Focusing-Oriented/Experiential Psychotherapy

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This article reviews more than 80 research studies on Focusing and Experiencing Level.

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Introduction and Overview:

C: But why in the hell do I get so scared? I mean, I'm just sick to think I have to meet him. I get this feeling like some pressure's gonna come on me. Like...like when I was talking to him on the phone today, he goes, "I've really missed you." Wouldn't you think that would make me feel good?

T: It feels like pressure, you say. Can you sense what is the quality of that pressure?

C: I don't know. I mean...I...I just feel like...like he could make me do something that I didn't want to. Or something. Now what could he make me do that I don't wanta do? I don't know.

T: Why don't we just slow down and see if you can sense that. It feels like pressure, like you could do something you don't wanta do. What is your sense of all that?

C: Gee, I'm not sure... (deep breath).....(long pause).....this is kinda dumb; you know, I'm thinking that...(tears)...I mean, what if I even liked him more or something? Or something. I don't know what it is (tears).

T: That you might like him more...

C: Uhum...

When people do well in psychotherapy, this is how they usually sound, regardless of the orientation of their therapist. They pause and grope for words or images. They pay attention to an unclear, but bodily-sensed aspect of how they are in a situation. They don't just think about the situation and they don't drown in emotions. They attend to what we call a "bodily felt sense of--" a situation or problem. Words or images arise directly from that sense. What comes is often a surprise. A new aspect of experience emerges, a small step of change that brings a body response, like a slight physical easing of tension, or tears, or a deeper breath. We call this a "felt shift." This kind of process is one "motor of change" in psychotherapy.

Focusing-Oriented/ Experiential Psychotherapy is an interaction in which clients can contact their direct experience in this manner. It grew out of a collaboration in the 1950s at the University of Chicago between Carl Rogers, the founder of Client-Centered Psychotherapy and philosopher, Eugene Gendlin. Coming from the philosophical tradition of Dilthey, Dewey, Merleau-Ponty and McKeon, Gendlin developed a Philosophy of the "Implicit" and applied it to the work Rogers was doing. He asked what is actually going on when empathic conditions are present. Out of this interaction came a further theory of personality change (Gendlin, 1964) and psychotherapy (Gendlin, 1996), which involved a fundamental shift from looking at content--what the client discusses--to the manner of process--how the client is relating to experience. From examining hundreds of transcripts and hours of taped psychotherapy interviews, Gendlin and Zimring formulated the Experiencing Level variable. A Process Scale and eventually The Experiencing Scale (Klein et al 1969; 1986) were developed to measure it. The hypothesis was that clients who are more successful in therapy will show an increasing ability to refer directly to bodily felt experience, as illustrated in the example above. To their surprise and dismay, some findings indicated that Experiencing Level early in therapy predicted outcome. Clients who began therapy already able to speak from their inner experience did well and those that started unable to do this didn't necessarily learn and had a poorer outcome. In response to the problem that failure could be predicted from the outset, specific instructions were developed to teach people how to do this important process, which was named, "Focusing."

The importance of emotion and the relationship with the therapist have been acknowledged as central to psychotherapy, beginning with Freud's initial emphasis on abreaction and transference. These lines were further developed through the work of Rank and Rogers. Rogers saw therapy as involving personality change along "a continuum which reaches from rigidity and fixity of psychological functioning ...to psychological flow and changingness." Going even farther in the direction of a process definition of therapy Gendlin says, "Therapy does not consist mainly of familiar, already defined kinds of experience, whether dreams or emotion, actions or images. Therapy is rather a process that centrally involves experience before it becomes one of these defined "packages" and again afterward when it dips back into the zone at the edge of consciousness." His contribution was the articulation of the felt sense, as distinct from emotions, and his specification of exactly how the therapeutic interaction supports this focusing process. Over the last forty years, focusing has been applied and researched in other areas from medicine, business, schools, creative writing, churches, to experiential thinking. Its inherent interactional

character has led to the development of "focusing partnerships" in which focusing is applied to personal concerns and to thinking and work tasks.

The philosophy that underlies Experiential Psychotherapy uses a special kind of concept that puts interaction first. There is a whole model with such concepts which gives us new ways to talk about plants, animals, human behavior, perception, language, emotion, felt sense and interpersonal symbolic interaction (Gendlin, 1997). We will discuss a few of the main concepts about psychotherapy and change

Experiencing: A new understanding of Body and Environment

"Experiencing" refers to what you can sense in your body right now as you read this. Human beings have bodies that live in situations, not just in physical space. A little bit of good news in the mail about a situation you are worried about changes your body. You have been living in that interaction, even though the other person is in another part of the world. This also happens when someone suddenly understands something you have been trying to say to them. You feel the relief in your body when they get it. Experiencing is neither just "inside" you or just "out there." Human activities are both bodily and environmental. Walking implies the ground and the body. If it is dark and you don't see that the sidewalk suddenly ends, you fall, or if there is deep water, you thrash. In a certain sense, walking IS the ground and IS your body. The muscles in your legs imply the pressure of the ground pushing back. Breathing IS the air and IS your lungs. If there is no air, breathing stops and eventually the body structure disintegrates. Living organisms cannot continue to exist apart from activity. It is a powerful philosophical move to put activity or interaction as the basic, first term. It gives us concepts modeled on humans, rather than on mathematical units. The unit model of our atomistic science has great power in relation to machines, but it is inadequate to understand people. You can put your car in a garage, ignore it for a year, and return to find it pretty much as you left it. A living creature dies within a few days, if the interactions which constitute it cannot go on. Experiencing is on-going process. One implication is that pathology is blocked process.

Felt Sense: How The Body Is Wise

When we pay attention to our bodily experiencing, we find that it has in it the complexity of how we are living with others. At first this is an unclear, whole sense in your body that doesn't yet have words or parts, but is felt quite distinctly. Stop now for a minute and pay attention to your whole sense of a friendship with someone with whom you love to spend time. It has a distinct feel, before you have yet thought any words. Now sense your relationship with someone who is difficult for you. Again, you have a distinct felt sense , but different from the first one. This fuzzy sense is an intricate mesh of past history, current meanings, the other person, the physical setting, the relationship and much more. All this is implicitly present. This body-sense is not like a cramped muscle, but the body as it lives in a situation. This is called a " felt sense". It is neither just thinking, nor is it emotion. It refers to meanings felt in the body.

Carrying Forward; Implied Next Steps Of Living

Living implies its own next steps in a highly ordered sequence. In digestion, eating implies saliva in the mouth, which implies juices in the stomach, which implies absorption of nutrients by the blood, which implies elimination of toxins and wastes. If the events that are implied do not occur, there is a disruption of this very fine order. There is trouble. Our felt experiencing has this same implying of next steps in our interactions. Our bodies can also imply brand new action steps. Carl Rogers observed that when therapists expressed empathy, unconditional regard and congruence some clients seemed to naturally grow into fuller living, without any content directives by the therapist. He called this the "self-actualizing tendency." Now we can understand this more exactly when we see that living organisms imply exact next steps.

Reconstituting Blocked Process In Psychotherapy

When a needed interaction is lacking and the implied sequence cannot occur, the body continues to imply its forward living. Sometimes, we can respond to ourselves to change the situation. If we cannot, we may need a new interaction in which our living can be carried forward. Our concern in psychotherapy is to participate in such an interaction. Since a person's experiencing involves language, culture, other human beings, symbols, dreams, actions, interpersonal behavior, any of these avenues may carry blocked experiencing forward. This is why many different kinds of therapy modalities can be helpful. The interaction with the therapist may provide the opportunity for stopped aspects of the client's living to flow into further process.

Felt Shift: When The Body Eases

When process is blocked, a person goes on in whatever way is still possible, but often with a sense of constriction and pain. When what is implied can eventually occur, this is felt as relief in the body. The attention both therapist and client pay to the client's felt sense allows exact words, or images or gestures or new action steps to arise from the felt sense to carry the body forward into fuller living. This brings an easing in the body which we call a "felt shift." With many such small shifts, life changes.

Focusing and Experiencing: Defining and Measuring A Process Variable

Research in the Client-Centered/Experiential tradition goes back forty years. Initially, it consisted of content analyses. The shift to process variables (Gendlin and Zimring 1997), about how the client related to experience, led Rogers to redefine the self in process terms. Clients who self actualize in successful therapy should become "able to live more fully and acceptantly in the process of experiencing, and to symbolize the meanings which are implicitly in the immediate moment." (Rogers, 1959, pg. 102). Reliability and validity were developed for the Experiencing Scale. Judges are trained separately through standardized

materials. The scale measures a continuum, from externalized narrative to inwardly elaborated feeling statements, but this may not be a single variable measure. Middle stages measure the presence of emotions, but focusing on a felt sense is distinctly different from emotions. This begins at stage four. The following are excerpts from the Training Manual.

