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James Iberg

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INVITED ARTICLE

Working with anxiety in focusing-oriented psychotherapy

James Iberg*

Evanston, Illinois, USA

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Some elementary philosophical concepts are foundational for the Focusing-oriented Therapy (FOT) approach, and are briefly described to frame the discussion of my perspective on working with anxiety. Anxiety is seen as a useful sign indicating blockage of the client's process, rather than simply an undesirable symptom to be eliminated. The sign gives clues as to the specific values and objectives that are blocked for the client. Some traps will be described and illustrated that some clients fall into when anxious. Some features of the therapist's functional role in therapy are specified and illustrated with clinical vignettes. Finally, a description of the flow of a typical session is characterized to highlight the place to which Focusing-oriented Therapists are especially attuned.

Keywords: psychotherapy; focusing; anxiety; empathy

Die Arbeit an der Angst in der focusing-orientierten Psychotherapie

Einige elementare philosophische Konzepte sind für den Focusing-orientierten Therapieansatzes grundlegend. Diese werden kurz beschrieben, um den Kontext meiner Sicht auf die Arbeit an Angst aufzuzeigen. Angst wird dabei viel eher als sinnvolles Zeichen gesehen, das eine Blockade des Prozesses beim Klienten signalisiert, statt als störendes Symptom, das man eliminieren müsste. Dieses Zeichen gibt Hinweise auf die spezifischen Werte und Ziele, die beim Klienten blockiert sind. Einige Fallen werden beschrieben und illustriert, in die Klienten tappen, wenn sie Angst haben. Einige Merkmale der therapeutischen Funktion werden spezifiziert und mit klinischen Vignetten dargestellt. Abschließend wird der Ablauf einer typischen Sitzung beschrieben und charakterisiert, um die Phase hervorzuheben, auf die Focusing-orientierte Therapeuten speziell sensibilisiert sind.

Trabajando con ansiedad en psicoterapia orientada al focusing

Algunos conceptos filosóficos elementales son el fundamento para la de Focusing (FOT en inglés) y se describen brevemente para dar marco a la discusión de mi perspectiva sobre el trabajo con trastornos de ansiedad. La ansiedad es vista como una señal útil que indica el bloqueo del proceso del cliente, en lugar de simplemente un síntoma indeseable a eliminarse. Esta señal da pistas sobre los valores específicos y los objetivos que están bloqueadas en el consultante. Describo y doy ejemplos de algunas trampas en las que algunos consultantes caen cuando están ansiosos. Especifico y doy ejemplos clínicos de algunas de las características de la función del terapeuta. Por último, caracterizo una descripción del flujo de una sesión típica para resaltar como los terapeutas orientados al Focusing están especialmente adaptados.

*Email: iberg@empathywork.com

Le travail sur l'anxiété dans la psychothérapie "focusing-oriented"

Certains concepts philosophiques élémentaires appartiennent au fondement de l'approche « Thérapie Orientée Focusing » (TOF) et sont brièvement décrits pour donner un cadre à la discussion dans mon approche du travail sur l'anxiété. L'anxiété est vue comme un signe utile indiquant un blocage dans le processus du client et non seulement comme un symptôme non désirable à éliminer. Cet indicateur donne des indices concernant les valeurs et les objectifs spécifiques qui sont bloqués chez le client anxieux. Certains pièges pour les clients qui sont anxieux sont décrits et illustrés par des exemples. Certains aspects du rôle fonctionnel du thérapeute en thérapie sont spécifiés et illustrés par des vignettes cliniques. Finalement, les caractéristiques du processus d'une session typique sont décrites pour éclairer les phases durant lesquelles les thérapeutes orientés Focusing sont particulièrement à l'écoute.

