The Use of Focusing in the Treatment of Posttraumatic Stress:

An Exploratory Study

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The Use of Focusing in the Treatment of Posttraumatic Stress:

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BY

Catherina Dona Maria Hudek

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

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Dedication

This thesis is dedicated to

Diana Breen

With gratitude for her friendship and help.

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Abstract

Focusing is a client-centred, body-centred, experiential approach to psychotherapy developed out of research conducted in the 1960's and 70's by Dr. Eugene Gendlin and colleagues. More recently, Focusing has been adapted for the treatment of posttraumatic stress, and a two year certification program, Focusing and PTSD, has been developed and taught in various parts of Canada, including Winnipeg. As the use of Focusing with this population is still relatively new, it is largely unrecognized and unresearched. This is an exploratory study of the use of Focusing in the treatment of posttraumatic stress sufferers. Fourteen therapists who use Focusing in their treatment of trauma survivors, including eleven graduates of the certification program, were interviewed, using a semi-structured interview format. Topics covered included: the benefits and limitations of using Focusing with this population, as well as recommendations for safety and optimal use of this approach. While no definite conclusions can be drawn from the opinions of a small group of therapists, they contribute some interesting thoughts and observations to the discussion of these issues. While there was general agreement that Focusing must be adapted in order to be used safely in the treatment of people suffering from posttraumatic stress, numerous benefits were noted by all participants in their use of Focusing with trauma survivors. The data suggest that the work of these therapists meets both social work standards and current guidelines for the treatment of PTSD. It is hoped that this study will stimulate interest in the use of Focusing in the treatment of trauma survivors, and awareness of the training required in order to use such a powerful tool with such a vulnerable population.

Introduction

In February, 2004, the writer began an exploratory study on the use of Focusing in the treatment of posttraumatic stress. While there has been some interest of late in the use of Focusing to treat the effects of severe trauma, as of yet, there has been little, if any, research on the subject.

Post Traumatic Stress Disorder (PTSD) is one of very few diagnoses in the Diagnostic and Statistical Manual of Mental Disorders where the symptoms are recognized as resulting from external events (Matsakis, 1996). While events such as accidents and natural disasters can cause PTSD, higher incidence (Matsakis, 1996) and more severe outcomes have been noted where the trauma is intentionally inflicted, such as war, concentration camps, assault, rape, domestic violence and child abuse (Herman, 1992). PTSD can also result from institutional and societal abuse. For example, it is now recognized that PTSD is prevalent in some Aboriginal communities as a result of the abuse and oppression so many experienced in the residential school system (Fournier & Crey, 1997). Given social work's commitment to social justice (CASW, 1994), the treatment of survivors of trauma is of major interest to this profession.

Focusing is a research-based approach to therapy for any type of problem. It is a holistic, respectful, client-centered approach that is consistent with social work values

(Gendlin, 1981; CASW, 1994). It is, therefore, a form of therapy that may be expected to interest the social work profession.

Originally, an attempt was made to explore, in a more objective way, the effectiveness of Focusing oriented psychotherapy in reducing the frequency of symptoms in people suffering from posttraumatic stress. This was to have been done through a pre and post test approach with trauma survivors as study subjects. This original study design used the Screen for Posttraumatic Stress Symptoms (SPTSS), a brief self report measure of frequency of PTSD symptoms developed by Eve Carlson (1997).

Between March and October 2003, 66 therapists trained in the use of Focusing in the treatment of PTSD were contacted by letter (see Appendix) and by phone, and requested to assist in this study by distributing to clients who were survivors of severe trauma, a participant package. Each package included two parts, part A to be provided at the beginning of therapy, and part B, six months into therapy. Of the 62 who could be reached, 50 agreed to assist. Accordingly, approximately 90 participant packages for trauma survivors, including both pretest posttest envelopes, were mailed out during that time period. Each envelope contained two symptom checklists, one for the survivor's own use, plus one to be mailed back if the survivor was willing. Each envelope also contained information to ensure that consent was informed, an introductory letter, introducing the researcher and explaining the study and the auspices under which it was being conducted (see Appendix N), and a self-addressed stamped return envelope.

By December, 2003, out of the 90 participants packages sent out, only 5 pre-tests and no post-tests were returned. As a result, there were no useable data. Even if the pre-test results alone were of any interest, they could not be utilized, as prospective participants had been informed that, just as returning both the pre and post test would be understood as consent for their use in the study, refraining from returning the post test would signify that they had chosen to withdraw from the study, and the pre-test would not be used.

A positive side effect of this aborted study was the lesson that trauma survivors just entering therapy for PTSD likely were uninterested in taking part in a study on Focusing and PTSD. Their therapists, on the other hand, were excited by and most cooperative, as well as greatly interested in the results that might emerge from *any* research on this topic. A new study was devised, therefore, that would shift emphasis from gathering data directly from trauma sufferers, to studying the experience of therapists who use Focusing as a primary approach to treatment of trauma survivors.

The initial study was intended to explore whether a particular group of persons suffering from PTSD experienced a reduction in symptom frequency after 6 months of therapy which included Focusing as a primary modality. While interviewing therapists about their experience in using Focusing in trauma treatment would yield subjective rather than objective data, it was also expected that a study of therapists' experiences would explore a wider scope of questions. Since no studies could be found in a search of the literature on this topic, an exploratory study, in which qualitative data could be gathered seemed appropriate.

Focusing

Brief history of Focusing

Focusing was not originally developed as a treatment method for PTSD. As a matter of fact, it was not "developed" at all, but was, rather, a natural process utilized spontaneously by those clients who tended to make the best progress in therapy. It was noticed by Dr. Gendlin and his colleagues, then studied systematically, labeled, and finally taught, both to clinicians and to clients (Gendlin, 1981).

Focusing, as a therapeutic approach, grew out of research conducted by Dr. Eugene Gendlin and his colleagues at the University of Chicago on the questions: "Why doesn't therapy succeed more often? Why does it so often fail to make a real difference in people's lives? In the rarer cases where it does succeed, what is it that those clients and therapists do? What is it that the majority fail to do?" (Gendlin, 1981, p. 3). Their research involved many forms of therapy, as there were successes and failures within each. They discovered that the difference, the common thread that occurred in successful therapy and was absent when therapy was unsuccessful, lay in what the client was doing rather than in the therapist's actions or in the type of therapy being provided. Successful clients were tapping into a "special kind of internal bodily awareness" (Gendlin, 1981, p.10) which Gendlin called the Felt Sense. Fundamental to the concept of Focusing is the idea that the Felt Sense is meaningful and useful in resolving problems. It provides a holistic and implicit sense of the problem unfettered by the distracting chatter of defenses and explanations (Gendlin, 1981).

Further study of *how* successful clients were utilizing this inner awareness allowed Gendlin to break down the process into six teachable movements or steps, thereby making this skill accessible to all who wish to learn it (1981).

As a result of his research, Gendlin shifted in his own psychotherapy practice to teaching the client how to use Focusing, and then keeping the client company during the process through active, focused listening. "We want to give people the process, not [just] the experience. We don't want to give them a fish: we want to teach them how to fish" (Gendlin, 1995, p.34).

Description of Focusing steps

The first step in Focusing is Clearing Space. It is the process of setting aside, or putting down all of the problems, issues and concerns affecting a person at the time they are beginning the Focusing process. By clearing aside all of that clutter, a person can then focus in on one particular problem of their choice. (Gendlin, 1981) Clearing Space should be done from the body rather than from the head. The therapist can assist by asking the client to check into their body and ask if anything is in the way of feeling fine, and instructing them to wait for an answer from their body. If something comes up, the client is instructed to greet whatever comes, and, without going into it, set it aside and check in again with the same question (Gendlin).

Once the client has Cleared Space, and the problem to be worked on has been selected, the person can then check into the trunk of the body, and notice their Felt Sense of the

whole problem. The Felt Sense "is a body sensation that is meaningful" (Cornell, 1994). It is usually felt in the middle of the body: the throat, chest, stomach or abdomen, though it occasionally can be felt elsewhere in the body (Cornell). It is a bodily awareness of a person, situation or event (Gendlin, 1981). Examples of a Felt Sense that most people are familiar with include "butterflies in the stomach" before speaking in public, or "a lump in the throat" when deeply touched.

The next step is to find a Handle, a word, phrase or image that describes the Felt Sense fully and accurately. This can assist the person in staying with the Felt Sense or getting back to it if it is lost. The Felt Sense may be vague and hard to describe, especially for someone who is unfamiliar with noticing their bodily experience. It may be heavy, light, loose, tight, hot, cold, warm, prickly, hard, soft, sharp, dull, fuzzy, full, empty, hollow or dense. It may be something else entirely. It may best be described by an image: like a knife, a branch, a brick, a ball, or anything else. It may contain emotions but it is more than that (Gendlin, 1981), so if a client identifies an emotion first, it is useful to ask: "Where does that sit in your body?" and "What is that like, there where that emotion sits?" helping the client to identify the *quality* of the sensation of which the emotion may be a part.

The fourth movement of Focusing, Resonating, involves checking back with the Felt Sense to see if there is a *fit*. Resonating can be used to check if the Handle really captures the Felt Sense well. If there is a good fit, there will be some felt response, such as a deep breath inside, or a confirming sensation such as "Ah, that's it". As with any of

the steps, it is important to be patient. It may take a while to find a Handle that is "just right", especially if the Felt Sense you are experiencing is vague and fuzzy or if you are unaccustomed to paying attention to what is going on inside your body. Resonating can also be used to check anything else that comes up, in order to see if it is coming from the body, or is merely chatter from the head. (Gendlin, 1981)

The fifth step, or movement, of Focusing involves asking "into" the Felt Sense, and gently waiting for whatever needs to come forward. The Asking stage is where most of the therapeutic work takes place. Questions should always be open ended (Gendlin, 1981), such as: "What is this?" "What more is there?" "What would it like you to know?" or "What brings this now?" Then more pointed, but still open-ended questions can be asked: "What is the crux of this?" or "What is the worst of this?" Once the client has a clear sense of the core of the problem, forward moving questions can be asked, such as "What does this need?" Questions should be directed into the Felt Sense and the clients should be instructed to wait for an answer to come from there.

The sixth step of Focusing is Receiving, accepting whatever comes throughout the process without judging, analyzing or trying to fix it. (Gendlin, 1981) Time should always be given for the client to sit with the newness that comes from any shift in the Felt Sense. It is this *felt shift* that is the essence of internal change (Gendlin).

While the steps may follow the order in which they are presented, the process of Focusing is not linear, and any step can be used at any time in the process as it is needed.

For example, when Resonating on a Handle, if there is no bodily sense of confirmation, then the person should check back into the Felt Sense" for a Handle that is a better "fit". The Asking and Receiving steps frequently alternate. Resonating may be used to check whether an interpretation offered by the therapist "fits" with the client's Felt Sense. If something unrelated to the problem at hand comes up during the process, that can be "cleared away" as in the first step of Focusing.

A "Focusing Attitude"

A Focusing Attitude is one of curiosity (friendly interest), openness and acceptance (Gendlin, 1996), an attitude that is very gentle and helpful in dealing with past trauma. The therapist should maintain this attitude throughout therapy and encourage the client in this attitude towards whatever comes from their Felt Sense.

> A safe and steady human presence willing to be with whatever comes up is a most powerful factor. If we do not try to improve or change anything, if we add nothing, if however bad something is, we only say what we understand exactly, such a response adds our presence and helps clients to stay with and go deeper into whatever they sense and feel just then (p.11).

Focusing in psychotherapy

Gendlin emphasizes that an essential aspect of the use of Focusing in psychotherapy is the need to keep the process client-centered and client-led.

> This emphasis on the client's control of the process is not a question of democracy, or some abstract desire to let people do it themselves. Rather, it has to

> do with the kind of change we want, or more exactly, with psychological change as such. Psychological change comes from inside. What the therapist can do deliberately is insignificant compared to the client's inwardly arising change (1996, p.106).

Focusing is not meant to be used in isolation of other tools and approaches to therapy. While Gendlin holds that cognitive therapy alone is not effective in producing much in the way of lasting change, he does see it as an important ingredient in the therapy process. "Focusing is a conversation between the felt sense and the cognitive side" (1996, p.238).

Gendlin considers the therapeutic relationship to be of the utmost importance in therapy. "*In therapy the relationship (the person in there) is of first importance, listening is second, and focusing instructions come only third*" (1996, p.297).

Trauma: Theoretical Overview

In order to understand the significance of trauma in our society, and the importance of ensuring ways and means of providing effective healing alternatives, it will be useful to review briefly, a history of trauma, its forms, its prevalence and its impacts.

History of the Study of Trauma

Interest in the effects of trauma on humans has been evident in the psychological literature over the past several decades (Herman, 1992). For the purposes of this review,

discussion will be limited to the controversies which have arisen and have affected societal response to people suffering from posttraumatic stress.

Research on the effect of traumatic experiences on human beings other than isolated case studies initially focused on soldiers suffering from "shell shock" in WWI and WWII, the Korean war, and the war in Vietnam (Herman, 1992; Southwick, Bremner, Krystal, & Charney, 1994). "Only in recent years has the correspondence between men's reactions to the trauma of war, children's responses to abuse, and women's responses to sexual and domestic violence been made explicit." (van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996, p. 84).

The study of psychological trauma is fraught with inconsistency, denial, and dispute, as well as emotional reactions and judgments by clinicians, researchers and society in general (Herman, 1972; van der Kolk, 1996b). Skeptics have challenged the concept of posttraumatic stress disorder, for example arguing that flashbacks are not real phenomena but are creations of filmmakers of Vietnam war films, who used flashbacks as a plot device in many Vietnam war films of the 1960s (Brewin, 2003). These skeptics have suggested that this disorder was added to DSM mainly for political reasons, as a result of lobbying by Vietnam veterans and their clinicians, and have expressed concern about its ramifications for entitlement to disability benefits (Brewin).

Another area of controversy, which has engendered a great deal of media attention, arose as adult survivors of child sexual abuse began to seek treatment for the abuse they had

suffered. When the parents of Dr. Jennifer Freyd were confronted by their daughter regarding sexual abuse by her father, of which she had no memory until adulthood, they proceeded to create The False Memory Syndrome Foundation, an organization that promulgates the view that memories of sexual abuse can not be forgotten and then recovered, but rather, are "planted" by therapists who are treating people for concerns such as depression (Freyd, 1993).

Wide spread propagation by the mass-media of the concept of "false memory syndrome" resulted from the fact that parents accused of abuse, and groups such as The False Memory Syndrome Foundation, are open to give interviews and put their views forward, while the accused and their therapists are rarely willing to speak directly to the media. This discrepancy has resulted in a very one-sided media coverage of the issue (Brewin, 2003). The "false memory syndrome" controversy has been further fueled by extreme and unsubstantiated views on both sides: for example, that recovered memories are always false and arise from overly suggestive therapy techniques, or, on the other side, that persons experiencing symptoms of abuse while having no memory of abuse should assume that they were abused and take part in therapy aimed at recovering abuse memories (Brewin).

In addition to these controversies, there is a high level of denial in society regarding both the prevalence of trauma and its effects. People expect trauma survivors to recover quickly. Certain classes of people are expected to be able to deal with trauma without any effects, for example, police and the military (Brewin, 2003). In addition, survivors

of childhood trauma are frequently discounted or disbelieved. Jannof-Bulman theorized: "We spend our lives preserving positive illusions about ourselves and the world. These same illusions, which are shattered in victims by the experience of traumatic life events, are threatened in others by the acknowledgement of such victimization" (Brewin, p. 18).

Given this atmosphere of controversy and ambivalence, any approach to trauma therapy is bound to have critics as well as proponents.

Prevalence (Number of people affected)

Since 1980, when PTSD finally became a diagnostic category in the AMA's diagnostic manual, study has revealed that PTSD is one of the most common of psychiatric disorders, with a "lifetime prevalence of between 1.3% (Helzer, Robins, & McEvoy, 1987) and 9% (Breslau, Davis,& Andreski, 1991) in the general population and at least 15% in psychiatric in-patients (Saxe et al., 1993)" (van der Kolk, van der Hart & Burbridge, 2002, pp.23-24). A recent study in the southern US found that 69% of those in the sample has experienced some form of traumatic stress in their lives (McFarlane & Girolamo, 1996), and studies have shown that PTSD affects 10-30% of people who have been exposed to any type of extreme stress (van der Kolk & McFarlane, 1996; Carlson, 1997).

PTSD rates are even higher when the trauma involves "extensive torture, violent rape, or savage and life threatening combat...Life time PTSD prevalence for these at risk groups begins at around 30% for the *experienced* combat veteran and reaches to an excess of

90% for the most brutalized of prisoners of war or the victim of severe prolonged torture." (Tomb, 1994, p. 244) In a study by Kessler, Sonnega, Bromat, Hughes, & Nelson (1995) "45.9% of women who reported rape as their most upsetting trauma developed PTSD." (Tull & Roemer, 2002, p. 152)

Prognosis (likelihood of recovery)

Today it has been well documented and is generally accepted that "trauma can affect victims on every level of functioning: biological, psychological, social and spiritual" (van der Kolk & McFarlane, 1996). The effects can be both debilitating and long-lasting, continuing for years or even decades (Herman, 1992; Southwick et al. 1994; Tomb, 1994; van der Kolk & McFarlane). "The National Vietnam Veteran's readjustment study (Kulka, Schlanger & Fairbank, 1990) found that approximately twenty years after the end of the Vietnam war 15.2% of Vietnam theatre veterans continue to suffer from PTSD." (van der Kolk, van der Hart & Burbridge, 2002, p. 23) Even with long term skilled intervention, Herman asserts that "Resolution of the trauma is never final; recovery is never complete." (1992, p. 211) Southwick et al. agree that treatment may only be partially effective. Symptoms may be brought under control only to resurface later due to retraumatization, reminders of the original trauma, stress, or the losses and physical incapacitation that often accompany old age (Tomb).

The treatment of PTSD has some additional challenges. "PTSD often remains unchanged in the absence of treatment" (Taylor, Thordarson, Fedoroff, Ogrodniczuk, Maxfield, & Lovell, 2003, p. 331), yet "the majority of individuals with PTSD never

come to professional or research attention...[and] even patients who do seek care are frequently difficult to keep in treatment" (Tomb, 1994, p. 245). "People who suffer from PTSD seek treatment for such issues of modulation of anger, suicidal behavior, and dissociative symptoms, but tend not to seek treatment for their self destructiveness, difficulty modulating sexual involvements or somatisization, in mental health settings" (van der Kolk, Pelcovitz, et al., 1996, p. 86). Matsakis, in her self help manual for trauma survivors warns that the healing process is "neither painless nor quick" (1996, p.2) and that symptoms are likely to get worse before they get better. This explains, at least in part, the high drop out rate for people in treatment for PTSD. Matsakis further cautions that "there are those who have been so severely traumatized that they may be better off leaving the past unexamined" (p. 6).

With all of the above in mind, it is clear that careful attention must be paid to ensuring that thorough assessment occurs before the beginning of therapy, that client expectations are realistic, that the goals of therapy are clarified, and that the termination process includes planning for dealing with the possible reoccurrence of symptoms.

Comorbidity (presence of other disorders along with PTSD)

Experts in the trauma field have found that PTSD, especially when chronic, and related to multiple trauma or a period of ongoing trauma, rarely is a sufficient diagnosis to describe the full extent of the person's suffering (Horowitz, 2001; van der Kolk, Pelcovitz, et al. 1996). Other disorders most commonly associated with PTSD include other anxiety disorders such as generalized anxiety disorder or panic disorder, major

depression, or substance abuse disorders (Tomb, 1994). Comorbidity with substance abuse disorders is particularly common for PTSD sufferers. Alcohol abuse affects 52% of males and 28% of females with PTSD, while drug abuse is a problem for 35% of males and 27% of females with PTSD (Foa, Keane & Friedman, 2000).

Substance abuse disorders can not only exacerbate the symptoms of PTSD, but can also complicate treatment (Foa, et al., 2000). The VA National Center for PTSD recommends that relapse prevention for substance abuse programs must include preparation for the possibility that PTSD symptoms may worsen as a result of sobriety. The need for PTSD treatment to be provided as soon as possible after substance abuse treatment for those affected was confirmed by a study which found that "The odds of being in remission at the five year follow-up were 3.6 times higher (95%ci = 1.42-8.94) for patients who received PTSD treatment in the first three months after discharge [from a substance abuse treatment program] than they were for those who did not" (Ouimette, Moos, & Finney, 2003, p.412).

Diagnostic Criteria

The first edition of Horowitz's book *Stress Response Syndromes* with its thorough review of research on the impact of traumatic stress, served as a basis for the formulation of the symptom criteria for the diagnosis of PTSD, which first appeared in DSM III (Horowitz, 2001). As a result of further study, a number of changes were made to the diagnostic criteria for PTSD in DSM IV.

One of these changes involved Criterion A. In DSM III-R, criterion A required the stressor event be "outside the range of normal human experience" (American Psychiatric Association, 1987). Two studies on the lifetime exposure of people to traumatic events made it clear that traumatic events that had the potential to result in PTSD symptoms were *not outside the norm*: the National Woman's Study, which found that 69% of respondents reported having been exposed to a traumatic event, and the National Co-morbidity Study, which found that 60.7% of men and 51.2% of women had at least one traumatic experience that would qualify as a Criterion A event (Ozer, Weiss, Best, & Lipsey, 2003). Therefore, the phrase, "outside the range of normal human experience" was deleted, and was replaced with a requirement that the person's response to the stressor should involve "intense fear, helplessness or horror" (American Psychiatric Association, 1994).

The requirement that a person must have at least one symptom related to reexperiencing the trauma (Criterion B), at least three symptoms related to numbing or avoidance of stimuli related to the trauma (Criterion C), and at least two symptoms related to increased arousal (Criterion D), remained unchanged (American Psychiatric Association, 1987 & 1994). However, one symptom, "Physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event" was reworded and moved from Criterion D to Criterion B (American Psychiatric Association, 1987 & 1994). Also, notes regarding differences in how a symptom may present in children were added to Criterion A and to two more of the symptom descriptions under Criterion B (American Psychiatric Association, 1987 & 1994).

(Refer to Appendix A for a complete description of the diagnostic features of PTSD as presented in DSM-IV.)

Variations in Trauma Effects

Prior to the publication of DSM-IV, Herman argued that the effects of extreme, ongoing and pervasive trauma, such as experienced by many survivors of incest or of concentration camps, should be subsumed under a separate category, which she called Complex PTSD (Herman, 1992). DSM-IV acknowledges this distinction under "Associated Features and Disorders":

> The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics. (American Psychiatric Association, 1994, p.425)

However, this controversy regarding whether there should be a separate category for complex forms of the disorder continues (van der Kolk, Pelkovitz et al., 1996; Flack, Litz, Weathers, & Beaudreau, 2002).

Physiological effects (How trauma can affect the body and the brain)

"Many of the long lived symptoms of PTSD seem to have a biologic basis, even though the condition has environmental roots; it is one of the rare conditions in psychiatry for which one can create an animal model." (Tomb, 1994, p. 247) The fact that increased arousal, hyper vigilance, insomnia, poor concentration, autonomic hyper reactivity, and exaggerated startle response are symptoms which, for some people with PTSD, increase in magnitude over time rather than decrease, has been suggested to be a form of behavioral sensitization (Southwick et al., 1994). Research supports this theory, as described below.

One major area of research has been on the effect that extreme trauma can have on the brain. Findings in lab studies demonstrate two significant differences in the brains of people with PTSD: a decrease in the volume of the hippocampus (Bremner, 1997), and excessive activation of the amygdala and related structures (van der Kolk, 1996b). Both of these structures are directly involved in how memories are processed and stored. Sensory input is passed through the thalamus to both the amygdala and the prefrontal cortex. The amygdala evaluates the information for emotional significance before passing it on the hippocampus. The hippocampus has the task of organizing information, and integrating it with earlier similar experiences before forwarding it to the prefrontal cortex for appropriate storage. If the information indicates danger, the amygdala becomes highly activated and signals the part of the brain that triggers the "fight or flight" response (Brewin, 2003). Normally, in a traumatic situation, the hippocampus is

signaled that the information is important, and the memory stored will be particularly vivid and resilient. However, with repeated trauma, the amygdala may become aggravated and interfere with normal functioning of the hippocampus in integrating memory (Brewin, 2003). As a result, memory of traumatic events may become fragmented and disconnected from consciousness. "The experience is laid down, and later retrieved, as isolated images, bodily sensations, smells, and sounds that feel alien and separate from other life experiences" (van der Kolk, p.295).

These findings and attendant theories help to explain certain important additional features of PTSD which are intrinsic to this diagnosis. "Brain imaging studies... have...suggested that there is a sub-cortical pathway to the amygdala that processes visual fear-relevant information and can activate defensive responses even when participants are consciously unaware of what is triggering their fear" (Brewin, 2003, p. 117). This can account for the hyperarousal features of PTSD. The avoidance and numbing symptoms of PTSD, which may be exhibited in emotional numbing or in behaviors such as self mutilation, bingeing and purging, or the use of drugs or alcohol, can be seen as attempts by the affected person to compensate and self regulate their feelings. (Tull & Roemer, 2002; van der Kolk, 1996a).

Another area of the brain which appears to be affected by trauma is "Broca's area", a part of the brain which enables experiences to be translated into language. In one study, where the brain emissions of persons with PTSD were monitored while their own descriptions of their traumatic experiences were read back to them, it was found that

Broca's area, in essense, "turned off" (van der Kolk, 1996b p.293). This may explain why people with PTSD may experience great difficulty in putting feelings into words.

It is recognized that the the endocrine system, the nervous system, the immune system all interact with the brain on a continual basis (Ray, 2004). This provides a theoretical basis to studies which suggest that PTSD may increase vulnerability to diseases such as: Irritable Bowel Syndrome, Interstitial Cystitis, chronic pain syndromes, Fibromyalgia, Hypertension, Peptic Ulcer Disease, Ulcerative Colitis, Atherosclerotic Coronary Artery Disease, and Idiopathic Autoimmune Syndromes (Scaer, 2001).

Children may be particularly vulnerable to lasting disturbances in their functioning if they are abused, neglected or suffer separation from primary caretakers, as the central nervous system is still in the process of development during childhood (van der Kolk et al., 2002).

Levine contends that the hyperarousal symptoms associated with PTSD are due to undischarged energy from the defensive fight, flight or freeze responses to danger (2003). When a person is able to successfully fend off or escape from danger through these mechanisms, the energy generated is released naturally.

