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Focusing-Oriented Therapy with an Adolescent Sex Offender

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In this chapter, I show how focusing-oriented therapy (Gendlin, 1996) as modified for complex trauma (Centre for Focusing Oriented Therapy, 2012; Turcotte, 2012) can be a useful part of the treatment program for an adolescent sex offender. I briefly explain what focusing is, how it works, how it has been adapted for treating complex trauma, and how it can be used to help adolescent sex offenders whether or not they suffer from complex trauma. I conclude by discussing three characteristics of this approach: (1) its precision, both in process and in outcome; (2) the speed with which growth can take place; and (3) the pervasiveness and durability of the resulting change.

Focusing

Focusing is a way of attending to the body's implicit knowing of situations (Gendlin, 1991). It was developed by philosopher Eugene Gendlin (Gendlin, 1997b; Gendlin, Beebe, Cassens, Klein, & Oberlander, 1968) as part of an investigation into the relation between implicit and explicit knowing.

Implicit knowing might sound exotic, but it is an everyday fact of life. For example, you might notice your experience as you read this paragraph. You probably don't think about the meaning of each word. Instead, you probably have an implicit sense of the meaning of the words, while you focus your attention on the explicit meaning of the sentences. Of course, you could explicitly define any single word, *sentence*, for example. But

notice what happens: You start with the implicit sense of meaningfulness, and you gradually find words and concepts that go with that sensing, until you formulate an explicit definition of *sentence*. And your definition is formulated with words whose meaning is implicit. This illustrates a basic relationship between explicit and implicit knowing: Explicit knowing is never alone but always in a context or background of implicit knowing (Gendlin, 2012).

Implicit knowing is, by definition, outside of awareness, but it is possible to bring it into awareness by paying attention to how a problem or situation "feels." William James described this "feel" in his *Principles of Psychology*:

> Suppose we try to recall a forgotten name. The state of our consciousness is peculiar. There is a gap therein; but no mere gap. It is a gap that is intensely active. A sort of wraith of the name is in it, beckoning us in a given direction. . . . If wrong names are proposed to us, this singularly definite gap acts immediately so as to negate them. . . . And the gap of one word does not feel like the gap of another, all empty of content as both might seem necessarily to be when described as gaps. When I vainly try to recall the name of Spalding, my consciousness is far removed from what it is when I vainly try to recall the name of Bowles. . . . (1890/2009, p. 251)

When it becomes the focus of attention, implicit knowing is called a *felt sense*. Without going into a detailed discussion of Gendlin's philosophy (see Gendlin, 2003, for a summary, or Gendlin 1997a and 1997b for more detail), we can note two things about the felt sense that are not immediately obvious.

First, implicit knowing (and therefore the felt sense, when it comes) is a sense of what is needed. Our bodies know implicitly how to breathe; but if we try to hold our breath for 60 seconds, we feel in our bodies something like a "needing" or "wanting" to breathe. So we see that implicit knowing includes something like "needing" or "wanting." Gendlin calls this *implying*; our bodies *imply* breathing. Another example is feeling uncomfortable if someone is standing too close. Most people do not even know what the right distance is for them until someone stands too close. Our bodies know and *imply* the right distance.

How can this be? Our living bodies *are* in ongoing interaction with our environments, including our social environments. Thus it should not be surprising that our bodies sense and implicitly know our situation and what it needs; or that, as James noted, what we are calling the felt sense is "intensely active . . . beckoning us in a given direction . . . [acting] immediately so as to negate [a bad suggestion]."

Another important thing about the felt sense is that, if we pay attention to it in a certain way, some of the body's implicit knowing can be

formulated explicitly in words, so that James, for example, could have used his felt sense to recover the name he had forgotten. This is interesting because a felt sense initially feels frustratingly vague, ephemeral, and impossible to describe. It can also be remarkably helpful, because in situations in which one feels "stuck" (i.e., currently available explicit understanding is not adequate), the felt sense often leads to a deeper understanding of the problem that includes a way forward.