Trabalhar a ansiedade na psicoterapia orientada para o focusing

Existem alguns conceitos filosóficos elementares que constituem as fundações da Terapia Orientada pelo *Focusing* e que são brevemente descritos para enquadrar a discussão acerca da minha perspectiva de trabalho com a ansiedade. A ansiedade é vista como um sinal útil, indicador de um bloqueio do processo do cliente em vez de ser apenas considerada como um sintoma a ser eliminado. Esse sinal fornece pistas relativas aos valores e objetivos específicos que se encontram bloqueados no cliente. Serão descritas e ilustradas algumas armadilhas nas quais os clientes caem quando se encontram ansiosos. São especificadas algumas características do papel funcional desempenhado pelo terapeuta na terapia, que é ilustrado por situações clínicas. Por fim, apresenta-se uma descrição do decorrer de uma sessão típica, de forma a dar destaque à componente com a qual os terapeutas orientados para o *focusing* se encontram particularmente sintonizados.

フォーカシング指向心理療法における不安への取り組み

いくつかの基本的な哲学概念がフォーカシング指向心理療法 (FOT) のアプローチを基盤付けており、筆者の不安への取り組みの枠組みとなっているため、それらを簡単に概説する。不安は除去されるべき好まざる症状と単純にとらえるのではなく、クライアントのプロセスのブロックを指し示す有用なサインとみなすことができる。このサインはクライアントにとってブロックされている特定の価値や目的の手がかりとなる。クライアントが不安を感じたときに陥りやすいトラップのいくつかを記述する。セラピストのセラピーにおける機能的な役割のいくつかを特定し、臨床例を用いてそれらを提示する。最後に、典型的なセッションの流れを示し、フォーカシング指向心理療法家が特に注目するところをハイライトする。

Introduction

Freud, Sullivan, Rogers, Heidegger, Kurt Goldstein, and many others have seen anxiety as an experience that everyone is familiar with on a day-to-day basis. It becomes of clinical interest when it persists too much of the time, or when there seems to be no objective reason for anxiety, or when it is at such an intensity that it is debilitating.

Research and literature related to anxiety and focusing-oriented psychotherapy

Elliott and Freire (2010) reviewed a series of meta-analyses and drew the conclusion that there is strong empirical support for the general effectiveness of person-centered and

experiential approaches to therapy. Results specific to anxiety were designated “possibly efficacious” (p. 8). When Cognitive Behavior Therapy (CBT) was compared to Person-centered/Experiential (PCEP) therapies, at first it appeared that PCEP was inferior to CBT. They urge us to do more research to shore up our demonstrated effectiveness with anxiety, but they do report that when the studies that used “supportive” conditions to represent PCEP were dropped out, the remaining effects for PCEP were at least equal to CBT. They state that the supportive condition was not fairly representative of the experiential approaches, being a more “watered down” approximation.

Another resource for literature on the use of Focusing-oriented Psychotherapy with anxiety is *The Folio: A Journal for Focusing and Experiential Therapy*. Volume 12, number 2 includes articles by three Focusing-oriented therapists describing their clinical adaptation of Focusing methods with traumatized clients. McGuire (1993, pp. 17–34) addresses working with “the inner child” with eyes-closed Focusing. Armstrong (1993, pp. 35–44) emphasizes the importance of maintaining boundaries with clients presenting with dissociation and multiple personality phenomena. Santen (1993, pp. 45–58) describes using painting as a method adapted for an abused adolescent that enabled her to Focus and reconstitute experiencing (Gendlin, 1964). Volume 17 (1998), numbers 1–2 is an issue on working with Trauma. Hendricks (1998, pp. 31–34) gives a detailed clinical example of the very slow pace and careful way of responding to help a dissociated client better maintain a sense of her whole self from which to experience. Volume 20 (2007), number 1, is an issue dealing with fear. One example from that volume is Leijsson’s (2007, pp. 25–35) clinically detailed description of her work with anxiety and fear. She emphasizes the importance of the therapist’s solid, well-boundaried empathic presence while working with Focusing moves. The tables of contents for these and other issues can be seen at <http://www.focusing.org/folio.html>

In this paper, I will address the use of Focusing therapy with anxiety from my personal clinical experience, seen through the conceptual/philosophical framework that Gendlin has provided for us.

