Trauma, Imagery and Focusing

Trauma, bildhafte Vorstellungen und Focusing
Trauma, evocación de imágenes y Focusing
Trauma, fantasie en Focusing

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Abstract. This practice-oriented paper describes new work with three clients who had Post-Traumatic Stress Disorder from a recent trauma. The first client had been in a war, the second had experienced a traumatic loss, and the third had developed the disorder after undergoing a Caesarean section. With each of these clients I improvised on the spot, combining imagery with focusing. One client imagined returning to the place of the trauma and afterwards focused explicitly. This experience was different from having flashbacks. The other clients did the opposite: they moved away from the traumatic place through the first step of focusing, Clearing a Space. The clients were able to focus as if they had used the process before, and the change that each experienced was impressive. Three vignettes are given. The procedure chosen for each client is explained after the fact, along with the conditions that were needed with each.

Zusammenfassung. Dieser praxisorientierte Artikel beschreibt neue Arbeit mit drei Klienten bzw. Klientinnen, die an einer Posttraumatischen Belastungsstörung von einem kürzlich erlebten Trauma litten. Der erste war in einem Krieg gewesen, die zweite hatte einen traumatischen Verlust erlebt und bei der dritten hatte sich die Störung nach einem Kaiserschnitt entwickelt. Mit jedem der drei improvisierte ich vor Ort und kombinierte bildhafte Vorstellungen mit Focusing. Ein Klient stellte sich vor, an den Ort des Traumas zurückzukehren und fokussierte anschliessend explizit. Diese Erfahrung unterschied sich von Flashbacks. Die anderen Klientinnen taten das Gegenteil: Sie gingen mit Hilfe des ersten Focusing-Schrittes, dem Schaffen von Raum, weg vom Ort der traumatischen Erfahrung. Die Klientinnen waren in der Lage zu fokussieren, als hätten sie das schon zuvor getan, und die Veränderung, die jede der

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beiden erlebte, war eindrücklich. Drei Vignetten werden geschildert. Das Vorgehen, das für jeden der Klienten gewählt wurde, wird danach vorgestellt zusammen mit den Bedingungen, die dazu für jeden notwendig waren.

Resumen. Este artículo orientado a la práctica describe un nuevo trabajo realizado con tres consultantes que padecían de estrés post traumático a partir de un trauma reciente. El primer consultante había estado en una guerra, el segundo había tenido una pérdida traumática, y la tercera había desarrollado el trastorno luego de una operación cesárea. Con cada uno de estos consultantes, improvisé en el momento, combinando evocación de imágenes con focusing. Un consultante imaginó regresar al lugar del trauma y luego focalizó explícitamente. Esta experiencia fue diferente a la de tener *flashbacks*. Los otros consultantes hicieron lo opuesto: se movieron fuera del lugar traumático a través del primer paso de focusing, despejar *un espacio*. Los consultantes pudieron focalizar como si hubieran usado el proceso anteriormente, y el cambio que cada uno vivenció fue impresionante. Se ofrecen tres viñetas clínicas. El procedimiento elegido para cada consultante es explicado, luego del hecho, junto con las condiciones que fueron necesarias con cada uno.

Samenvatting. Dit artikel komt uit de praktijk, en beschrijft de behandeling van drie cliënten met een PTSS na een recent trauma. De eerste cliënt kwam uit een oorlogsgebied, de tweede had een traumatisch verlies, en de derde kreeg de stoor-nis na een keizersnede. Bij elke cliënt improviseerde ik ter plekke, met gebruik van geleide fantasie en focusing. Een cliënt stelde zich voor dat hij naar de plaats van het trauma terugging; na afloop focuste hij expliciet op wat hij gedaan had. Deze ervaring was anders dan een herbeleving. De andere cliënten deden het tegenovergestelde: zij verwijder-den zich van de traumatische plek met behulp van de eerste stap van focusing, Ruimte Maken. De cliënten focusten alsof ze het al eerder hadden gedaan, en hun verandering was indrukwek-kend. De aanpak, die per cliënt verschilde, zal aan het einde worden toegelicht, evenals de basisvoorwaarden voor een derge-lijke behandeling.