The key to listening to the felt sense is to protect it from already-formed concepts by attending to it with a gentle and supportive attitude, gently and tentatively trying out different words that might describe the feel of it. We can tell when we have found the right words, because there is a feeling of resonance (the words feel right) and because the felt sense responds by bringing out more of what is implicit. Then we can attend to the new felt sense by finding new words to describe it. Again, the felt sense brings out more, and we attend to that and find new words to describe it, and so on. If we continue the process, always gently allowing the felt sense to choose its own words, it will often (not always) lead to a *felt shift* that includes a solution to the problem at hand but often has implications far beyond the original problem. This way of interacting with the felt sense, including the felt shift, is called *focusing* (Gendlin, 1982).

Focusing is not psychotherapy, but it is useful in therapy. For example, a considerable body of research has used the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1970), a measure of client focusing in psychotherapy, to study the process of psychotherapy. The resulting studies, spanning more than four decades, suggest that clients who interact with their felt sense during therapy have significantly better outcomes in many forms of therapy, including cognitive-behavioral therapy, process experiential therapy, and client-centered psychotherapy (e.g., Watson & Bedard, 2006; for summaries of this research, see Elliott, Greenberg, & Lietaer, 2004; Elliott, Watson, Greenberg, Timulak, & Freire, 2013; Greenberg, Elliott, & Lietaer, 1994; and Parker, 2014).

Frozen Structures

The felt sense is a kind of awareness, but it can be experienced as an object that one "stands apart from" and "interacts with," just as one might figuratively stand apart from and interact with (e.g., describe) an emotion or idea. This standing apart requires a clear sense of self, separate from the felt sense. Sometimes, however, the client's sense of self is merged with an implicit knowing and is thus unable to stand apart from it and interact with it. Then, instead of experiencing the present moment freshly in all its details, the client notices primarily what was relevant at some earlier time, finding aspects of the present situation that seem overwhelming and thus

implicitly *reliving* the earlier experience. This reliving is called *regression* (Turcotte, 2012). With no interaction between explicit conceptual knowing and implicit knowing, neither can change. We call this a *frozen structure* (Gendlin, 1964). Psychological trauma is an example of frozen structure but the "small-t" traumas of everyday life can also produce frozen structures, reliving, and regression.

The signs of a frozen structure can be subtle, but with practice they are easily recognized; for example, the client may display a repetitive behavior or gesture, or the gaze may briefly shift into space as if seeing something in the room that is not actually there. These are signs that the client could be reliving something. It is important to recognize these signs, because if reliving becomes too vivid, it will become retraumatizing and will reinforce the frozen structure.

Shirley Turcotte (Centre for Focusing Oriented Therapy, 2012; Turcotte, 2012) has addressed this problem by developing focusing-oriented therapy for complex trauma (FOT-CT). Like focusing, FOT-CT is *client centered* (it is based on the client's implicit knowing), but it is *therapist driven* (the therapist must actively look for and follow signs of regression). Because a frozen structure does not interact with explicit conceptual knowing, the client cannot verbalize it, and the therapist must actively look for it in the client's body language and reflect it back to the client. The therapist carefully regulates this process, ensuring that the client always has a strong enough sense of self to observe and interact with the frozen structure, so that it can change (i.e., become a felt sense). If more comes than the client can handle, the client will lose his or her sense of self and begin reliving the frozen structure. There are specific ways to avoid this by helping clients strengthen sense of self before starting the focusing phase of therapy and by helping them maintain sense of self during each therapy session.

Working with Sex Offenders

Sexual offending, by its nature, often involves a rigid way of experiencing that is insensitive to details of the present moment, such as a victim's expressions of suffering. Therefore, an awareness of frozen structures, focusing, and FOT-CT is often useful in the treatment of adolescent sex offenders.

