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AN INVESTIGATION OF MICROTRAINING IN EXPERIENTIAL
FOCUSING FOR PSYCHIATRIC OUTPATIENTS

by

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CHAPTER I
INTRODUCTION

Purpose and Scope

In our society, the use of mental health services has burgeoned in the decades since the Second World War. As the demand for these services increased, the availability of them has increased as well. For example, the number of Veterans Administration outpatient clinics and neuropsychiatric hospitals has expanded dramatically in the last 50 years. Community mental health agencies have proliferated to the point where they have become available in nearly every neighborhood or town of at least moderate size. Counseling centers have become common in colleges and universities. Mental health programming is frequently seen on educational stations on television, and psychological problems are often an issue considered in the characterizations found on some programs from the major networks, indicating an interest in mental health issues on the part of the general public.

As the demand for mental health services has increased, and as more have been supplied, numerous formulations of the "best" way of providing these services have come about. Techniques include individual psychotherapy, group psychotherapy, family therapy, training groups for organizational

change, school consultation, and attempts to change the social structure of communities (Gendlin, 1975). Theoretical formulations about the nature of personality change include such diverse conceptualizations as the psychoanalytic, the behavioristic, and the client-centered. Research studies on psychotherapies, especially in the behavioristic and the client-centered schools of thought, are numerous.

Despite this diversity and proliferation, some theoreticians and many practitioners have searched for important factors which all psychotherapies might have in common. Behaviorists have claimed that the principles of learning can be found in use across orientations (Patterson, 1973). Client-centered therapists have suggested that a certain kind of experiential process is common across therapies (Gendlin, 1966a, 1975). C. H. Patterson (1973) has commented on aspects of psychotherapy which cut across orientations. He states that the relationship is the most important common ground in therapies and that this relationship can be used to minimize external threat so that anxiety-arousing ideas and feelings can be free to appear and gradually to be extinguished.

This study will investigate an aspect of psychotherapy which Gendlin (1964, 1966a, 1969, 1973, 1975) believes to be found across orientations, the experiential process, an awareness of one's meaningful feelings. A specific

way of rapidly inducing that process, focusing, will be utilized. In addition, a paradigm for quickly teaching focusing which uses behavioristic principles, microtraining, will be employed.

Review of the Literature

The experiential process has become a central concept of client-centered psychotherapy (Gendlin, 1973; Hart, 1970; Shlien & Zimring, 1970; Van der Veen, 1970). The development of the concept stemmed from work with hospitalized schizophrenic patients, whose awareness of their own meaningful feelings was significantly lower than that of the populations with which client-centered therapists had previously been successful (Gendlin, Beebe, Cassens, Klein, & Oberlander, 1968). While the therapist-client relationship and therapist genuineness remain central, the role of the therapist as one who is neutral, and who avoids descriptions of his/her own inner process has been discarded in favor of a more real relationship. The therapist's ability to describe his/her own experiential process is considered to enable his/her client to become more aware of his/her own experiencing (Gendlin, 1966a, 1970; Hart, 1970). Gendlin has suggested that any technique which the therapist might employ within this relationship to deepen the client's experiential process will enable a therapeutic process to occur.

The specific technique Gendlin has suggested for deepening experiential process is use of his Focusing Manual (Gendlin, 1969) (see Appendix A). The Focusing Manual contains specific instructions with silent periods in which to carry them out. By following the steps in the manual, the therapist attempts to help his/her client center his/her attention on his/her conceptually not yet clear but concretely felt mass of experiencing, from which words and images can flow. The person compares these verbal and pictorial labels to his/her experiencing until some of the words and pictures "feel" as though they accurately describe the experiencing, thereby making the meaning of his/her experiencing clearer to the person. By attending to this "flow of experiencing" (Gendlin, 1969), new aspects of it becomes clear to the client, and a shift in the flow of experiencing, to a slightly different "feel" in the experiencing, begins to occur. As a person becomes increasingly conscious of his/her experiencing, theoretically his/her self-concept will change to incorporate his/her new awareness so as to become more congruent with it (Hart, 1970).

Schizophrenics with a low level of experiential process, that is, patients having no personally felt involvement in what they discussed, were found to be unsuccessful in psychotherapy on a variety of therapy outcome

measures, including MMPI scales, two Q-sort scales, the Wittenborn Scales, and TAT analysis in the Wisconsin study (Rogers, Gendlin, Kiesler, & Truax, 1967). Gendlin et al. (1968) suggested both that success in psychotherapy, as measured by instruments such as those in the above study, could be predicted from a measure of initial experiential level; and also that a higher level of experiential process could be taught, as some therapists in the Wisconsin study had been able to do. The Focusing Manual was developed for the purpose of teaching a higher level of experiential process.

Gendlin et al. (1968) hypothesized that personality problems could be prevented and creativity enhanced by teaching focusing in the school system. While Gendlin et al. (1968) do not present data supporting the former hypothesis, they provide evidence that focusing ability is associated with creativity as measured by the Hidden Figures Test. In attempting to teach focusing to high school students and to college sophomores, Gendlin has found that about half of them were able to engage in focusing from the instructions in the manual alone (Gendlin et al., 1968). Research is needed, however, on teaching focusing to clients in psychotherapy, especially clients who had been patients in psychiatric hospitals. Such patients typify individuals who in past studies had started at a low level of experiencing, and who had typically found

little benefit in psychotherapy (Gendlin et al., 1968).

Gendlin (1976) has stated that he has been able to teach focusing to outpatients from a VA hospital where he works as a consultant, although he has presented no data demonstrating this. Gendlin (1976) has identified the most serious training problem as conveying to the patient the concept of focusing. While Gendlin has used the Focusing Manual as his method, there is an alternative method available, microtraining (Ivey, 1971), which might have afforded him greater success. In addition to conveying to the subjects the concept of focusing, microtraining could help a subject to manifest behaviors which would signal his/her ability to experientially focus.

Microtraining has been used to successfully instruct neophyte counselors in basic counseling skills, to instruct educators in more successful ways of teaching, and to instruct students in socially adaptive skills (Ivey, 1971). In addition, it has been used to teach pairs of individuals to interact on a more personal, meaningful level (Higgins, Ivey, & Uhlemann, 1970). Further, schizophrenic patients have been taught skills useful to them in applying for jobs (Keil, 1968), such as appropriate dress and mannerisms, and ways of explaining their psychiatric history to employers. Schizophrenics have also been taught skills which improved their interpersonal behavior on an inpatient ward (Donk, 1972). It seems logical that

microtraining could be used to teach outpatients in psychotherapy an important client skill, experiential focusing. The purpose of the current study is to put this proposition to an empirical test.

The review of the literature will discuss first the nature of microtraining, and the merits of studies utilizing microtraining. Second, the theoretical and empirical literature on focusing will be reviewed. Third, schizophrenic deficit and problems associated with the teaching of schizophrenics will be considered.

Microtraining

Combinations of psychotherapy and behavior therapy being used together are becoming more widely accepted and consequently more discussed in the literature (D'Alessio, 1968; Gendlin & Rychlak, 1970; Lazarus, 1968; Levin, Hirsch, Shugar, & Kapche, 1968). Thus while using a behavioral method such as microtraining to teach an experiential process such as "focusing" may seem contradictory on the surface, it may be usable to therapists if the idea proves workable in this study.

Microtraining is based on "microteaching" as developed by Allen and his colleagues at Stanford (Allen, 1967; Allen & Ryan, 1969; Allen, Ryan, Bush, & Cooper, 1969), and "microcounseling" as developed by Ivey and his colleagues (Ivey, 1970, 1971, 1973, 1974a, 1974b;

Ivey & Gluckstern, 1976; Ivey, Normington, Miller, Morrill, & Haase, 1968). Microtraining is a structural or methodological approach to skills acquisition, with emphasis on the person in training implementing the skills and practicing them. The emphasis is on participation by the trainee. It involves a narrowing of emphasis to one skill at a time, so that the trainee is not confused or overwhelmed with too much data.

An example taken from Ivey's microcounseling might help to illuminate the process as it generally takes place (Ivey, 1971). An interviewing trainee is instructed to talk with a "client" for five minutes, to "get to know the client better", while the trainee's supervisor videotapes the session and takes notes on it. Afterwards, the client fills out a brief form evaluating the "counselor" and leaves the room. The trainee reads a written manual describing the specific skill to be learned and views a video model of the skill being performed well, and, separately, of the skill being performed poorly. The trainee and supervisor discuss the manual and the model shown and then view the trainee's initial interview. They discuss the session, go over the evaluation form, and then review the skill and plan for the next interview. The trainee is asked to identify on the tape of his/her last session specific examples of when he/she engaged in or failed to apply the skill in question. During this process, the

supervisor provides a model for the skill by his/her own behavior. The trainee then conducts a second interview with the same client for five minutes, and the process of recording, evaluation, and feedback is repeated.

This technique has been successful as measured by ratings of judges and behavioral counts in teaching such skills as attending behavior (Aldrige & Ivey, in press; Ivey et al., 1968), reflection of feeling and summarization of feeling (Ivey et al., 1968), use of open-ended questions and "minimal encourages to talk" (Moreland, Ivey, & Phillips, 1973), direct and mutual sharing of feelings (Higgins et al., 1970), counseling skills to paraprofessionals (Gluckstern, 1972, 1973; Haase & DiMattia, 1970), attending behavior to hospitalized psychiatric patients (Donk, 1972), interpersonal skills of their own choice to hospitalized psychiatric patients (Ivey, 1973), and expression of feeling and empathic understanding to black and white school children in interaction with one another (Noel, 1976). These studies will be elaborated in sections dealing with various areas in which microtraining has been researched.

A likely explanation of why microtraining is effective is its behavioral framework, emphasizing single skill acquisition and providing intensive practice until a skill is learned thoroughly. Feedback techniques provide important support for the learning. Ivey (1971) has pointed

out the behavioral aspects of microcounseling as follows:

It may be observed that the training procedures involve cue discrimination and specific suggestions for improvement, video models (Bandura and Walters, 1963), written materials, and supervisor's comments. Operant techniques (Skinner, 1953) are stressed, in that appropriate interviewer behavior is rewarded; the emphasis is on positive growth and relatively little attention is paid to interviewer errors. The positive approach of operant psychology coupled with specific suggestions is important in rapid trainee growth. (p. 6-7)

So the training process involves modeling a behavior to be learned, and once the behavior has been emitted, reinforcing it by approval (Ivey, 1971; Skinner, 1953).

Ivey suggests that the experience of success in learning the skill, and in seeing one's self improve rapidly, is highly reinforcing (Ivey, 1971), and cites as evidence studies by Bank (1968), Bear (1968), and Loovas (1968), which give examples of the sense of mastery and skill that comes from learning a new skill. This is a cogent reason for using such a training process with patients who typically experience all too little success in their lives (Goldstein & Simmonson, 1971), and who feel badly about themselves (Rogers et al., 1967). Gendlin and Rychlak (1970) discuss the intrinsic reinforcement that comes from learning a new skill. Ivey (1971) theorizes that this feeling of mastery can become a generalized feeling for an individual, and can lead to increased ability to learn other new skills. It seems reasonable that this feeling of confidence would be helpful in

psychotherapy.

In summary, microtraining is a methodological approach to teaching skills which utilizes behavioral principles. Behavioral elements in microtraining include (a) the formulation of a specific skill to be learned, (b) presentation of positive and negative models of that skill, (c) trainee practice in the skill, and (d) feedback on the trainee's performance of the skill from self-observation and from supervisor comments. The microtraining structure has proven useful in teaching a variety of skills, as we shall now consider in more detail.

Training Counselors. Ivey et al. (1968) used the microcounseling structure to teach neophyte counselors the skills of attending behavior, reflection of feelings, and summarization of feelings in a series of three studies. In the first study, attending behavior was taught. Attending behavior was broken into component parts including maintaining eye contact, maintaining a relaxed postural position with appropriate gestures, and accurate verbal following behavior (no bringing up topics unless the client discussed them first). In the second study, accurate reflection of feeling was taught. This skill was defined as a component of attending behavior in which the interviewer would selectively attend to the feeling component of a client's communication and then reflect empathic understanding back to the client. The third study focused on

summarization of feelings, which was described as being like reflection of feeling, only more integrative and covering a longer time span.

Results of these studies showed significant improvement in the behaviors being taught. Clients' reactions to the counselor trainees were significantly more positive after the counselors were trained. This was measured by an instrument designed by Ivey et al. (1968), the Counselor Effectiveness Scale, a semantic-differential listing 25 counselor qualities such as "sensitive--insensitive", and by a relationship questionnaire adapted from Truax and Carkhuff (1967). Five-point rating scales were used to assess improvement in the novice counselors' behaviors, and improvement was found for all three aspects of attending behavior, and for reflections and summarization of feelings.

Ivey et al. suggest that these studies provide convincing evidence of the power and validity of the micro-counseling procedure for teaching specific skills of counseling. One implication of the Ivey et al. (1968) study was that brief training, focused on the specific skills of being a successful client, could be useful in psychotherapy. In the present study, an attempt was made to teach the skill of experiential focusing, thought to be important for a client to have (Gendlin et al., 1968).

It might be considered that the skills of reflection

of feeling and summarization of feeling are components of the client-centered construct of empathy (Ivey, 1971). This would link these specific counselor skills with outcome studies done on psychotherapy. Truax and Mitchell (1971) review studies indicating that therapist empathy, warmth, and genuineness, as assessed by ratings of counselor behaviors on taped psychotherapy interviews, tend to result in client improvement as measured by such indices as the client's concept of his ideal self matching more closely his self-concept, the MMPI Schizophrenic and Psychasthenia Scales, and the Welsh anxiety index obtained from the MMPI.

Some limitations might be noted for the three studies conducted by Ivey et al. (1968), however. First, the clients were paid volunteers, and therefore they may not have manifested the kinds of behaviors which might be manifested by clients with problems serious enough that they would seek counseling. Second, the time spent in the interview, five minutes, further makes the session atypical of counseling interviews. Finally, there were no control groups utilized in the studies on reflection of feeling or summarization of feeling. Therefore, the improvements in trainee performance of these skills may have been partly an artifact of the counselor trainee and the "client" being more comfortable with one another, rather than a direct result of the training.

Moreland and Ivey (1969) used the microcounseling framework to teach the skill of interpretation, which was defined as bringing forth another frame of reference, hopefully a more functional one, for the client to consider in relation to his problem. The criterion of an interpretation's success was whether or not the client could use it to cope effectively with his problem, both intellectually and emotionally. Moreland and Ivey operationalize this concept by presenting stimulus sentences from clients, such as one indicating that in a dream the client planted a seedling which grew into a tree and was mysteriously cut down. These stimulus sentences are followed by several possible interpretations, such as (a) the client lost something he had worked hard for, or (b) the client is unsure of his successes. Moreland and Ivey indicate that they have had success in teaching this skill to counseling students, but present no data in support of this contention.

Moreland and Ivey purposely make the skill of interpretation devoid of theoretical foundation. It is possible that interpretations stemming from a variety of theoretical perspectives could result in both the therapist and the client floundering with no sense of the purpose of the interpretations. The purpose of an interpretation would more typically stem from the orientation (e.g., psychoanalytic or Adlerian) upon which the interpretation is based.

Greenall (1969) extended concepts of microcounseling to training of therapists in appropriate behaviors to use at different points in an interview. Greenall divided the counseling interview into four parts, and devised positive and negative models for each part. The first part dealt with the beginning of the interview, including possible seating arrangements, and listening to the client's viewpoints and feelings. The second and third parts dealt with the middle of the interview, focusing on nonverbal communication in part two and ways of responding to the client in part three. Part four dealt with the end of the interview, involving skills such as summarizing the interview, giving advice, and terminating the session. Although specific measures are not given, Greenall reports that if these parts are taught all at once, trainees become confused. Greenall suggests teaching each part of the interview in a separate training session. Research on Greenall's potentially meaningful integration of counselor skills is necessary to demonstrate its utility in training competent counselors.

Haase and DiMattia (1970) trained paraprofessionals in the use of attending behavior, reflection of feeling, and expression of feeling. In a follow-up one year later, they found that the trainees had retained their improved nonverbal communication and their ability to express feelings. Verbal following behavior, that is, responding to

the client's last comment without introducing new data, and reflection of feeling statements had decreased, although remaining above pretraining levels (Haase, DiMattia, & Guttman, 1972). They suggested that the environment only partly reinforced the trainees' use of these skills, and that therefore, their use was partly extinguished over time. It should be noted that Haase and DiMattia's subjects were secretaries and clerical workers at a mental health agency, who would have little opportunity to practice the skills taught. It may be that this population was selected because of the easy availability of trainees. These trainees would perhaps differ in education and interests from individuals actively working with clients in a therapeutic capacity, making the usefulness of Haase and DiMattia's results somewhat questionable.

Using the microcounseling paradigm, Miller, Morrill, and Uhlemann (1970) taught counseling students skills useful in conveying interpretations of psychological test data to clients. Miller, Morrill, Ivey, Normington, and Uhlemann (1969) taught the use of attending behavior to shape the client's verbal behavior when discussing the client's attitudes towards tests. The counselor was taught to recognize the client's attitudes towards the tests, and to balance expression of information with the client's reaction to that information. Ivey (1971) suggests that the client would be more likely to listen to a test

interpretation if he could first honestly express his own feelings towards the tests, though he does not provide data supporting this statement. Ivey's statement does, however, recall Rogers' (1959) theorizing that one individual can more readily receive another fully if he first feels fully received himself.

Zeevi (1970) used the microcounseling format to train volunteers for a "hot line" telephone counseling and referral service. He reports finding that listening skills learned in these settings generalized to home situations, though it is not clear how this was assessed. Similarly, we would hope that focusing once learned would generalize to psychotherapy.

Gluckstern (1972, 1973) trained parent drug counselors in microcounseling skills. They improved their skills and maintained this increase in a six-month follow-up. Their impact on clients showed in more client focus on self (instead of external topics) and in more client expression of feelings as measured by judges' ratings of videotape segments. It should be noted, however, that Gluckstern used no control group in her research, and her results may have been an effect of the attention her experimental group received. Further, her subjects were highly motivated, carefully screened, from an upper-middle class environment, and typically had two years of college, thus limiting the generalizability of her results. Gluckstern's subjects

were primed for the training by a twenty-hour structured encounter group. Finally, the "clients" her counselor trainees interviewed before and after training were volunteers instructed to talk about their "attitudes and feelings about drugs" (p. 60). Generalizations about the effects of Gluckstern's training on preparing paraprofessionals to deal with real clients talking about real problems must therefore be limited.

Comparing traditional psychiatric training of second year medical students with microcounseling procedures, Moreland, Ivey, and Phillips (1973) compared microcounseling to traditional training (individual-didactic) of psychiatric residents. Both groups improved significantly on their interviewing skills as assessed by judges rating videotaped interview segments. On an attending behavior rating scale, as well as on number of reflection of feeling statements and number of open-ended questions, the microcounseling group scored more favorably than the group in traditional training. The microcounseling group also scored better on the Therapist Error Checklist, an instrument developed by Matarazzo, Phillips, Weins, and Saslow (1965), used for rating therapist utterances as good, fair, or poor in accordance with various types of therapist errors. There were no significant differences between groups on a series of five-point Carkhuff-Truax type scales. A limitation must be noted in interpreting

the results from this study. Different instructors taught the microtrained group than the instructors teaching via the traditional didactic framework. The alternate explanation that the teachers using traditional methods were less skillful must be considered.

Toukmanian and Rennie (1975) compared microcounseling with Carkhuff's human relations training (Carkhuff, 1969a, 1969b). They taught the microcounseling skills of attending behavior, verbal following behavior, minimal activity responses, reflection of feeling, and open inquiry to students in psychology. Trainees in both groups improved over no-training controls on all criteria, with microcounseling trainees gaining significantly more on empathy than did the human relations training students. The potency of the microcounseling approach even relative to an alternative proven method (Carkhuff, 1969b) is impressive.

The results of the Toukmanian and Rennie study must be limited in that the "clients" used in their study were psychology students instructed to role play standard problems having to do with interpersonal difficulties. Whether the counselors trained via microcounseling would demonstrate more empathy in dealing with individuals presenting real problems than those trained by the Carkhuff method is therefore uncertain.

Hearn (1976) compared sensitivity training, a new

programmed text, and a microcounseling workshop in the training of psychiatric nurses. Microcounseling-trained nurses produced more of the skills. In addition, clients of the nurses trained through microcounseling talked more about themselves and less on external topics than the other two groups. Furthermore, the nurses made less errors on the Therapist Error Checklist. Yet in a one-month follow-up the learned behaviors had decreased. Hearn attributed this to a possible lack of bringing all the trainees up to full competence, and a complete lack of opportunity to practice learned behaviors on the ward.

Authier and Gustafson (1975) found negative results in using microcounseling to train paraprofessionals; that is, the trainees did not learn the behaviors over time. The authors speculate that they might not have brought the trainees up to criterion levels of behavior, that constant rescheduling of appointments may have lowered motivation for training, and that the reluctance of some trainees to conduct pre- and/or posttraining interviews was detrimental.

Hutchcraft (1970) reported rapid extinction of skills learned. Again the level of first learning and the lack of opportunities for further experience were possible explanations. Other studies have revealed that trainees have retained skills over time (Haase et al., 1972; Miller et al., 1969; Moreland, Phillips, Ivey, & Lockhart, 1970).

In summary, the microcounseling structure has shown generally positive results in teaching beginning counselors specific skills. Further, these counselor trainees have generally been rated in more positive terms by their "clients." These findings are somewhat limited in generalizability, however, because frequently the "clients" have not been individuals actually seeking help for their problems, and because of the lack of a control group in some of the studies.

Research on the elements present in microtraining.

Some research has concentrated on the relative importance of the various aspects of microtraining. In general, those aspects include (a) positive and negative models of the skill, (b) applied practice, (c) instruction, (d) feedback, through self-observation and supervisor comments, (e) presence of a supervisor, and (f) the need for reinforcement of the learned skills in the trainees' environment.

A study conducted by Hutchcraft (1970) found that more complete modeling of a skill helped trainees to learn the skill most effectively. There were four groups in his experiment. One group viewed a videotape of a skilled counselor interviewing a client, followed by a videotape of the counselor being reinforced by his supervisor. Another group viewed only the tape of the counselor conducting the interview. A third group viewed only the tape of the supervisor reinforcing the counselor, and a fourth

group viewed neither of the tapes. All of the groups conducted four interviews each, and received feedback on their performance. Hutchcraft found that either of the conditions in which the supervisor tape was shown led to most improvement on measures of (a) frequency of counselor interruptions, (b) frequency of times the counselor paused after the client's dialogue before saying something, (c) total number of counselor responses, and (d) duration of counselor talk time. It was less effective to present the counselor model alone. The model of a supervisor was more potent than a model of a person having less status. Another finding in the Hutchcraft study was that the learned skills had extinguished after 24 hours. Hutchcraft concluded that there was need for applied practice in the skills taught. Perhaps the need for reinforcement of practice in the skill could also be considered necessary for a skill to be retained.

Residence hall counselors were taught the skills of attending behavior, reflection of feeling, and summarization of feeling using variations of the microcounseling technique by Perkins and Atkinson (1973). After the initial interview, participants listened to a tape recorded lecture followed by either (a) discussion, (b) modeling, or (c) role playing. Subjects in all three groups maintained eye contact longer than controls. The groups trained via lecture-discussion and lecture-modeling performed

significantly better than the control group in reflection of feeling. The lecture itself contained many positive and negative examples of the skills being taught, which may have served to model the skills.

The importance of modeling in teaching a skill is again underscored. The limitation must be noted in this study, as it has been in many other studies on micro-training, that the "clients" were not actually troubled individuals. Ten volunteer students were given mimeographed sheets of the problems they were to present, and were coached by the experimenter. It is therefore not certain that these residence hall counselors would have been more effective in dealing with students presenting real problems than a comparable group of untrained residence hall counselors.

Goldberg (1970) compared the effectiveness of audio-tape models and instructions under four conditions in a well designed study. Her groups were trained by (a) models plus instruction, (b) models only, (c) instructions only, and (d) a placebo experience. Goldberg found that an audiotape model plus instruction was most effective in teaching the skill of accurate reflection of feeling, as rated on a five-point scale by judges. Use of the audio-tape model alone was next best, and use of instructions alone was not significantly better than receiving neither instructions nor exposure to a model.

Frankel (1970) found further evidence of the importance of modeling a skill being taught. Videotape modeling of accurate reflection of feeling, followed by feedback, produced the highest level of the skill as assessed on a five-point scale by judges. Feedback preceding the presentation of the model was less effective, and least effective was receiving instructions only.

In a 1971 study, Kelly examined the effects of different kinds of reinforcement on teaching microcounseling skills. Her trainees were master's level students in counseling and guidance. She found that trainees reinforced by a supervisor tended to learn the skills somewhat better than trainees using self-reinforcement, and that both groups receiving reinforcement learned significantly better than trainees in her control group. Her "clients" were beginning graduate students in counseling and guidance, who were instructed to talk about their interests. Since she was examining primarily the effects of different kinds of reinforcement rather than generalizing about the effectiveness of her trainees in the skills involved, use of these "clients" tends to be less of a limitation in this study than in other microtraining studies.

McDonald and Allen (1967), in a series of controlled studies, investigated elements of the microtraining method in training teachers. They found that the most powerful aspect of the method was self-viewing accompanied by

supervisor feedback. Video-modeling was best for describing the behavior to be learned. McDonald and Allen concluded that the use of all the microtraining methods, including feedback, modeling, and supervision, was the most effective way to teach skills.

Haase, DiMattia, and Guttman (1972) found that skills of verbal following behavior and reflection of feeling decreased after a year, although they remained higher than before microtraining as measured by judges ratings. As noted previously, however, this is in the context of training clerical personnel who would have little opportunity to practice these skills. Still, in conjunction with the Hutchcraft (1970) study, the Haase et al. findings again suggest the need for applied practice and reinforcement if skills are to be maintained over time.

Ivey (1971) draws the conclusion that taken as a whole, these studies indicate the special importance of feedback, or seeing yourself as others see you, in microtraining. For microtraining to be maximally effective, several elements must be present. These include a model, especially a model of a prestigious figure such as a supervisor, feedback from self-observation and from a supervisor, and applied practice in a skill with reinforcement for successful performance of the skill.

Teaching other skills. There are other studies in which the microtraining structure has been used to teach

skills other than those of counselors, making apparent the effectiveness of the method across a wide variety of purposes.

In a well designed series of studies, Allen (1967) and Aubertine (1967) developed 18 microteaching skills. Microteaching is similar to microcounseling except that the teacher instructs a small group of students for a brief period of time. Their research efforts suggest that the microteaching structure helps teacher trainees to learn the skills by clearly identifying for the trainees a measurable skill, such as ability to increase student participation by reinforcement, by providing a model of the skill, practice in the skill while being videotaped, and feedback from watching the videotape accompanied by supervisor comments. Allen and Aubertine's research demonstrates the efficacy of the microtraining method by providing evidence that teacher trainees can improve in specific skills.

A study of special import to the present one involved teaching the skill of direct, mutual communication to volunteer couples (Higgins et al., 1970). This skill involves both listening to another person as he states his feelings on an issue, and also clearly expressing one's own feelings on this issue and being heard by one's partner. Sharing personal feelings could involve focusing on one's felt sense of his/her relationship with another person,

which would link the study to the present one, although focusing was not directly taught in the Higgins et al. study.

A programmed text was integrated with a videotape model depicting the skill. Higgins et al. developed a scale to assess the degree of direct mutual communication from the Affective Sensitivity Scale (Kagan & Krathwohl, 1967), a semantic-differential assessing such factors as emphasis on feelings. Judges rated videotaped segments of trainees' verbal interaction before and after training. Significant improvement was found in direct mutual communication. A limitation in the Higgins et al. study is that the trainees were paid volunteers, whose interactions may have been affected by the videotape equipment. Therefore, it cannot be known from this study whether the couples would have maintained their improved skills in direct, mutual communication in a more natural setting. Still, in the examples given the reader becomes aware of a shift in the couples' experiencing of a problem in a direction approaching that occurring in focusing. These couples were not mental patients, but the potential of the paradigm in helping clients to develop this sort of skill is seen.