Keywords**:** trauma, Post-Traumatic Stress Disorder, Focusing, imagery.

Victims of a recent trauma (trauma Type I; Terr, 1994) often have symptoms of an Acute Traumatic Stress (Shalev, 1996). Most of them recover on their own, through their own resilience (Bonano, 2004). Others develop PostTraumatic Stress Disorder (PTSD; van der Kolk, McFarlane and Weisaeth, 1996). These victims have flashbacks of the trauma, triggered often by an event, smell or sound that reminds them of it. To prevent that, they avoid places, newspapers or TV. They avoid feeling and they become numb. Many are depressed. At the same time their bodies are in a state of alarm, with anxiety, stress and irritability. Alert for danger, they don't sleep.

Type I trauma should be distinguished from Type II (Terr, 1994), which refers to a history of repeated traumas or traumas from childhood. The victims of the latter are said to have a *Complex Post-traumatic Stress Disorder* (Herman, 1992), often with symptoms of dissociation (Ross, 1997). They need a different approach, which is process-oriented and which involves more time (Adshead, 2000; Coffeng, 2002a, b; van der Hart, van der Kolk and Boon, 1998).

For PTSD (Type I trauma) therapies have been developed, coming from various orientations and including techniques such as hypnosis, rituals or eye movement desensitization

and reprocessing (EMDR) (van der Hart, van der Kolk and Boon, 1998; Kleber and Brom, 1992; van der Kolk, McFarlane and van der Hart, 1996; Shapiro, 1995). These therapies resemble grief therapies, with the recovery from trauma resembling the process of mourning (Bowlby, 1980; Lamb, 1988). There is also an overlap in content: a traumatic experience often involves a loss, and a loss can be traumatic as well (Jacobs, 1999).

Therapies for trauma and grief can be divided into two groups. Therapists in the first approach go straight to the issue with directive, intensive, confronting and time limited strategies (e.g. Saigh, 1998). Those in the second group try to decrease the client's arousal with relaxation. They may follow ways that are more symbolic, assigning writing tasks or rituals, without addressing the client's feelings directly (e.g. van der Hart and Goossens, 1988). Some therapists combine both approaches.

The Focusing/experiential method takes a middle position between confrontation and relaxation. Gendlin (1964, p. 164) points to an interesting phenomenon:

> A very important and surprising fact about direct reference to felt meaning is that, if the matter under consideration is anxiety-producing or highly uncomfortable, this felt discomfort decreases as the individual directly refers to the felt meaning. . . . [G]iven the topic, the more we focus upon the felt meaning, and the more we symbolize correctly, the more relief we feel.

When one is assisted to stay with an anxiety-producing problem, *and* to attend to the inner complexity of how it is felt inside ('the felt sense'), the anxiety subsides. There is a relief. What is more, there is also change. The felt sense changes, and the problem feels different afterwards. This effect is increased when words or images are found that match the felt sense.

Focusing typically occurs when one brings attention to one's felt sense (Gendlin, 1981; Iberg, 1981). It is done in steps, which can be learned. One can focus alone or with a helper or therapist. In both cases the focuser remains in charge of the process. The first step of focusing is *clearing a space*. One asks: 'What is getting in the way of feeling fine?' Problems experienced as taking up space in the body are put out on the ground. A distance is made between oneself and a problem, until the space between is felt. One sits next to a problem without having to carry it. The second step of the process is *getting a felt sense*. A felt sense is a vague feeling in the center of the body, containing both emotional and rational aspects of an issue (often problematic). It is the key to the whole issue. By asking, 'What is the crux of the problem?' a felt sense forms itself. With the third step, *finding a handle*, one asks for words or images which capture the essence of the felt sense. The correct handle is recognized by the felt sense. This is confirmed with the fourth step of *resonating*, in which the handle is repeated and the felt sense becomes more present. This step also often brings a change of the felt sense: an *experiential felt shift*. The problem feels different, and new words are then needed. With the sixth step of *receiving*, one acknowledges the steps one has gone through, and welcomes whatever came out of the process.