FOT-CT is not appropriate in all situations, but the requirements are relatively simple. The therapist, of course, must be experienced in working with this population. Clients must be able and willing to explore their inner experience, at least introspectively. It is not absolutely necessary that they share their inner experience with the therapist, because the therapist can respond to body language during the first few sessions while the client builds trust. However, clients who externalize their problems and/or are relatively unaware of their inner experience may need some preparatory

work focused on those issues. Generally, clients who can benefit from individual therapy can benefit from FOT-CT.

For those who can benefit, FOT-CT can be a remarkably rapid and effective intervention. The following vignette (a composite of several actual therapy sessions) illustrates some of the key characteristics of FOT-CT and also the process of focusing.

Case Example

John is a 14-year-old boy who was adopted at age 6. He had adapted easily to his new home; everyone liked him, and he seemed to excel at everything he tried. About a year before he was seen, John's foster mother began babysitting her sister's 4-year-old daughter for several hours a day on weekdays. After about 4 months, she went into John's bedroom one day to discover the girl performing fellatio on him. Investigation suggested that the sexual behavior had started with roughhousing and wrestling shortly after the girl moved in and had escalated over several weeks to more or less daily sexual touching with rewards such as candy and attention.

John was adjudicated and sentenced, in lieu of detention, to a residential treatment program for adolescent sex offenders. He followed his treatment program diligently and was well liked by staff and peers. He quickly understood why his behavior was wrong, and he appeared to be sincerely remorseful. But his reason for molesting a 4-year-old remained unclear. He did not appear to be sexually attracted to children, and he was popular at school and had many female same-age friends, so there was no apparent reason for him to do this.

There were some clues. John was very good at almost everything he tried. He usually handled this gracefully, but there were signs that he was putting himself under pressure; for example, he avoided activities he felt he might not be good at, and he could be quite hard on himself if he lost a game or got a bad grade at school. A fear of failure and a need to always be in control and to always succeed could have been a factor in his offense; perhaps he could not risk a relationship with a female peer but could with a 4-year-old child.

The following session took place after about 4 months of individual, group, and milieu therapy.

THERAPIST: What would you like to work on today?

CLIENT: My anger.

THERAPIST: OK, tell me about a time when you were angry.

[Anger is a label that we put on certain emotional experiences. It is not a felt sense, but it can be a way in, if John can go beyond the label and open

himself to the actual experience. John tells me about starting a fight when somebody "messed with" him on the basketball court, causing him to miss a shot. His description is filled with self-justification (it was the other boy's fault, etc.). But we're not here to discuss whether starting a fight was a good or bad thing to do. We need to go beyond labels and preconceptions, to the actual experience.]

THERAPIST: So, can you remember that feeling? Can you feel it inside, right now?

CLIENT: (*pause*) Yes.

THERAPIST: Where inside do you feel it?

CLIENT: (*pause*) In my chest . . .

THERAPIST: In your chest. . . . What is that feeling like? . . . How heavy is it, what color is it?

[Asking him to describe his feeling as if it were an object is a way of inviting him to encounter it freshly, without his usual concepts and labels. Surprisingly, most people will answer such "nonsense questions" with certainty and precision, after only a few moments of reflection.]

CLIENT: It's heavy . . . and red. . . . It has jagged sharp edges, and it explodes.

THERAPIST: So it's heavy and red . . . it has jagged sharp edges . . . and it explodes.

[We are going beyond the culturally defined concept of "anger." Saying John's words back slowly helps him to compare the words with his actual experience. This typically leads to a new and more differentiated description (the reflection-correction process described earlier).]

CLIENT: Well . . . sometimes it's gray . . . but it turns red when I start feeling angry.

THERAPIST: So it's gray sometimes . . . and it turns red when you start feeling angry. . . .

CLIENT: That's right.

[I try a few more reflections, but nothing more comes. This could be a frozen structure, and he may need help finding it. It could be my imagination, but the way he sits makes him seem younger than his actual age; and even though he's talking about anger, his eyes look sad.]

THERAPIST: . . . What can you call that part? Could you give it a name?

CLIENT: (*after several attempts to name it*) "Bad news."