Elementary philosophical considerations at the foundation of the Focusing-oriented Therapy approach

Throughout Gendlin’s writings, he alerts us to the tendency to think and perceive on the assumption that objects are the basic elements. Although powerfully useful for thinking about the material world, this is not as appropriate for thinking about human processes. He offers an alternative way of thinking, in which the objects we perceive are a later result of the more fundamental interactions that are essential and central to life from the very beginning. In “A theory of personality change” (Gendlin, 1964), he argues that this tendency is the root of a problem that many psychological theories have with explaining how personality can *change*, since personality is so often conceptualized in terms of static contents.

Gendlin argues that the major personality theories share the “repression paradigm:”

They agree that in an individual’s early family relations he introjected certain values, according to which he was loved only if he felt and behaved in certain ways. Experiences which contradicted these demands on him came to be “repressed” (Freud), or “denied to awareness” (Rogers), or “not me” (Sullivan). Later, when the individual encounters experiences of this contradicting sort, he must either distort them or remain totally unaware of them. For, were he to notice the contradictory experiences, he would become intolerably anxious. The ego (Freud), or self-concept (Rogers), or self-dynamism (Sullivan), thus basically influences awareness and perception. (Gendlin, 1964, pp. 104–105)

This way of conceiving does a reasonably good job of explaining why the structures of personality tend to persist and resist change, but it's not very good at explaining how the structures *can change* through therapy. In agreement with all the theorists mentioned, Gendlin grants that experiences that would change personality structures are anxiety producing.

With the goal of enabling us to think more powerfully about how personality can change, more recently Gendlin (1998) has written *A Process Model*. In this philosophical work, the basic elements with which his conceptions are built are *interactions*, not physical objects (like atoms and molecules). Thus, our attention is oriented to the interactive life process between environment and organism, rather than oriented to sorting people and their characteristics into object-like categories.

The favorable state of affairs for a living organism is one in which the environment-body interaction proceeds smoothly and the body gets from the environment what it needs to continue living and developing. When this is happening, we say the organism's process is *carried forward* by the interaction with the environment. However, it is not especially unusual for developments in the interaction to result in *blockage* of some aspect of the carrying forward.

Gendlin distinguishes four perspectives on the relation between the body and the environment:

- (1) Body-environment perspective #1: The spectator environment. The organism's body is viewed as an entity within the environment. This is perhaps the most familiar way of construing the environment. We envision a three-dimensional space within which the body exists and events take place. As spectator, we observe from a perspective outside of what is occurring in the environment – much of the environment, including the spectator, appears to be independent of (not interacting with) the body.
- (2) Body-environment perspective #2: The interwoven body and environment. The body and environment are two aspects of the same event from this perspective. This conception draws our attention to the ways in which the body is in constant and immediate interaction with specific features of the environment. This perspective highlights that the body is a different body when the environment is changed: e.g. at 10,000 feet altitude, the physical body may look the same as it did at sea level from the spectator perspective, but many physical changes begin immediately (http://en.wikipedia.org/wiki/Effects_of_high_altitude_on_humans).
- (3) Body-environment perspective #3: Lasting structures produced by the body-environment interaction. These are the structures within which living continues, including the physical body. These are not necessarily at every moment in direct interaction with the living processes (e.g. the house one lives in when one goes away to work, or one's conditioning about appropriate behavior with authority figures when one is not in the room with an authority figure), but they will influence which moves are readily available to the body. Personality has been shaped by past experience to expect certain responses from others, for example, which expectations may be a poor predictor of the present-day behavior of others.
- (4) Body-environment perspective #0: Yet-to-be-interacted with aspects of the world. Although these elements of the world have not yet been in interaction with the body, they may enter into that interaction. Of special interest from this perspective are things in the world that could enable carrying forward where something is blocked for the person in question. For example, if a client has never

experienced an accepting, understanding response from an authority figure, receiving that could enable expression of wishes and intentions that have always been stifled.

When a part of the life process is blocked (prevented from carrying forward), the other parts of the life process that are still carrying forward are affected by what is blocked, and they go on differently. Examples of this point abound: if a therapist has an unusually challenging interaction with a client with whom things normally go smoothly and productively, and the session ends without resolution, the subsequent hour with another client will likely involve more than the usual challenges to concentration for the therapist, even though the therapist can interact pretty much as usual with the second client.