Coffeng (1992) has shown that Focusing can be helpful for clients with complicated grief. With these clients it replaced confronting techniques (e.g. Ramsay, 1977). Clients began to cry spontaneously as soon as they learned Focusing. They didn't need to be confronted.

Their grief had small *experiential steps* (Gendlin, 1990), instead of stressful catharsis. When their emotions arose they came after a felt shift, which brought relief.

The first step of focusing was found to be especially helpful. Given the experience of being able to find emotional distance in relation to their loss, they could attend to the loss without having to plunge into emotions (Coffeng, 2000a).

The first step of focusing, Clearing a Space (CAS) is an important process in itself (Gendlin, 1982/1983; 1999). When the body has a feeling of getting more air, it relaxes into its original position. The change is visible in clients. Their faces, voices and body posture change. They are surprised themselves that they feel differently.

By itself, CAS has been found to be very helpful for clients who were in difficult situations, such as those in a crisis (McGuire, 1982/1983; 1984a; 1984b); with cancer (Grindler-Katonah, 1996; 1999); with borderline personality structure (Grindler, 1982/1983); as well as those with weight problems (Holstein and Flaxman, 1996). In these cases focusing was limited to the first step alone; all the time was devoted to moving through this step in detail.

McGuire (1983) invented a variation of CAS for clients who were in a severe crisis. They were too upset to focus in the usual way, and so it was not the right time to teach the process. Looking for something that these clients could hold onto, McGuire asked them if they had ever had a positive experience. When the experience came to mind, she encouraged them to describe and imagine it fully. Then she invited them to return to the place of that experience together with her. Imagining themselves there with the therapist, the clients experienced a sense of space and relief. McGuire helped to protect the place (image) and space (feeling) of the client. The upsetting problem was placed at the edge of the image. Supported in this way, the clients could look at their stressful situations from a safe distance. McGuire's work inspired me as I assisted the three clients in the following vignettes.

CLINICAL VIGNETTES

1. War

The first client was a refugee from the former Yugoslavia, a survivor of an area where many people had been killed. He had PTSD, with nightmares and aggressive outbursts. He was afraid of losing control and attacking his children. This man had given witness about his war experiences in public and had been interviewed by journalists also.

It was unusual that I had been asked to see him, as I generally work with clients with Type II trauma. We have a special unit for refugees, where the therapists are experienced in using EMDR to work with Type I trauma, and are used to working with interpreters. But, being aware of issues with the press, the agency preferred me as a senior therapist. This preference suggested that this man was a special case and the pressure made me feel uncomfortable. I feared that these circumstances would complicate the therapy. But as the agency insisted, I consented to meet the client and to discuss the problem with him.

He came with an interpreter, which was something new for me. Fortunately she was

both experienced and cooperative. The client seemed to know what he was doing and appeared determined to start. When I mentioned my mixed feelings about the complex circumstances, he assured me not to worry: he would keep the press out of our work. I apologized to him for having to improvise. I said that I didn't know EMDR, but could refer him to a colleague who did. The client said that he trusted me, and that he didn't mind whichever way I worked. There was also another complication. Next to this recent war experience, this man had also gone through an early trauma. As a child, his mother had died in his arms. He told me we wouldn't need to attend to this loss, however, as it had been dealt with in a previous therapy.

Having no excuses left, I realized that I had to decide to go ahead. I would face his trauma, not knowing what to expect. It was like jumping into the dark. The interpreter also seemed to be concerned, but looked at me, waiting for my decision. Fortunately the client helped me with my hesitation: I felt his trust in me and in himself. So I decided to do it.

The client had recurrent flashbacks of his flight from village A to village B. Just before A was taken over by the enemy, a group of male citizens who were fit enough to walk had decided to escape on foot to B. The client was one of them. The journey had taken several days. They had crossed the country, avoiding roads in order to avoid the enemy. However, this had not prevented confrontation. There were many casualties, including relatives of the client. He felt guilty that he and the others had not been able to look after the wounded and the dead. The client was obsessed by this journey. From his face and body one could see his urge to go back there and to witness what he had seen.