Crowley and Ivey (1976) factor analyzed and studied word counts of the direct, mutual communication transcript of the Higgins et al. (1970) study. Two factors

markedly described people who had been trained: (a) increased use of affective words, and (b) increased use of personal pronouns. As we shall discuss in the section on experiential focusing, Gendlin (1964) theorizes that it is attending to felt meaning rather than emotional tonalities which results in a therapeutic process. Therefore, Crowley and Ivey's findings may reflect superficial aspects of the interpersonal process rather than the more concretely beneficial aspects of that process.

In a recent dissertation, Noel (1976) was successful in using systematic training in direct, mutual communication to train black and white high school students in this skill. She found that after training the students were better able to communicate their own feelings and to empathically understand their partner than before training in racially mixed dyads. She considered this to be a sharing of "experiencing" in Gendlin's sense of the word.

There are several problems with Noel's study. The most important problem is that she attempted to teach "experiencing" and interpersonal sharing of "experiencing" in the sense that Gendlin (1962) uses the term, but her discussion of the nature of experiencing does not appear to be accurate in Gendlin's sense. Noel describes "experiencing" as "...the flow of feeling present in all individuals at every moment" (p. 103), and consistently

describes experiencing in terms of feelings in a general sense rather than in terms of an individual's complexly meaningful felt sense of situations or problems in his/her life. This distinction will be considered more fully in the section on experiential focusing.

Other problems with Noel's study have to do with her experimental design. First, she lacked a control group, so her results may have been due to increased attention received by the subjects, or to the subjects merely knowing one another better from more contact with one another as the experiment progressed. Secondly, all of her subjects were volunteers, and perhaps felt more comfortable talking to an individual of another race even before the experiment. Finally, Noel used no conventional measures of experiential process, such as the Experiencing Scale or the Process Scale (Rogers et al., 1967). It is not clear that her instruments measured an experiential process as described by Gendlin (1969). Noel's instruments were instead either devised by her or adapted in a modified form from instruments used in previous microtraining studies. This lack of commonality with previous research in focusing tends to isolate her results and to make them less meaningful.

As another use for the microtraining approach, Gormally, Hill, Otis, and Rainey (1975) trained situationally nonassertive clients in assertive expression. They found that the microtraining format increased

self-rated and objectively rated assertiveness as compared with an insight-oriented counseling control. Although it might be pointed out that it was a very short time for insight-oriented counseling to have specific behavioral effect, and that the measure of success was specific behavior changes which would tend to differ from the more global goals an insight oriented therapist might work towards, the study is important in that it again shows the adaptability of the microtraining framework to a variety of potential skills.

Ivey (1974b) has suggested that skills of counselors could be taught to the general public. He cites as an example training married couples and families in attending skills, which has proven helpful for married couples, especially as effective listening skills tend to be absent in disturbed families. Ivey and Rollin (1972) used the microtraining framework to teach individuals some "skills of being people", including relaxation, attending behavior, nonverbal skills, decision making, and self-expression skills.

In summary, the microtraining framework has been used successfully in (a) teacher education, (b) teaching direct, mutual communication, and (c) training nonassertive college students in assertive expression. Although an attempt was made to teach "experiencing", it is more likely that direct, mutual communication was taught instead.

Now we shall examine the use of microtraining techniques with psychiatric patients.

Psychiatric patients. The final studies we shall consider are those involving the use of the microtraining structure in teaching skills to psychiatric inpatients. Since the present research involved teaching a specific skill, focusing, to psychiatric outpatients, these studies have special relevance.

Keil (1968) trained groups of mental patients in job interviewing skills using the microtraining framework. He used two four-hour training sessions. In the first session patients were presented with videotaped models of dress and appearance, appropriate mannerisms, and a way of explaining hospitalization and past history. The patients role-played possible ways of handling these situations. Suggestions were given to the patients on filling out application forms, and the patients were helped to consider their assets in relation to potential jobs.

In the second session, patients role-played job interviews and were given feedback on their positive and negative behaviors. They were reinforced for appropriate behavior by their trainer. As a result, some patients who had been judged as unemployable previously found jobs after training. It should be noted, however, that this was not a formal research program,

and lacked both formal evaluation and comparison to an untrained control group.

Another study directly related to the present research was conducted by Haase, Forsyth, Julius, and Lee (1969). They divided clients coming to a college counseling center into three groups. In the experimental group, the clients were trained in accurate expression of feelings before their first counseling interview. Haase et al. prepared a short training manual discussing the importance of being able to express feelings, and making a distinction between expression of feeling and expression of content. Haase et al. presented examples involving various topics (e.g., opinion of a teacher) and gave a model of expression of feeling and expression of content for each example. Next, Haase et al. asked the client to provide examples and to discriminate between expression of feeling and expression of content for the client's own examples, as a trainer provided feedback.

In one control group, clients were seen in a regular intake interview and in the other control group they had no intake interview. The trained group expressed more emotion as rated by judges in the first session of actual counseling compared to the control subjects. Further, the clients who were taught this skill of being a client tended to view their counseling more positively. The Haase et al. study appears to be a well designed study demonstrating the efficacy of the microtraining method in

teaching a specific skill. Focusing on a felt sense is different, however, than expression of emotion, as will be discussed in the section on focusing. Patients who were trained in the present study were psychiatric outpatients from a VA hospital rather than college students, and engaging in experiential focusing is more subtle than direct expression of feeling. Within these limitations there was reason to believe that the Haase et al. study portended success in the present training effort. In the client-centered framework, Truax and Carkhuff (1965) used tapes of "good" client behavior as a model for new clients and reported moderate gains from counseling as a result.

Donk (1972) adapted the microtraining framework to instruct hospitalized mental patients in the skill of attending behavior. Donk used the microtraining format to train pairs of psychiatric patients in the component skills of attending behavior, as described previously in the Ivey et al. (1968) study. Videotapes and typescripts were made of conversations of the experimental dyads and of control dyads who had not been trained. Ratings were made of the videotapes and typescripts. In addition, nurses from the patients' ward were asked to rate the patients' behavior on five scales. Each patient rated his partner on attending behavior. Results indicated that the trained group was rated as significantly better

on attending behavior than the control group. As compared to nontreatment controls, Donk's patients who had learned attending behavior demonstrated improved ward adjustment. The skills of attending behavior generalized to the patients' ward behavior. Again the success of the paradigm in teaching specific skills to mental patients is seen, and also generalization of the skill beyond the training setting.

Donk's results indicate that a simple skill can be taught to hospitalized psychiatric patients using micro-training. It might be argued that attending behavior would be of doubtful value in helping to improve a thinking disorder underlying schizophrenia, or that in general, it is unlikely that clinicians would bother to instruct patients in this skill. On the other hand, it seems that attending behavior could be useful as a goal for those involved in token economy wards, or for behaviorally oriented therapists to adopt.

Using the microtraining model as a method of psychotherapy with psychiatric inpatients has proven effective in several studies (Freiband & Rudman, cited in Ivey, 1971; Ivey, 1971, 1973) as have closely related techniques (Boyd & Sisney, 1967; Moore, Cherrell, & West, 1965; Rogers, 1968). In this model the patient is first videotaped in interaction with a counselor. Then they view the tape together and the patient sets goals for specific behaviors

he would like to change. At this point, manuals appropriate to the behavior are written and a model of the behavior to be learned is made. Then the skill is practiced until it is part of the patient's behavioral repertoire.

Within this paradigm, skills are taught one at a time. Skills selected have included changing body language, relaxation training, attending and listening skills, and expression of feeling. Ivey (1973) reports that training in one or more of these skills has been done with approximately 20 patients, with the training being the central treatment modality rather than another form of psychotherapy. The training has been successful in helping patients to learn the behaviors they wish to adopt. It was not assessed whether these skills were maintained outside of the hospital environment, however. Also there was no control group; thus it is possible that the effects were due to the attention received by the patients, and possibly the effects primarily stemmed from the relationship of the client with the therapist (Patterson, 1973).

Ivey suggests that with more regressed patients the treatment could be supplemented with concrete reinforcers, such as financial incentives or a token economy, and that smaller units of behavior change could be attempted. Ivey (1973) reported success with psychiatric inpatients,

including on the parameter of training some of them in expression of feelings. This behavioral skill begins to approach experiential focusing in that it has to do with feelings. A distinction must be made between "feelings" and a meaningful felt sense of a problem, however, as will be discussed in the next section.

Ivey and Gluckstern (1976) describe some of the implications of microtraining research. They state that each of the microtraining skills is based on research on the ability of trainees to demonstrate the specific behaviors after training. They suggest that if microtraining skills are to be retained: (a) trainees must be able to demonstrate the skill before they are considered trained, (b) trainees must be able to use the skills they have learned in settings outside of the laboratory (in this study, in psychotherapy), (c) whenever possible, followup training is helpful, and (d) measurement of behavior retention should relate to the learned skills.

Ivey (1971) has stated that microtraining systematically teaches a specific skill rather than relying on the trainee to acquire the skill in a trial and error fashion. Gendlin et al. (1968) suggest that typically focusing is not taught in psychotherapy. Perhaps this is because the client might typically have to learn it through trial and error in therapy. Direct instruction in focusing might be more successful.

Ivey and Gluckstern (1976) state that combinations of microcounseling with other programs, such as more traditional didactic approaches and more recent encounter approaches, could result in a more complete understanding of the helping process. It is hoped that the present study will be a step in that direction.

Overall then, microtraining shows promise in being useful towards teaching focusing, even for what might be considered a "difficult" population of clients, such as mental patients.

Experiential Focusing

In 1958, Carl Rogers set forth a conception of psychotherapy as enabling a client's manner of inner process to change as a result of the client's feeling warmly received by his psychotherapist. He developed the Process Scale to help make this psychological process observable. On the Process Scale, Rogers construed the person in therapy as moving from a state of fixity, rigid structure, and stasis to a state of changingness, flow, and process.

At the low end of the scale a rigid perception of the world and remoteness from experiencing are described as the client's psychological state. The client's psychological process is observably rigid, undifferentiated and impersonal, with feelings and personal meaning neither recognized nor owned. The client tends to communicate only

about things external to himself. The high end of the scale describes a psychological process in which new feelings are experienced with immediacy and richness of detail, these new feelings being trusted and used as a referent by the individual as he interprets new situations. The person trusts and accepts his feelings, and understands them quickly.

A quote from Rogers (1961) might help to illuminate the continuum:

The process involves a change in the manner of experiencing. The continuum begins with a fixity in which the individual is very remote from his experiencing and unable to draw upon or symbolize its implicit meaning. Experiencing must be safely in the past before a meaning can be drawn from it and the present is interpreted in terms of these past meanings. From this remoteness in relation to his experiencing the person moves toward the recognition of experiencing as a troubling process going on within him. Experiencing gradually becomes a more accepted inner referent to which he can turn for increasingly accurate meanings. Finally he becomes able to live freely and acceptantly in a fluid process in experiencing; using it comfortably as a major reference for his behavior. (p. 156-157)

Rogers' belief in 1958 was that reaching higher levels on the Process Scale was an effect of successful psychotherapy. Gendlin et al., (1968), going over tapes from the study on schizophrenics and earlier tapes from psychotherapy with neurotics, presented evidence demonstrating that if a sufficiently high level of process did not occur within the first three sessions the person would not improve in therapy. Improvement was assessed by therapist and

patient ratings of improvement and by Q-sorts of changes in self-concept for neurotic patients, and by the MMPI Sc Scale for schizophrenics. For neurotics, success was predicted if the patient's statements were rated an average of 4.0 or higher on the Experiencing Scale, indicating that the person was communicating what it was like to be him in terms of his feelings. For 12 schizophrenics success was predicted if the patient's utterances were rated 2.0 or higher on the Experiencing Scale, indicating ownership of a personal role in his narrative by the patient. Findings were less clear for predicting failure. Eleven of fifteen neurotic patients were designated failures who scored less than 3.0 on the Experiencing Scale, indicating lack of reference to feelings. Five of six schizophrenics rated below 1.75 on the Experiencing Scale were termed failures, indicating less use of personal reference than was used by schizophrenics designated as successes.

Gendlin et al. (1968) found that on the average neurotic clients who were more successful moved only a half scale point on the seven point Experiencing Scale during the course of therapy. Successful schizophrenic patients showed even less movement. From the above data, Gendlin et al. (1968) concluded that higher levels of experiential process were not an effect of, but a necessary pre-condition for successful therapy. The determination

that patients in psychotherapy do not tend to move towards a higher (more success-predicted) level of experiencing caused Gendlin et al. to make the strong statement that teaching of experiential focusing was the only apparent way to reach the majority of patients.

It might be argued that Gendlin et al.'s conclusion concerning the necessity of teaching experiential focusing was too strong a statement to make since it was based on so little data. Yet more than half of the clients (21 out of 38 neurotics and 6 out of 12 schizophrenics) had been classified as therapeutic failures, which would indicate the necessity of improving the nature of the therapeutic intervention. Further, use of the experiencing scale had indicated that the patient's experiential level at the beginning of therapy was predictive of success. This finding was well grounded in theory (Gendlin, 1962, 1964), and the data was taken from controlled studies of psychotherapy outcome. Thus, although the sheer number of cases may be small compared to large numbers which could be gathered in an artificial laboratory setting, Gendlin et al.'s conclusions seem reasonable in light of the fact that they are drawn from a practical, real setting.

Experiential theory. Gendlin (1962) has stated that each individual is aware of the world through his own subjective experience of his environment as he interacts with it. One's perception of the world, his interpretation

of it, and his decisions to act are grounded in this subjective awareness. In its broadest sense, "experiencing" refers to this subjective process (Gendlin, 1962). In a narrower sense, Gendlin (1962) refers to experiencing as involving a heightened awareness of one's complexly meaningful felt sense of some situation, personal relationship or other event in life. "Experiencing", as used by Gendlin, refers to "the process of concrete, bodily feeling, which constitutes the basic matter of psychological and personality phenomena" (Gendlin, 1964, p. 138). By "process", Gendlin means that experiencing is ongoing, as if in motion, rather than a container of entities which is unchanging. "Concrete, bodily feeling" refers to experiencing as being something real, something tangibly sensed by a person. Experiencing, one's inward bodily feeling or sensing, can always be directly referred to by a person turning his attention to it. As Gendlin uses the term, experiencing as it is happening in a person in a given moment is partly a result of that person's interaction with events in the present. Also is partly a result of his interaction with related events in the past, which to some extent predispose him to feel as he does in his current situation.

As experiencing occurs in psychotherapy, it is often first encountered by the client as something he feels, but cannot yet formulate clearly and explicitly. The

therapist, by responding to this felt sense, or experiencing, attempts to help the client to keep his attention on it, so that he may explore it until its meaning becomes clear to him. Rogers (1961) has described this process as he first became aware of it:

I would like to tell you of my fresh discovery of the way feelings "hit" clients--a word they frequently use. The client is talking about something of importance, when wham! he is hit by a feeling--not something named or labeled but an experiencing of an unknown something which has to be cautiously explored before it can be named at all. As one client says, "It's a feeling that I'm caught with. I can't even know what it connects with." (p. 129)

It is attending to this concretely felt but conceptually unclear awareness with which focusing is concerned (Gendlin et al., 1968). Paying attention to this bodily felt sense results in successful psychotherapy according to Gendlin and his associates.

To help clarify what is meant by experiencing, or felt sense, one might consider the following example. If a person were to picture in his/her mind's eye a person he/she knew well, but were to stop himself/herself from letting a stream of words come to him/her about the person, he/she could get a felt sense of what that person was like to him/her without using words to describe it.

After he/she succeeded in doing this, he/she could picture another person he/she knew, again attempting to gain a felt sense of this second person without using words to describe the person. He/she could try to feel

what all of the person was like to him/her, avoiding descriptive words. After he/she succeeded in doing this for the second person, he/she could compare his/her felt sense of the first person with his/her felt sense of the second person, without using words to do so. He/she could feel the difference in his/her felt sense of each of these two persons without labeling the difference.

If he/she were able to do this successfully, he/she would have some idea of what a concretely felt awareness is when there are no words to describe it. The felt sense is too "full" for any single adjective to completely describe it.

Another example might further clarify what is meant by this felt sense. When the author was teaching a woman to focus, and asked her to concentrate on a problem, she selected as a problem her angry feelings towards her husband. At first she concentrated on the anger, and typical streams of thoughts about why she was angry just seemed to intensify the anger. To help her to focus on a felt sense, she was instructed to stop this barrage of thoughts, and just to stay with her felt sense of the problem as a whole. She was instructed to keep this sense of anger, but in a less intense way--to get a more calmly experienced felt sense of the problem. She was asked to ignore words that might come and to again direct her attention on the felt sense. Eventually her

felt sense shifted. It became a sadness, and she recognized more clearly that the anger and the sadness were related to wanting things to be more like they had been at a better time in the past. This psychological process she went through describes a higher level of experiencing on Rogers' Process Scale. It is the kind of process which Gendlin et al. (1968) argue is necessary for successful psychotherapy to occur.

Examining what happened with her in more detail might further illuminate the specific aspects of this process. When she was first concentrating on her anger, a stream of typical thoughts about the anger came to her. Gendlin (1976) indicates that it is often necessary to stop this barrage of words several times and to redirect attention to the felt sense.

At first, her attention to the anger and to the words describing the anger caused the anger to intensify. Gendlin (1964) describes emotions as being like the winds in a hurricane, through which one must pass to get to the calm center in the eye of the hurricane. The eye, the felt sense, is part of the hurricane, but is much less intense. Centering one's attention on the emotion, the anger in this example, merely intensifies the emotion, without helping a person to better understand or resolve it (Gendlin, 1964). It is attending to the calmer felt sense of the problem as a whole which results in a

therapeutic process.

Gendlin (1964) states that one must stay with the felt sense for what subjectively feels like a very long time, even though it might be only 30 seconds or a minute before the felt sense will "give" or "shift" or "move." When this movement occurs the person can specify more clearly what the felt sense was about--the person can "symbolize" or name the feeling. Then the person will tend to see the situation or problem in a new light. This final interaction of the felt sense with symbols (e.g., words) identifies the meaning of the felt sense (Gendlin, 1964). The person's felt awareness becomes increasingly differentiated and specified--as when the feelings of the woman in the example became more finely differentiated, and her felt sense of her anger changed into a felt sense involving sadness. Then she could specify that the felt sense was about a loss of a better time she had had with her husband.

At this point the reader might like to refer to the Focusing Manual in Appendix A.

In the situation with her husband, the woman could have described the situation in an intellectualized or externalized manner. She could have intellectualized by describing various courses of action to take, such as activities she might have engaged in with her husband. Or, she might have externalized, by blaming her husband

instead of looking into herself. Neither intellectualization nor externalization would result in a relatively higher experiential psychotherapeutic process in the client, which would eventuate in successful outcome as measured by therapist and client ratings of success, self-concept Q-sorts, and the Sc Scale of the MMPI (Gendlin et al., 1968).

Experiential focusing as it occurs in psychotherapy consists of the client's referring inwardly to his/her ongoing experiential process and describing it as it is happening (Gendlin et al., 1968). The client's initial felt sense of a problem, before he/she can name or symbolize the felt sense, would correspond to what Gendlin (1962, 1964) would label implicit experiencing. Afterwards, the client would become able to use verbal symbols to accurately describe his/her felt sense, with words coming up from the feeling. This would correspond to what Gendlin labels explicit experiencing. As the client becomes able to accurately describe his/her felt sense, the felt sense will change slightly, and the client will feel relieved that he/she was able to describe it accurately. Gendlin would have the client refocus on this changed felt sense until it too became clear, and through this process the original feeling would become more and more differentiated as it was pursued (Gendlin, 1962).

The process of experiencing, and awareness of it, is

considered by Gendlin to be basic to psychotherapy (Gendlin, 1962, 1964). Successful clients in psychotherapy as measured by therapist and client ratings of success, self-concept Q-sorts, and the Sc Scale of the MMPI, are able to be aware of their experiencing, and are able to directly refer to this implicit, as yet unformulated experiencing, and then to describe it with symbols to make it explicit. This process is labeled "carrying forward" of experiencing by Gendlin.

Gendlin (1964) uses the example of hunger to help clarify "carrying forward." Implicit feelings are incomplete, in a way analogous to the felt sensation of muscle movement in one's stomach which a person would call hunger. "Hunger" is incomplete because although it "implies" something about eating, hunger does not contain eating in itself. Hunger is not "repressed" eating. Hunger does not contain within itself the steps going to the refrigerator, selecting food, cooking, eating, and digesting the food. Just as all these steps do not exist in the sensation of hunger, the "meaning" of hunger does not lie in the physical sensation by itself. The symbolization (or labeling) of "hunger", like other aspects of a person's search for food, is a learned step in the process of satisfying hunger which carries that process forward. Eating is hunger that has been carried forward and completed.

After labeling the physical sensation "hunger", a person could take steps to "carry forward" the hunger into eating. Analogously, by a person attending to his unclear felt sense (as in his stomach muscles churning) until the meaning of that felt sense became clear to him (the need for food) the person would be carrying forward the meaning inherent in the felt sense. The felt sense would take form and become clarified, and hence be different from what it was when it was still unclear, just as eating is different from hunger. Thus, the implicit, preconceptual bodily feeling is carried forward and changed as it becomes conceptually symbolized, or labeled. So long as a felt sense is implicit, it is incomplete, needing symbols such as words describing it to carry it forward and make the meaning of the felt sense explicit.

Carrying forward need not be only verbal explication; experiencing can be carried forward or symbolized by actions as well, just as hunger could be carried forward or completed by eating any of a variety of foods. An example of this would be a hug after an especially intense nonverbal communication exercise in an encounter group. Perhaps the two participants felt a vague need for an undefined something, and had previously not experienced the felt sense of warmly hugging another person and being fully accepted. Without verbalization, each individual could, by his actions (hugging), carry forward his

experiencing (gain a new meaningful feeling), and later be able to recapture the feeling of the hug and know that he was somehow different than he had been before the hug. So experiencing is seen to be carried forward and completed by both verbal symbolization and by actions which would be a nonverbal symbolization. Other events which one might encounter in his interacting with his environment (e.g., feedback), might also serve to symbolize implicit meanings and thereby carry them forward.

Note that by experiencing we are describing a feeling process, but it is one of felt meaning and the richness of bodily felt meanings rather than merely emotional tonalities, as this difference was described in the example of the woman's anger. An "emotional tonality" is different from a felt sense in that while a felt sense is complex, an emotion is all one quality. The woman's anger was an emotional tonality, whereas her felt sense of what was wrong in her relationship with her husband was complexly meaningful. By concentrating awareness on an emotional tonality, such as anger, the tonality would tend either to be unchanged or perhaps to increase. For example, if when asked to give your impression of this manuscript, you felt angry, and you were asked to concentrate your awareness on this anger, the anger might remain the same or increase slightly. But, if instead you were asked, "What's wrong, that you feel angry?", you could perhaps

describe your irritation at having one more tiresome task to clutter up your busy schedule, your desire for a vacation which is not forthcoming, and so forth. You would then be exploring the felt meaning implied in your experiencing.

This experiencing, or process of concrete, bodily feeling in interaction with symbols (which come up from the feeling and eventually name the feeling and carry it forward), is theorized by Gendlin (1962, 1964) to be continually a part of each person's living. So the question then becomes, if this is a basic, ongoing life process in human beings, what could happen that would make psychotherapy necessary to help carry it forward? Why would it not be ongoing in each person in such a way that it would obviate the need for psychotherapy?

The answer lies in the fact that human beings are basically beings in interaction, and that certain kinds of interactions can cause a person to become less aware of his ongoing experiencing. Gendlin (1973) considers human beings to be continually in interaction. We are in interaction with our physical environment (e.g., breathing) and with other people with whom we interact from birth (Gendlin, 1973). As children, certain aspects of our experiencing can become psychologically "frozen" as we try to live according to the values of others, and begin to interact with others in set ways which become automatic.

For example, if one finds that to avoid constantly emotionally painful interaction with one's parents one must consistently act in a withdrawn way when around them, then in future encounters of the child with his/her parents the child will tend to again become withdrawn. A routine behavioral pattern will be established in the child's way of relating to his/her parents. Instead of becoming aware of fresh aspects of his/her interaction with his/her parents the child will continue to consistently feel the same when confronted with his/her parents. This may, for example, then generalize to other authority figures, such as teachers, and the child may then act and feel withdrawn around teachers. To avoid painful feelings, the child avoids being aware of the experiencing or meaningful feelings he/she has around his/her parents and other authority figures. The child's experiencing in this area of authority will become remote to him/her, and would require an encounter with a person who would behave blatantly different with him/her, such as a warm and understanding therapist, to help the person become aware of his/her feelings towards authority and towards his/her parents, and to become aware of what these feelings mean to him/her (Gendlin, 1966a). When these set, or "frozen" ways of behaving and of avoiding one's meaningful feelings become pervasive in one's interactions with others, severe psychopathology such as schizophrenia may result.

As the person becomes increasingly isolated from other people the range of his/her experiencing or meaningful feelings about other people is correspondingly narrowed, and he/she doesn't learn to interpret and find meaning in the missed life situations because he/she has never lived through them and thus never had an opportunity to experience these normal life situations nor to find meaning in them. Thus, psychopathology is seen to be a manner of process that can happen to anyone. Rather than some sort of pathological contents, psychopathology is a pathological process (Gendlin, 1964). Psychotherapy is then seen as an attempt to help change this manner of process.

Psychotherapy involves helping an individual to become aware of his experiencing, and to help him/her to carry it forward through symbolization (Gendlin, 1964). Although some aspects of an individual's experiencing have become frozen and remote from his/her awareness, Gendlin (1964) theorizes that experiencing is never entirely frozen, or lost to awareness, that to some extent experiencing is ongoing in each person. The therapist's job is thus to help the person to become aware of what experiencing is ongoing in him/her and to help him/her to carry it forward. The therapist helps a client to carry forward his/her experiencing by helping the person to turn his/her attention to his/her concretely felt but

conceptually unclear experiencing, and to attend to this experiencing, helping the client attempt to describe it until the meaning of the experiencing becomes clear to the client. Then the client will tend to see a broad array of applications for his/her new awareness in his/her life. He/she will tend to see many of his/her life situations in a somewhat new light. A new felt sense will then evolve, and the therapist will help the client to attend to this new felt sense.

The client's experiencing is carried forward in small steps, in a direction Gendlin considers to be inherent in the experiencing, much as eating is inherent in hunger as the only way that hunger can be satisfied. When the experiencing is carried forward, it may include some aspect of the individual's interactive life which was frozen. For example, as the individual perhaps becomes increasingly able to be aware of his relationship with his/her therapist, the nature of the therapeutic relationship may change. The client may be able to experience increasing feelings of warmth for the therapist, and may become increasingly aware of them. As he/she verbally symbolizes and describes these feelings, he/she may then become aware that it would be possible to risk these warm feelings with other persons. The symbolization will have carried forward the experiencing, helping the client to become more aware of the richness of detail in the specific

encounters with his/her therapist and then with other people. His/her experiencing becomes an ever-widening process; the client becomes increasingly aware of his/her experiencing and better able to carry it forward.

Research has shown that for individuals able to be aware of and to articulate their experiencing, psychotherapy tends to be successful (Gendlin et al., 1968). Some clients in psychotherapy do not engage in an experiential process in psychotherapy. Gendlin et al. do not indicate why some clients engage in focusing in therapy while others do not. They state that apparently this is not related to level of adjustment, as was once thought. It might be speculated that skill in focusing, as is the case with many other skills, is normally distributed in the population and perhaps learned. Some individuals would then be able to engage in focusing more readily than others. Gendlin et al. state that typically therapists of clients unable to focus are unable to teach this manner of process to their clients. Gendlin et al. suggest that this may be because psychotherapists have not known how to positively identify the nature of the process in psychotherapy eventuating in successful outcome. Therefore, therapists have not known exactly what manner of process to attempt to teach to clients. It was to help clients engage in a therapeutic experiential process that Gendlin and his associates (1968, 1969) developed the Focusing Manual, to

teach this manner of experiencing directly.

