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# 8

## FOCUSING-ORIENTED-EXPERIENTIAL PSYCHOTHERAPY: FROM RESEARCH TO PRACTICE

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With more than 50 years of studies demonstrating the usefulness of focusing-oriented-experiential therapy (FOT), new research findings have provided further evidence of its efficacy in the treatment of various psychological disorders and issues. Traditional outcome research studies are being augmented by other microprocess-oriented studies, which look closely at the small change events clients and therapists report when reflecting on therapy. Microprocess research on FOT represents a growing body of research that illuminates these small steps of therapeutic change found in FOT sessions and provides practitioners with further evidence of how and why FOT works.

This chapter includes a summary of the research on FOT since the last review conducted by Hendricks (2002), who looked at 89 empirical experimental research studies on focusing and focusing-oriented therapy, mainly those using the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969; Klein,

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Mathieu-Coughlan, & Kiesler, 1986). This summary positively correlates experiencing level and participant-reported positive therapy outcome. We present a discussion of the philosophical foundation for FOT. We also include transcripts from client sessions at key points to help illuminate the principles discussed. We conclude with suggestions on how process-oriented research modalities might shape the trajectory of future research on FOT.

### A DISTINCT APPROACH TO THE CLIENT CHANGE PROCESS

Important to our work as psychotherapists is assisting clients in finding a lasting way of living better. This will undoubtedly involve change, most often change that takes place over the course of several therapy sessions and in many small steps. FOT has a distinct approach to helping clients find and follow the leading edge of their own change process. Therapeutic change is accomplished through first attending to one's bodily sense of the issue, pausing with it, and then following the steps of change that emerge.

As the following segment of a therapy session demonstrates, the client touches on a felt sense of something tightening up. The therapist's responses empathically guide the client toward acknowledging the appearance of this sense in the present moment. Note the physically felt relief the client expresses after the therapist reflects the client's own gesturing for a second time.

*Client:* I was thinking about what to talk about before getting here . . . in the car. I got here a bit early, and so I had some time to think.

*Therapist:* Uh-huh. And something came to mind while you were getting ready to come up?

*Client:* Well, yes, but I'm kind of not sure about it.

*Therapist:* Okay, so some hesitation . . . or "not sure" about it. Let me check first: Do you want to take a minute now to check with yourself to make sure this is the right topic—to see if it's okay on the inside to talk about this now?

*Client:* Yeah, let's do that.

*Therapist:* Okay, so take a moment to settle back and get comfortable . . . feeling yourself sitting in the chair . . . feeling your body resting against the seat and your arms . . . feeling how they feel. [After a pause, noticing the client's shoulders have dropped a little and he has shifted in his chair several times] So, if you can, find just the right way to sit in the chair so you can be okay.

*Client:* I don't really feel all that comfortable, but I don't think it's about the chair.

*Therapist:* So, something is like an uncomfortable feeling . . . not about the chair?

*Client:* Right.

*Therapist:* Let's make sure to go carefully here. You are having an uncomfortable feeling now, just noticing . . . this isn't about the chair.

*Client:* Right, right . . . it's more . . . than . . . that . . . [pausing, then trailing off]

*Therapist:* More than uncomfortable?

*Client:* Right, more like . . . [takes a deep breath]. . . more like a tight feeling right here. [pointing to the middle of his chest]

*Therapist:* Tight feeling . . . right here. [mirror motion]

*Client:* Ughhhh, it's not painful like pain or something, but tightening up. . . .

*Therapist:* The feeling is like tightening up in your middle chest area?

*Client:* No, IT IS tightening up.

*Therapist:* Ah, okay, this something right here [gesturing to the middle of the chest] is tightening up right now as we're talking about it, right?

*Client:* Yeah, right. It's okay though, it's a bit better now.

*Therapist:* Okay, it's eased a bit now too.

This particular client had something important to talk about, which was at first unclear to him. The therapist, probably rightly, guessed that they should go slowly as they discovered together what the nature of the discomfort was. Inquiring more about the tightening would have been disruptive to the process of discovery at this stage. More than likely, doing so would have obliged the client to engage in cognitive reasoning at the diminishment of directly experiencing the tightening. Going slowly, empathically guiding the client to pay attention to subtle bodily cues, pausing, helping the client find the right word or expression for what he or she is experiencing in the moment, being corrected by the client, following the shifts in perception as they move forward in small change steps—these are the basic elements that characterize the FOT approach. This entire sequence, summed up as attending, pausing, and following, demonstrates how the FOT practitioner assists the client's change process.

## BACKGROUND OF FOCUSING-ORIENTED- EXPERIENTIAL THERAPY

FOT is a seamless extension of Gendlin's philosophy, which asserts that all life is an interaction with its environment. Experiencing, people's touchstone in life, is an interaction and exists before their conscious knowledge of it. According to Gendlin (1961), people can understand experiencing as the bodily felt sense they have of life, as it is in the present moment. Gendlin's works offer a philosophically sound basis for practice and research that support the basic values of the humanistic tradition. We discuss these assertions in the ensuing sections.

Many already know of Gendlin through the process called *focusing* (Gendlin, 1978/2007). Focusing is the process of sensing what is bodily felt but not yet a specific or identifiable feeling or thought. Gendlin first introduced focusing to the psychological community in the 1960s as a distinct therapeutic process that assists client change. This was roughly the same period in which he was assisting Rogers with outcomes studies that sought to verify certain facets of Rogers's client-centered psychotherapy.

Early on, Gendlin (1973) used the term *experiential psychotherapy* to refer to his modification of person-centered theory and practice, stating, "Experiential psychotherapy works with immediate concreteness" (p. 317). This somewhat curious statement points to the crux of what distinguishes FOT from other experiential methods—that is, the explicit use of one's directly felt bodily experiencing. It is important to keep in mind that experiencing is "a direct feel of the complexity of situations and difficulties" (Gendlin, 1973, p. 317). Put another way, people's bodily sense of the present moment is their sense of the whole situation, not of any particular thought or feeling they may have about it. In FOT, accessing experiencing—attending to it, pausing with it, and following it—is data and is at the very heart of clinical work and a client's change process. To assist clients in their growth process, FOT practitioners empathically guide their clients to explore their experiences in the present moment without self-judgment and without suggesting any particular psychological or behavioral outcome.

Today, the term *focusing-oriented therapy* (Gendlin, 1996) is used instead of *experiential psychotherapy* to differentiate those using Gendlin's theory from those using one of the many other approaches in the extended family of experiential psychotherapies (Greenberg, Elliott, Lietaer, & Watson, 2013).