Stage One: The content is not about the speaker. The speaker tells a story, describes other people or events in which he or she is not involved or presents a generalized or detached account of ideas.

Stage Two: Either the speaker is the central character in the narrative or his or her interest is clear. Commentsand reactions serve to get the story across but do not refer to the speaker's feelings.

Stage Three: The content is a narrative about the speaker in external or behavioral terms with added comments on feelings or private experiences These remarks are limited to the situations described, giving the narrative a personal touch without describing the speaker more generally.

Stage Four: Feelings or the experience of events, rather than the events themselves, are the subject of the discourse. The client tries to attend to and hold onto the direct inner reference of experiencing and make it the basic datum of communications.

Stage Five: The content is a purposeful exploration of the speaker's feelings and experiencing. The speaker must pose or define a problem or proposition about self explicitly in terms of feelings. And must explore or work with the problem in a personal way. The client now can focus on the vague, implicitly meaningful aspects of experiencing and struggle to elaborate it.

Stage Six: The subject matter concerns the speaker's present, emergent experience. A sense of active, immediate involvement in an experientially anchored issue is conveyed with evidence of its resolution or acceptance. The feelings themselves change or shift.

Stage Seven: Experiencing at stage seven is expansive, unfolding. The speaker readily uses a fresh way of knowing the self to expand experiencing further. The experiential perspective is now a trusted and reliable source of self-awareness and is steadily carried forward and employed as the primary referent for thought and action. (Klein et al 1970, Pgs. 6 and 56-63)

Sachse and Neumann (1983), developed a Focusing Rating Scale (FRS), which was validated indirectly against the EXP scale with a correlation of .90+. Clients who are able to focus immediately in response to standard instructions were also found to be high on the EXP Scale. Focusing distinguishes High and Low Experiencing. Sachse also designed three paper and pencil measures which correlate very highly with each other and with the FRS. A Post-Focusing Questionnaire and a Post- Focusing Checklist (Wolf &Vandenbos 1971) are two more paper and pencil measures. Researchers Lambert & Hall (1994) state, "Perhaps the most widely used and best-researched observer-rated measure(s) of client involvement in the therapy process (is) the Experiencing Scale...." (Pg. 94)

Research Studies:

We review eighty nine studies in relation to three research questions: 1.) Does Experiencing Level correlate with psychotherapy outcome? 2) Does Focusing correlate with outcome? 3) Can we teach low experiencing clients to Focus?

Experiencing Level (EXP) and Session and Psychotherapy Outcomes

Twenty seven studies have shown that Higher Experiencing correlates with more successful outcome in therapy. Higher Experiencing from averaged, early, middle, and late sessions of therapy and increases in EXP over the course of therapy all show this correlation. However, many studies found the correlation only in one of these phases of therapy and not in the others. One study showed a negative correlation between Experiencing and client satisfaction measured by self statements at the end of therapy. Outcome has been measured by therapist and client reports and independent evaluations. The correlation has been found with clients in a variety of therapeutic orientations and diagnostic categories. The EXP-Outcome studies are summarized in Table 1, arranged by date.

Klein (1969) says of the early studies," experiencing... ratings of brief therapy segments are consistently and highly reliable, and yield a meaningful differentiation between more and less successful cases and between neurotics and schizophrenics." Researcher Jules Seeman (1997) reviewed and summarized the results of seven of the early studies. He concludes that "initial high levels of experiencing are likely at a better than chance level to facilitate a fruitful therapy outcome and that increase in level of EXP during therapy is associated with positive therapy outcome." (pg. 15.)

In an elegantly designed recent study using residual gain scores on outcome measures and hierarchical regression analyses, Goldman (1997) found that higher EXP in session two correlated with greater reduction in depression symptoms. However, theme related EXP level, at Stage 4 and even more so at Stage 6 in the last half of therapy, are even stronger predictors for reduction in depressive symptoms and Stage 6 predicts an increase in self-esteem. This study furthers our research method by the use of theme-related EXP, rather than random sampling from sessions. Again, higher EXP in initial sessions predicts success, but further increases in EXP during therapy strengthen successful outcome. Another recent study (Warwar, 1996) took one High EXP and one Low EXP session from each of fourteen depressed clients and found that Higher EXP sessions correlated with better session outcomes. Similarly, Kubota & Ikemi (1991) found sessions rated as successful by clients had higher client EXP levels.

Focusing and Psychotherapy Outcome:

Twenty three studies find that Focusing, measured by instruments other than the EXP Scale, correlates with successful outcome. They are summarized in Table 2.

In a Belgian study, Leijssen (1996) audio taped 810 sessions from 26 clients over six years and conducted a series of analyses. In an initial study she took sessions with explicitly

positive and negative evaluations by client and/or therapist. To be included as positive, the client had to say something spontaneously about the helpfulness of the session, without the therapist asking. Transcripts of the complete sessions were read, and focusing was judged present when the therapist gave a focusing instruction and the client accepted the invitation, or when the client spontaneously did one of the six steps of focusing. Seventy-five percent of positive sessions contained focusing, and only 33 % of negative sessions contained focusing.

In a second analysis, all clients who successfully terminated therapy in less than 20 sessions were studied. "Remarkable was the prominent use of focusing in all eight cases. Almost every session acquired an intense experience-oriented character and the client discovered aspects of the problem which had remained hitherto out of reach. All these clients achieved contact with their bodily felt experience without being flooded by it. Four of these clients seemed to find a personal form of self-transcendency during focusing." (Leijssen, in press)

Sachse's (1992) research over many years has not been reviewed in depth in the United States. He found that clients who received focusing instructions as part of client-centered therapy had significantly better outcomes on Therapist Success Ratings, Client Ratings of Success, and the Client Change in Behavior and Experience Questionnaire than clients who received only client-centered therapy. In a second phase, Sachse's Focusing Rating Scale was applied to tape recorded *first* sessions for each client in the focusing group. Clients were rated on how far they were able to progress in the steps of focusing, and then divided into High (Stage four and above) and Low groups. The clients in the High Focusing subgroup scored better on the Therapist Success Rating and the Client Change Questionnaire. Focusing ability in the first session predicted outcome. It was concluded that just the introduction of focusing instructions into client-centered therapy has a significant, positive effect on successful therapy outcome**.** The study again supports the finding that focusing predicts success from the beginning of therapy.

Sachse (1990) found that "depth" of client experiencing in the middle phase of therapy is related to success, measured by objective personality tests and even more so with therapist estimates of success. In further studies, the therapists of successful clients made significantly more "deepening processing proposals" than the therapists of less successful clients,. and a higher percentage of the successful clients responded to them. Iberg (1998) also found that client rated focusing events were related to improvement in therapy, measured on the Symptom Checklist Outcome Questionnaire. Lietaur & Neirinck (1986) asked clients in post session questionnaires what they felt had happened in the session that was "really helpful". A content analysis was done using a category system derived from the data. A cluster of focusing related factors, "deep exploration of experience," "experiencing fully," "fruitful self-exploration" were most often identified as helpful and best discriminated the most from least successful sessions.

Focusing-Oriented Therapy has been found to correlate with successful outcome for prison inmates (Wolfus & Bierman 1996; Goldman et al 1996)), psychotic patients (Gray, 1976; Hinterkopf & Brunswick 1975; 1979; 1981; Egendorf 1982), the elderly (Sherman 1990) and in patients with health related issues (Katonah 1999; Shiraiwa 1998; Holstein & Flaxman 1997). Focusing achieved desensitization as effectively as the use of behavior

therapy (Weitzman 1967) and Focusing was equivalent to RET in successful stress management (Weld 1992). Focusing and Gestalt therapy were both found effective in resolving a specific therapy task and on outcome measures, compared to a control group, but Gestalt therapy was more effective than Focusing (Greenberg & Higgins 1980). Focusing was included as part of the process experiential therapy treatment condition in several studies (Greenberg & Watson 1998; Elliot et al 1990) which showed change effects comparable to behavioral studies with depressed patients.

Can Clients Be Taught To Focus and To Increase EXP Level?