THERAPIST: OK, how does "bad news" feel, what's he like?

[Personifying the experience is another way of encountering it freshly, without the conceptual and cultural baggage that a label such as "anger" would carry.]

CLIENT: He's angry.

[John reverts to the old label; I want to help him away from the label and back to what he is actually experiencing.]

THERAPIST: What bothers him? What makes him angry?

CLIENT: It's people messing with me.

[The look of sadness is still there, and for a few moments his eyes are focused several feet in front of him, as if he's looking at something that I can't see. This is a sign of regression. John is on the edge of reliving something but is still clearly present in the room, so he is OK so far. We can begin tracking the regression, to see where it leads.]

THERAPIST: . . . and part of you feels angry about that, and also maybe sad, is that right?

CLIENT: Kind of sad, but more angry. . . . It's like they're criticizing me for no reason.

THERAPIST: What's it like to be criticized?

CLIENT: It's like, I'm already doing badly, I've missed the basket, and I already feel bad, and they're trying to make me feel worse. . . .

[After a series of reflections from me and corrections from John, John realizes that it is not so much a feeling that they are criticizing him, but more a feeling that he has failed. As he says this, he again appears to be looking at something in front of him, with sadness in his eyes; and he is still clearly in the room and relating to me. So we can continue following the regression; and to do that we need to find out more about how he experiences failure.]

THERAPIST: What does it feel like inside when you fail?

CLIENT: I feel like a failure, sad, depressed, frustrated. . . .

[John kept himself "separate" from his anger, personifying it with the name "bad news." In contrast, "I feel like a failure" suggests he's beginning to identify with something. The next reflection aims to help him get some distance so he can *observe* the experience of failure instead of identifying with it.]

THERAPIST: . . . So there's a place inside of you that feels sad . . . depressed . . . and frustrated . . . about failing; what's that like?

CLIENT: I don't know. . . .

[We go back and forth a few times, but he can't say anything more about the feeling of failure. John sits in his chair like a small child, looking at me, and sometimes at the space in front of him, with sad eyes. He appears to be reliving something, but he has no words for it. This is probably a frozen structure, which will require a different kind of reflection. We start by making sure he is maintaining an observing self, separate from the frozen structure.]

THERAPIST: Can you feel that in your body, that feeling of being a failure?

CLIENT: Yes.

THERAPIST: OK, where inside do you feel it?

CLIENT: In my chest.

THERAPIST: How old does that place feel?

[The question works on two levels. First, I want to learn something about how old he is and what he is looking at. But at the same time, it is a process intervention. A frozen structure is like wallpaper; it's a context that we take for granted. If this is a frozen structure, imagining how old it is will help John maintain his own identity separate from it and simultaneously connect it to some period in his life, helping him experience it freshly and with more detail, so that he and it can begin to change.]

CLIENT: It feels like when I was little. . . .

THERAPIST: What was going on in your life when you were that age?

[We are now looking for something in his history that may connect with the feel of the frozen structure. John describes his family. His mother was verbally and physically abusive. I explore for feelings of failure about pleasing his mother, but nothing comes. Her abuse was like getting caught in a thunderstorm; it had nothing to do with him. It is the same with his father, who was more distant, would disappear for days a time, and basically had very little to do with him. Again, John has no sense of failure about this.]

THERAPIST: Who did you look to for approval? Who did you try to please?

CLIENT: My brother and sisters . . . and maybe one teacher at school.

[There appear to be no significant feelings of failure with any of these individuals. But as he talks, his body language reminds me of a small child, maybe 4 or 5 years old. He looks very sad, and although he is still clearly present in the room, for brief moments he appears to gaze at something several feet in front of him. These signs of reliving are subtle but unmistakable. He is on the edge of something. But what?]

THERAPIST: OK, imagine you're a child again, living with your mother and father, and look for that feeling of failure. Back in those days, when you were living at home, when did you experience that feeling?

CLIENT: (*long pause*) It was when my mother died.