### An Overview of Gendlin's Philosophy

Gendlin is a philosopher and psychologist whose central assertions about psychotherapy and psychological research come from the traditions of

continental phenomenology and American pragmatism. Heidegger, Merleau-Ponty, Dewey, Dilthey, and McKeon heavily influenced his work. From this intellectual convergence came two primary insights: There is a basic unity to human experience that people can sense, and experiencing is the threshold of existence. The latter is an elaboration of the existentialist dictum "existence precedes definitions" (Gendlin, 1973, p. 322). In the practice of FOT, experiencing is a therapeutically critical concept and a lived reality to which FOT practitioners return again and again in sessions and in reflection on their work.

"The sense of, and access, to existence is the life of the body as felt from the inside, 'your sense of being your living body just now'" (Gendlin, 1973, p. 322). *Experiencing*, a richly nuanced philosophical and psychological term, is first of all an interactional process that involves one's self and the environment (i.e., physical context, personal history, biology, and relationships). It is presymbolic by nature, in other words before the formation of thoughts, emotions, or words. This formulation leads to the position that human experiencing is vastly more complex and intricate than any words can describe. Experiencing is thus a vast inner territory that can be intentionally moved into using processes such as focusing and empathically guiding the client toward the felt sense. FOT is based on a philosophical model in which experiencing is the basis for any higher level function of human consciousness one may identify, such as language, cognition, concepts, memory, or emotions.

Gendlin and colleagues built a practice of psychotherapy on this distinctive understanding of experiencing. The philosophy and practice emphasize that experience and, therefore, client change are recognized bodily. Especially important for the practice of FOT is the appreciation that creating the best environment for change involves assisting clients in accessing what is bodily sensed by both the client and the therapist.

### Interaction First: Body, Environment, and Symbolization

Interaction suggests that a human being is interaction, an extension of his or her body and the environment. Everyday experiences, as well as those explored in depth in therapy, and the efforts made to understand or communicate them are symbolizations of a much more complex interactional base. Feelings, like thoughts, are the symbolized contents of experience that partially reveal its salient aspects.

Another important principle is that one's bodily felt sense gives one access to experiencing the basic unity of body and environment. People's bodily felt sense is a partial symbolization of experience, one not yet fully articulated in words or concepts people would recognize in everyday conversation. Because the felt sense is only partly symbolized, it is often unnoticed

in therapy or dismissed as something inconsequential. A felt sense might be a funny or odd feeling one has about a concern that emerges during a period when the client struggles for words. The felt sense, as partly symbolized content, may also be present when clients encounter a wordlessness or sense of being stuck in therapy that does not appear to represent resistance or defensiveness. Instead, the wordless experience is rich and meaningful.

If experiencing is the presymbolic ground from which people's thoughts or feelings about a situation are derived, as Gendlin (1996) suggested, then it makes sense that they pay more attention to it. For Gendlin and the many experiential therapists influenced by him, consciously working with experiencing is at the heart of the changes therapists see in psychotherapy. Therapists in the FOT tradition assist their clients to access this interactional, partly symbolized level of the client's experiencing and empathically guide it.

### Implicit Intricacy: Never the Same and Always Interesting

The focusing-oriented therapist assumes that clients are multifaceted and complex sentient beings. Clients, or any person for that matter, may never fully know the depths of existence, but they have the capacity to touch the experience of this complexity through their bodily sense. In therapy, the present moment is implicitly intricate, layered with meaning and subtle experiential awareness, all of which are focused on an issue or concern. This insight is well known today, but at the time of Gendlin's (1961) early work it was a provocative claim.

The FOT practitioner is skilled at noticing when clients spontaneously engage in searching for the tentative, fluid quality of the felt sense. A client may find and label many feelings and thoughts in therapy (e.g., self-hatred, fear). The FOT practitioner understands that the labeled feeling, or cognition, is just the tip of the iceberg in relation to all else that accompanies its appearance in consciousness. There is always more implicitly present in any communication. Attending to the direct feel of the concern or situation helps clients touch the implicit intricacy of their experience and carry it forward.

### Carrying Forward: The Felt Sense Is More Than a Feeling

Central to FOT is assisting the client in carrying his or her experience forward. From the first two principles, it is clear that there is always more available to people than the symbols they initially use to represent their experience. Carrying experience forward is the sign of change in therapy and is most often noticed when the symbolizations used by clients change. When a

client makes a step forward in therapy, that step is not the end but rather an event that will most likely lead to and shape many more.

In the example below, a client has come to therapy with the hope of unraveling why he is overeating. After several sessions, the client begins to verbalize how his overeating is somehow linked to sadness and grief. In this case, overeating is taken to be a symbolization of his grieving. Here in this small example, one can see what the symbolization process looks like in the middle stages of therapy, where the therapist is helping the client find the felt sense of his experience. The felt sense is then carried forward into a different, more precise awareness at the end of this segment:

Client: I just can't get moving along; I just keep thinking of her and missing her.

Therapist: You're still missing her after all this time.

Client: Yeah, 2 years, and the only thing that makes a difference is, like, finding ways of getting my mind off her.

Therapist: Getting your mind off her?

Client: Eating, I guess. I've gained 25 pounds since she died. I hate myself for that.

[later]

Client: It's like there's a confusion or something about it all.

Therapist: Right, okay. So there's confusion. And let's just make some room for that feeling, not just rush over it, okay?

Client: How do you mean?

Therapist: Just sit quietly for a moment, if you can, and keep it company, like you would with a friend.

Client: Oh, I see. Okay. [long pause] It's like a not very friendly friend! That's for sure.

Therapist: Not very friendly, huh?

Client: Right.

Therapist: And can you get a sense of what the not-friendly feels like from the inside?

Client: Uhh, it's sort of like cold, feeling like being cold. [Client rubs his arm as if trying to warm up]

Therapist: Cold. The feeling is like being cold.

Client: Yes, there's more too, a sinking thing.

Therapist: Cold and sinking. Is that right?

*Client:* Yes, cold, and the feeling of sinking is familiar somehow.

*Therapist:* Familiar to you, right. Something about the cold sinking feeling is familiar.

*Client:* I know this. It's . . . it's . . . I'm feeling sad. Yeah, I'm pretty sad about all this.