This question is important, given the replicated finding that Focusing or Higher Experiencing in first or early sessions predicts successful outcome and that short term successful clients focus during every session. Thirty nine studies find that Focusing or EXP level can be increased by training or specific therapist interventions. (Table 3)

Durak et al (1997) measured client EXP in two therapy sessions before and two after focusing training. The whole group was higher on EXP after training. Of the ten clients who started at an EXP level below 3, six were rated as effectively trained. Of these six, 4 were then successful in therapy. Of the four clients who started low and were not successfully trained, one succeeded. Of the 7 clients who were high on EXP in pre-training sessions, 6 were successful in outcome. This study indicates that people who come into therapy without the ability to focus, can be trained to do so and are then able to succeed in therapy.

Eleven more studies (Leijssen 1996; Clark 1980; Schoeninger 1965; Olsen 1975; Gibbs 1978; McMullin 1972; Hinterkopf & Brunswick 1975; 1979;1981; Bierman et al 1976; vandenBos 1973;) found that EXP level or Focusing ability can be increased by training, although the increase is not always maintained after training is completed. Having a listener who refers to the focuser's experiencing and who helps the focuser find a right distance from the problem, creating a safe space (Tamura 1990) and "trusting one's experiencing," and "clearing a space" (Morikaya 1997) were identified by clients as factors that helped them focus.

Therapists Can Help Clients Focus During Sessions Or Can Hinder Them:

In a series of studies, Sachse(1990) did a fine grained analysis and found that therapist "processing proposals" can deepen or flatten subsequent client responses. He developed a Client Processing Scale and a Therapist Processing Scale, based on Gendlin's Experiencing theory. The higher stages are focusing. The Therapist scale rates the level which the therapist intended to facilitate in the client. Sachse established reliabilities between .79 and .94. An initial study analyzing 1520 triplets (C-T-C statement units) from 152 clients at mid therapy, found that clients deepened their process 70% of the time when the therapist made a deepening proposal and flattened their process 73% of the time when the therapist made a flattening proposal. As mentioned above, therapists of more successful clients made more deepening proposals than those of less successful clients and the more successful clients accepted the deepening proposals their therapists made more often than less

successful clients. These findings are corroborated by two studies (Yakin 1970; Adams 1999) that used the EXP scale to analyze triplets. Elliott et al (1982; 1983) found greater residual gain in EXP following therapist interventions rated as high in helpful experiencing, depth and empathy.

Three studies (Kris 1992; Jennen 1978; Gibbs 1978) find that Therapist qualities of Empathy, Depth, and/or High Therapist EXP level correlate with higher Client EXP level. One study (McMullin,1972) showed that even when therapists were instructed to deliberately not express Empathy or Positive Regard, client EXP Level still increased when Focusing instructions were given.. Most researchers have looked at the effect of therapist interventions or conditions on client experiencing. Several studies looked at the impact of higher client experiencing on the client's perception of the therapist. Vanderveen (1967) found that higher Experiencing clients perceived their therapists as more congruent and that client EXP level predicted the perception of the therapist's congruence and empathy three months later. Elliott et al (1982;1983) found that higher client EXP segments correlated with the *following* therapist statement being rated as more helpful by both therapist and client. The experiencing level of our clients may affect our own capacity to be helpful.

Other studies found focusing training or higher EXP level in trainee therapists, compared to controls, correlated with more Empathy (Corcoran, 1981), better ability to sustain facilitative communication during action-oriented skills training (Rennie, 1985) and to scoring higher on Spontaneity, Feeling Reactivity, Regard and Facilitativeness, rated by volunteer clients (Swaine 1986; p= .06 to .09)

Therapist interventions in other orientations increased EXP level or Focusing ability from pre to post measures or compared to controls. This included good psychoanalytic interpretations (Fretter 1985; Silberschatz 1977), gestalt (Klein 1970; Greenberg 1980), guided daydream (Smith 1980) , Encounter Group Training (Tetran 1981) and Re-Evaluation Co-Couseling (Riemer, 1965). Meditation (King, 1979) plus focusing and GSR biofeedback training plus focusing (Henderson 1982) increased EXP more in comparison to focusing instructions alone. The gestalt two chair work increased EXP more than focusing instructions with empathic responses did. Not only did the Gestalt work increase EXP level, but it moved it into the higher range, which is focusing. Except for this study, it is not clear whether any of these other interventions increased focusing ability or just emotional involvement, since stage data for the increase is not reported.

Training Therapists to Focus Helps Their Clients Focus:

Sachse (1999) developed a training model for therapists. He hypothesized that therapists who focus and also understand it theoretically will be better able to help clients focus. Standardized focusing instructions are not as helpful as when the therapist can adjust the focusing intervention to "fit" a particular client. Forty therapists received focusing training for six months and were rated for Focusing ability on the FRS Scale. The therapists then did focusing sessions with their clients. These sessions were judged for "realized fit," the therapist's capacity to give client-specific focusing invitations. The intent was to help the client arrive at a felt shift, working with intervening process steps. The therapist must

empathically accompany both the content and process, in what Sachse calls, "Process Empathy." Therapist focusing ability and technical knowledge score predicted fit ability at a highly significant correlation of .75 p= .001. Two further studies (Sachse, 1999) found a high correlation between the therapist "fit" ability and the client's ability to focus.

Physiological, Attentional and Cognitive Correlates of Focusing:

Focusing is a kind of inner attention that is based in the body. We talk about a **"bodily felt sense"** of our situations. Focusers or high EXP subjects are better able to discriminate physiological states (Kolilis 1988) and the process of focusing is accompanied by body relaxation indicators (Gendlin 1961; Bernick 1969). The felt shift correlates with an increase in EEG alpha frequencies (Don 1977).

A series of five studies (Zimring 1974; 1983; 1985; 1988; 1990) show that performance on complex mental tasks requiring attention to internally generated stimuli is increased by the first step of Focusing, Clearing A Space. In line with the idea that focusing enhances non automatic cognitive process, Focusers were found to do better on measures of creativity (Gendlin 1968), intuition Vandenbos 1971), flexible use of attention (Oberhoff 1990; Iberg 1990) and conceptual complexity (Fontana 1980). Focusers can maintain concentration and withstand distractions while attending to an internal body sense (Tamura 1987; Oishi 1989; Oberhoff 1990.)

Personality Correlates of High EXP or Focusing Ability:

Higher EXP subjects were found to be more anxious and depressed (Fishman 1971) and insecurely attached (Halsey 1991). However, they also have higher scores on "intelligence, ego strength, character and self-control, emotional stability, tender mindedness and introspectiveness."(Gendlin 1968) They repress less (Platt 1971; Schneider & Sachse 1991), are less defensive(Summers 1980), are more self-disclosing (Stiles 1979), attribute difficulties to internal and emotional causes(Fishman 1971) and are more able to articulate previously unknown aspects of self (Pattyn 1975). They are more psychologically differentiated (Wexler 1974; Hendricks 1986) and have better ego strength (Miller 1970; Ryan 1966; Atkins 1976; Warner 1979; Tarule 1978) They have more mastery and insight (Olsen 1974; Riemer 1975) and deal with stress by more active involvement rather than avoidance (Grindler-Ketonah 1999 ; Stukes 1979; Kabsfird & Birdub 1983). These findings make sense together, indicating that focusers have a capacity for a wide range of internal experiences both positive and negative in the context of a stable personality structure. They engage issues and problems, rather than avoiding or repressing. These findings are relevant to therapy. These characteristics are those we wish for in clients and consider aspects of a mature personality. These findings further support the idea that interacting with clients in therapy in a way that helps them become able to focus is itself a desirable developmental process.

Discussion of the Findings:

The following are strong, repeated findings:

- Clients who process in a High Experiencing manner or focus do better in therapy according to client, therapist and objective outcome measures.
- Clients and therapists judge sessions in which focusing takes place as more successful.
- Successful short term therapy clients focus in every session.
- Some clients focus immediately in therapy; Others require training.
- Clients who process in a Low Experiencing manner can be taught to focus and increase in Experiencing manner, either in therapy or in a separate training.
- Therapist responses deepen or flatten client Experiencing. Therapists who focus effectively help their clients do so.
- Successful training in focusing is best maintained by those clients who are the strongest focusers during training.