> To avoid being traumatized, the organism must use up all the energy that has been mobilized to deal with the threat. Whatever energy is not discharged does not simply go away; instead, it lingers, creating the potential for traumatic reaction to occur. The fewer resources the organism has to meet the situation, the more

> undischarged energy there will be and the greater the likelihood that trauma symptoms will develop in the future. (Levine, 2003, p. 2)

Psychological effects (How trauma can affect thoughts and emotions)

Bolton and Hill describe certain core beliefs that people need for healthy functioning, which include: "the self is sufficiently competent to act", "the world is sufficiently predictable", and "the world provides sufficient satisfaction of needs" (Brewin, 2003, p. 5). The highly unpleasant and unpredictable nature of traumatic events is sufficient to challenge and perhaps even shatter these kinds of beliefs, resulting in feelings of helplessness and hopelessness (Brewin). The shift from a sense of self as competent to a sense of incompetence can result in a lowering of self esteem and self confidence, which may present in self-criticism, increased dependency, or alternatively, isolation (Horowitz, 2001). Existential crises can result from the experience of trauma. For example, a child who has no supportive figures to turn to for hope of rescue from an abusive situation may experience the existential crisis of isolation (van der Hart, Steele, Boon, & Brown, 1993) "Psychologist Paul G. Zimbardo has gone so far as to propose that 'most mental illness represents not a cognitive impairment, but an [attempted] interpretation of discontinuous or inexplicable internal states.' Tonic immobility [as in a 'freeze' reaction], murderous rage, and non directed flight are such examples" (Levine, 1997).

Similarly, shattered views about the safety and predictability of the world can play a role in the recurrent feelings of anxiety and fear experienced by many trauma survivors.

> Instead of speaking of a lack of integration of the trauma in the overall life story, it seems more precise to speak of a dysfunctional integration, according to our results...Having a traumatic memory as a central component of the life story and personal identity may simply be harmful to a person's well being. (Berntsen, Willert & Rubin, 2003, p. 690)

Horowitz compared the work of two theorists, Janis, who considered emotions to be the motive or cause for cognitive processing and defense formations, and Lazarus, who considered emotions to be the responses to the person's way of thinking about things. "But these positions are not incompatible, as there may be many levels of conscious and unconscious information processing, with emotional responses serving as both cause and effect at different levels of representation" (2001, p. 115). This may explain why it seems useful for survivors of trauma to receive treatment that addresses both the cognitive and the emotional aspects of the traumatic experience.

A case has been made for the view that the hyperarousal features are the result of conditioned responses. Beck describes panic and posttraumatic anxiety as having in common, the experience of dread combined with the perception of inescapability (Levine, n.d.). This combination is present in many situations of ongoing trauma such as child abuse and the experience of prisoners of POW or concentration camps. Southwick et al. contend that "If an individual experiences a life threatening trauma, a wide variety of stimuli that were present at the time of the trauma can become conditioned to the attendant feelings of terror and extreme anxiety" (1994, p. 256). In

this way, defensive responses such as fight, flight or freezing, and their attendant feelings of rage, panic and terror may be triggered in a person through pattern recognition even before the situation is registered in the person's consciousness (Levine, n.d.).

Trauma and memory

The theory that traumatic memories may be repressed in some people continues to be controversial in spite of numerous studies that have confirmed the phenomenon (Brewin, 2003; Bremner et al, 1996; Terr, 1994; van der Kolk & Fisler, 1995; van der Kolk, Weisaeth, & van der Hart. 1996). Elizabeth Loftus and two colleagues published a study in 1994, regarding memories of childhood sexual abuse. They criticize the methodology of other studies, and suggest that these studies had inflated numbers of sexual abuse survivors who had repressed any memory of their abuse for some part of their lives. Yet 19% of the women in the Loftus study also had forgotten the abuse completely for a period of time and an additional 12% had gaps in their memories. In *The Myth of Repressed Memory,* a book by Loftus published that same year, Loftus omitted any reference to studies which found evidence for repression, including this information from her own study (McFarlane & van der Kolk, 1996b).

While retrieval of repressed memories is just one aspect of the use of Focusing in the treatment of PTSD, it is this aspect that is likely to draw the most impassioned criticism. At the same time, retrieval of repressed memories is not the goal of Focusing, but rather

an occasional result of the process of tracing "triggers" such as panic reactions, to their source.

Repression, which is usually seen as a maladaptive coping mechanism, can be perceived as very adaptive when it comes to extreme stress or trauma. In a recent study of child sexual abuse survivors, where the abuse was independently confirmed, those who had repressed their memories of the abuse "showed better adjustment than other survivors" (Bonanno, 2004, p. 26).

Consistent with the previously described effects of trauma on the brain, trauma can affect memory in a number of ways in addition to the repression of traumatic memories, including various levels of dissociation, fragmentation of memories, and the intrusion of traumatic memories through various types of flashbacks. Indeed, some experts contend that "PTSD is in large part a disorder of memory" (Southwick et al., 1994).

A study by Zoellner, Foa and Sacks explored the connection of dissociation (referring to a way of coping with trauma whereby the person disconnects, to varying degrees, from the reality of the trauma, or from their body sensations and emotions) with impaired encoding processes (as when an aggravated amygdala impairs the normal functioning of the hippocampus in organizing memories before sending them to the prefrontal cortex for storage) in PTSD. Their findings suggest that dissociation may impair encoding processes. Possible explanations are that dissociation may impair the elaboration of incoming information or that dissociation impairs source monitoring. The authors were

surprised to find, however, that individuals with PTSD were not any more amenable to being induced to dissociate than those that do not have PTSD (2003). This finding suggests that dissociation is a product of the trauma, and is consistent with Ogden and Minton's contention that dissociation can be caused both by hyper-arousal and hypo-arousal (2000).

Three levels of dissociation have been identified in relation to trauma responses. Primary dissociation involves a complete disconnection of the traumatic memory from consciousness, resulting in amnesia for the traumatic event. Secondary dissociation involves the fragmentation and compartmentalization of the various components of memory. Tertiary dissociation involves fragmentation of the person's identity, as found in Dissociative Identity Disorder. Of these, secondary dissociation is the most common (Cardina, Maldonado, van der Hart, & Spiegel, 2000).

Because of the fragmentation of memory due to secondary dissociation, memories of the trauma may have no verbal or narrative component at all, but present, at least initially, as "fragments of the sensory components of the event: as visual images, olfactory, auditory, or kinesthetic sensation or intense waves of feelings" (van der Kolk & Fisler, 1995, p. 511).

Brewin provides a description of some important features of flashbacks.

> Flashbacks are a highly perceptual form of memory that are elicited automatically and are under only limited conscious control. They have been claimed to be

> relatively stereotyped and un-changing even after multiple recall episodes, whereas ordinary memories are altered by repeated recall. They are also re-experienced in the present; that is, they do not possess an associated temporal context. All these features are suggestive of an image-based, non-hippocampally dependant form of memory that is unable to encode information about past versus present." (2003, pp. 123 – 124)

Van der Hart et al. identify two forms of flashbacks: partial re-experiences in which the memory is reactivated, but the person is still in touch with the present and current situation and the second type is the complete re-experience; during which "the trauma becomes the total current reality for the dominant personality" (1993, p. 164). Partial re-experiences tend to be fragmentary, with any part or dimension of the trauma being reactivated and relived while the whole story may remain in the unconscious. Usually the person can remember the flashback after it is finished. If the flashback only involves aspects such as pain, or emotions such as fear and anger that are disconnected and disassociated from the rest of the memory, the person may be confused and unable to comprehend what it is that is happening to them, leaving them feeling crazy. On the other hand, flashbacks that involve a complete re-experience of the trauma are more likely to be lost to consciousness afterwards. It is like a separate state of consciousness, where the person has no connection to the current reality while in the midst of a flashback, and then, after it is over, has no memory of the flashback. Complete re-experiences of this type are more common with people with Dissociative Identity Disorder (van der Hart et al., 1993).

Risk factors (for development of PTSD)

While it has not yet been fully established what factors make the difference between those who develop PTSD after experiencing trauma and those who do not, a number of factors have been linked to the development of PTSD. These include the severity of the trauma, the chronicity of trauma, the first experience of trauma at an early age, the degree to which the trauma is experienced as life threatening, the degree of personal violation experienced, and the use of dissociation as a coping mechanism during the traumatic event(s) (Herman, 1992; McFarlane & Yehuda, 1996).

One study found that women were almost twice as likely to develop PTSD after trauma than men (McFarlane & Girolamo, 1996). One possible explanation is that, because women are, generally, less physically powerful than men, they may experience greater feelings of powerlessness, and have less opportunity to utilize "fight or flight" mechanisms in traumatic situations. Another possible explanation is that the incidence in men is underestimated, as men may be less likely to admit to emotional problems or to seek help when experiencing emotional pain.

A more recent meta-analysis of studies identifying possible risk factors for the development of PTSD found that the factor with the greatest strength in predicting PTSD was a lack of social support. Other factors identified, in order of strength of findings, were: stress occurring after the traumatic event, trauma severity, other adverse

childhood events, low intelligence, low socio-economic status, childhood abuse, female gender, psychiatric history, and lack of education (Brewin, 2003).

A concurrent meta-analysis which looked at some different studies and examined some different factors, found that the largest predictor for the development of PTSD was the presence of peritraumatic (occurring during the traumatic event) dissociation, followed by peritraumatic emotional responses, post trauma social support, and perceived life threat during the trauma. Family history of psychopathology, prior trauma, and prior psychological assessment were found to be equal in predicting PTSD, though less powerful than any of the previously mentioned factors (Ozer, Weiss, Best & Lipsey, 2003).

Scaer describes a model of looking at the effects of trauma on the individual, which he calls the boundary model. He notes that closeness or distance, both of the trauma, and of the perpetrators of trauma, make a large difference in the degree of trauma inflicted. For example, experiencing a trauma first hand is more damaging than witnessing a traumatic experience someone else is going through, which in turn is worse than hearing about a traumatic experience. Where trauma is inflicted by another person, the closer that person is to the victim, the more traumatic the event is likely to be. This factor is particularly evident when children suffer from trauma from their primary caregivers, which is when trauma is its most devastating (2001).

Normal recovery from trauma

Although any person, if subjected to sufficient stress, can be expected to suffer from at least some stress response symptoms (Horowitz, 2001), "even life threatening events may not be traumatic for people who can respond and process them in a natural and effective way" (Levine, 2003). Factors that have been found to correlate with normal recovery from traumatic events include the ability to escape or fight back successfully in response to the threat (Levine), the opportunity to express and release emotion at the time or shortly after the traumatic event (Levine), an attitude of hope (Ray, 2004), the personality trait of "hardiness" (Bonnano, 2004), effective coping skills (Horowitz; Ray), and the opportunity to share their experience with others (Purves & Irwin, 2004).

Research has also shown that positive emotions and laughter can reduce distress following adversive events, both by undoing the negative emotions that would be raised by the trauma and by increasing mastery of the distressing experience (Bonanno, 2004). Bonanno also contends that self-enhancement, or an unrealistic or overly positive bias about the person's own being, is less problematic in context of highly aversive events. When a person is being threatened, a sense of invulnerability can be an advantage.

Differing responses to stressful events can also be accounted for, in part, by how each person's own history and internal schema "colors their personal meanings of an event and in part how their current life tasks and environment are affected by the event" (Horowitz, 2001, p. 129). The nature of the traumatic event appears to be less important than the survivor's perception of the event. "What one person sees as an insurmountable

demand is welcomed as an interesting challenge by another while not even recognized as a unique situation by a third" (Ray, 2004, p. 33).

Post-traumatic growth

The concept of post traumatic growth has been identified increasingly in the literature over the past decade (Brewin, 2003; Horowitz, 2001; Tedeschi & Calhoun, 2004; Tomb, 1994).

Tedeschi and Calhoun define post traumatic growth as "the experience of positive change that occurs as a result of the struggle with highly challenging life crises." (2004, p.1) It is differentiated from resilience, and other factors that reduce the experience of distress after a traumatic event, in that it can take place while the person is still dealing with symptoms of distress. Indeed, it is the struggle with managing the distressing effects of the trauma that produces the positive change in the person's level of functioning (Tedeschi & Calhoun).

Three areas of post traumatic growth identified by Brewin are: increased importance of family and friends, increase in volunteer or advocacy activities, and an increase in spirituality (2003). Horowitz notes that struggle with stressful events "can lead to a higher level of maturation than was present before the events" (2001, p.143). For survivors of childhood trauma who later experience further trauma in adulthood "adaptive change after the adult trauma can repair the prior damage and aid in self reorganization." (Horowitz, p. 144) Tedeschi and Calhoun have found evidence of

further areas of post traumatic growth: a greater appreciation for life and changed sense of priorities, a general sense of increased personal power or strength, and the recognition of new possibilities or paths for ones life (2004).

Tedeschi and Calhoun were able to locate studies supporting the experience of post traumatic growth in a variety of populations including college students experiencing negative events (one study), people experiencing bereavement (seven studies), rheumatoid arthritis sufferers (one study), people with HIV infection (two studies), people with cancer (two studies), people undergoing bone marrow transplantation (two studies), heart attack sufferers (two studies), parents coping with the medical problems of children (two studies), people who have experienced transportation accidents (one study) or house fires (one study), survivors of sexual assault and sexual abuse (six studies), soldiers who have experienced direct combat (two studies), refugees (one study), and people who have been taken hostage (two studies) (2004).

Treatment of PTSD

The nature of PTSD seems to call for differential treatment depending on various factors including the nature of the trauma, type of symptoms, chronicity of the disorder and age of the client (van der Kolk, McFarlane, & van der Hart, 1996). This section will focus on ethical guidelines and standards for practice in the treatment of trauma survivors, treatment goals, and stages of treatment as well as a brief overview of the many modes of therapy used in trauma recovery work, a review of the available treatment outcome

studies, and a discussion of issues which need to be addressed in the treatment of trauma survivors.

Ethical issues in the treatment of PTSD

William and Sommer provide ethical guidelines for therapists providing treatment to survivors of posttraumatic stress, including personal traits such as: belief in their own ability to make a difference, a personal sense of self- worth and self-confidence, the continual seeking of training as well as advise and support from colleagues, the ability to admit mistakes, the ability to stay fully present during sessions, and capacity to be a model of a safe and trustworthy human being (2002).

Other ethical issues identified regarding treatment of trauma survivors include having clear boundaries (Steele, van der Hart & Nijenhuis, 2001), paying attention to effects the therapy itself may have on the survivor's personal relationships (van der Hart et al., 1993), and the ability to bear witness to the trauma with understanding and empathy (van der Hart et al.). In the treatment of posttraumatic stress, it is particularly important to be careful of timing and pacing, and of ensuring safety in the process, as there is a danger of causing further damage if the therapist is not cautious (Levine, 2003, Ogden & Minton, 2000, van der Hart et al.).

The Social Work Code of Ethics provides additional guidelines for ethical practice (CASW, 1994).

Standards of Practice in the treatment of PTSD

Standards of practice for social workers have been developed by the Canadian Association of Social Workers (1995). Additional standards and guidelines for practice specific to the treatment of trauma survivors have been developed under the auspices of the International Society for Traumatic Stress Studies (Foa, Keane & Friedman, 2000). These are addressed more specifically later in this paper, where the use of Focusing oriented psychotherapy in the treatment of trauma survivors is evaluated in terms of its adherence to accepted standards and guidelines for ethical and competent practice.

Treatment goals

A number of authors have identified three major goals or components of treatment with survivors of trauma:

1. processing of the traumatic events, and assigning meaning to them, which enables the survivor to integrate the traumatic experiences appropriately into their personal life narrative,
2. mastering the physiological and biological stress reactions, and
3. regaining, on the part of the survivor, of a sense of control and personal efficacy, through the development or re-establishment of social connections and personal coping skills. (Baldwin, 1997; van der Hart et al. 1993; van der Kolk et al., 2002)

Because of the extreme isolation experienced by many trauma survivors, it is important for the client, during the realization process, not only to develop knowledge and a

narrative around what happened, but also to share that with others. "Testimony must not only be given, it must also be heard" (van der Hart et al.).

Stages of treatment

A number of experts recommend that treatment of trauma survivors should occur in stages (Herman 1992; Horowitz, 2001; van der Hart et al., 1993; van der Kolk et al., 2002; van der Kolk, McFarlane & van der Hart, 1996). Horowitz also includes a pre-treatment stage involving evaluation, diagnostic formulations and treatment planning. Herman and van der Hart et al. divide the treatment process into three stages. Horowitz and Van der Kolk and his co-authors divide the middle phase of therapy into three stages, for a total of five, or in the case of Horowitz, six stages.

The first stage of therapy involves the stabilization of symptoms and the establishment of a therapeutic relationship. This stage may also include the establishment of social supports, stress inoculation, and pharmacology where needed (Herman 1992; Horowitz, 2001; van der Hart et al., 1993; van der Kolk et al., 2002; van der Kolk, McFarlane & van der Hart, 1996).

The second stage, or middle phase of therapy, involves working with the traumatic memories (Herman 1992; Horowitz, 2001; van der Hart et al., 1993; van der Kolk et al., 2002; van der Kolk, McFarlane & van der Hart, 1996). This involves a controlled reactivation of the traumatic memory. During the re-experiencing of the trauma the therapist helps the patient place the memory in time, helping them to notice it has a

beginning and an end. The therapist also helps the patient recover their subjective experience of the trauma including the various meanings given to the trauma in addition to the internalized injunctions against remembering or against telling. The patient is also assisted to retrieve any sensations or emotions as well as any existential crisis experienced (van der Hart et al.).

Horowitz and van der Kolk et al. both divide this middle phase into three stages. The first involves the mastering of the trauma through putting it into words, identifying feelings, and exploring meanings. The second involves de-conditioning of traumatic memory and responses. The third, involves working through the trauma, and addresses the effects that the trauma has had on the person's sense of self, on their capacity for trust and intimacy, and on their ability to negotiate their personal needs and feel empathy for others (2001; 2002).

The final stage of treatment involves integration of the internal changes achieved through therapy, including the process of grief and mourning regarding the losses experienced as a result of the trauma (van der Hart et al., 1993). Van der Kolk et al. recommend exposure to experiences that provide survivors with feelings of mastery and pleasure (2002). As part of the termination process, Horowitz recommends preparing the survivor for the possibility of future struggles.

> It may be helpful to inform the much improved patient that internal work digesting the stress inducing experiences will continue. Some alarm reactions that have subsided may reoccur. This should not lead to dismay. It will be one indication of

the importance of patients repeating on their own what they have learned in treatment." (2001, p. 203)

Treatment approaches

It is beyond the scope of this paper to provide detailed descriptions of all of the approaches currently used in the treatment of trauma survivors. As pointed out by McFarlane, "Virtually every form of psychotherapy has been attempted with PTSD" (1994, p.401). Later in this paper, in the section on the use of Focusing in the treatment of trauma, some comparisons will be made between Focusing and some of these approaches. For further information on individual approaches, please refer to the references attached to each.

Specific treatment approaches include: *cognitive approaches* (Putnam, 1996), including cognitive therapy (Rothbaum, Meadows, Resick, & Foy, 2000), a biopsychosocial model (Ray, 2004), a self-help workbook approach (Rosenbloom & Williams, 2000), supportive counseling (Purves & Irwin, 2004), and psycho-educational approaches (Fournier, 2002); *behavioral approaches* (Putnam), such as behavioral sensitization (Southwick et al., 1994), and imaginal exposure (Taylor, Thordalson, Federoff, Ogrodniczuk, Maxfield, & Lovell, 2003); *cognitive behavioral therapies*, including systematic desensitization (SD) (Rothbaum et al.; Zoellner, Foa & Fitzgibbons, 2002), stress inoculation therapy (SIT) (Rothbaum et al.; Zoellner et al.), exposure therapy (EEX) (Rothbaum et al), prolonged exposure treatment (PE) (Zoellner et al.), cognitive

processing therapy (CPT) (Rothbaum et al.; Zoellner et al.), cognitive restructuring (CR) (Zoellner et al.), assertiveness training (Rothbaum et al.), somatic experiencing (Levine, 1997), and biofeedback (Rothbaum et al.); *EMDR* (Chemtob, Tolin, van der Kolk, & Pitman, 2000; van der Kolk, McFarlane, & van der Hart, 1996); *psychotherapeutic approaches*, such as psychodynamic psychotherapy (Kudler, Blank & Krupnick, 2000), inter-personal psychotherapy (Kudler et al.), and sensorimotor psychotherapy (Ogden & Minton); *creative arts therapies* (Johnson, 2000); *in-patient programs* (Courtois & Bloom, 2000); support and treatment groups (Foy, Glynn, Schnurr, Jankowski, Wattenburg, Weiss, Marmar, & Gussman, 2000; van der Kolk et al., 2002); *brief treatment approaches* (Tinnon, Bills & Gantt, 2002; Turnbull, Clairmont, Jackson, Hanbury-Aggs, Mills, Busuttil, & West, 2002); *marital or family therapy* (Riggs, 2000); and *psychosocial rehabilitation* (Penk & Flannery, 2000). *Hypnosis*, while not an approach in itself, but rather, a technique, can be integrated into various other psychotherapeutic or cognitive-behavioral therapies (Cardena, Maldonado, van der Hart, & Spiegel, 2000).

An *integrated approach*, combining these treatments as needed is recommended for more complicated forms of the disorder (Marmar, Foy, Kagan & Pynoos, 1993; van der Kolk, Pelcovitz et al, 1996).

Treatment outcome studies

According to Rothbaum et al., exposure therapy is the most studied of treatment strategies under the cognitive-behavioral umbrella, has been tested with the most types

of trauma, and also has the most well controlled studies (2000). The results have generally been favorable, so it is a mode of therapy that comes strongly recommended by the PTSD Treatment Guidelines Task Force, unless contraindicated. Contraindications include people who cannot tolerate the high anxiety and the temporarily increased symptoms that sometimes occur during exposure therapy. There is also some evidence that exposure therapy is not a good choice for people with PTSD who are also perpetrators of abuse (Rothbaum et al.).

One study comparing exposure therapy with systematic desensitization found them both to be equally effective (Rothbaum et al., 2000). In another study, systematic desensitization was found to be equally effective as compared to cognitive therapy (Blake, 1993). A further study compared systematic desensitization, hypnotherapy, and psychodynamic therapy with a control group. All three were found to be equally effective, and more effective than no treatment (Blake, 1993). In a controlled study of systematic desensitization assisted by biofeedback, this combination was found to have positive effects which were maintained over a two year follow up period (Blake).

Rothbaum et al. reviewed a number of controlled studies of cognitive therapy and found that it was at least equally helpful to any other treatments tested, and more helpful than no treatment (2000). Also supporting a cognitive approach, some studies have shown a reduction in psychosomatic symptoms in people who were able to talk about their traumatic experiences (van der Kolk, 1996a). However, even well studied treatment approaches with proven effectiveness have their limitations. Brewin notes that "Both

exposure and cognitive methods have been demonstrated to be clinically effective, though not all patients are able to tolerate them, and not all patients become symptom free as a result." (2003, p. 192)

One study comparing stress inoculation training, imaginal flooding and supportive counseling found that imaginal flooding and stress inoculation training both were more effective than supportive counseling in reducing depression, anxiety, and PTSD symptoms in rape victims (Blake, 1993). However, another study, also with rape victims, where stress inoculation training was compared to assertiveness training, and to supportive counseling combined with information/education found all to be equally effective in reducing anxiety and depression (Blake).

Three outcome studies comparing imaginal flooding with other, more conventional therapies all found imaginal flooding to have superior effects (Blake, 1993). However, a more recent study indicated that 31% of people treated with this method experienced a worsening of PTSD symptoms after treatment (Taylor et al., 2003).

Cognitive processing therapy has shown effectiveness in controlled studies, but these involved rape victims only (Blake, 1993; Rothbaum et al, 2000).

A recent study comparing exposure therapy, EMDR and relaxation training found equal effectiveness in reducing numbing and hyperarousal symptoms. However greater

effectiveness in reducing avoidance and re-experiencing symptoms was found where exposure therapy was used (Taylor et al., 2003).

Blake notes that some studies indicate that conventional psychotherapy is not effective as a treatment for PTSD. One study, comparing conventional psychotherapy with transcendental meditation, found that transcendental meditation was effective in reducing PTSD symptoms, but conventional psychotherapy was not (1993).

A review of studies on the use of medications in reducing PTSD symptoms found that SSRI's (Selective Seratonin Reuptake Inhibitors) appear to have the greatest benefit (Friedman, Davidson, Mellman, & Southwick, 2000). Another found that SSRI's, MAOI's (Monoamine Oxidase Inhibitors) and TCA's (Tricyclic Antidepressants) were equally effective, but SSRI's have a lower risk of harm in over-dose, as well as some indication of fewer side effects (Albucher, van Etten-Lee, & Liberzon, 2002).

Deters and Range conducted a study to determine the effectiveness of writing in reducing PTSD symptoms. They compared writing about the trauma with writing about a trivial topic and found, to their surprise, that both were equally effective in reducing symptoms. Another surprising finding was that, even though people found writing about the trauma to be more upsetting than writing about a trivial topic, they considered the writing about the trauma to be of more value (2003).

Because hypnosis has been used in trauma therapy over several decades, there is evidence through case studies and other clinical findings that hypnosis can facilitate, intensify and even shorten treatment (Cardena et al., 2000). However, this method must be used with caution in the treatment of trauma survivors as it is believed by some, that a person under hypnosis is very suggestible, and that transference reactions can be particularly strong (Cardena et al.).

Issues in the treatment of PTSD

Issues of transference, counter transference and burnout are pertinent to psychotherapy with any population. In the treatment of trauma survivors, therapists must also be concerned with the occupational hazards of vicarious traumatization and secondary PTSD.

Transference refers to "the redirection of childhood emotions to a new object" (Pearsall & Trumble, 1996, p. 1530), often the therapist. Gendlin indicates that it is useful to first acknowledge what the client expressed about the present, before "inviting the client to sense whether something from the past is involved *as well*" (1996, p.294). Transference, can be a part of the healing process if the therapist is able to maintain good boundaries and respond with flexibility and warmth. "The secure base developed in the therapeutic attachment provides a catalyst to develop other satisfying and consistent attachment relationships with others in daily life, and to function adaptively in normal life" (Steele, van der Hart & Nijenhuis, 2001, p. 86).

"Counter transference focuses on the possible consequences of the counsellor's past experiences for the client" (Baird & Jenkins, 2003, p. 74). Counter transference must be carefully managed by the therapist in order to avoid distortions in judgment (Jackson, 1999). This issue may be particularly relevant to trauma therapists as one study found that over 75% of therapists treating survivors of childhood trauma had experienced some form of maltreatment as a child (Way, Van Deusen, Martin, Applegate, & Jandle, 2004). Qualities thought to be helpful in managing counter transference include anxiety management skills, self-insight and self-integration (Jackson, 1999).

Burnout has been defined as "a state of physical, emotional and mental exhaustion, caused by long-term involvement in emotionally demanding interactions' (Pines & Aronson, 1988, p. 9)" (Jackson, 1999, p. 2). The burnout literature does not address the impact of working with trauma survivors specifically. However, burnout appears to be related more to the work situation than to the therapist or the client having a trauma history (Jackson). Social support, including adequate supervision, communication and positive feedback, manageable workload, and adequate training are associated with lower levels of burnout (Baird & Jenkins, 2003).