At this point, the client has come from being relatively sure he hated himself for gaining weight to not being exactly sure that this is the feeling he means. With the help of the empathically attuned guiding therapist, his process was carried forward, and now he is sure he is sad. "Being cold" in this case was not quite right; it was close, but only an approximation that pointed to something more, to sadness. Hate only partially carried the meaning of overeating, but *sadness* was the better fitting word.

As this transcript shows, the felt sense is at first fuzzy, subtle, and tentative, an implicit intricacy just beyond words. FOT practitioners recognize this fuzziness as an indication that clients are working at the edge of their experiencing, on the border zone between the presymbolic and symbolic. The first words clients choose to represent this fuzzy edge are their tentative sense of what is presently known to them about an issue. These tentative understandings change, often quite rapidly, in the course of a therapy session.

Not all clients are comfortable with the tentativeness or fuzziness of the felt sense, especially if they are looking for something definite about which they can take action. It may take some time for clients to trust their own searching, to see it as a valuable part of the healing process. The felt sense can be elusive as well when one is purposefully searching for it. However difficult following a felt sense might be, it is important to note that most clients can be taught how to attend to it.

In total, these three assertions about experiencing affirm why it is important that the therapist be open to guide the process of discovery in a curious, searching manner, centering on the concrete lived expressions of the client. As Rogers (1975) put it, the client is "checking them [the therapist's responses] against the ongoing psycho-physiological flow within himself to see if they fit. This flow is a very real thing, and people are able to use it as a referent" (p. 4).

## DEVELOPMENTS AND DEPARTURES

In the mid- to late 1950s, Gendlin and colleagues at the University of Chicago, under the direction of Carl Rogers, conducted a series of studies that influenced the direction of psychotherapy outcome research (Gendlin,

1962; Gendlin & Berlin, 1961). Around the same time, Rogers wrote on what he felt were the core psychological qualities of the therapist needed for positive therapeutic outcomes (Rogers, 1957).

By 1968, Gendlin had diverged from Rogers in a key way: Gendlin saw that it was the manner in which the client processed experience that made the difference between successful and unsuccessful outcomes. The therapeutic relationship mattered, of course, but Gendlin believed that a promising approach in research would be to investigate more specifically what the empathically attuned therapist was following while listening to the client.

Another departure from Rogers lay in Gendlin's theory of psychotherapy and personality change (Gendlin, 1964). Gendlin's theory, in many ways a refinement of Rogers's (1959) original theory, went in a different direction. Gendlin's view was that growth occurs when clients attend to their experience (i.e., focusing) rather than as a function of assisting clients' actualizing tendency. Gendlin also differed from Rogers regarding whether the client must perceive the core therapist conditions. He thought Rogers's emphasis on whether a client consciously perceived these conditions was misguided, because the body is already engaging in the therapeutic process before perceiving these conditions.

Last, Gendlin diverged from what Purton (2004) called the standard view of person-centered therapy regarding whether any procedures such as instructions that guide focusing are compatible. Complete adherence to non-directivity in person-centered therapy appears to be at odds with the process-guiding approach found in FOT.

Although focusing instructions in therapy may seem like an intrusion or imposition of a technique, when therapists introduce focusing instructions they are ideally grounded in deep empathy. When clients are stuck and need help identifying their lived feeling of a problem, the focusing-oriented therapist helps by gently guiding the process. Most often, clients do not experience this guiding as intrusive or controlling. Not only is recognizing and then helping clients move toward experiencing practicable for success in therapy, it is highly prized in FOT.

Eventually, Rogers (1975) did embrace Gendlin's experiencing concept, although he did not engage in focusing with his own clients. It is clear that Rogers's reformulation of empathy came about partly because of his agreement with Gendlin's assertions, about which Rogers stated, "I believe it to be a process, rather than a state" (p. 4). Thus, for both Gendlin and Rogers, psychotherapy and research eventually came to focus on how therapists and clients together encourage the further flow of experiencing when expression closely matches its feel.

Hendricks (2002) reported on the body of research that has established the empirical validity of FOT. Hendricks reviewed 89 studies from a variety of clinical settings and problems. The research showed that a strong predictor of positive outcome in therapy was the manner and extent to which the therapist was able to help clients find and follow their present moment experiencing in session. Twenty-seven studies showed that (a) higher experiencing levels correlate with a more successful outcome in therapy in a variety of therapeutic orientations and client problem types; (b) clients can be taught the ability to focus and increase the experiencing level; and (c) therapists who themselves focus seem to be more effective in enabling their clients to focus.

### Experiencing Scale

Gendlin and colleagues developed an observer-rated scale called the Experiencing Scale (EXP; Gendlin, 1961; Klein et al., 1969, 1986), which measures the level of experiencing. A higher level of experiencing was predicted to correlate positively with good therapy outcomes. This central hypothesis has held up over the course of 5 decades of research (Greenberg, Elliott, & Lietaer, 1994; Hendricks, 2002).

In the typical research protocol using EXP, a trained rater reviews videotaped session recordings and determines the EXP level. At lower levels of experiencing, clients speak of external events only or refuse to participate and reference personal reactions to external events. At the middle levels of experiencing, clients will describe personal experiences and feelings, will readily present problems or theories about them, and will be able to synthesize these readily available feelings and experiences toward resolution of problematic or significant issues. At the highest EXP level, clients demonstrate full and easy access to experiencing, and all its elements are confidently integrated (Klein et al., 1969, p. 64).

In 39 studies reviewed in Hendricks (2002) on whether teaching focusing would significantly increase EXP level, it was found that focusing or EXP level increased when focusing was introduced by a trained focusing professional (e.g., by helping a client sense inside and pause to find a feeling quality or felt sense). Hendricks noted that in 11 studies a higher EXP level could be achieved during the training period, but this high level of experiencing was not maintained very long after ending focusing training. These studies did not fully address the decrease in EXP level after training. Two factors may have contributed to that decrease: (a) The studies were of relatively short duration and (b) it takes time to learn focusing fully.

Statistically significant correlations with successful outcome were found when participants reached the higher EXP levels (Stages 4–7). Goldman's (1997) multiple-case study showed that the experiencing level increases as the client is able to identify, accept, and stay with unclear, or fuzzy, thoughts or feelings. His study affirmed that clients at the highest experiencing level, Stage 7, spontaneously refer to the edges of their awareness and pause to find clarity, with little help needed from the therapist. Furthermore, Goldman found that good therapy outcomes required some preparation for most participants and clients.

A series of studies reported by Sachse (1990; Sachse & Atrops, 1991) showed that the quality of the therapists' responses could increase, maintain, or even flatten the clients' depth of experiencing. For these clients, the presence of a skilled focusing professional who makes high-quality deepening processing proposals facilitated successful therapy.