Some of the studies can be faulted methodologically because reliability is low, sample sizes are small and control groups are lacking. Other studies have a small spread of Experiencing Level, with few clients reaching the higher ranges. Higher Experiencing can improve therapy outcome without reaching the Focusing stage, but if clients at Stage 4 and above are separately looked at, as in Goldman's study (1997), the correlations with successful outcome are even stronger.

The finding that Higher EXP and Focusing correlate with success holds across cultures, therapeutic orientations, different patient populations and different modalities of outcome measures. The client-therapist relationship is well recognized as a major factor that makes therapy successful, aside from specific effects of orientation. Focusing seems to be another such cross factor. Whether the client is processing at this body felt sense level should be taken into account, regardless of therapeutic orientation.

For clients who can focus immediately, usually the therapy process is quickly and successfully established. Helping the client trust this already developed capacity leads to steps of change, as will be seen in the Practice Section. For clients who lack this ability, learning it becomes a crucial issue.

Since the impact of therapist responses is so strong in deepening or hindering client process, and since therapists who can focus enable their clients to focus better, the implication is that therapists should be trained in focusing. Focusing does not conflict with any therapeutic method. The therapist who does not recognize this process may inadvertently discourage the beginnings of focusing in the client. As Experiential therapists we are happy when our clients say, "it's vague", or "I don't have words for it." We encourage them to stay with exactly this felt, but not yet symbolized experience. We become comfortable with "not knowing" the answer before our client does, and with not imposing our concepts or models on our client's richer experiencing.

With Schizophrenic patients, even slight development of Experiencing capacity seems to be helpful. In an area where there is little effective help other than medication, this repeated finding deserves attention. If schizophrenia involves cognitive and attentional difficulties,

focusing training may help patients be less overwhelmed by stimulation. Helping such a person distinguish between emotions and felt senses and providing an interaction that attends to the person's body sense of situations helps experiencing become ordinary and manageable.

Focusing occurs at the mind-body interface. Carrying forward stuck situations so that they release in the body probably aids healing. The physiological, health and immune system (Lutgendorf et al, 1994) correlates suggest that focusing be tested as an intervention both for prevention and for coping with illness. Sachse (1991) found that 95% of psychosomatic patients do not form a felt sense. If they could be taught to do so, this might decrease such illnesses.

From Research To Practice

The Interaction is First

The basic criteria of Focusing Oriented Psychotherapy is whether the client's experience is being carried forward in the moment in the particular interaction with the therapist. We want to interact with our client in such a way that the client can contact a bodily felt sense of life situations. To do this requires that we respond to that which is vague and unclear, at the edge of the client's attention. If we pre-define or rely on a technique or model to form our responses, we will not be able to hear what is sensed by the client but not yet articulated. Many clients have only a fragile connection to their felt sense. If we don't respond to it, then they cannot enter further into it.

Listening is the Baseline

We listen to the person's experience, rather than to our ideas about the person. We say back what the client *intends* to convey. In addition to acknowledging the client's experience, this allows the client to resonate the words or images against the felt sense and correct them or see what emerges next. We listen to the texture and intricacy in experience and respond to the unclear edge from which steps of change come. What will carry forward the client's experience is very exact. Just this word, action, image touches or moves something right now, while many others do not. We try to protect the emergent process, knowing it is more likely than anything we might come up with to carry experience forward. This is why the therapist baseline behavior is an empathic listening attitude. Empathy, congruence and positive regard are increased in both therapist and client when we let words or expressions arise from the felt sense.

When the Client and Therapist Both Respond to the Felt Sense

In the session below, we see what focusing looks like when it is working. Sometimes we think of Focusing in steps. Although not formally named, the client forms a **felt sense, asks (**inner questions are directed into the felt sense), **symbolizes** (lets words/images emerge from it)**, resonates** (checks to see if there is a response in the body to the words) and **receives** (makes welcoming, non-judgemental room inside for what has come). There are a

series of small **felt shifts** and beginning **small steps** of change. This client is in her early thirties and has told a dream. The therapist invites the client to get a felt sense of the whole thing.

T1: Can you sense where in all that you want to pay attention? (Focusing question)

C1: (Silence as she checks inside.) The only place I can really **connect to feeling-wise** is if I say to myself..."maybe my infinite energy doesn't have to come through being sexual, maybe I can let it...maybe it just wants to come now..."

(The client has found the issue that has a bodily felt dimension, rather than just words.)

T2: I want to say that back to you...(Saying back welcomes the person, and exactly whatever content came and lets the client resonate the words with her felt sense.) You get a real feeling response when you say, "maybe now the spiritual can come in its own form, it doesn't have to come only through being sexual."

C2: Yes. And that's very hard for me but that **feels like the right place**.

(What she means by "place" is a felt sense in her body. What she means by "right" is a quality of resonance. Her body says, "yes, that is right," and she also senses that there is more that wants to open right at that point.)

T3: Oh, **there's something that's hard about that**.

The therapist is acknowledging the client's felt sense. Notice that he says "something." He and the client are both comfortable with the edge being unclear. The therapist has no need for the content to be clear before it arises.)

C3: (Silence as she asks herself what is in this sense of "hard") ...There's **some way that I don't want to let go** of it only coming through the sexual space... (Beginning symbolization from felt sense. She doesn't yet know in what way this is true, but can sense there is "some" way. It is sensed but not yet in words.)...like...that's the only place I've known it coming through, so to let loose at all...maybe then I won't have it at all..**that's where it is (**felt shift**)**...(begins to cry--a whole body response.)... it's like...it's so important to have a channel. (Creates a metaphor) So if they came along and said, "well move over here and you can have an even wider channel..." It's so scary (sobs) cause (sobs) what if you lose the only channel you have....

T4: I see.

C4: **There's more there** (felt sense). ...**What is that**?(She is asking into her felt sense. This is not a cognitive or deductive question.) ...**why is that so scary**? (Again she is asking right into her felt sense which then starts to open.) ...It's also **something in it like** ...(sobs...) Keeping the channel only sexual also narrowed how much energy could come through or

something...some part of it is really scary..**maybe I could really live in relation to that energy all the time** if I didn't restrict it to that channel (symbolization). (Felt shift)

T5: Scary to live in relation to it all the time?

(The therapist is confused by the fact that this content is the *opposite* of the previous statements. There is an exact experiential order in this kind of process but it is different than the order of logic.)

C5: Uh hum...I've always been hidden. It's saying, "don't do that anymore, .Look!...**Let your energy be visible**, **use it, live in it, that would be such a change in who I *am*!**..Be in it in the daylight. (Change Step. She is being more visible right now.)

T6: Uhmm.....let it manifest, perceive it, see it...(Welcoming, reflecting)

C6: Right... (big sigh)...(crying)..take it seriously..(big sigh, breath, quieter... laughs)...that old energy still wants to pull me down and back into that dark hole..but, it's a little more free, it's moved a little, it's like, "oh, maybe there is a road."

When people focus they use language in a new way. Notice the frequent use of open pronouns like "something," and "it" and "some". Words are being used to point towards the felt sense that is not in words, but is tangibly present. There is no way to use content words yet, without closing the felt sense.

When the Therapist Fails to Respond to the Client's Felt Sense

Unfortunately, it can happen that the client is close to focusing and the therapist does not recognize the client's felt sense. Because the therapist is the expert, the client may become confused, feel inadequate, defer to the therapist's authority and disconnect from her direct experience. We saw in Sachse's study, that a "flattening" response by the therapist leads to a flattening of experiential depth in 73% of subsequent client responses. There is an unhappy stalemate, which the therapist may interpret as "resistance," on the client's part, when it really is an undeveloped capacity in the therapist that is the problem.

C1: And yet I feel...***there's something underneath it all but I don't know what***... (felt sense) and if I kind of knew what it was...I might feel differently, I don't know. But it's ***vague right now***.

T1: Okay. If things could be a little more ***definite.*** If you were really able to ***identify the cause***..you really think that you'd be able to ***cope*** with it then. But right now you can't seem to put your finger on what the ***real problem*** is.

C2: Yuh..and...that..like when you say that...that makes me mad because I feel...you know like I'm..intelligent. I can figure things out. And yet...right now I don't know what the hell's going on with me.

The therapist is unable to respond to the client's felt sense, which is the rich intricate, not yet known place from which movement would come. The client has given a clear prescription of what needs to happen next. She literally tells the therapist that if she could just sense more into this unclear place underneath it all, she has a sense that something would move from there. Because the therapist does not know about this level of process, he uses his words in a cognitive, closed, defined way that cannot point to or invite what is not known to open. The client is left self critical and, probably, rightfully, angry at the therapist. This kind of interaction underscores the need for therapists to develop this sensitivity as part of their training.