In the following session, I proposed that we go there. I would join him, and together we would walk his journey from A to B again. We would do it in imagination, and slowly. We would have time to bury the dead along the way, if he wished. I let him know that he should give me a sign when he was upset, so that we could stop. We could stop at any moment. I could assist him with grieving. I also mentioned Focusing as something that might be helpful to him. I explained what it was and gave him a paper about it to read. I took an atlas, copied the map of his country and enlarged the copy of the area of his journey, so that he could show me exactly where we were. He became active immediately, and pointed to various places.

In the third session I gave the client the map and asked if he was ready to go. I made gestures as if I was putting on my mountain boots. He asked me to wait: he had to say farewell to his family first. He did so in his imagination and spoke to them one by one: then nodded that we could go. He told me how many people we were with and how we were grouped. He pointed to the map and described the land. Along the way we met the first casualties. He noticed the dead body of his uncle. At the time they had had no time to bury him, as they had needed to keep going. Now he wanted to bury him properly. I gave him a sheet of paper and asked him to write his uncle's name on it. I laid the paper on the floor and we dug a grave, in imagination, and laid the body in it. I asked him if he had a wish to say something, and he stood up and spoke to his uncle. He apologized for not having buried him that time. He said farewell solemnly, and when he was ready, nodded that we could go on. We walked again and he pointed to the map to show where we were.

We arrived at a place where there had been much shooting, and he got upset. I took a piece of paper and set fire to it with my lighter. When the paper was burned, I said that the

fighting was over and that he could relax. We attended to the casualties. He wrote their names on papers, which I laid on the floor. We buried the dead one by one, and he said farewell to them. At the end of the hour, I told him that we had been watching a movie of a war. I invited him to leave the cinema and to have coffee with me in the bar outside. I put my keys on the desk, as if they were the keys of the cinema. I asked him to focus: to concentrate on the middle of his chest and see what he felt. He was silent. His face relaxed and he smiled. He said it felt as if the window of an old barn had been opened. He felt a fresh breeze in the stuffy air. He was relieved.

In the fourth session, we went to places with more fighting and more victims. We laid many papers with names on the floor. We dug graves and the client spoke to the dead. He described stressful events. Having walked all day in the rain, his clothes were soaked. He sat near to a fire to dry them and, exhausted, he had fallen asleep. His clothes had caught on fire, and others of his party had rescued him. At another dramatic moment he and his companions had come upon enemy soldiers and were, in fact, surrounded by them. There was no escape or shelter. There were casualties everywhere. He didn't know where to go, or whether to crawl or to run. Stricken by panic, he had started to hallucinate. As he told me about this, he got very upset and I advised him to imagine a relative who understood how upset he was and who would comfort him. He imagined his brother and burst into tears. He left the room, and we could hear that he was weeping outside. When he came back he apologized for having cried. Again we stopped, left the cinema and had coffee. He was tired.

The fifth session was full of danger. He looked at the map. They could not continue; the enemy army was in their way. Scouts came back and said that all the escape routes were full of soldiers. The leaders discussed what to do and concluded that there was no alternative other than to go forward, even while realizing the risk. As expected, there was much shooting, with many people wounded and killed. Again I burned a piece of paper. When the fire or the fighting was over, we counted the victims. He preferred to bury the dead together in one big grave and he spoke to them.

In the sixth session, which was the last part of the journey, the client became hurried. He talked quickly and had no time to stop. When we finally reached our destination, he was not relieved and explained that this had to do with the many victims. He had tried to outdistance his emotions. It was all too much. This lack of relief also had something to do with the mixed feelings he had upon arriving in B. He had looked forward to getting there, but was disappointed by what he and the others experienced after arriving. Fellow citizens had not reached out to them. They were not welcome, either, as the city was overcrowded. He was disillusioned to see people quarrelling.

I proposed that we repeat the last part of the journey, but more slowly this time. We would bury all the dead, and we would attend to his disappointments. So in the seventh session, we buried the dead and he made many speeches. He also spoke to the people in B, and told them what he thought of them. After having done this he felt much better. I suggested to him that we should rest after the eighth session. I expected that his body would process it further. We planned follow-up sessions for one and two months later.