In a study not reviewed in Hendricks (2002), Kubota and Ikemi (1991) investigated whether focusing ability, as rated by the EXP, was a personality trait that is relatively stable and not easily affected by the immediate therapeutic relationship. To investigate this, they studied videotaped interviews of 35 medical students who were training in experiential listening for four 3-hour listening sessions. Both the speaker and the listener filled out the Short Form Relationship Inventory after the interview. This inventory measures listeners' congruence, unconditional positive regard, and empathy, as perceived by the speakers and by the listeners themselves. Trained raters using the EXP then rated the recordings. Kubota and Ikemi found no correlation between the EXP and the Short Form Relationship Inventory. They concluded that the manner of experiencing is not immediately affected by the perceived relationship. However, they did not rule out the possibility that the relationship may be enhanced as it develops over time.

In another study, Hiramatsu, Ikemi, and Yamaguchi (1998) devised an EXP for sand-play therapy, a form of art therapy popular in Japan and originally developed in a Jungian context by Kalff (1996/2004) in Switzerland. The sand-play EXP rates the verbalizations of clients talking to their therapists about the sand-play art they have just created. Fifteen clients participated in sand-play therapy for 12 sessions. Five expert sand-play therapists using a checklist for sand-play evaluation rated photographs of the sand-play art. The evaluation found that four of the clients made considerable progress during the 12 sessions, and four others showed little or no progress. Three trained raters rated the EXP levels of these eight clients under a blind condition, using the sand-play EXP. Their ratings were reliable, and the ratings were done again 2 months later to confirm test-retest reliability. Significant differences in both mode and peak EXP levels were found between the four high-progress clients and the four low-progress clients. This study may have

been the first to find that the manner of experiencing is related to psychotherapy outcome even in nonverbal forms of therapy such as sand play.

Hendricks's (2002) review clearly showed that experiencing was the central process in focusing, yet focusing practice had already evolved by then to include specific use of other experiential dimensions (e.g., the body, interaction, spirituality). One of the most prominent and well documented of these is CAS.

### Clearing a Space

Clearing a space (CAS) was the first microprocess of FOT to be studied in a systematic manner (Gendlin, Grindler, & McGuire, 1984). Originally understood as an optional preparation for focusing, in the Gendlin et al. (1984) study the CAS protocol was developed with the aim of assisting women with cancer with finding a psychologically safe space between themselves and their bodily felt concerns. It was thought that pinpointing such a distance would reduce the stresses associated with being diagnosed with cancer.

The CAS protocol begins with helping individuals find a way to focus internally in an accepting and nonjudgmental way while taking an inventory of their current felt issues or concerns and gently placing each concern aside for the moment. After one or more issues of concern are identified, the individual is guided to clear an inner space and to spend some time there. Several studies summarized below have confirmed that CAS helps establish an emotionally safe place from which people are better able to identify which concerns are of most importance and then work with them in a more productive manner.

Results showed that practicing CAS resulted in a statistically significant reduction in depression and increased positive body attitudes by lowering the level of stress experienced and increasing clients' positive body image. Katonah (1999) also found a significant correlation between her CAS Checklist and the EXP along with solid interrater reliability. Validity was established through correlation with the Secord and Jourard (1953) Body Cathexis Scale. Reliability was verified using the Spearman-Brown split-half reliability test (Katonah, 1999).

Results from Katonah's (1999) initial study—as well as two others, one using CAS with AIDS patients (Krycka, 1997) and the other with weight loss (Holstein, 1990)—showed promise for CAS use in health-related populations. In addition, the CAS protocol has been used as a therapeutic tool in case studies that looked at borderline personality disorder (Katonah, 1984) and suicidal ideation (McGuire, 1984). These studies showed that teaching CAS produced constructive psychological outcomes such as an increase in a positive sense of self and body image and a decrease in depression.

An invitation to find a clear space can be made in any therapy session. For example, in the following therapy excerpt, Gendlin (1996) demonstrated how his responses encouraged the client to dwell in this clear space:

- C3: Feel like I'm crumbling. That shakiness inside, and . . . I feel real shaky about coming here.
- T3: It would be nice if we could first ease it. Let's make a little space and stand back a little from it . . . and say, "Oh yes . . . that's right to be there. . . . It feels like . . . it feels at least like there's going to be a lot of stuff crumbling, and it's going to be very shaky-making." . . . It feels like that now, at least . . . do you know, like if a building were going to crumble, you would stand back half a block.
- C4: Hmm. We don't know how much crumbling it needs, but—  
(Long silence)
- C5: Yes, I feel a little bit back, but—
- T5: Hmm, spend a few minutes until you can have a nice feeling about this, like there's going to be a big change, and—. (Gendlin, 1996, p. 121)

As is evident in T3 and T5, the therapist's responses here are not intended to carry forward the experiencing of crumbling or the shakiness inside that the client reports (C3). Instead, they aim to help the client stand back (T3) and to secure a space where the client can have a nice feeling about it (T5).

Thus, space, or the adequate control of experiential distance from overwhelming feelings or situations, seems to constitute one of the therapeutic agents of FOT. Practitioners of FOT began to note the therapeutic effects of CAS by itself. Case studies such as those of Gendlin (1961, 1967; Gendlin & Berlin, 1961) and several research studies such as those summarized above and also below have continued to demonstrate the effectiveness of CAS as a therapeutically valuable, supplementary process to FOT practice.

### CURRENT LITERATURE REVIEW: FROM 2000 TO THE PRESENT

In this section, we include both macro- and microprocess research. The EXP and the Focusing Manner Scale—Aoki—English version developed in Japan (Aoki & Ikemi, 2014) are two of the most widely used of the macroprocess research tools that link FOT process with therapy outcomes. Microprocess research that focuses on what occurs within a session, or inferred psychological processes related to focusing, has included the CAS protocol and case

studies. The case study method continues to be a common way for researchers to augment quantitative data or simply to explore dimensions of therapy inaccessible to quantitative approaches. In general, the entirety of the research reviewed in this section has continued to support FOT as an empirically supported practice. New to this review of FOT are promising avenues for future research that focus more specifically on in-session client change and therapist behavior.

Current FOT research has shown a gradual change in what is considered most relevant by FOT researchers and practitioners. The research has shifted from more traditionally defined macroprocess, or outcomes research, to microprocess-oriented research. This is an important development, one that we discuss further below.