When Clients Do Not Focus

There has been a great elaboration over years of how to help clients learn Focusing when it is not spontaneously present. (Weiser Cornell 1996; Hendricks 1986; Wiltschko 1996; Leijssen 1990; 1998a). Because a felt sense is initially a vague body sense of a whole situation, it can be elusive, especially compared to intense, obvious emotions or to interpretations which let us feel we understand ourselves. The following excerpts illustrate some typical difficulties and how we can respond to help a felt sense form.

Getting A Felt Sense Instead of Just Thinking or Deducing or Reporting

When clients do not know how to focus, there are several typical problems. (Gendlin, 1996). Clients can be stuck in ideas about themselves instead of seeing what is actually in their felt experience. The client below felt fearful in his legal work and offered ideas about why he might be. The therapist invites him to sense directly into that whole thing he calls "fear." The client is unable to do so and continues to get involved in ideas about it. The therapist again invites him to form a felt sense. He is able to briefly do so, but then jumps back up to the level of ideas and analyzing. But this has been a beginning.

T1: So ***wait for a minute*** and let's see if we ***can sense what the fear is***. Can you do that? Is that a right question? ***Where in all this would you like to sense into it more****?*

C: (Client does not stop and form a felt sense. He continues on with his ideas and analysis.) Yeah. I think that's right. I know in the last sessions there's been a tremendous duality in the images we found. Freedom and resistance. Adult and baby. An assertive pushing out into the world and a pushing away. Which would also be freedom and separateness.

T2: So there are all kinds of ideas about it, but let's ***just stay with sensing the fear. Can you feel it right now? Can you sense that whole thing about work that feels fearful in your body right now?***

C3: (Silence) ***Part of the scary feeling is a vague sense*** (Felt sense) of being adrift and groping.

T3: Adrift and groping...

C4: ***Like I'm in outer space and I can't grab onto anything...***(Words coming from felt sense)

T4: Can you just check that image of you groping and can't grab anything in your body. Does that feel right?

C5: Very much. (Resonating) ... And now that I have it I remember having similar kinds of images in different sessions in different ways.

A client like this will often say things like, "Well, I probably feel this way because of the way my parents treated me when I was little." Or, "My therapist says I must have been very angry as a child to have withdrawn so much." Such clients do not have their own direct sense. Connections do not emerge from their own process, but are imposed down on their experience either by themselves or the therapist. This kind of client is also likely to narrate many reports of events during the week with no reference to personal felt meaning of the events.

Clearing A Space or Getting Distance Instead of Drowning In Emotions

The other dead end in therapy comes when clients drown in emotions. They just re-experiecne painful events or feelings. Focusing distinguishes between emotions and a felt sense. An emotion is narrower and tends to be the "universal" response to given situations e.g. if someone dies, one is sad. To get a felt sense, one must step back and form one's own complex, unclear sense of some "whole thing." This will be particular to the individual. The elderly client below has suffered from a very severe depression all of his life and has been completely identified with intensely painful emotions. .

C1: I feel very upset. I cannot take action. I didn't call him and follow through. I never follow through. I've been this way my whole life. I think this is related to my mother always saying to me, "Dan, remember, you are very sick." I feel terrible. Now I will be depressed all week. I don't want to leave feeling like this! (The client is angry, agitated and depressed).

This is familiar. Any approach to his relationship with his mother sends him down a chute of extreme bad feeling. He may not sleep well and his agitation and depression interfere with his life for several days. He has no capacity to process this experience. He is simply retraumatized each time.

T1: Well, this is an old place, where you just slide into that bad feeling. That's an old familiar place. We don't need it. Lets see. **Why don't you put that outside of you**. That was *her,* not you. **Let's put that whole thing about her out there** on the other side of the room.

C2: (Looking slightly startled and puzzled.) I didn't know I could do that!

T3: Well you can just take that **whole thing about her and put it all as far away as you need to get it out of your body.** How about across the river in New Jersey?

C3: (Client begins to laugh!) Yeah! I think that would be good! (**Gestures with his hands as he pushes that whole thing about her out from his stomach area** towards the river.(Clearing A Space and Getting Distance**.**)

T4: You have a right to have some space for you.

C4: I do? (Slightly tearful) That's the first time in my life I ever had the feeling that I didn't have to accept that. (Small felt shift with body easing.)

This client gradually became able to discern when he was not at the right distance from emotions. Falling into emotions is not focusing, nor are abreaction or catharsis.

Friendly Focusing Attitude Instead of the Inner Critic

Getting a felt sense and letting it unfold requires an inner attitude of friendliness, waiting, listening, and tolerating not yet knowing what will come. Many people have trouble maintaining this attitude. They attack or disrupt themselves. Often, just at the point where the clients come to the edge of what they know, they back away with a comment like, "Oh, I don't know,' or "This is too stupid," or "It's too vague." "It's not clear." It is just at this edge, when they are finished with what they have already thought, that a felt sense can form. A self attacking attitude is one of the major blocks to focusing. We have many ways to help clients move past these disruptions. Below is a simple example where the client begins the session attacking herself and the therapist ignores the self attack and the content details of her story. Instead, the client is invited to step back and form her felt sense of the whole situation. She is able to do so. What unfolds from her felt sense surprises her and is a small felt shift. Notice how differently she feels and how much better connected to herself she is after this simple exchange.

C1: I feel like no one wants to relate to me. Like **something is wrong with me** and I don't know what. Like **I am a monster**. (Self attack) I know what set off the feeling. Maybe I should tell you that. I feel like I'm never going to have just regular relationships. Last night at church... (She tells of a brief conversation with a friend about babysitters in which she ended up feeling criticized by her friend.)

T1: So, can you just step back a little and get a sense for that whole situation, that whole thing with her. What is your sense of the situation?

C2: (She is quiet, getting a felt sense, and then begins to cry.) **Oh! I know what it is. I was so *excited!*** (Symbolization from Felt Sense). My daughter wants to babysit so much and I thought it was going to happen. And I feel like I spoiled it...I felt so excited I think I didn't pay attention to what was coming back to me from her. I just kept talking because I was so excited and I wanted it to happen...**actually now that I think of it, I did feel sort of like I**

didn’t really agree with some of the way she was thinking about child care. I remember feeling like **she seemed sort of overly protective or rigid in her approach.**

T2: So, in your excitement you really didn’t pay attention to some of your own signals. You actually didn’t like what she was saying, but you didn’t stop and pay attention to your own feeling.

C3: Yeah...that’s right...I feel better now that I have a sense of what happened for me.

The emergence of the words, "Oh! I know what it is. I was so excited!" is a small felt shift. The words are new and surprising to the client. The content "excitement" is quite different from "I am a monster." And the movement of the felt sense into words that carry her forward in her body is felt as relief and tears, a whole body response. Change is directly felt in the body in this kind of therapy. The client does not need to speculate about whether she is changing. It is an immediate experience. This is also an example of the experiential version of a psychodynamic point. The concept that depression is anger turned inward fits this material. But, the emergence of her dislike from her own sense is more powerful than if the therapist had offered the interpretation that she was angry at the friend. We can see here a small step of change and ego development in her ability to form her own perspective.

Implied Forward Direction and Emergence of Steps

In the section on basic concepts, we spoke of living organisms implying their next step of living in a finely ordered, experiential way. The body "knows" what needs to happen next. Sometimes the felt sense does not respond to waiting and sensing into it with the question, "What is in this whole sense?" Then we can ask a different kind of question. We ask, "What is needed here?" or, "What would be right to happen next?" These are not abstract, intellectual questions, but rather focusing questions that ask directly into the felt sense of what would carry life forward now in this situation. Then we wait and see if something forms. The example below marks a turning point in therapy for a client with a severe post traumatic stress disorder, when her body responds to the question, "What does it need now?" She has been unable to find a proper distance from her abuse experience and so cannot focus on it. She has flashbacks, partially dissociated states, is chronically hyper vigilant and feels terror most of the time. She feels deep grief that, even though she functions at a high level job, normal life is passing her by and she will never be able to have children because she cannot tolerate sexual contact with her husband. When she focuses, what always comes is her longing to have a child. She is 38 years old.

...The tension level has been even more than usual and it’s unbearable even the way it usually is. There’s a racing in my chest. Nothing we are doing is touching this. Nothing touches it. I’m taking something like twenty pills a day right now and nothing is any different than it’s ever been. I don’t know what to do.