It is now clear that professionals who work with traumatized clients can become traumatized themselves through "traumatic countertransference" or "vicarious traumatization" (Herman, 1992). The construct of vicarious traumaization refers to the way in which working with trauma survivors can affect the cognitive schema of therapists (Baird & Jenkins, 2003). Areas of disruption include safety, esteem, trust,

intimacy and control (Baird Jenkins). Vicarious traumatization is related to the cumulative effect of traumatic material, and is seen as an inevitable effect of working with trauma survivors (Jackson, 1999). An interesting finding in several recent studies is that clinicians with more years of experience in the trauma field experience less cognitive disruption than more inexperienced therapists (Cunningham, 2003; Jackson, 1999; Way et al. 2004).

Secondary traumatic stress disorder, also known as compassion fatigue, is defined as "the experiencing of emotional duress in persons who have had close contact with a trauma survivor, which may include family members as well as therapists" (Baird & Jenkins, 2003, p. 73). The affected person may develop symptoms of PTSD even though the traumatic event is experienced second-hand (Jackson, 1999). Factors thought to influence severity of impact include the level of exposure and severity of the trauma (Jackson, 1999), as well as inexperience in trauma work, and having a personal trauma history (Baird & Jenkins).

The concepts of counter-transference, burnout, secondary traumatic stress, and vicarious traumatization all have features that overlap, and also can have an interactional effect (Way et al., 2004).

The Use of Focusing in the Treatment of Posttraumatic Stress

The use of Focusing in the treatment of trauma survivors has much to recommend it. It can be a powerful tool for accessing and working with traumatic memories.

> Being able to clear a space to attend to an earlier part of you, even when that part was in very scary and dangerous situations, allows for growth and healing and the rebuilding of identity and trust. With Focusing, the therapist and the client can enter a terrible past scene, freeze frame it and contain what needs to be contained in order for the client to be safe. Then the client can attend to his or herself and do what he/she needs to do and was unable to do at the time of the trauma. One is able to regain personal power, identity and dignity. (Turcotte, 1998)

In addition, "Focusing complements traditional practices and beliefs, promotes self-management, and provides a framework for people who have suffered from multiple losses and trauma" (Young, 1998).

At the same time, there are a number of considerations in using Focusing with traumatized clients. There is a need for the therapist to become grounded in current research and theory regarding PTSD. This is important both for reasons of safety, given the risk of suicide or other self harming behaviour (Herman, 1992), and for the purpose of sharing information with the client which can be helpful in normalizing their symptoms (Ochberg, 1992). There is a need to assess and ensure that a client's current situation is relatively safe and stable prior to beginning work on past trauma (Matsakis, 1996).

There is also a need to assist the client in developing skills and strategies for managing their symptoms and dealing with the backlash that can accompany the resurfacing of trauma memories (Herman, 1992), for example, learning how to manage intense feelings (Turcotte & Poonwassie, 2000).

Most importantly, there is a need to learn how to use Focusing safely with trauma survivors. There are many pitfalls and dangers inherent in helping a person to focus on the core of a problem when that core may involve a traumatic experience.

> You can learn Focusing very quickly, and you can get yourself into trouble quickly. With the Focusing and PTSD program you will learn Focusing and you will learn PTSD. That doesn't take very long. Then you will spend the two years marrying them, and having them have a good relationship and be in a solid marriage so you can actually use the tools. Otherwise you should go nowhere near trauma survivors. (A. Poonwassie, personal communication, February 23, 2004)

Focusing and PTSD: the course

The use of Focusing in psychotherapy has been further developed and refined by Shirley Turcotte for use in treating people suffering from PTSD (Turcotte & Poonwassie, 2000). A two-year certification program in Focusing and PTSD has been offered in Manitoba by the Prairie Region Centre for Focusing since 1997, resulting in almost 65 graduates from this program, alone. Similar programs are also offered in Ontario and British Columbia (A. Poonwassie, personal communication, July 21, 2002).

The course involves 320 hours of classroom instruction with an equal emphasis on knowledge and application, 120 hours of logged and supervised therapy sessions, 40 hours of debriefed observation of therapy practice, 80 hours of research in experiential therapies and other related topics, and 30 hours of curriculum development and group facilitation on various topics related to Focusing, other experiential therapies, and PTSD (Turcotte & Poonwassie, 2002).

While some of the course material is presented here to illustrate various points, this is not a manual for using Focusing in the treatment of PTSD, and the information here should not be seen as comparable in any way to proper training. The Focusing and PTSD course provides experiential training in all of the concepts taught, which cannot be replicated on paper. Also, much of the learning takes place through observing live therapy sessions in the classroom conducted by the instructor and followed by commentary and discussion, as well as in the therapy sessions which are part of the practicum, and in the supervision provided. Only a small portion of the material covered is reflected in this paper.

Application of the Focusing approach to the treatment of PTSD

Clearing Space is both the first step in the Focusing process, and an initial exercise in helping trauma survivors to be able to separate their experiences and problems from their personal identity. Full Focusing sessions are not usually undertaken with trauma survivors until they are adept at this step of the process. In Clearing Space with trauma survivors, it is also important that they are conscious of where they put things (when

they externalize and set down any problems or concerns they have been carrying), so they can find them again at will (class notes, Module 1). As many trauma survivors have learned *not* to pay attention to themselves, Clearing Space and having a break from carrying the burden of responsibilities and worries can, in itself, be therapeutic (Lyon, 1998).

Since Focusing can take the client directly to a trauma memory in a very vivid way, the Focusing and PTSD program involves considerable instruction on how to make Focusing "PTSD friendly." Crucial to the safety of the Focusing process when dealing with trauma is the development of the client's ability to observe the process from the perspective of an adult firmly grounded in the present. The presence of this "Observer" aspect of self throughout the process "supports adult decisions that are helpful to the person and stabilizes the client's balance and perspective" (Young, 1998). Without this perspective there is a risk of the client re-experiencing the trauma in a way that can be retraumatizing. This, therefore, is another pre-requisite skill for the trauma survivor to master prior to the use of Focusing to process trauma memories.

Another important preparatory piece is to ensure that the client can safely experience and process intense feelings which can flood a person who is reconnecting with a traumatic experience. Sometimes a client needs to be taught how to do this through breathing deeply and letting the feeling flow through them like a river. Feelings such as rage may need to be released physically, for example, by twisting a rolled up towel in their hands (class notes, Module 2). "Sometimes clients are afraid that something will

creep up on them later. Check if they know what to do if this does happen. If they don't know, help them find the solutions they need" (class notes, Module 3, p. 10).

While managing and releasing intense emotions is important, as otherwise a person can remain "stuck" in a feeling, preventing forward movement (Hendricks, 1998), "what is really significant is the meaning under the feeling" (class notes, Module 2).

Some Focusing therapists instruct their clients to close their eyes while Focusing, as it can be it easier to focus inwardly in the absence of distractions (McGuire, 1993). However, Turcotte maintains that trauma survivors should never be instructed to close their eyes during Focusing, as it can be a trigger for some. They will, naturally, close their eyes or keep them open, whichever is more comfortable or workable for them (class notes, Module 1).

Shirley Turcotte emphasized throughout the program that Focusing on the past is always and *only* done in service of the client's present life. Therefore, the Focusing process always begins with a current concern or issue. Once the survivor is able to connect with their Felt Sense of that concern or issue, and find a Handle that Resonates within, they can proceed to the Asking stage of Focusing. It is here that they can discover what the *crux*, or core of the problem really is. For trauma survivors, asking "What is the core of this problem?" may take them to a particular traumatic event. It is the clients who steer the direction of the therapy, using their own inner bodily sensed knowledge of what is affecting them in their life today.

Focusing training, as originally devised by Gendlin, includes three types of questions in the Asking phase of Focusing: general questions, "crux" questions, and "forward direction" questions (Cornell, 1993). When working with trauma survivors, there are two additional levels of questioning that are used. "Safety" questions, such as: "Is it OK to be with the felt sense for a while?" and/or "What do you need in order to be where it is so uncomfortable?" may need to be asked at the beginning and/or throughout the Asking stage, whenever the client shows signs of distress (class handout). Another addition is the use of "closing" questions before ending a session. These may include: "Is there anything else there that needs attention?" or "What needs to happen there, before you leave this place?" These are necessary because a trauma place may be difficult to close up, and leaving it open can cause fallout for the client. (class handout)

Creating imaginary "containers" for offenders, making them the right size and placing them at a comfortable distance, is another technique that can make it safe to visit a trauma memory. With the offender safely contained, it is possible to attend to the "traumatized self" in the memory (class notes, Module 1). It is important not to go too deep with a first time client. Safety and trust need to be established first, as well as a strong connection between therapist and client.

Focusing provides tools for separating out and containing, sorting, getting the right perspective and the right distance from whatever aspect or piece of the trauma needs work (Turcotte & Poonwassie, 2000). These ensure that there is one issue or thing that

the client will focus on. "If there is more than one thing there, check with the client 'Which of those do you need to attend to first?'" (class notes, Module 3, p.10) If a client seems to be reacting rather than responding to a particular issue, the therapist can help the client to contain that, (place it in an imaginary container), adjust the size until it is neutral, neither overwhelming nor insignificant, and place it just the right distance away so that it can be worked with, without reaction (class notes, Module 7).

Turcotte and Poonwassie also emphasize that it is important to avoid making any assumptions about what would be the most traumatizing aspect of the experience for the client. The experience of trauma is very specific to the individual. "The fallout from the trauma, or the waiting for the trauma may be more horrible/damaging than the actual event" (class notes, Module 1, p.9). Similarly, witnessing trauma can be very difficult, especially for a child, and where the violence involves loved ones (class notes, Module 9). "Be careful not to assume that all issues are related to childhood trauma...Clients often need company in dealing with a current issue – follow the client!" (class notes, Module 8, p.8)

When dealing with a past trauma, particularly childhood trauma, "the experiences should always be referred to in the past tense: 'That's how it was when you were five' NOT 'That's how it is there where you are five'" (class notes, Module 9, p. 9). Also, always go full circle in a session. Once the memory has been attended to, the therapist should shift their focus back to the "adult", and the current issue the client started with, and

check with the client regarding any change they notice *there* as a result of the Focusing that was done (class notes, Module 1).

Boundaries are also very important in Focusing, especially with trauma survivors, many of whom suffered extreme boundary violations. Turcotte advises that a therapist should never do a Focusing session without first contracting to do so. Also, the therapist is advised to keep to what ever contract was made with the client. If the client contracted to work on a particular issue or problem, stick to that (class notes, Module 8). Another rule provided is that the therapist should never "caretake" or rescue a client. "If we act on our urge to comfort, we steal the clients' opportunity to do that for themselves" (class notes, Module 4, p.7). Rather than providing words of comfort directly, the therapist can ask the client "What does the wisest part of you have to say about this?"

Similar to Gendlin (1996), Turcotte teaches that the connection between the therapist and client is crucial to the therapeutic process. This connection must be maintained throughout the Focusing process so the client is never alone in re-visiting trauma memories. The therapist can achieve this through following the client's process closely, actively listening to and observing the client, and reflecting back what is seen and heard, so the client is very aware of the therapist's presence in that journey. As the therapist gains experience, it is this connection that increasingly guides the therapist in what questions to ask and when to ask them (class notes, Module 7).

Another point emphasized in the course is that, while Focusing can be very effective in working with PTSD, it is important "not to misrepresent Focusing as a treatment that works all of the time for all people" (class notes, Module 4, p.4). Focusing is usually integrated with other therapies. Indeed, the Focusing and PTSD program provides some training in a number of other therapeutic modalities (Turcotte & Poonwassie, 2002). Mary Armstrong combines Focusing with EMDR in the treatment of trauma survivors (1998). Rappaport indicates that "art therapy provides concrete expression of the focusing process that serves as a visual guide and reminder of where to go on the journey of recovery" (1998, p. 17). Gendlin recommends including a cognitive component, in order to process the changes which occur during Focusing (1996).

The "Critic"

The concept of the "superego" is not a new one to psychotherapy. Gendlin sees this judgmental and self critical voice as needing to be moved aside or disarmed through disrespect (1996). Shirley Turcotte uses the term "the Critic", for this concept, and examines it as a coping mechanism for dealing with the powerlessness experienced by a child victim of ongoing abuse, the child's "greatest ally in hell" (Turcotte & Poonwassie, 2000). This is consistent with current theory about the effects of ongoing trauma on children (van der Kolk & McFarlane, 1996: van der Kolk, van der Hart & Marmar, 1996). Approaching the Critic with this attitude normalizes it and clarifies that its development was adaptive rather than maladaptive (van der Kolk, van der Hart & Marmar, 1996). While the messages of the Critic need to be recognized and not taken as truth, the Critic can aid in therapy. Checking into how the client experiences the "hit" of

the Critic in the body and focusing on that may lead to whatever most needs attending and healing (Turcotte & Poonwassie, 2000). Muller, another psychotherapist who uses Focusing oriented therapy, agrees: "the inner critic is the 'signpost' not the 'destination' of therapeutic work" (1998, p.8).

Theoretical support for the use of Focusing in the treatment of trauma survivors

One principle of PTSD treatment cited repeatedly in the literature is the need for a therapeutic alliance between client and therapist which is safe, collaborative, and empowering (Herman, 1992; Ochberg, 1992; Turner, McFarlane & van der Kolk, 1996a). This type of therapeutic alliance is fundamental to Focusing (Gendlin, 1996).

David Lee, drawing from the research on how trauma affects memory, the brain, and the limbic system, recommends the combination of "'Right Brain therapeutic approaches' including story-telling, hypnosis, Neuro-Linguistic Programming, art therapy, music therapy, sand tray therapy" with interventions such as bodywork, movement, and expressive therapy approaches which tap into the "Reptilian Brain", thus allowing nonverbally coded experiences to be accessed" (Lee, 1996). Focusing is experiential and body focused. David Lee indicates that "therapeutic approaches which include bodywork and experiential components are critical to the accessing and working through of traumatic memories" (1997, p.10).

Focusing involves accessing naturally the altered state of mind which occurred in response to the trauma, while the client is fully conscious and in control (Turcotte &

Poonwassie, 2000). This can assist in the important task of mastery of the trauma experience (Herman, 1992).

When examining new ideas for treatment, Brewin notes that "closer study of people re-living traumatic events has identified that most have a small number of "hot spots", often quite brief moments when emotions are exceptionally intense" (2003, p.200). He cites Ehlers & Clark's suggestion that "these moments might be associated with important meanings and that exposure treatment could be more efficient if it focused specifically on hot spots rather than on the entire event" (p. 200). Focusing, is body-centered and client led. "A client's *inwardly arising* life-forward direction is more precise and more finely tuned" than anything an outside person can determine (Gendlin, 1996, p. 264). "Central to uncovering the trauma is the body *felt sense* (Gendlin, 1964) which incorporates the complexity of the trauma" (Coffeng, 1998, p.44). The ability of a person to access these "hot spots" using their Felt Sense around a current problem or symptom, may be anticipated to have the effect of reducing the time needed in therapy, and the techniques built into the process by Shirley Turcotte are designed to make the process of dealing with traumatic memories as safe and gentle as possible.

William and Sommer hold that "The key to healing is connection and listening" (2002, p.393). As previously discussed, connection and listening are hallmarks of the Focusing approach. Judith Herman states that "the first principle of recovery is the empowerment of the survivor. She must be the author of her own recovery" (1992, p.133). Focusing

enables the client to in fact be the author of her own recovery as "Focusing allows the survivor total control in setting their own pace and direction for healing" (Costo, 1998).

Van der Kolk et al. indicate that "because the core problem in PTSD consists of a failure to integrate an upsetting experience into autobiographical memory, the goal of treatment is to find a way in which people can acknowledge the reality of what happened without having to re-experience the trauma all over again" (2002, p.25). The core of the Focusing and PTSD program involves providing training on how to do just that. (Turcotte & Poonwassie, 2000).

Elsewhere in the literature "it has been remarked that re-visiting traumatic memories may be counter-productive unless the patient experiences safety and has enough ego strength to deal with such material." (Cardena, Maldonado, van der Hart, & Spiegel, 2000, p. 255) The measures described above, including the development of a strong adult "observer", ensure the safe use of Focusing in re-visiting trauma memories.

Similarities and Differences between Focusing and other approaches to the treatment of PTSD

There are some striking similarities between Focusing and other approaches to therapy. The client-centred approach and attitudes of genuineness, acceptance, and empathy inherent in Carl Roger's approach (1961) are also equally crucial to Focusing oriented psychotherapy, although the actual *process* of Focusing is missing in Roger's approach.

Laury Rappaport, a psychotherapist who uses Focusing combined with art therapy in her work with trauma survivors, organizes her clients' therapy around Herman's three stage model of recovery (1998). Mary Armstrong, a social worker who uses Focusing in combination with EMDR in the treatment of trauma survivors, finds many parallels between the two approaches (1998). The similarities are also evident in reading the description of EMDR by Chemtob, Tolin, van der Kolk and Pitman (2000). From their description, the main difference between of EMDR and Focusing, aside from the attention to eye movements in EMDR, is that in EMDR the therapist leads and directs the process. In Focusing it is the client's inner sense that leads the way. Noticing the primary sensations that are associated with the traumatic memory in EMDR, can be similar to noticing into a Felt Sense in Focusing. Rating the "felt truth" of a statement as part of EMDR is parallel to the process of Resonating in Focusing. Installation of the positive cognitions in EMDR is parallel to the Asking and Receiving phases of Focusing, especially where the client is asked, "What does this part need?" The step in EMDR where the client is asked to do a body scan, also has a parallel in Focusing. Once the client finishes a piece of work, he or she checks into his or her body and asks, "Is there more?" The closure phase of EMDR is also similar to the closure phase in Focusing.

Another therapy approach which was developed specifically for the treatment of trauma survivors, sensorimotor processing, also has some interesting parallels to Focusing. In sensorimotor processing the client starts with talking about the trauma situation, then checks into their body sense around it. Then the client focuses on calming the body

sensations before again talking about the trauma (Ogden & Minton). In Focusing, the client starts with a *current* concern or issue, and checks into his or her bodily felt sense of that. This process can take the client back to a trauma memory, where he or she can attend to the body sensations, emotions, and thoughts experienced during the trauma, and in doing so, achieve a *shift* in their internal sense of the trauma, in how it fits in their overall sense of themselves. Finally, the therapist brings the client back to the present concern to notice how that has changed as well (Turcotte & Poonwassie, 2000).

Brewin writes about cognitive therapy in a way that has a parallel to one concept in Focusing. "Negative beliefs are sometimes experienced by people with PTSD as being 'spoken by "internal voices' in their heads that reinforce and make concrete feared identities by telling them that they are weak, incompetent, worthless, guilty, and so forth" (2003, p.198). In cognitive therapy "the first task is to distance themselves from the voice, treating it as an interesting phenomenon rather than as authoritative guide on what they are *really* like and what they should think" (Brewin, p.199). This is parallel to the concept of the Critic in Focusing. The difference is in the second step, where, in cognitive therapy, the negative ideas about self are countered by the therapist with positive thoughts and ideas, or the patient is encouraged to counter them with positive thought and ideas (Brewin). In Focusing the Critic's messages are used as a guiding point to get to the part of the memory that is most in need of attention at that time. The client checks into the Felt Sense of where they take "the hit" from the critical voice (where and how they experience that message in their body), to arrive at the aspect of the trauma most pertinent to the current Critic attacks, often the helplessness and

hopelessness experienced during the trauma, which resulted in these critical messages developing as a defense (Turcotte & Poonwassie, 2000).

Cognitive-behavioral approaches are based on the belief by many experts that trauma therapy should include both a cognitive component, to dispel dysfunctional beliefs trauma survivors tend to have about themselves and the world, and an experiential component, to manage and decondition the physiological responses inherent in posttraumatic stress (Rothbaum, Meadows, Resick & Foa, 2000). While Focusing oriented psychotherapy is very different in methodology and general approach, it also combines these two elements, with similar end goals. Focusing itself is an experiential method, and some form of cognitive therapy is almost always used in conjunction to process the experiential work (Gendlin, 1996).

Imaginal exposure, on the other hand, while being another experiential method, is quite different from the process of Focusing. "During imaginal exposure, the client recalls the memory as vividly as possible, imagining the trauma as if it is happening at that moment. The client is encouraged to describe the trauma in the present tense and recount as many details as possible, including specific thoughts and feelings" (Zoellner, Foa & Fitzgibbons, 2002, p.83). This is in contrast with the way in which memories are visited and described in the process of Focusing, where the person is firmly grounded in the present, and is encouraged to describe the trauma from the perspective that it is already over and in the past (class notes, Module 9).

Ethical Issues in using Focusing with PTSD

Like social work, Focusing is based on a humanitarian and egalitarian ideals (CASW, 1994; Gendlin, 1996). The Focusing attitude of openness, curiosity (interest) and acceptance regarding the person, as well as whatever comes up from their own Felt Sense, is innately respectful. The process of Focusing oriented psychotherapy is one in which the client is seen as the expert regarding their own therapeutic needs. The therapist is merely a facilitator, a companion and a witness to the person's therapeutic process (Gendlin, 1996). This is consistent with the social work belief in self-determination (CASW, 1994)

The Social Work Code of Ethics requires social workers to "maintain an acceptable level of health and well-being in order to provide a competent level of service to a client" (CASW, 1994, sec. 3.4). This is an area given considerable attention in the course on Focusing and PTSD. Areas covered include an understanding of vicarious traumatization, how vicarious trauma can affect both individuals and organizations, how to recognize and attend to personal "triggers", and how to minimize the occurrence of vicarious traumatization (Poonwassie & Turcotte, 2000). Given the fact that vicarious trauma is an occupational hazard facing those working with trauma survivors, the attention paid to this issue in the course on Focusing and PTSD provides further motivation for studying the effectiveness of this approach.

While the issue of repression of trauma memory is still up in the air, and the work of memory retrieval is hotly debated (McFarlane & van der Kolk, 1996a; Brewin, 2003), the client-centered role of the therapist in Focusing helps diffuse concerns about false memories being implanted. In Focusing the therapist generally follows rather than leads the client. Most of the time, the most important job of the therapist, other than bearing witness and ensuring safety, is to stay out of the client's way (Gendlin, 1981).

How well does Focusing meet standards of practice for treatment of PTSD in theory?

While Focusing practitioners come from many other disciplines as well as social work, Focusing oriented psychotherapy, as taught in the Focusing and PTSD program, measures up well to the standards of practice set be the Canadian Association of Social Workers (1995). This is discussed at length in the data analysis section of this paper.

Present Study

Data from this study arose from interviews with 14 therapists who use Focusing oriented psychotherapy as a primary treatment modality with trauma survivors.

The short time frame available for the study of therapists' utilization of Focusing in the treatment of trauma survivors (approximately six months from approval to defense) restricted the number of interviews that could be conducted as well as the distance that could be traveled to obtain interviews.

The earlier, aborted study was concerned specifically with PTSD from the perspective of persons suffering from this disorder, and involved the use of a measure that had some established reliability as a screen for PTSD (Carlson, 2001). Although the participants who had graduated from the Focusing and PTSD program did have considerable training in recognizing the symptoms of PTSD, this study has no reliable way of measuring the diagnostic skills of the therapists interviewed. This study also includes 3 participants who received Focusing training without any PTSD component. It therefore cannot be assumed that the clients of these therapists had diagnosable PTSD rather than suffering from other types of trauma effects.

Research Questions

The idea for this study started with a general interest in the experiences of other therapists using Focusing in the treatment of trauma, with a particular interest in their

impressions of the benefits as well as the limitations of using this approach. Over time, and with each additional consultation, more questions which could be of considerable interest and refinement were added, such as: "Is Focusing more helpful at some stages of therapy than at others?" and "Is Focusing more helpful with some clients than others?" As the process of organizing and analyzing the data progressed, additional questions arose: "How well does the practice of these therapists, in their use of Focusing with traumatized clients fit with current standards of practice in the field of trauma therapy?" and "What are the measures that must be taken in order to ensure safety in the processing of traumatic experiences through the Focusing method of psychotherapy?"

Method

Qualifying therapists were contacted by phone to see if they were willing and able to participate in this study. Clinicians were qualified to participate in this study only if they have been providing therapy to trauma survivors since they received qualification as a Focusing practitioner.

Face to face interviews were conducted in a semi-structured format using nine pre-developed questions (see Interview Schedule, Appendix C). Additional questions and prompts were used in order to elicit further clarification or expansion of responses. All but one of the interviews was tape recorded (audio only). The exception was an oversight rather than intentional. Notes were also taken on all interviews, which proved to be fortuitous, as three of the tapes had chunks that were not possible to transcribe, one

due to static interference (perhaps an error was made in hooking up the microphone), and the other two due to voices dropping to a volume that was too low to be properly picked up. The audio tapes were stored in a locked cabinet until they were transcribed and checked. They have now all been erased with the exception of Anne Poonwassie's.

Anne Poonwassie is a special case in this study, being both an informal advisor on the initial study as well as this one, as well as participating in this study as a "test subject". Anne has given permission for her name to be used, which also differentiates her from the other study participants. Anne is the director of the Prairie Region Center for Focusing and is now the principal instructor of the Focusing and PTSD certification program in Manitoba. She is the interviewee in interview 1.

Prospective participants were informed of the purpose and methodology of the study in the initial phone call inviting their participation. In addition, time was taken prior to the commencement of the interview for the participant to read and ask questions before signing the attached Information for Informed Consent. They were provided a copy for their own records. Only those willing to provide this written consent after receiving full information were interviewed.

This study did not involve any cost or perceivable risk to the participants. However, it did involve giving of their time, and the only compensation provided was the promise that they will receive a copy of the study results.

As the interviews were face to face, the identities of the participants are known to the researcher. However, with the exception of Anne Poonwassie, the name and any identifying information about the participants, other than their training, has been, and will continue to be kept confidential.

Participants:

Information gathered regarding the participants themselves focused specifically around their training and experience, both in working with trauma, and in using Focusing in this work (see Table 1). Initially, it was anticipated that all participants would be graduates or students of the Focusing and PTSD, program. However that changed, when it was learned that there are a fair number of Focusing practitioners in Manitoba who received their training in Focusing and in trauma work separately rather than in a combined course, but who did meet the criteria of providing therapy to trauma survivors since they received qualification as a Focusing practitioner. Three persons were identified early in the recruitment process who met the criteria for participation in this study, although their training was different. All three showed a willingness to participate. Other participants were recruited through the same list of graduates of the Focusing and PTSD program that was used for the initial study. Indeed, all of these program graduates had assisted with the previous study by providing "participant packages" to any new clients with PTSD who began therapy between March 2002 and December, 2003.

However, most of the therapists who assisted in the initial attempt to study this topic lived outside of Manitoba, or too far north to travel given the constraints on time and

money resulting from the fact that much of both was expended in the first attempt. Also, unlike in the aborted study, current students of the Focusing and PTSD program were not approached. Most people who met the criteria and were geographically accessible agreed to participate, although two people who initially agreed to take part, later changed their minds. One made it clear that the problem was time constraints. The other person did not give a reason.