In the instructions on experiential focusing, the client is first asked to stop talking silently to himself/herself. This helps him/her to avoid frozen, typical ways he/she tends to interact with himself/herself. He/she is asked to shift his/her awareness to his/her "feelings"--to his/her bodily felt awareness of himself/herself. He/she is asked to let himself/herself feel this and to concentrate on the feeling, to "focus" on it. If words or images come to him/her, he/she is asked to ignore them and to stay with the feeling unless some of the words or images have an "experiential effect", that is unless the words intensify the feeling, or change it, or cause it to shift. A central aspect of the feeling, the "crux" of the feeling, will emerge and the person is asked to follow this crux, to stay with it. Again, he/she is asked to let words and images go by unless they have an experiential effect. If the client were to find words emerging which exactly described the feeling, these words would have an experiential effect, and would carry forward his/her experiencing.

In therapy, the therapist would try to respond to this new felt meaning, and then to let the person freshly focus, thus engendering a process of focusing on concretely felt but conceptually unclear awareness, and then explicating the awareness and carrying it forward (Gendlin.

1969). That therapists can theoretically teach experiential focusing to clients implies that some individuals lack the skill because they have not had the opportunity to learn it.

The experiential process represented by focusing, theoretically vital to psychotherapy and hopefully teachable through instruction in focusing, is the concern of the present study. In order to place the present study in the broader context of directly relevant research, we shall next examine other studies concerning the experiential process and those concerning focusing in particular.

Research on experiencing and focusing. As client-centered theory moved from observing content variables in therapy towards formulating process variables, previous client-centered research on psychotherapy was reexamined in light of process variables related to experiencing (Gendlin, Jenney, & Shlien, 1960). The investigators formulated scales based on questions which included, "How important to the client is the relationship as a source of new experience?" and "To what extent does the client express his feelings, and to what extent does he rather talk about them?" These scales, which concerned the client's manner of experiencing, correlated with success in psychotherapy as assessed by therapist ratings of success. This study might be criticized in that the therapist's assessment of success may not correlate well with either the client's assessment of success or assessment of success

by an outside rater (Rogers et al., 1967). Nevertheless, the Gendlin, Jenney, and Shlien study represents an early attempt at reformulating content variables into process variables of psychotherapy, and was therefore based on an influential developing theoretical framework (Gendlin, 1957, Rogers, 1958).

In a series of studies either the Process Scale, or the related Experiencing Scale, was applied to tape recordings of neurotic clients (Tomlinson, 1959, 1962; Tomlinson & Hart, 1962; Walker, Rablen, & Rogers, 1959). The common finding of these studies was that more successful clients, as measured by therapist ratings of outcome, patient ratings of outcome, and self-concept Q-sort, were judged as functioning at significantly higher levels on these scales both early and late in psychotherapy. Therefore, these scales measured an experiential manner of client behavior which was related to a successful outcome in psychotherapy (Gendlin et al., 1968).

Further studies on experiential level in psychotherapy have shown higher experiential levels to be related to more successful outcome of treatment (Gendlin, 1966b; Rogers et al., 1967). Gendlin and Tomlinson (1967) tape recorded and analyzed psychotherapeutic interviews on the Experiencing Scale. They found failure on the

outcome measures (therapist's ratings, patient's own rating, and psychometric instruments) to be highly correlated with low experiential level during interviews. High experiential level during interviews was significantly correlated with positive outcome.

As Gendlin et al. (1968) point out, outcome must be assessed independently of the measures of in-therapy experiential process. In the earlier studies in which neurotic clients' levels of process were assessed and related to outcome, the judgments of levels of experiential process came from tape recorded interviews. Outcome had been assessed in previous studies on the same data, in which variables considered by the researchers had nothing to do with experiential level. Rather, the previous researchers were considering such issues as therapist facilitative conditions in relation to outcome.

In the studies reported in Rogers and Dymond (1954), for example, measures included self-reports made by the clients' counselor ratings of client success, judgments of "outside" individuals (such as a friend of the client), projective tests scored "blind" by a psychodiagnostician, TAT ratings, correlations of perceived self--ideal self-Q-sorts, MMPI scale scores, sentence completion, and scales such as "adequacy of contentedness of relationships with others" and "energy deployment over courses of action."

The Tomlinson and Hart study might be criticized in

that it used only the three measures, of therapist rating of outcome, client rating of outcome, and self-concept Q-sort, rather than considering all of the measures available on the neurotic clients. The different measures of outcome did not correlate well with one another, however, so choice of which outcome measures to use had to be made. This is a concession necessary in pursuing research in a practical setting, although it does tend to make the results less definitive.

Later studies relating process to outcome also involved a variety of measures of outcome. In the Rogers et al. (1967) Wisconsin study on schizophrenics, some of the measures used included time out of the hospital, MMPI profiles, correlation of self--expert judgment of adjustment Q-sorts, assessment of Rorschach protocols, therapist rating of outcome, Wittenborn Psychiatric Rating Scales, and the WAIS. Gendlin et al. (1968) refer to the Sc Scale of the MMPI as the outcome measure relating to experiential level for these patients. Again, outcome differed depending on the measurement used, making choice of outcome assessment necessary.

It may be that no relationship would have been found between experiential level and outcome measures other than the Sc Scale of the MMPI. Gendlin et al., for example, simply state that assessment of outcome varied with the measure selected, and that the measure of psychotherapy

outcome that they chose, the Sc Scale, did relate to experiential level.

To summarize, psychotherapy outcome results do tend to differ, which leads to ambiguity and the necessity for making value judgments as to which measure a researcher weighs most heavily. Several studies have shown that experiential level is correlated with outcome on at least some of these measures. The consistency of these results lends credibility to them, and makes the relationship between experiential level and outcome worthy of further investigation.

It might be noted that Gendlin (1968, 1973) views higher experiential level in the client as being necessary for improvement in all psychotherapy. Rogers (1961) takes the most conservative position that level of experiential process probably relates to successful therapy outcome only in psychotherapy emphasizing affective aspects of a client's behavior. Despite Gendlin's (1973) elegant theoretical scheme indicating that behavioral and cognitive orientations may be effective because of their effect on client's experiential process, data providing evidence for this assertion is lacking. Rogers' formulation may be more accurate.

Gendlin et al. (1968) correlated the Post-Focusing Questionnaire (a measure of experiential focusing, see Appendix B) with Cattell's High School Personality

Questionnaire. For the 47 high school students participating in the study, the investigators found significant correlations between the focusing measure and a variety of personality factors. Students high in focusing ability were found to be more intelligent, abstract thinkers, bright, controlled, socially precise, self-disciplined, compulsive, effective leaders, steady, conscientious, persevering, staid, rule-bound, good organizers of thought, persistent; deliberate, not restless, not impulsive; sober, prudent, serious, taciturn, secretive, daydreamers, not extrovert, not to have mood swings, tenderminded, dependent, sensitive; emotionally stable, people who faced reality, calm; relaxed, unfrustrated, not irrationally worried and tense; not overfatigued by excitement, not lonely, not autistic.

Gendlin et al. contended that these correlations implied that focusing as measured was a meaningful variable, since focusing was shown to relate to complex personality variables. Focusing ability did not correlate with Cattell's adjustment score. This lack of correlation may be a consequence of the subject pool, high school students, on whom there was no evidence presented which indicated some were maladjusted. Gendlin et al. suggest on the basis of the lack of correlation that high experiential ability may not relate to adjustment, but is still evidently necessary to move from maladjustment to

adjustment in psychotherapy as seen in the relationship of experiential level to the various measures of outcome already discussed. In general terms, those who were initially good at focusing were individuals who, on the personality measure, had greater access to affective material, greater awareness of environmental contingencies, and less anxiety than nonfocusers.

Although Gendlin et al. found no correlation between adjustment and focusing ability, the blanket statement that these two variables are unrelated might be questioned. First, Gendlin et al.'s sample consisted of "normal" high school students. Second, Gendlin et al. (1968) present data showing experiential level for neurotic and schizophrenic psychotherapy cases, from which the opposite conclusion could be drawn. The average level for neurotic patients was 3.18, and for schizophrenic patients only 1.77, taking into account ratings both early and late in psychotherapy. Further, VandenBos (1973) found that lack of psychopathology as measured by the Hutt Adaptation of the Bender-Gestalt test was significantly correlated with the ability of his nonfocusing normal college undergraduate students to learn focusing under one of his training conditions. Thus, it seems likely that adjustment could be related to experiential level.

Gendlin et al. (1968) also studied the relationship between focusing ability and creativity as measured by

the Hidden Figures Test with 22 college sophomores. They found focusing ability to be related with ability to do well on the Hidden Figures Test. This study might be criticized in that Gendlin et al. chose to dichotomize data from which they had a continuous range of scores on each variable, and to use a chi-square statistic on the data, rather than a Pearson correlation ratio. Perhaps the latter method would not have yielded a significant correlation. Still, Gendlin et al.'s reconceptualization of creativity from a negative view (letting go of given constructs), to a positive view (the ability to pay attention to conceptually vague but concretely felt impressions), appears to be a step forward in theory on creativity.

A line of research indicating differences between focusers and nonfocusers involved perceptual task performance. Richert (1968) found that focusing ability was negatively correlated with ability to accurately estimate a 10-second time interval. Drury (1969) found focusers to be more field-dependent on the Rod-Frame Test. Since these findings were unexpected, as it was assumed that focusers would be more perceptive than nonfocusers, Wolf (1970) re-analyzed the data from these two experiments. He found that in each case the negative relationship between perceptual performance and focusing ability was a function of the first trial on each of the tasks. In

each experiment, the focusers significantly altered their performance after the first trial. On the second trial, focusers and nonfocusers were comparable in their performance.

VandenBos (1970), further examining the distribution of scores on the initial series of trials in Drury's study, found nonfocusers to have extreme scores--strongly field dependent or strongly field independent. The focusers all clustered in the field independent direction, but not as extremely as the nonfocusers. VandenBos concluded that the findings suggested that focusers tend to function in a less rigid manner than nonfocusers, responding to more sources of stimulation. Further, he concluded that focusers appear to be able to more readily alter their behavior to fit the situation upon their examining of their performance in that situation.

Consistent with the finding of Gendlin et al. (1968) that focusers have greater access to affective material was Drury's (1969) finding that focusers made significantly more references to emotion in TAT stories than nonfocusers. Platt (1971) found that focusers describe themselves as "sensitive" more frequently than nonfocusers. That focusers see themselves as more sensitive, and that they appear to have greater awareness of emotions, could be taken as further evidence that focusers have a better level of psychological adjustment than nonfocusers.

Rogers' (1961) view of the fully functioning person is of a person who is aware of his/her feelings and who is able to experience his/her feelings fully.

Several studies have found no significant differences between focusers and nonfocusers on various measures of introversion-extroversion, including the Cattell Introvert/Extrovert Scale, the Rotter I-E Scale, the Eysenck I-E Scale, the the Myer-Briggs I-E Scale (Gendlin et al., 1968; Platt, 1971; VandenBos & Miller, 1970, 1971). This was an unexpected finding, since focusers were assumed to be more introverted, as they seem to focus on internal aspects of themselves more readily. One speculation as to why there would be this lack of difference between focusers and nonfocusers on introversion and extroversion is based on the manner in which focusing ability is assessed. The Focusing Manual, which was initially intended to teach focusing, always precedes measurement of focusing ability by the Post-Focusing Questionnaire and the Post-Focusing Checklist. The Focusing Manual directs an individual to turn his/her attention to his/her ongoing experiencing. Thus even if an extrovert would not tend to turn his/her attention inwards as his/her first inclination, the Focusing Manual would be directing him/her to do so. Because of the manner in which focusing is presently assessed, it is impossible to differentiate between those individuals who could readily focus before exposure to the

Focusing Manual, and those individuals who learned to focus as a result of following the directions in the Focusing Manual. Therefore, differences between introverts and extroverts in focusing ability would tend to be obscured because of the method of assessing focusing ability.

Another obscuring factor would be that introverts may prefer to look inward first, but are capable of directing attention to outward sources of stimulation. Similarly, extroverts may prefer to direct their attention outward at first, but are still capable of directing attention inward. Introversion-extroversion might be viewed as a preference rather than as an indicator of level of skill in looking inward or outward. Thus an extrovert could be expected to have some level of skill in an introspective activity like focusing even if he/she would normally tend to direct attention outward.

VandenBos and Miller (1971) found focusers to differ significantly from nonfocusers on the sensing-intuition dimension of the Myers-Briggs Type Indicator Scale. High focusing ability was related to intuition (utilization of unconscious processes) whereas low focusing ability was related to sensing (utilization of perceived object as "what it is" and nothing else). VandenBos and Miller suggest that this implies that focusers tend to be more flexible than nonfocusers, focusers utilize more sources

of stimulation, and that focusers use more remote association. A problem with the VandenBos and Miller study, however, is that although the Post-Focusing Questionnaire was administered, data from it was not used in the study. Only results from the Post-Focusing Checklist were used. Since the checklist has been less widely used in research, results from the questionnaire should have been used to help corroborate classification of focusers and nonfocusers. Had the questionnaire data been included, the results may have been different. This criticism is mitigated somewhat in that the checklist was used with a college population, upon which the instrument was standardized.

Another study supporting the contention that focusers make more use of unconscious or preconscious processes is provided by Miller (1970). He had two raters score 50 Rorschachs from unselected hospitalized schizophrenics using Holt's scoring system for "ability to regress in the service of the ego." He found that all the focusers in his sample were adaptive regressors: That is, they were able to handle effectively primitive material and benefit from exposure to it. Nonfocusers were evenly distributed between adaptive and maladaptive regressors. It appears from this that some schizophrenics were able to focus, which would be consistent with Gendlin et al.'s (1968) contention that adjustment is unrelated to focusing

ability. Those schizophrenics who were focusers did consistently score as adaptive regressors, however, perhaps indicating a better level of psychological adjustment. Further, since medication is not discussed, it cannot be ruled out that medication may have affected ability to focus, and/or ability to adaptively regress.

In summary, focusers, as compared to nonfocusers, tend to have (a) greater openness to affective material, (b) more flexibility in altering their perceptions when given feedback as to the accuracy of those perceptions (c) less anxiety, (d) more creativity, (e) more openness to their unconscious process. There is an uncertain relationship of focusing to psychological adjustment, with Gendlin et al. (1968) contending that focusing and adjustment are unrelated. Finally, there is a problem in the measurement of focusing in that its measurement involves use of the Focusing Manual. The Focusing Manual may teach some individuals to focus who would not be seen as focusers if native focusing ability could somehow be assessed without use of the manual.

Studies on focusing training. An attempt was made by Hyman (1970) to evaluate the effect of focusing training on the level of experiencing of 94 volunteers. Each subject was first asked to write eight to ten sentences about a current interpersonal difficulty. In the next phase of the study, three treatment conditions were used:

(a) Presentation of the Focusing Manual, (b) thinking about the "problem" by looking for a new perspective, and (c) mathematical problem solving. In the third phase subjects were again asked to write eight to ten sentences about a current (the same or different) interpersonal difficulty. Finally, all subjects completed the Post-Focusing Questionnaire. The pre- and posttreatment descriptions of interpersonal difficulty were scored using Gendlin, Tomlinson, Mathieu, and Klein's Scale for the Rating of Experiencing (Rogers et al., 1967). No significant differences in level of experiencing were found. The entire experiment took only an hour, however, with the only training in focusing being the Focusing Manual. The Post-Focusing Questionnaire was not even considered in the analysis. It might be concluded from this study that use of the Focusing Manual alone is a questionable way of teaching focusing, but even this conclusion is tenuous, since the analysis did not include the available data from the direct measure of focusing.

Platt (1971) compared the effectiveness of three methods of teaching focusing. His subjects were 120 undergraduate college students. The first teaching method was five exposures to the Focusing Manual, which was ineffective. The second method had two subparts, both involving hypnosis--focusing under hypnosis and focusing immediately after hypnosis. Neither had any significant

effect on focusing ability. The third group, involving didactic training with suggestion of success, did manifest a significant increase in focusing ability. The training for this group involved discussion of the Focusing Manual, especially parts of it which were confusing to the subjects, and the suggestion that on the third experience with focusing people usually were able to focus well. This study suggests that focusing can be taught to normal subjects when the Focusing Manual is supplemented by other techniques. Since both focusers and nonfocusers were used in this study, and the analysis considered each treatment group as a whole rather than nonfocusers alone, changes in the groups trained by the first two methods may have been obscured. It might be noted that the finding that hypnosis was not helpful in teaching focusing is consistent with Gendlin's (1966a) statement that in psychotherapy hypnosis would cause a person to less fully interact with his therapist, and that in successful psychotherapy the client needs to be alert and fully involved to gain maximum benefit.

Using techniques going beyond use of the Focusing Manual alone, VandenBos (1973) was successful in teaching focusing to volunteer college students who were identified by the Post-Focusing Checklist as nonfocusers. Half of his 64 subjects were male and half female. VandenBos combined scores from three tests assumed to be related to

focusing ability to get an "index" of potential to learn focusing. Attributes measured included associative ability as measured by the Remote Associates Test, openness to affect as measured by the TAT, and psychopathology as assessed by the Hutt Adaptation of the Bender-Gestalt test. Subjects assigned to treatment groups were matched on his "index" of potential to learn focusing, with half of the subjects in each group being male and half female. Twelve subjects were assigned to each of his three training groups, and sixteen subjects were assigned to his control group. Within each of the three experimental groups, two training sessions were conducted.

VandenBos' first training method, "affective association training", involved having the subject describe a conflictual situation which he might encounter, and then describing various emotional reactions that a person might have in such a situation. Subjects were encouraged to consider as many emotional reactions as possible, with the trainer adding any obvious possibilities not mentioned by the subject. Then the subject was asked to describe concrete ways in which one would bodily experience each emotional response. Finally, the trainer had the subject imagine experiencing two or more conflicting affective responses simultaneously, and this was explained to be what was meant by feeling "all of the problem."

VandenBos' second training method, "partial desensitization", involved the trainer asking the subject to describe a situation which the subject found troubling. The trainer and subject constructed a hierarchy of four similar and increasingly stressful situations based on the one described by the subject. The trainer then briefly explained systematic desensitization and spent five minutes teaching deep muscle relaxation. The subject spent an hour going through desensitization on the four situations, and then was instructed to focus on the most stressful one utilizing the instructions from the Focusing Manual.

Vandenbos' third training method, "standard focusing training", consisted of the trainer elaborating on the nature of focusing, and answering questions raised by subjects, based on the subjects' experience in following the instructions in the Focusing Manual. This was followed by the subjects focusing according to the instructions in the manual.

The remaining 16 subjects were assigned to the control group, and received no training beyond what they might have learned in the initial focusing assessment. After several weeks, their focusing was reassessed.

The three groups receiving focusing training demonstrated significant increases in focusing ability over those shown by the control group. Differences between

subjects in the three training methods were not statistically significant. No significant differences in post-training ability to focus were found between subjects identified as having a high or low potential to learn focusing, nor between sexes.

Although VandenBos had his subjects fill out the Post-Focusing Questionnaire before answering the Post-Focusing Checklist, only the checklist scores were used in his results. Considering that the Post-Focusing Questionnaire is used far more often in research on focusing, this was a dubious procedure. Possibly his nonfocusers would have been rated focusers on the questionnaire, or possibly changes would not have been identified had the questionnaire been used.

Perhaps the most important problem with the study is that VandenBos included only normal subjects and screened out individuals evidencing psychopathology. It was in the context of psychotherapy that the need for increasing patients' experiential level was found. A study in which training was conducted to increase the focusing ability of subjects in psychotherapy would have been more meaningful.

We can use the three studies of Hyman, Platt, and VandenBos to conclude: (a) Focusing can be taught to normal subjects, (b) use of the Focusing Manual alone is a questionable way of doing it, and (c) even when the

Focusing Manual is supplemented by other techniques (e.g., suggestion and didactic training), it is still unknown whether severely disturbed patients are able to learn focusing from training in it. The present study is directed towards an examination of the possibility that these patients can benefit from focusing training.

Schizophrenic Deficit

Although the microtraining method has been successful in teaching many specific skills to individuals, including schizophrenics (Ivey, 1971), there is reason to believe that schizophrenics could manifest impaired performance in learning focusing. In a comprehensive review of the literature on thought disorder in schizophrenia, Chapman and Chapman (1973) have indicated that schizophrenics tend to show performance deficits on most tasks in which they are compared to "normal" subjects. Learning the skills of focusing might be one of these tasks.

Psychotherapy research. Reviewing the literature on psychotherapy with schizophrenics one can find evidence suggesting that schizophrenics often tend not to profit from psychotherapy (May, 1975). This could be taken as an indication that schizophrenic patients do not readily learn the skills necessary to profit from psychotherapy.

Phillip May has reviewed many of the recent studies concerning the effectiveness of psychotherapy with

schizophrenic patients, and has evaluated them in terms of their adequacy of design. A consideration of the studies which he considered well designed should help to demonstrate the difficulty of conducting successful psychotherapy with schizophrenics. "Success" generally indicates such aspects of the schizophrenic patient's adjustment as degree of withdrawal, work record, living situation, and duration of hospital stay (Pokorny & Fabish, 1968).

May (1975) indicates that there is little difference between psychotherapy plus drugs and drug therapy alone for hospitalized schizophrenic patients. Both treatment conditions, however, are superior to psychotherapy alone. May states that there is no well designed study in which psychotherapy with drugs has been more effective than a control in dealing with schizophrenic inpatients. He defines a well designed study as one in which (a) there are equivalent control groups, with random assignment of subjects, (b) treatments such as drug therapy, when not part of the experimental condition, are controlled, (c) evaluation is comprehensive, and (d) N is adequate (preferably with 24 or more in each group) or outcome evaluation is limited in scope.

Previously, May (1968) found that there was no difference between drug-free patients receiving milieu treatment alone and those receiving milieu treatment plus psychotherapy. Psychotherapy was given an average of

two times a week for a minimum of six months unless the patient had been successfully released earlier. May's outcome measure included co-varied scores for hospital stay, release rate, nurses' and therapists' ratings, and assessment by two independent raters.

O'Brien, Hamm, Ray, Pierce, Luborsky, and Mintz (1972) studied schizophrenics discharged to outpatient care and randomly assigned to group therapy and individual therapy. All patients were on drugs, though two were discontinued later because they were doing well. Based on social effectiveness and psychiatric rating scales, patients in group therapy did significantly better at 12 and 24 months, though rehospitalization rates were not significantly different. O'Brien et al. speculated that patients in group therapy may have been more reliable in taking drugs, since there was considerable pressure to take medications as prescribed.

May severely criticized the studies by Karon and his associates (Karon & O'Grady, 1969; Karon & VandenBos, 1970, 1972) which indicated that experienced psychotherapists obtained more improvement than inexperienced therapists in thought disorder and less rehospitalization, whether or not drugs were used. Criticisms of the studies included (a) lack of random assignment of patients to therapists, (b) small number of experienced therapists in the study (2), (c) use of subjects unresponsive to

medication who probably were biased against drug therapy, and (d) inappropriate statistical analysis.

Luborsky, Chandler, Auerback, Cohen, and Bachrach (1971), in a review of psychotherapy of adult outpatients, listed seven studies showing that psychotics do worse in therapy than other patients, with no studies indicating otherwise. It should be noted that they included studies of poor design in their review.

The lack of success in treating schizophrenics with psychotherapy, however, may be a function of their inability to learn certain tasks. Although psychotherapy is widely practiced with schizophrenics--thereby prompting the study of parameters such as focusing ability which might make the endeavor more successful--it might be concluded simply on the basis of the accepted theories of schizophrenic deficit that teaching schizophrenics skills helpful in psychotherapy would be an unfruitful task.

Schizophrenic thought disorder. Considerations of schizophrenic deficit are based on the primary symptom upon which the diagnosis is made, that is, disordered thinking (Chapman & Chapman, 1973). More specifically Bleuler (1911), originator of the term "schizophrenia", described the underlying disorder that accounted for the symptoms of schizophrenia as being a disturbance of associations. By this he meant an isolation of ideas from one another without connective "threads." Instead of

being able to choose ideas relating to his purpose while excluding irrelevant ideas, according to the demands of a situation, the schizophrenic would express himself using less appropriate meanings of words. As the schizophrenic's associative threads would become broken, his ideas would become isolated from one another, and he would entertain logically incompatible notions.

Many investigations have shown that schizophrenics as a group give more uncommon responses than normal persons (Deering, 1963; Dokecki, Polidoro, & Cromwell, 1965; Johnson, Weiss, & Zelhart, 1964; Kent & Rosanoff, 1910; Moran, Mefferd, & Kimbel, 1964; Murphy, 1923; Rappaport, Gill, & Shafer, 1945; Rawlings, 1921; Shakow & Jellinek, 1965; Sommer, Dewar, & Osmond, 1960; Sommer, Witney, & Osmond, 1962). On the other hand O'Brian and Weingartner (1970) suggested that on a word association test, even a normal subject's uncommon associations increase as a response to transient conditions, such as anxiety and prior set in approaching the task. Idiosyncratic association on this type of task may then not reflect a permanent associative disorder. Furthermore, Moon, Mefferd, Wieland, Pokorny, and Falconer (1968) found that schizophrenics with normal learning mishear a stimulus word more often than nonschizophrenics, which Moon et al. attributed to a defect in the ability to attend selectively to stimulus words. Finally, Moran,

Mefferd, and Kimbel (1964) found that schizophrenics used the same types of clusters of associations as normals, and concluded that the associational structure in schizophrenics is not aberrant. Others have also found that schizophrenics sample from an associational repertoire much the same as that of matched normals (Cohen & Camhi, 1967; Fuller & Kates, 1969; O'Brian & Weingartner, 1970).

It can be noted from this evidence that schizophrenic associative threads do not necessarily appear to break in the goal-related tasks used in some studies. Despite conflicting research findings, Bleuler's theory has served as a precursor for other theories, such as Chapman and Chapman's (1973) formulation concerning which associative threads become broken and which remain intact.

Accentuation of normal response bias. Chapman and Chapman (1973) provide evidence that schizophrenic thinking involves an excessive yielding to biases common to normal individuals. That is, a schizophrenic will replace an appropriate response with one with which a normal person might respond if a task were demanding enough to elicit a mistake, or if he didn't know the correct answer.

Chapman and Chapman list some normal biases:

- (1) Strength of stimulus: One tends to respond to stimuli that are strong rather than to those that are weak....
- (2) Recency of stimulus: One responds more readily to stimuli that have occurred recently than to those that have occurred in the more distant past....
- (3) Novelty of stimulus: In situations in which most stimuli are familiar, one tends to respond

to the novel stimuli. (4) Familiarity of stimulus: In a situation in which most stimuli are unfamiliar... one tends to respond to the more familiar stimulus... (5) Similarity of stimuli: In problem solving, a person is likely to respond to an object or word that is similar to the one he is already considering. (p. 121)

This tendency to substitute normal associates for appropriate responses has been demonstrated in a variety of tasks (Blumberg & Giller, 1965; Boland & Chapman, 1971; Burstein, 1964; Chapman, 1958; Chapman & Chapman, 1973; Craig, 1967; Downing, Ebert, & Shubrooks, 1963a, 1963b; Downing, Shubrooks, & Ebert, 1966; Feinbert & Mercer, 1960; Gonen, 1970; Maher, McLean, & McLaughlin, 1966; Rattan & Chapman, 1973). The Chapman (1958) study, for example, had both normal and schizophrenic subjects choose an alternative word in the same conceptual class as a stimulus word. There was a correct alternative (e.g., "Steel" for the stimulus "Gold"), an incorrect alternative which was associated with the stimulus word (e.g., "Fish"), and an irrelevant alternative to check for random responding (e.g., "Typewriter"). On some items the incorrect alternatives were strongly associated with the stimulus word (something that would come to mind right away) and on others weakly associated (something that would come to mind after several more common associations). There were both easy and hard concepts across the association conditions. Associative errors of both normals and schizophrenics increased, but the errors of schizophrenics

increased much more than those of normal subjects. Errors of both normals and schizophrenics in the strong associative alternative condition were almost entirely choices of the associative alternatives rather than the irrelevant alternatives. Since this happened with both groups it shows that the increased errors with schizophrenics could be considered an accentuation of the same types of errors committed by normals--a normal response bias. Other studies have had similar findings (Feinbert & Mercer, 1960; Gonen, 1970).

