Focusing Oriented Therapy: The message from research

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Introduction

Psychology's interest in what we now call the "felt sense" is as old as psychology itself, and formal research into what we call "focusing" has been going on for over half a century. In this chapter, we will review the history of this research, what recent studies have to say about the relationship between client focusing and therapy outcomes, and how future research might be improved.

Early Research

Psychologists have been interested in the felt sense for about as long as there has been a discipline of psychology. In 1890, barely 10 years after Wundt established the first laboratory for psychological research, William James described the experience of a "felt meaning" or "gap" when one tries to recall a forgotten name (James 2009, pp.251-2, first published 1890).

Formal research on what we call the felt sense began in 1958, when William Kirtner, a young PhD student at the University of Chicago, investigated how therapy clients described their problems. Kirtner & Cartwright (1958) created a rating scale with five categories, ranging from the externally focused client who

'…[describes] problems as though they are almost entirely external.... There is avoidance of discussion of internal feelings... even though feeling may be apparent in voice tone, gesture, words used, etc.'

to the internally focused client who '...has a very strong and very apparent drive to generate and examine impulses, thoughts, ideas, despite resultant fear, guilt, sadness, etc.' (p.329).

In Kirtner's sample of 24 clients, six were in the top two (internally focused) categories and 14 clients were in the bottom (externally focused) categories. This simple scale produced a startling result: *All* clients in the top two categories had successful therapy outcomes, and *all* clients in the bottom two categories had unsuccessful outcomes. Kirtner could predict, after one session, which clients would benefit from therapy and which would not. One might have expected such a finding to be of great interest to anyone practicing or researching psychotherapy, but it was largely ignored until Gendlin and colleagues rediscovered it several years later while pursuing a separate line of research.

The EXP scale

When Kirtner published his research, Eugene Gendlin was working with Carl Rogers at the University of Chicago Counseling Center. Rogers had already developed a scale to measure client behavior in therapy, but like Kirtner's scale, Rogers' scale focused on the *content* of what the client said. In contrast, Gendlin was more interested in the client's *process*, specifically the extent to which the client focused 'on his not yet conceptually clear, but directly felt, experiencing' (Gendlin, Beebe, Cassens, Klein & Oberlander 1968).

This research led to the development of the Experiencing (EXP) Scale (Klein, Mathieu, Gendlin, & Kiesler 1970; Table 1), a seven point scale measuring the extent to which clients interact with their felt experience.

Table 1

The EXP Scale (Klein et al., 1969, pp 56-63)

Level	Description
1	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.
2	Either the speaker is the central character in the narrative or his or her interest is clear. Comments and reactions serve to get the story across but do not refer to the speaker's feelings.
3	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.
4	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.
5	The content is a purposeful exploration of the speaker's feelings and experiencing. The speaker pose[s] or define[s] a problem or proposition about self explicitly in terms of feelings.... [and] explore[s] or work[s] 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.
6	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.
7	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.

While they were developing the EXP Scale, Gendlin and his colleagues also explored the relationship between EXP levels and psychotherapy outcome. In a series of studies, Gendlin et al. (1968) confirmed what Kirtner and Cartwright (1958) had found: that EXP was a strong predictor of who would benefit, and who wouldn't, in therapy.

Gendlin and his team had also expected that therapy would improve clients' EXP levels, but that prediction was not borne out. Gendlin's team was very concerned about this because if clients with low EXP did not benefit from therapy, and there was no way to raise EXP, it meant that some people couldn't be helped by therapy. Gendlin (1964) had already given the name *focusing* to "the whole process which ensues when the individual attends to the direct referent of experiencing" (i.e. EXP levels 6 and 7). Now, realizing how crucial EXP was for therapy outcome, Gendlin developed a procedure to teach people how to focus (Gendlin et al. 1968).

Recent Research

After Gendlin's early work in the 1960s, research on focusing and EXP continued to grow (e.g. Hendricks 2002; Rennie, Bohart, & Pos 2010). Some of the most significant research, both in quality and quantity, has concerned the relation between EXP and psychotherapy process (for a review see Elliott, Greenberg, & Lietaer 2004, and Elliott, Watson, Greenberg, Timulak, & Freire, 2013). As we've already noted, this is relevant to focusing because the EXP scale measures 'the extent to which [an individual's] ongoing, bodily, felt flow of experiencing is the basic datum of his awareness and communications about himself....' (Klein et al. 1970, p. 1); in other words, focusing.