Another example: if one has been unable to relieve the bladder for several hours, and the sensations of needing to urinate become intense, one may continue with other activities, like writing a letter or talking with a friend on the phone, but the pace at which one proceeds, and the attitude one has are likely to be different because of the urgent sensations.

Finally, as an example even more relevant to the subject of this paper, if carrying forward one's authentic expression (say, telling the truth about something, or performing on something that is important to you) involves the anticipation that a significant other will disapprove, everything else one says and does is likely to feel more tense and fearful – i.e. one will likely be anxious.

As a clinician, I see anxiety as a valuable signal that some aspect(s) of the life process is (are) blocked, and in need of something not yet present to the person, in order to resume carrying forward. From the Gendlin quote above, we infer that it is also likely that some ways that the person has been conditioned to think and feel about which behaviors and feelings are acceptable, and which are not, have become relevant to the possible ways for the life process to proceed. Anxiety is the subjective experience of conflicts and dilemmas in how proceeding could involve behaving and feeling in ways inconsistent with how we have been conditioned to think it appropriate to behave and feel. This will tend to stop the carrying forward of the life process in some aspect(s). The intensity of the anxiety can range widely, depending on the centrality to life (psychological and physical) of the blocked process(es).

Thus, therapeutic efforts are directed at understanding the subtle complexities of the person's processes and thoughts, memories, and emotions related to the blockage. These complexities reside in the person's bodily felt sense of their dilemmas, not in their thoughts or in their anxiety (also see Purton, 2004, pp. 251–254).

The hope is that in the therapeutic alliance we can discover ways in the person's existing repertoire and current circumstances, or new ways and circumstances, which enable the person to interact with his/her environment to permit the life process to carry forward.

This way of understanding anxiety is very different than seeing it as an undesirable symptom that is to be eliminated in whatever way possible. Of course we hope and expect, as we find ways for the life process to carry forward, that the anxiety will subside, but for real progress, we should not be happy to eliminate the anxiety without getting at the information it points to about what is blocked and what is needed. As Gendlin has said (1962, p. 12) “A very important and surprising fact about direct reference to felt meanings is that if the matter under consideration is anxiety producing or highly uncomfortable, this felt discomfort decreases as the individual directly refers to the felt meaning.”

When you come to a traffic signal, and the light is red, it's wise to use the signal as a cue to look both ways, and as a reminder to slow down and stop so that you can proceed safely (and without getting arrested!) when the light changes. Your doctor wouldn't serve you well to simply come and remove the traffic light.

Coffeng makes a related point in connection with trauma survivors: "the client is the one who can tell what happened. She had to survive the horror, so she is an expert in surviving. She knows whether the helping profession helps. Symptoms must be respected as defenses which can prevent terror or disintegration... But symptoms must also be seen as fragments of historic life events, which are distorted by succeeding life events: they imply cues which have the potential to reveal traumatic details..." (Coffeng, 1998, p. 44).

Some ingredients of anxiety

Harry Stack Sullivan (1953, p. 190) emphasized how much anxiety has to do with one's relations to other people. If one anticipates or actually receives punishment or condemnation from a significant other for the ways in which need satisfaction is sought, anxiety results. Carl Rogers put a similar point in terms of "conditions of worth" which the individual learns from the significant others in his circumstances. Once conditions of worth are internalized, it doesn't require an actual condemnation from someone to produce anxiety: if the individual's behavior or impulses violate these conditions, it is likely that anxiety will be experienced (see Rogers, 1959). Freud (1926, Chapter II) discussed this notion with his basic terms of Id, Ego, and Superego: if the urges of the Id are objectionable to the Superego or the Ego, the Ego is probably going to experience anxiety.

Since it is not the lot of a human being to receive unconditional positive regard for what one does no matter what it is, no one avoids anxiety entirely. Our lives are essentially interactive with other people who have their own motives, and often different understandings of which social behaviors are acceptable, so each individual will encounter a certain amount of disapproval from others.

To wish to avoid receiving disapproval is natural, since, especially as children, our well-being is partly a function of the way our caregivers feel about us. Thus when we receive disapproval, or we anticipate it, anxiety will be present. It is unlikely that an individual, in the pursuit of getting needs met, will receive no disapproval. Along the path to becoming an individual in society one receives many positive and negative reinforcers that serve as incentives to discover ways in which individual needs can be met that minimize the disapproval and maximize the approval of others.