We believe that this shift is driving the kinds of research being conducted. For many FOT researchers and therapists, the relevant questions for research now revolve around whether and how clients access their ongoing experiencing and its relationship to client change (i.e., microprocesses). Thus, studies examining the activities of the client in session (e.g., FOT microprocesses) have become the main thrust of recent research.

A final important question is whether CAS is a new form of FOT or, rather, as it was conceived when it was first developed, it is a helpful step that assists clients in creating a psychologically safe place from which to work therapeutically in FOT. Katonah (2012) characterized CAS as “an experiential process [that has been studied] in its own right” (p. 138). Klagsbrun, Lennox, and Summers (2010) went so far as to state that it “can be used alone as a freestanding stress-reduction method” (p. 155). The evidence we present below has shown that CAS is a mechanism for therapeutic change, but this evidence does not completely answer the question of whether CAS is a distinct focusing-inspired form of therapy. This question remains to be explored.

### Macroprocess Research: Experience Is Key to Outcome

#### EXP

Studies using the EXP have continued from 2000 to the present, with researchers investigating such areas as the manner of experiencing in senile dementia (Ichioka, 2000) and using changes in EXP levels before and after the pause (i.e., moments of silence in focusing and therapy) to explore what happens within that pause (Uchida, 2002). A Five-Stage EXP (Miyake, Ikemi, & Tamura, 2008) has been developed that simplified the original rating criteria to eventually develop a paper-and-pencil therapist evaluation form of the EXP. In addition, this scale has been used by other FOT researchers in similar therapeutic approaches to help validate their own theories of

psychotherapy and to explore such in-session microprocesses as awareness of emotion. Excellent reviews by these theorists are available elsewhere, and we therefore do not repeat them here (Elliott, Greenberg, & Lietaer, 2004; Elliott, Greenberg, Watson, Timulak, & Freire, 2013; MacLeod & Elliott, 2012).

In a study involving 40 adult therapy clients, Toukmanian, Jadda, and Armstrong (2010) hypothesized that a strong positive correlation would exist between depth of experiencing (EXP) and the ability to engage in complex, internally focused mental operations. Three mental operations were studied—differentiating, reevaluating, and integrating. To test the hypothesis, the EXP was correlated with several scales, including the Tennessee Self-Concept Scale and the Perceptual Congruence Score developed by Toukmanian et al. (2010), which measures self-schema change. Such change is

conceptualized as the process of moving away from a less complex and rigid view of self that is incongruent with one's felt experience of self, to a more complex and flexible construal of self that is congruent with one's perceptions of self in interpersonal situations. (Toukmanian et al., 2010, p. 43)

The treatment group showed significant early to late therapy improvement in the three mental operations. The EXP Scale significantly correlated with participants' level of perceptual processing. This is important for therapists because it indicates that as clients deepen their experiencing level, their ability to evaluate their mental state and differentiate it from other states of mind also increases. The ability to differentiate depression from worry, for instance, could point to more realistic self-evaluation, reevaluation, integration, and improvement.

#### Focusing Manner Scale

In Japan, Aoki and Ikemi (2014) developed a new and potentially important scale for English-speaking researchers, namely, the Focusing Manner Scale—Aoki—English version (FMS). The FMS was originally developed by Fukumori and Morikawa (2004) and validated in Japan for a Japanese-speaking and -writing population. The FMS, along with its later versions, tests the degree to which focusing attitudes are present. The FMS subfactors related to focusing manner are (a) accepting and acting from experiencing, (b) bringing awareness to experiencing, and (c) finding a comfortable distance from experiencing. The scale has been revised several times in an attempt to better communicate the indicators of focusing attitude for a Japanese audience and then again for an English audience, resulting in the English version of the FMS. One advantage of the FMS is that it can be extended to the population at large, whether the respondents have had



focusing experiences or not. Thus, Japanese studies with the FMS could be carried out with a relatively large sample size.

Aoki and Ikemi (2014) reviewed 19 studies with the FMS done in Japan, many of them correlational studies in which the FMS was found to correlate positively with such scales as the General Health Questionnaire (Fukumori & Morikawa, 2004), Cornell Medical Index (Nakagaki, 2007), Tri-Axial Coping Scale (Yamazaki, 2005), Narcissistic Vulnerability Scale (Matsuoka, 2006), Tokyo University Egogram (Nakagaki, 2006), Emotional Intelligence Scale (Nakagaki, 2006), Sense of Trust Questionnaire (Kawasaki & Aoki, 2008), Self-Actualization Scale (Aoki, 2008), Resilience Scale (Aoki, 2008), Self-Affirmation Scale (Saito, 2008), Assertive Mind Scale (Saito, 2008), General Self-Efficacy Scale (Doi & Morinaga, 2009), Kikuchi's Social Skill Scale (Doi & Morinaga, 2009), and Locus of Control Scale (Doi & Morinaga, 2009). Two studies investigating correlations between the FMS and EXP showed conflicting and, therefore, inconclusive results. An important study on the FMS is that of Yamazaki, Uchida, and Itoh (2008), who studied the FMS with 146 college students and used path analysis to interpret the data. They found that focusing attitudes as measured by the FMS reduced the tendency for depression as measured by the Japanese version of the Self-Rating Depression Scale. The use of path analysis in this study is significant because it shows causal relationships—that is to say, focusing attitudes had a causal influence on the reduction of depression.

Aoki and Ikemi (2014) also showed that certified focusing professionals scored significantly higher on all subscales of the FMS compared with non-focusers. Thus, one can speculate that long-term focusing experience may enhance focusing attitudes.

These studies using the FMS have shown that attitudes toward one's experiencing, frequently called *focusing attitudes*, correlated with positive psychological qualities and reduced the tendency toward depression. Moreover, long-term practice of focusing may enhance focusing attitudes, which in turn may augment the psychological qualities mentioned above. Although the FMS has only now been published for English speakers, it holds great promise as another focusing-specific instrument used in research.

### Microprocess Research: Documenting Client In-Session Change

#### CAS Protocol

A number of recent studies, including several from Japan, have examined the usefulness of the CAS protocol as a valuable addition to FOT research. CAS studies have been applied to a wide range of subject populations, including college students, patients with cancer, people with chronic

pain, and people who have experienced childhood trauma. As discussed below, the research has indicated that CAS functions more therapeutically than originally conceptualized and is related to changes in self-perception and stress reduction.