At the first follow-up session the client told me that his depression had become less

severe. He had fewer nightmares or other PTSD symptoms. To illustrate the change, he told of how he used to run to try to get rid of tension. He had gone early in the morning, as the town was quiet then. As soon as people appeared in the streets, his mood would sink. But now he no longer felt any need to run. He preferred to relax. He discovered that he liked to fish. The following month the man reported further improvement. Antidepressants could be decreased. He had no traumatic flashbacks any longer and he was not as tense as before. He was confident. He became interested in his wife and children, who also had scars from the war, and wanted to be transferred to another place where relatives lived, as his wife would feel better there. He asked me a favor. Could I write a letter to recommend this transfer? I wrote the letter and, two months later, I learned that he had moved to the other place and that it was going well with him.

2. Cherry blossom

For privacy reasons, some details are left out of this second vignette. I saw this client during the absence of her therapist. She had had a recent loss, which came completely unexpectedly and was traumatic. When I first saw her she was in shock, and seemed more dead than alive. Her face was pale, her eyes bewildered, and her body was without motion or gesture. She kept her overcoat closed. Her voice was soft. She didn't know what to think and asked herself continuously why it had happened. She had all the symptoms of PTSD and couldn't sleep. The tranquilizers didn't help and she asked for stronger ones. Concerned that the medication would blur her emotional process, I proposed that we try something else, having McGuire's adaptation of Clearing a Space in mind (McGuire, 1983). For this, we needed a positive memory, so I asked about her background. She told me that her father had an orchard with cherry trees when she was young. Images of the trees in blossom came to me immediately, as it was springtime. I asked her if she had had enjoyment in those days, and she described how she had looked at the trees. In the orchard there were towers that contained a mill on top. Tin cans, attached to the wings of the mill, made a noise when the wings moved and chased the birds away. She had climbed the tower with her father and was allowed to turn the switch of the mill. From up there above, they had looked at the trees. Telling me about this, she became animated.

I invited her to climb with me again to the top of the mill. She could turn the switch if she wished and we would watch the trees. I asked if she could imagine the orchard and could smell the blossoms. We were at the top of the mill and would leave her trouble outside of the image. She could imagine doing this and seemed to concentrate. A smile came to her face. Then I asked her to concentrate on the middle of her body, and to see how it felt to be in the orchard. After a silence, she began to shake. I became worried and asked if she was all right. She replied: 'Wait!' — so I waited. After some minutes, she opened her eyes and moved her body as if shaking dust from it. She looked at me and said: 'So, that feels much better!' She felt space inside. I relaxed.

I explained that she had a normal reaction to an exceptional event, even though her symptoms were alarming. I explained that she was in the first stage of grief, the stage of shock, bewilderment, disbelief and denial (Bowlby, 1980). She needed time. As the cherry

trees seemed to help, I suggested that she return to that image at home.

Afterwards, I thought back to how she was when she first arrived, and I thought that if she was depressed, she might need antidepressants. I felt stupid to think of this so late, especially being a psychiatrist myself.

The next week, it was as if a different woman came in to the session: she had no coat, was wearing a summer dress and was wearing make-up. She was alive and energetic. Her voice was clear. She told me she was fine. I wondered aloud how she had been managing. She said that she had told her friends to leave her alone, and had returned to the image of the orchard. Not yet believing my eyes, I apologized for having forgotten to consider antidepressants. She reacted with indignation: I had warned her against drugs! She had stopped them all, without having any side effects. She had slept well. And there was another improvement: having tried before to undo the loss, she felt that she could now face it. She was further ahead and began to look at the future. There was a lot to organize, but she was confident. She had passed the stages of grief in a few days. A few months later, I saw her therapist who told me that she was doing well.