One's propensity to have anxiety triggered has much to do with the particular events of his or her life history: if there has been relatively more conditional approval than unconditional positive regard, one is likely to be more easily made anxious. Being frequently shamed or humiliated by significant others or peers can leave a lasting tendency toward anxiety. However, the environment that we can provide for a client in therapy can enable this tendency toward anxiety to gradually change (Davidson & Begley, 2012, pp. 105–110, show that temperament and even brain wave patterns are less fixed in the individual than was once believed).

Traumatic events, whether early betrayals of trust by significant others, or by shocking and/or life threatening events at any point in life, can leave one prone to anxiety (see Coffeng, 2004 for some distinctions in types of trauma). One can become highly attuned to very subtle cues indicating danger or threat from others or the environment. Certain cues associated with past trauma may trigger anxiety when there is objectively no threat

present, and it can be a very slow process to learn that those cues don't always signal danger and to restore a sense of safety.

Anxiety traps

I have observed some unproductive patterns that people can fall into when they experience anxiety. These traps seem to sustain and sometimes increase anxiety, rather than alleviate it.

Trap 1: Rumination can easily sustain and even intensify anxiety. Going over and over the external circumstances related to the anxiety can remind you of other instances of similar situations in which you felt anxious, and distract you from getting at the underlying felt sense that could bring relief.

Clinical example:

A recently married young man tends to ruminate over the past sexual relationships his wife had before they met, and feel anxious about whether he can trust her to be faithful to him. He gets stuck in thinking back over the details of the relationships about which she has openly told him, thinking about the timing and the circumstances. This gives him no relief. When he was able to focus in on the tension in his body, and to welcome various conflicting feelings he has related to this, it brought back memories of his childhood when, as one of five children, his father would fairly regularly get physically and emotionally harsh with his mother. He feared that his mother would eventually leave the family to escape this. As he recalled these facts, he got visibly sad, and said that his vulnerability to the unwanted end of his family of origin is part of what is behind his anxiety about his wife's sexual history. He expressed relief at realizing this, and a positive feeling about having this connection to his past, which was free of negative judgments of his wife, to share with her. It helped to see that she wasn't the cause of this part of his anxiety.

Trap 2: There are several risky ways that people sometimes try to soothe anxiety. Alcohol or drugs can give some temporary relief. Eating comfort foods may be tempting and soothing. Sexual acting out can be exciting and distracting. Throwing oneself into a fitness regime or extreme diets may also be used as attempts to escape anxiety. These things may give some relief, and can possibly sometimes help one sleep, or relax, or avoid rumination, and, if done as part of an approach that includes exploring the inner complexity related to the anxiety, may be useful. But they are risky because they can easily be overdone to the point where they have their own negative consequences and can interfere with getting at the inner complexity involved in how carrying forward is blocked, producing new problems while one still has the anxiety.

Trap 3: Another trap is interpreting anxiety as evidence of personal failings. This is fairly common for people with a strong "inner critic" and if this part of one takes over, it can interfere with getting at the underlying complexity (the felt sense). This trap often adds depression to anxiety.

Clinical example:

A young female client is a doctoral student, nearing the end of her dissertation work. Her husband began pushing for them to have a child, which she too eventually wants to do, but the timing is important. She worried that trying to do this too soon could seriously interfere with her completing her studies. She told her husband she wanted to discuss this further, but she was quite anxious about that conversation. As she explored her feelings about this, she realized that she anticipates that he will quickly push for what he wants and try to talk her into doing what he wants. This has happened before on some big decisions.

She then said some self-critical things about how she never stands up for herself, which seemed to make her discouraged about her chances for success. She began thinking of other

times when she has done things wrong, when she “messed up,” and others became critical of her.

(Below there will be more discussion of this example.)

Trap 4: Interpreting anxious feelings as evidence that something terrible is going to happen when there is no objective danger in the present situation. This trap can lead the person to react with unwarranted negative interpretations of the other people in their situation, which can evoke defensiveness and produce responses from others that seem to justify the anxiety.