A problem with the Chapman (1958) study is that since both normals and schizophrenics made more errors on the task with associative distractors, the greater number of errors made by schizophrenic subjects may have reflected a general schizophrenic deficit, rather than the specific deficit of accentuation of normal response bias which was predicted.

Rattan and Chapman (1973) believed they were able to rule out the possibility that the schizophrenic group did more poorly simply because of a generalized deficit. They developed two tests--one like that in the Chapman (1958) study and the other similar but with two irrelevant alternatives and no associative distractor. Normal subjects attained similar scores on both forms of the test, which indicates that the tests were matched on discriminating power. Schizophrenic subjects were less

accurate on the test with associative distractors. Greater errors with distracting associates is again evidence of accentuated normal response bias. Since the schizophrenics were matched with a group of dull-normal subjects, and the tests were matched on discriminating power, these results could not be attributed to a generalized schizophrenic deficit but instead supported the specific prediction of accentuation of normal response bias.

Miller and Chapman (1968) did a study of two aspects of schizophrenic beliefs which are accentuations of normal response biases. The first belief was the "halo effect" for example, making an erroneous judgment about a person on the basis of one's general beliefs about that person. The second was "logical error"--judging two things to be related that are not related because it seems reasonable to the person that they would be related. Both schizophrenics and normals were found to make these types of logical errors, with schizophrenics making significantly more of them. Again the schizophrenics were matched with a group of dull normals, and the tests were matched on discriminating power. So the differences found could be attributed to accentuation of normal response bias rather than generalized schizophrenic deficit.

Chapman and his co-workers (Chapman & Chapman, 1965; Chapman, Chapman, & Miller, 1964) hypothesized that

schizophrenics would tend to interpret a word as if it had only the single aspect of its meaning that is preferred by normal subjects, disregarding the word's context which could serve to indicate the appropriateness of the word's less preferred meanings. That both normal subjects and schizophrenics have the same preferred meanings to common words was supported by the Chapman, Chapman, and Miller (1964) study. Chapman and Chapman (1965) found that schizophrenics treated word pairs of similar meanings as synonymous, provided that the dominant meaning of the words were the same for normal subjects. Further Chapman, Chapman, and Miller (1964) found that when schizophrenics encountered a word in a context that required use of a nonpreferred meaning of the word, they would interpret the word in accordance with the meaning that normal subjects prefer when they encounter the word out of context. Finally, it has been found that schizophrenics have not lost the nonpreferred meanings of the words (Brelje, 1967; Chapman, Chapman, & Miller, 1964), so the thinking disorder is not based on lack of knowledge. These studies also involved matching tests on discriminating power and matching of schizophrenics with dull normal subjects, thus discounting interpretation of results in terms of generalized schizophrenic deficit.

Chapman and Chapman (1973) put forward several possible theories of why schizophrenics demonstrate this normal

response bias despite contextual cues. The general explanation they offer is that schizophrenics fail to edit potential responses they might make for appropriateness in a situation. Instead, they pick the dominant response without censoring it in light of contextual cues. Chapman and Chapman suggest several reasons that schizophrenics would fail to screen possible responses: (a) an inability to disattend from strong stimuli (Cromwell & Dokecki, 1968); (b) diminished attention available to screen out potential responses which might be inappropriate (Jung, 1906); (c) narrowing of attention resulting in the exclusion of contextual cues from awareness (Broen & Storms, 1966; Venables, 1964); and (d) loss of motivation to perform the screening (Sullivan, 1944).

Chapman and Chapman (1973) admit that accentuation of normal bias does not explain all observed schizophrenic phenomena, particularly the bizarre and autistic quality of many schizophrenic responses. Yet they suggest that accentuation of normal bias does describe a variety of seemingly diverse phenomenon observed in schizophrenic behavior.

Implications for focusing. In tying this in with focusing, we might consider Gendlin's (1962, 1976) formulation, that words can lose their connection to one's felt experiencing. Besides having a subjective, felt element to them, words have a more commonly, consensually valid meaning which an individual learns. These consensual

meanings form associations with the consensual meaning of other words. The individual can learn to "think" with these words without tying them into their experiential referent. One might suggest that this consensual, dominant meaning of words appears related to Chapman and Chapman's (1973) findings that schizophrenics tend to use primarily the dominant meaning of a word.

To experientially focus, a person must be aware of his/her own felt meanings, a subtle process which is quite different from thinking in consensual forms of words. Gendlin describes incidents in successful psychotherapy where the felt shift in meaning is accompanied by a shift in the person's felt sense of the words he/she uses, such that no words exactly capture the person's new experiencing, and the person tends to qualify his/her expression of his/her feelings as a result (e.g., "It's sort of like...") (Gendlin, 1964). Chapman and Chapman's (1973) findings would indicate that schizophrenics respond in a way different from focusing, using dominant instead of felt meanings of words.

That schizophrenics may have a deficit in attending to felt cues is suggested in Rosenbaum, Ebner, & Ritzler's (1966) finding that schizophrenics have a greater deficit in proprioceptive discrimination than in auditory discrimination. Although theirs was an examination of a physical task (lifting weights) and thus not identical to focusing,

both involve a bodily felt awareness.

Chapman and Chapman's (1973) explanation that schizophrenics may tend not to edit out inappropriate responses despite contextual cues also can be integrated with focusing theory. If the schizophrenic is isolated from his/her felt sense of a situation and its meaning to him/her (Gendlin, 1964), this might also involve an exclusion of his/her felt sense of the appropriateness of a response in that situation. Further, in trying to learn focusing, difficulty in editing responses might make appropriate response in the learning situation more unlikely for a schizophrenic trainee, and he/she would not be screening out inappropriate, nonfocusing responses as successfully as a normal person might.

The four possible explanations given by Chapman and Chapman (1973) for schizophrenic failure to edit responses for their appropriateness would also be consistent with schizophrenic difficulty in learning focusing: (a) an inability to disattend from strong stimuli, perhaps such as the trainer's presence in the room, might draw the schizophrenics attention away from his/her internal experiencing, (b) diminished attention could include less attention to subtle experiencing, (c) narrowing of attention could exclude a subtle felt sense from awareness, (d) loss of motivation in pleasing others would make it less likely the schizophrenic would try to please an

instructor and make the effort to perform well.

Another theoretical consideration of schizophrenic deficit, loss of abstract thinking (Cameron, 1939; Goldstein & Scheerer, 1941), can also be considered as an accentuation of normal response bias (Chapman & Chapman, 1973). Chapman (1956) showed that schizophrenics tend to make more concrete errors in sorting cards according to one of several conceptual classes printed on the cards when distracting stimuli are present. Normal subjects tended to use concrete criteria in the task also, if asked to sort cards without instruction to attend to conceptual categories. Thus, when distractors are present, schizophrenics tend to make more concrete errors, which can be seen as an accentuation of normal response bias. With the potentially distracting presence of another person, schizophrenics could tend to make more concrete errors, rather than attending to the nuances of felt meaning.

Loss of major set. A major formulation concerning schizophrenic deficit was advanced by Shakow (1950, 1962, 1963, 1971) concerning loss of major set. In the course of many studies in diverse areas including reaction time and learning, Shakow and his associates found schizophrenics show a deficit in nearly any kind of voluntary behavior, which in itself would make it more likely that schizophrenics would show a deficit in learning the skill

of focusing. The specific formulation of loss of major set would make it unlikely that a schizophrenic subject would remain "focused" on his/her felt sense of a problem over the ten minutes it takes to direct him/her to do so with the Focusing Manual. Even normal subjects typically became distracted when focusing and must make an effort to pull themselves back to the task.

In reaction time studies, Rodnick and Shakow (1940) had each subject press a button when a bell sounded and release the button when a light went on in front of him. Various lengths of intervals were used, called preparatory intervals, since reaction was measured by how long it took to release the button after the light went on. In the "regular" condition, subjects were given 10 trials in a row with each of the intervals; in the "irregular" condition the interval lengths were mixed up. Normal subjects were of approximately the same range of intelligence and education as the schizophrenics.

Schizophrenic subjects were slower overall. Normal subjects were consistently faster in the "regular" procedure except in 25 second or longer preparatory intervals in which they were equally fast under both conditions. Schizophrenics showed a "cross-over" effect. They were faster under the regular condition for the short preparatory intervals, and faster under the irregular condition for longer preparatory intervals (7.5 seconds or longer).

For the longer intervals, schizophrenics failed to benefit from being able to form an expectation of the length of the next preparatory interval. This failure to attain a state of readiness was described by Rodnick and Shakow as a loss of "major set." There was no overlap of scores between schizophrenics and normals. These results were replicated by Tizard and Venables (1956).

Zahn, Rosenthal, and Shakow (1963) attempted to clarify the meaning of this finding by suggesting that schizophrenics respond excessively to the preparatory interval on the trial immediately before the one on which reaction time was measured. Since on the "irregular" procedure, long intervals frequently preceded short ones, Zahn et al., suggested that these preceding preparatory intervals (PPI's) were having an abnormally great effect on the schizophrenics' set. Zahn et al.'s findings supported this. They went on to suggest that schizophrenics were unable to gain the overall set of preparing for an interval of any of several lengths, and therefore prepared for an interval of the same length as the preceding interval.

Shakow (1950, 1962, 1963, 1971) has suggested that establishing a "segmental set", for example, responding to the task by just responding to the PPI instead of the task as a whole, may account for symptoms of schizophrenia. This generalization is based on these and other reaction

time studies. Chapman and Chapman (1973) criticized the formulation as being so general as to lose specific predictive power, while retaining its ability to explain many events post hoc. The durability of these findings in reaction time is seen in more recent studies, although only with chronic schizophrenics (Bellissimo & Steffy, 1972, 1975; Kaplan, 1974; Nideffer, Neale, Kopfstein, & Cromwell, 1971; Steffy & Galbraith, 1974, 1975).

Deficit in attention. Another area of theory concerning schizophrenic deficit concerns defects in attention and in information processing. Lang and Buss (1965), after an extensive review of the literature on psychological deficit, considered interference theory to be a broad explanation of schizophrenic deficit. That is, external competing stimuli and internal stimuli would interfere with the schizophrenic's conceptual process. This interference would make focusing difficult for a schizophrenic patient, because focusing requires staying with one's felt sense for an extended period of time.

Cohen and his associates (Cohen & Camhi, 1967; Lisman & Cohen, 1972; Nachmani & Cohen, 1969; Rosenberg & Cohen, 1966) have hypothesized that schizophrenic error comes from a failure to edit potential responses to exclude those irrelevant to the task according to the context of the task. In attempting to focus, then, we would expect schizophrenics to be inefficient at editing

responses irrelevant to the task, and thus to show impairment in attempting to learn it. Support for the defective editing process comes from the studies by Cohen and his associates and other recent studies (Cohen, Nachmani, & Rosenberg, 1974; Friedrich, Emery, & Fuller, 1974; Smith, 1970). A description of two of the more recent studies of Cohen and his associates should help to clarify their formulations.

Lisman and Cohen (1972) had chronic schizophrenics and normals take a word association test in which the examiner presented a stimulus word and then asked for the first response word that came to mind. They found under this condition schizophrenics responded with fewer common associations than normal subjects. Under a second condition, Lisman and Cohen asked subjects to respond to a word they were reminded of but that few people would say. Schizophrenics gave more common associations than normal subjects under this condition. Lisman and Cohen explained these results by theorizing that schizophrenics sample from a nondeviant repertoire of associations, but fail to edit out situationally inappropriate responses.

Cohen, Nachmani, and Rosenberg (1974) compared normal and schizophrenic subjects in a task in which two differently colored discs were presented to each subject. The subject was to speak into a tape recorder, giving clues to help a potential listener pick out one of the colored

discs. When the discs were completely different colors, such as red and blue, schizophrenic and normal subjects did equally well in providing clues for potential listeners. When discs were very similar in color, for example two shades of pinkish salmon, schizophrenics did much more poorly in providing clues. The schizophrenics seemed unable to move past their initial association naming the color to a new association making the discrimination. Cohen et al. attributed this to schizophrenic inability to reject an inappropriate association in order to search for a more appropriate one. Since normal subjects as well as schizophrenics did more poorly in describing the difficult discriminations, however, the poorer performance on the part of the schizophrenics could be attributed to a generalized schizophrenic deficit.

Venables (1964) has marshalled evidence to suggest that chronic nonparanoid schizophrenics have heightened cortical arousal resulting in a restriction of their range of attention. There is considerable evidence that chronic schizophrenics have heightened arousal (Buss, 1966; Lang & Buss, 1965; Maher, 1966; Venables, 1964). Chapman and Chapman (1973) suggest that Venables' view of narrowed attention in chronic schizophrenics is compatible with their own theory of accentuation or normal bias in that chronic schizophrenics would be more likely to respond to those stimuli to which normals are more likely to respond,

and to exclude stimuli to which normals are less inclined to respond.

Broen (1966) has theorized that disturbed schizophrenics show "response disorganization." By this Broen means that various response alternatives become more nearly equal in frequency for schizophrenics than for normal subjects. An aspect of this response disorganization is a disorganization of "focusing responses." That is, schizophrenics have trouble attending to one stimulus more than another, and thus respond to stimuli that normal subjects ignore as much as those stimuli that normal subjects would attend to as more central. This difficulty in focusing attention would make Gendlin's experiential focusing difficult in that the schizophrenic might be expected to attend to irrelevant stimuli.

Mednick's theory of heightened drive and overgeneralization has lacked support in research (Chapman & Chapman, 1973; Cromwell, 1973; Lang & Buss, 1965). Similarly, Broen and Storm's theory that there is a lowered ceiling on response strength in schizophrenics has failed to receive support in a well constructed experiment (Boland & Chapman, 1971), which failed to find their hypothesized "response ceiling."

Physiological basis for schizophrenia. There is support for the position that schizophrenic deficit might have a physiological basis. Lang and Buss (1965) reviewed

numerous studies indicating that chronic schizophrenics have a higher arousal level than normal subjects. Although basal skin resistance appears to be similar to that of normals, other measures indicate that a higher activation level exists. Studies of muscle tension indicate higher than normal muscle tension for schizophrenics, with highest muscle tension being found with chronic schizophrenics. In addition cardiovascular measures and respiration rates indicate a higher activation level for schizophrenics than normal subjects.

Solomon, Darrow, and Blaurock (1939) suggest that the neurohormonal inhibition of cholinergic response systems may be related to psychotic withdrawal. Ruben (1962) suggested that an adrenergic-cholinergic imbalance is an important aspect of functional psychosis. Lang and Buss suggest that schizophrenia represents an inefficient system in that high muscle tone is not directed toward a focused activity and results in less efficiency. High muscle tone may be involved in somatic delusions (Angyal, 1935) and auditory hallucinations (Gould, 1950).

Lang and Buss reconcile this high level of activation with diminished autonomic nervous system responsiveness in chronic schizophrenics under stress, which they found in many studies. Lang and Buss suggest that the higher basal level in schizophrenics leads to reduced

response to stress since the stress would normally only bring a person a little above the level at which the schizophrenic is already functioning. Since the physiological system is at a higher homeostatic level of arousal for the schizophrenic, one would expect reduced responses (Lacey, 1956; Reynolds, 1962; Wilder, 1950; Williams, 1953). Lang and Buss' review of the literature reveals that there is less reactivity in acute schizophrenics than normals, and less reactivity in chronic schizophrenics than either. Improvement in the clinical condition of schizophrenics tends to bring the basal levels down near those of normals (Funderstein, Greenblatt, & Solomon, 1951; Gellhorn, 1953; Gunderson, 1953). Patients on tranquilizing medication showed polygraphs more like those of normals than patients off medication (Reynolds, 1962).

Other evidence concerning physiological conditions associated with schizophrenia has to do with studies of drugs which induce schizophrenic-like symptoms in normal subjects. Barron, Jarvik, and Bunnell (1964), discussing LSD, point out that the basic physiological effects of the drug are those typical of a mild excitement of the central nervous system. Electroencephalograms show that the effect of LSD is of a nonspecific "arousal" nature. Barron et al. report animal experiments which suggest that LSD stimulates the reticular formation of the midbrain indirectly by stepping up sensory input.

LSD also tends to reduce drowsiness and induce insomnia. Barron et al. point out that under the influence of LSD, performance is impaired on standard tests of reasoning, memory, arithmetic, spelling, and drawing, though they suggest that these results may reflect a lack of cooperation with the tester. Barron et al. suggest that it is possible that LSD acts to cause an imbalance in the metabolism of serotonin. The activating effects of LSD are consistent with the higher activation level found in chronic schizophrenics.

Carlson (1972) suggests that LSD achieves its hallucinogenic effect by stimulating the metabolism and production of serotonin, thus stimulating the pathway from the Raphe system (slow wave sleep center) to the anterior locus caeruleus (paradoxical sleep center) without blocking the reticular activating system. This produces the symptoms of dream sleep, producing hallucinations like dreams without putting the person to sleep. Carlson (1972) also points out that anti-psychotic drugs interfere with the synthesis of LSD, and will counteract the effects of LSD.

Rinkle, DeShon, Hyde, and Solomon (1952) reported that LSD psychosis was characterized by marked difficulties in thinking, including retardation, blocking, autism, disconnected thought, and distractability. They point out also, however, the LSD produced visual hallucinations,

which are much less prominent in schizophrenia. Lang and Buss (1965) point out that LSD seems to produce secondary, rather than primary symptoms, and suggest that sernyl may better produce primary symptoms mimicking schizophrenia.

Snyder (1972) contends that amphetamine psychosis resembles schizophrenia, and that both may be caused by excessive activity of the dopamine tracts in the brain. Snyder, Banerjee, Yamamura, and Greenberg (1976) present evidence consistent with the dopamine hypothesis, although they admit that the evidence is at this point in time tentative.

Both the LSD and amphetamine psychosis theories would be consistent with the higher physiological arousal found in chronic schizophrenics. That sleep deprivation can also mimic psychotic states (Tyler, 1947, 1955) would further be consistent with conditions brought about by these drugs. Further, Holzman, Proctor, Levy, Yasillo, Meltzer, and Hurt (1976) have indicated that their findings concerning eye-tracking dysfunctions in schizophrenic patients and their relatives may be due to a neuromuscular dysfunction, which disrupts proprioceptive and interoceptive feedback. Holzman et al. admit, however, that the eye-tracking dysfunction is not yet well understood.

That there are physiological changes manifested in

schizophrenia seems widely supported. Perhaps physiological changes seen in schizophrenia would impair ability to focus experientially, or impair ability to learn focusing, if not directly, indirectly by bringing about performance deficits such as those already mentioned in other theories of schizophrenic deficit.

Manipulating the hospital environment. A final viewpoint to consider in why schizophrenics might fail to learn focusing is that of Braginsky and his associates (Braginsky & Braginsky, 1967; Braginsky, Braginsky, & Ring, 1969; Braginsky, Grosse, & Ring, 1966) and that of Ludwig and Farrelly (1966). This view is that psychiatric hospitalization can result in a number of rewards for an individual which the schizophrenic does not wish to lose. For example, a variety of behaviors are excused, the patient can be concerned with just his own comfort and needs, and members of the hospital staff are available to provide sympathy and reassurance. In order not to lose these benefits, Braginsky suggests that schizophrenics behave in ways to keep from getting discharged until they want to be. It might be expected that patients would avoid appearing to benefit too much from training which might make them seem to do well in therapy, to avoid risking some of their secondary gains, and would therefore fail to experientially focus. Evidence to support Braginsky's more extreme view that such secondary gain

would cause schizophrenia, however, is lacking.

In the majority of the research done comparing schizophrenics with normals, the schizophrenics were chronic and unmedicated. VA patients receive their medications free and are encouraged to take them. Chapman and Chapman (1973) state that deficits are often not found with VA patients because of the relatively high level of care they receive. One would also expect a patient at a VA hospital to have premorbid history which was healthy enough that he was able to enter the armed forces. Meichenbaum (1969) demonstrated that schizophrenics can improve in their coherency of speech under conditions of operant reinforcement. Although difficulty in teaching a skill such as focusing to schizophrenics can be expected, these mitigating factors help make it worth attempting. Finally, most of the research conducted with schizophrenics has been with chronic inpatients, leaving a hiatus in the consideration of outpatient schizophrenics.

Statement of the Problem

Gendlin's finding that if a high level of experiential process was not occurring within the first three sessions of psychotherapy a client would not improve led to his determination to teach focusing (Gendlin et al., 1968). The Focusing Manual was developed to help therapists to instruct their clients in the kind of experiential process which would eventuate in successful therapeutic outcome.

Research has been done demonstrating that brief training in focusing can be effective, if utilizing techniques beyond the Focusing Manual alone (Platt, 1971; VandenBos, 1973). But this research has been done with college students rather than with clients in psychotherapy. To the extent that psychopathology has been evident in potential subjects, they have been eliminated from training. Although Gendlin (1976) reports the personal observation that focusing can be taught to a population manifesting severe psychopathology, research is needed in this area.

A considerable body of evidence exists which can be taken to indicate that schizophrenics typically demonstrate impaired performance in nearly any task they undertake (Chapman & Chapman, 1973). The conclusion reached from Chapman and Chapman's (1973) and Lisman and Cohen's (1972) research, that schizophrenics suffer from an inability to edit inappropriate associations from their thinking, would pose a special problem to teaching focusing to schizophrenics. Failure to edit out inappropriate associations could perhaps cause a schizophrenic subject to have difficulty in sustaining attention on his/her felt sense of a problem. Similarly, inability of schizophrenics to maintain the "set" (Shakow, 1971) of attending to their felt sense could make focusing training ineffective, as focusing requires holding one's attention on his/her ongoing experiencing for a period of time. Physiological factors

which impair schizophrenic performance (Lang & Buss, 1965) might either directly or indirectly make it difficult for schizophrenic subjects to learn to focus.

The need for improving the psychotherapy process with schizophrenics, however, necessitates an attempt at teaching a higher level of experiential process to them despite the difficulties which might be encountered. May (1975) indicates that there is no study providing well designed experimental evidence that psychotherapy is significantly more effective in treating schizophrenia than anti-psychotic medication. Despite the lack of evidence for efficacy of psychotherapy with schizophrenics, psychotherapy is often attempted with schizophrenics. Therefore, there exists a need for improving the psychotherapy process with schizophrenics.

A format for teaching specific skills, microtraining, has been elaborated by Ivey (1971). In this method a person's level of ability in a specific skill is assessed, a model of the skill is provided, practice in the skill is encouraged, feedback is given, and the person's level of ability in the skill is reassessed. Microtraining has been used successfully to teach a wide range of skills (Ivey, 1971)

The purpose of the present study was to assess empirically whether a method for teaching experiential focusing based on Ivey's microtraining (Ivey, 1971) would be

effective with schizophrenic outpatients currently in psychotherapy. To accomplish this, outpatients in psychotherapy at a Veterans Administration hospital who had demonstrated a lack of skill in experiential focusing were instructed in focusing. Assessment of focusing ability was made before training, and reassessment was made after training.

Success in training these outpatients in experiential focusing would imply that experiential process can be raised, thus making the likelihood of benefit from psychotherapy more probable according to Gendlin et al. (1968). As Gendlin (1975) has stated, "Getting the person in touch with the felt sense level (under emotions) is the first order of business, if this is lacking" (p. 128). This study is to initiate steps in research with focusing in a setting where such research could be most potentially fruitful.

CHAPTER II

METHOD

A schematic view of the overall research design is presented in Figure 1. The study was completed in four phases. The first phase involved recruitment of outpatients in psychotherapy and their therapists. Second was an assessment of focusing ability before training, using the Post-Focusing Questionnaire, and the Post-Focusing Checklist. Third was the microtraining of subjects in the experimental group. Fourth was a post-training administration of the Post-Focusing Questionnaire, the Post-Focusing Checklist, and a Rating Scale, followed by the therapist's observations of the outpatient's therapy behavior in regards to focusing. Finally, a statistical analysis of the variables was performed.

Subjects

Subjects for this study consisted of patients currently in outpatient group or individual insight-oriented psychotherapy at the Veterans Administration Neuropsychiatric Hospital, Highland Drive, Pittsburgh, Pennsylvania. Guidelines for outpatient services at that hospital suggest that these services be offered with the aim of averting imminent psychiatric hospitalization.

The investigator asked therapists' permission to

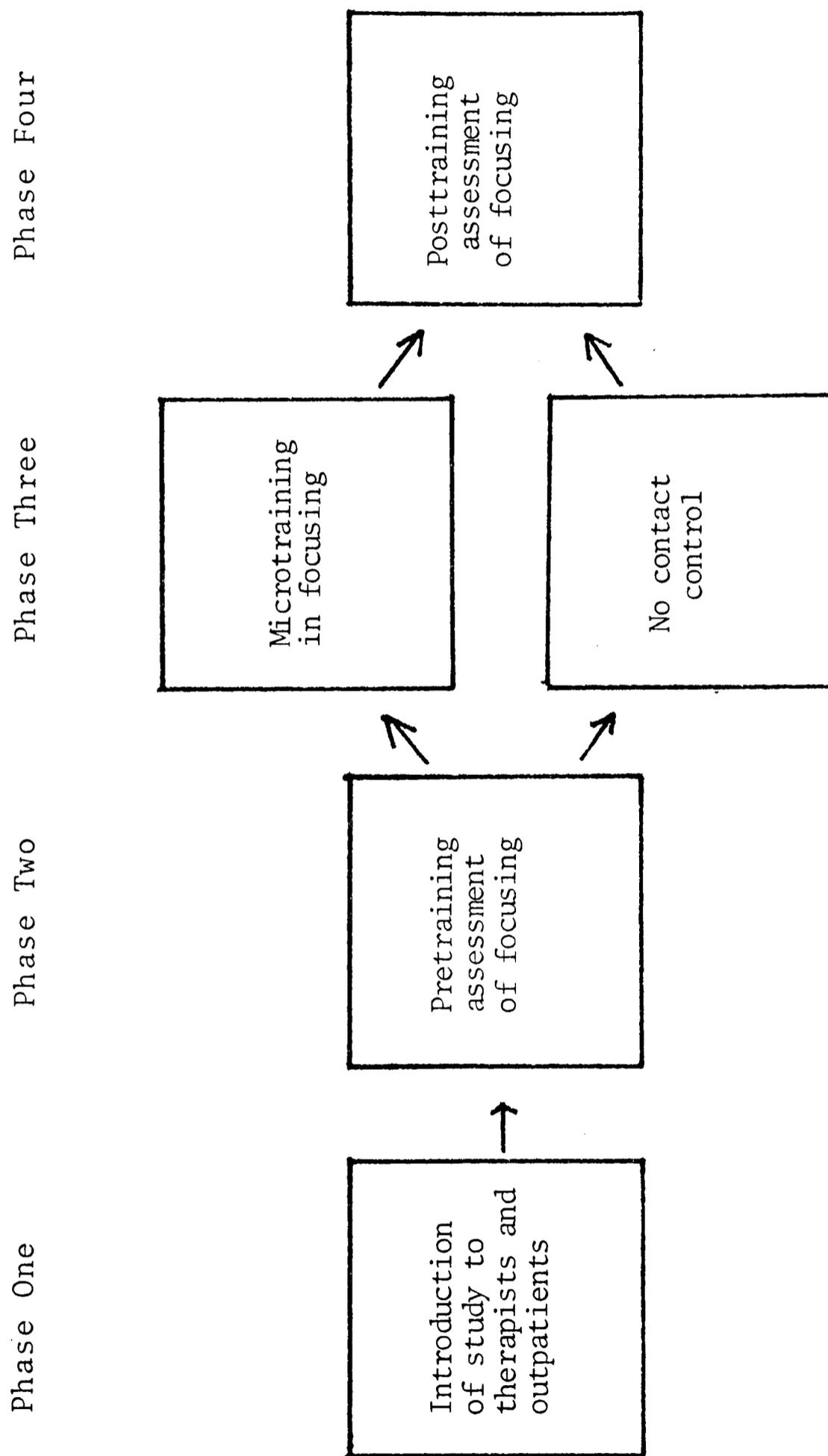


Figure 1. Overall research design

visit their outpatient psychotherapy groups in order to explain the study and to ask for volunteers. In addition, outpatient psychotherapists were asked to explain to potential subjects currently in individual therapy with them that an introduction to a "technique of self-understanding", which would be useful to them in their therapy, would be offered as part of a research project on self-understanding. Only those patients who volunteered to participate were considered for inclusion in the study.