3. Horses or fish?

This vignette concerns a client with PTSD about whom I was consulted. The woman's PTSD dated from an emergency Caesarean section two years earlier and her symptoms had become worse after a treatment with EMDR. She had had a normal pregnancy (twins), but at the end suddenly developed pre-eclampsia and was admitted to the hospital. From there, she was rushed to an academic medical center to have a Caesarean section. There was no time to prepare her emotionally. Hearing that they would give her spinal analgesia, she got images immediately of becoming paralyzed and feared that she would not to be able to ride a horse any longer. She was overwhelmed and felt that she had no control. She underwent the surgery in a dreamy state. The next day, not yet feeling back in reality, she was brought to her babies, who were in incubators with drips and tubes and looked more dead than alive. She was shocked to see them and couldn't believe they were her babies. She showed symptoms of PTSD: flashbacks of the operating room and of the 'dead' babies in incubators.

When she was discharged, the babies went to separate hospitals in two different towns, owing to a lack of incubators. She travelled a lot to see them and, being anxious about driving alone, had to find people to join her. It was a hectic time. When the babies finally came home she did not feel ready for them: they didn't seem to be her babies and she feared taking responsibility for them. In addition, she already had to care for the other children at home. She found that she couldn't cope. Her partner didn't understand this, which gave rise to conflict, and finally he left with his children. They divorced and she moved to another house. Alone with her twins her stressful state had improved, but the flashbacks, sleeping disturbance and feeling of unreality remained. She kept a distance from her babies, who still triggered, for her, flashbacks of the hospital. Before she came to our agency, she had had these symptoms for two years.

To me, the client seemed to tire easily. I respected her fragile balance and postponed interventions, wanting first to understand why it had gone this way. I asked about her life. There was nothing special: she had had a normal childhood. Talking about it didn't change

anything for her, but at least she appreciated the fact that we didn't discuss the trauma.

In the next session, the woman told me that she was afraid of losing her therapist, who had offered the EMDR and whom she trusted. I had no objection to her continuing to see him, and he had no objection either. We would alternate: she would see me one week and him the other. I wondered if Focusing could give some relief, thinking of McGuire's (1982/83) version of Clearing a Space, and I suggested that we try it. As she had mentioned riding horses, I asked her about horses and she smiled. She had liked horses since she was young. But then her smile disappeared: her horses were far away and she had no time for them. And, further, horses were also linked to the moment in the hospital when she feared she would become paralyzed. I dropped 'the horses' and asked if she could think of other happy moments. When she was a child, she had played in the fields with other children; lying on their bellies at the side of a ditch, they had watched small fish in the water. She smiled. I invited her to go there again, and encouraged her to imagine that place: the landscape, sounds, smell, and the fish. I kept her company so she could enjoy it without being disturbed. She looked happy. Then I asked her to fix her attention on the middle of her body, to see if she could feel the 'looking at the fish' inside. She was uneasy with feelings, but admitted that she felt relief. I advised her to return to that image at home, and gave her a paper about Focusing. She told her therapist afterwards that our session had given her hope.

Two weeks later, this effect was gone. Her symptoms had returned and Focusing had slipped out of her mind. When asked about her daily life, she said that she was busy with a rabbit she had recently bought. She looked proud: it was a special rabbit. I suggested that I could join her and share her admiration. In imagination, we would sit around the cage and look at the rabbit. I asked her to describe it and when she had, I asked her to fix her attention on the middle of her body again and feel how it was in there, watching the rabbit. She felt energy and space.

This effect lasted longer. At our next session, the woman told me that she had felt relaxed a few moments at home. We then did the first step of Focusing in its original form. She should ask her stomach if her life was fine. She didn't feel her stomach but her head, which was heavy and tended to sink. Her neck and shoulders were tense and tired. I reflected that with words, and directed her attention gently to her stomach again. Finally, she could sense her stomach and felt something heavy there. However, she did not know what it was. Suddenly, the word 'hospital' came to her. She was shocked and surprised that this sensitive word came from her stomach and not from her head. I suggested that she place that 'hospital feeling' outside, as far away from her as needed. In her imagination she put it at the edge of our province, and got a sense of space inside. In contrast to the start of the process, her head felt light, her neck and shoulders relaxed. Having been tired at first, she now felt energetic and wanted to continue. And so we did the second step of focusing as well. She could concentrate and was able to experience a felt sense. She left feeling confident, with a perspective of becoming in control again.