In Japan, two graduate clinical psychology students taught CAS on an individual basis to 12 peer supporters for three sessions over a 3-month period (Koshikawa, Isobe, & Ikemi, 2012). Peer supporters are contemporaries of currently enrolled students who provide a variety of help to students. The Tri-Axial Coping Scale, a measure of stress coping, and the FMS, a measure of focusing attitudes, were administered to the 12 peer supporters before and after this 3-month period. Results indicated that Avoid-Thinking (a subscale of the Tri-Axial Coping Scale) showed statistically significant increases over this period. This finding suggests that peer supporters were more able to cope with issues by distancing themselves, avoiding thinking about or being obsessed with issues.

Ide and Murayama (2008) conducted CAS with 15 elementary school children in a child residential shelter. They measured the effects with the Sentence Completion Test (Sano & Makita, 2008) and the Self-Direction Scale (Asami, 1999). CAS facilitated children's sense of self-direction and reflective self-expression, producing positive changes in the relationships between children and care workers.

In another study (Uemura, Yamami, Saeko, Hikari, & Ikemi, 2012), 22 Japanese university students were taught CAS as a way to reduce state anxiety, which was measured by the State-Trait Anxiety Index (Hidano, Fukuhara, Iwawaki, & Soga, 2000). Results showed that state anxiety declined significantly during CAS.

These findings suggest that CAS allows one to find a safe space, a comfortable psychological distance from one's problems or concerns, as indicated by significant increases on the Avoid-Thinking subscale in the Koshikawa et al. (2012) study. Despite the fact that avoid-thinking gives an impression of avoidance, it is an effective coping strategy; Uemura et al. (2012) found that state anxiety is indeed reduced through CAS. Ide and Murayama (2008) found self-direction, reflexive self-expressions, and positive changes in relationships with the reduction of anxiety and a comfortable psychological distance from concerns. When the results of these three studies are considered together, their seemingly paradoxical findings can be woven together into a coherent whole.

In what was the first art therapy study to use a mixed-methods approach incorporating focusing (Klagsbrun et al., 2005), 18 women with breast cancer were taught CAS before a 2-day therapy retreat that included use of various forms of the expressive arts such as painting and movement. Significant improvements were found on such pre-post measures as Functional Assessment

of Cancer Therapy for breast cancer (FACT-B; Brady et al., 1997) and Functional Assessment of Chronic Illness Therapy—Spiritual (Peterman, Fitchett, Brady, Hernandez, & Cella, 2002). FACT-B is a 44-item self-report measure assessing one's quality of life, including physical, social, family, emotional, and functional well-being. The Functional Assessment of Chronic Illness Therapy—Spiritual measures the relative importance of spiritual values and beliefs for the cancer patient. Klagsbrun et al. (2005) found only modest change to higher levels of experiencing as a result of learning CAS, but a strong correlation between learning how to clear a space and quality of life (FACT-B). Interestingly, the participants showed significant improvement in body image when those with an already high EXP level were factored out.

Klagsbrun et al. (2005) suggested that the increase in experiencing level overall was due to the composition of the subject pool, most of whom were involved in other nonmedical treatment modalities that likely heightened their experiencing level before the study. The strong improvement in body image in those who were not rated high on the EXP suggests, however, that CAS does increase the experiencing level for those who are not already actively involved in other self-improvement strategies.

In another study conducted by Klagsbrun et al. (2010), 17 participants were taught CAS in six 30-minute sessions. Participants were all Caucasian and between 43 and 65 years old. All but two had children, and nearly all (16 of 17) had a college or graduate-level education. All participants completed a post-CAS checklist to ascertain the degree to which they were able to set aside a difficulty and reach a "cleared space." Two delivery methods were used. Sessions 1 and 6 were in person; the others were conducted over the phone. A waiting-list control group was administered four pre-post instruments (FACT-B, Grindler Body Attitude Scale [Grindler, 1991], Inventory of Positive Psychological Attitudes 32R [Kass et al., 1991], and Brief Symptom Inventory [Grindler, 1991]) after Sessions 1 and 6 and then again after 6 weeks. Pre-post intervention results showed a statistically significant difference between treatment and control groups on the FACT-B instrument. No significant differences were found on the other instruments (Grindler Body Attitude Scale, Inventory of Positive Psychological Attitudes 32R, Brief Symptom Inventory) or delivery methods. This study demonstrated that teaching CAS can improve one's quality of life, as measured by the four instruments used. Also important for many therapists is the finding that providing CAS in either delivery method (in person or over the telephone) increases one's overall sense of well-being, calmness, and enhanced emotional regulation. It appears that providing CAS over the phone is as beneficial an alternative treatment as being taught CAS in person. For some, being able to receive CAS in a cost-effective manner would be important.

The effects of focusing and CAS on the experience of chronic pain were studied by Ferraro (2010). Focusing and CAS were taught over a 10-week period. The study assessed levels of depression, anxiety, and pain and body attitude. Results described participants as having a 28% decrease in depression, a 23% decrease in anxiety, a 21% decrease in experienced pain, and a 34% improvement in body attitude. Although these gains are modest, the results are augmented by the qualitative analysis of session transcripts, which indicate that patients did find a pain-free area in their bodies—a primary reason to use the CAS protocol with clients with medical conditions. In this case, the session transcripts supported this use while failing to make clear whether the entire focusing process or the CAS alone was responsible for the changes. As in the other studies mentioned that used the CAS protocol, this study showed the benefit of becoming aware of one's present-moment experience, finding a sense of optimal psychological distance from it, and then identifying a state in which one experiences a relative absence of or relief from the condition being studied (e.g., chronic pain or anxiety). This procedure is not unusual in the treatment of anxiety, in which it is important to find, first, an emotionally safe place from which to work on the issues or concerns.

Leijssen (2007) discussed her use of CAS in helping clients develop a healthy intrapsychic relationship by connecting with ongoing bodily experiencing. The case studies presented demonstrated the importance of finding just the right relationship with one's experiencing through what Leijssen called the *inner guide*. Being too close to a feeling state can be just as problematic for psychological equilibrium as being too far from the feeling. Negotiating one's inner terrain is assisted by the use of CAS. Leijssen concluded by suggesting that internalized success at finding just the right distance from one's problems becomes "a powerful [re]source" (p. 269) for intra- and interpersonal change.

Katonah's (2010) work, along with that of the growing number of researchers using her protocol, demonstrated that "clearing a space shifts one's relationship to particular issues towards a greater unification of the person and alignment with higher values and purpose" (p. 157). It now appears that clearing a space is a therapeutic modality with demonstrated positive impact on increased self-care, body image, recovery from trauma, and experiences of wholeness, among other psychological states.