Clinical example:

A professionally successful young man gets anxious when he and his wife are socializing if she seems to be enjoying conversation with someone else. He interprets this as ignoring him. He has a tendency to say things to her that imply she is being inappropriately flirtatious. She feels insulted by this and withdraws from him, which triggers his anxiety again.

What is the therapist's function in the therapeutic interaction with anxiety?

One thing the therapist need *not* take responsibility for is supplying the energy or the drive to gain need satisfaction. The client's own organism has momentum for that, and can be relied upon, once a suitable way forward is found, to carry forward his or her process.

As I see it, the therapist is a crucial aspect of the client's environment, in the sense of Gendlin's body-environment #2. The therapist can provide deep, accurate understanding and positive regard, which allows the client to experience more of their implicit meanings, and to identify learning from the past that was different than the reactions the therapist has. The therapist has minimal investment in the particular mix of ways that the client adopts to get his or her needs met – far less investment than the client's parents, or spouse, or other significant persons. This frees the therapist to listen more patiently and with more positive regard than most other relationships. Providing this tends to reduce the pressure and sense of constraints that the client feels, helping to reveal more of the detail and complexity of the clients' experience and the set of possibilities available to the client.

A woman client came in seeking relief from panic attacks (her description) that she had been suffering for a few weeks. Her internist had prescribed an antidepressant and blood pressure medication, which was troubling to her since she prefers to avoid medication when possible. Sometime later, she referred back to that time period and said our work had been very helpful to her. I asked her what was helpful about it and she said one prominent thing was that I was accepting of her wish to minimize the use of medication. She also mentioned that I invited her to browse the books on my bookshelf, and she found one written by a cognitive behavior therapy psychiatrist that she found helpful and reassuring. Finally, she said our work gave her a place to express her emotional reactions to having very many important things to deal with at once (which was objectively true), and have them received with empathy, which seemed to lighten the burden and help her prioritize.

In addition to being solidly empathic and client-centered, Focusing-oriented therapists are keenly attuned to subtle cues of additional implicit meanings, and we point to those gently to invite them to be articulated. These are things that the client may tend to ignore or hide (for any number of reasons). Simply acknowledging what you observe, with a gentle, friendly guess at the quality it seems to have is a specific form of empathy that has great potential to help the client notice and explore further into the bodily felt sense. Such moments where subtle cues of the formation of bodily responses are visible or audible are

opportunities to provide the light of awareness and a non-evaluative attitude of curiosity where the client may not be naturally inclined to have such attitudes.

This is a very common and frequent form of empathy for me. It can sound very simple, but have a powerful empathic effect: “I thought I saw a flicker of sadness [or tenderness, or anger, or fear – whatever it seemed to be] cross your face just then. Was that a feeling connected to what you are talking about?”

Carrying forward of the client’s process is facilitated by making explicit the complexity of the client’s situation that is involved in any blockages. This naturally further differentiates the possible ways for the client’s process to carry forward. An example of this point comes from the woman mentioned earlier who came suffering panic attacks:

The implicit complexity that became explicit as I listened to her, certainly qualified as overwhelming: her father had died a couple of months before, so she was grieving. She took on the job of helping her mother get her finances in order and deal with the loss of her spouse, and her mother lived in a distant suburb. Her husband fell and injured his neck, requiring a neck brace and extra safety measures around their home, and they were dog sitting their daughter’s two dogs, one of which was not yet house-trained. In explaining all this, she also mentioned that her role in her family when she was younger (before marriage and college) was to monitor how her parents and her older brother were getting along. She became skillful at keeping the peace, and helping to organize the household. Her skills and inclinations were well developed for attending to the needs of others. As all this became explicit, she started to realize that she needed to set some limits for herself. She said that our work supported her setting some limits to her availability, and that made an important difference in her level of anxiety. She then felt she could support her loved ones while also taking care of her own needs for rest and solitude.