Procedures for Extracting, Organizing and Presenting the Data

Data extraction involved a number of steps. First, the interviews were transcribed, word for word where possible, i.e. where the interview was taped and the tape was clear enough for transcription. Interview 4 was not taped, and interviews 2, 8 and 10 had sections that could not be heard clearly enough for transcription. In those cases, notes made by the researcher during the interview, as well as notes provided by the participants in interviews 4 and 12, were used to fill in the gaps, and to create transcripts that were as complete as possible.

The second step involved going through the transcripts with a Hi-Liter marker and highlighting all of the points made in response to the interview questions, as well as all illustrations and elaborations of these points. A second copy of the transcripts was then made, including only the highlighted material. The data were then organized by general topic area, starting with the points that were in direct response to the questions asked. Strauss and Corbin's method of open coding, questioning each data piece to determine what it tells us, was utilized in organizing each piece of data into a category with other

data pieces that provide essentially the same information (1990). Names for these categories were then developed, based on what the contents seemed, in essence, to be saying. In this way, the categories arose from the data, as recommended by Strauss and Corbin (1990) rather than being imposed on the data. Categories were then checked to see if they properly fit into the topic area under which each was organized, and adjustments were made accordingly.

Arising from this process, one topic area, the ways in which Focusing was used in the treatment of trauma was subdivided, as the data seemed to group around two different questions. First, "How was Focusing used?" and secondly, "For what purposes was Focusing used?" In addition, two topic areas: "Do you find that Focusing is more helpful with some clients than with others?" and "Do you find that Focusing is more helpful in some stages than in others?" were combined under the general topic: "When Focusing is most helpful", although each of the original topic areas was addressed separately as major categories within this topic, with further subcategories of responses subsumed under each.

Charts were then developed to display the categories of data under each topic area. These charts are located in Appendices D to L.

The next step involved going back through the streamlined copies of the interviews and doing a line by line analysis (Glaser, 1978), asking various questions such as: "Does this piece make a point, elaborate on a point, or illustrate a point?" "What point is being

made here?" "What point does this text elaborate or illustrate?" and "Into what category does this point best fit?" As a result of this process, some categories were shifted from one topic area to another, some were combined, and some new categories were created and placed under the topic areas where they best fit. As well, points made were matched with elaborations and illustrations of those points. Care was taken at this stage to ensure that categories developed were both comprehensive, encompassing all of the data, and mutually exclusive, avoiding repetition.

The data were then presented in narrative form, arranged around first the topic areas, then the major categories under each topic, and then the sub-categories within each major category. Finally, each category was described with elaborations and illustrations from the text of the interviews. During this process, patterns were noted as they emerged from the data (Marlow, 1993). This resulted in some further division of the existing categories under sub-headings in certain topic areas, such as Limitations of Using Focusing in the Treatment of Trauma, and Barriers to using Focusing in the Treatment of Trauma.

Data Analysis Procedures

Once the data were organized, and presented in a form that allowed all of them to be viewed simultaneously by spreading out all of the charts developed, further patterns emerged, including the relationships between categories in different topic areas. These patterns facilitated the emergence of new questions, starting with: "What questions are informed by this data?" and "Who would be interested in the results of this study?"

Some questions emerged immediately from the topic areas already identified, such as: "What are some of the ways in which Focusing is being used in the treatment of posttraumatic stress?" "How do these 14 Focusing practitioners perceive the benefits of Focusing in the treatment of posttraumatic stress?" and "What drawbacks, limitations and barriers are therapists encountering in using Focusing in the treatment of posttraumatic stress, and how are these being addressed?" This last question suggested a further question: "What do these therapists see as indications and contra-indications for using Focusing in the treatment of posttraumatic stress?"

One question arose from the review of the literature, which was started prior to the formulation of the research proposal, but continued through the period where the data was gathered, extracted, organized, and presented. Several sources in the literature on treatment of posttraumatic stress addressed both ethical and procedural standards of practice in this area. Examining the data in the light of those standards, it was clear that the data provided some substantive information on the question: "How does Focusing, as implemented by these therapists, compare *in practice* to accepted standards and guidelines for the treatment of posttraumatic stress?"

Further questions emerged by looking at the target audiences for this study. For example, Focusing practitioners would likely be interested in the question: "What, if any, special considerations are there for the use of Focusing in the treatment of posttraumatic stress?" while researchers would be interested in the question: "What is

there about Focusing that would make it worthy of further exploration as a treatment approach for sufferers of posttraumatic stress?"

Care was taken when analyzing the data to keep these questions in mind, to ensure that gaps and contradictions in the data were identified, as well as to be alert to patterns that could shed some light on their answers.

Results

Experience of Participants

Fourteen therapists participated in this study. Their experience in providing therapy to trauma survivors ranged from 3 years to 20+ years, and averaged 8.9 years of experience per person. One participant did trauma therapy with three clients outside of her normal job. For the remaining thirteen participants, trauma therapy comprised an average of 61.5% of their total workload, with a range of 10% to 100%. Of the 14 study participants, 8 learned Focusing after they had been working in the field of trauma therapy for some time. Therefore, the overall level of experience in using Focusing as a treatment approach in this work was somewhat lower, ranging from 2years to 20+ years, and averaging 5.3 years. A summary of the training and experience of the study participants can be found in Table 1, Appendix D.

Use of Focusing

A summary of *how* the study participants used Focusing can be found in Table 2, Appendix E. The purposes for which Focusing was used is summarized in Table 3, Appendix F.

All 14 of the participants indicated that they use Focusing in the treatment of trauma, and all fourteen use the Focusing Attitude of openness, curiosity and acceptance regarding the client, as well as whatever comes forward from the client's Felt Sense. All but one of the participants mentioned using full Focusing sessions, where all of the steps of Focusing are used (although not necessarily in a particular order). The one participant who did not mention specifically using full Focusing sessions described using the core steps of checking into the Felt Sense and asking into that Felt Sense:

> I kind of help them to identify what is going on and where they feel it in their bodies, and establish a comfortable space from it, and pay attention rather than fighting it or letting it overwhelm them. I might just ask them to find some kind of way to be with it in a caring way and serve it, and then just ask a question like: "So, how old do you think you feel? When is the first time that you can remember feeling that kind of way?"...I have worked with people with feelings that go back to three year old, four year old, twelve year old, eighteen year old, what ever, so then we kind of refer to it as a twelve year old part of you, and then working at how that person might be able to relate to that twelve year old part. (interview 5)

Of the 14 study participants, 12, including all of the Focusing and PTSD graduates, emphasized the role of the therapist as *following*, rather than leading the client through the Focusing process.

All participants described using the various steps of Focusing in a variety of ways. The step most commonly used on it's own was Clearing Space, with 12 participants using this step themselves, as a way to clear aside their own issues prior to and/or just after a therapy session. Some of the purposes for therapists Clearing Space, included using it as a means to keep their own issues separate from the client's, reducing counter-transference, reducing vicarious traumatization, and enabling themselves to be fully present for the client. Additionally, 12 of the therapists mentioned that they taught the technique of Clearing Space to clients, so it could be used as a tool for stress management. Most frequently, Clearing Space was used at the beginning of sessions to help the client to identify one issue to work on at a time: "People often come with many issues and are confused. I find the process of Clearing Space is advantageous to single out the most pressing issue. By doing this, we eliminate some of the confusion right at the start" (interview 12). Five of the therapists who teach classes mentioned teaching clearing space to their students, and having their students clear space at the beginning of each class in order improve their ability to attend to the class. Two additional study participants teach Focusing, and so teach all of the steps.

Eight of the participants indicated that they use Focusing with every client they see. The remainder use Focusing as the main approach with some, but not all of their clients.

However, a few of these indicate that they use "snippets" of Focusing even where that is not the primary approach used:

> You know you can sneak it in a little bit during conventional counseling sessions. Then they have little light bulb moments. That is all you dare do, just little snippets of it. (interview 14)

> Some, you can focus them using different techniques, but you don't call it Focusing. You can just say: "How is that feeling in the trunk of your body?" You throw in some Focusing questions, but it is not a complete Focusing. (interview 3)

> Often if something comes up, I go: "Oh, that's interesting", and we kind of explore: "What else is there with that?" I will say "Let's just focus inward", and it will be like a Focusing session, in session. (interview 7)

All but one of the participants indicated that they adapt Focusing to meet the individualized needs of each client. A good example was supplied in interview 14:

> I talk about gut feelings. Men don't like the Focusing words. They don't like doing internal work. But if you rephrase it to, "you must have a gut feeling about that." And oh yes they all have an opinion on the gut feeling or they knew, just knew. I would call it internal work, to tidy up some space, any thing they have left, some raw stuff in there. So that is a tool, to rephrase it, and listen.

Five therapists specifically mentioned using Focusing sessions for themselves.

> I still find as a Focuser, myself personally, would like to do more Focusing. You run into your own obstacles in life, and you need to be able to deal with those as well. If you are not dealing with them, how can you help someone else deal with them? (interview 13)

Once again, it is safe to assume that these are not the only participants who have used Focusing for their own growth and healing, since learning Focusing involves using it on yourself, and the Focusing and PTSD course includes 40 sessions where the trainee does Focusing as a "client" in addition to 80 sessions as a therapist.

Two of the participants use Focusing with children.

> It works wonderful. They are just amazing because they are so imaginative. And their containing piece is so amazing. Even with teens too, a lot of troubled teens, it works really well with them...With kids or with anybody, it is going to their level, being with them at their level. Being comfortable with them at their level where ever that is. Keep it totally client centered, totally at their level. (interview 9)

In Focusing with children who have experienced trauma, the Observer is the aspect of the child that is grounded in the present. The adult presence is provided by the therapist.

All of the participants indicated that they use a Focusing Attitude of curiosity, openness and acceptance in all of their therapeutic work no matter what other therapeutic approach they may be using. Several mentioned that this attitude is very helpful in establishing a therapeutic relationship.

Purposes for Using Focusing in the Treatment of Trauma

The participants mentioned various specific purposes for which they used Focusing (as outlined in Table 3). The most frequently cited purposes were to help people in managing triggers, and in tracing triggers to their source.

> When there's something going on, I get them to check into their body, and I get them to go with that sense, and do a session around that. It is usually triggered by a current issue or situation in their life, so I bring it back to the current situation and have them problem solve around that after they do the session. (interview 9)

A number indicated they use Focusing to increase a person's self awareness and connection to themselves.

> In teaching Focusing, you want to help the person to trust themselves. To listen to themselves and to trust what comes out and not shut it down. (interview 6)

> I use Focusing as a way for clients to connect to themselves...as a way for them to be present to the traumatized part in an adult way, and as a way to teach self-awareness and mindfulness. (interview 7)

Three participants mentioned the development of an "Observer" (adult aspect of self, firmly grounded in the present) as a purpose for Focusing: "developing the ability to keep their adult self present when dealing with the trauma" (interview 10) though one pointed out that the Observer is an integral part of the Focusing process. The fact that

"the development of the Observer" is not mentioned by every participant should not be taken to mean that the concept is not utilized by others. For example, the quote above from interview 7 mentioned using Focusing "as a way for them [clients] to be present to the traumatized part in an adult way".

Many cited the purpose of helping people develop tools that they can use, not only for their own healing but for the rest of their lives. This idea will be elaborated later under "Benefits of Focusing"

Five participants use Focusing in various ways in their teaching or training, from getting students to clear space as a tool for improving concentration to using a "demo" of a Focusing session as a tool in teaching about trauma.

One participant said that one of the uses of Focusing is to help a person to find an inner place of strength:

> When we start to Focus I ask them to recall a time that they were really strong...so that they have some place inside when we start in this exploration of all these memories...some place inside that they can connect to. Where you felt loved, where you felt strong, and you can go back to that place. (interview 10)

One participant mentioned using Focusing as a means of assessing a client's readiness:

> I don't do a lot of assessment in terms of readiness, just because, it will either go, or not. I can ask somebody "If you check inside, in the trunk of your body, what

> do you get there? What is your Felt Sense of that? What is your sense of it in your body?" People will say "nothing" and then you know they're not ready. Or people will say, " I get a little bit of this." and then I know, ok, they have a connection. They connect their head to the rest of their body now. That is a good thing. Then the issue is, can they stay in, and can they work implicitly? Just because they have a sense of it, doesn't mean they are ready to do the work implicitly. They might have a sense of it and then if you ask them to describe it or to be more specific about it, they might either lose it, they may dissociate from it, they may get frightened of it, there are many responses people might present at that point. So then you figure out, this is as far as we can go with this. (interview 1)

A variety of other purposes were also attributed to Focusing by study participants. They described the use of Focusing in therapy as a means of cutting through client defenses, guiding the direction of therapy, helping clients in getting "unstuck", and helping clients to gain distance from the trauma. One therapist mentioned the use of Focusing in supervision, as a process that can assist in debriefing from sessions with clients. Focusing was also seen as useful to clients, empowering them with tools that assist in problem solving, increasing self-acceptance, regaining dignity, and regaining trust in themselves.

Combining Focusing With Other Approaches in the Treatment of Trauma

The great diversity of the participant group is evident from the wide range of other approaches known and used by participants in the treatment of trauma. Participants

cited 48 different approaches which they use in therapy in combination with Focusing. Usually, Focusing is not the modality of choice if the client is unwilling or is not ready to use Focusing (Table 4). On the other hand, 3 therapists indicated that, with a few clients, sessions involve Focusing only, and the client does the cognitive processing of that work on their own, or with other supportive people in their lives. These data suggest that Focusing is not usually a "stand alone" method, but that it does combine well with a wide variety of other approaches.

> Whatever the client needs. So with some people it is more talking and thinking initially; with some people, they stick with it at a feeling level. With some people they will work emotions at different levels. They will start up there, "It feels like this" and when I go "Can you describe it?" they will go deeper, deeper, deeper into it until eventually we end up at the Felt Sense level. I use everything to the end of Focusing and whatever works and what the other experiential therapies give me is an opportunity to work up to Focusing. (interview 1)

> I am using myself in everything that has gone into my life. Every experience, every book, every reading, every person, every other person, it is sort of a conglomeration of all of what has been, gotten into me up to this point in my life. (interview 6)

> I find narrative works quite well with Focusing, because narrative is really about getting at some of those alternative stories, which is what Focusing can bring up at different times. I ask people to tell me stories about times in their life that really

stood out, that were really charged, or where they really exhibited qualities like strength and courage. I use drawing and writing a lot as well, to assist with processing, to make things visible. Letter writing can be a way in to Focusing for some clients. (interview 10)

Benefits of Using Focusing in the Treatment of Trauma

The benefits of using Focusing in the treatment of trauma as perceived by the fourteen therapists who participated in this study are considerable. A summary of these benefits can be found in Table 5, Appendix G.

The most frequently noted benefit of the Focusing approach is that Focusing is a safe and gentle way to deal with past trauma. In contrast to their experience during the trauma, the client is in control of the process, and they are no longer alone in it. They can deal with the trauma from a safe distance, so they are able to observe it rather than relive it.

> It is gentle, and not retraumatizing...because a person will have complete control over what is happening there, so they know how to handle themselves there. If you have a therapist handling you, you might not always have the sense of: "Ok, what? How much exactly? Where exactly? What exactly?" (interview 1)

> Focusing allows you to revisit the trauma place without reliving the trauma. (interview 2)

I think people increasingly start to feel more safe inside themselves. (interview 5)

I am actually giving them this kind of safe space where it feels safe enough, secure enough to even begin to trust what is in there. Because if you have never have had a person in your life who has accepted you in that trusting secure way, then you don't even know what it is. If you have been with people from whom you had to defend yourself then you have that same attitude toward this thing that has been held toward you is not ok. From early, early childhood, you are not ok...You are there to be violated. You are there to be somehow abused. So having a person there, who says, "Lets sort of be there with you" and they are sort of in this Receiving [Focusing term for acceptance of whatever is there] way. "Come into the womb." (interview 6)

Breaking things down, taking smaller chunks, safety, all of that, Shirley added that. (interview 7) ("Shirley" refers to Shirley Turcotte and the Focusing and PTSD course.)

People can visit a trauma place and do the work they need to there without reliving the trauma...It is a very gentle and honoring form of therapy. (interview 8)

There is a good sense of strong connection. A lot of the clients I work with, after they come out of a session, some of the responses are, "I felt you were really with me going back there". It is really neat because sometimes some of those places, if you go back they are not very nice and you need so much support. So having someone there with them makes a big difference. (interview 9)

There is also the ability to be retrieving memories without getting overwhelmed. The body will bring what needs attention right now, and what we can cope with right now. I am not bringing too much. I'll not flood with a lot of memories. The body has its own sequence, so it might bring up a few memories and then there might come up a few issues, for example, a caregiver that didn't protect, so you may go off in a different direction to deal with that. (interview 10)

It makes it safe to deal with traumatic material, even on an educational basis, as well as in therapy. I was invited to present at a workshop on sexual abuse. Sexual abuse is a very traumatizing topic. So, what I did is, I had everybody clear space. I lead them through the exercise and everyone participated... the youth, they were able to do that. Later, at the end I was able to do a session with them, where they were able to put things away, whatever came up for them. (interview 11)

It is helpful to break things down...We are going to work at one thing at a time and then it is not so unmanageable. (interview 14)

Another frequently noted benefit is the fact that this approach is client centered and client driven. Of the 8 therapists who cited this as a benefit, only half felt it was necessary to describe or elaborate, as this is a benefit that is, in many ways, self-explanatory.

> Focusing can't happen without the person being in control. Focusing is the person being in control in their inside place...It is an absolutely intrinsic part of Focusing...when a person is in control and a person is in their own place so to speak, it also contributes to that effectiveness. As a therapist you don't have to search. (interview 1)

> It is a much more collaborative way to work...very client centered. (interview 7)

> Focusing's client centered process ensures you don't go deeper than people want to go. (interview 10)

> The client leads and has control of where or how far or deep the session will go. (interview 12)

A potentially important benefit cited by 8 of the participants is that when using Focusing, major breakthroughs are possible, as clients come to understand, in an integrated cognitive-kinesthetic way, what is happening internally to them.

It can lead to real internal change...there is no comparison. Being able to introduce Focusing even initially, even if we just touch and go, what I am finding is that whole theory of personality that Gene Gendlin talks about. He says "Knowing does not necessarily lead to change." So just because I know something: "This has happened to me, and I know this happened to me, and I know I shouldn't do this, and I know I should do that", that means nothing. That does not mean that a person will make the change. The head is a tool. It is not the tool that leads to actual change. So whatever happens in terms of a change, a shift in the hard drive of the person where the personality stuff is, where it all got messed up, its got to happen in there, in that hard drive. That hard drive is not in the head, it's in the body. (interview 1)

Even a one-shot session can make a big difference when someone is triggering and doesn't realize what is happening. (interview 2)

It makes a difference that lasts. If someone comes in with extreme anxiety about an exam, and we go inside and find out what is triggering and attend to that, and then they can go and write the exam. And the next time they have an exam they don't even have to come in again. They are in control because they know what it's about. (interview 3)

Some clients make major breakthroughs; experience a sense of relief at knowing where their issues are coming from. (interview 4)

> Checking into the body takes a person to the deepest level of the experience. (interview 5)

> I find it is helping a lot of the clients I work with move forward. (interview 11)

> If we just ask the right question, the person can move right along. For instance, the question "What is the worst of it?" often brings us right to the heart of the matter. (interview 12)

> I find myself, once I have used Focusing with myself, big changes. (interview 13)

More than half of the participants see Focusing as an efficient and precise tool for therapy. By using the client's bodily felt sense of direction takes the therapy where it needs to go, saving years of pain, effort and expense for the client.

> What Focusing does is it saves years, because years of talking and years of re-visiting and retelling and rehashing will often not have any actual results in terms of control of the person's symptoms or even make a dent in terms of symptoms...or their attitude or belief system, it might not. People just re-visit and re-visit almost till people re-traumatize as the part of the process. Where Focusing takes you to the place and time very quickly. You don't have to spend time

searching, cognitively, "Where the heck is it? What the heck is it that happened?" The body takes you right there, like a fast express train. Once you get there then you are able to basically observe the trauma place from an adult place and find the meaning in it. Bring the part of you that got stuck there out into the adult world, and separate the past from the present. That can all happen in the space of twenty minutes...Because it's a lot more efficient, it's also a lot easier on the system, on the body and the psyche. (interview 1)

Focusing points them to where they can do some really good work. (interview 2)

When people come back for follow up I noticed a difference; that it wasn't like I had to see them every month. They came back two or three times and that was it...People have said to me, they have learned more about themselves in this ten months when they have been going to counseling one on one for three, four years. (interview 3)

I feel like it is quick and precise for therapy because immediately you are going to the trauma place that needs attention, (interview 8)

Normal psychotherapy, it could take five to ten years to get to that core issue. So that is a lot of time and money wasted needlessly, I think. Whereas, when you use Focusing, you can get to that place in twenty minutes. Go back and visit it from a

safe distance and a safe place. Work through the needs aspect around it and then bring it back to the current situation. (interview 9)

Many times in Focusing, it is really interesting, that if one piece is healed that has impact on other pieces, you know, because it's holistic. You just don't have to look at every piece of the pie...You can look at the...whole pie and the flavor will effect the whole thing. You may not have to trace each memory the body will bring, but when they seem to be important they can be representative of that whole thing. So, not needing to recall every single event. (interview 10)

Focusing helps people identify the most pressing issue. It dissolves some confusion. If we were to attempt to touch on all issues, hard to move forward. By singling out the main issue, and going as far as we can with it, it often seems to touch and give relief to some of the other issues. (interview 12)

The clients that are willing to embrace it and are willing to journey that way and experiment have great success. The ones that will try it and are open to take a look...I think, have the upper hand. I really do. I think they are taking control in some way of their lives. Do they tend to take less time in therapy? Yes. (interview 14)

Eight of the participants mentioned the benefit that Focusing brings in connecting people to their bodies, the source of inner wisdom or "what their body knows". The

authenticity of their bodily felt reality helps survivors to regain trust in their bodies and in themselves.

> It helps people connect with what the body knows, which, for trauma survivors is more reliable than what their head comes up with. (interview 1)

> Making a connection that resonates within. (interview 4)

> Focusing helps people to become comfortable around their inner self. Their bodily felt reality is strongly connected to that authenticity. (interview 5)

> The benefit of Focusing in particular is always again and again pointing them to their body wisdom, and then using what comes, and then somehow enhancing it for them, through who I am. (interview 6)

> Focusing provides a beginning awareness of connecting with their body and expanding their awareness of how trauma has been organized in their body. (interview 7)

> With Focusing, people develop a deeper level of understanding and connecting, finding the answers from within. (interview 9)

> Developing trust in the body...usually survivors do not have trust in the body...starting to know what is inside there and knowing through this process that

things can be dealt with as parts and in a safe way, starts to build confidence in the body so we get more connection between the self and the body. (interview 10)

People have the benefit of really connecting to the inner self. (interview 13)

Client empowerment was cited as a benefit by 5 participants. The client is in control of the therapy, and can take pride in "doing it for themselves".

The client has a choice: they can go in deep and change things, or they can just learn how to contain; refine that skill so they can at least keep the past out of the way for now. (interview 2)

It is such a sense of empowerment. "I have the confidence. I can do this." That is from one or two Focusing sessions. (interview 3)

It doesn't create dependency how I do it, because I am always teaching them that they are doing it themselves. "I am just asking you questions. You are going through it all in yourselves." It is very important for client empowerment I find. (interview 9)

Empowerment is a benefit. "I have some control. I didn't have control back then. Now I can choose how I am for the rest of my life." (interview 14)

Another major benefit of Focusing mentioned by 5 of the participants is that the client learns tools that can be applied in many areas of their life. As they learn to trust in their bodily felt sense of any situation, they begin to use that as a guide in solving problems, and making decisions.

> Focusing gives people tools they can use throughout their life. It impacts on what they do, just about anywhere, any time, just because they have this resource now...that they can utilize more fully, which is their gut. So they sense, they get into situations and they sense. They have the wisdom of that, of the gut sense of their intuition, their spiritual knowing and connecting. (interview 1)

> They can apply it to all areas of their life. (interview 3)

> It is this kind of sensing inside that becomes a way of life. (interview 6)

> I have some clients who just come in and we just start a Focusing session right there and just go straight through. Some of them have set everything aside on the way in. Some are very knowledgeable that way. They say, "Everything's out, I am here and this is what I want to do." (interview 8)

> It gives you clarity, just being able to check in with that Felt Sense. And that's a skill that can be used in any situation...I have one client who uses it in her everyday life: Focusing with her eyes open. Just using that to check in about

whatever comes up. So it's very useful in making decisions and just in knowing what is right for you right now. (interview 10)

Another potentially valuable benefit cited by four of the therapists participating in this study is that Focusing can reduce a person's reactivity to triggers so they are less disruptive to day-to-day life. People learn to identify when overwhelming feelings are being triggered from past trauma, and, as a result, don't "react to their reaction".

Reduced reactivity to triggers is another benefit. If they can be friendly with it, then that stuff doesn't need to cause a lot. The attention getting kind of is not necessary. "Yeah, you got my attention...I know I will figure out what that is and I am interested." It is not like: Oh my God! Oh my God!" They don't react to their reaction. There is one thing worse than reaction, is reacting to reaction. That can blow a person, big time. (interview 1)

There may be triggers and experiencing feeling like it is. But there is an understanding: "Oh ya, oh I know where this is from now. Instead of something to do with me it's all about this, or it's all about the other person." (interview 3)

I will use Focusing with people after they have been able to identify that there are some kinds of overwhelming feeling states or regression that's taken place, some way they have been triggered. Then I would use Focusing in varying kinds of ways to help that person to be able to be able to hold the feeling; to be able to

> carry the feeling, have a safe enough distance from the feeling, to be able to do some taking care of the feeling, or self soothing, that kind of thing. To develop a caring, compassionate... relationship to the inside feeling. (interview 5)

> When someone has PTSD then often some parts will have grown out of proportion and may be extreme And then parts may be kind of warring with each other...and so a lot of energy goes into just managing all that...and so...we try to accept all of our parts, and really recognize that we are complex beings and have many parts. (interview 10)

Six of the therapists indicated that Focusing helps a person in connecting back to the source of triggers, so that change can happen at that level. The client's Felt Sense guides them to right place, where, as a result of observing from a safe distance, they can attend to the hurt part of themselves, healing the wound there.