Therapist and client spend about 40 minutes trying to find some way to work with this tension, to no avail. She is unable to get a felt sense of it and nothing else helps either. She remains locked in this awful tension state that has no psychological content. The therapist

then asks her this other kind of focusing question, trying to engage her body's own knowledge or implying of what is needed now.

T1: So, why don't you gently bring your attention in the front part of your body. Keeping your attention there, let's see if we can ***get a sense, maybe an image of what would help. Let's ask inside, "What does it need now for all this whole thing to gently ease, so you can feel OK in your body?"***

C1: (Long silence) ***I get two things*** (words emerging from the felt sense)....One is if I didn't have to leave until I wasn't worried anymore about leaving. If I didn't have to be aware of the clock ticking...And I got another thing. A dog--a Collie. (She begins to cry. Felt shift with body response.). I don't know if I've told you but when I was a kid and so scared all the time, so terrified, I used to ask my parents for a dog, a Collie, like Lassie. Lassie sat on Timmie's bed and would have protected him from anyone coming in the window, so no one could hurt him. And Lassie was his friend and kept him company too. I used to feel a Collie could make me less scared and be my friend. Every single Christmas, every Birthday, anytime I would ever get anything, I would ask them for just that one thing, a dog. They always said if I did something a certain way or for long enough or whatever, they would give me one. But they never did. They always said I didn't do whatever it was good enough or some other excuse. (She is still crying.)

T2: So you knew even then, as that little person, something that would help, but they wouldn't do it.

C2: Dan (her husband) says they were really mean not to give it to me.

T3: Yeah, I was just feeling the same thing. I feel mad at them. But, ***that whole thing is what comes now. A feeling that if you had your own Lassie that would help, would let the tension ease inside.*** (Therapist is returning to the felt sense. By saying it back the client can reconnect to it.)

C3: I asked Dan could we get a Collie. He said yes. But I'm the one who always nixes it. (She gives many practical reasons why it would be difficult.)

T4: But, maybe it would be right, now. ***You have a feeling sense that getting a dog would make you feel more safe in the inside place and like there was company.*** (Again the therapist is returning to the point where there was an opening, a felt sense of what would help.)

C4: Yeah. Last week Dan and I were in the bookstore. He found me reading a book on training Collies. He said, "I'll buy it for you." I said, "Naw. That's OK."

T5: So, maybe you could start with getting the book? (Therapist is suggesting a small step of change)

C5: Yeah, maybe. Dan said he was scared if I got a dog I would stop trying to get pregnant.

T6: No, it isn't like that. Having a warm living creature to love and take care of would help your body relax into getting pregnant..***maybe it would be right to let yourself have*** that now...You could get a dog for yourself now. (Therapist is still trying to protect and make room for the step that came, so it isn't overwhelmed by all these objections)

C6: Maybe I could get that small kind of Collie that only grows to two feet.

T7: Well, how about not compromising, but really doing what that place needs?

C7: (She is quiet for awhile. A laugh wells up in her body.) Hey! For Christmas! I could get my Lassie for Christmas.

T8: Oh yes! That's just right. (Notice that the client feels better in her body. She has cried and laughed. Her body is no longer locked in contentless agitation.)

The client's felt sense has responded to our focusing question of what is needed to ease this whole awful tenseness. The therapist tries hard to get the client to receive, protect and make room for this step that her body has formed. Getting a dog is certainly not the therapist's idea or a traditional formula for treating this kind of problem. It emerged from the intricate complexity of this person, now.

Four Months Later:

C: The other day I was looking at Tucker, how big she is and I was thinking about how we roll around on the grass and wrestle and squeal and chase each other. I thought, "Gee, I'm glad you're not some little fluff dog. You're a real Lassie."...I thought of you saying to me ...remember how I said, "Well maybe I could get a toy Collie," and you said, "How about not compromising. How about getting your real Lassie." I think that's a metaphor for a lot of things.

Twenty Months Later in a note to her therapist:

You've probably looked at the picture I sent....Leah (her baby daughter) is getting big ...She is such a joy to me. I can't even put it into words in any kind of right way. I just hold her and cuddle her and thank God every day for her. I wish we had about four!

Focusing touches a level in us which has its own direction and momentum. When we can get out of the way, the organism creates and implies precise next interactions. We are too often trained to relate to our client's experiencing through concepts or techniques. We are supposed to be "experts". In our anxiety to perform well we can impose our concepts, missing the experiential intricacy and the unfolding inherent in the client's own process. The small needed steps of change that emerge directly from the client's felt sense of the problem are more creative and exact than we can generate.

Conclusion

Clients in a variety of therapy orientations, with a variety of diagnoses, do better if they focus. The therapeutic relationship can allow this capacity to develop and be sustained, until it becomes available to clients in their everyday living. Focusing Oriented/ Experiential therapy works with a level of human process which is still not well known. It is not emotion, not thoughts, not literal body sensations. It is rather a felt sense of our situations. This process can be found by every human being. One spends time with a bodily sense of a situation, problem, difficulty or puzzle, without yet having words or symbols. At such an unclear edge, new and creative steps of living emerge. This could be a dancer waiting for next steps in her choreography, or a poet sensing for the right word, or a physicist pursuing an implicit sense of the answer to a puzzle. As therapists we can point to this felt sense level by asking the client the simple question, "How does that whole situation feel in your body?" This may immediately deepen the process. Because the relationship is vital, focusing partnerships and training workshops can be offered as a part of therapy. One hour a week with a professional therapist is very little, especially if it is only in this interaction that the client can be in this kind of process. People can be taught to provide this kind of interaction for each other.

The research developed in an historical sequence from the early studies relating Experiencing to outcome, to the formulation of Focusing and its relation to outcome and then to the large body of research on teaching Focusing to clients and therapists. Many of these studies, are part of coordinated research efforts in major universities in the USA, Canada, Belgium, Germany and Japan, including recent studies with good reliabilities and more sophisticated design which build on and replicate the findings of the early studies. The fact that therapy outcome and session outcome, measured by therapist, client and objective ratings all correlate with Experiencing or Focusing, and the relation to health, physiological and personality measures, lend support to the findings. The research, theory and clinical base of Focusing Oriented/ Experiential Psychotherapy has influenced most subsequent developments in the Humanistic Psychotherapies. Many Humanistic approaches have incorporated the notion of manner of process and responding to the client's bodily felt sense and implicit meanings. Focusing, embedded in its Client-Centered roots is a therapy in itself, but can also be added to any model of therapy and ground its effectiveness in the Client's experience. In clinical research, we are gradually identifying significant cross factors of which any therapist or clinical researcher would want to be aware. How our clients are relating to their own on-going, body sensed experience is one of those factors.

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Table 1 Experiencing Level and Outcome

Study	Experiencing Ratings	Orientation Population	Outcome Measures and Findings
Kirtner & Cartwright 1958	Manner of Process rated for first	42 University counseling center clients.	Higher Process manner in first session differentiated success and failure cases, measured by Therapist

	therapy hour.	CC	rating on a nine point scale.
Tomlinson, 1959	Process Scale Early sessions r = .47 - .63	20 cases CC	High Process early in therapy correlates with better outcome on multiple criteria
Gendlin et al, 1960	Counselor ratings on "content" vs "process" Scale 7th and last sessions.	39 University Counseling Center Clients 16 Therapists CC	Counselors rated successful clients higher on 3 process items: Express feelings rather than talk about them; uses the therapy relationship as a source of new experience, and uses the relationship as an instance of difficulties he has in living. Finding is for the last session ratings, not found for 7th session ratings.
Walker et al 1960	Process Scale Change r = .83	6 cases, 3 high success and 3 low success	Successful group, judged by Counselor Ratings and Objective Measures, shows more change to higher levels of Process
Tomlinson & Hart 1962	Process Scale Early and Late sessions r = .65	5 more success 5 less success Replicated Walker Study	High Process in early and late sessions discriminates the more and less successful cases on multicriteria outcome measures. (T and C outcome ratings and Q sort) 4 of 5 in more successfel group at Stage 4 and above. In less successful group, none reach Stage 4.
Truax & Carkhuff 1965	Depth of Intrapersonal Exploration Scale ratings of every fifth session	14 Schizophrenic	The greater the patient's intrapersonal exploration, the greater degree of constructive personality change, measured by change of pre and post tests, and time spent hospitalized.
Ryan 1966	EXP Change r=77	Diverse 32 University Counseling Center clients	Higher EXP in clients relates to better outcome, measured by Hunt Kogan Movement Scale and Terminal Counselor Ratings of Client Self-Perception
Rogers et al 1967	EXP Average for Treatment	14 Schizophrenics	Higher EXP correlated with therapist and client ratings of success, scores