A second example of this point:

A male client was describing a recent interaction with his wife in which he felt she insulted him. They had been out to dinner with a friend and when the check came, he had suggested they split the check. She later angrily said he was being cheap and insensitive to the friend, who was short of funds. He got angry and made a sarcastic remark, which escalated the conflict and misunderstanding. Part of what I said in trying to understand the complexity of the situation was this: “it sounds like you hadn’t picked up on the fact that your actor friend was short on funds, and your wife reacted to your suggestion about splitting the check as if you didn’t care about his plight. This doesn’t give you credit for how you are caring and considerate of this friend, so you were misunderstood.” He affirmed that enthusiastically. Then I said “and you are easily irritated when people seem to be talking down to you, ‘correcting’ you.” This was also affirmed. “And when she seems so angry, I get the sense that it scares you about just how close she may be to leaving you.” He affirmed this, stating that she has sometimes talked like she might leave, and he wonders if she’s staying with him just for the financial benefits.

When gripped by anger and anxiety, it can be very difficult for a person, just on their own, to get to this kind of underlying complexity. It is somehow easier, perhaps feels safer, to justify the anger, or make the case for what the other is doing wrong. So as his therapist, I spoke from my implicit understanding of him (my own felt sense of him), built from things said earlier in the session, and from previous sessions, as well as what he’s expressing in the moment, to make gentle, friendly guesses at the meanings implicit for him. I intend to check carefully, and frequently, how my guesses are being received, and if they are not on target, I will drop them and return to following empathically. The material I guess at that hasn’t just been referenced by the client is what I know of his

body-environment #3. Although it may not be in his immediate awareness, some of it is probably relevant, and if the conditions are right, what is relevant can become accessible to him with such gentle pointers.

The therapist can provide valuable objectivity when the client's inner critic starts to jump in, and suggest acknowledging, but not identifying with that. The value of "dis-identifying" from the critic (Cornell, 2005) is something Focusing-oriented therapists appreciate from what we have learned about the cognitive attitudes that seem most productive in the project of assisting the felt sense to disclose implicit meaning. The following clinical example is the way I responded to the client in the clinical example above under *Trap 3*:

I invited her to notice that part of what seemed to be happening was that her inner critic was getting activated and predicting the worst. I suggested we might listen to the concerns of the critical voice without immediately getting stuck in its dreary forecast. The critical voice was fearful that she wouldn't get her husband to listen and it would become another failure. We talked about what might help her get her point across, and together came up with the idea that she could ask him to listen for a period of time without reacting from his own perspective. She remembered another time when she had asked him to do this and it got good results, which brought her relief and hope for a good outcome.

At that point, she got more in touch with her sense of her own tender and vulnerable needs, and felt more confident about standing up for them. She was less anxious about the conversation with her husband.

The therapist can also offer possible interpersonal moves that may not have become part of the client's repertoire, but could be helpful (Gendlin's body-environment #0 for the client). This is a form of congruence.

With anxiety, an interpersonal move that can be surprisingly helpful is simply declaring what you are experiencing. When anxious, a person tends to anticipate disapproval of almost anything they feel or do. This often underestimates a present-day companion's willingness to respond sympathetically. Taking the risk of stating what you feel may result in a positive response, which can be tremendously healing. The therapist is perhaps the first one safe enough with whom to risk doing this, and getting a non-critical, understanding response from the therapist can really feel good. When the therapist perceives others in the client's life with whom it is likely to go well, giving a little encouragement to do this may be just what enables the client to risk it there, too.

Therapist congruence can also play a helpful role if a situation in which the client's process is blocked reminds you of a similar situation you have personally experienced. Sharing that may help normalize it (if the client seems to exaggerate how condemning it is) or suggest resolutions or meanings the situation may have for the other actor(s) in their situation that are more open-ended than what the client imagines.

A psychology graduate student was meeting with her internship supervisor, feeling anxious about the meeting. She said the supervisor often has numerous suggestions for how she could have done things differently. The student worries that her supervisor is forming a negative impression of her skillfulness as a therapist. I told the client that I was reminded of an experience early in my years as a supervisor. One of my supervisees tearfully asked me, after I had given her several (I thought) insightful suggestions, "But did I do *anything* right?" This was an important learning for me as a supervisor, about the balance of the feedback I was giving. It's much better if I include things that I like as well as suggestions for what to do differently, so the supervisee doesn't think I only see problems in what they are doing. Although I was trying to do my best to be helpful,

I was not appreciating the vulnerable position the supervisee was in, wanting to make a good impression on me.

