to talk to you." We may explore this as an issue, but I might also say, "Sometimes people are afraid of what will happen if they close their eyes. I want you to know that you can open them if it's really too hard. I also want you to know that no one has ever fallen apart and been unable to leave my office. I'd like you to try closing your eyes and Focusing. I'll help you." I do this with clients thought not to be psychologically sophisticated enough for Focusing. Often, it works perfectly well. Sometimes they choose not to work with me, since this is what I do. But this can be true for "sophisticated" people as well. It doesn't happen often and is a good indication that a Focusing approach will be difficult for someone, eyes open or closed.

(2) A client has been referred to me by a physician because of depression related to chemotherapy for cancer. She clears a space, making a list of issues she is carrying in her body. The cancer/depression issue is not on her list. I say, "And I know you are also carrying the issue about cancer. I wonder if you can feel how you are carrying that in your body...it might just be that you can't handle looking at it, and we can work with that feeling."

(3) A client comes in every week and spends almost the entire session clearing a space. We never have time to go on to work on anything. I will point this out and say, "Can we take one of the issues from last week and go into it?"

(4) A client consistently only wants to Focus upon positive feelings. I work with this as an issue, but point out that therapy is about working on things that hurt, that are unresolved, as well as developing happy feelings.

(5) Often when a client goes inside, there is nothing. I will gather information before Focusing: "Any important incidences during the week? Any thoughts about what we talked about last week? Any dreams?" Often dream images clue me in to what s/he may not consciously be able to address. This conversation functions like clearing a space for some people, and the information gathered helps me guide them toward potentially important material if they don't find anything when they go inside.

(6) The week before the person touched into incest material. This week that is not on her list, and the things on her list seem superficial, without much feeling. I may say, "Last week we touched into some really scary stuff around incest. Unless something else on your list is really pressing, I think that we should try to find our way back to those feelings and keep working through it. It's the only way to get free." In fact, this is the intervention that I make most often, carrying a theme from one session to the next.

(7) A client is Focusing and comes upon some tears or anger about an issue. S/he goes on to another issue, which doesn't seem to bring up much that is "implicit." I may say, "There seemed to be a lot of unresolved feeling around _____. Can we go back there?" I will do that over and over at appropriate times in the therapy until the issue has been resolved.

(8) A client Focuses, eyes closed, for a while, then comes out to talk. I will talk for a while, then I will say, "But I'd like you to close your eyes and try to touch the feeling about this." I do this again and again in the session, backing off with sensitivity to the dignity and self-empowerment of the person's own process but coming back again in recognition of my responsibility as therapist to facilitate healing.

Reactions to Closing Eyes

Many clients feel more at peace and less embarrassed when they can work with their eyes closed. However, simply closing the eyes can have an overwhelming effect upon some people.

One time a client was talking in a conversational style, removed from feeling. When she closed her eyes for the first time, she immediately flushed all over with tearful emotion. She could find no words or images for the feeling. In future sessions, she would close her eyes and the room would immediately start spinning. Another person closed her eyes for the first time, felt a rush of tearfulness, and said she was afraid she had been sexually abused. This had not come up as an issue for her before. Another client closed his eyes, focused upon a childhood incident, and the room began spinning. The spinning continued for several minutes after he opened his eyes. In all of these instances, severe physical or sexual abuse in childhood eventually came out of continued Focusing.

When people have such a strong reaction, I let them say whether they can tolerate sitting with it and asking, "What's this about?" or whether they need to open their eyes. I may suggest they open their eyes if they seem to be "sinking into," rather than relating to, a feeling. I will say that such a strong reaction is the body's way of protecting them from information which they could not handle as a child, that they are bigger now, that I am there to help, and that we will slowly work on feeling safe enough to explore the memories under these reactions. All the techniques for "finding the right distance" come into play here.

Strong bodily reactions may come up during any point in Focusing upon childhood situations. Clients may begin to hyperventilate, to cough, gag as if throwing up, become nauseous, start to shake. All of these are indications that the body is unblocking painful material.

It has been my experience that the body can be trusted to pace itself through scary material. I usually ask people to continue Focusing upon the reaction as long as they can. However, if they back away, my job is to create safety in the moment but to store the information. Later I will say, "I want to go back to the place where you started coughing. It was about..." If they cannot go deeper then, I will store the information and bring us back there *sometime*. I see this as part of my job as a therapist--to see what clients cannot see, and to help them to see it.

Interpersonal Issues (Transference)

Interpersonal issues with me are greatly reduced using the eyes-closed Focusing method. The eyes-closed format selects clients with a higher level of self-awareness. They also often come upon the issue while Focusing and describe it in terms of their own inner process: "I'm sitting here wondering what you think of me...That reminds me of spending my whole life doing that;" "I got scared when you said that...it sounds just like the critical voice inside of me."

If transference issues are brought up in a more interactional way ("I'm not sure Focusing is good for me;" "I'm not sure I can trust you enough to go inside;" "You're trying to control me," etc.), I work with them interpersonally and interpret transference material, if necessary. However, if at all possible, I ask people to close their eyes, go inside, and look for the feel of the interaction in their body and work with it in a Focusing way.

I say that I am also willing to Focus on my side of the interaction, that, of course, there are two sides, each of us is contributing something, but therapy for them right now would be to look at their feelings in a Focusing way. I say I'll look at my own side in my own Focusing turns, or, if they insist, right in their session if they want to spend some of the time listening to me.

I used to enter into the transference in a more interpersonal way, living the feel of the interaction in my own body and then trying to tell the client about it: "I feel like we're having this push/pull, that maybe you had that with your mother. Does that seem familiar to you?" (McGuire, 1983). However, this hasn't felt good for my body anymore. I'm doing too much of the work. I want to get the interaction back inside the client for them to Focus upon instead of acting it out with me.

I am open to and skilled in working with the transference, and I think that a therapist must be able to handle such interactions. However, I no longer believe that is the only way to resolve internalized parent/child dynamics. The distinctions between the Inner Child, the Inner Critic, and the Inner Nurturing Adult or Listener, facilitated by eyes-closed Focusing, provide another format for healing these dynamics.

While I try to avoid open-eyed, conversation-style interaction, my clients experience me as very present during their closed-eyed sessions. They know that I cry for their Inner Child. I will touch them if I think touch is appropriate. My reflections are warm, embracing, and welcoming of their pain. Closed-eyed sessions actually seem to allow more intimacy between us. I have conversations directly with the Inner Child. No wall of words distances us from each other.

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