> Focusing will do it. It is like a pointed pencil...It will go to the place within the space of twenty minutes. We will generally do what they need to do and come out of it. There is a piece of the hard drive that is permanently attended to and got shifted to the right place where it needs to be...It is amazing how it works, the difference. (interview 1)

Real benefits for Aboriginal clients who may be affected by residential schools and their legacy. Often able to make a connection, for the first time, between what

they are experiencing now, and their [or their parents'] experiences at the Residential School. (interview 4)

I kind of help them to identify what is going on and where they feel it in their bodies, and establish a comfortable space from it, and pay attention rather than fighting it or letting it overwhelm them. I might just ask them to find some kind of way to be with it in a caring way and serve it and then just ask a question like: So, how old do you think you feel? When is the first time that you can remember feeling that kind of way?...I have worked with people with feelings that go back to three year old, four year old, twelve year old, eighteen year old, what ever, so then we kind of refer to it as "a twelve year old part of you", and then working at how that person might be able to relate to that twelve year old part. (interview 5)

The felt sense can connect the current trigger to an earlier source of pain. Thereby the adult begins to recognize the child's feelings vs. the adult that has been triggered. (interview 12)

It gives them dignity; it gives them a little more self-respect. They maybe don't judge themselves so harshly, when they realize, "Wait a minute, this isn't my twenty-six or thirty year old self that is reacting to this. This is that place from when I was way back then, where I have gotten stuck". They start to understand that their reaction comes from a different place and not from today. (interview 13)

Several of the participants indicated that Focusing can help a person gain a new, and more helpful perspective about their past experiences and their reactions to early traumatic learning. Focusing provides new ways of achieving insights, and modifying and redefining emotional reactions and belief systems.

> I think it's the honor there. You know, that there is no shame. I think that is the greatest barrier that's been identified, that shame, the oppressor, and how they internalize that. So for me, the letting go of it, you know, that it wasn't their fault, and however they reacted was about maintaining and surviving. So they have a totally different paradigm. (interview 2)

> Recognizing they have been through the worst of it; they are not in the trauma any more They can handle what ever it is today has to offer. (interview 3)

> With Focusing I am not shy about offering interpretations, or that kind of thing. I offer it and I tell the person: "You check inside. How does that feel?" An interpretation is valid if the *body* feels it is valid. It gives an easy insight. (interview 5)

> Focusing helps people in dealing with misplaced guilt...They need to forgive themselves for not being able to say no, or from a child place, not being able to stop what was going to happen. (interview 14)

Another important benefit cited by several of the participants is that Focusing is consistent with aboriginal values and traditional ways of healing. Focusing is holistic, involving mind, body and spirit, and shares the values of respect, honoring, non-interference, and acceptance.

> For Aboriginal people this feels like a reclaiming of spiritual and emotional health. It fits with the ethic of non-interference and respect. (interview 2)

> Our population in general, for residential school; there is an understanding of the holistic approach using your spirituality, your emotions, your physical. (interview 3)

> The Focusing approach is consistent with Aboriginal traditional values: respect, honoring, non-interference, honesty, loyalty, loyalty to self, non-judgemental. (interview 4)

> It's a fit for aboriginal people: the mind/body/spirit connection. (interview 9)

One participant also remarked on the holistic nature of Focusing as a benefit, but without mentioning that this fits with aboriginal healing traditions.

> You address the mind the body the spirit the emotions. Cognitive, it's mind only, behavioral it's physical, all physical stuff, right? Focusing, you get the four, mind, body, spirit, and emotions. How powerful is that? (interview 1)

Another aspect of Focusing mentioned, which is potentially of great benefit, is that people learn to attend to themselves. They learn to use Focusing on their own between sessions to attend to any hurt places which may become activated. Four of the five who cited this as a benefit elaborated or provided an example.

> I think the biggest benefits to clients is that they will eventually be able to attend to themselves. There may be stuff that they choose not to attend to because they need company with that...But the little stuff they will attend to...and they will welcome and they will process it. They don't even know they are doing it. They will come into a session and they will say, "I had this happen...but I got through that one, and that is all gone." Ok, that is good. There are clients that begin to do their own stuff. That is a huge benefit. (interview 1)

> It is good for them to have those tools that they know they can use. That way I don't get no calls at three o'clock in the morning. You know, cause they can solve those things themselves. It is so important ... because it is always an ongoing process as well. You are always looking at things. (interview 9)

> Sexual abuse survivors can use it as a tool for reclaiming their sexuality...checking in with your body, just checking in to see if things have to be more gradual or more gentle or whatever. (interview 10)

> They are given a tool to work with so they can do some of their work. There are financial benefits for clients, because they aren't totally dependant on a therapist to do healing work...You need to have some skills so you can function. Maybe you need to plug in once in a while to get a little hit of energy, but then go away and use your tools. (interview 14)

Five of the participants indicated that a major benefit of Focusing is that it makes life more manageable for people. The skills of Clearing Space and "containing" provide them with a sense of personal control and a new confidence in handling stressful situations.

> I find that, if I look at the survivors I have worked with, I would say all of them would have experienced a major change after ten sessions, major change in how they do and how they are in life. These are survivors who can get into Focusing at the beginning of those ten sessions, where we can begin to do implicit work. (interview 1)

> One benefit is their confidence in themselves that they can handle day to day things. Their life has become more manageable. They feel, "Oh yah, I can do this." They can un-learn old ways of coping that don't work. Also, being able to apply what they learn or gain from a session to their life today. They can apply it to all areas of life, problem solving. (interview 3)

> The more they practice Clearing Space the more they have a sense of control over their lives. (interview 9)

> Clearing Space can help when a person is feeling overwhelmed. Having a clear space is very freeing, because if you have been overwhelmed for a long time and then you can actually have a time, even though it might be brief in the beginning, a period in which that issue is not ruling you, and it's not you. There are other things and there are other times in your life or other parts that are there. There is strength and there is courage. There is hope. (interview 10)

> It is helpful for people to learn to contain things and know they have the power to do that. There are times during the day or week or times in your life when you are better able to cope with something. If you can contain something till you have the strength, when you are well rested and you want to take a look. The ideal time for you...Still it is your work to do, but if you can know that, I can re-visit this, without re-traumatizing myself and just take pieces of it. I think we try to solve too many things at once and we are overwhelmed with trying to fix everything, (interview 14)

Four participants indicated that an important benefit of using Focusing in the treatment of trauma survivors is that it is possible to work with the deepest levels of their traumatic experiences, and yet achieve a level of closure in that work that allows them to be immediately ok and able to go about their day.

> Focusing has the amazing safety of that whole process of closing it up. That we are going, "how do we make sure this stays where it needs to stay?" There is often a bit of an extended closure when survivor has a sense that they have gone someplace that "is not going to go over well with the rest of me". (interview 1)

> That people can go back into a trauma place and honor their survival, and come back into the room and be ok even if deep work was done. (interview 2)

> You can go so deep and yet close it all up and be adult and ok. (interview 3)

> Receiving and "closing" in Focusing. We don't want to send anyone out the door that is stuck in a child place. (interview 12)

Another benefit of a Focusing approach involves the use of Clearing Space and/or other Focusing steps by the therapist, and for the therapist. This is cited by 4 of the participants as helping the therapist to "remain present" during the therapy session.

> You are there, right there. You have to be able to be there and witness that and not take that on, and be the support, be the companion. You are right at the Felt Sense. You're right at the scene…so you have to be able to separate out everything that is yours. Only the part of you that needs to be there is there. (interview 1)

> The more that I do Focusing myself, the more comfortable I am with the ups and downs and shadows in my inner life, then the more I am able to be present with other people. (interview 5)

> Usually when I go into a session I'll clear out everything of my own too. I find that is really important, you know, to clear out your own self. So none of your influences and none of your biases get in the way. It makes you really present, very quiet and centered...less reactive, more interactive." (interview 9)

> For me I find that I am more focused, present for the client. I am not into my stuff and my triggers for my own stuff is not there, because I clear space before going in. (interview 11)

A benefit noted by three of the therapists interviewed was that the client gained a heightened self-awareness.

> In teaching, Focusing can be a tool for helping students to develop their Observer Self, as a part of the life skills lesson under self-awareness. (interview 3)

> People gain a heightened awareness for themselves, about themselves. (interview 6)

> People just saying to themselves "a part of me was abused, a part of me was a victim, a part of me is very hurt about this." And then just recognizing there are

other parts…some adult part that could be helping with the situation. It just allows you to have more compassion for yourself when you recognize all of the parts within yourself and to have an attitude of acceptance of all your parts and of whatever comes. (interview 10)

A few therapists described how learning and using Focusing has expanded their own therapeutic skills.

There is a much more broader range of affective response and experience that I am comfortable being around. So that makes a big difference in the safety space. Then having had the experience of learning to be inwardly compassionate to various parts of myself and experiencing shifts that have happened in terms of that relationship, then I know and I believe in people being able to do that too. So that becomes a goal. (interview 5)

Focusing expands therapeutic skills. It takes them way out ahead. It expands therapeutically how you work. I think all therapists need to have Focusing training. It is the basics of doing therapy. (interview 7)

I find that, when they trigger, I can see it right away. I know to actually how to calm them down. Recognizing that symptom right away and having that knowledge makes such a tremendous difference in the work that I do. (interview 13)

Another benefit for the therapist mentioned by 3 study participants is that using Focusing can reduce effects on the therapist of working with trauma. Clearing Space and using Focusing sessions for themselves can reduce counter-transference and/or Vicarious Traumatization.

> [It provides] personal benefits as well. [I am] able to use it on self to manage stress and reduce counter-transference issues. (interview 4)

> It is very helpful for me after I do a session, because sometimes what they talk about is very heavy, very negative energy. When I am finished I am able to check inside [myself] and clear it out, so I can move again. (interview 11)

> It's helpful in reducing the effects of working with trauma. You know there has been times when you are kind of feeling overwhelmed, you think is this mine...? It protects you too, because you can check and see. If it is not mine, I have got my own stuff. I certainly don't need to be carrying somebody else's. (interview 14)

Three participants indicated that a benefit of Focusing lies in its normalizing effect. "It helps for people with PTSD to know they are not crazy" (interview 13). Two more cited increased trust in self, and two indicated the benefit of a client really feeling heard and attended to.

In addition to those who mentioned "respect" in the context of its fit with aboriginal values and traditions, 2 participants remarked on the respectful nature

of Focusing. "I like that it is so private, that you don't have to tell your whole life story *again*." (interview 3) "I really like the Focusing Attitude, very respectful. (interview 12)

Evidence that "It works"

The question: "How can you tell that it's working?" was not one of the structured questions, and, unfortunately was not asked of every participant. This question arose during the first interview, and, as the response seemed useful, was also asked during interviews 2 and 3. There was a small time gap after interview 3, due to cancellations, and, unfortunately, this question was forgotten for the next four interviews. The process of editing the transcripts of earlier interviews provided a reminder of this question, and it was worked into the remaining interviews, 8 through 14. Those who were asked readily provided answers. A summary of responses to this question can be found in Table 6, Appendix H.

All but one of those who were asked this question indicated that client feedback was one way in which they could tell that Focusing was useful for that person. "People identify the change and how it works for them. They tell you" (interview 2). "They know when it's helpful and they'll tell you" (interview 8). "They will tell you how much better they have been" (interview 14). More specific examples of client feedback were provided by two therapists. "It's a good fit. They notice a difference in themselves. They feel empowered, more independent" (interview 10). "I have clients who have been 15, 7

years in therapy and people who say: 'You know what? This few months have given me more than all the years'" (interview 3).

Four therapists said that they could tell that Focusing was working for the client when the client would start to use the skills and tools learned on their own, to soothe the hurt part of themselves or to handle crises.

> They have a good Observer so they are able to step back from situations. All of this, everybody walks away with. Even a soldier...He figured out that if he is in reaction he needs to always do something to reset himself. He figured out what works, getting up and walking away. He does something, which has a huge impact on not just resolving trauma and changing how you respond to situations, to stress situations, but the quality of his life. Which to me is major. (interview 1)

> They will say, "There was a time during the week when I thought I was going to lose it. I went back to something you said in session. I thought, ok, so I have a choice. I can do this. I have a tool and I can use that tool." People still say to me a year later in a grocery store, " I am so grateful for the tools you have given me. I can't tell you how many times I consulted them over the past year." (interview 14)

Four saw other positive changes in clients' behavior. "You see it in amazing changes in terms of their behavior" (interview 1).

> I worked with this one lady who come into our circle and she was high on pills at the time, but she wanted help. Now she is off of pills. She is one of the most committed people to the group. So it has been going really well with her. (interview 11)

> Seeing someone change...from constantly radiating anger, to smiling and being her self; and seeing how that changes their whole demeanor and their whole outlook on life, being out and able to enjoy an active lifestyle. Being able to feel, I am not crazy. (interview 13)

> They are doing better in our community. They are better parents. They are better spouses. They are better community members. They are everything because they are doing better. (interview 14)

Two of the participants noticed when their clients became freed up from constraints that their symptomology had formerly imposed. "They are out and about again. They are feeling like they don't need to close themselves" (interview 14).

> At first: "I won't go out where there's crowds". Now: "I go out where there's crowds". That is a big huge thing. You can go to a movie now. You can go to a conference; you can go to a mall on a Saturday. This is a way back. (interview 1)

Two therapists pointed to seeing "Ah-hah!" moments, instances where clients came to a new understanding about themselves, as evidence that the process is working for those

clients. " I can tell that it is helpful by the client's reaction: "Ah, that's it" (interview 12). "All of a sudden, it was: "Oh my God! I understand! I've got it!" And then we rock...They want to do more, more, more" (interview 13).

Three participants indicated that they could see the change in their client's face and in their body (interviews 1, 8, and 11). One said: "You can see it in their eyes, the change" (interview 2). Another reported being able to see the "shifts" (interview 8), referring to the "felt shift" which Gendlin found, in his research, to be the critical difference in those who benefited from therapy of any sort (1984).

One therapist felt confident that people are finding Focusing helpful because they have gone on to refer other members of their families to her for therapy (interview 3). Another 3 indicated that they know the approach is working because clients continue to move forward (interviews 10, 11, and 12). Another mentioned: "seeing the client leave that much lighter" (interview 12). One therapist, who lives in a small community, indicated that this provided the advantage of being able to see how current and former clients are functioning in the community. "I guess living in a small community...we see each other all over the place. They are smiling, they make eye contact, they are happy" (interview 14).

Limitations and Drawbacks to Using Focusing in the Treatment of Trauma

Perhaps the most important of the structured questions asked was "What, if any, are the drawbacks and limitations of using Focusing in the treatment of trauma? A summary of

the responses to this question can be found in Table 7, Appendix I. It is important to know the limitations of any treatment approach used, especially when working with a population where the costs of mistakes can be high.

The responses in this area seem to fall into three major categories. The first includes the steps that need to be taken in order that Focusing is safe to use in the treatment of trauma. The second category involves therapist prerequisites. The third category relates to issues regarding the clients themselves.

In the first category, 6 study participants confirm the fact that Focusing can be very scary and/or intense, when the step of "Asking into the Felt Sense" brings forward a trauma memory. This speaks to the reason that care is needed when using Focusing with trauma. One therapist, who uses demonstrations of Focusing as a way of familiarizing people with the process, indicates that some who witness the demonstrations are frightened by the intensity (interview 2). Others spoke of people being frightened at first when trying it or contemplating trying it. "Some are afraid of it, going back to that memory piece" (interview 3). "It is scary to go inside" (interview 10). "People's natural hesitation to check into their bodies" can be a limitation "especially if there is a lot there. It can be scary" (interview 12). Another connected it to what must be done.

> A lot of people are very afraid to go there because it is painful. But once you work with them, and build up the safety, and let them know they are not going back there to re-live it, that is very important. (interview 8)

One person put it in another way.

> It takes some courage. Lets face it...nobody really wants to truly really lay themselves out on the table. Nobody really wants to expose who they are...That is the piece that is so hidden and so pushed and stuffed so far down that they don't even know that piece of them exists. (interview 13)

Five of the participants caution that it is important not to push too fast. One therapist indicated that it is important to respect the client's sense of what they are ready to deal with (interview 11). Another indicated that the way to build in safety is: "You work at their speed and you don't make them go where they don't want to go" (interview 8). One warned: "You need to be able to take your time and sense it out. If you rush it you could have a lot of reoccurring intrusive thoughts come back" (interview 9). Two spoke at greater length.

> It's important not to push too fast. That to me is the biggest thing is to get people comfortable. I am very cautious. I will lay off. If I err, it will be on the side of caution. I will lay off if I sense a lot of discomfort, and a lot of, sort of, people are almost, there is fear but it's more than that. I don't know how to describe it. To me it is like the person where they are at with it, they are standing on the edge of a cliff and they are looking down and they are going "I am going to have to take a leap here", and at that point, when I sense that is how it is, I don't encourage the leap. We just talk about it. "Yeah that would be a big leap." We talk about the leap itself rather than going and leaping. What would make that leap a bit safer? What would need to happen so that you are more comfortable with that? Recognizing,

yeah it is a long way down there. Just observing it because it is very easy just to give people a push...I will wait it out. (interview 1)

You can't force anybody to do something they are not comfortable with. That is a major thing for me. That is something that is very important. I will never ask somebody to do something that they don't feel comfortable with. Or are you ready. I make sure the big question is "Are you ready?" (interview 13)

Four therapists indicate that trust and safety must be established before beginning to work with trauma pieces. One simply recommended that this be done. "Clearing space is helpful in the beginning, containing, creating safety." (interview 9) Others spoke of the problem, then indicated the solution.

For female clients, particularly if they have been abused by a male, they may feel uncomfortable sitting there, with a male counselor with her eyes closed. It's important to do relationship building first, establishing trust and safety. (interview 5)

You build up the relationship and the trust with them, then that lets all the barriers down so you can get past them. And make sure that they know that it is a safe place to go and a safe thing to do. (interview 8)

The limitation is where, to throw themselves out there and to open up you really have to establish that trusting relationship. If you don't have that, forget it. They

are not letting you anywhere near them. That is what I have found anyway…If the trust isn't there, people won't go in deep. (interview 13)

Two of the participants emphasized that Focusing is not safe to use in trauma work if the therapist controls the process rather than ensuring that they follow the client. One merely stated: "You need to keep it client centered and client led" (interview 9). The other went into more detail.

> Now the hazards of Focusing would be a therapist being controlling in the process. A therapist could easily manipulate the process simply in the movement [step] of Asking. Depending on what you are asking, the person being in charge is key here. Without that there can be an overload. The therapist can move too fast before the person gets a good sense of where they are at and what it is about. A therapist might also divert from the focus of it, the crux of it, inadvertently because they don't know. That is where there can be a lot of frustration on the part of the client and where a client might be in danger. (interview 1)

One participant indicated that the therapist must be fully present in doing this work. "When you are Focusing with another person and you are not able to be really fully present, again that is another drawback. If I cannot put my stuff under the table for the time being, I cannot be there (interview 6).

Two more indicated that it is crucial to close the session properly, ensuring that the client does not leave in a regressed or agitated state.

> Focusing in itself as Gene Gendlin had presented it is a process to go in, and do work, and come out. It is not a process that acknowledges the whole complexity of what happens if you hit trauma or regression. I had seen the demos at conferences. People hit trauma, people hit regression and they have no idea and they big time mess up. I have seen people walk out and their memory not being put back together. They walk out at the age of five, not twenty and there is no closure… We work with overwhelming emotions, so that when those emotions come they can get through them quickly and safely and move on with the rest of their life that day. (interview 1)

> There is a risk of leaving that open and re-traumatizing [the client] or leaving…[the client] triggered. But as a Focusing therapist, you need to know that when you go there [to a trauma memory], there is something that you need to do there [to tend to that wound], and to close it, to make sure they are ok. (interview 8)

Four participants indicated directly that Focusing must be adapted for trauma work, or it can be unsafe.

> The important piece, that Focusing alone isn't going to do it with trauma survivors. I really want to flag that out, so there isn't a misconception it would. On its own it can be pretty dangerous. There are many, many steps that are added to the Focusing process to be able to do trauma work. Therapists who know their PTSD, they know all the extra steps they need to layer in. They know how to work

them, when to work them, how to juggle all that and that is what makes Focusing a powerful tool. Focusing on its own is only dangerous to trauma survivors. (interview 1)

There is some risk involved if you don't understand what is happening there. There is a risk and I see this all the time with therapists that don't necessarily know Focusing or understand trauma, is that when you do go there and touch that place you need to do something there...You need to honor that place that they are allowing you to go to with them. You also have to do work there. (Interview 8)

One therapist, who learned Focusing without the PTSD training, described some of the difficulties that occurred before he undertook the task of learning how to build in safety measures when using Focusing with trauma.

I have done classes in which I didn't know enough, and people have issues and some people have been overwhelmed in the classes....When I was first starting, before I learned about how to get a safe distance from traumatic material, I was working with a guy doing a kind of cognitive behavioral gradual approach. When he got stuck, we tried some Focusing around that. Now what happened is he got in touch with a lot of rage, and a lot of rage was directed towards himself. I was able to help him get a safe distance from it, hold it and all of those kinds of things. He could have gone into crisis and I didn't know what to do....It is not so much a limitation of the approach, but precautions [are necessary]. Do we work with "safe

> distance" from trauma? At first, with trauma, I didn't do enough with working with safety. (interview 5)

Another therapist spoke of her frustration at the general lack of awareness of trauma work in the Focusing community outside of the Focusing and PTSD graduates and trainers.

> I think the limitation in the Focusing model is that it didn't include trauma. It was Shirley Turcotte who added the trauma piece to it, where sensory-motor was developed to work with trauma. I know when I first learned Focusing, everything about it, the readings, the manuals and all seemed so useless...in comparison to the new kind of information on trauma and trauma therapy. The Focusing movement has not really kept abreast of the recent literature and new techniques based in trauma. Focusing does not encompass the understanding of how the body responds to trauma. With trauma, just following a client often is not enough. Often with Focusing, once you are into something and clients happen to touch a place where there is flashback or something, it is difficult. When their body has an innate way to organize the trauma it is difficult to slow down the process. Once you end there it is like a land mine. (interview 7)

Four participants raised the need for therapists to be able to individualize their approach in order to meet the needs of all clients. Two additional participants indicated that one of the benefits of Focusing is that it can be adapted to meet the individual needs of clients. All of those who cited the need to individualize, also have indicated, under the

heading: How Focusing is Used in the Treatment of Trauma (Table 2), that they do just that. One stated: "Some people may not want it. You need with some people to just work in bits and pieces of Focusing without going through all of the steps. Accept what people's preferences are." (interview 10) One participant went into more detail around the need to have this flexibility.

> Sometimes the Focusing is a little overwhelming for them. So I guess you need to know when to back off. There are people that have so much...stuff there, that if you go in every week, and do a Focusing session with them every week,...it just gets so exhausting for them. You really need to read your client and know sometimes you get to go there [Focusing] and sometimes you just need to chat. Integration of it is very important. (interview 8)

Another participant provided an example of the need to individualize the approach.

> There is no "one way" to focus. You actually have to follow the client. For some people, you can't just jump into it. Example, I tried focusing with this one person. I could not get her into her body, into any kind of feeling place, because she was so stuck in not feeling anything. She was numb...so I have had to navigate my way in. (interview 13)

The remaining two therapists who identified a need for adapting the process to fit the client, both also lauded the flexibility of Focusing. "Focusing is not a type of method that you have to fit into. You can fit Focusing into whatever works for whoever is in front of you, and that is important" (interview 9). "You don't need to use all the tools

every time, just the tools you need, you use. You put that in you bucket. I find that really handy to have that" (interview 14).

Four therapists indicated that they felt that there were no limitations in using Focusing with PTSD, *providing you do it properly*. "Well, I don't feel any drawbacks or limitations when I am doing it in that way" (interview 6). "Once you overcome the barriers there are no limitations because you are going to that place of danger with them" (interview 8). "I don't see any...[drawbacks or limitations]. Everybody that I have been working with, they love and have something good to say about our sessions" (interview 11). "None that I have encountered, once you get past the barriers" (interview 12). It is clear from the context of those interviews that "doing it properly" involves staying present, building in safety and adapting to client needs.

In the second major category, therapist prerequisites, several issues were also addressed. Three therapists indicate that experience is required to do this work well.

> We always tell students when they are leaving, [that] it will take them a good year before they can just drop into the connection clean and clear. Lots of experience before they can make a clear honest connection, before they can not go to their head, before they can just be there for whatever the client needs, not search, just be in the moment and let things come from inside of them....That doesn't mean that people don't get good Focusing sessions when students first begin, too. They are just a bit clumsier sometimes. It just takes a bit longer....You might have to go to something again...in the next session, because you realize that you didn't see

> something that was right in front of you....Your surgical tool is not a precise as it might be after that first year. Of course, the more years, the faster, more efficient, effective, clean, clear, gentle the process is. (interview 1)

> I am very concerned, actually at times, about people who learn Focusing in a weekend workshop, or in a few sessions, and now think they know all of it. (interview 6)

> Even though there is a process to Focusing and stages, they may not happen in those specific stages. So if you force that issue, if you force those stages...it may not work for the client. Just knowing what to use, when to use, and how to use it, and that comes with practice. (interview 9)

Two participants expressed the view that it is important for the therapist to deal with their own baggage, in order to maintain their own mental health, and to reduce the possibility of counter-transference.

> You need to deal with your own history, and any trauma there...students come in and everybody's got a history. Everybody's got issues. They also know what they will be exposed to: that they will see themselves on the inside. That initially can be a very frightening enterprise, especially for therapists...They might have had a few glitches, where they get triggered a bit, but they have done fine without really exploring the depths of themselves often. Now they are faced with it. Sometimes they are afraid at the beginning...Some of them never quite move past that and it is

> the ones that don't move past that, that make poor leaders because they... haven't gone through the process enough times to separate themselves from what happened to them. People need to...be able to take just the part of themselves that the survivor needs [to have present] in the work, and not their trauma. This is the thing. Often they will bring their trauma into the crux of things. Then they have a really hard time leading, and being there, and doing the asking, because a part of them is also triggered by the process. (interview 1)

> I find a lot of drawbacks and limitations when people are using the Focusing without really having cleared up their own lives, because then there is sort of a lot of stuff that might be interfering. (interview 6)

Two participants indicate that the therapists need to experience Focusing themselves before using it as a tool in the treatment of trauma. One puts it simply. "You need to practice what you preach." Another supplied more detail.

> You need to have experienced Focusing yourself...You have to know how it is to be there for yourself. So, the more people do Focusing the more they can do the separating, the more they can do the containing over there, they know how to be in a time zone. They know how to be in today and leave that there. If they haven't done enough of that they haven't done enough good sessions with some of their deeper issues, they are not going to make a good leader. (interview 1)

Two of the participants indicated that supervision is essential in this work. One mentioned a particular aspect of supervision: "Debriefing after a session is important" (interview 10). Another was more adamant.

> Supervision is essential...You can't do this stuff without having very good clinical supervision, without having done your own work clinically and with a Focusing therapist. (interview 1)

The final category of limitations and drawbacks involves issues regarding the clients themselves. One of the most frequently noted issues in this core category is the difficulty that some people have in connecting inwards to their bodies rather than working from their heads. The participants put it a variety of ways. "The only limitation that I see is that it's very hard for some people to get out of their heads" (interview 2). "For some people, it is hard for them to go into their body. It is too intimate" (interview 5). "People who have not used their imagination for a long time, it takes a few sessions to get into it" (interview 9). "Talking, staying in the head can be more comfortable. Sometimes it may seem less scary just talking about it. I mean I tell people that they don't have to do Focusing. It is always a choice" (interview 10). "It seems (that) very cerebral clients have more difficulty, but I am sure this is true for a lot of methods. This is why I like an eclectic approach to counselling" (interview 12).