Numerous studies have found a positive association between EXP and therapy outcome, for a variety of therapies including client centered, process experiential, and cognitive behavioral. In her review of the literature, Hendricks (2002) found that out of 28 studies measuring the correlation between EXP and successful outcome in therapy, 27 studies showed positive correlations. In addition, 23 out of 25 studies found that using focusing in therapy also correlates with successful outcomes.

In an a review of the literature on humanistic-experiential psychotherapies (HEPs), Elliott et al. (2013) performed a meta-analysis of 199 outcome studies, including 31 randomized controlled trials. Among many interesting results, two are of particular interest here. First, they found that HEPs (excluding therapies researchers labeled as "supportive" or "nondirective," which are often used as placebos) were as effective as other evidence based therapies, including CBT (p.855).

Second, they found that EXP levels were consistently associated with successful outcomes, not only in HEPs, but also in many other forms of therapy as well (p.847). This conclusion was based in part on six replications of the Gendlin et al. (1968) finding of a strong positive correlation between EXP levels and treatment outcome (pp.847-848).

Elliott et al. (2013) also cited a number of researchers who have raised an interesting methodological question about how this research is done. Most studies sample EXP at arbitrarily chosen times such as the beginning, middle, and end of therapy, but some studies have suggested that the relationship between EXP and treatment outcome may be stronger when EXP is

measured during critical moments in therapy (Elliott et al. 2004, 2013). This makes sense; people don't focus all the time, even in therapy. It is quite possible that a client might have just one or two intense periods of focusing during an entire course of therapy, and might show considerable improvement as a result. Arbitrary sampling might miss those one or two periods of focusing, and could thus weaken the statistical correlation between EXP and treatment outcome. We will return to this question later.

Two Studies

Two studies (Watson et. al 2003; Watson & Bedard 2006) are interesting examples of the kind of research that has been done on psychotherapy and EXP. Both studies were part of a project that compared Cognitive Behavior Therapy (CBT) with Process Experiential Therapy (PET), an experiential therapy that uses focusing in addition to a number of therapeutic tasks and techniques (Elliott, Watson, Goldman, & Greenberg 2004, p. 179ff).

In the first study (Watson et al. 2003) sixty-six clients were randomly assigned to receive either CBT or PET. All therapists were adherents of the treatment approach they used, all therapists were trained and supervised by an expert in their particular approach, and all therapy sessions were recorded. After 16 sessions, the clients who received PET and CBT had the same improvement on measures of depression, self-esteem, general symptom distress, and dysfunctional attitudes; but in addition, the clients who received PET showed greater improvement on a measure of interpersonal problems. In other words, PET was as effective as CBT for the specific disorder that CBT was originally designed to treat (Beck, Rush, Shaw & Emery 1987), and also showed additional benefits beyond those provided by CBT.

The second study (Watson and Bedard 2006) was based on the same data. Their procedure was too complex to fully describe here, but basically they used the audio recordings from the previous study to measure EXP levels of 10 good outcome and 10 poor outcome clients in each treatment modality (PET and CBT). For each of the resulting 40 subjects, EXP was rated during three 20 minute segments at the beginning, middle, and end of therapy. Watson and Bedard found that the clients who showed the most improvement at the end of therapy also had the highest EXP ratings at the beginning, middle, and end of therapy. That, of course, was not surprising; it was merely a replication of Kirtner and Cartwright (1958), Gendlin et al. (1968), and many others. What was surprising was that the relationship between EXP and treatment outcome held for CBT as well as for PET. This is interesting, because CBT is concerned with dysfunctional thinking (Beck 2011, p.3), not with focusing or EXP.