	Course r= .76; .79	Control Group	on the MMPI Sc Scale and Time out of Hospital.
van der Veen 1967	Process Scale : case means over five sessions spread across the therapy	15 Schizophrenic Also analyzed subgroups of most and least successful	Higher average process level related to better combined outcome score, and MMPI change score and Clinicians Rating Score. Slope scores not significant.Most successful subgroup showed more patients reaching high stages of the Process scales.
Tomlinson 1967	Change	Schizophrenic and Neurotic	Success correlates with increased EXP for whole group. Neurotics higher than schizophrenics
Gendlin et al 1968	EXP Scale Early sessions and Change	Reanalysis of 8 Neurotic and 12 schizophrenic	Higher EXP in early sessions and more increase in success Schizophrenic group starts lower on Exp then Neurotics
Kiesler 1971	Sessions 1-30 rated on EXP scale. (Included reanalysis of Roger's data for psychotic clients) r=.79	38 clients: 12 psychotic, 26 neurotic. CC, Adlerian, Freudian and Electic	More successful have higher EXP in both groups. Successful neurotics highest EXP; less successful next. More successful schizophrenic next and less last. Neurotics higher on EXP than Schizophrenics at all points. No overlap. However, the mean scores of all clients were in the low stages of the scale. (1.77 – 2.44)
Fishman 1971	EXP Late r=.92 Early ns	Dynamic	Therapist, Client and Independent measures of success correlate with High EXP in late sessions
Custers 1973	EXPChange Early ns	neurotic	More change to higher EXP over the course of therapy relates to better outcome, measured by MMPI and Q-sort scores.
Richert 1976	EXP samples from latter half of therapy	26 clients, 13 therapists.	Higher EXP level relates to less Satisfaction at end of therapy, measured by pre-post change in clients' satisfaction with self

			descriptions that included positive and negative self statements.
Jennen 1978	Late r=.80 Change	13 patients	Higher EXP relates to better outcome on Inner Support scale of Personal Orientation Inventory.
Bommert & Dalhoff 1978	EXP at Mid Early sessions	neurotic	Successful group had a mean of 4.18. Less Successful 3.51 for mid therapy sessions. Early session n.s.
Greenberg &Rice 1981	EXP During Two Chair work	Gestalt	In Split Resolution both chairs start out at Low EXP and reach High EXP as resolution occurs.
Nixon 1982	Pre-therapy	Primal	Client ratings of success correlate with higher EXP in a pre therapy consultation session
Luborsky 1982	Early Peak Composite residual gain	Dynamic	Whole sample n.s. In a subsample of male outpatients more successful had higher Peak EXP
Elliott et al 1982; 1983	Average over therapy. 10 sessions	Electic-psychodynamic Single case	Higher EXP ratings highly correlated with client overall session effectiveness ratings.
Greenberg 1983	EXP During two chair work	Gestalt Replication	Higher EXP in 14 instances of two-chair resolution compared to 14 instances of nonresolution
Ikemi 1986	EXPon least and most successful sessions.	5 pairs in 5 Focusing sessions	Focusers selected most and least successful sessions. EXP higher in successful sessions
Johnson & Greenberg 88	EXP Scale	Emotionally Focusing Marital	Good outcome associated with higher EXP in "blaming spouse."
Kubota & Ikemi 1991	EXP rating of video segments	18 physicians and 14 students	Sessions rated as successful by the clients had higher client EXP peak levels.
Warwar 1996	One Low and one High EXP session for each	16 Depressed 16-20 Sessions	High EXP sessions correlated with better session outcomes. Therapeutic modality not related to

	client	Divided into CC or Process Experiential	success of sessions
Goldman 1997	2nd session EXP Theme-related EXP ratings for second half of therapy r=.78	35 Depressed 17CC 18 Process-Experiential	Higher EXP in 2nd session predicts outcome Second half of therapy theme related EXP at Stage 4 and even more at Stage 6 correlates with success on resideual gain scores on BDI, SCL-90R and, at Stage 6 with Rosenberg Self-Esteem.

r = interjudge reliability obtained on EXP ratings.
All studies are significant at p = .05 or better unless noted.
n.s.= not significant
CC = Client-centered therapy

Table 2 Focusing and Outcome

Study	Treatment	Population	Outcome Measure	Findings
Leijssen 1996	Experiential Psychotherapy	University Counseling Center 102 sessions	Positive or Negative C or T rated sessions	75% positive 33% of negative had focusing
Leijssen 1996	Experiential Psychotherapy	University counseling Center 8 clients	Successful termination in 20 or fewer sessions	Every session contained focusing
Sachse 1992	CC plus Focusing vs CC Focusing sessions rated on FRS	50 Neurotic clients 5 therapists	Therapist Success Rating; Client Change in Behavior and Experience Questionnaire; Client rating	CC plus Focusing group did better. High Focusing group in first session predicted better outcome.

Sachse (in press) cited in Sachse 1990, August)	CC/Experiential mid therapy session	80 Neurotic clients 30 CC/E therapists	Personality Tests Therapist Ratings Client Processing Scale	Deeper C experiencing in more successful cases on both outcome measures
Sachse 1989b cited in Sachse 1990, August	CC/Experiential mid therapy session FRS Scale	Neurotic	Client Processing Scale Therapist Processing Scale	When success, T's make more deepening proposals Higher % of successful Cs accept deepening proposal
Yakin, 1970	Concrete Effect Scale (Effect of T statement on C Focusing level); T. Set Scale (frame of reference.)	16 completed therapy cases, 8CC and 8 Psychoanalytic	CC group: C rating; TAT adjustment: Self-Ideal Q sort AnalyticGroup: P and T Final Questionnaire	Higher Focusing Level in Cs and more T. responses to C's immediately felt experience in successful cases in both groups.
Iberg 1998	Focusing Therapy	38 clients 4 therapists	Symptom Checklist Outcome Questionnaire (QQ45.2) T ratings of C Process	C ratings of two focusing indices discriminated improvement on QQ45.2; Also r w T ratings of C Process
Wolfus & Bierman 1994	1)Assaultive RWV Focusing Group 2)Assaultive w no RWV 3)Non-assaultive w no	Domestic crime prison inmates	Conflict Tactics Scale Personality Research Form Aggression Scale PRF Defendance	Improved on all measures compared to both other groups Reduces Coercive Power & Control;

	RWV		Scale	Aggression and Defensiveness
Goldman et al, 1996	RWV groups	48 Domestic Crime prison inmates	State-Trait Anger Expression Inventory	Initially higher than 90% of men. After RWV, within normal range.
Study	Treatment	Population	Outcome Measure	Findings
Gray, 1976	1) Hypnotic Relaxation with Problem Solving Suggestions 2) Focusing 3) Hypnotic Relaxation with Focusing	N = 60 Day treatment population psychotic, neurotic, schizophrenic, 78% on psychotropic medication.	PFQ r = .75 ; PFC STAI & Means-Ends Problem Solving (MEPS)	Reduced anxiety and increased problem solving for all groups. No differences between groups.
Hinterkopf & Don 1975	Pretherapy Experiential individual sessions weekly for 6 months	20 inpatient chronic schizophrenics Control group	Pretherapy Questionnaire and Pretherapy Rating Scale .85 reliability	Decreased pathological behavior, increased reality contact and emotive words.
Hinterkopf & Brunswick 1975	Teaching focusing and listening skills in pairs 8 sessions	42 psychotic inpatients Control group	Discharge Readiness Inventory	Better on Community Adjustment
Egendorf	Focusing and listening instruction	23 Chronic schizophrenic inpatients	Written and oral staff and patient evaluations	Both "overwhelmingly favorable"
Sherman 1990	Experiential reminiscence vs conventional	104 Elderly Control Group	Type of Life Review EXP	Shift from avoidant to engaged, inclusive. Continued Groups on their own