The fact that some people need some preparatory work before beginning Focusing was highlighted by 6 participants. One spoke to the need for the client to connect inside to a

well-developed adult Observer prior to using Focusing to deal with trauma, in order to ensure safety in the process:

> In Focusing as Gendlin had presented it there isn't recognition of many time zones. The Observer is you today looking at you today. Now, when you start working with trauma and you go to an earlier time zone and a memory place, that's a child there. You don't want the child to be observing. For the child to be observing, the child will re-live the trauma. The adult has to stand close to that and the adult has to observe it. The adult has to go, " Yes, I see myself there when I am five". This is crucial, a crucial piece, that in Focusing the Observer is your adult self...The Observer is the difference between observing the memory and processing it from an adult place, [as opposed to]...re-living the memory through the eyes of a child. (interview 1)

Another mentioned the preparation needed for some people need before they can notice a Felt Sense:

> Sometimes you have to train people to connect with their body, so it can be slow work. Some people when you say: "Ok now, I want you to bring your attention to the trunk of your body." They are not really sure what that means. They have a really hard time listening to their body. So we do some of the exercises that Shirley used to do. You know, imagine somebody you love walked into the room, how does that fit in your body? And someone you are having conflict with? - And then just kind of validate them that: "Yah, that is a little different", because we don't do that every day, listen to our bodies. (interview 3)

The remaining participants who cited the need for preparation, addressed the need to educate many clients about Focusing, about PTSD, and/or about tools they can use in order to keep the trauma work separate from their everyday lives.

> First they need some balance in their lives. Also, being comfortable with their feelings. Also, having some ability to contain. People need really a lot of help with containment in order to be able to not shoot themselves in the foot in their life. (interview 5)

> For people who are really just extremely traumatized, and who aren't functioning there is a huge psycho educational piece that goes with it. (interview 7)

> A drawback is...[many clients] do not have...much knowledge of the Focusing process, and they don't have knowledge of post-traumatic stress disorder. There is no recognition at all. (interview 13)

> I will explain Focusing to them and say, "Is this what you may need?" I continue doing some of the traditional things. With that, they maybe get to the point where they say, "You know what? It is time. I don't have much faith in it, but I will give it a try." They are usually pleasantly surprised. (interview 14)

Two therapists indicated that Focusing is not a "stand alone" model. They identified that sometimes other tools or approaches are necessary. While others did not mention

this directly, it is clear that all of the therapists in this study have many other approaches and tools that they use in addition to, or in conjunction with Focusing (see Table 4: Other Approaches Used in the Treatment of Trauma).

> I don't think it should be used as the only thing that we do in therapy. There is relationship building, there is information, there is cognitive kind of work. You can use a lot of resources, cognitive, perspective, confirming, change. (interview 5)

One person stated that a limitation with Focusing is that a client "may just fake it through". (interview 4) Another expressed her concern that "It can be difficult to stay connected with a person when they are new, and you don't yet know them" (interview 10). So timing, and attention to the stages of therapy is significant to effective utilization.

A serious drawback that was mentioned only by one study participant, is the fact that symptoms may worsen in the early stages of healing from trama. As this respondent points out, this is a drawback to any approach to therapy for complex PTSD that aims at actual healing rather than merely symptom management. Perhaps this is the reason that it was not mentioned by others:

> When they start to connect [to trauma memories], that could increase symptoms. That happens regardless, no matter what kind of therapy that you do, once you start opening the doors…[although this is] much less [of a problem] with Focusing than anywhere else, because in any kind of experiential therapy, cognitive,

behavioral, you have to open a lot of doors to find the right door...and you begin to open a lot of doors that probably should have stayed closed. Again with Focusing you open *the* door, the one door that needs to open gets opened. Your body knows. It goes straight for that. Yes, but once even one door opens, the coping mechanisms get anxious, because "This isn't working anymore. We are going places. This, and this is happening." So, sometimes, in response to that the symptoms will intensify.

Now the other thing that can happen often is that the one memory will be in some way connected to other memories. Even though Focusing takes you to the right door, there may be a door to the adjoining room...This is when people often experience...(that) things begin to pop up. The system, the hard drive, goes into the program that says "Oh my, there is something going on we don't want. We are either going to scare off or prevent it with something else." Or the hard drive gets overwhelmed and stuff starts leaking all over. It is just a part of the process. It doesn't always happen. I would say that the symptoms intensify in probably about 60 % of my clients.

By this time client has a good Observer. By this time client knows how to contain. So they have tools, where with other therapies you are very much at the mercy of what happens, because there isn't that process where, because it is coming from the inside, you can attend to it on the inside. With cognitive, narrative, behavior kind of therapies, you can only attend to it from the outside and that doesn't often

work. So people go back to their coping skills: like the stopping mechanisms, like not feeling, like taking meds, drinking, whatever it is that they need to medicate, because they don't have a way of attending to it. Which is not good.

Focusing clients will know how to deal with it, although it can be quite difficult and we might see clients a bit more often. We work more on containing. We normalize the whole thing and explain to them what is going on. We say "Good! The stuff is coming. Good! We can work on it. We know what to go to next". That is a good thing. So, we help client to see the other side of the coin. Just help them in a Focusing way…

The funny thing is once survivors get in there and they begin to do the work implicitly, it is amazing. Just last week I did a piece with a woman and she says to me after the session, "I am going to pay for this, right?" [This client is aware of the potential for "backlash", as a result of the "doors opened" in the Focusing session; the possibility of increased symptoms for a time.] It's like she knows. They know, because they begin to know how they work on the inside. They begin to know that there are certain things they can control and there are certain things they can't yet control and that to every action there may at this point be a reaction. I found that really amazing. I said, "Geez, you are probably right. Let's 'think on this for a bit'." Cause now this is the cognitive piece right? We do protection planning now at that point…

> Once you begin to do Focusing and begin to do good chunks of it. Yeah, you will go possibly through some more intense symptoms you will go through some difficulty there, but after the ten sessions generally the positives will out weigh the other stuff. They know they have crossed over. They got on the top of the mountain and they are on the way down. And then they also start working faster. (interview 1)

Barriers to Using Focusing in the Treatment of Trauma

The therapists' responses to the question about barriers to using Focusing in the treatment of trauma survivors also fell into three broad categories. They identified, first, the circumstances where the effects of trauma present a barrier. A second set of barriers related to the fact that Focusing is both new and unusual as an approach to the treatment of trauma. The third core category of barriers involved the work setting. The first core category, the effects of trauma, elicited the most frequent responses. The third category contains the smallest response pool. A summary of the barriers noted by the therapists in this study can be found in Table 8, Appendix J.

In the first category, client reluctance was one of the most frequently cited barriers to the use of Focusing, with eight of the fourteen participants identifying this as a problem. Five of the responses fit well in this core category, as they relate to reluctance on the part of the client to deal directly with the trauma. As one participant explained: "Some people just, you know, do not want to go there. It is just too hard for them. They made

a lifetime of not wanting to go there." (interview 8) All of these five therapists indicated that they would respect the choice of the client. For example, one therapist said: "Some people prefer to stay in their heads. Some are not ready to deal with their stuff. Some people contain it forever" (interview 2)

The reasons for the reluctance of the client were not always necessarily related to trauma. In three of the responses, involuntary clients were identified as being reluctant to use Focusing.

Eight of the participants identified the client not being ready for the deep work that Focusing involves. Two put this down to the fact that "Focusing can be hard to get used to" (interview 10) and "Some people are really in their head; need to spend some time there first" (interview 9). The remaining five participants attribute lack of readiness to the emotionally charged nature of the trauma memories which Focusing brings forward. "People who are very closed up and overwhelmed by feelings, it may not be the right thing at that particular time" (interview 5). "Some people are just not ready yet to deal with their stuff" (interview 11). Two participants spoke to the need for the therapist to assist the client in getting to the point of readiness for this work. "I try and coach them to get to that place" (interview 14). "You recognize you have to go at their pace. They will get into their bodies eventually" (interview 13). One provided some explanation of how trauma effects can impact on readiness.

> I think it is where they are at on their healing journey. If they have done some healing, they are open to doing more, or looking at different ways of

> helping themselves. If you're just starting you may have some fear about ...visiting trauma and doing some healing work. Just the thought about going back there emotionally, some people are afraid of that, or don't ever want to do that again. (interview 3)

Another expanded further to explain how to prepare people for doing the Focusing.

> It would be [the] readiness of the survivor to engage in it. That can be really a pretty huge barrier. Because people have often survived by not going to where the emotion lives. Often survivors come in and...there isn't a real down and a real up, there is just a kind of flat. Then you know you have got a long way to go. How they survived is by severing the connection between their head and their body, between what they think and what they feel, between what they are seeing and what they are experiencing emotionally...We totally want to validate that as an amazing skill to develop. Learning how to handle intense, distressing emotions is an important part of preparation. (interview 1)

Two participants identified the defences and coping mechanisms a trauma survivor develops as a potential barrier to the Focusing process. "People's defenses, people's coping mechanisms, those are all the things that they put into place so that you don't go there" (interview 8). "The body's protective mechanisms can kick in because Focusing is such a powerful tool. It can take you right to a trauma place, and people with PTSD have all of these avoidance mechanisms to keep them from going there" (interview 10).

One participant indicated that: "Sometimes clients are just too activated [emotionally distraught] to use Focusing" (interview 7).

Another explained how "programming" (a conditioned response of fear regarding looking at or talking about the trauma) can be a barrier to Focusing.

> The thing is, that when you begin to re-attach there is often a lot in place in terms of either self-programming or, with ritual abuse, outside programming, to prevent that to happen, for things to get re-connected. That is a big, big barrier. What I find is that it is actually the little bits of Focusing that we can shove in there that can get things re-connected. It is often just on some of the things that are safe to check out, I'll ask clients do they ever get butterflies, or if you get a happy letter...kind of begin from a safe place, to see if there is anything there and just start to notice. I ask them to start noticing and check into their body a bit. They don't like doing that at first. Then again they get a bit curious. Then they will come in and say "A strange thing happened and this is what I have experienced." (interview 1)

The final barrier identified in this category is that body memory can get mixed up with the Felt Sense. One participant raised this issue:

> They begin to try to get a sense of the trunk of their body. Then as they are trying to get connected with their body they go: "Oh, my arm felt like it was broken." That is a piece of a memory, but it the external, it is the body memory that is coming and yet the gut is still not doing anything with that. Then you go "ok that

> is interesting. Great you had that". You can't really do much with that other than: "If you sense that broken arm in the trunk of your body, what happens there?" Often nothing for a while. It is a process.
>
> (interview 1)

The second core category involves barriers that arise from the fact that Focusing is a relatively new and unusual therapy approach. The most frequently noted barrier in this core category is the fact that Focusing is not well known. Four participants saw this as a barrier. One explained: "Some people are a little less receptive to it because it is kind of foreign to them" (interview 9). One noted the irony of this in that Focusing is a naturally occurring process for some people:

> I was just a conference with this gal for three days. I said: "You know you are not calling it Focusing but that is exactly what you are doing." She said, "Oh, it has got a name?" She was doing it exactly the same. She is a doctor. (interview 14)

Four participants found it to be a barrier that Focusing is hard to explain: "The language is so elusive." (interview 7) One participant elaborated.

> Before I started demonstrating and role modeling sometimes people just didn't get it. It is hard to explain. I just didn't get it myself at first until it was demonstrated. Even then, I didn't get the Felt Sense until I experienced it myself. (interview 2)

Three participants indicated that the view some people have of Focusing as strange, weird, or "New Age" can be a barrier. Two have met other professionals who have vaguely heard of Focusing and dismissed it as "New Age" (interviews 9&14). The other two found that some clients found Focusing "just way too strange" (interview 5). "There are some guys that say: 'No, it's not for me'" (interview 3).

Another three found that client expectations could be a barrier to Focusing. One explained: "People [may have a] sort of stereotypical idea of what therapy is when they come in. That is a little bit difficult at the beginning, until you begin to work with them" (interview 8). Another participant identified that a client may have something else in mind: "If they are coming in for something different, then you need to stay with that" (interview 5).

One participant felt that the dearth of controlled research on the use of Focusing is a barrier to it's credibility in the profession (interview 9). Another indicated that this lack of credibility in the professional community could be a barrier to the use of Focusing in some workplaces.

> I have colleagues that did have a boss who said, "This is not for real. I haven't heard of anything like this. I don't know if I want her doing this in our workplace." But it works. If people can get a piece of their lives back, who is it hurting? (interview 14)

The final core category, barriers related to the workplace, was addressed only by a few of the participants, likely because the majority of participants worked in private practice. Three respondents indicated that job related constraints on their time, such as: not being able to commit to a long term process, or not being able to schedule regular reliable appointments, or not being able to take all of the time they would like to with a client, was a barrier to using Focusing with clients who need long term reliable therapy, or who work at a slow pace.

Two participants indicated that job perameters could be a barrier to Focusing, "If I was in an office strictly doing Focusing, it would be completely different. I would have the freedom...and the time" (interview 13). "In the context of a demanding job which involves a large caseload and a lot of crises, emergencies can pull you away and make it impossible to commit to a particular weekly time frame for doing this therapy" (interview 4).

Distractions were identified as a barrier by two therapists. "I probably better not do this with an animal around because animals get really bizarre when I go into therapy. He [my dog] just howls" (interview 2). "Distractions can be a barrier. I had a client who could not find a babysitter, so brought her child along, and we really couldn't get any work done" (interview 6).

One participant indicated that it can be a barrier if people's basic needs are not being fulfilled.

> Often we don't have the time or the luxury to fully use Focusing, because people who come to us are often struggling with the bottom rung in Maslow's Hierarchy of Needs. They may be wondering where their next meal is going to come from, or have no housing, or are involved in obtaining protection orders, or dealing with custody or child care issues. They need their immediate needs attended to before they can begin therapy. However, even then, [they] can...use some of the Focusing steps, such as Clearing Space. (interview 12)

Is Focusing More Helpful With Some Clients Than With Others?

The vast majority of participants, 11 out of 14 indicated that they found Focusing to be more helpful to some clients than to others. Six of these found that Focusing was less helpful to people who were very disconnected from their bodies.

> "Some clients are very receptive. Others are so socialized into being in their heads that it is hard for them to get into their bodies" (interview 2).
>
> "It is harder for people who are moving toward intellectualizing...people who are very distant from their inner processes for sure" (interview 5).
>
> "Difficult if people are very disconnected from themselves" (interview 7).
>
> "Some people are really in their head. Need to spend some time there first" (interview 9).
>
> "I feel some clients just lend themselves to the process very naturally and easily. Some clients respond to some steps, but not others" (interview 12).
>
> "Some just don't get it, and never will" (interview 14).

The other four felt that client motivation was the deciding factor regarding how helpful people found Focusing. "It's more beneficial for clients who really want to deal with their issues" (interview 4). "People in crisis are often more open to Focusing, to try something new" (interview 10). "I find it is very helpful for the ones that really want to help themselves, that really want to make a difference in their lives" (interview 11). "I have worked with clients that, no matter how hard I have tried to do Focusing with them, they have skirted, jumped, ran, done everything they can to get around it" (interview 13).

One participant cited both of the above factors as affecting how helpful Focusing is for people. "Some people don't want it, or are afraid of it, or just can't get connected to their Felt Sense" (interview 3).

Three therapists indicated that, while the benefits are different for each person, Focusing benefited all clients equally in the end. "It goes as far as they are ready to go...but not more or less helpful. It is just helpful in different degrees of their readiness" (interview 6). "I guess it's not a question of working better, because it works with everybody. I guess it is more a matter of it works faster with some clients than with others" (interview 8).

> There are different kinds of benefits for different clients. It is always more helpful right away with clients who are intuitive, with clients who have a very good spiritual connection. It is just more helpful there, but that is only till the point when the other survivor catches up. It is the survivors who have not been able to

> make the connection that find Focusing, in the end, the most helpful, because they have these incredible shifts. People who are well connected will have their shifts and things will re-organize in the hard drive and they may have 3 or 4 shifts in a session and you can just see clickety-click, things are going. Now the survivors who take a lot of preparation, who are very disconnected, initially have huge shifts. They are sometimes just totally blown by them....You can see all the stuff going on, but you can also see how incredible that is for them. It is like a bigger gift, like a bigger something. (interview 1)

Is Focusing More Helpful in Some Stages Than in Others?

Four of the therapists interviewed indicate that they find Focusing more helpful after, or towards the end of the first stage, after a good working relationship and some trust have been built and people "have started their healing journey and do have that friendly and curious attitude about what's going on for them" (interview 3).

Another indicated that Focusing seems most effective toward the end of the first stage and throughout the middle stage of therapy. This participant also indicated that they "may alternate between Focusing and the processing and adjusting to the changes that result" (interview 10). One participant indicated that Focusing is most helpful "further on in the therapy process where you have processed a lot of trauma pieces" (interview 7). Another said that Focusing is most helpful when the client is in a "stuck place" (interview 4).

One participant went into some detail about when Focusing was most helpful in therapy.

> It is a lot more helpful when people have a clear understanding, a clear issue....Focusing needs, it wants a way in. There has to be something that takes us in. With trauma survivors, I would not go and say, "Check in the body. What is there?" I start with the issue, because the issue is what contains it. The issue is what gives the safety because it points it to something. Where, if we clear space and check and see what is in the body, we might come up with something we are not at all ready to look at. It is people who come in and they know why they are there, pretty clearly, that Focusing will be more helpful to. People who come in and they are still all over the place and are still very much in the present and what is going on in the present, and they haven't crossed to make connection: "There is something stuck here." We are just still feeling our way around. If people are not able to connect, then Focusing is not at all helpful to them. We have to work to make that connection...Focusing would not be helpful to anybody who is in an overwhelmed, extreme reaction. We would use Focusing only to contain and to ground the person. Let us say we have a client who is suicidal, we are not going to use Focusing to do therapy, we are going to use Focusing to contain and manage at that point. In crisis situations we really don't do crux work. (interview 1)

Five of the participants found Focusing to be helpful in all stages of therapy, "Focusing can be used at any stage of therapy, since the client is always is always in control, and it is such a gentle process." (interview 12)

> It is in every stage. It is in different degrees. As I say, you can just use it for having this decision to make. This is maybe one stage; somebody comes and has a decision to make. I use it all the way to living life in a Focusing way...It is more helpful if you live Focusing than if you just use it the occasional time when you are sitting as a Focusing person. (interview 6)

One participant indicated that it varies with the client since the process is client based and client driven (interview 8).

Analysis and Discussion

In considering the question, "Who would be interested in the results of this study, and why?" a number of potential audiences come to mind. Focusing practitioners with PTSD training would find all of the information arising from this study to be interesting. A major benefit of this study is that it has provided a forum for discussion of issues related to the work they are doing.

Focusing practitioners without PTSD training will most likely be interested in learning some of the special considerations there may be for the use of Focusing in the treatment of survivors of serious trauma. They will also likely want to learn of any limitations and barriers that were encountered by the therapists in this study, and how they have been addressed. They may be interested, as well, in the benefits of using Focusing with trauma survivors. Some may be interested in learning about the Focusing and PTSD training which eleven of these therapists received, and in whether there are any

differences between the experiences of those who do this work without having taken this training, and those who graduated from the full two year certification program.

Trainers of the Focusing and PTSD program will be interested in learning to what extent graduates of the program are using Focusing in the treatment of trauma survivors, and in what ways graduates are applying the knowledge and skills that were taught.

PTSD practitioners without Focusing training may be interested in learning a little about *how* Focusing is used in the treatment of trauma survivors. Those interested in the Focusing will want to know the perceived benefits and limitations of this approach. Other questions which would likely be of interest are: "How does the practice of these Focusing practitioners measure up to guidelines and standards of practice for the treatment of people with PTSD?", and "Can Focusing be combined with other approaches and tools for trauma therapy?"

Researchers will primarily be interested in evaluating whether Focusing is worthy of further investigation as a treatment approach for people suffering from posttraumatic stress. They will want to know the theoretical basis for this approach, as well as the perceived benefits and limitations of Focusing in the treatment of trauma survivors. Adherence to recognized guidelines and standards for practice in the treatment of PTSD would likely be of interest to this group of people. Researchers will also be interested in the indications and contra-indications for Focusing oriented psychotherapy in the treatment of trauma survivors.

Social workers unfamiliar with Focusing will likely be interested in learning whether the practice of Focusing in the treatment of trauma survivors is consistent with the "Standards of Practice in Social Work" developed by the Canadian Association of Social Workers (1995).

As a result of examining the data collected in this study, it was evident that a number of significant questions or themes could be addressed.

How is Focusing is being used in the treatment of trauma survivors?

Focusing is used in a variety of ways by all of therapists interviewed for this study. Indeed, flexibility seems to be a hallmark of this approach. Focusing clearly can be used in combination with a wide variety of other approaches. This diverse group of therapists identified 47 different therapeutic approaches that they use along with, or in combination with Focusing. However, Focusing is the primary approach used for at least some, and in most cases, all of their clients, and a Focusing Attitude is used no matter what the approach.

The specific processes and methods for use cannot easily be summarized, but are described in the literature review under the headings of Focusing, and The Use of Focusing in the treatment of Posttraumatic Stress, as well as throughout the presentation of the study results.

What are the purposes for which Focusing is being used in the treatment of trauma survivors?

The purposes for which Focusing is used seems to fall under four core categories.

1. Creating safety:

This includes establishing a therapeutic relationship, assessment of readiness, containing, development of an adult Observer, and getting distance from trauma.

2. Encouraging client empowerment:

Sub categories in this area include connecting clients to their own inner strength, development of self-awareness on the part of the client, development of tools that clients can use on their own for guiding direction, problem solving and managing triggers. In addition, focusing is used to help clients in regaining dignity and trust in themselves, both of which would increase a person's sense of empowerment.

3. Moving toward resolution of traumatic experiences:

This includes helping clients connect to their own body wisdom, cutting through defenses, getting unstuck, and tracing triggers to their source.

4. Personal use:

Therapists in this study use Focusing both as a tool for teaching and training and for self-care and the maintenance of good boundaries. This latter purpose includes using the step of Clearing Space for themselves prior to sessions so that they can remain present with the client and have their own issues out of the way, using Focusing to assist in the debriefing process after sessions, and using Focusing as a means of attending to their own personal issues.

How do these 14 Focusing practitioners perceive the benefits of Focusing in the treatment of posttraumatic stress?

The benefits cited by the therapists in this study are numerous and sometimes striking. They can best be conceptualized by identifying the core categories under which they seem to fall.

1. Benefits related to the approach inherent in this method:

Focusing is seen by these therapists as a safe and gentle approach, even when dealing with traumatic experiences. It is client-centered with the client in control of the pace and direction of the therapy, which is important both to the safety of the process and to client empowerment. The Focusing approach is also seen as a good "fit" with aboriginal values and traditional ways of healing because it is holistic, involving mind, body and spirit in the healing process. It is also seen as a respectful and normalizing approach, and one in which the client feels heard and attended to. Benefits inherent in the Focusing approach were mentioned a total of 36 times, and every therapist in this study recognized at least one benefit in this category.

2. The potency of Focusing as a tool for achieving resolution of trauma:

One of the benefits noted in this category is the view that Focusing is efficient and precise as a tool for identifying and accessing the specific aspect of the trauma experience that most needs attention. This is seen in connection to, and as a result of, another benefit raised: the fact that a defining characteristic of Focusing is its ability to connect a person to "what the body knows". Through this process, most of these therapists find that major breakthroughs are possible and over 35% expressed that clients gain a change in perspective. A final benefit mentioned in this category is that clients

can achieve closure even after deep work, so they leave the session feeling present, centered and in control, rather than upset or emotionally charged as a result of spending time dealing with upsetting and emotionally charged memories. These are all especially useful benefits in work with trauma survivors. These benefits are also quite well supported in this study, as this category received the greatest number of responses, at 39. In this category as well, every therapist in the study noticed at least one benefit.

3. Client empowerment:

Two major benefits noticed in this category involve clients learning tools for their own use. The first benefit identifies tools that can be utilized for a variety of purposes throughout the client's life. Additionally, clients learn to attend to themselves when symptoms arise, making them less dependant on the therapist for assistance in times of crisis. Two additional benefits that emerge directly from these, are that clients find their lives more manageable, and that clients experience reduced reactivity to triggers. A number of participants noted client empowerment itself as an advantage of Focusing. Also noticed were benefits that enhance feelings of empowerment, such as heightened self-awareness and increased trust in self. Benefits in this category were raised by 10 of the 14 therapists interviewed, and an additional two therapists mentioned purposes for using Focusing that fall in the empowerment core category. Benefits in this category included a total of 29 responses.

4. Benefits to the therapist:

While benefits in this core category were raised by fewer study participants, the benefits mentioned are of interest. These include: helping the therapist remain present, enhancing therapeutic skills, and reducing the effects on the therapist which are common

in the treatment of posttraumatic stress, vicarious traumatization and counter-transference. All of these, while benefiting the therapist in a direct way, would benefit the client as well.

Further support for the benefits of using Focusing in the treatment of posttraumatic effects can be found in the responses given by those participants who were asked how they could tell that this approach was working (Table 6). These therapists found evidence that the therapy was working through client feedback, positive changes in their clients' behavior patterns, freedom from constraints which had been imposed by their symptoms, continued forward movement in therapy, and observations of improved client functioning in the community. Some indicated that they could see evidence of therapeutic change in their clients' eyes, face, and body. A few highlighted that they noticed the "shifts" (a Focusing term for the visible sign of internal change), noticed the client leave a session "that much lighter", or noticed when the client had an "Ah-hah moment", signifying a new understanding or change in perspective. Three mentioned clients' ability to tend to themselves using the tools they had learned, and one indicated that more than one of her clients have gone on the refer other family members to her for therapy.

What, if any, special considerations are there for the use of Focusing in the treatment of people with posttraumatic stress?

There is ample evidence in this study that there are a number of special considerations that must be addressed when using Focusing in the treatment of posttraumatic stress.

Two of the limitations raised by participants speak to the difference between trauma survivors and other client populations: with trauma survivors Focusing can be very intense/scary, and symptoms may worsen at first for some clients. Eight more of the limitations address the special measures that should be taken when using Focusing with this population: it is important not to push too fast; trust and safety are needed before beginning; Focusing with trauma survivors can be unsafe if it is therapist controlled rather than patient led, or if the process is not adapted for trauma work; the therapist must remain fully present during the session; it is crucial to close the session properly; the process must be individualized to adapt to the needs of each client; and some people need preparation before beginning to use Focusing in treatment. Another three limitations identify considerations for the context of therapy with this population: experience is required for optimal effectiveness; therapists must deal with their own baggage; and supervision is essential.

In addition, four of the purposes identified for using Focusing in the treatment of a client's posttraumatic stress: assessment of readiness, getting distance from the trauma, development of an adult Observer, and development of tools that clients can use on their own, can assist them in the fifth purpose, managing triggers. Special considerations in using Focusing with trauma survivors are also addressed under the topic of barriers: some clients may not be ready for Focusing, defenses and coping mechanisms may become activated when doing this work, the effects of "programming" can get in the way of Focusing and/or initially intensify defenses, and, with trauma survivors, body memory may get mixed up with the Felt Sense.