I think the value of sharing this experience with the client was that it helped her see that a supervisor is likely also a person trying to do things effectively, and not simply an authority whose only concern is to evaluate the student. My client said it was very helpful that I had shared this story with her.

As a whole, I believe the Focusing-oriented Therapist has the effect of enlarging the relative influence of the *present situation* in relation to the other domains of implicit complexity operating for the client (such as one's learned sense of the expectations of significant others, one's learned sense of societal norms, one's memories of historical traumas). This helps the client make a more objective assessment of the danger represented by present cues associated with past disapproval or other unwanted responses from others that have been traumatizing in the past. This can help break the cycle of renewed hypersensitive reactions to cues that no longer represent the same threat they once did.

The intention of the Focusing-oriented psychotherapist is to carefully attend to the body-environment #2 situation between therapist and client, aiming to create and maintain safety for the client, and non-judgmental welcoming attitudes toward all the complexity of the client's experiencing, including aspects of it to which the client may not so easily bring such attitudes.

We generally eschew assuming the spectator perspective (body-environment #1) in relation to the client (e.g. a diagnostic perspective) because of the potential for this posture to trigger, for the client, signals of danger and critical evaluation from the therapist. That would be a low-quality body-environment #2 for promoting the emergence of implicit complexity.

The flow of a typical session

From my perspective, the key to success with anxiety is to accomplish the transition from the gripping discomforts of anxiety, to the bodily sense of the underlying complexity of feelings, thoughts, values, and past experiences. A woman recently characterized this change as "going from the breathless tension in my chest to the prickly sense of the complexity that I feel much lower down, in my belly."

Typically, the first large part of an hour session is spent in empathic listening, carefully listening and communicating what I understand to the client, to make sure I'm following correctly, and to convey to them that I want to and am attempting to understand with great accuracy. When this is done well, it creates an atmosphere of safety and welcome that, in the language of neuroscience (Atkinson, 2005; Panskepp, 1998) may evoke the "sorrow" executive operating system for the client, leading to feeling more emotion and to seeking affiliation and support from the therapist. (For some clients, especially those with more severe traumatic histories, it may take several sessions of experiencing the safety of non-judgmental careful listening, rather than just the first part of a session, to establish enough of a sense of safety and trust to move into the next phase).

The special moments when a felt sense begins to form for the client (the next phase: see Iberg, 1990, 1997, for more on phases in the therapy hour) are visible and/or audible to the therapist: you will see signs of feeling in the client's face, and hear changes in their vocal expression, perhaps a quaver in the voice, or what we sometimes refer to as becoming "choked up." These moments are rich with potential for healing, insight, and relief of anxiety.

Realizing this potential is a delicate interactive affair: for the client, the personal history of how significant others have responded to such feelingful events will greatly influence whether or not they easily go further with it. If the client has often been mocked or punished for becoming emotional, they are likely to feel highly vulnerable and anticipate a negative response, and try to steer away from the felt sense. So it's a delicate time with many clients, as they carefully watch how you react to them.

As the therapist, how the client's "welling up" with bodily feeling strikes you will influence how you respond. Your own experiential history with how significant others reacted to emotional/felt sense developments will have left you with reaction tendencies, some of which may interfere with your responding therapeutically. However, a few experiences of how rewarding it can be to stay with and explore further these emotional events quickly rewards welcoming them, as Focusing-oriented therapists know well. Also, this is a point at which some of our training could interfere with success: if you get propelled into an assessment frame of mind at these moments, you may end up thinking about how to diagnose the client, entering the spectator environment. This may send cues to the client that frighten the client or evoke defensiveness. Better we should allow ourselves to be touched with the emotion of the moment, and stay in our caring, empathic response set with careful attention to Focusing attitudes. If we can do this, it will facilitate the client's further exploration of the experiential complexity related to their anxiety, and that often leads to less anxiety.

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