The 20 subjects finally accepted were taken from a total of 62 volunteers who were screened for focusing ability. Those excluded consisted of 30 subjects who were screened out because their initial measured focusing ability exceeded the skill level decided upon before initiation of the study as rated by an independent, trained judge (see section on Post-Focusing Questionnaire). An additional six were eliminated because their performance on the screening instrument contained insufficient information to be scorable. This left 26 nonfocusers who were randomly assigned to the experimental and control groups. After the collection of data, five of the subjects were eliminated because the judges rated them as focusers on the pretests. This left one more subject in the control group than in the experimental group. Therefore, one subject was randomly eliminated from the control group, this being a more conservative and less questionable

procedure than computing scores for unequal n's (Goldstein, in press).

Demographic variables were obtained from the treatment folders of the 20 patients included in the study in order to provide for a more complete description of the population (see Table 1). All of the veterans included in the study were male. Their ages ranged from 24 to 61, with a mean age of 43 years. Almost all patients participated in several courses of outpatient therapy. The total number of sessions for all courses ranged from 20 sessions to 912, with a mean of 255 sessions, indicating a very heavy investment in therapy made by and for these patients. All of the veterans had been previously hospitalized at least once for psychiatric problems, with total time spend in the hospital ranging from 1 week to 20 years, the median time being 3 years 6 months. These veterans have on the average spent a good deal of time in psychiatric hospitals as well as in outpatient therapy. Length of time since the last psychiatric hospitalization ranged from 1½ months to 23 years, with a median of 4½ years. There were no significant differences between the control and experimental groups on any of these variables, nor on any of the variables described in this section.

The patients included in the study were diagnosed as schizophrenic, 11 paranoid and 9 chronic undifferentiated. All but one were taking antipsychotic medication, with

Table 1
Demographic Information

| | Central Tendency | | Range | |
|---|------------------|----------|----------|---------|
| | Mean | Median | Low | High |
| Age (years) | 43 | 43 | 24 | 61 |
| Education (years) | 12 | 12 | 10 | 13 |
| Sessions of outpatient therapy | 284 | 144 | 20 | 912 |
| Time spent in last psychiatric hospitalization | 2.7 yrs. | 4 mos. | 1 day | 20 yrs. |
| Total time in psychiatric hospitalization | 5.1 yrs. | 3.5 yrs. | 1 wk. | 20 yrs. |
| Time since last psychiatric hospitalization | 6.5 yrs. | 4.5 yrs. | 1.5 mos. | 23 yrs. |

seven on a tricyclic antidepressant including the one not taking antipsychotic medication. Sixteen were unemployed, one of them was taking college courses, and four were employed in blue-collar jobs. All were receiving disability compensation: 13 were service-connected, the others were receiving nonservice-connected pensions, social security disability benefits, welfare, or disability insurance.

Eighteen of the subjects were caucasian and two were black. Education ranged from tenth grade to one year of college, the average being twelve years of schooling. Fourteen of the subjects were single, four were married, and two were separated. Fifteen had no children, the remaining five had an average of two children. Five patients lived in family-care homes, nine lived with their families, three lived alone, two with their girlfriends, and one shared an apartment with other patients.

Correlation of the variables discussed above with outcome variables will be described in the results chapter.

Procedure

Pretraining Assessment of Focusing Ability

After both the pretraining and posttraining presentation of the procedure described in Gendlin's Focusing Manual (Gendlin, 1969; Appendix A), the 20 patients

completed the Post-Focusing Questionnaire (Gendlin, 1969; Appendix B), and the Post-Focusing Checklist (Wolf & VandenBos, 1970; Appendix C). The pretest served as an initial measure of the psychiatric outpatient's focusing ability before instituting the training program. All of the pretesting was completed before the patients were randomly assigned to either the experimental (trained) group or the control group.

Instructions to all subjects prior to testing consisted of the following:

Although in psychotherapy it can be helpful for a person to gain insight into himself, people are often unsure of how to go about this. One way of gaining this self-knowledge is through what is called "focusing", but we need information to find out how well focusing works. By finding out we can know how to make psychotherapy work better for those in it. The only reliable way to get this information about focusing is to have a person try to focus, and then ask about how well it worked for him.

The purpose of what we will do is to gather information which will contribute to a better understanding of people in psychotherapy and how to best help them. The information will build knowledge that may better therapy for persons like yourself. There are no right or wrong answers to any of the questions. We'd like very much for your cooperation, time, and interest.

The subjects were informed that their names and all information would remain confidential. In addition, they were asked to sign a form giving their consent to participate in the study. The pre- and posttraining sessions lasted approximately a half hour each.

All subjects in the experimental group were contacted

and invited to receive brief intensive training in a technique of self-understanding called "focusing." The purpose of the training was briefly explained, and endorsed by the patient's therapist. A time for the training was set. Subjects in the control group were notified that training would be made available to them in the near future, within two weeks. Members of the control group electing training were not trained until the posttest administration was completed.

After being pretested, the experimental group participated in the microtraining in focusing. The training took approximately one hour and was held within a week of the pretesting.

Microtraining in Focusing

This program incorporated the central elements of microtraining as described by Ivey (1971). Actual training in focusing was conducted by the investigator.

The training session began with a verbal administration of the Focusing Manual (Gendlin, 1969). The trainee was then asked to write a brief essay according to these instructions:

In this questionnaire we are asking your help in evaluating the instructions which were just given to you. In no more than four (4) sentences (one short paragraph) please describe what was happening to you, and what you have experienced in the last 10 minutes. (Mellett & Coblentz, 1966, p. 7)

The trainee then read the Programmed Manual prepared

by the present investigator (Appendix H), describing the specific skill of focusing in detail. The Programmed Manual was designed to be self-explanatory, although the trainer was available to answer any questions which the trainee might have. The trainer then modeled the skill being performed poorly (with intellectualization and externalization), and afterwards modeled the skill being performed well. The trainee and the trainer discussed the Programmed Manual and the modeling, and then read together the trainee's initial essay describing his focusing experience. They discussed this experience and the essay, and the subject was asked to identify whether he engaged in focusing or failed to experientially focus. The trainee was asked what would be different if he were to successfully focus. The trainee was encouraged to engage in aspects of focusing as the trainer came up with example situations to practice with. The trainer then encouraged the trainee to focus on his own felt sense of a situation important to him. The trainer facilitated this process by responding to the trainee's description of his focusing, and by suggesting what the trainer's own felt sense might be in response to such a situation. Any questions were answered as completely as possible.

A second administration of the Focusing Manual then took place, followed by the essay. The process of

evaluation and feedback was then repeated.

At the end of the session, the subject was debriefed. He was then asked that he not discuss the training for at least two weeks in order that other participants would remain naive about its nature until the research was completed.

Overall, the training endeavored to stimulate active participation by outpatients. The emphasis was on the specific skill of focusing, which would be useful to the patients in resolving the problems they talk about in psychotherapy. Gendlin (1969) considers focusing to be an essential subprocess of successful psychotherapy, and a skill which patients manifesting severe pathology often lack (Gendlin et al., 1968).

Posttraining Assessment of Focusing Ability

Within a week after the training, the Focusing Manual was administered to all subjects, followed by the Post-Focusing Questionnaire and the Post-Focusing Checklist. In addition, each psychotherapist was asked to evaluate whether he thought an individual subject had engaged in an experiential process according to a Rating Scale devised by Gendlin, Jenney, and Shlien (1960) (see Appendix D), at the end of the psychotherapy interview immediately following the training. If the patient was in group therapy, the psychotherapist was asked to draw out that

individual in the session, in order to have data to go by in making the judgment. A request was made that the psychotherapist not ask the patient whether he had had the training.

Instruments

The comparison of the control and experimental subjects with respect to the research variables was accomplished through the use of four instruments. They were selected on the basis of their ability to measure the variables which relate most closely to the expressed goals of focusing training. A description of instruments is presented below.

Post-Focusing Questionnaire

Focusing ability was operationally defined in terms of scores based on the Post-Focusing Questionnaire (see Appendix B), developed by Gendlin et al. (1968). This instrument was the result of several years of research and was the first instrument intended specifically to assess whether focusing had occurred. Studies were made of students in high school and college, as well as informally with clients in psychotherapy, to determine its validity and to refine it. The Post-Focusing Questionnaire's construction was based upon the assumption that engaging in experiential focusing is an important aspect of enabling a client to move from a lower level of adjustment to a

higher level of adjustment through psychotherapy.

The Post-Focusing Questionnaire is the basic instrument which researchers have used in assessing whether focusing has occurred. Reliability estimates have varied depending on whether clinicians or college students have made the judgments, and depending on how the judgments have been made. Richert (1968) obtained interjudge correlations of .68, although the type of judge he used was unspecified; later studies (Miller, 1970; Platt, 1971) obtained interjudge correlations in the mid-seventies. Although it is unclear what type of judge they used, the judges may have been trained undergraduate students.

VandenBos (1972), employing undergraduate psychology research assistants, found that with no training those that had been rated as nonfocusers correlated in the .20's with experienced judges' ratings of 30 Post-Focusing Questionnaires. Undergraduates rated as focusers correlated in the .50's with expert judges. It is unclear whether the judges were rating the questionnaires as a whole or item-by-item, although it was probably as a whole.

VandenBos (1972) then briefly trained both groups of undergraduate judges. Training consisted of the researcher and each judge reviewing the differences between each rater's scoring and giving the rationale for rating each questionnaire as the experienced rater had done.

Then the undergraduate judges scored a different batch of 30 protocols. The nonfocuser judges averaged correlations of only .45 with the experienced judges' ratings. The focuser judges correlated between .72 and .85 with the experienced raters. Thus with minimal training, undergraduate judges who were themselves focusers were able to obtain satisfactory reliability in rating the Post-Focusing Questionnaire. This investigation points to the importance of selecting focusers to make the ratings when using undergraduate raters with minimal training. Probably undergraduate raters who themselves can focus are better able to understand what focusing is, both conceptually and experientially.

The reliability of the judges seems to increase if the Post-Focusing Questionnaire is rated as a whole instead of as an average of each question individually rated. Mellett and Coblentz (1966) obtained an interjudge reliability of .91 using five experienced clinicians as judges. Similarly, Wolf and VandenBos (1970), using two experienced raters, obtained interjudge correlations of .89 making judgment of the Post-Focusing Questionnaire as a whole. Several later studies using this procedure have found interjudge correlations of .80 or better (Platt, 1971; VandenBos & Miller, 1971), even using inexperienced judges.

In the present study, the questionnaires were judged

both as a whole and item-by-item. First the questionnaires were randomized so that the judges would not know which questionnaires were pre or post and which came from the experimental or control groups. The judges were then asked to rate the questionnaires as a whole. Then the questionnaires were broken up, and after randomization the individual questions were presented to the judges for rating. In each of the above cases the averages of the two judges were used in computation of the statistics for this study.

The judges scored the questionnaire according to the following system: (1) did not focus, had random thoughts about problems or other matters, (2) thought about a problem, but did not gain a clearly bodily felt sense of the problem, (3) focused on a specific felt meaning and obtained some words or images, but did not refocus, (4) focused with experiential effect.

The judges, two women college graduates, received extensive training to prepare them to rate the questionnaires. They were selected because of their interest in the study, and because of their high focusing ability as determined by the Post-Focusing Checklist and the Post-Focusing Questionnaire (as rated by this investigator). They were chosen over clinical psychologists because (a) two clinical psychologists were initially tried, but failed to correlate well with one another, as is

considered in detail in Appendix M, and (b) the female judges used were willing to spend as much time as was needed to thoroughly train them to be competent judges.

Training began with an initial assessment of focusing ability followed by the same microtraining procedure as was used to train the outpatients. Painstaking care was taken to go over every aspect of focusing to insure a cognitive understanding of the process as well as skill in engaging in it. Next the investigator and judge carefully went over an extensive set of criteria to be used in judging (see Appendix F), until the judge understood the reason behind each rule and when it might be used.

The judges rated 18 questionnaires from a previous study (see Appendix I) and then discussed the rating of each questionnaire with the other judge and with the investigator.

Next, 50 questionnaires from a previous study were rated by each of the judges individually. The ratings correlated .92 and .89 with ratings made by experts. The judges correlated .83 with each other. Finally, the two judges and the investigator discussed each of the 50 questionnaires they had rated in order to more fully understand reasons for discrepancies and similarities in ratings, and to come to agreement on how to rate types of questionnaires which were difficult to judge.

Data were presented to the judges one part at a time. First they were asked to rate the Post-Focusing Questionnaire as a whole. Their correlation on this was .82. Next they were given the Post-Focusing Essay Question to rate. They correlated .71. Finally the judges rated the Post-Focusing Questionnaire item-by-item, with the items presented separately. The ratings of each item were then combined with the other eight items comprising each questionnaire, and averaged, yielding a set of 52 ratings for each judge. They correlated .87 on these average scores. Since there was less information available from the individual items rated in isolation (item-by-item), some additional rules were added to help make the ratings, and are presented in Appendix G.

A separate judge, an intern in counseling psychology, made the screening assessment of focusing ability. He received microtraining in focusing, and his rating of the data from previous studies correlated .77 with the average rating of the original judges of that data. Only subjects rated 1 or 2 (out of a possible 4) on the Post-Focusing Questionnaire rated as a whole were included in the study.

Post-Focusing Checklist

VandenBos (1973) states that despite the Post-Focusing Questionnaire's good reliability, little research has been done on focusing because of the time consumed

in rating large numbers of verbatim reports. An objective self-report measure was needed. Thus, Wolf and VandenBos (1970) developed the Post-Focusing Checklist, consisting of 28 items describing thoughts, feelings, and reactions which in view of the authors and Gendlin (VandenBos, 1973) are reflective of focusing and nonfocusing. Subjects check whether an item is descriptive of their experience or not. Low scores on the Post-Focusing Checklist reflect successful focusing and high scores reflect nonfocusing.

In several studies by Wolf and VandenBos (1970), the Post-Focusing Checklist correlated between .74 and .89 with the Post-Focusing Questionnaire. In another study (Platt, 1971) the correlation between the Post-Focusing Checklist and the Post-Focusing Questionnaire was .48. No reason is given for this correlation being so low. Despite the low correlation from the Platt study, the Post-Focusing Checklist provides an additional cross-validating assessment of whether focusing occurred with subjects in the present study. The present study provides further data regarding the usefulness of the Post-Focusing Checklist.

VandenBos, Miller, and Wolf (1977) have found that individuals with scores of 6 or less (out of a possible 28) on the Post-Focusing Checklist are clearly focusers, whereas individuals with scores of 18 or more are clearly

nonfocusers. In the extremes of its range it is most efficient. VandenBos (1973) asserts that, "The PFC [Post-Focusing Checklist] appears a reasonably reliable and valid measure of focusing ability. It appears to be most efficient in discriminating individuals who are clearly focusers or clearly nonfocusers" (p. 24). It should be noted, however, that VandenBos has not published his findings on reliability for the checklist, although this reliability data is in preparation for publication (VandenBos et al., 1977).

Rating Scale

As a measure to determine whether the effect of the training was noticeable to the patient's psychotherapist, the therapist was asked to fill out a Rating Scale (see Appendix D) assessing experiential process in psychotherapy, developed by Gendlin, Jenney, and Shlien (1960). This rating was made at the end of the psychotherapy interview immediately following the training.

The Rating Scale was devised to examine the association between outcome ratings of psychotherapy and the psychotherapist's observations of the process of therapy (Gendlin, Jenney, & Shlien, 1960). Gendlin, Jenney and Shlien consider Scales 1, 2, and 5 to be theoretically indicative of "relationship focus" as the client's topic of discussion. Scales 3, 4, and 6 theoretically define

"relationship focus" as the client's use of the psychotherapy relationship as a source of significant experiencing. Gendlin, Jenney, and Shlien found that successful outcome ratings, as judged by therapists in the cases, were significantly associated with use of the relationship for significant experiencing, as measured by the Rating Scale.

Gendlin, Jenney, and Shlien reported that correlations with outcome were .34 for Scale 3 (client finding his relationship with the counselor an instance of his general interpersonal difficulties); .40 for Scale 4 (client deriving from the relationship itself new and significant experience); and .49 for Scale 6 (client expressing his feelings directly rather than reporting them). Change in experiential process was found in Scale 6 as the clients moved from reporting their feelings to expressing them directly (Gendlin, Jenney, & Shlien, 1960). It is on this scale that change was expected to occur as a result of the brief training in experiential process being conducted in the present study.

Therapist Assessment of Focusing

The therapist or therapists working with the patient were also asked to make a judgment of the patient's focusing ability on the four-point scale presented above. All of the patients were rated by one of their therapists. Some

of the therapists were willing to partake of the micro-training in focusing themselves. When there was more than one therapist in a psychotherapy group, and one of the therapists had had this training, that therapist's rating was used. At least some discussion of focusing, and written information on focusing and how to judge it (see Appendix D and E) took place with each of the therapists whose judgments were utilized. Data from therapists who had been unwilling or unable to partake of any discussion on focusing was thrown out, as their judgments were so disparate from those of the "trained" therapists, and from one another, as to be meaningless. Therapists included three Ph.D. psychologists, a master's level psychologist, and a psychiatric registered nurse, all with years of experience in working with patients such as those in the present study.

Although the main purpose of the present study was to determine whether focusing could be taught to psychiatric outpatients using the microtraining method, it was thought that a quick assessment of whether training has generalized to the psychotherapy session could prove interesting.

Order of Instruments

VandenBos (1973) suggests using the Post-Focusing Checklist after the Post-Focusing Questionnaire, as the

subject then seems better able to clarify to himself the nature of his experience and hence the discrimination of the checklist items is improved. Therefore, this order, Post-Focusing Questionnaire followed by the Post-Focusing Checklist, was used in the present study.

Hypotheses

It was predicted that the microtraining in focusing would yield a significant difference in focusing ability among the two groups after "waiting" or training.

The previous section describes the instruments used to test the following hypotheses.

1. The experimental group would be judged as significantly better at focusing following treatment than the control group as measured by the Post-Focusing Questionnaire rated as a whole.
2. The experimental group would be judged as significantly better at focusing following treatment than the control group as measured by the Post-Focusing Questionnaire rated one item at a time.
3. The experimental group would reveal a significantly improved score following treatment than the control group on the Post-Focusing Checklist.
4. The experimental group would be judged as significantly more experiential in their manner of process on the Rating Scale following treatment than the control group as determined by the psychotherapists.
5. The experimental group would be judged as significantly better at focusing following treatment than the control group as rated by the psychotherapists.

Statistical Procedures

A Pretest-Posttest Control Group Design (Campbell & Stanley, 1963) was employed in the investigation of Hypotheses 1, 2, and 3. A Posttest-Only Control Group Design was employed in the investigation of Hypotheses 4 and 5. The diagrams below and in Table 2 are schematic representations of the designs.

Pretest-Posttest Control Group Design

R O₁ X O₂

R O₃ O₄

Posttest-Only Control Group Design

R X O₁

R O₂

Three distinct steps were employed: (a) Each subject was given a pretest battery, (b) microtraining in focusing was administered to the experimental group, and (c) all subjects were given a posttest battery at the end of treatment. The results were compared to determine what significant differences occurred. The primary question proposed was whether microtraining in experiential focusing would result in significant changes in the outpatient sample. The Pretest-Posttest Control Group Design and the Posttest-Only Control Group Design provided the opportunity to

Table 2
Experimental Design

| <u>Pretest-Posttest Control Group Design</u> | | | |
|--|--------------------|---|--|
| | | <u>Pretest</u> | <u>Posttest</u> |
| Randomization | Experimental Group | 1. PFQ ^a 2. PFC ^b (Treatment) | 1. PFQ 2. PFC |
| | Control Group | 1. PFQ 2. PFC (no contact) | 1. PFQ 2. PFC |
| <u>Posttest-Only Control Group Design</u> | | | |
| | | | |
| Randomization | Experimental Group | (Treatment) | 1. Rating Scale 2. Therapist Assessment of focusing |
| | Control Group | (no contact) | 1. Rating Scale 2. Therapist Assessment of focusing |

^aPFQ = Post-Focusing Questionnaire
^bPFC = Post-Focusing Checklist

distinguish between changes in function which resulted from the passage of time as opposed to those which were directly related to the treatment program. The Pretest-Posttest Control Group Design provided an opportunity to allow comparisons to be made between and within groups, and eliminate most of the extraneous variables which might influence changes in focusing ability during the investigation.

The following data analyses were computed: For the Post-Focusing Questionnaire and for the Post-Focusing Checklist, a 2×2 split-plot factorial analysis of variance (Kirk, 1968), to determine the significance of change, and Tukey's Honestly Significant Difference (HSD) procedure to further measure between group differences. For the Rating Scale and the therapist's rating of focusing, a one-tailed t test was selected since the direction of the differences were predicted in advance.

CHAPTER III

RESULTS

The results of the investigation are presented in two sections. The first consists of findings directly related to the stated hypotheses. The second section presents additional post hoc analyses, utilizing t tests and correlation ratios, that were carried out on variables that could add information about the nature of experiential focusing with this group of schizophrenic outpatients.

Testing the Hypotheses

Five hypotheses were formulated to test for significant differences in experiential process between the control and experimental groups. The nonsignificant t tests obtained for the first three variables indicated that the two groups were comparable at the onset of treatment. A summary of these results is presented in Table 3. Means and standard deviations for the experimental and control groups at the pretesting and posttesting points on all the research variables can be seen in Table 4.

The F_{-max} test for homogeneity of variance (Kirk, 1968) was applied to the data for the first three variables under analysis. Table 5 reports the results of all six F_{-max} tests and indicates that homogeneity of variance was obtained in all cases. These results made it unnecessary

Table 3
Comparison^a of Control and Experimental
Group^b Pretest Variables

| Variable | <u>t</u> |
|---|----------|
| Post-Focusing Questionnaire rated as a whole | .000 |
| Post-Focusing Questionnaire rated item-by-item | 1.555 |
| Post-Focusing Checklist | 1.169 |

^at (18) = 2.101, p < .05

^bn = 10 for each group

Table 4
Means and Standard Deviations for
Control and Experimental Groups^a

| Variable | Control | | | | Experimental | | | |
|---|---------|------|-------|------|--------------|------|-------|------|
| | Pre | | Post | | Pre | | Post | |
| | M | SD | M | SD | M | SD | M | SD |
| Focusing (PFQ rated as a whole) | 1.45 | .50 | 1.90 | .91 | 1.45 | .60 | 2.10 | .99 |
| Focusing (PFQ rated item-by-item) | 2.10 | .37 | 2.09 | .58 | 1.80 | .49 | 2.20 | .57 |
| Focusing (PFC) | 11.80 | 3.68 | 12.70 | 3.95 | 13.90 | 4.33 | 10.30 | 3.53 |
| Focusing (Therapist Rating) | | | 2.10 | .99 | | | 2.20 | 1.03 |
| Direct Expression of Feelings (Therapist Rating) | | | 4.90 | 2.56 | | | 7.10 | 2.56 |

^a $n = 10$ for each group

Table 5
 Test for Homogeneity of Variance
 Among Dependent Measures

| Variable | F_{max} Value |
|---|------------------------|
| Post-Focusing Questionnaire rated as a whole | |
| Subjects within groups | 2.02 |
| B × subjects within groups | 1.70 |
| Post-Focusing Questionnaire rated as a whole--converted | |
| Subjects within groups | 1.90 |
| B × subjects within groups | 1.62 |
| Post-Focusing Questionnaire rated item-by-item | |
| Subjects within groups | 1.67 |
| B × subjects within groups | 3.94 |
| Post-Focusing Checklist | |
| Subjects within groups | 1.67 |
| B × subjects within groups | 1.83 |

F_{max} (2, 9) = 4.03, $p < .05$

to transform the data in any of the three cases.

The tests for equality and symmetry of covariance matrices for type SPF-p.q design (Kirk, 1968) were applied to the data for the first three variables under analysis. Table 6 reports the results of all three chi-square tests and indicates that although equality of covariance matrices was obtained in all cases, symmetry of covariance matrices was not obtained for the data on the Post-Focusing Questionnaire rated as a whole. Therefore, the data on this variable was transformed using an inverse transformation (Kirk, 1968), and was afterwards found to meet all of the necessary assumptions. It was unnecessary to transform the data for the Post-Focusing Questionnaire rated item-by-item or for the Post-Focusing Checklist.

At this point, the analyses of variance could be performed to assess the effect of treatment (Kirk, 1968). Results which reached a level of significance of .05 were further analyzed by Tukey's HSD procedure (Kirk, 1968) to make between-group comparisons of mean change scores. The source tables of these data appear in Appendix J.

Hypothesis 1

It was predicted that the experimental group would become significantly better at focusing than the control group as measured by the Post-Focusing Questionnaire rated as a whole. The analysis is summarized in Table 7.

Table 6
 Equality^a and Symmetry^b of Covariance Matrices
 for Dependent Measures

| Variable | χ^2 |
|---|----------|
| Post-Focusing Questionnaire rated as a whole | |
| Equality of Matrices | 2.054 |
| Symmetry of Matrices | 5.128* |
| Post-Focusing Questionnaire rated as a whole--converted | |
| Equality of Matrices | 1.286 |
| Symmetry of Matrices | .524 |
| Post-Focusing Questionnaire rated item-by-item | |
| Equality of Matrices | 4.296 |
| Symmetry of Matrices | 2.174 |
| Post-Focusing Checklist | |
| Equality of Matrices | 1.556 |
| Symmetry of Matrices | .084 |

^a χ^2 (3) = 7.815, $\underline{p} < .05$ for Equality of Matrices

^b χ^2 (1) = 3.841, $\underline{p} < .05$ for Symmetry of Matrices

* $\underline{p} < .05$

Table 7

Analysis of Variance for Control and Experimental Group
 Pretest and Posttest Post-Focusing Questionnaire Scores
 Rated as a Whole--Inverse Transformation

| Source | Sum of Squares | df | Mean Square | F |
|----------------------------|----------------|----|-------------|-------|
| Between Subjects | 2.06636 | 19 | | |
| A (Experimental-Control) | .00009 | 1 | .0009 | .00 |
| Subjects within groups | 2.06627 | 18 | .1147927778 | |
| Within Subjects | 1.10240 | 20 | | |
| B (pre-post) | .24025 | 1 | .24025 | 5.04* |
| AB | .00400 | 1 | .00400 | .08 |
| B × subjects within groups | .85815 | 18 | .047675 | |
| Total | 3.16876 | 39 | | |

* $p < .05$

From the table it can be seen that the difference pre-post is statistically significant at the .05 level. The subjects in both groups, experimental and control, had an increase in their focusing score. A Tukey's HSD test for pairwise comparisons also yielded an overall difference pre-post ($p < .01$).

The results are presented graphically in Figure 2, from which it can be seen that the experimental and control groups increased their focusing level significantly from pre-to posttest. The experimental group increased their focusing from a mean of 1.45 at pretest to a mean of 2.10 at posttest. The control group had a pretest mean of 1.45 and a posttest mean of 1.90. Since the AB interaction was not significant, Hypothesis 1 was not confirmed, as the control group showed gains sufficiently close to those of the experimental group. Both groups improved in focusing skill level.

Hypothesis 2

It was predicted that the experimental group would become significantly better at focusing than the control group as measured by the Post-Focusing Questionnaire rated item-by-item. The analysis is summarized in Table 8.