Means and Standard Deviations of the Percentages of Modal EXP Ratings

	Level 2		Level 3		Level 4		Level 5		Level 6	
Group	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
PET										
Total	40.75	15.05	41.42	9.37	9.77	8.61	5.93	7.53	2.13	4.36
Good outcome	37.98	18.05	41.10	9.19	7.75	10.73	9.13	7.07	4.05	5.60
Poor outcome	43.53	11.65	41.75	10.04	11.80	5.68	2.73	6.84	0.20	0.64
CBT										
Total	58.80	16.21	32.66	11.81	5.59	4.91	1.82	3.31	1.13	3.90
Good outcome	52.60	14.72	36.67	12.02	4.90	3.13	3.65	3.97	2.18	5.44
Poor outcome	64.99	15.89	28.65	10.68	6.27	6.32	0.00	0.00	0.08	0.25
Combined therapy										
Total	49.78	17.94	37.04	11.42	7.68	7.23	3.88	6.10	1.63	4.13
Good outcome	45.29	17.70	38.88	10.66	6.33	7.83	6.39	6.25	3.12	5.46
Poor outcome	54.26	17.47	35.20	12.13	9.03	6.50	1.36	4.91	0.14	0.48

Note. EXP = Experiencing Scale, PET = process-experiential therapy, CBT = cognitive behavioral therapy.

Table 2. Data from Watson and Bedard (2006, p.156)

Table 2 (from Watson & Bedard 2006) shows the results: For both PET and CBT, the average percentage of statements in the good and poor outcome groups was about the same for EXP levels 2, 3, and 4. But subjects with good outcomes have a noticeably higher percentage of EXP 5 statements, and the difference is dramatic for EXP level 6.

I have analyzed their data further to show more clearly the relationship between EXP level and treatment outcome. In Figure 1, the height of each bar indicates the average percentage of statements made by clients with good outcomes, divided by the average percentage of statements made by clients with poor outcomes, for each treatment group and EXP level.

Thus, for good outcome clients receiving PET, an average of 37.98% of their statements were rated at EXP level 2, while for poor outcome clients the average percentage of level 2 statements was 43.53%. The ratio is .87, which shows up as close to one on the bar graph. We can see that for levels 2, 3, and 4, the ratio hovers around one, indicating that for each of those EXP levels, good and poor outcome clients give about the same percentage of statements. But at level 5, the ratio is around four, indicating that good outcome clients made about four times as many level 5 statements as did poor outcome clients. And at level 6, the ratio explodes: in PET, good outcome clients made *20 times* more level 6 statements; and in CBT, good outcome made *27 times* more level 6 statements!

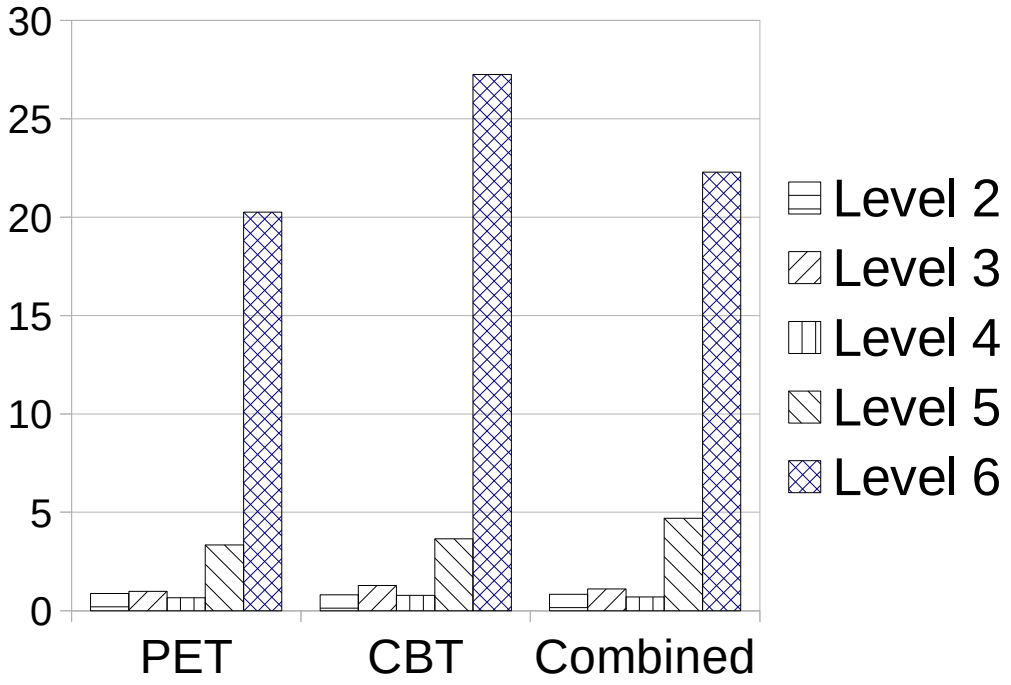

Figure 1

Mean percentage of statements at each EXP level, for good outcome clients divided by poor outcome clients. (Note: For CBT Level 5, poor outcome was changed from 0% to 1% to avoid division by zero; see Table 2)