[The immediate, felt certainty shows that John is speaking from a felt sense. The frozen structure is shifting from an implicit, pervasive mood that fills his life to *this* feeling, related to *this* event. The frozen structure is beginning to melt.

But we still do not know very much. John has already described, in earlier sessions, fragmented memories of his mother's illness and death from cancer when he was about 5. We could speculate that this was traumatic

for John, but such speculation would be irrelevant. John's regression is telling us that he is reliving something about failure. We need to follow the regression.]

THERAPIST: So you had that feeling of failure when your mother died, like it was your fault in some way?

CLIENT: No, it wasn't my fault, I just had that feeling of failure.

[This is interesting: if it wasn't his fault, why is there a feeling of failure? But further exploration goes nowhere.]

THERAPIST: Let's try an experiment, OK? (*John agrees.*) Suppose I say to you "It's your fault that your mother died." How do those words feel inside?

[We have done this exercise before in other contexts, and John understands that the words have nothing to do with what I believe; it is an experiment, a therapist-driven reflection, to see if anything inside of him responds to those words.]

CLIENT: I don't feel anything inside, because it's not true. It's not my fault that she died . . . (*long pause*). It's just that when she died, I felt like I should have done something to save her; I should have gotten her to change the way she was living, maybe spoken to her and gotten her to take better care of herself. . . . I should have done something.

[Of course! Five-year-old John had wanted to save his mother.]

THERAPIST: So your failure was that you failed to do something to keep her from dying, you failed to help her.

CLIENT: Right.

[Again, the felt certainty and the new perspective indicate that this is his felt sense speaking.]

THERAPIST: And you've carried that feeling with you ever since?

CLIENT: Yes.

THERAPIST: And how strong is that feeling, the feeling that you failed to save your mother, on a scale of 1 to 10?

CLIENT: It's a 10.

[We've found the frozen structure; now we need to connect it to the present. As John learns to recognize the frozen structure functioning in different areas of his life, it will become a felt sense.]

THERAPIST: How close is this feeling to the feeling of failure that you sometimes have these days?

CLIENT: Not close at all, they're different feelings; if I fail to make a basket, that has nothing to do with my mother dying.

[People often confuse the magnitude of a felt sense with the qualitative

aspect, so this is worth going over again. A felt sense is very precise. If we're on the right track, the felt senses will be exactly the same; if they're only close, we're missing something and may have to start over.]

THERAPIST: OK, get the two feelings. . . . Can you feel them now?

CLIENT: Yes.

THERAPIST: OK, how are they different?

CLIENT: Well, the feeling of my mother dying is much bigger than the feeling of failure if I miss a basket.

THERAPIST: . . . so one feeling is much bigger than the other feeling; but apart from that, how are they different?

CLIENT: (*Pause*) Apart from that, they're not different at all, they're the same.

THERAPIST: OK . . . do you mean they're exactly the same, or just very close?

CLIENT: They're exactly the same, except that one is much bigger than the other.

THERAPIST: OK, now how are they related to each other?

CLIENT: The two feelings aren't related, my mother dying has nothing to do with me missing a basket.

[I try to explore this further, but get unclear answers and a tendency to go off on tangents. I'm not sure what he means, he is becoming unfocused, and I'm afraid he'll lose his connection with the felt sense.]

THERAPIST: OK, now I'm going to say something to you, and I want you to check it inside, you know what I mean? Not in your head, but inside your body, see how these words feel.

CLIENT: OK.

THERAPIST: So, you're not saying this exactly, but what I'm hearing is that you're carrying around this big burden, that it's your fault that you didn't save your mother, and that this weighs down on you all the time. How does that feel inside?

CLIENT: Right (*with some release of tension, visible in the face*).

THERAPIST: So, whenever anything goes wrong, if you miss a basket, or you do bad in school, or whatever, you feel like a failure, and that feeling of being a failure goes right to the big feeling of being a failure because of your mother. So whenever a small thing gets touched off, the big thing gets touched off at the same time. How close is that to what you feel?