From the table it can be seen that the interaction effect is significant at the .05 level. The subjects in the experimental group had an increase in their focusing

| | | Pre | Post |
|--------------|-----|------|------|
| Control | (C) | 1.45 | 1.90 |
| Experimental | (E) | 1.45 | 2.10 |

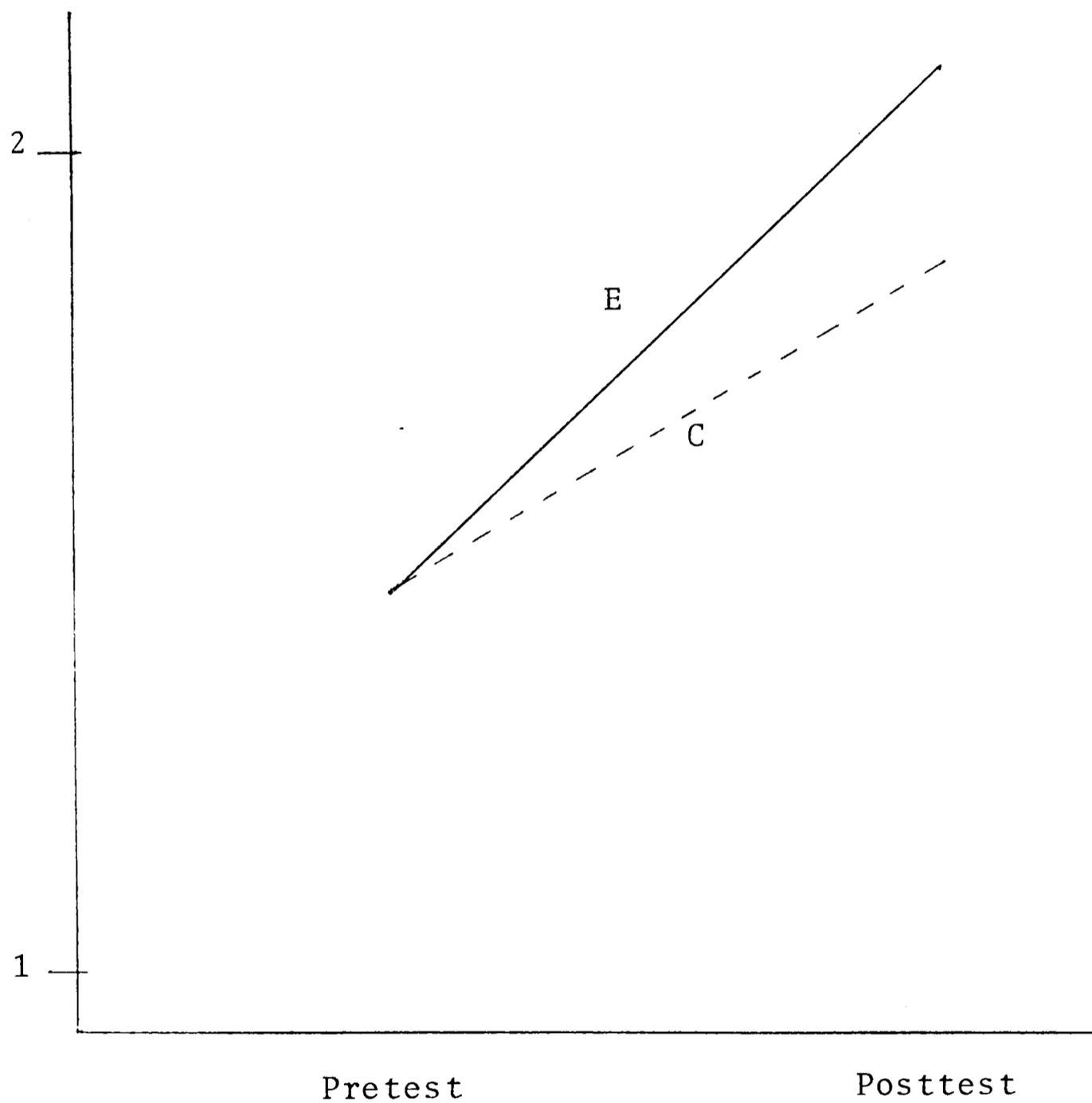


Figure 2. Pre- and posttest Post-Focusing Questionnaire scores rated as a whole.

Table 8

Analysis of Variance for Control and Experimental Group
 Pretest and Posttest Post-Focusing Questionnaire Scores
 Rated Item-by-Item

| Source | Sum of Squares | df | Mean Square | F |
|----------------------------|----------------|----|-------------|-------|
| Between Subjects | 7.68055 | 19 | | |
| A (Experimental-Control) | .08836 | 1 | .08836 | .21 |
| Subjects within groups | 7.59219 | 18 | .42178833 | |
| Within Subjects | 2.56400 | 20 | | |
| B (pre-post) | .38025 | 1 | .38025 | 3.91 |
| AB | .43264 | 1 | .43264 | 4.45* |
| B × subjects within groups | 1.75111 | 18 | .09728389 | |
| Total | 10.24455 | 39 | | |

* $\underline{p} < .05$

score which was significantly greater than the change exhibited by the control subjects. A Tukey's HSD test for pairwise comparisons also yielded a difference in the predicted direction ($p < .01$), with the difference pre-post being significant only for the experimental group.

The results are presented graphically in Figure 3 from which it can be seen that the experimental group increased its focusing level significantly from pretest to posttest. The experimental group increased their focusing from a mean of 1.80 at pretest to a mean of 2.20 posttest. The control group had a pretest mean of 2.10 and a posttest mean of 2.09. Hypothesis 2 was confirmed.

Hypothesis 3

It was predicted that the experimental group would become significantly better at focusing than the control group as measured by the Post-Focusing Checklist. The analysis is summarized in Table 9.

From the table it can be seen that the interaction effect approaches statistical significance ($p < .09$). The subjects in the experimental group had an increase in their focusing score which was greater than the change exhibited by the control subjects.

The results are presented graphically in Figure 4 from which it can be seen that the experimental group increased its focusing level from pretest to posttest. The experimental group improved their focusing from a mean

| | | Pre | Post |
|--------------|-----|------|------|
| Control | (C) | 2.10 | 2.09 |
| Experimental | (E) | 1.80 | 2.20 |

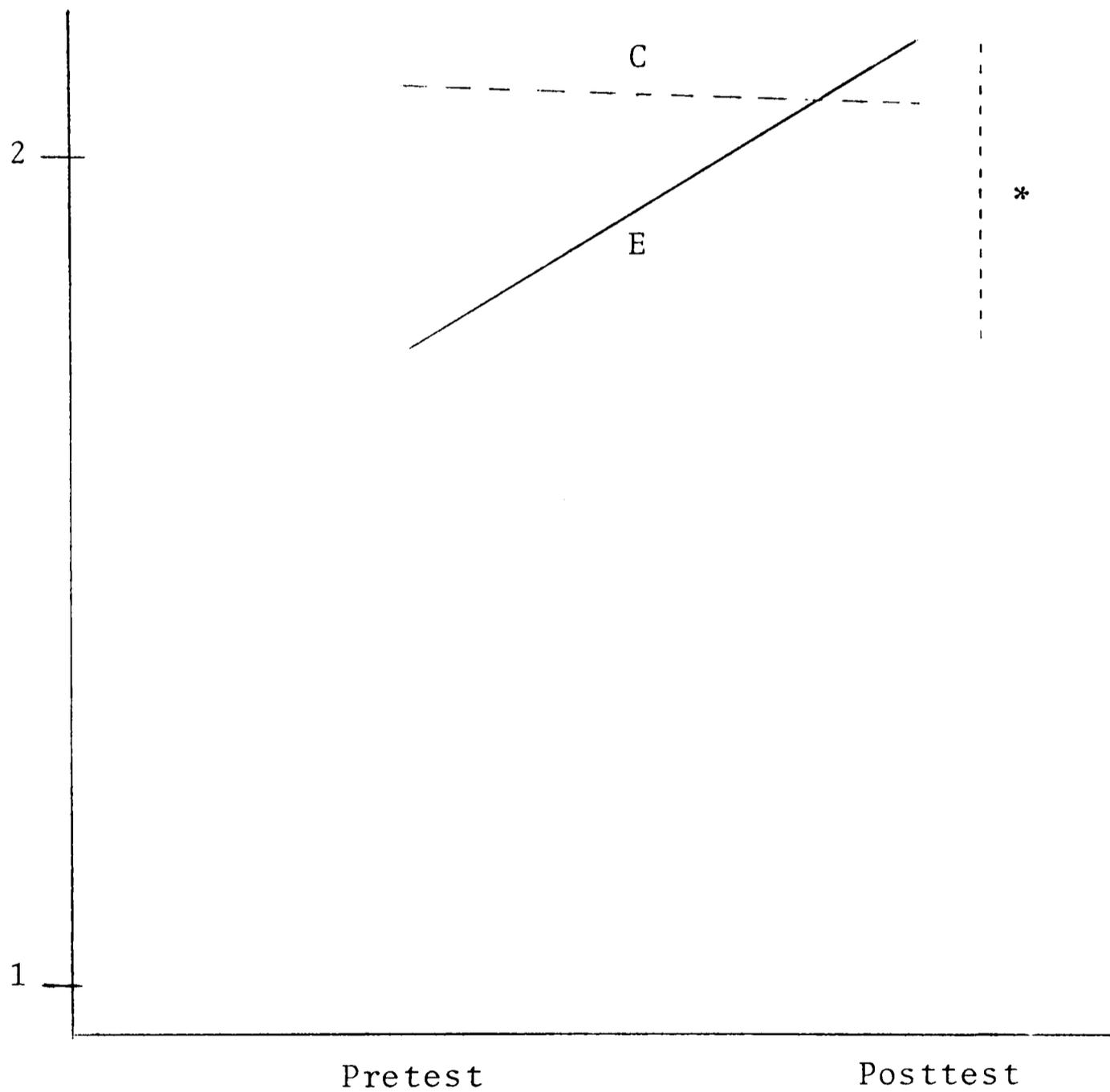


Figure 3. Pre- and posttest Post-Focusing Questionnaire scores rated item-by-item.
* $p < .05$: Comparison of pretest with posttest for experimental group

Table 9

Analysis of Variance for Control and Experimental Group
Pretest and Posttest Post-Focusing Checklist Scores

| Source | Sum of Squares | df | Mean Squares | F |
|----------------------------|----------------|----|--------------|-------|
| Between Subjects | 256.275 | 19 | | |
| A (Experimental-Control) | .225 | 1 | .225 | .02 |
| Subjects within groups | 256.050 | 18 | 14.225 | |
| Within Subjects | 355.500 | 20 | | |
| B (pre-post) | 18.225 | 1 | 18.225 | 1.14 |
| AB | 50.625 | 1 | 50.625 | 3.18* |
| B × subjects within groups | 286.650 | 18 | 15.925 | |
| Total | 611.775 | 39 | | |

* $p < .10$

| | | Pre | Post |
|--------------|-----|------|------|
| Control | (C) | 11.8 | 12.7 |
| Experimental | (E) | 13.9 | 10.3 |

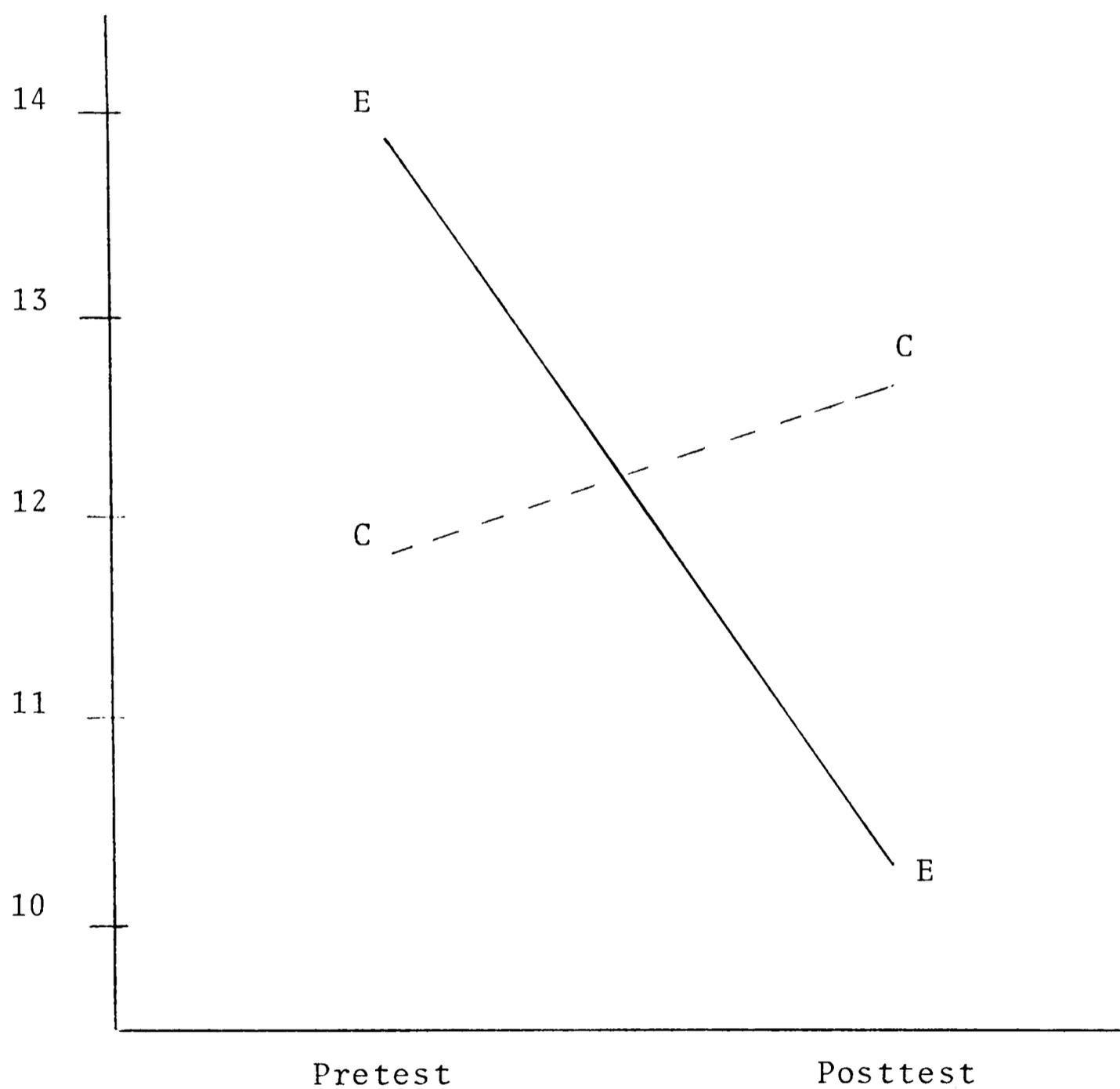


Figure 4. Pre- and posttest Post-Focusing Checklist scores.

of 13.9 at pretest to a mean of 10.3 at posttest. The control group had a pretest mean of 11.8 and a posttest mean of 12.7. Since the results were not significant, Hypothesis 3 was not confirmed, although the change rated was in the predicted direction. The experimental group showed improved focusing skill and the control group showed a decrement in focusing skill.

Hypothesis 4

It was predicted that the experimental group would be judged as significantly more experiential in their manner of process on the rating scale following treatment than the control group as determined by the psychotherapists. Specifically it was predicted that the experimental group would express their feelings more directly, whereas the control group would tend more towards reporting their feelings. The analysis summarized in Table 10 yielded significant results. A one-tailed test was appropriate since the direction of the difference was predicted in advance.

From Table 10 it can be seen that the difference is statistically significant at the .05 level. The subjects in the experimental group exhibited a score indicative of more direct expression of feelings than the control subjects.

The results are presented graphically in Figure 5 from which it can be seen that the experimental group

Table 10
Comparison of Control and Experimental Group^a
Posttreatment Rating Scale Scores

| Variable | <u>t</u> |
|-------------------------------|----------|
| Direct Expression of Feelings | 1.923* |

^a
n = 10 for each group

*p < .05

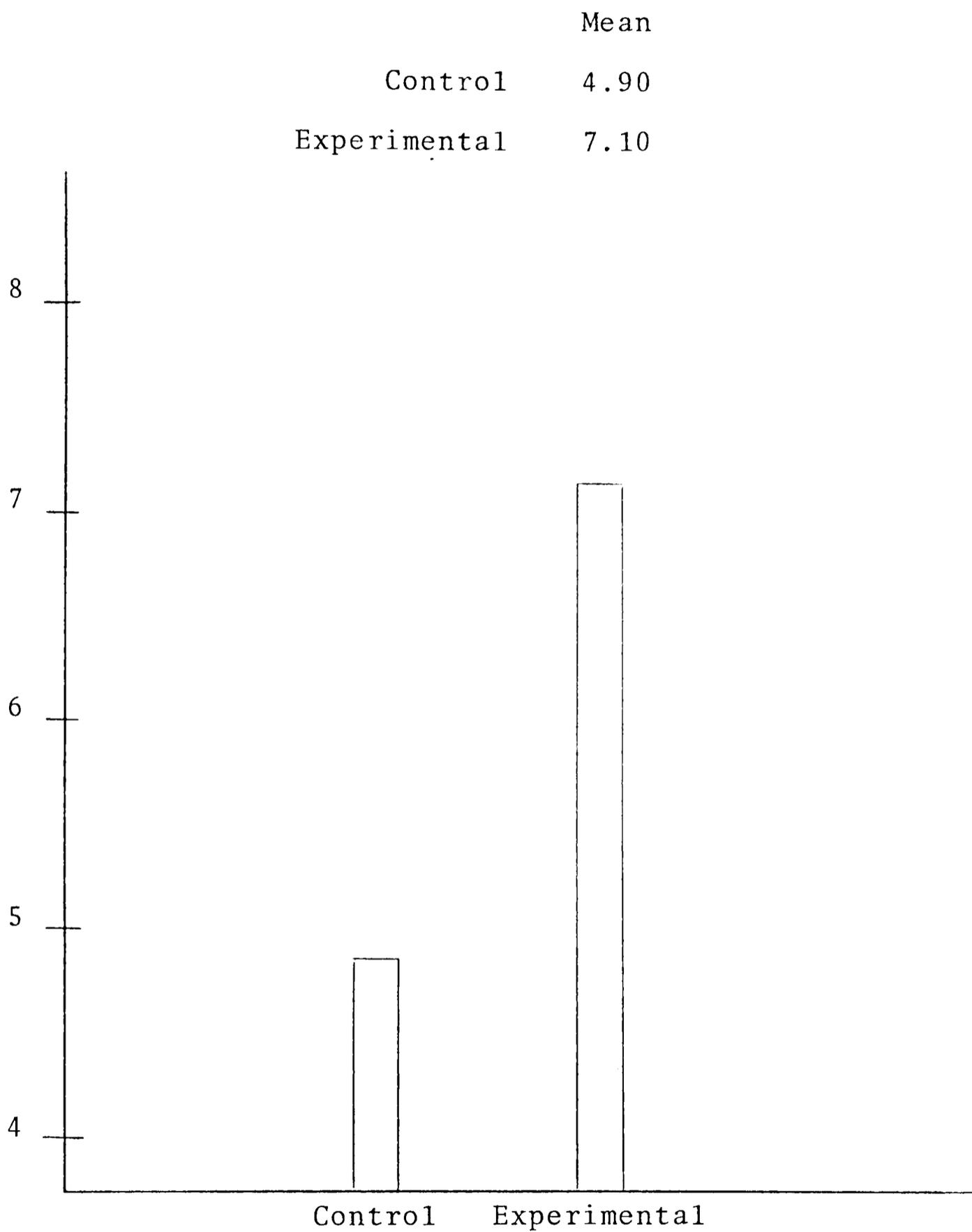


Figure 5. Posttreatment direct expression of feeling scores.

had a higher posttreatment direct expression-of-feelings level than the control group. The experimental group mean was 7.10 and the control group mean was 4.90.

Hypothesis 4 was confirmed.

Hypothesis 5

It was predicted that the experimental group would be judged as significantly better at focusing following treatment than the control group as rated by the psychotherapists. The analysis summarized in Table 11 yielded nonsignificant results, although the difference was in the predicted direction. The results are presented graphically in Figure 6 from which it can be seen that the experimental group mean was 2.20 and the control group mean was 2.10. Hypothesis 5 was not confirmed.

Additional Analyses

In addition to the research hypotheses mentioned above, several additional analyses were carried out that could add information regarding the nature of the change process resulting from the training in focusing.

Post-Focusing Essay Question

The essay question which was administered after the initial and final focusing experience during the micro-training session was evaluated to determine whether improvement in focusing had occurred. The questionnaires were

Table 11
Comparison^a of Control and Experimental Group^b
Posttreatment Therapist Rating of Focusing

| Variable | <u>t</u> |
|------------------------------|----------|
| Therapist Rating of Focusing | .221 |

^at (18, 1-tailed) = 1.734, p < .05

^bn = 10 for each group

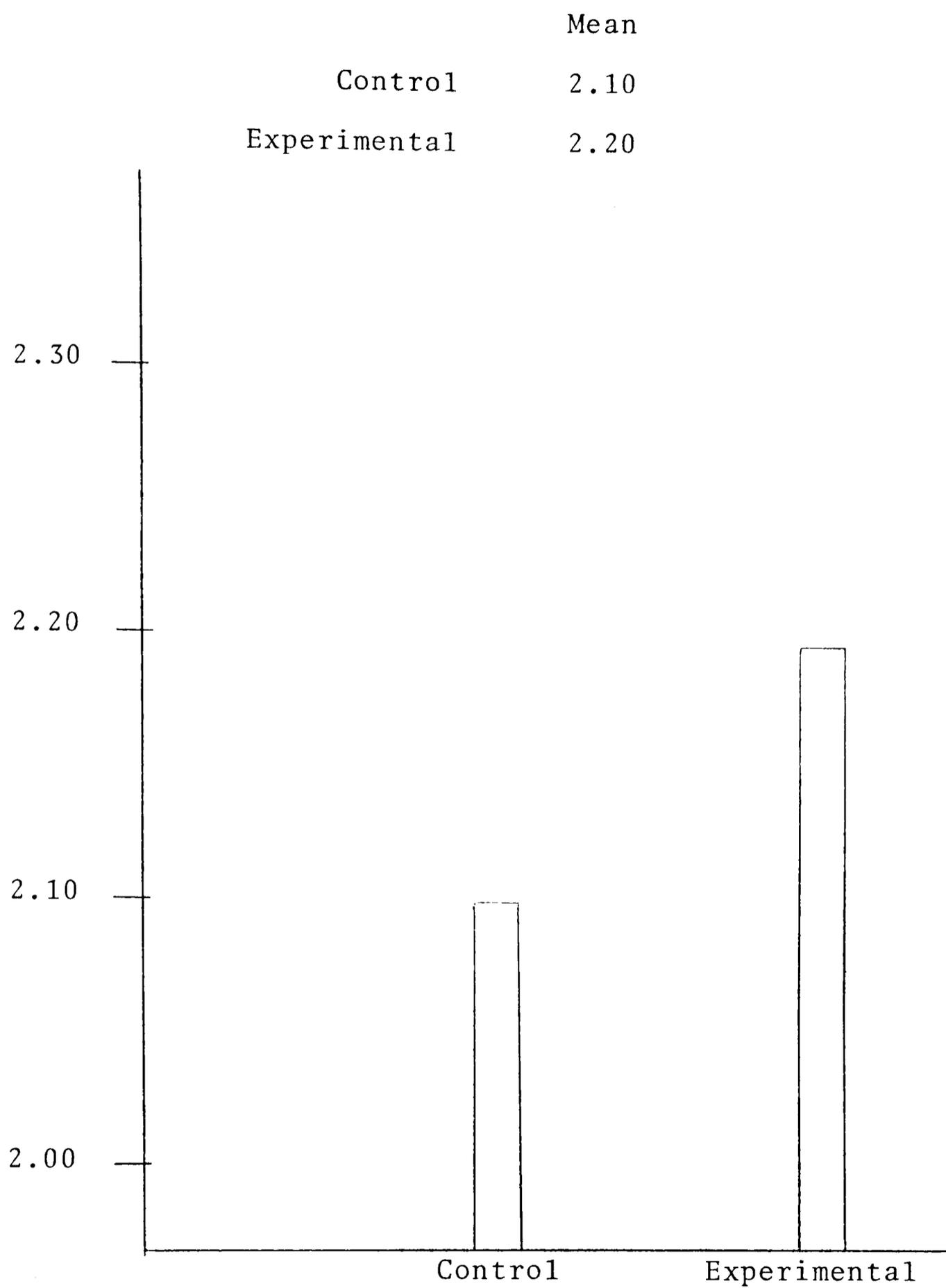


Figure 6. Posttreatment therapist rating of focusing scores.

randomized and presented to the judges. The judges correlated .71 in making the ratings. As can be seen from Table 12, the one-tailed t test for correlated variances (Guilford, 1965) performed on this data yielded highly significant results, indicating that improvement in focusing ability did occur during the training sessions.

As can be seen from Figure 7, the score in focusing attained at the beginning of the microtraining session was 1.5 and the mean score attained at the end of the session was 2.5. These results support the contention that the microtraining was successful.

Rating Scales

Besides the rating scale from which the hypothesized difference was found in direct expression of feelings, therapists were asked to rate their patients' behavior on the five other scales that make up the instrument (Gendlin, Jenney, & Shlien, 1960). (See Appendix D.)

Scale 1. This scale assesses the degree to which therapy focuses on the patient's relationship with his therapist as a topic of discussion. No significant differences were found between the experimental group and the control group on this scale, as can be seen in Table 13. The results are presented graphically in Figure 8, from which it can be seen that the experimental group mean was 5.30 and the control group mean was 5.00.

Table 12
 Means, Standard Deviations, and Comparison of
 Post-Focusing Essay Question Scores at the
 Beginning and End of the Training Sessions

| Variable | Initial Score | Final Score | t |
|-------------------------|---------------|-------------|--------|
| | M | M | SD |
| Score on Essay Question | 1.5 | 2.5 | .88 |
| | .67 | | -4.243 |

$p < .005$

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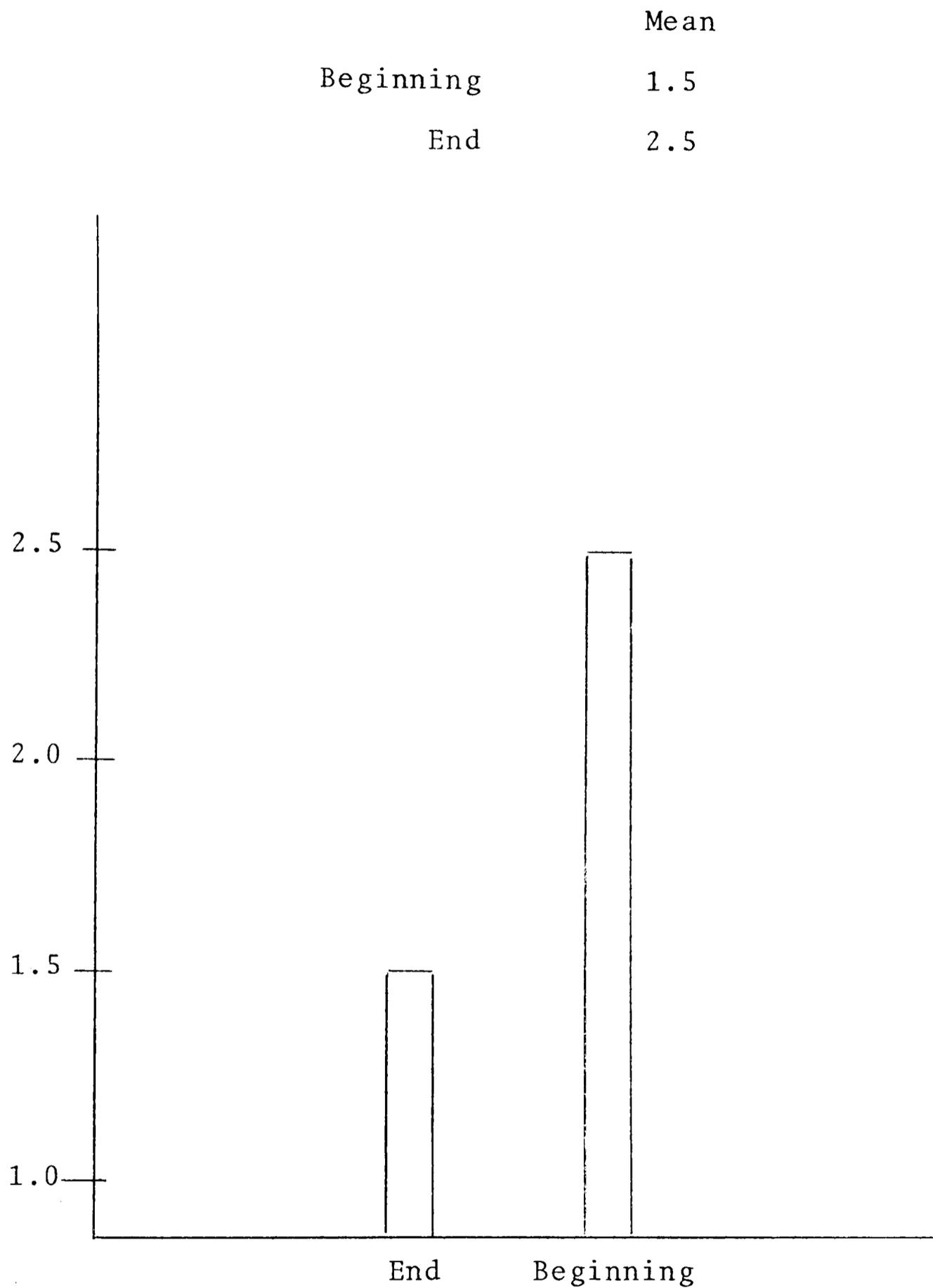


Figure 7. Post-Focusing Essay Question scores beginning and end of training session.