In addition, these studies suggest that the process of clearing a space is not merely a pretherapy option but stands on its own as an important addition to traditional treatment for a variety of psychological conditions. As mentioned earlier, whether CAS will be studied as a stand-alone, focusing-inspired, psychotherapy practice remains to be seen. At the time of this writing, this course seems probable, in which case CAS and focusing will likely remain linked.

### Case Studies

A growing body of case studies have demonstrated successful psychotherapy outcomes of FOT. Several published in psychological journals have either shown a successful psychotherapy outcome with FOT or demonstrated particular focusing-oriented ways of approaching the client's condition. These studies have covered a wide range of disorders, difficulties, and modalities, including writer's cramp (Harada, 1994), somatoform disorders (Ikemi, 1997), chronic pain (Geiser, 2010), depression (Hikasa, 1998; Ikemi, 2010; Kurose, 2008), borderline personality disorder (Hoshika, 2007), dissociation (Coffeng, 2005; Krycka, 2010), depersonalization (Hoshika, 2012), trauma (Coffeng, 2004; Rappaport, 2010), anxiety disorder (Koizumi, 2010), panic disorder (Ikemi, 1997; Uchida, 2011), eating disorder (Hikasa, 2011), HIV/AIDS (Krycka, 1997), couples (Amodeo, 2007), parent interview of a child with adjustment difficulties (Doi, 2006), family therapy (Arimura & Kameguchi, 1990), and art therapy (Rappaport, 2009). These case studies and applications of FOT open up a wide variety of conditions to which FOT has been applied. Some have shown specific modalities of implementing FOT or specific ways of approaching particular conditions.

### Other Developments: Special Populations and Therapist Relationships

We briefly discuss two other developments below, because an increasing number of focusing-oriented therapists are involved in them. Although these areas carry the potential for future research, there are currently few or no rigorous outcome studies in these areas.

### Children's Focusing

The application of focusing to children has continued to grow since Martha Stapert integrated focusing into individual child psychotherapy in 1985 in the Netherlands. Since 1998, the International Children's Focusing Conference has been held every other year. National organizations for children's focusing have formed in the Netherlands, Japan, and Romania, testifying to the significance of this development. Literature regarding children's focusing is found on The Focusing Institute website (<http://www.focusing.org>), which currently carries 78 articles on the subject. These articles embrace such applications as child psychotherapy, methods of teaching focusing to children, the significance of focusing for school teachers, and the use of focusing-oriented teaching methods in the classroom.

### Therapist Focusing

A substantial body of studies is developing, particularly in Japan, on the use of focusing by therapists. This application includes using focusing

for therapy supervision (Itoh & Yamanaka, 2005; Kobayashi & Itoh, 2010; Madison, 2004), for therapy training (Ikemi & Kawata, 2006), for therapists who are experiencing difficulties with their clients (Kira, 2002, 2010), and for the therapists' own reflection about their clients (Yamazaki, 2013). These studies have consistently reported that therapist focusing enhanced understanding of the client or understanding of the therapist's way of relating to the client. Controlled outcome studies are needed in this area.

The *Manual for Therapist Focusing* was developed to assist therapists to focus on the felt sense of their clients (Hirano, 2012; Kira, 2010). It serves as a supplement to therapy supervision or as an alternative approach to aid therapists with difficult clients.

We conclude our review by reiterating that both macro- and micro-process research has demonstrated that FOT is a valuable, reliable, and effective psychotherapeutic practice. Research since Hendricks's (2002) review has supported her findings, showing that FOT is an evidence-based practice.

## FROM RESEARCH TO PRACTICE

Research on FOT has a number of practical implications of interest to researchers and psychotherapists, particularly as they identify best practices for FOT practitioners. In general, research has suggested that therapy will be effective if the therapist focuses on the three key tasks of FOT: (a) assisting clients in self-exploration through their bodily felt sense, (b) being a genuine and empathic companion to that exploration, and (c) assisting clients in identifying the next step forward in their lives. The findings also support the assumption made by most FOT practitioners that processing the bodily felt sense appears to help clients deepen their therapeutic work and achieve a better therapy outcome. It seems useful to consider briefly the therapeutic tasks associated with FOT and how client change occurs in the FOT approach.

Following is a longer transcription of a therapy session highlighting these key elements as well as helpful empathic guiding responses. The transcript is from a psychotherapy session with a woman who had just learned of a new, potentially life-threatening cancer diagnosis. She was very upset, as one would expect, yet she was honoring and being with her present-moment experience. Clinicians and researchers might appreciate the development of the session over several distinct periods, marked by the intensification of her experiential processing and a return to honoring and being with her experience. The entire focusing process of finding, attending to the felt sense, pausing, and carrying it forward into one's life is demonstrated here.

*Client:* I just got tired of everyone telling me that I would be fine and everything would work out. I just wanted someone to

sit with me and state the obvious, that sometimes cancer SUCKS!

*Therapist:* Ah, yes, this sucks [*takes a deep breath*] and you just want someone to be upfront about that and not give platitudes.

*Client:* I mean, I guess people are trying to be helpful, but that isn't what I need now. [*pausing briefly*] I feel it's so important to ME to . . . to . . . I don't know . . . to . . . [*becomes still and looks down*]

*Therapist:* Let me see right here if we can pause for a minute or so. Something feels so important . . . to YOU.

*Client:* [*Clutching a tissue in her fist*] I'm . . . [*takes a big breath*] . . . I'm swimming inside my head . . . my guts are all jumbled . . . I . . .

*Therapist:* So, there's some intensity here, as you say there's swimming inside your head and [*therapist mirrors the clutching motion*] your guts are jumbled up. . . .

*Client:* Yeah [*making a circling motion around her lower abdomen*], right here . . . it's all jumbled.

*Therapist:* Right here [*mirroring*], right here is where you feel the jumbled-upness. Can you just take a moment more here to see if that has something to say more?

*Client:* [*Takes another deep breath*] I'm sure it's . . . no, no . . . not jumbled . . . more like certain. Yes, it's . . . I'm certain of. . . [*appears to be searching again for something*]

*Therapist:* Certain of something, not jumbled, down here.