[This is not an interpretation, it is a kind of reflection. I'm not asking for agreement, I'm asking how the words feel inside, and I know from experience that John will tell me if they don't feel right. John's body language and

his description of his childhood situation have given me a sense of his frozen structure, but neither John nor I can know for sure if my sense is right. Only his body can tell us. As I listen to and reflect his frozen structure, I am teaching John to do the same. In doing this exercise, he is learning to stand outside the frozen structure and look at it, so that it becomes a felt sense he can interact with and learn from.]

CLIENT: That's it, that's what happens (*enormous release of tension, visible in face and body posture*).

[We go over this a few times, making sure that it feels right to John.]

THERAPIST: So there is a feeling that you failed to save your mother, and that's a very important feeling in your life. I think we both know that you couldn't have done anything to save your mother at age 5, but can the place inside hear that and take that in?

[This is a real question. As I noted earlier, the felt sense is experienced as an active agent; it is a "still small voice" that one can ignore but cannot control. There is no guarantee that John's felt sense will agree with us. His felt sense might say "no," which would mean we are missing something and have to do some more listening.]

CLIENT: Yes (*with visible relaxation and apparent relief*).

[The body shift (not the verbal "yes") indicates that John has received an accurate reflection, meaning that he can recognize it as a reflection of himself at a deep level. And as he takes it in, both implicitly and explicitly, he will begin to know himself and the world in a new way.]

THERAPIST: So, it seems that where we're at is *[I summarize*]. Does this feel like a good place to stop?

CLIENT: Yes.

THERAPIST: So, how is that failure place feeling right now?

CLIENT: It's feeling gratitude (*looking at me with moist eyes, as if the gratitude is for me*).

THERAPIST: Who is it grateful to?

CLIENT: It's grateful to both of us, to me for recognizing it, and to you for helping me recognize it.

Because John was able to interact with it, the frozen structure had "melted" and become a felt sense, able to change with experience. In a sense, John forgave himself for letting his mother die.

We had gone into this session with the hypothesis that John's motive for offending might have involved a fear of failure that prevented him from relating to girls his own age. By the end of the session, we had a clear confirmation of the fear of failure. The sense of relief was immediate, but there were also deep changes in his self-concept and social relationships

that manifested more gradually and suggested that the fear of failure had indeed shaped his life and motivated him to molest a child.

In therapy, John realized that his relationship with the 4-year-old girl had indeed given him a feeling of safety by protecting him from feelings of rejection and failure. He was struck by the absurdity of seeking safety with a child, when there was no need to be so afraid of failure in the first place.

More important, over the following weeks John developed a new attitude, as well as new body language and behavior. His attitude toward sports and schoolwork changed; instead of treating each new activity as a test of his competence, he began enjoying things for their own sake and because he enjoyed being with people. He became interested in girls his own age, immersed himself in extracurricular activities, and in general became more relaxed and playful, like a normal teenager. In our last session together, he spoke excitedly about his activities on the school choir, which was about to go on tour out of state, and he asked to end our session early so he could meet a female classmate.

During a 2-year follow-up period, there was no evidence of any inappropriate sexual behavior or inappropriate interest in younger children.

Discussion

This clinical vignette illustrates three characteristics of FOT-CT mentioned in the introduction: (1) its precision, both in process and in outcome; (2) the speed with which growth can take place; and (3) the pervasiveness and durability of the resulting change.

We can now see why this is possible. FOT-CT allows a youthful offender to engage directly with his own implicit knowing, with the therapist acting as a coach or facilitator. However, this requires a particular kind of listening that can be problematic for both therapist and client.

Listening

To understand where the offense came from, both offender and therapist must be open to the offender's experience, which means listening to and accepting who he is so that he can grow from his own center in a way that has integrity for him. Teaching him to follow rules is sometimes the best we can do, but it is not the same as helping him grow from the inside.