Even though the absolute numbers are small, the ratios are impressive. Clearly, it is not just higher EXP levels that predict therapy outcome. It is specifically the percentage of client statements at EXP level 6, in other words *the percentage of time the client spends focusing*, that predicts successful therapy outcome. And, it doesn't take much focusing to make a difference.

This finding bears on the question of why therapy doesn't appear to raise client EXP levels. An initial clue can be found in the low EXP levels reported in most studies. For example, Gendlin et al. (1968, p.226) found that 89% of their "neurotic" clients began therapy at EXP level 3 or below (on an early but roughly equivalent version of the EXP scale). Of those, the successful clients increased their EXP levels by an average of about .6, while the unsuccessful clients hardly changed at all. Similarly, Watson & Bedard (2006, Table 1), found that the average EXP level for good outcome clients started at 2.60 at the beginning of therapy, increased to 2.99 at the middle of therapy, and dropped to 2.87 at the end of therapy. For poor outcome clients, the figures were 2.38, 2.78, and 2.67.

Why are these EXP levels so low? The answer is probably that therapy clients spend most of their time describing their situations and feelings about those situations. Clients are most likely

to focus while they are working on some crux issue, but that might not happen very often. Therapy is likely to consist of a considerable amount of EXP levels 2 through 4, punctuated by occasional level 5, and very occasional level 6.

But these numbers are *average* EXP levels, and averages tend to obscure patterns of diversity. Ten minutes of focusing (EXP level 6) could make the difference between a successful and unsuccessful therapy outcome, yet the average EXP level would show only a very slight increase if the rest of the sample consisted of 50 minutes of level 2 or 3 discussion. Furthermore, if only a few arbitrarily chosen segments of therapy were scored (for example 20 minutes at the beginning, middle and end of therapy) from a total of 12 hours of therapy, 10 minutes of focusing might not be scored at all, even though it could be decisive in terms of outcome. This could explain why overall EXP levels are so low and why therapy doesn't appear to increase clients' EXP levels: as part of an average, small percentages of EXP level 6 would be washed out by the much larger percentages of EXP levels 2 and 3.

Thus the data in Table 2 and Figure 1 suggest that instead of asking about the relationship between EXP and therapy outcome, or whether EXP increases during therapy, it would be more relevant to focus specifically on EXP level 6, either throughout the course of therapy or during periods that were judged most significant by the client.

Another way to assess the relationship between EXP and therapy would be to give psychotherapy candidates either focusing training or relaxation training prior to beginning therapy, and then to measure the effect on treatment outcome. This approach would present some difficulties, for example it might be difficult to keep therapists from guessing which pretreatment their clients had received; but it would have the advantages of being relatively easy to implement, and of producing results that would be of immediate practical use.

CBT and FOT

As noted above, there is strong evidence indicating that EXP is related to outcome in many forms of therapy. CBT is an interesting example because outwardly it is quite different from FOT. CBT has been assumed to be a cognitive approach, not experiential and presumably not concerned with the felt sense. Why, then, should EXP be related to therapeutic outcome in CBT?

CBT holds that symptoms arise from core beliefs that are inaccurate or dysfunctional (Beck 2011, p.3). These core beliefs are often not verbalized and the patient is often not aware of them. Although CBT generally uses "intellectual" techniques (Ibid. p. 248), in some cases experiential methods may be included, for example (Beck 2011, pp. 249-250):

> Therapist: Do you feel this sadness and incompetency somewhere in your body?
>
> Patient: Behind my eyes. And my shoulders feel heavy.

The purpose, however, is always to challenge and change dysfunctional core beliefs. According to Beck, '… the quickest way to help patients... is to facilitate the direct modification of their core beliefs as soon as possible…' (Ibid. p.35). But because challenging core beliefs too quickly can disrupt the therapeutic relationship, therapists must usually approach core beliefs gradually,

by first teaching the patient to identify and challenge automatic thoughts that stem from the core beliefs. After the client has learned to challenge automatic thoughts, it becomes possible to challenge the core beliefs which are thought to be the root of the problem.