At the next session all the symptoms of PTSD were back. She had returned to this state when she learned that a friend was expecting twins. That was the trigger. But as she told this to me, she realized that she was already recovering from it. Hearing afterwards that the delivery of the twins had gone all right, she felt reassured. After having discussed this I went ahead and

explained the complete Focusing, with all of its steps, and assisted her in doing them. She did all the six steps and experienced a sense of space in her stomach and in her head. It surprised her that she felt different. Then she remembered a special experience she had had at home. For the first time, she had looked at her children without flashbacks or the fear of flashbacks. They looked like her children, without that extra burden. She could feel like a mother!

The following sessions were similar. We started with Clearing a Space. When the 'hospital experience' was felt in her body, she put it far away. Sometimes, this memory was not in her body. She could not believe that at first, as she had come to expect that she should feel 'the hospital'. But later she felt hope, when she noticed that the trauma was not always in her body. Her mind had to get used to it. When we continued after the first step, we chose a positive theme or image to focus on, instead of her trauma.

The effect she experienced in our sessions was a contrast with how she felt at home. Fearing flashbacks, she could not relax at home and did not dare to focus there. Her therapist became concerned and suggested that she should see me more often. I maintained our pace, however, feeling that her recovery needed time. Moreover, I had observed progress already. Though she slipped back into her stressful state at home, she recovered quickly in our sessions. Gradually she had small positive experiences at home, and tried a few Focusing steps there.

The therapy is still going and the client is improving slowly. Recently she went on holiday for the first time since the trauma, and felt peaceful the whole week. We are 18 months from the start, and have had 23 sessions. The full account of it would go too far for the purposes of this paper.

DISCUSSION

Focusing was the main procedure with these clients and I wish to repeat its principles here: when clients are assisted in staying with an anxiety-provoking issue *and* with their felt sense of it, there is a release of tension and a change: the issue is felt and judged differently afterwards (Gendlin, 1964). Focusing is not only relieving, but it facilitates change as well.

Before one can attend to a problematic issue, one needs to have the right distance from it; it has to stay in focus. When it is too near, one is overwhelmed by emotions and not able to distinguish a vague felt sense; when it is too far away, one doesn't feel anything and can only think of it (Leijssen, 1993; Weiser, 1991). The right distance is somewhere in between and is felt with the first step of focusing. Then, focusers see the problem from a certain distance and feel space inside at the same time. They can look at it without being upset (Gendlin, 1979).

Clients with traumatic flashbacks re-experience the trauma with images and emotions. In this state, they don't feel the underlying, vaguely felt complexity of their trauma. They need the first step of Focusing (Clearing a Space) in order to watch the trauma from a safe distance. This step — to feel the trauma and to put it aside — is difficult for them. With McGuire's modification of the first step, a positive memory is used to help. In this way, the clients' attention is diverted from the trauma. The positive memory reconnects them with

how they have felt before and gives them something to hold onto when they clear a space (McGuire, 1983). There is no suggestion that the traumatic experience has gone away. It is identified and moved to the edge of the remembered positive place. The therapist accompanies the client in the image, and helps to protect the place and to keep the trauma at the edge.

Which technique was used for which client? The first client was eager to go back to the traumatic war situation. He knew where he was going. I followed him and hoped for the best. He didn't seem to worry. He had experience with therapy and knew what he was doing. Feeling his trust, I trusted we would manage. Remembering how McGuire (1983) joined her clients, I got the idea of joining him when he went to his traumatic place again, with the idea that his experience would be different from a flashback if he had company. The use of imagination made yet another difference. To make the image concrete I brought a map, so we knew where we were. Another difference was the use of the client's 'blueprint': his body's sense of what went wrong and what should have happened (Gendlin, 1991; 1993). He got the opportunity to do what he had wished to do, but couldn't, during the war. I offered him a ritual to bury the dead and to express his grief. By giving him a paper with their names, I made it concrete. With grief and trauma, there is also a need for attention to the client's wish to reconstruct or repair: to express what should have happened or should have been said (Coffeng, 1996).