All but one of the participants affirmed at least two of the above considerations. The one exception is different from the other participants in two other ways that may explain this. This therapist uded Focusing only with a small number of clients outside of her full time job, so perhaps inexperience was a factor. More significantly, this was the one interview that was not taped, so there is a greater likelihood that some points were missed by the researcher.

The need for special considerations in the use of Focusing with trauma survivors was emphasized as much by the three participants who were non-graduates of the Focusing and PTSD program as by the graduates. Of the three who learned Focusing separately from their training in trauma work, one (interview 5) ran into some problems before undertaking to learn more about how to build safety into the process when dealing with trauma. Two of the three non-graduates of Focusing and PTSD refer clients with a history of serious or complicated trauma such as child sexual abuse to Anne Poonwassie, who has coordinated the Focusing and PTSD program and is now the principal instructor for the program in Manitoba (interviews 5 & 6). The one non-graduate who did not identify a need to refer some cases out, and who works primarily with trauma such as child sexual abuse, did attend three days of training in Focusing and PTSD instructed by Shirley Turcotte after having already learned and gained some experience in Focusing, as well as considerable training in the treatment of child sexual abuse.

What drawbacks, limitations and barriers are therapists encountering in using Focusing in the treatment of posttraumatic stress, and how are these being addressed?

Four of the participants in this study assert that there are no limitations or drawbacks to using Focusing in the treatment of posttraumatic stress, *provided it is done properly.* Even though not stated by the other participants directly, this view is supported by the overall results of this study. For each drawback or limitation identified there is a solution and/or a mitigating factor identified elsewhere in the data.

1. It can be very intense/scary:

This must be understood as inevitable given that a purpose and benefit of using Focusing in the treatment of trauma is to connect triggers to their source (Tables 3 & 5). This is also true of any treatment approach that is aimed at resolution rather than merely symptom management of posttraumatic stress (Foa et al., 2000; Herman, 1992; Matsakis, 1996; Rothbaum et al., 2000; van der Kolk et al., 2002). With Focusing there are ways of mitigating this effect, such as helping the client to get the right distance from the trauma, and the development of a strong adult Observer (the ability to observe the memory from the perspective of their present adult self) that can keep the person from being re-traumatized in the process (Table 3). Indeed, a benefit cited by twelve of the fourteen participants is that Focusing is an exceptionally safe and gentle process for doing trauma work (Table 5).

2. It is important not to push too fast, and may be unsafe if therapist led:

These ideas are connected and share the same solution, ensuring that the process is client centered and client led (Table 5).

3. The therapist needs to establish trust and safety first:

This can be addressed by taking the time to first establish a therapeutic relationship and by assessing client readiness (which includes some stability in the client's current life, motivation to deal with the trauma, the ability to connect with the "felt sense", and ability to manage intense emotions) before proceeding (Table 3).

4. The therapist must be fully present:

This limitation is counterbalanced by the use of Clearing Space by the therapist prior to sessions (Table 2), which can help the therapist to remain present in the session (Table 5).

5. It is crucial to provide proper closure after a session:

The solution to this limitation is to ensure that closure does take place at the end of each session. "Closure even after deep work" is one of the cited benefits of Focusing in the treatment of posttraumatic stress (Table 5).

6. The therapist must be able to individualize the approach:

One of the most frequently mentioned benefits of using Focusing in the treatment of trauma survivors is that it can be individualized, adapted to each client's needs (Table 5).

7. Three of the limitations raised are related to the therapist's experience in using Focusing in their own healing or internal processing, as well as with others:

These three limitations are categorized as: "experience required", "must deal with own baggage", and "must have experienced Focusing yourself". All three of these are addressed directly by the Focusing and PTSD certification program, as experiencing 40 Focusing sessions as a client and facilitating 80 Focusing sessions as a therapist are

requirements of the program (interview 1). Another benefit relevant to this area, is that learning, experiencing and using Focusing expands therapeutic skills (Table 5).

8. Supervision is essential:

This is true for all forms of trauma therapy. The obvious solution is to only do this work when supervision is available. The 120 Focusing sessions, which are required of every student in the Focusing and PTSD program, are all supervised (interview 1).

9. Some people need preparation:

This can be resolved by careful assessment of client readiness (see #3 above) and by attending to the special considerations for use of Focusing in the treatment of posttraumatic stress as described in the literature review under that heading, and as discussed above under the question "What, if any, special considerations are there for the use of Focusing in the treatment of people with posttraumatic stress?"

10. Focusing is not a "stand alone" model:

This is supported by the fact that Focusing can be combined with other approaches (Table 2). It is also addressed in the Focusing and PTSD program both by the requirement that applicants have some other training and experience before entering the program, and by the fact that, within the program, other tools and approaches are taught in addition to Focusing.

11. Some may fake it through:

The ability to tell when a client is really making progress or is just "faking", may come with experience. This limitation was mentioned by only one participant, and a number of others indicated that they can see when a person is really making meaningful change

by observing changes in the person's eyes, face, body, behavior, and general functioning (Table 6).

12. It can be difficult to stay connected if the client is new.

This may well also be a function of experience, as the therapist who identified this as a limitation did not have the benefit of the 120 supervised Focusing sessions which were experienced by graduates of the Focusing and PTSD program (Table 1). This limitation can also be addressed by the therapist through using Focusing to deal with their own baggage, and clearing space before sessions (Table 3).

13. Symptoms may worsen at first:

This limitation is also true of other approaches to the treatment of posttraumatic stress (Foa et al., 2000; Matsakis, 1996; Rothbaum et al., 2000; van der Kolk et al., 2002). When a Focusing approach is used, the client has the advantage of tools that they can use to manage triggers and attend to themselves (Tables 3 & 5).

What do these therapists see as indications and contraindications for using Focusing in the treatment of posttraumatic stress?"

Indications for the use of Focusing in the treatment of posttraumatic stress are addressed in Table 9. Focusing is indicated once a person is able to connect into their body, and where a client is motivated to resolve past trauma, according to the therapists interviewed, as it is an approach that is seen as highly efficient and effective in addition to being safe and gentle. Other indications for the use of this approach include: those times when a person is "stuck", unable to move forward with the use of other

approaches; when a person has a particular issue to work on; and when a person is in crisis due to posttraumatic stress rather than to current life circumstances.

Contraindications for the use of Focusing in the treatment of posttraumatic stress are addressed primarily in Table 8. However, the first and most crucial contraindication is the preparedness of the therapist to use this approach in the treatment of trauma survivors (see question above relating to special considerations in the use of Focusing in the treatment of posttraumatic stress). Other contraindications relate to the full use of Focusing sessions and do not preclude a Focusing *approach*. These contraindications would include: those times when the client is not ready, or when the client is reluctant to use Focusing, when a client is too activated (triggered or emotionally charged), or where the client's current life is unsafe or unstable. The use of full Focusing sessions is also contraindicated if requirements such as a setting that is private and undisturbed by distractions, and the availability of the therapist for regular scheduled sessions cannot be met.

How does Focusing, as implemented by these therapists, compare *in practice* to guidelines for the treatment of posttraumatic stress set out in the literature?"

A number of sources can be drawn upon from the literature regarding guidelines for treatment of posttraumatic stress. Foa, Keane and Friedman (2000), present treatment guidelines developed by a task force established by the board of the International Society for Traumatic Stress Studies (ISTSS). "First, the clinician must form and maintain a therapeutic alliance. Special attention should be given to trust and safety

issues" (p.15). There is some support in the data for adherence to the first part of this guideline , as one of the purposes identified for the use of Focusing was "establishing a therapeutic relationship". However, only three participants cited this item (Table 3). There is greater support for the second half of this guideline, as four of the purposes identified for using Focusing relate to the establishment of safety (Table 3). Also, twelve participants consider that a benefit of using Focusing in the treatment of trauma is that it is a safe and gentle approach (Table 5), seven of the limitations raised address precautions that must be taken to increase safety in the treatment process (Table 7), and the majority of participants indicated that therapy should not proceed if the client is reluctant or not ready for this type of treatment (Table 8). Every participant identified at least one of these safety related issues.

The second guideline for treatment proposes that "the therapist should demonstrate concern with the patient's physical safety when planning the treatment" (Foa et al. 2000, p.15). This issue was largely unaddressed in this study, although one participant indicated that basic needs such as safety, housing, etc. may need to be addressed before treatment starts (Table 8).

The third guideline suggests that "the clinician should provide education and reassurance with regard to PTSD symptoms and related problems" (Foa et al. 2000, p.15). This area was not addressed directly through the structured interview questions in this study, although three participants indicated that they use a psycho-educational approach in conjunction with Focusing (Table 4). In addition, three of the identified benefits of

using Focusing in the treatment of trauma were it's normalizing effect (Table 5), heightened self-awareness, and increased trust in self, and two of the purposes mentioned for using Focusing were: to assist the client in regaining trust in self, and increasing self-acceptance (Table 3). Eight of the participants cited at least one of these categories of response.

A fourth guideline states that "the patient's PTSD symptoms and general functioning should be monitored over time (Foa et al. 2000, p.15). There is some support in the data for adherence to this guideline in the responses to the question: "How can you tell that the treatment is working?"(Table 6) However, this question was not asked of every participant, and no one was asked if they monitored symptoms in any systematic way. The fifth guideline, "co-morbid conditions should be identified and addressed" (Foa et al. p.15) was not dealt with in this study.

The final guideline involves addressing crises that may arise during the course of treatment (Foa et al. 2000). While this issue was not addressed in the way suggested by the authors, it did receive considerable attention by most of the therapists in this study. Eight participants identified one or more items related to teaching clients tools which they could use to attend to themselves (Tables 3 & 5).

More than one source refers to the importance of the therapist being able to stay present with the client during therapy sessions (Steele, van der Hart & Nijenhuis, 2001; Williams & Sommer, 2002). There is considerable support in the data for adherence to

this guideline. Twelve participants indicate that they "clear space" (set aside their own issues and concerns) prior to sessions (Table 2), the main purpose of which is to help the therapist remain grounded and present. In addition, four mention that a benefit of Focusing is that it helps the therapist to remain present (Table 5). In all, thirteen of the fourteen participants cited at least one of these categories.

Two sources (Levine, 2003, Ogden & Minton, 2000) emphasize the need to avoid manipulating or rushing the healing process. The data suggest that there is good adherence to this guideline as well. 12 of the 14 therapists interviewed indicated clearly that they follow rather than lead in the therapy process (Table 2). Eight cite as a benefit the fact that Focusing is client-centered and client-led (Table 5). Five indicated that it is important not to push to hard (Table 7). All but one participant cited at least one of the above categories. (Foa et al. 2000, p.15).

McFarlane (1994) lists a number of ingredients that are generally considered to be therapeutic in the treatment of PTSD: "dealing with the meaning of traumatic events, exposure to the traumatic memories and their reworking, the provision of and assistance in the utilization of social support, and the development of coping skills." (p.405) While the issue of social support was not addressed in this study, the data indicate that *all* of the therapists in this study use Focusing to assist in the reworking of traumatic memories. In Focusing, this includes dealing with the meaning of traumatic events. Benefits which relate to this area include: the possibility of major breakthroughs in therapy, the fact that Focusing is efficient and precise in accessing the particular

memory or aspect of the trauma that needs attention, and that Focusing can connect triggers to their source (Table 5).

The development of coping skills was also mentioned in a number of ways: the client learns useful tools, the client learns to tend to self, and enhanced client empowerment, are all seen as benefits of the Focusing method (Table 5). In addition, a number of participants noted the development of tools that the client can use, and assisting the client in learning to use Focusing to assist in problem solving, as two of the purposes for using Focusing (Table 3). Ten out of fourteen participants mentioned at least one of the above.

Another source asserts that: "Psychotherapy must address two fundamental aspects of PTSD: the de-conditioning of anxiety, and the pervasive effects that trauma has on the way victims view themselves and the world." (van der Kolk, van der Hart & Burbridge, 2002, p.35) The data suggest that the de-conditioning of anxiety is also a major feature of Focusing for many of these therapists. Indicators include benefits such as: the client's life becoming more manageable, the ability to obtain closure even after deep work (therapeutic work involving the deeper layers of the trauma), and a reduction in reactivity to triggers (Table 5). Managing triggers was also mentioned as a purpose for using Focusing (Table 3). Eight of the participants identified at least one of these features.

While only half of the participants identified factors that are clearly related to a change in view of themselves and the world, many such factors were identified, both under the topic of Benefits: change in perspective, normalizing, heightened self-awareness, and increased trust in self (Table 5); and under Purposes for using Focusing: connecting to inner strength, increasing self-acceptance, regaining dignity, and regaining trust in self.

Although compliance with recognized treatment guidelines was not a topic considered during the proposal or the data gathering stage, the available data seem to suggest that Focusing, as practiced by these therapists, meets the criteria identified in the literature as essential to good practice in the treatment of trauma survivors.

How does Focusing, as implemented by these therapists, compare *in practice* to <u>The Standards of Practice in Social Work</u> developed by the Canadian Association of Social Workers (1995)?

While this study was not designed to examine adherence to standards of practice, there is considerable evidence in the data to suggest that the 14 therapists who participated in this study meet the standards of practice expected of social workers.

Standard I involves responsibilities that are involved in all social work practice (CASW, 1995). Section 1 of this standard holds that a social worker shall "be respectful to clients in all circumstances" (CASW). Respect for clients, and indeed for all human beings is inherent in the Focusing approach. All of the therapists who participated in this study mentioned using a Focusing attitude of curiosity (friendly interest), openness and

acceptance (Gendlin, 1981), not only in their use of Focusing, but also in any therapeutic approach they use with clients.

Section 2 relates to collaboration with others to meet the needs of clients (CASW, 1995). The issue of collaboration and teamwork was covered in a variety of ways in the Focusing and PTSD program, but was not addressed in this study.

Section 3 deals with accountability and responsiveness to complaints or challenges (CASW, 1995). While this area was not addressed directly in this study, there are some indications for adherence to this section of Standard I. Openness to client feedback is demonstrated by the fact that 8 of the 10 study participants who were asked how they could tell whether the therapy was working noted client feedback as a response (Table 6). In addition, client motivation and readiness for Focusing were identified as prerequisites to using Focusing in therapy (Table 8), and all but one participant indicated that they adapt their use of Focusing to fit with individual client needs (Table 2).

Section 4 of this standard relates to organization of workload (CASW, 1995). Section 5 deals with legislation (CASW). Neither of these issues was addressed in this study.

Section 6 involves working towards change in legislation and social policy as well as promoting social justice (CASW, 1995). While this standard was not addressed directly in this study, if tending to the suffering of people who have been traumatized, often as a result of injustices in our society, can be viewed as promoting social justice, then the fact

that all of these therapists are involved in the treatment of trauma survivors can be seen as evidence of adherence to at least one aspect of this section of the standard.

Standard II requires that social workers "demonstrate knowledge and abilities essential to the social work profession" (CASW, 1995). Sections 1-8 in this standard all relate to areas of knowledge that were covered in the Focusing and PTSD program (Turcotte & Poonwassie, 2002). This suggests that at least the 11 study participants who graduated from that program have reasonable knowledge in the areas outlined in those sections of this standard. Additionally, there is evidence in the data that all of the study participants exceed the standard set in section 6, which states that social workers should have knowledge of "at least one method of practice. As indicated in Table 4, the therapists in this study confirmed that they have knowledge of several therapeutic approaches and techniques in addition to Focusing.

Standard III states "The social worker shall demonstrate skill in all aspects of the intervention process with clients" (CASW, 1995). The level of skill utilized by the study participants in the treatment of trauma survivors is most clearly demonstrated in the text of their responses which are presented under the heading of Results above.

Section 1a of this standard relates to the need for social workers to "determine the authority to intervene" as part of preparation for any intervention (CASW, 1995). There is some evidence in the data to suggest that informed consent was a prerequisite to the use of Focusing sessions in therapy. "Client reluctance" and/or "client not ready" were

seen as barriers to providing this service by 12 of the 14 participants in this study (Table 8).

Section 1b of Standard III requires that social workers assess whether they have the necessary skills to assist the client, before intervening in the client's life (CASW, 1995). Self-assessment was emphasized in the Focusing and PTSD course. In addition, the two therapists in this study who did not receive any training specific to the application of Focusing to the treatment of trauma survivors, both indicated that they refer clients suffering from complex forms of posttraumatic stress to The Prairie Region Centre for Focusing, which delivers the Focusing and PTSD training program in Manitoba.

Section 1c, related to physical setting and section 1d, regarding previous documentation or experience with the client (CASW, 1995), were not addressed in this study.

Section 2 of Standard III demands that social workers "establish egalitarian relationships with clients" (CASW, 1995). Focusing is, by nature, an egalitarian approach, where the client is in control of the therapy and the therapist follows the client's process closely as a companion and witness (Gendlin, 1981, 1996; Turcotte & Poonwassie, 2000).

Section 2a states the need to provide for "the physical and psychological comfort of clients in all contacts" (CASW, 1995). The issue of physical comfort was not addressed in this study. However, there is evidence of concern for the psychological comfort of clients in the fact that 12 of the 14 study participants indicated that a major benefit of

using Focusing in the treatment of trauma survivors is that it is "safe and gentle" (Table 5).

Section 2b relates to "accepting the client as they present themselves" (CASW, 1995). "Acceptance" is one aspect of the "Focusing attitude", which all of the participants confirmed that they use (Table 2).

Section 2c involves "listening to clients and clarifying what the social worker has understood from clients' verbal and nonverbal communications" (CASW, 1995). The process of "following" the client during Focusing sessions involves listening and observing closely, and reflecting back what is heard from the client or observed in the clients' body language (class notes, Module 7). Here again, 12 of the 14 study participants highlighted "following" as an essential part of the use of Focusing in therapy (Table 2). Of the 2 participants who did not raise this technique directly, one indicated that a benefit of Focusing is that it is client centered and client led; the other noted that "being heard and attended to" was a benefit for clients when Focusing is used in therapy (Table 5).

Empathy for clients is the subject of Section 2d of Standard III. Empathy for the suffering of their clients is evident throughout the text of the interviews excerpted for presentation under the heading "Results", as well as in their selection of a mode of therapy that they believe to be safe and gentle, even when dealing with traumatic material (Table 5).

Section 2e emphasizes the use of a nonjudgemental approach with clients (CASW, 1995). The openness and acceptance aspects of the Focusing attitude (Gendlin, 1981, 1996), again, cited by all of the study participants, confirm that a nonjudgemental attitude is maintained by these therapists.

Section 2f of Standard III relates to "giving clients the time they need" prior to the start of any intervention (CASW, 1995). As exhibited in Table 8, client willingness and readiness are closely considered in deciding when and if to use Focusing. Table 7 also contains some evidence of compliance to this standard. Three of the categories cited here, that it is important not to push too fast, that trust and safety are needed before beginning to use Focusing sessions in therapy, and that some people need preparation prior to the use of Focusing, all suggest that clients are given whatever time they need to feel ready before Focusing sessions are used.

Section 2g demands that social workers demonstrate an awareness of the implications of the power inherent in their position. Two of the therapists in this study showed a keen awareness of the implications of power in the therapist-client relationship, emphasizing that Focusing is unsafe if the therapist, rather than the client, is in control (Table 7). There is evidence for adherence to this standard by other study participants as well, in the benefits noted for the use of Focusing. Relevant categories include: that the approach is client centered and client led, that the clients are empowered by this approach, that clients learn tools they can use on their own, that clients learn to attend to

their own needs (Table 5). In addition, 12 of the therapists indicated that they "follow" the client's lead during Focusing sessions (Table 2). Every participant in this study raised at least one of these factors during the interview process.

Section 2h of Standard III involves providing to the client an explanation of services that can be provided as well as of "the limitations of the contractual relationship" (CASW, 1995). The fact that 4 of the study participants found the difficulty in explaining Focusing to be a potential barrier to its use implies that they do see a need to explain the process before using it with clients. In addition, many participants indicated that they will not use Focusing if the client is reluctant, not ready, or has different expectations. All but one participant mentioned at least one of these factors (Table 8).

Section 3 of Standard III stresses open communication with clients (CASW, 1995). "Openness" is an integral part of the Focusing attitude, espoused by all of the study participants (Table 2).

Section 3a highlights the need for social workers to use understandable language (CASW, 1995). The text of the participants' responses (above, under "Results") shows that the language used by them is clear and understandable.

Section 3b relates to the need to clarify roles (CASW, 1995). Participants of this study were not asked if roles were clarified with their clients. However, in Focusing, the role of the client is clear. The client is in control of the therapy (Gendlin, 1996; Turcotte &

Poonwassie, 2000). This principle is confirmed by the fact that 12 of the participants spoke of "following" the client throughout the process of Focusing (Table 2).

Section 3c of Standdard III demands that social workers clarify goals with their clients (CASW, 1995). There is some evidence that these therapists clarify goals with their clients in that all but one indicated that they adapted Focusing to meet the individual needs of clients (Table 2).

Section 3d states that social workers should "empathize with and respond constructively to the range of clients' emotions and concerns and facilitate their expression" (CASW, 1995). The use of empathy in Focusing is described above, under Standard III 2d. The Focusing process itself promotes self-expression. "Following" the client's process involves active listening as well as reflection of the client's body language. Both of these activities on the part of the therapist facilitate the client's ability to delve more deeply into their issues and to express both thoughts and emotions (Gendlin, 1996). A Focusing attitude of interest, openness and acceptance, was declared by every therapist in this study to be the main factor guiding their responses to clients' expression of thoughts and feelings (Table 2).

Section 3e instructs social workers to "invite, accept and offer feedback" (CASW, 1995). There is evidence for these therapists' receptivity and responsiveness to clients' feedback both in the fact that client motivation and client readiness are considered

before using Focusing (Table 8), and in the willingness and ability of 13 of the therapists studied, to adapt Focusing to meet the individual needs of clients (Table 2).

Section 3f of Standard III, relating to the need to meet commitments made to clients, was not addressed in this study.

Section 3g refers to social workers' obligation to "respect and promote clients' right to self-determination" (CASW, 1995). Respect for clients' right to self-determination is supported by the fact that these therapists have chosen to learn and utilize a client centered approach, where the client is in control of the pace and direction of therapy. Additional evidence of adherence to this standard can be found in the study participants' affirmation of the following benefits of Focusing for clients: empowerment, the development of tools that can be used in day to day life, the ability to attend to their own needs, increased self awareness and increased self-trust (Table 5)

Section 3h calls for social workers to "be aware of personal feelings and values regarding the client's situation and deal with such feelings appropriately (CASW, 1995). There is considerable evidence to support adherence to this standard, as 13 of the 14 therapists interviewed indicated that they use Clearing Space prior to sessions as a way to set aside their own issues, feelings and biases so they will not interfere with the client's process (Table 2).

Section 4 of this standard relates to the need for client participation in the assessment process, and sections 4a and 4b deal with "determining the client's needs and priorities" and "identifying the client's strengths and limitations" (CASW, 1995). The assessment process was not addressed specifically in this study, but there is evidence, as described above, under Standard III, sections 2 and 3, that the participants in this study worked in a collaborative way with their clients, and that clients' needs and goals, as well as their readiness and willingness to engage in Focusing sessions were assessed.

Section 5 of Standard III outlines information that should be shared with clients, including information about any problems of concern to the client (CASW, 1995). This study did not address this issue directly, although a number of participants mentioned educating clients regarding PTSD, and 3 of the participants indicated using a psycho-educational approach (Table 4).

Section 6 requires that social workers develop agreements with clients which, among other things, "a) help clients to define the problem", and "b) involve clients in resolving the problem" (CASW, 1995). The nature of agreements between therapist and client was not addressed in this study. However, there is considerable evidence that these therapists involved their clients in resolving the problems they are facing. Focusing is, by nature, a collaborative approach, and many of the benefits cited by participants confirm that clients not only were involved, but took on a primary role in resolving their own problems (Table 5).

Section 7 outlines expectations of social workers regarding referrals to other professionals or agencies (CASW, 1995). This issue was not dealt with directly in this study. However, the 2 participants who mentioned referring clients to other professionals, did indicate that they involved the client in the decision, and assisted the client in obtaining required services.

Section 8a of Standard III urges that, in any service plan the social worker should "use the theories and methods which fall within the relevant field of practice (CASW, 1995). A comparison between the description of how Focusing *should* be applied in the treatment of trauma survivors, and the descriptions by the participants of their use of Focusing with trauma survivors, reveals considerable evidence that these therapists use the theory and methods appropriate to their work in treating trauma survivors. The relevance of Focusing to their work is underlined by the purposes and benefits raised regarding the use of Focusing in the treatment of trauma survivors (Tables 3 and 5).

Section 8b calls on social workers to "utilize clients' personal strengths and resources to promote their sense of power and competence" (CASW, 1995). Evidence for adherence to this standard can be found in how the therapists in this study use Focusing (Table 2), as well as in the purposes for which they use Focusing (Table 3) and in the benefits that they see for clients (Table 5). The technique of "following" the client, enabling the client to be in control of the pace and direction of the therapy, utilizes clients' personal strengths and inner resources in a way that actively promotes their sense of power and competence.

Purposes for using Focusing that are consistent with section 8b include: connecting the client to their own body knowledge, assisting clients to connect with their own inner strength, developing clients' self-awareness, developing clients' ability to "observe" their traumatic memories from the perspective of an adult grounded in present reality, the development of tools that clients can use on their own, empowering clients, increasing the clients' level of self-acceptance, assisting clients in managing triggers, assisting clients in the development of problem solving skills, and helping clients to regain dignity and trust in themselves (Table 3).

Benefits seen by these therapists that are relevant to section 8b of Standard III include: the fact that Focusing is client centered and client led, the connection that clients develop to their own body knowledge, the learning of useful tools by the client, client empowerment, the development of skills in the client that enable the client to attend to and soothe their own pain, and client gains in self awareness and increased trust in themselves (Table 5). Every therapist in this study raised at least one of the factors relevant to this section of the standard.

The final section in this standard relates to the termination process (CASW, 1995). The termination process was not an area covered in this study.

Standard IV discusses factors related to documentation and the maintenance of files. This area is not in the scope of this study.

Standard V requires that social workers "maintain knowledge and skills that are current and directly related to the services to be rendered (CASW, 1995). While the specifics of what the study participants do on a yearly basis to further their skills was not addressed specifically in this study, there is evidence that these therapists do have a commitment to upgrading knowledge and skills related to the treatment of trauma survivors. The Focusing and PTSD program requires considerable time and expense, and yet 8 of the 11 graduates in this study were already working in the field of trauma therapy before they entered the program (Table 1). This commitment was, in itself a sizeable investment in furthering their knowledge and skills.

In addition, one of the therapists who did not take the full Focusing and PTSD program, did attend a three day workshop on Focusing and PTSD after having learned Focusing, and having gained training in the treatment of child sexual abuse. Another indicated upgrading skills in the use of Focusing with trauma survivors through self directed learning methods. The fact that all the study participants had knowledge of a range of other therapeutic approaches in addition to Focusing (Table 4) also implies some ongoing skill development on their part.