Table 13

Means, Standard Deviations, and Comparison^a of
Control and Experimental Groups^b on Rating Scale Scores

| Variable | Control | | Experimental | | \underline{t} |
|--|---------|------|--------------|------|-----------------|
| | M | SD | M | SD | |
| Relationship with therapist as topic of discussion | 5.00 | 2.75 | 5.30 | 2.95 | .235 |
| Characteristics of therapist as topic of discussion | 5.50 | 2.72 | 5.60 | 3.60 | .070 |
| Relationship with therapist as instance of patient difficulties | 3.90 | 2.96 | 5.20 | 2.74 | 1.019 |
| Relationship with therapist as source of new experience | 4.90 | 2.38 | 6.00 | 2.83 | .941 |
| Extent problems focus on the past (childhood) | 5.40 | 2.59 | 7.30 | 1.70 | 1.938 |

^a \underline{t} (18) = 2.101, $\underline{p} < .05$

^b $\underline{n} = 10$ for each group

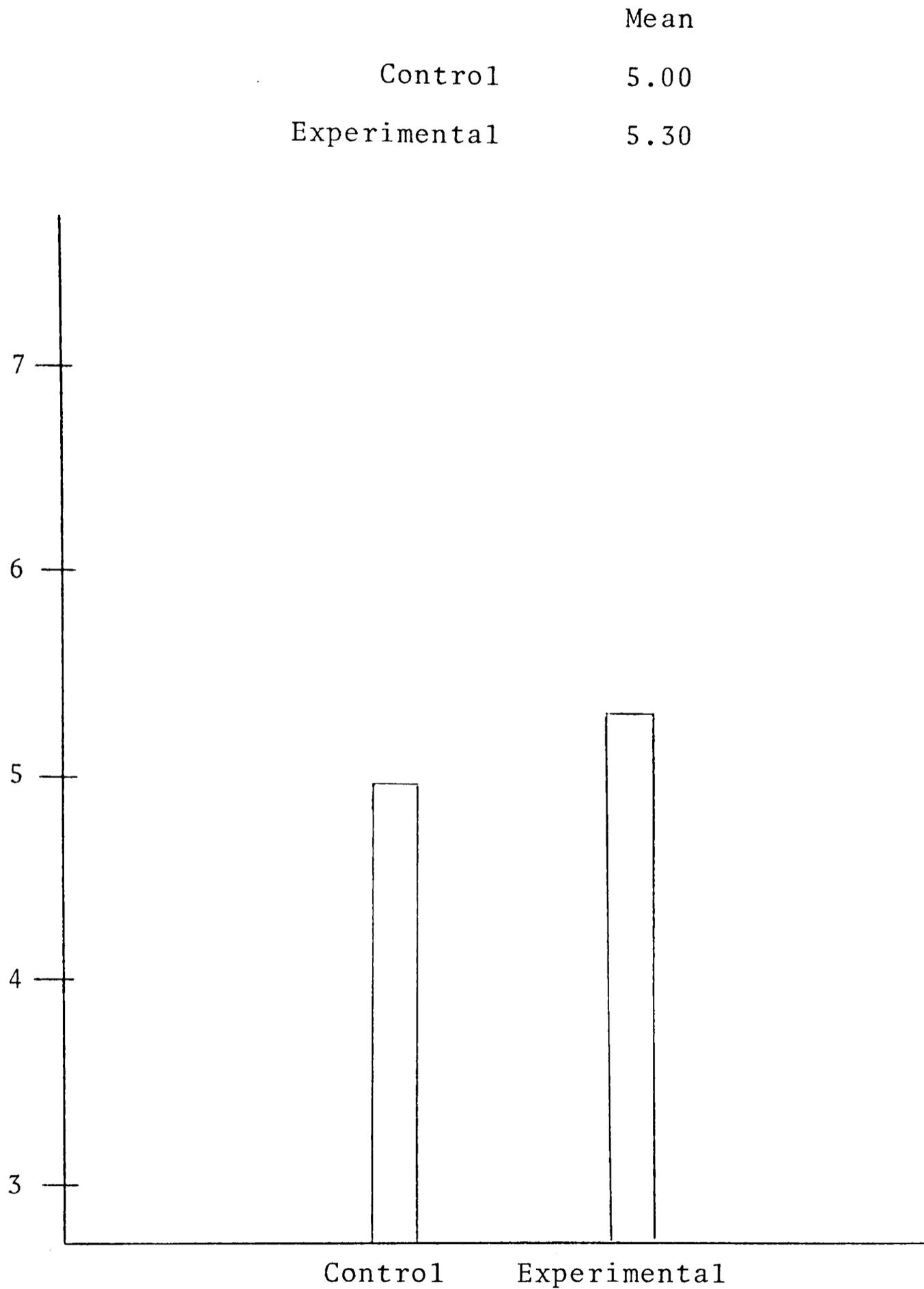


Figure 8. Posttreatment therapist rating of relationship with therapist as patient's topic of discussion.

Scale 2. This scale assesses the degree to which therapy focuses on characteristics of the therapist as a topic of discussion. No significant differences were found between the experimental group and the control group on this scale, as can be seen in Table 13. The results are presented graphically in Figure 9, from which it can be seen that the experimental group mean was 5.60, and the control group mean was 5.50.

Scale 3. This scale assesses the degree to which therapy focuses on the patient's relationship with the therapist as an instance of the patient's difficulties. No significant differences were found between the experimental group and the control group on this scale, as can be seen in Table 13. The results are presented graphically in Figure 10, from which it can be seen that the experimental group mean was 5.20, and the control group mean was 3.90.

Scale 4. This scale assesses the degree to which the patient's relationship with the therapist is a source of new experience for the patient. No significant differences were found between the experimental group and the control group on this scale, as can be seen in Table 13. The results are presented graphically in Figure 11, from which it can be seen that the experimental group mean was 6.00 and the control group mean was 4.90.

Scale 5. This scale assesses the extent to which

| | Mean |
|--------------|------|
| Control | 5.50 |
| Experimental | 5.60 |

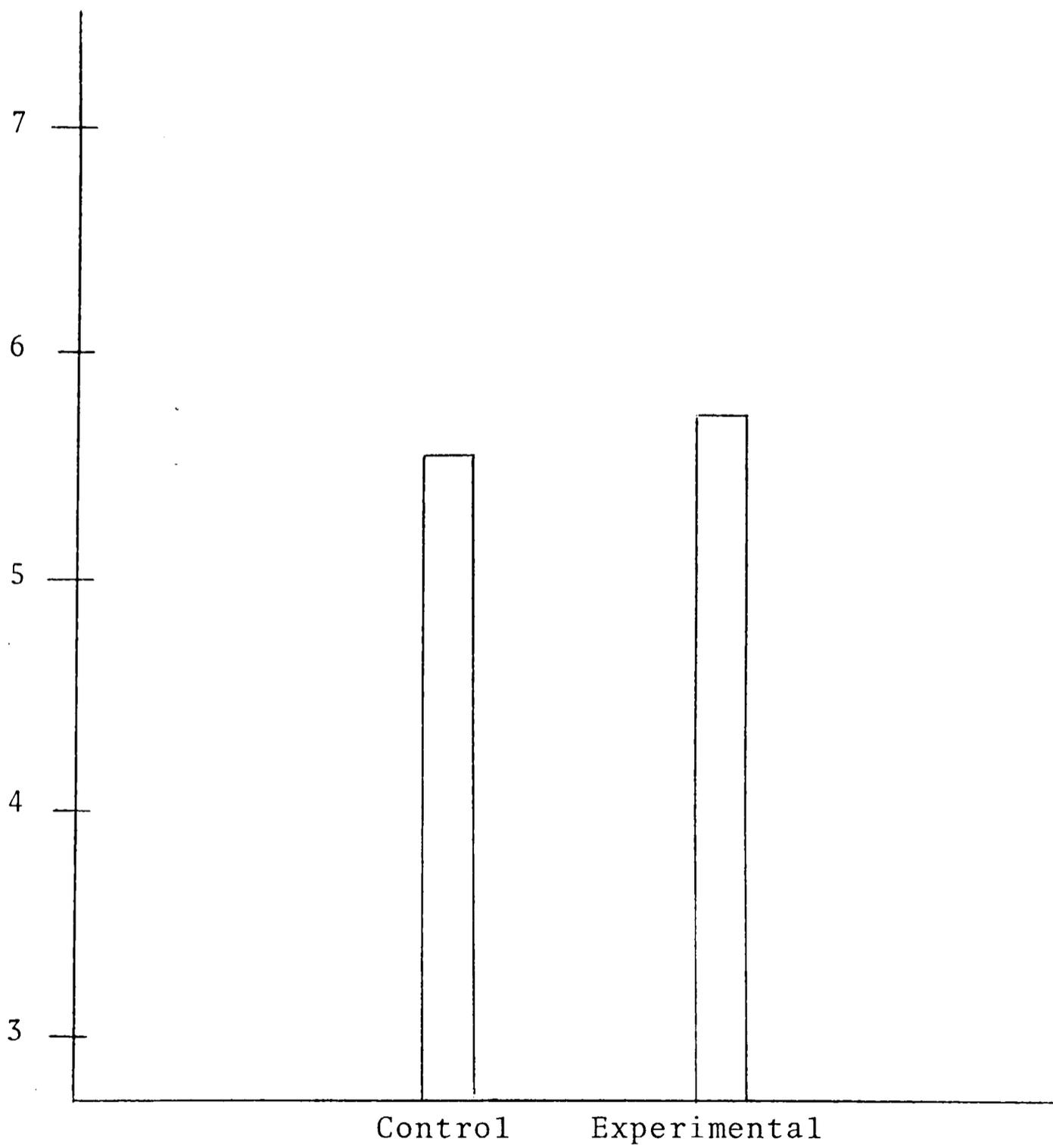


Figure 9. Posttreatment therapist rating of characteristics of therapist as patient's topic of discussion.

| | Mean |
|--------------|------|
| Control | 3.90 |
| Experimental | 5.20 |

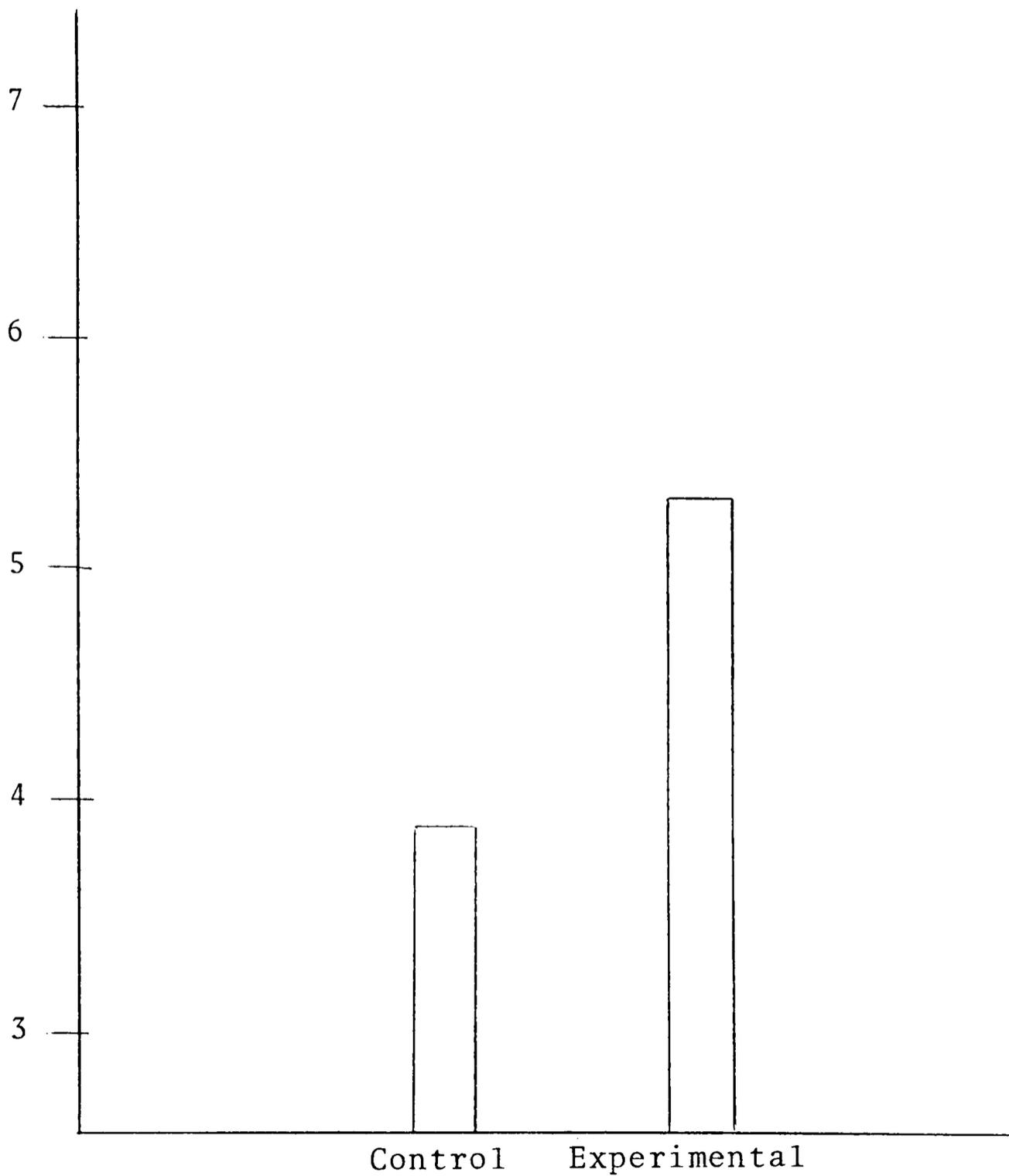


Figure 10. Posttreatment therapist rating of relationship with therapist as instance of patient difficulties.

| | Mean |
|--------------|------|
| Control | 4.90 |
| Experimental | 6.00 |

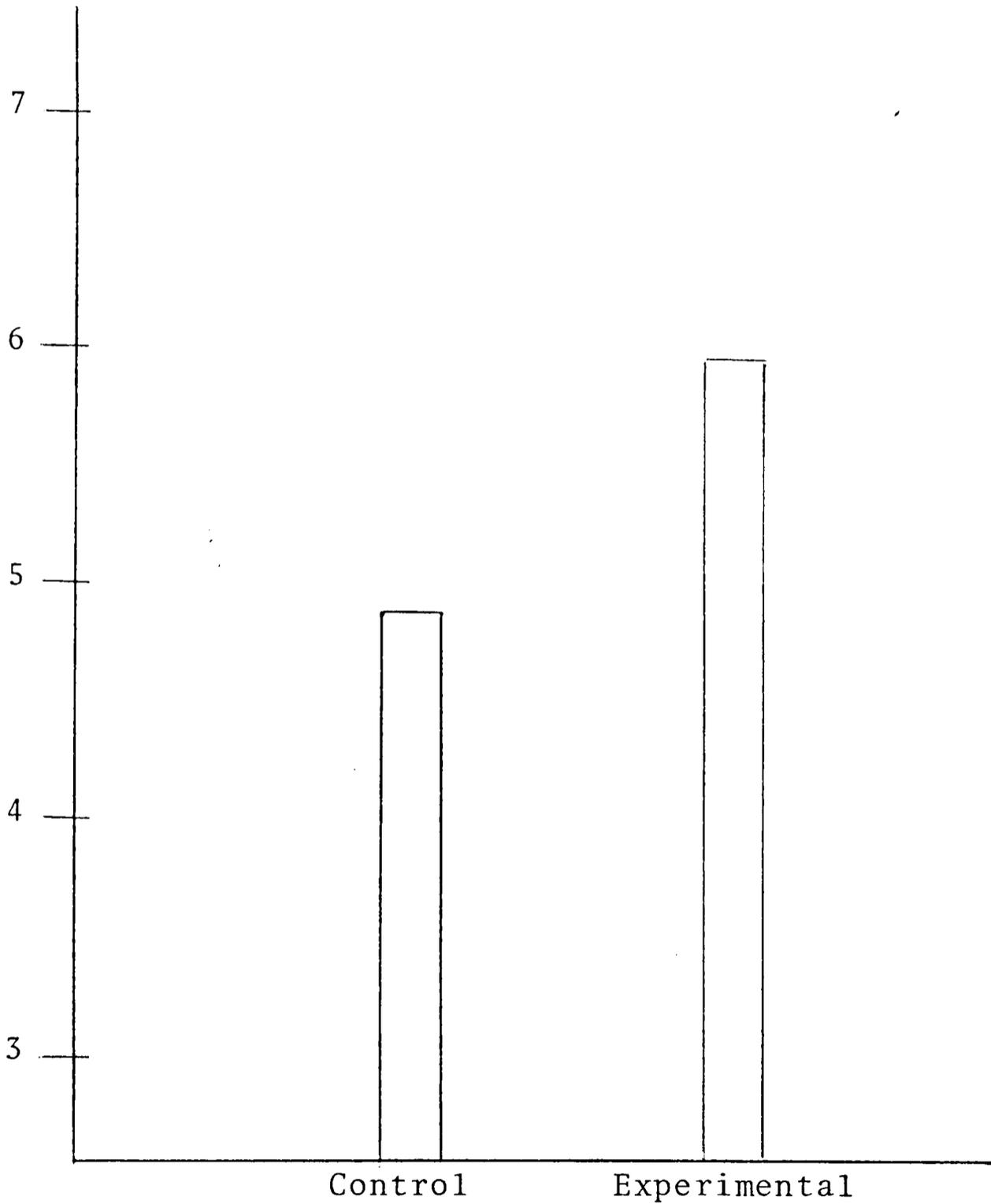


Figure 11. Posttreatment therapist rating of relationship with therapist as source of new experience.

the patient's discussion of his problem focuses on his childhood or the present. No significant differences were found between the experimental group and the control group on this scale, as can be seen in Table 13. The results are presented graphically in Figure 12, from which it can be seen that the experimental group mean was 7.30 and the control group mean was 5.40.

Demographic Variables

The demographic variables which were studied in this investigation were selected because it was thought that they might potentially have an effect on treatment outcome. It was anticipated that randomization of the subjects would remove effects of these variables across treatments. That this was successful can be seen from Table 14.

The demographic variables were correlated with the outcome measures to examine their relationship to improvement in focusing ability. The correlation matrix is presented in Table 15. Most of the correlations were nonsignificant. There were three significant correlations. Age of the patient was negatively correlated (-.46) with the before-treatment score on the Post-Focusing Questionnaire rated both as a whole and item-by-item: That is, younger patients tended to score as better focusers before training. Another significant correlation of .49 was

| | Mean |
|--------------|------|
| Control | 5.40 |
| Experimental | 7.30 |

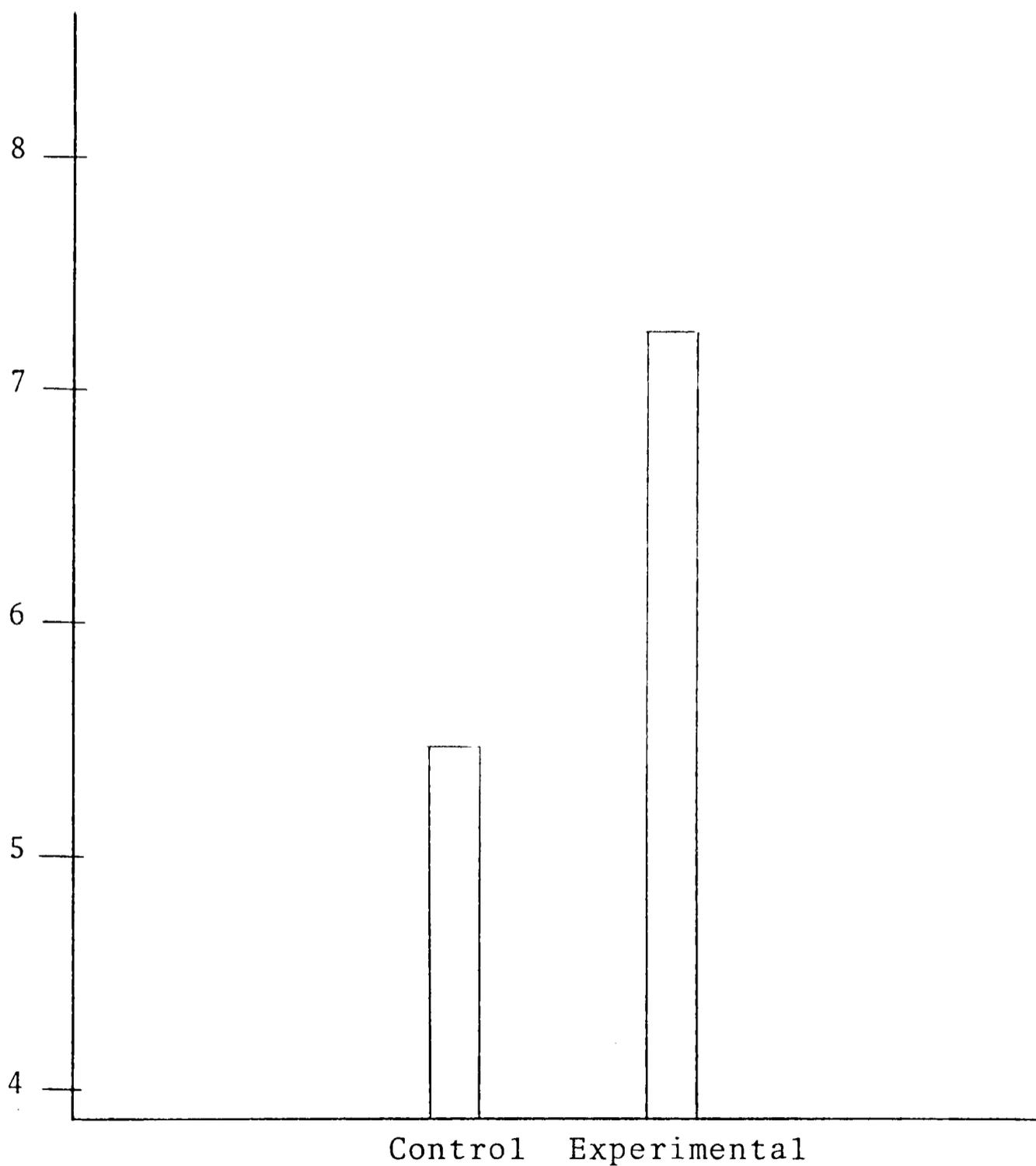


Figure 12. Posttreatment therapist rating of extent problems focus on the past (childhood) as patient's topic of discussion.

Table 14
 Comparison^a of Control and Experimental Groups^b
 on Demographic Variables

| Variable | <u>t</u> |
|---|----------|
| Educational Level | .679 |
| Age | 1.708 |
| Sessions of Outpatient Psychotherapy | .366 |
| Time since Last Psychiatric Hospitalization | 1.867 |
| Length of Last Psychiatric Hospitalization | .160 |
| Total Length of Psychiatric Hospitalization | .254 |

^at (18) = 2.101, p < .05

^bn = 10 for each group

Table 15
Correlation Ratios for Demographic Variables with Outcome Measures

| | Educational Level | Age | Sessions of Outpatient psychotherapy | Time since last psychiatric hospitalization | Length of last psychiatric hospitalization | Total Length of psychiatric hospitalization | Diagnosis (Paranoid-Nonparanoid) |
|---|-------------------|-------|--------------------------------------|---|--|---|----------------------------------|
| Pre-Score: Post-Focusing Questionnaire (rated as a whole) | .20 | -.46* | .02 | -.34 | .01 | .10 | .01 |
| Pre-Score: Post-Focusing Questionnaire (rated item-by-item) | .01 | -.46* | -.02 | -.49* | -.02 | -.05 | .07 |
| Pre-Score: Post-Focusing Checklist | .09 | -.14 | -.24 | .07 | .02 | -.26 | .30 |
| Posttreatment Score: Post-Focusing Questionnaire (rated as a whole) | .26 | -.36 | .10 | -.17 | -.12 | -.29 | .06 |

Pre-Score: Post-Focusing Questionnaire (rated as a whole)

Pre-Score: Post-Focusing Questionnaire (rated item-by-item)

Pre-Score: Post-Focusing Checklist

Posttreatment Score: Post-Focusing Questionnaire (rated as a whole)

Table 15 (Continued)

| | Educational Level | Age | Sessions of Outpatient Psychotherapy | Time since Last Psychiatric Hospitalization | Length of Last Psychiatric Hospitalization | Total Length of Psychiatric Hospitalization | Diagnosis (Paranoid-Non-paranoid) |
|---|-------------------|------|--------------------------------------|---|--|---|-----------------------------------|
| Posttreatment Score: Post-Focusing Questionnaire (rated item-by-item) | .07 | -.36 | .12 | -.25 | -.14 | -.26 | .10 |
| Posttreatment Score: Post-Focusing Checklist | .17 | .24 | -.16 | .19 | .29 | .36 | -.07 |
| Change Score: Post-Focusing Questionnaire (rated as a whole) | .24 | -.10 | .10 | -.07 | -.05 | -.35 | .05 |
| Change Score: Post-Focusing Questionnaire (rated item-by-item) | .22 | .08 | .16 | .03 | .18 | -.27 | .12 |
| Change Score: Post Focusing Checklist | -.31 | -.25 | -.06 | .10 | -.13 | -.41 | .24 |
| Direct Expression of Feeling | -.18 | .25 | .31 | .30 | -.10 | -.07 | .19 |
| Focusing: Rated by Therapist | .25 | -.32 | -.25 | -.33 | -.26 | -.30 | -.17 |

* $p < .05$

found between the before-treatment Post-Focusing Questionnaire rated item-by-item and the length of time since the patient's last psychiatric hospitalization.

There were three significant correlations between the demographic variables (see Table 16). The patient's age was found to correlate .72 with the length of time since his last psychiatric hospitalization. Total length of psychiatric hospitalization correlated .79 with length of last psychiatric hospitalization. Length of last psychiatric hospitalization correlated -.52 with paranoid-nonparanoid diagnosis: That is, patients diagnosed paranoid tended to be in the hospital for a shorter period the last time they were hospitalized than patients diagnosed nonparanoid.