When this client got upset about the fighting, I guessed he was re-experiencing it (flashback). It came into my mind to burn a paper. He could use it as a symbol for the fighting and for his anxiety. It also distracted his attention from the flashback: he was concerned I would burn my fingers. At the same time I connected the burning paper with the fight by saying it was the fight. When it was burned, I told him the fighting was over and suggested he could relax, which he did.

I was not thinking of focusing while we were on our way. The process went smoothly, so I just reflected what he said. Moreover, he didn't like to be interrupted or to waste time. He wanted to carry on and do something. At the end I told him we had been watching a war movie. I took him out of the cinema, closed the door and put the keys on my desk (in imagination). In this way we cleared a space. Then we had time to address his feelings quietly and to focus. Moreover, I wanted to check whether he had felt what we had been doing. If he had only had flashbacks, it would have meant that no change had happened. Instead, because our journey had been guided by his felt sense of the images, we had worked experientially and change had happened (Gendlin and Olsen, 1970; Gendlin, 1996). So afterwards, and outside the 'cinema', he focused. He closed his eyes and was silent. When he opened his eyes again, he told me that he felt fresh air in his chest. He had space. He was also satisfied, since we had addressed his trauma properly. He had had a change.

With the last two clients, I chose to clear a space with McGuire's variation, supposing they needed a distance from their trauma. The second client wanted this badly, as she was in such an acute, distressed state. The positive image of the cherry trees worked: she felt space inside. She had an experiential shift as well. The effect was visible on her face and body, and evidenced by what she reported afterwards: she had made progress in her grief process. Through returning to the image between the sessions, the change was reinforced.

With the third client, I used McGuire's variation of CAS several times. Her trauma was

complicated and she had had PTSD for two years. She was used to flashbacks and didn't remember how she had felt before. When she became familiar with having space, with the help of McGuire's approach, I was able to teach her the steps of Focusing the original way. She could concentrate without being disturbed by flashbacks. She was surprised by the effect of the process and it restored her confidence in herself. Initially, the effect was only temporary, as her stressful state returned at home. I assumed her recovery needed time. Gradually she started to have a few good moments at home. Later on she dared to try a bit of Focusing there.

I postponed addressing her trauma. As long as she needed to put the hospital experience far away, it was not the right moment yet to focus on it. Her fragile emotional balance did not allow it either. For the time being we focused on something positive, and she left the session with a word or image (handle) of the feeling (felt sense) of it. I supposed it would help her in the long run. Hence she could enjoy her recent holiday without getting flashbacks.

It is not only a matter of luck when interventions work in crisis situations such as with acute PTSD and grief. Van der Kolk, McFarlane and van der Hart (1996) emphasize the required commitment of the therapist in dealing with a traumatized client. This intensely personal element is often neglected in publications about techniques, but it is critical to the success of therapy. In order to do this work the therapist must be willing to step into a traumatic situation. It is a natural tendency to avoid people who are in distress. One risks getting contaminated by the misery or horror. It requires an extra effort to overcome one's reluctance and to reach out to help (van Dantzig, 1999; Dasberg, 1991). McGuire's (1983) imaginative journey was preceded by such basic steps. She showed commitment, canceling her appointments for that day in the presence of the client. Moreover, she sent policemen away while one client had a gun and was still intending to kill her husband and herself. Thus she showed trust. This enabled her to use her creativity and to invent her imaginative procedure. Stepping into a traumatic situation should not be something forced, but a free choice. With the refugee, I felt reluctant at first and allowed myself to refuse and express my reluctance. When it was heard, I could step in. Nevertheless, I felt the heaviness of his trauma and my tendency to want to escape.

In closing, it seems to me that there are four preconditions for this work. First, the therapist must be willing to step into a traumatic situation. A second precondition is the client's attitude. The clients I have described were ready to work. This helped me to step in as well. A third precondition is the match between therapist and client, and with these clients it felt OK to me. The last precondition is to realize that it is a stressful job. For this reason, I arranged extra coffee time with the interpreter, and free time for myself after the sessions with the other clients.

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