*Client:* Definitely certain now . . . yep . . . certain. [*Hands making more circling gestures*]

*Therapist:* Ah, okay, that part's for sure . . . it's certain of something. Ah, okay . . . certain . . . with this part too. [*Repeats similar hand gesturing*]

*Client:* [*Looks up at therapist*] Certain. I like hearing that back from you. [*Therapist holds client gaze; client settles back into her chair, appearing to be more relaxed, her hands now unclenched.*]

*Therapist:* It's good to hear "certain" back. [*Therapist settles back as well, unclenching own hands. A few moments of silence pass.*]

In this transcription, one can see person-centered work going on, but also guiding in the service of helping the participant find her felt sense and stay with it. She has a clear felt sense that, in this case, is demonstrated not

so much with explicit words but with simple language accompanied by gestures. Often the felt sense is still only partly articulated, but it nonetheless has movement in it. The session resumes after the silence into a more meta-cognitive self-appraisal, though it is still connected to the felt sense.

*Client:* I have truly learned the value of letting myself be exactly where I am rather than where I sometimes want to be. So many lessons along this journey! I cannot go around any of it, but must move through it with as much grace as I can muster.

*Therapist:* [*Takes a deep breath*] There seems to a big realization here . . . something inside has shifted to a . . . can I say . . . new perspective?

*Client:* Yes, something has shifted [*said with emphasis and leaning forward*] . . . and I guess it's big, but not so much "big" as . . . hmm, well maybe something tectonic is going on now inside me. . . .

*Therapist:* Something tectonic? Like deep underneath, it all is moving? [*Several-second pause. She is looking down in her lap.*]

*Client:* Ah, that really hits me right here in my heart. [*Points to the middle of her chest*]

*Therapist:* Ah, okay, that hit you right here. [*Mirrors participant movements*] Something deep is moving inside.

*Client:* Yes, deeply moving in places I can't really see [*motioning between her heart area and lower abdomen area*]. I know something is happening, because I feel the difference just sitting here has made, but I can't quite say why.

*Therapist:* Ah, so there is something here that can't quite say why [*mirroring her movements*]. [*Long pause, perhaps a full minute; therapist notices what appears to be a calmness in the client's facial features, but chooses not to mention that.*] And if you didn't have to say why this is happening, this tectonic shifting deep inside, what would you have then?

*Client:* I'd have me. I'd have me having cancer and having some sense of it all moving, not stuck, moving. I'd have ME moving. [*Client rests back in her chair, bringing her hands to her face, not clawing, but holding her own head.*]

*Therapist:* You'd have you . . . you moving.

*Client:* Can I just be quiet here for a while now? I want to take this in.

*Therapist:* Of course. I'll wait here for you.

For this woman, it was not only the revelation of tectonic moving (noted in the client's saying "ME moving") that was important. In addition, it is her own request for space in which perhaps the next new step that appears valued comes. The client's belief in her agency to choose her own response to challenges is buttressed by also recognizing the importance of actually allowing herself to feel the whole range of emotions that come with this diagnosis.

In a later therapy session, this client is at a deeper level of experiencing, as the transcript demonstrates.

*Client:* Too many things . . . there are just too many things I have to keep track of now. I'm getting overwhelmed by the meds and the scheduling. . . .

*Therapist:* This seems pretty important to you, the overwhelm you feel with all of the things you need to track now. How about we just make some space for this?

*Client:* Yes, sure . . . I think that would be a good thing.

*Therapist:* Then let's take a moment now to just let your attention settle down inside. Is that okay . . . er, possible, or do you need some help in that?

*Client:* No, I can do it . . . hmm, let me see [*closing her eyes and folding her hands in her lap*].

*Therapist:* I'm just going to wait for you quietly here; let me know if you need something from me.

*Client:* [*After a few moments of silence*] Well, it feels crowded inside . . . like all whirling around . . . and I'm just almost bombarded by it all.

*Therapist:* So there's a crowded feeling, like a whirling going on inside . . . and a sense of something like bombarded. . . . Did I get that right?

*Client:* Yep, but it's changed now, just now it seemed to shift or something. It's different.

*Therapist:* Different?

*Client:* Well, kinda now more like bombarded isn't quite right . . . the whirling is still going on.

*Therapist:* So, whirling inside is still there, it's just that it isn't so much a bombarded feeling now.

*Client:* Right, not bombarded . . . still whirling. Like I'm not so overwhelmed either.

*Therapist:* And is this someplace you could stay a little while and keep company?

*Client:* Yes, I could do that. It's even calmer now, too.

*Therapist:* It's even calmer. So, let's pause here for a moment or so, just keeping that company.

In this part of the session, the client is self-directing much of her own processing about the manner in which her life has changed since her cancer diagnosis. The therapist is a guide whose job is only to assist her at this point. She is following her own feeling of it all inside, and even though she is not using overt body-focused words (e.g., *tingly*, *funny in my gut*), it is clear she is feeling the whirling and later the sense of being more calm inside that arose. Her own microprocess has led to shifting the way she is experiencing her inner life.

## SUMMARY AND CONCLUSION

The evidence from studies on experiencing level, focusing manner, clearing a space, and the case studies presented here represents a continued effort by FOT researchers to understand further the role that depth of experiencing plays in psychotherapy. Discovering the personal meanings and the character of changed experience is, of course, important for clients, because it assists them to move forward in their lives. FOT practitioners are now better able to describe practice that is congruent with its philosophical and theoretical basis, an approach that remains deeply humanistic and that offers a way of speaking about therapy that honors human experience and meaning-making.

As Katonah (2012) stated, "Scientific inquiry begins with differentiating human processes and looking for their contributions to human living" (p. 138). Today, research on FOT includes specific topics important to the practice of psychotherapy in general: working with dreams, the therapeutic relationship, what assists recovery from illness, the influence on therapy of the therapist's own experiencing, and what helps clients improve their quality of life.

As stated earlier, today there are certainly fewer outcome studies on FOT, though there is more research on microprocesses than in the past. Legitimate questions can be raised as to why so few experimental studies on FOT, particularly those with control groups, have been conducted of late. Perhaps it is because of the wider use of process measures in general and, as suggested by Gendlin (1986), because the correlation between a higher experiencing level and positive psychotherapy outcome has already been sufficiently established.

We note too that current and emerging process research on FOT has used refinements to traditional methodologies that are typically based on cause-effect principles. To this end, future evidence of the successes or limitations of FOT will likely take the form of establishing shared definitions of what constitutes the quality of attending and pausing and the ability to trace patterns forward in one's living over the course of many sessions. Finally, although it is clear that FOT continues in the tradition of person-centered humanistic psychology, it is also true that its renewed emphasis on examining psychotherapy by defining process variables is helping the field retain its emphasis on lived experience and human dignity.

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