Listening to a sex offender can be difficult for both the therapist and the offender, for a number of reasons. The offense itself is difficult to accept. The therapist may have feelings about what the offender did and probably wants the offending to stop, whereas the offender wants to convince everyone that he is cured and should go home. Both want the offense to go

away, and this agenda makes it difficult for both to accept and listen to the offender. A related problem is that listening to oneself requires an attitude of openness, curiosity, and kindness toward oneself. This can be difficult and frightening for a kid who was emotionally abused and is especially difficult for an offender who feels stigmatized by his family and society (Gilbert, McEwan, Gibbons, Chotai, Duarte, & Matos, 2012). Offenders often do not want to look inside for fear of what they will find.

Listening means surrendering preconceptions and opening to the possibility of something new that one hasn't considered before, something for which one might not even have words. In the preceding example, John initially did not have words for his sense of failure; it was a pervasive background feeling, like wallpaper. His conscious formulation was not about failure at all; it was about people picking on him. The therapist's job was to help him notice the murky inchoate background feeling, his implicit knowing, and to notice and find words for different aspects of it. As John noticed and named different aspects, it changed from a murky unknown to something with more and more qualities; so that "It's heavy, and red . . . sometimes it's gray" became "I feel like a failure, sad, depressed, frustrated. . . . " This is a radical kind of listening. The therapist is teaching John to listen to himself, and neither knows where it is going to lead. It takes a lot of trust.

But this radical listening is in some ways easier than normal listening. It tends to bypass hidden agendas; neither client nor therapist needs to persuade the other of anything. The client is less likely to feel evaluated because the process is descriptive and whatever he says is honored and appreciated. Thus, although listening presents difficulties, FOT-CT cuts through many of these difficulties, allowing growth to come from the inside.

Speed and Precision of Therapy

When therapist and client are both able to listen in this way, then FOT-CT can proceed with considerable speed and precision. As the therapist looks for and reflects nonverbal signs of regression, the client's body immediately shows how accurate the reflection was, so the next reflection can be more precise. With each reflection, more of what was implicit tends to emerge, so the back-and-forth process tracks the regression and leads directly to the frozen structure. The client learns from inside, not from the therapist. Situations that have been frozen structures, relived implicitly for years, become explicit and can be reevaluated.

In John's case, for example, a 5-year-old boy *implied* (needed . . . wanted . . .) a mother, so his mother's illness *implied* that he should save her. When she died, that implying had no way forward, no resolution, so he continued to live it as a frozen structure. When he finally experienced the implying explicitly, he finally could live it forward and resolve it, simply

by realizing that a 5-year-old cannot change things like that and that his failure then does not make him a failure now.

No amount of brilliant clinical insight or client introspection could have achieved this, and both John and his therapist were equally surprised by it. The therapist carefully tracked the regression and did some reflecting in order to clarify issues, but the actual change came from John's implicit knowing and, in the end, from his felt sense.

Pervasiveness and Durability of Change

There are many ways to do therapy, but there is an advantage in working "from the inside out" rather than "from the outside in." We can encourage sex offenders to memorize offense cycles and relapse prevention plans, but none of that is likely to change their way of experiencing the world, which is where the offense often comes from. If the offense is related to a frozen structure, then real change is more likely to come from the inside, when the frozen structure becomes a felt sense and the offender wants to change because he has discovered a better way to live. In that case, change tends to be pervasive and durable, as we saw with John.

Conclusion

FOT-CT can be thought of as a guided mindfulness practice. Normally, when we experience frozen structures, there is a tendency to become disoriented; we lose track of who we are and implicitly identify with the frozen, blocked implyings from some earlier, formative time. In FOT-CT, the therapist provides steady, accurate reflections of the client's experience, so clients can stay oriented and remember who they are as they walk through this disorienting passageway.

Adolescents commit sexual offenses for many reasons, and no single approach will help everyone. FOT-CT is most likely to be helpful for offenders like John who are able and willing (with the necessary support) to attend to and describe their felt experience. By helping youth like John to remember who they are, we can free them to form healthy relationships and find or return to a positive developmental path.

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