Ito et al 1994	BCS method of Focusing	Children (9-10) for two years	Self questionnaire	Self-understanding, comfortable in body
Ketonah 1999	Focusing 6 individual sessions Waiting List Controls	12 Cancer Patients; Matched pairs	Focusing Check List r=.84 MMPI Depression Scale Hardiness Scale Grindler Body Image Scale	Less Depression and better Body Image compared to controls. Clinical improvement on all measures pre and post in Focusing group
Shiraiwa 1998	Focusing Plus Body Relaxation	Cancer Patients referred by radiologist ; 3 groups, n=6/group	Profile of Mood States Questionnaire Pre and Post	Decreased on Tension-Anxiety, Depression, Fatigue and Confusion. Increased on Vigor
Hostein & Flaxman 1997	Focusing vs. Cognitive Behavior	Weight Loss	% of weight loss	Focusing better end weight loss
Weld 1992	Focusing, RET and Control	Stress Management	Symptom Check List-90-R	RET and Focusing equivalent and better than Control
Greenberg & Watson 1998	Focusing included in process experiential approach		Beck Depression Inventory	Change effect comparable to behavioral studies
Greenberg & Higgins 1980	Gestalt vs Focusing plus reflection applied to a split	14 in each condition Control, Gestale, Focsuing. 7	Shift in Awareness Target	Both Focusing and Gestalt groups show improvement over controls.

		therapists.	Complaints EXP Level r=.83	Gestalt group higher EXP levels than Focusing
Weitzman 1967	Focusing Desensitization	Case study of 3 patients	Self report & in vivo behavior	Desensitization occurred
Elliot 1990	Experiential (Focusing included with other interventions)		Beck Depression Inverntory Hamilton SCL-90	Change effect comparable to behavioral studies
Dosamantes-Alperson 1980	Experiential Movement Therapy	Neurotics	Personal Orientation Scale; Body Cathexis Scale	Better from pre to post

Table 3 Increasing Experiencing Level Or Focusing Ability

Study	Intervention	Population Measures	Findings
Leijssen 1996	Focusing Process Directives and Open Questions	4 failure clients 24 transcripts EXP Scale	All Increased EXP during training; 2 maintained
Durak et al 1997	Focusing Training	20 therapy clients EXP Scale	Pre to post therapy sessions increased in EXP. Increase correlated with successful outcome
VandenBos 1973	1) Focusing 2) Desensitization plus Focusing	78 non-focusers identified by PFC 2 training sessions in each	Focusing increased for all treatment conditions compared to controls. No difference between types of Focusing training.

	3) Affective Association Focusing 4) Controls	condition	
Olsen 1975	Image Focusing Instructions with Relaxation	26 private practice individual therapy clients EXP; PFC, IF	EXP (Reliability .76 - .80) increased from pretraining therapy sessions during training.. Most reached stage 4. `Not maintained in post training therapy sessions 67% of non-focuseres in first training session were ableto Focusing during training. Higher Focusing during training, better maintaining after.
Bierman et al 1976; Bierman and Lumly 1973	16 session Communications Workshops	3 Samples ; Job readiness	Increase in EXP for each sample
Platt 1969	1) Focusing 2)Waking Suggestion to do well in Focusing 3)Hypnosis, then F 4)F in hypnosis	120 College Students All received F in Sessions 1 and 2; then special conditions in 3 and F again in 4 and 5	PFQ (.95 reliability) and PFC-L . Focusing under hypnosis is lower than waking suggestion group and Focusing group. Waking suggestion group did better than all others. Hypnosis impedes focusing.
Clark 1980	Focusing Training Focusing instruction after baseline period	Therapy patients EXP Scale	Increase EXP when E gave focusing instructions versus baseline periods during therapy analogue interviews.
Schoeninger 1965	Self-Experiencing Training (1 session)	32 Undergraduates EXP Scale	Increase EXP in first part of analogue therapy interview (.75- .77)

Hinterkopf & Brunswick 1975	Teaching focusing and listening skills in pairs 8 sessions	42 psychotic inpatients Control group	Increased in Talker and Helper Skills
Hinterkopf &Brunswick, 1979	8 Focusing and Listening Training sessions in pairs	21 schizophrenic, acute and chronic	Increase on Talker and Helper Skills scales.
Hinterkopf 1981	8 Focusing and Listening Training sessions in pairs.	Psychotic	Increase in EXP level correlated with success
Tamura 1990	130 Focusing sessions	Questionnaires factor analyzed	Clients identified "Focuser-listener resonance" (listener refers to C experience) and "safe field" (right distance) as related to successful focusing
Morikaya 1997	Focusing session	31 students Questionnaires factor analyzed	"Trusting one's experience," "connecting to one's experience" and "clearing a space," help Ss use focusing in their daily lives.
Gibbs 1978	High vs. Low EXP therapists; Focusing vs Doodling conditions	Clients from intake list of a free clinic T & C EXP Scales	Higher C EXP in sessions with High EXP T. Highest EXP in Ss receiving pre session Focusing traiing, matched with High EXP T.
Yakin 1970	High and Low T EXP; Focusing training or controls	8 CC cases 8 Psychoanalytic cases	T. who responded to C's immediate experience produced higher C EXP. And Focusing training before sessions, also increased C. EXP.
Kria et al 1992	Therapist Referent EXP Level higher than Client EXP	Rogers therapy session with Gloria	Client EXP increased
Sachse	Therapist Processing	152 clients at mid therapy; 51	T deepening response leads to C deepening experiencing 70% of

	Proposals. Therapist intends to deepen Client's Experiencing Level.	T Client Processing Scale (EXP depth) Therapist Processing Scale	the time T flattening response leads to C flattening response 73% of time
Sachse 1990	Therapist Processing Proposals	48 Clients mid therapy; 48 CC therapists Same measures as above plus text analysis	T has strongest effect when responds to core of C statement. When T misunderstood C, resulted in flattening response 82% of the time
Sachse	Focusing training program for therapists.	40 therapists trained for six months	Therapists did learn to focus and those most able were better able to help their clients focus during therapy sessions.
Sachse students 1999	CC/E therapy	Therapist Fit Capacity Focusing Rating Scale	High correlation between T ability to fit focusing instructions to the particular client and client ability to focus
Iberg 1996	CC/E therapy T frame of reference question vs empathic clarification	Client rating of Focusing Impact Type of Therapist statement	Therapist Focusing type question quarter of way through session predicted an increased "Focusing Impact"
Mc Curry 1991	Therapist Rate of Metaphor Use		Higher Metaphor Use with Higher Client EXP
Elliot et al 1982; 1983	Therapist High empathy, helpful experiencing, depth	Single case study	Correlated with residual gain in client EXP
Jannen et al 1978	T high accurate empathy	therapy patients	Higher Client EXP in these segments than others

	segments		
Van der Veen 1967	T Congruence, Empahty, UPR	15 hospitalized Schizophrenics	Patients who had higher process levels, perceived therapists as more congruent. Process levels in first sessions predicted perception of therapist conditions three months later.
McMullin 1972	1) Low Empathy, Warmth, Genuineness 2) Low EWG plus Focusing	10 college students	Increased EXP 2.89 to 5.02 even under low attitudinal conditions in therapy analogue interview. Dropped to 3.18 when instructions discontinued
Fretter 1985	Accurate psychoanalytic interpretations	therapy patients	Increase client EXP from before to after the interpretation
Silberschatz 1977; 1981	Correct handling of transference	therapy patients	Increase in EXP from before to after.
Smith	Guided Daydream , placebo, control	19 therapy patients	Daydream Group increased in EXP over placebo and controls in post therapy sessions.
King 1979	Meditation Group Contro Group	students PFQ and PFC	Meditation group increased in focusing ability compared to controls.
Henderson 1982	GSR Biofeedback plus focusing	subjects	Increased in EXP compared to focusing training alone
Klein 1970	Gestalt training	subjects	Increase EXP from pre to post journal logs
Greenberg 1980	Gestalt two chair vs Focusing plus empathic responses		Higher EXP than after Focusing and empathic responding
Tetran 1981	Encounter Group	subjects	Increased EXP

	training		
Riemer, 1965	1) Reevaluation Co counseling class plus weekly pairs 2) Individual counseling plus class to discuss feelings about sessions.	48 college students	Both groups increased Focusing ability on PFQ and PFC. No difference between groups.

The Focusing Institute is a not-for-profit organization which collects and makes resources on Focusing available to the academic and professional worlds and to the public. It conducts post-graduate training in Focusing-Oriented Psychotherapy, has an international network of Focusing teachers and makes training protocols and research instruments available. It maintains a website at www.focusing.org and a discussion list.

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