Finally, the willingness of these therapists to participate in this study, and their interest in the study results provides further evidence of a commitment to continued development of knowledge and skills in this area.

Standard VI addresses the need for social workers to "assist and support clients in communicating their needs to the appropriate community or government resource" (CASW, 1995). This area is outside of the scope of this study.

In summary, while many of the therapists in this study received their initial training in disciplines other than social work, the results of this study provide ample evidence that, at least in the areas within the scope of this study, social work standards for practice are met, and in some areas, exceeded.

Is Focusing worth further exploration as a treatment approach for posttraumatic stress?"

This study, limited as it is, does provide support for the idea that Focusing is worth further exploration as a treatment approach for posttraumatic stress. There are a number of points within this study that are relevant to this question.

1. The benefits cited by the participants of this study are considerable.
2. The limitations of using Focusing in the treatment of posttraumatic stress, as identified by the participants of this study can all be mitigated or overcome by precautionary measures as described above. Indeed, some of the identified limitations, when properly addressed, can be transformed into benefits.
3. A review of the literature on Focusing and on PTSD suggests strong theoretical support for this approach in the treatment of posttraumatic stress.
4. Focusing, when practiced as taught in the Focusing and PTSD certification program, adheres well to guidelines for treatment of posttraumatic stress.

5. While there are some gaps in the data from this study regarding how well the use of Focusing by these fourteen therapists fits with the standards and guidelines and standards for PTSD treatment, the data available show a reasonable fit with these guidelines for practice, and none of the data suggest that any of the guidelines are not being met.
6. There is also evidence that, in the areas addressed by the data in this study, the practice of these therapists meets, and in some areas, exceeds the standards of practice developed by the Canadian Association of Social Workers (1995).
7. Given the relatively high rate of trauma experienced by Canada's aboriginal population due to the legacy of abuse in residential schools and the political, economic and cultural oppression related to colonialism, Focusing's fit with aboriginal values and traditional healing methods should also stimulate interest in further study of this topic.
8. Clearly, more research is needed. In this writer's search of the literature, no published research on this topic was found. This study, with it's limitations, is a beginning.

Strengths and Limitations of This Study

One strength of this study is that the questions asked were open-ended and carefully phrased in order to avoid imposing any assumptions or researcher bias upon the responses. Also, interviews were taped (with one exception), and transcribed word for word where possible, in order to ensure accuracy in reporting of responses. Categories into which the data were organized were developed directly from the data, rather than

being imposed on the data. Finally, procedural steps in extracting and organizing the data have been set out in some detail, and followed recommended procedures for qualitative analysis (Glaser, 1978, Marlow, 1993, Strauss & Corbin, 1990).

There are a number of limitations to this study. First, sampling procedures combined the methods of purposive sampling (only therapists who use Focusing in the treatment of posttraumatic stress were interviewed), availability sampling (only those therapists who could be contacted within a narrow period of time and who lived within 200 kilometers of Winnipeg were interviewed), and snowball sampling (some of the contacts were made as a result of recommendations by other participants). In addition, this study involved only a small number of participants. These factors limit the generalizability of these findings (Marlow, 1993). Therefore these findings cannot be seen as pertaining to anyone outside of this group of participants.

Second, there was some inconsistency in data gathering procedures, partly due to researcher error (neglecting to tape one of the interviews), and partly due to technical problems (two of the tapes could not be transcribed completely). In addition, one question, "How can you tell that the therapy is working?" was not asked of four of the participants. While this specific question was not part of the originally developed structured interview questions, the data arising from the responses proved interesting. In retrospect, this question should have been included as one of those asked of all participants.

Third, all of the data gathered in this study, with the exception of the data presented in Table 1, are subjective, resting on the opinions and observations of the participants.

Fourth, there is the limitation of researcher bias. While, attempts were made to minimize the effect of personal bias on the study results, as described above under the strengths of this study, I am a graduate of the Focusing and PTSD program, and am currently a registered Focusing practitioner and trainer.

Finally, those interviewed can all be expected to have a bias towards the use of Focusing as a treatment method, since all are Focusing practitioners. This bias would especially affect the strength of findings regarding the benefits of Focusing in the treatment of posttraumatic stress. While the responses to the question: "How can you tell that the therapy is working?" strengthens those findings to some extent, the most frequently identified response to this question was related to client feedback. A study cited by McFarlane (1994) states, in cautionary terms, the difference between objective and subjective measures of treatment outcome.

> A group of mental health professionals who were international authorities on traumatic stress organized a novel program for the treatment of PTSD based on cognitive, behavioral, and social theories. Both therapists and participants were generally positive about its effectiveness and the outcome. Contrary to these subjective impressions, however, careful psychometric assessment demonstrated both short term and long term negative effects." (p.395)

McFarlane does not identify whether the negative effects were related to the treatment itself, or were due to other factors, and he does not mention if any benefits were noticed as well in the testing.

While these limitations mean that no definite conclusions can be drawn from these data, this is an exploratory study. The purpose was not to test a hypothesis, but rather to stimulate interest in Focusing as a treatment method which, while under-researched as a tool that can be used in PTSD treatment, may hold promise.

Recommendations for Further Research

This study is a beginning step in the exploration of the application of Focusing oriented psychotherapy in the treatment of people suffering from posttraumatic stress. One accomplishment of this study is the development of categories of response regarding how Focusing is used and for what purposes, as well as the perceived benefits, limitations and barriers to this approach when treating survivors of trauma. These categories could be utilized in future research. For example, a questionnaire could now be developed using these categories which would facilitate reaching a larger number of therapists, as location of a therapist need not be a barrier, and completing a survey takes less time than a face to face interview.

A number of the perceived benefits of the Focusing approach could be tested out more objectively through a pre and post test methodology. Given the low response rate in the

earlier aborted attempt to utilize that methodology, it is recommended that some incentive should be offered for participation.

The need for controlled studies of treatment effectiveness was voiced by one of the participants of this study, and could do much to establish the credibility of this approach. Indeed the treatment modality most highly recommended by the PTSD Treatment Guidelines Task Force of the International Society for Traumatic Stress Studies, Exposure Therapy, was chosen primarily because it was the most studied using controlled methods, and therefore had the most compelling evidence of effectiveness (Rothbaum et al., 2000).

A frequently mentioned concern for the participants of this study is that Focusing is difficult to describe, and is difficult to understand without experiencing it first hand. Case studies would be most helpful in getting across *how* Focusing works in the treatment of trauma survivors.

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Appendices

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2) The person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently experienced in one (or more) of the following ways:

1) Recurrent and intrusive distress recollection of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2) Recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative, flashbacks episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur
4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
5) Physiological or reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
2) efforts to avoid activities, places, or people that arouse recollections of the trauma
3) inability to recall an important aspect of the trauma
4) markedly diminished interest or participation in significant activities
5) feeling of detachment or estrangement from others
6) restricted range of affect (e.g., unable to have loving feelings)
7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1) Difficulty falling or staying asleep
2) Irritability or outbursts of anger
3) Difficulty concentrating
4) Hypervigilance
5) Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas in functioning

Specify if:
Acute: if duration of symptoms is less than 3 months
Chronic: id duration of symptoms is 3 months or more

Specify if:
With Delayed Onset: if onset of symptoms is at least 6 months after stressor

American Psychiatric Association, 1994
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
Washington, D.C.: American Psychiatric Association
Excerpt from pp. 427-429.

UNIVERSITY OF MANITOBA | Faculty of Social Work

521 Tier Building
Winnipeg, Manitoba
Canada R3T 2N2
Telephone (204) 474-7050
Fax (204) 474-7594
Social_Work@UManitoba.CA

Important Information for Participants

Research Project Title: The Use of Focusing in the Treatment of Posttraumatic Stress: An Exploratory Study

Researcher: Catherine Hudek

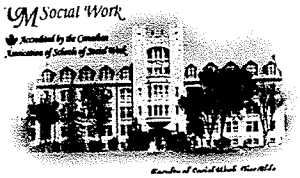
This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The purpose of this study is to explore the use of Focusing in the treatment of PTSD. I am requesting your participation in this study because you are qualified to use Focusing with clients who have PTSD and have had the opportunity to do so. Your participation, should you agree, will involve a semi-structured interview exploring your experience with and impressions of the use of Focusing in the treatment of PTSD, including benefits, timing, drawbacks, limitations and barriers to this approach.

For the purposes of this study, PTSD refers to any configuration of symptoms which in your opinion are related to trauma experienced by your client.

The interview will be taped (audio only) in order to ensure thoroughness and accuracy in my documentation of your responses. Once I have transcribed the information, the tape will be erased.

I can meet with you at a time and place of your convenience. The interview should take approximately one hour.



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I will be interviewing as many qualified practitioners as are available and agreeable to participate in this study. Your responses will be compiled along with those of other participants to address the above questions. The findings will be presented in my MSW Thesis and will also be provided to all participants of this study. The therapists who participate will not be identified by name, demographics, or place of work.

If you are interested, once the study is complete, the findings will be sent to you by mail or email, according to your preference.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

Principal researcher: Catherine Hudek

Supervisor: Dennis Bracken, Faculty of Social Work

This research has been approved by the Joint Faculty Research Ethics Board of the University of Manitoba. If you have any concerns or complaints about this project you may contact either of the above-named persons or the Human Ethics Secretariat

A copy of this consent form has been given to you to keep for your records and reference.

Participant's Signature Date

Researcher's Signature Date

Interview Schedule

How long have you been working with trauma survivors?

What proportion of your work involves the treatment of trauma survivors?

To what extent and in what ways do you use Focusing in your treatment of trauma survivors?

What other tools/approaches do you use in the treatment of these clients?

What (if any) benefits have you noticed in using Focusing with these clients?

What (if any) drawbacks or limitations have you noticed in using Focusing with these clients?

What (if any) barriers have you encountered to using Focusing with these clients?

Do you find that Focusing is more helpful with some clients than with others?

Do you find that Focusing is more helpful in some stages of therapy than in others?

(Further questions may be asked for the purpose of clarification or explication of responses.)

Table 1: Training and Experience of Participants in Focusing and PTSD

Question	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total
How long have you been working with trauma survivors?	12 yrs	12 yrs	8-9 yrs	3 yrs	4 yrs	20+ yrs	14 yrs	4 yrs	18 yrs	5 yrs	6 yrs	7 yrs	3 yrs	9 yrs	125 yrs
How long have you used Focusing in this work?	12 yrs	2 yrs	2 yrs	3 yrs	4 yrs	20+ yrs	7 yrs	2 yrs	5 yrs	5 yrs	3 yrs	3 yrs	3 yrs	3 yrs	74 yrs
What portion of your work involves the treatment of these clients?	33 %	10 %	50 %	OJ	50 %+	100 %	100 %	80 %	70 %	20 %	80 %	75 %	97 %	35 % +	
To what extent do you use Focusing in your treatment of trauma survivors?	80 %	V	50 % + TS	V	TS	TS	TS	80-90 %	TS	TS	TS	TS	TS	40 %+ TS	
Graduate of Focusing and PTSD Program	X	X	X	X			X	X	X		X	X	X	X	11

OJ=Outside of job
V= Various Ways
TS=Thoughout the Session

Table 2: How Focusing is used in the treatment of trauma

HOW USED	1	2	3	4	5	6	7	8	9	10	11	12	13	14	TOTAL
Full Focusing sessions	X	X	X	X		X	X	X	X	X	X	X	X	X	13
Interwoven throughout	X				X	X	X	X	X		X		X		8
Clearing Space - Client	X	X	X			X	X	X	X	X	X	X	X	X	12
Clearing Space - Therapist	X	X	X	X		X	X	X	X		X	X	X	X	13
Noticing in to the Felt Sense	X		X		X	X	X					X	X		7
Getting a handle	X		X												2
Resonating	X		X		X	X									4
Asking	X		X		X	X						X			5
Receiving	X					X						X			3
Focusing Attitude	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14
Following	X	X	X	X			X	X	X	X	X	X	X	X	12
Used with every client	X			X		X		X	X	X	X		X		8
Used with some clients		X	X		X		X					X		X	6
As the core of therapy	X										X				2
Combined with other approaches	X				X	X	X		X		X			X	7
Adapted to client (individualized)	X	X	X		X	X	X	X	X	X	X	X	X	X	13
Used intuitively	X					X									2
Psychotherapy tool	X					X	X								3
Breathing techniques incorporated	X					X							X		3
Used with kids	X								X						2
Used in workshops/training	X	X	X		X						X		X		6

Table 3: Purposes for use of Focusing in the treatment of trauma

Purposes for Use of Focusing	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total
1 Establishing a therapeutic relationship		X			X				X						3
1 Assessment of readiness	X														1
1 Containing		X													1
1 Getting distance from trauma					X										1
1 Development of Observer	X		X							X					3
2 Development of tools that people can use on their own	X	X	X			X									4
2 Connecting to inner strength										X					1
2 Empowering clients									X						1
2 Guiding direction										X					1
2 Regaining dignity		X													1
2 Increasing self-acceptance					X					X					2
2 Problem solving			X	X											2
2 Regaining trust in self						X				X					2
2 Developing self-awareness						X	X		X	X					4
2 Managing triggers	X	X	X	X	X								X		6
3 Cutting through defenses								X							1
3 Getting unstuck				X							X				2
3 Connecting to body knowing	X					X				X					3
3 Tracing triggers to source	X		X	X	X				X			X			6
4 Debriefing											X				1
4 Teaching/training		X	X		X						X		X		5
4 Therapist attending to self	X			X	X				X		X	X	X		7
Totals	7	6	6	4	7	4	1	1	5	7	4	2	3	-	

Table 4: Other approaches used in the treatment of trauma

APPROACHES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	TOTAL
Aboriginal Traditional Healing		1	1	1							1		1		5
Behavioral Therapy		1										1			2
Breathing					1	1					1		1		4
Cognitive Therapy	1						1				1				3
Counseling		1	1					1			1	1	1	1	7
Dream Work						1					1		1		3
Eclectic								1	1			1			2
Psycho-Educational		1					1						1		2
Emotion Focused - couples							1		1						2
Emotion Focused Therapy	1							1							2
Focusing integrated	1					1	1	1		1	1		1	1	8
Gestalt	1					1		1							3
Narrative Therapy	1									1					2
Play Therapy				1				1	1						3
Problem solving			1	1					1	1	1				5
Reality Therapy			1						1						2
Systems Theory			1							1					2
Solution Focused Therapy									1	1					2
Spiritual Healing					1	1				1					3
Transactional analysis		1	1												2
Trauma Recovery							1		1						2
referral to other resources					1	1							1		3
"tool box" approach	1					1								1	2
Writing								1		1					2
Other	2	1	3	1	6	3	1			2	3	2			24
TOTALS	8	6	9	4	9	10	6	7	7	9	10	5	7	3	

Supplement to Table 4: Approaches in "Other" category

Other Approaches: Whole body work, Adlarian, Personality and Human Relationships (PHR), "Returning to the Spirit", Art therapy, Guided imagery, Sentence Completion, Sensory-Motor Psychotherapy, Self Psychology, Rational Emotional Behavioral Therapy, Polarity Therapy, Object Relations, Mapping, Modeling, Life Skills Training, Inner Family systems work, Feeling Meditation, Experiential Therapies, Existentialism, Energy Psychology Tools, Cognitive/behavioral Therapy, Bio-spirituality, Active Imagination

Table 5: The Benefits of Using Focusing in the Treatment of Trauma

BENEFITS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	TOTAL
1 Safe and gentle	X	X			X	X	X	X	X	X	X	X	X	X	12
1 Client centered and client led	X	X	X			X	X	X		X		X			8
1 Fits with aboriginal traditions		X	X	X					X				X		5
1 Holistic: mind/body/spirit	X	X	X						X						4
1 Normalizing		X	X										X		3
1 Client heard and attended to					X			X							2
1 Respectful			X									X			2
2 Connection to body knowledge	X			X	X	X	X		X	X			X		8
2 Efficient / precise	X	X	X					X	X	X		X		X	8
2 Major breakthroughs possible	X	X	X	X	X						X	X	X		8
2 Connects triggers to source	X			X	X				X			X	X		6
2 Change in perspective		X	X		X								X	X	5
2 Closure even after deep work	X	X	X									X			4
3 Client learns useful tools	X		X			X		X		X				X	6
3 Client empowerment		X	X		X				X					X	5
3 Client learns to attend to self	X	X							X	X				X	5
3 Life more manageable	X		X						X	X				X	5
3 Reduce reactivity to triggers	X		X		X					X					4
3 Heightened self-awareness						X				X					2
3 Increased trust in self										X				X	2
4 Helps therapist remain present	X				X				X		X				4
4 Expands therapeutic skills					X		X						X		3
4 Reduced effects on therapist					X						X			X	3
Totals	13	11	13	4	11	5	4	5	10	10	4	7	8	9	

Table 6: Evidence that Focusing works in the treatment of trauma

Evidence That Focusing Works	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total
client feedback	X	X	X					X	X		X	X		X	8
see it in face and body	X							X			X				3
+ changes in behavior													X	X	2
freedom from previous constraints	X													X	2
people are able to do work on their own using the tools	X								X					X	3
see it in their eyes		X													1
clients referring family and friends			X												1
"Ah-hah" moments												X	X		2
Client continues to move forward										X	X	X			3
Can see the shifts								X							1
seeing the client leave "that much lighter"												X			1
seeing the client in the community, happier, doing much better													X	X	2
Totals	4	2	2	-	-	-	-	3	2	1	3	4	3	5	

Table 7: Limitations in using Focusing in the treatment of trauma

Limitations of Focusing	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total
can be very intense/scary		X	X					X		X		X	X		6
important not to push too fast	X							X	X		X		X		5
trust and safety needed first					X			X	X				X		4
unsafe if therapist controlled	X								X						2
therapist must be fully present						X									1
crucial to close properly	X							X							2
unsafe unless adapted for trauma work	X				X		X	X							4
Must be able to individualize					X			X	X	X			X	X	7
none-if done properly						X		X			X	X			4
experience required	X					X			X						3
must deal with own baggage	X					X									2
must have experienced focusing yourself	X								X						2
supervision is essential	X									X					2
hard for some people to get out of their heads		X			X				X	X		X			5
some people need preparation	X		X		X		X						X	X	6
not a "stand alone model"					X										1
some may "fake it through"				X											1
can be difficult to stay connected if client is new										X					1
symptoms may worsen at first	X														1
Totals	10	2	2	1	6	4	2	7	7	5	2	3	5	2	

Table 8: Barriers to using Focusing in the treatment of trauma

Barrier	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total
client reluctance		X		X		X		X		X	X		X	X	8
client not ready	X		X		X				X	X	X		X	X	8
defenses/coping mechanisms								X		X					2
client too activated							X								1
programming	X														1
body memory getting mixed up with Felt Sense	X														1
Focusing not well known			X					X	X					X	4
hard to explain Focusing		X					X		X	X					4
Some people find Focusing strange / weird / "New Age"			X		X				X					X	4
client expectations					X			X		X					3
not enough controlled research									X						1
lacks credibility														X	1
time constraints		X		X									X		3
job parameters				X									X		2
distractions		X				X									2
basic needs may need to be addressed (safety, housing, etc.)												X			1
Totals	3	4	3	3	3	2	2	4	5	5	2	1	4	5	

Table 9: When Focusing is most helpful in the treatment of trauma

When Focusing is Most Helpful	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total
With clients who can connect with their body	X	X	X				X		X			X		X	7
With higher functioning clients							X								1
With clients who are motivated			X	X	X			X			X		X		6
With any client	X					X		X							3
After the first stage			X		X								X	X	4
End of first stage and throughout the middle										X					1
Further on in the process							X								1
When client is "stuck"				X											1
When client is in crisis										X					1
When client has an issue	X														1
When client not in extreme reaction	X														1
In different stages for different people								X							1
In all stages		X				X			X		X			X	5

Date
Dear (name of therapist),

I am conducting research on Focusing and Post Traumatic Stress Disorder (PTSD). I am interested in exploring the effectiveness of Focusing in reducing the symptoms of post traumatic stress. I would require your assistance in distributing copies of the attached participant's package to potential participants for this study. If you are using Focusing in your therapeutic work with trauma survivors, then any new adult clients coming in during the next year who present with PTSD symptoms would qualify as participants.

Two major considerations have guided my design of this study.

1. I want to ensure that participation in this study is safe, easy, and has some potential benefit to participants.
2. I want this research to address questions that are meaningful and of interest to clinicians, particularly those who are already using Focusing in their work with trauma survivors.

In keeping with the first consideration, I have selected the Screen for Posttraumatic Stress Symptoms (SPTSS) by Eve Carlson as the tool for measuring the frequency of symptoms. As the SPTSS is self-administered and contains no identifying information whatsoever, it allows the participants of this study to maintain complete anonymity. The SPTSS takes only about 5 minutes to complete, and is clear and understandable, so it should not be an arduous task. Postage paid addressed envelopes will be provided for ease of return. The provision of a tool for clients to assess their own progress in therapy can be of therapeutic benefit to clients. Shirley Turcotte's presentation of the tool she had developed for that purpose was the spur that inspired the idea for this study. The tool I have selected is similar to Shirley's, but has the advantage of being standardized.

In keeping with the second consideration, this study will look into not only whether or not the overall frequency of symptoms is reduced, but also whether Focusing may be more effective with some symptoms than with others, at least over the short term. The limitations of this study preclude arriving at definitive answers, but data on symptom frequecy, at the onset of therapy and 6 months in, can inform these questions. Because of the anonymity protections inherent in my data gathering, my raw data can be made available to others. I will be providing a copy of the results of my research to each of the therapists who assist me in this study and to any of their clients who request a copy. I will also make the results available through email to anyone else who is interested.

Thank you for considering this request. If you have any questions or would like to know more about this study please feel free to ask. I can be reached by phone , or you can wait to hear from me, as I will be following up with a phone call.

Sincerely,
Catherine Hudek, B.S.W., R.F.P.T.

To the recipient of this package:

I am conducting research on Focusing and Post Traumatic Stress Disorder (PTSD). My goal is to explore the effectiveness of this treatment approach in reducing the painful aftereffects of trauma. I am requesting your help as a participant of this study.

In addition to this letter, your package should include:
- a 3 page document entitled "Important Information for Participants." This document provides details of what is involved in participation and the measures I am taking to ensure your privacy, as well as some additional information about the study and how you can obtain a copy of the results.
- two copies of a checklist entitled SPTSS.
- a postage prepaid, self-addressed envelope.

I have contacted therapists who have certification in Focusing and PTSD, and who are using Focusing in their practice, and have asked them to pass this on to any clients who are experiencing some of the symptoms described in the checklist.

Research is important to the treatment of emotional and psychological problems. We need to know which approaches are most effective for which problems and whether there is the potential for any harmful side effects. We also need to be able to make informed decisions as to where to put our resources in this area.

This study will be of interest to people who suffer from PTSD as well as to therapists and agencies providing service to people with PTSD and to other researchers studying PTSD and its treatment.

Thank you for considering this request. For those who choose to participate, your valuable contribution to this study will help to develop a better understanding of PTSD and its treatment. For this I offer my heartfelt thanks. The more responses I receive, the more can be learned from the results.

Sincerely,

Cathy Hudek, B.S.W., R.F.T.

UNIVERSITY OF MANITOBA | Faculty of Social Work

521 Tier Building
Winnipeg, Manitoba
Canada R3T 2N2
Telephone (204) 474-7050
Fax (204) 474-7594
Social_Work@UManitoba.CA

Important Information for Participants

Research Project Title: Focusing and Post Traumatic Stress Disorder

Researcher: Catherine Hudek

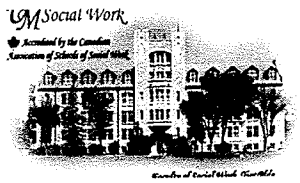
This consent form, which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

What is the purpose of this study?

The purpose of this study is to explore the effectiveness of Focusing in reducing the frequency of PTSD symptoms.

What is Post Traumatic Stress Disorder?

Post Traumatic Stress Disorder (PTSD) is the recognized diagnosis for a particular configuration of symptoms or problems resulting from an experience which overwhelmelmed the person's ability to cope. Some examples of such experiences include: war, terrorist action, domestic violence, and childhood abuse.



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What is Focusing?

Focusing is a client centred, body centered approach to therapy, which is based on the discovery that each person's body has an inner sense or awareness that is meaningful, and can be helpful in dealing with a variety of issues and in reaching personal goals. Focusing is based on the process of paying attention to this bodily awareness.

What does participation involve?

Participation involves completing the numbered SPTSS checklist included in this package, and mailing it to me in the envelope provided some time in the next two weeks. In about six months, your therapist will give you a second package. If at that time you are still willing to participate, you would again complete the numbered SPTSS checklist and again mail it to me in the envelope provided.

What if I change my mind later?

Participation in this study is completely voluntary. Even if you agree now to participate, you can change your mind at any time before the study is complete. If I do not receive your second checklist, the first one will be discarded.

Why do I have two copies of the SPTSS form now?

A second, non-numbered SPTSS checklist is provided to you for your own personal use to have as a record of the frequency of your symptoms now as you are beginning therapy. In the second package you will also be provided a second checklist for your own use. You are entitled to use these whether or not you choose to take part in this study

What measures are being taken to protect my privacy?

Participation in this study is anonymous. I will have no information about your identity, and your therapist will not know whether you have chosen to take part.

1. The checklist contains **no** identifying information other than a number which allows me to match the checklist you complete now with the one you will complete later. There is no list which identifies your name with this number. I will have your number but not your name. Your therapist of course knows your name, but does not know which number is on your forms.

2. As your therapist will not know who has chosen to participate, each person who is given this first package will be provided with a second package after six months or at the end of the therapy.

3. I am not keeping track of which packages are being sent to which therapist so I will not be able to identify your therapist by the number on your return.

4. As soon as I receive your response I will remove the checklist and discard the envelope so that information such as a postmark will not be connected to your response.

How do I obtain a copy of the results of this study?

In return for providing these packages to people who may participate in this study, I will be sending a copy of the results of this study to each of the therapists. Whether or not you choose to take part in this study you are also welcome to a copy of the results once they are complete (by September, 2004). You can obtain this through your therapist. When I send out the therapists' copies of my report, I will be sending a reply card on which they can indicate the number of extra copies they will require. In this way your privacy will continue to be protected.

In order to maintain your anonymity, you are not being asked to sign a consent form. Instead, the act of mailing in your completed SPTSS now, and again when the second package is provided to you, will be taken as an indication that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researcher or involved institution from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continues participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

Principal researcher: Catherine Hudek
phone:
Supervisor: Dennis Bracken
phone:

This research has been approved by the Joint Faculty Research Ethics Board of the University of Manitoba. If you have any concerns or complaints about this project you may contact either of the above-named persons or the Human Ethics Secretariat at (204) 474-7122. This consent form is for you to keep for your records and reference.

Researcher's Signature Date