Focusing oriented therapists are more concerned with the manner of experiencing than with the content. However, if we consider CBT's core beliefs as a kind of process, it becomes clear that core beliefs have many characteristics of what Gendlin calls *frozen wholes* or *frozen structures* (Gendlin 1964; Parker 2007; Parker in press). These are not contents, but a manner of experiencing in which the client attends only to certain aspects of situations and ignores other aspects. For example, while relating to authority figures the client might notice only the characteristics of an abusive father, while ignoring everything else.

When it is brought into awareness, a frozen structure can be experienced as a felt sense, often from an earlier time ('Oh… *That's* what it was like for me back then!'), and this awareness can be formulated as a statement ('I always felt like it was my fault, that I was no good'). When that happens, it can seem as if the statement had always been there (Gendlin 1964). This can lead to the illusion that the frozen structure was actually a verbal belief waiting to be discovered. This may help explain why CBT assumes that the core belief is a *belief*, such as 'I am incompetent' that can be uncovered and completely expressed in words. In FOT, we would say that the frozen structure is a kind of implicit experiencing, a stopped process (Gendlin 1964; Parker 2007).

A focusing oriented therapist wouldn't normally challenge the automatic thoughts or core beliefs associated with a frozen structure, partly because of the resistance that would entail, but primarily because the problem with them isn't that they are incorrect, but that they are part of a structure bound manner of experiencing. The client is no longer open to all aspects of a situation, but only to the aspect of (for example) personal failure. As FOT helps the client become more open to his/her experiencing, the frozen structure opens and becomes part of that experiencing. Automatic thoughts and core beliefs don't have to be challenged, because they are already interacting with everything else the client knows, and are quickly modified by that interaction.

Thus, core beliefs and frozen structures may represent two ways of thinking about the same basic experience, although of course, differences in thinking are associated with differences in practice.

Conclusions

The felt sense has been noticed and studied throughout the history of modern psychology, beginning with William James. Research on EXP goes back half a century. Numerous studies, conducted decades apart by independent researchers, have repeatedly shown that high EXP is associated with successful outcome in several forms of psychotherapy and may be an important ingredient in all forms of psychotherapy. On the other hand research has not supported the expectation of Gendlin et al. (1968) that therapy would increase client EXP levels.

However, most studies have rated EXP at arbitrary intervals of time. A number of researchers have questioned this approach, suggesting that rating EXP during particularly meaningful moments of therapy might produce more meaningful results, resulting in even higher correlations

between EXP and treatment outcome, and perhaps even an increase in client EXP during therapy (Elliott et al. 2004; 2013).

In addition, research so far has focused on average EXP levels, which tend to wash out relatively rare episodes of EXP level 6 (or focusing). Thus the relatively high EXP levels of good outcome clients are still only around 3.0, which is not very high. A reexamination of recent data (Watson & Bedard 2006) suggests that it is not EXP *per se* that leads to successful therapy outcome, but specifically EXP level 6, i.e., focusing. This suggests that research specifically targeting EXP level 6 could lead to new and interesting results.

However, the research available so far already has important implications for the practice of psychotherapy. Clearly EXP is a central factor in successful psychotherapy, and therefore psychotherapists of all persuasions would benefit from learning to focus so that they can support focusing in their clients and help raise their clients' EXP levels.

Also, therapists no longer need to argue over whether therapy should focus on cognitions, or behavior, or emotions, etc. (Gendlin 1996). All of these 'avenues' are intrinsically related, because they are all aspects of the implicit intricacy of the client's experiencing. Thus all avenues can lead to a felt sense, a "feel" of the situation one is concerned about; and when attended to, that felt sense can lead to a new formulation of the problem, so that a resolution is possible.

Finally, therapists don't need to wait years for research to tell them if a particular intervention is likely to help a particular client. A therapist who knows how to focus can tell from moment to moment whether a client's EXP level is going up or down, and can therefore tell almost immediately if the last intervention was helpful or not. Therapists can now be their own researchers, gathering their own evidence for practice with each specific client, in real time.

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