Table 16

Correlation ratios for Demographic Variables

| | Educational Level | Age | Sessions of Outpatient Psychotherapy | Time since Last Psychiatric Hospitalization | Length of Last Psychiatric Hospitalization | Total Length of Psychiatric Hospitalization | Diagnosis (Paranoid-Nonparanoid) |
|---|-------------------|------|--------------------------------------|---|--|---|----------------------------------|
| Educational Level | -.05 | -.12 | -.33 | .00 | -.17 | -.16 | |
| Age | | .30 | .72** | .24 | .40 | -.07 | |
| Sessions of Outpatient Psychotherapy | | | .35 | -.13 | .06 | .11 | |
| Time since Last Psychiatric Hospitalization | | | | .27 | .27 | -.05 | |
| Length of Last Psychiatric Hospitalization | | | | | .79** | -.52* | |
| Total Length of Psychiatric Hospitalization | | | | | | | -.38 |

*p < .05

**p < .01

1963

CHAPTER IV

DISCUSSION

The discussion of the results of this investigation is presented in several sections. The first section will deal with the results in relation to the hypotheses advanced. The second section will deal with an analysis of supplementary results and their relationship to the training and to experiential focusing. The third section will be a discussion of the implications of the results for theory. The fourth section will be concerned with specific aspects of the training to provide a broader understanding of the present study and to help provide guidelines for future studies related to the present one. The final section will be a discussion of possible future directions for research.

Hypotheses

Hypothesis 1

It was predicted that the experimental group would become significantly better at focusing than the control group as measured by the Post-Focusing Questionnaire rated as a whole. An analysis of variance and Tukey's HSD test showed that, instead, both the experimental group and the control group had a significant increase in their focusing

scores. It might be noted (see Figure 2) that at posttest, the experimental group mean (2.10) was somewhat higher than the control group mean (1.90).

Gendlin and his associates (Gendlin et al., 1968) originally intended that the Focusing Manual be used to teach focusing. It is possible that control subjects were able to learn enough about focusing from being exposed to the Focusing Manual twice (at the pretest and at the post-test) to have also learned to focus more effectively. That the experimental group learned to focus somewhat better than the control group would be consistent with other research findings that supplemental instructions are helpful in learning focusing (VandenBos, 1973).

Since both groups improved, it is possible that the results are a consequence of the increased attention received by both groups.

Another explanation for these results might be that the scores of both the experimental group and the control group on the posttest tended to regress towards the mean which the 56 outpatients scored on the pretest. The mean score on the Post-Focusing Questionnaires rated as a whole for the 56 outpatients tested during the screening, as rated by the judge who performed the screening, was 2.27. If scores for the 26 pretest questionnaires rated by the two final judges are substituted for the scores on the same questionnaires as rated by the screening judge, the average

for the 56 outpatients becomes 2.42. It can be seen from this that the posttest score for the experimental group (2.10) comes closer than the posttest score for the control group (1.90) to reaching the mean score for the entire group of 56 patients on the pretest. Since the regression to the mean effect would be expected to be the same for both groups, the somewhat higher score for the experimental group could then be seen to be an effect of the training.

A final possible explanation concerning why both the experimental and the control groups scored significantly higher on the posttest would be that both groups were uncertain of what was expected of them on the pretest, and perhaps somewhat confused by the unfamiliar procedure. None of them had previously been exposed to the Focusing Manual or to the Post-Focusing Questionnaire or to the Post-Focusing Checklist. By the posttesting, they may have better understood the procedure, or perhaps have tried harder to answer in a way which they thought might please the experimenter. That neither group on the posttest reached the mean of the 56 subjects screened on the pretest would tend to mitigate against this conclusion, however, since the subjects scoring as focusers on the pretest were no more familiar with the testing procedure than the subjects scoring as nonfocusers.

These results, stemming from the vantage point of scoring the questionnaires as a whole, are different from

the results obtained by scoring the questionnaires item-by-item. To more fully understand this we should examine the results from Hypothesis 2 and compare them.

Hypothesis 2

It was predicted that the experimental group would become significantly better at focusing than the control group as measured by the Post-Focusing Questionnaire rated item-by-item. Analysis of variance and a Tukey's HSD test supported this hypothesis. The results bear out the efficacy of Ivey's (1971) microtraining procedure in teaching focusing.

Either way the questionnaires were assessed, as a whole or item-by-item, many of the schizophrenics showed improved performance. These results are counter to the notion that schizophrenics would be unable to learn improved focusing. The results from item-by-item ratings are consistent with Ivey's (1973) findings which indicate that his method is useful in helping schizophrenics attain new skills.

The varying results for these two hypotheses are worth noting, since they come from the same questionnaires. The different methods of rating can apparently yield importantly different results. Rated as a whole, both groups started at the same level and improved, the experimental group improving somewhat more than the control group. Rated item-by-item, the experimental group started

at a level below the control group and finished at a level above it, while the control group did about the same at pretest and at posttest. The difference between the experimental and control group pretest scores on the Post-Focusing Questionnaire rated item-by-item may be due to the imperfect reliability of the judges.

Rated as a whole, five members of the experimental group improved, and five stayed the same. In the control group, four members improved, five stayed the same, and one did worse. Rated item-by-item, nine members of the experimental group improved, and one did the same. Four members of the control group did better, and six did worse.

To better understand this, questionnaires yielding the largest differences in ratings were examined. In general it was found that of the nine questions, some questions yielded answers ratable as representative of higher or lower levels of focusing than other questions. When the questionnaires were rated as a whole, the judges could tell more clearly if one item contradicted another, and get an overall picture of what was going on with the person when he answered the questionnaire. For example, a person might indicate that he had a felt sense of one item (scorable as a "3") and on another item indicate that he was confused, and therefore could not follow the exercise (scorable as a "1"). These would average out as a "2" if rated item-by-item, while clearly scoring a "1"

as a whole since the person indicated he could not follow the exercise (see Appendix F for rules of judging).

An example of an actual questionnaire showing one of the wider discrepancies of scores when rated item-by-item versus as a whole might be helpful here. Appendix K shows the questionnaire, and scores given by each judge on each item, these scores averaged, and the scores when the questionnaire is rated as a whole. It can be seen that the judges rated the various questions differently, with individual scores ranging from 1 to 4. Yet the judges agreed that overall the questionnaire should be rated a 3, indicating that the person had a felt sense of a problem.

The two ways of scoring the questionnaire might differentially affect the kinds of conclusions which could be drawn from results obtained. The result obtained from rating a questionnaire item-by-item might be considered as more ambiguous. A person filling out the questionnaire tends to give extensive answers to one of two of the questions, and less extensive answers to the rest of the questions, possibly assuming that whoever would read the questionnaire would already be aware of what he had written on the previous items. Therefore a person who had clearly focused could score a 4 on the more completely answered items, and a 1 on the items with less information, thus obtaining a moderately low score of 1.67. Conceptually,

it is difficult to understand what the averaged score means, whereas when the questionnaire is scored as a whole, one can refer to the descriptions judges use in making the rating and therefore more readily understand what the rating means.

Another advantage to rating the questionnaire as a whole is that extreme scores of 1 and 4 are possible. Rated item-by-item, the range of scores in the present study was 1.08 to 3.00. Rated as a whole the scores ranged from 1 to 4. Individuals tend not to answer all of the items in a way that could be scored a 4 even if they have clearly focused, nor do they tend to answer all of the items in a way that could be scored a 1 even if they have not even held their attention on a single problem throughout the focusing experience. Therefore, information about persons who would have scored a 1 or a 4 had the questionnaire been rated as a whole would be lost if the questionnaire were rated item-by-item and the scores then averaged.

One consideration favors rating the questionnaire item-by-item, however. When the questionnaire is rated as a whole, the number of possible intervals is 4 (1, 2, 3, 4). Rated item-by-item with all nine questions answered, the number of intervals can be 27 ($9/9 = 1$, with all nine questions answered and rated "1"; $36/9 = 4$, with all nine questions answered and rated "4", with variations

9, 10, 11, . . . , 36 between). The greater number of

9

intervals possible when rating the questionnaire item-by-item would increase the variance possible and thus make it easier to find significant differences between groups in conducting research. The increased variance could also make it easier to obtain acceptably high levels of correlation between judges of the questionnaire.

The central point to make about these two ways of judging the questionnaires is that they can yield different results, and that therefore, it is important to rate them both ways in research. Perhaps, eventually, the rules for making the judgments or the manner of eliciting information will be refined to a point where this is not necessary, but it appears to be necessary at this point in time. Yet it is seldom in research on focusing that both ways of rating the questionnaire are done.

Either way the questionnaire was rated, if the scores for each group are averaged, the training did not make focusers out of these nonfocusers. The averaged scores for the experimental group, either way the questionnaire was scored, indicated that the patients were better able to hold their attention on whatever problem they were considering (1.45 pre to 2.10 post, rated as a whole; 1.80 pre to 2.20 post rated item-by-item, see Appendix F), and that the patients were sometimes able to describe their

feelings. For the control group, the averaged scores for the questionnaire rated as a whole indicate that the patients were better able to hold their attention on a single problem (1.45 pre to 1.90 post). In the experimental group five of the ten subjects would be described as focusers ("3's") after the training with the questionnaire rated as a whole, and in the control group there was only one clear focuser (a "4", rated as a whole) after this brief training. It is not known from this experiment whether additional microtraining sessions would have helped more of the subjects become focusers, but it can be speculated that it might have since half of the trained group became focusers after the brief training provided. On the other hand, some patients might not be able to improve in focusing regardless of how much training they received.

Another area warranting comment involves Gendlin's (1970) assertion that often the "frozen wholes" where a person gets "stuck" in his experiencing are typically in the person's relationships with other people. On the Post-Focusing Questionnaire, the subject is asked to not write about the topic he focused on, only the process. Yet on half of the questionnaires the patient mentioned what it was that he had focused on. Most often it was about members of his family (7), then about his therapist or other patients in group therapy (3), or concerns about

relationships with other people, or social demands (5). One patient considered his job, two considered physical ailments, another considered painful aspects of his life, and one what he would do if given another chance at life. Thus many, though not all, of the questionnaires mentioning a topic had to do with interpersonal relationships.

Although taken as an average these subjects did not become clear focusers, the average improvement can be compared to that of the subjects in the Rogers et al. (1967) Wisconsin study on schizophrenics as reported by Gendlin et al. (1968). Gendlin et al. present a table showing that for schizophrenics starting above 1.75 on the Experiencing Scale, five out of six were successes in psychotherapy. Of those below 1.75, five out of six schizophrenics were failures in psychotherapy. A score of 1 on the Experiencing Scale means "No personal reference used. Narrative of events describing what amounts to a public involvement." A score of 2 means "Personal reference used to clarify that it is clearly his story" (Rogers et al., 1967, p. 590).

Although these are average scores representing more than one segment of tape, and therefore individual segments might have received more widely ranging ratings, the average is interesting in that even those patients scoring above 1.75 were still not referring to their felt sense as they spoke with their therapists. Yet Gendlin

et al. concluded that since above an average score of 1.75 most of the patients succeed in psychotherapy (as measured by the Sc Scale of the MMPI), they had enough of a "motor" going (Gendlin, 1969) that they were able to profit from psychotherapy as measured by the Sc Scale of the MMPI. Those patients in the Wisconsin study starting with a high enough experiencing score were also able to improve on the Experiencing Scale, moving up an average of a half scale point (to over 2.25). This moves them towards a score of 3, in which "affective involvement does go beyond specific content but passes by deeper meaning" (Rogers et al., 1967, p. 590).

In the present study the subjects who improved in their focusing scores make a similar movement, towards staying on a personally relevant subject and towards a bit more awareness of their feelings. Perhaps we could infer from this that the training was successful in bringing these subjects to a point where they would be more likely to benefit from psychotherapy. Maybe for these schizophrenic subjects this would provide enough of a "motor" for them to carry their experiencing forward in ways in which they could benefit.

The finding that patients were better able to stay on one topic might indicate improved functioning for schizophrenic subjects less able to stay on one topic before the training. If as Cohen and his associates (Cohen

& Camhi, 1967; Lisman & Cohen, 1972; Nachmani & Cohen, 1969) indicate, schizophrenic thinking disorder may involve a failure to edit out irrelevant or inappropriate associations, then staying on one topic would be an improvement in the thought disorder itself.

Hypothesis 3

It was predicted that the experimental group would become significantly better at focusing than the control group as measured by the Post-Focusing Checklist. Although the results were not statistically significant, the experimental group improved in their focusing scores whereas the control group did worse. As measured by this scale, the microtraining method netted some improvement, whereas the focusing instructions alone did not, again tending to support previous research indicating the necessity of training going beyond mere presentation of the Focusing Manual, such as the training provided in the present study, or such as the training provided by VandenBos as described in the review of the literature in Chapter I.

It should be noted that at the planning stages of the study this instrument was to be used to help screen out focusers. The correlation of this instrument with the Post-Focusing Questionnaire rated as a whole was so poor ($r = .24$), however, that no definite cutoff point could be found. Had the cut off point suggested by

VandenBos (1973) been used of 18 or higher, all but two of the subjects eventually used in the study would have been screened out. Sixteen of the Post-Focusing Questionnaires used in this study were rated as "1" (clear non-focuser) in which the corresponding Post-Focusing Checklist score was lower than 18.

Because this result was at odds with results from other studies, in which the Post-Focusing Questionnaire correlated with the Post-Focusing Checklist between .74 and .89 (VandenBos, 1973; Wolf & VandenBos, 1970), the investigator asked the subjects about how they were answering the checklist. From the patient's comments it could be inferred that some of the items in the checklist were written in a manner that made it difficult for them to understand. The subjects apparently answered items they did not understand randomly, rather than asking for clarification. This may have accounted for the scores not being extreme enough to fall into the nonfocusing category, since it would take 18 out of 28 items to score as a nonfocuser, whereas a score of 14 would be average if half the items were randomly answered in a nonfocusing direction. Of the 56 subjects screened, the initial Post-Focusing Checklist scores averaged 13.

The Post-Focusing Checklist has previously been used with college students. Used with schizophrenics having a high school education its results apparently do not have

the same meaning as with college undergraduates.

Even for the schizophrenics rated as clear nonfocusers and included in the study on the basis of the Post-Focusing Questionnaire, the average score on the Post-Focusing Checklist was 13. Again, random marking would produce a score of 14, out of 28 possible. Another explanation might be that on those items which the patients did understand they tended to answer in a way which they guessed would make them look good to the experimenter. Some of the items on the Post-Focusing Checklist are less ambiguous than those on the open-ended Post-Focusing Questionnaire. A patient who had had a great many psychotherapy sessions might be able to better guess what he thought the experimenter wanted him to answer on the checklist than on the questionnaire.

These two explanations, that many of the items were difficult for the patients to understand, and that subjects might try to look good to the experimenter, could help explain the somewhat positive results found with this instrument in the present study. After receiving the focusing training the subjects may have been more aware of what might make them look good, and also have a better idea of what the items on the checklist meant. This could account for their improvement on this scale.

Three factors mitigate against this conclusion, however. The first is that the analysis of variance approached significance ($p < .09$) in supporting the

hypothesis. This is supplemented by the findings on the Post-Focusing Questionnaire that the experimental group improved. Finally, the results can be compared to those VandenBos (1973) found in his study using normal subjects (college undergraduates), as we shall now consider.

In Table 17, average scores are presented from both the current study and from the VandenBos (1973) study. VandenBos tabled only his post-scores. It can be seen that the control group score for nonfocusers in VandenBos' study was 16.31, which was indicative of less successful focusing than the average score attained by the schizophrenics in the present study on any of the testings. The experimental groups in the VandenBos study showed more improvement after training than the experimental group in the present study. This might be expected from the difference between populations (Chapman & Chapman, 1973).

Yet after training, the schizophrenics in the present study were, on the average, within one item on the Post-Focusing Checklist of scoring as well as normal subjects under one of VandenBos' training conditions (his standard focusing training group). Under that training condition his subjects were presented with the Focusing Manual, followed by an explanation of focusing by a trainer. The trainer answered any questions the subjects might have. This was done for two sessions. This training method was the most similar to that of the present study, although

Table 17
 Post-Focusing Checklist Scores for
 Schizophrenic and Normal Subjects

| | Pre | Post |
|-------------------|-------|--------------|
| Schizophrenics | | |
| Experimental | 13.90 | <u>10.30</u> |
| Control | 11.80 | 12.70 |
| Normal Subjects | | |
| Experimental | | |
| Training Method A | | 7.25 |
| Training Method B | | 8.38 |
| Training Method C | | <u>9.38</u> |
| Control | | 16.31 |

Note. Scores for schizophrenics are from the present study, and for normals are from VandenBos, 1973.

elements from the other training methods used by VandenBos were also incorporated into the current investigation. The average score of 10.30 achieved by the schizophrenics in the present study after brief training was close to the average score of 9.38 achieved by the college students trained by VandenBos under his third training condition. This proximity of posttraining scores may indicate that some of the improvement on the checklist scores achieved by the schizophrenics in the present study was a result of the microtraining. Since VandenBos does not report pretest scores, it is not certain how much his normal subjects improved in the checklist from pretest to post-test as a consequence of training.

Results from the present study suggest that if the Post-Focusing Checklist is to be used with a schizophrenic population, it might be best if each item were explained to the subject individually. Perhaps the entire checklist could be revised with less esoteric wording.

It is also important to note that the researcher should be wary of using the Post-Focusing Checklist alone in a study, as VandenBos (1973) did. The meaning of results attained on this checklist appears to be questionable when used in isolation as they can differ from results obtained on the Post-Focusing Questionnaire. It is especially questionable to use the checklist in isolation if the researcher plans to use the instrument with a

population like the one in the present study.

In neither the VandenBos study nor the present study did subjects on the average score in the "clear focusers" range of six or less on the checklist. In the present study only two subjects scored six or lower. One of these subjects had scored 21 (clear nonfocuser) on the pretest, however, and thus showed the most dramatic benefit from the training on this measure as he was in the experimental group.

In the present study seven subjects in the experimental group showed improved scores on the checklist, one remained the same, and two did worse. In the control group two showed improvement, three stayed the same, and five did worse. This, too, suggests that exposure to training made a difference in how well subjects scored on the checklist.

A frequency distribution for the Post-Focusing Checklist shows it to be normally distributed with these patients, which might indicate that it could be worked into a good instrument for this type of population. For the Post-Focusing Questionnaire rated as a whole, there are clear peaks at 1 and 3, with 2 and 4 being about two-thirds as high. For the Post-Focusing Questionnaire rated item-by-item, the scores are distributed fairly evenly with a slight skew to the left. The subjects tended to score somewhat higher on the average when the questionnaire

was rated item-by-item. The increased range of scores obtained when rating the questionnaire item-by-item would make it easier to find statistical significance than rating it as a whole.

Hypothesis 4

It was predicted that the experimental group would express their feelings more directly, whereas the control group would report their feelings in the psychotherapy sessions following training, as rated by the patients' therapists. A t test supported this hypothesis.

Gendlin et al. (1960) found in their research that scores on this scale were amenable to change through psychotherapy. Gendlin et al. (1960) have found that this scale correlates .49 with success in psychotherapy as measured by therapist ratings of outcome. This indicates that the superior scores in direct expression of feelings achieved by the experimental group in the present study might reflect ability on the part of the trained patients to do better in psychotherapy than the control group patients.

An average score of 7.1 indicates that the therapist saw the patient as aware of, and able to express, his ongoing current feelings. The microtraining in focusing was heavily oriented towards the patient's recognizing his feelings and expressing them. Haase et al. (1969)

similarly report success in using microtraining as an aid in teaching expression of feelings to clients in counseling.

Hypothesis 5

It was predicted that the experimental group would be judged as significantly better at focusing following treatment than the control group as rated by the psychotherapists. The difference was not significant although it was in the direction of improved focusing for the trained subjects.

Although there is no difference in these therapists' ratings of focusing, an examination of the scores reveals that the therapists' ratings for the experimental group was on the average approximately equal to the scores achieved by the subjects on the Post-Focusing Questionnaire administered after training. Rated as a whole, the average focusing score for the experimental group on the questionnaire was 2.10 at posttest. Rated item-by-item it was 2.20 for the experimental group. The therapists ratings averaged 2.20 for the experimental group. The consistency of these three ratings suggests that the behavior learned in microtraining did carry over to the psychotherapy sessions. Perhaps the patients retained the skill because they had learned it thoroughly enough that they would remember it during the following psychotherapy session. The therapy

session in which the therapist evaluated the patient's focusing ability was only a week after the training. A longer interval than a week might have led to less retention of the skill by these patients, especially if they were not reinforced for focusing in later therapy sessions. Ivey (1971) theorizes that skills learned through micro-training will follow the usual extinction curves if the skills are not reinforced in the trainee's environment.

The average score on the posttest administration of the Post-Focusing Questionnaire for the control group was 1.90 when rated as a whole, and 2.09 when rated item-by-item. Therapist ratings of focusing for the control group averaged 2.10. The ratings of the therapists are consistent with ratings made of the Post-Focusing Questionnaire rated item-by-item, though not with the questionnaire rated as a whole. Perhaps the improvement seen with the control group on the Post-Focusing Questionnaire rated as a whole, taken together with the nearly identical performance of the experimental and control groups on the judges' ratings of focusing, could indicate that the control group improved in focusing ability as a result of two exposures to the Focusing Manual and to the instruments. As Gendlin et al. (1968) point out, the Focusing Manual was originally intended for teaching the skill of focusing. The questionnaires and checklist might have supplemented the Focusing Manual for the patients, helping them to have

in mind more clearly what focusing was about (VandenBos, 1973). That both groups improved might also be an effect of regression to the mean, as the posttest scores approached those of the 56 patients tested before screening. The results on the Post-Focusing Questionnaire rated item-by-item, however, indicate that the control group did the same on pretest and posttest, which would not support either of these two explanations.

The item-by-item rating of the checklist yielded posttest scores nearly identical to the ratings of the therapists. When the questionnaire is rated item-by-item, the scores indicate that the control group was somewhat better than the experimental group before training, a finding supported by scores on the checklist. It was only after training that the experimental group caught up with the control group and passed them, considering the questionnaire rated item-by-item. Perhaps on the average the control group was already near its potential ceiling for learning focusing and therefore did not improve. The different results obtained by the two ways of rating the questionnaire can again be seen to yield different possible conclusions. This further indicates the need for using both methods of rating in research, and for further refinement of the way in which ratings are made.

It might be noted again that these ratings indicate an ability to stay on one topic, taken overall, which

may signify an improvement in the basic thinking disorder (Chapman & Chapman, 1973; Cohen et al., 1974; Lisman & Cohen, 1972).

The results from the therapists' judgments might, in another way, be taken to indicate that the therapists lacked enough subtlety in discerning focusing behavior to recognize improved skill in focusing, since the therapists did recognize a difference in direct expression of feelings. Recognizing expression of feeling was more probably part of the training of the therapists. Further, the nine-point spread on the rating scale for direct expression of feeling would increase the variance of possible scores in comparison to the four-point spread in judging focusing, making it easier to detect a difference statistically.

Overall, these various measures demonstrate that it was possible for these patients to show some improvement in a skill which could be helpful to them in successful psychotherapy. Further, there is evidence that this learning generalized to the psychotherapy sessions following training. Maintenance of the skill over time would depend upon reinforcement by the patients' psychotherapists and other members of their environment (Ivey, 1971), which is beyond the scope of the present study.

Analysis of Supplemental Results

Post-Focusing Essay Question

It was predicted that the experimental group would be judged as better focusers at the end of their micro-training session than at the beginning of the session as measured by the Post-Focusing Essay Question (Mellett & Coblenz, 1966). A t test supported this prediction.

The pretraining average score (1.50) for the experimental group was similar to that obtained on the pretraining Post-Focusing Questionnaire rated as a whole (1.45), although somewhat lower than the pretraining item-by-item average score (1.80). The posttraining average score on the essay question (2.50) was higher than the posttraining scores for the experimental group on the Post-Focusing Questionnaire either way it was rated (2.10 as a whole, 2.20 item-by-item) and also higher than the therapist rating of focusing for the experimental group (2.20). This suggests that immediately after training the skill was fresh for the experimental subjects, and that the intervening time before final assessments of focusing (approximately a week) resulted in some decrease in the skill. As Ivey (1971) has indicated, a behavior will tend to follow the usual learning curves and will gradually extinguish unless reinforced fairly rapidly in the environment.

That the experimental subjects improved a full scale point in the ratings suggest that the training was effective. The average rating was still below one which would reflect a high level of experiential focusing, but did indicate an ability to stay with a problem, and that the subjects were better able to stay with felt aspects of that problem. Eight of the subjects improved on the essay, one remained the same, and one did worse. Immediately after the training the great majority of the subjects showed improvement.

Rating Scales

Beside the rating scale for which the hypothesized difference was found in direct expression of feelings, therapists were asked to rate their patients' behavior on the five other scales comprising the instrument (Gendlin, Jenney, & Shlien, 1960) (see Appendix D).

Scales 1, 2, and 5. These three scales have to do with the relationship between therapist and patient as a topic of discussion rather than as an ongoing process. No significant differences were expected on these scales and none were found. That Scale 5 approached significance, indicating experimental group patients tended to talk somewhat more about present problems than past problems as compared to control group patients, may reflect the emphasis on current feelings in the training on

focusing. Scales 1, 2, and 5 have been found to have an insignificant correlation with success in psychotherapy (Gendlin et al., 1960).

Scales 3 and 4. These two scales assess the relationship between therapist and patient as an ongoing process, and have been found to correlate significantly with success in psychotherapy (Gendlin et al., 1960). In the present investigation significant differences were not found between the experimental and control groups on these scales, although on both scales the experimental group scored somewhat more in the direction indicative of successful therapy than the control group. It cannot be concluded that the differences were brought about by the microtraining, since scores on these scales do not tend to change significantly during successful psychotherapy (Gendlin et al., 1960). Rather, they probably reflect the quality of the relationship between therapists and patients which had existed prior to the study.

Demographic Variables

The most notable finding concerning the demographic variables is their lack of correlation with the outcome measures. Differences between chronic and acute schizophrenics are found in many studies (Chapman & Chapman, 1973; Cromwell, 1975; Lang & Buss, 1965), but in the present study chronic patients seem to have improved as much as less chronic patients. Total length of hospital-

ization is a good estimate of chronicity (Chapman & Chapman, 1973), and was unrelated to any measure. There were significant correlations indicating that younger patients were better focusers on the Post-Focusing Questionnaire before training, although this is not supported by the correlation of length of hospitalization with initial scores. It might be speculated that the younger patients were in a more acute state in which their feelings were more on the surface and not well defended against, whereas older patients had made an adjustment to their schizophrenia over time (Fenichel, 1945).

Age of patients and length of time since last psychiatric hospitalization were positively correlated with each other (.72) and negatively correlated with prescores on the Post-Focusing Questionnaire rated item-by-item (-.46 and -.49). That younger patients tended to be better focusers than older patients before training is corroborated by the correlation indicating that patients most recently out of the hospital were better focusers than patients who had been out of the hospital for a long time. The relationship between age of patients and length of time since last psychiatric hospitalization is indicated indirectly by Babigan (1975) who states that "schizophrenia is an illness of adolescents and young adults" (p. 865) and that the highest rate for new admissions to mental hospitals for males is in the 15-24 year old age bracket.

It would be expected that of 77 correlations, 4 would be significant by chance if adopting the .05 level, and only 3 were found.

One speculation for the lack of correlation might be that the medication received by all of the patients helped even out differences in chronicity, and differences related to paranoid-nonparanoid diagnoses. It might even be that the antipsychotic medications helped the more chronic patients to perform more successfully, while for the acute nonparanoid patients their thinking disorder was made worse by the antipsychotic medication (Chapman & Chapman, 1973; May, 1975). It might also be that premorbid histories were not significantly different on the average since all of these patients had been accepted into military service. None of these speculations were investigated in this study, but might be investigated in future research.

It might also be that the lack of correlations had to do with the small sample size, and with the truncated nature of the sample, since it only included nonfusers.

The lack of correlation of education level with outcome measures may be because there was little variability in educational level, with most of the subjects being high school graduates.

That patients' age was found to correlate .72 with length of time since last hospitalization is possibly

due to having more years available to be out of the hospital, and to the introduction of antipsychotic medication. That total length of hospitalization correlated .79 with length of last hospitalization may also have to do with ataraxic medication, since some of the older patients had not returned to the hospital since their one long hospitalization years ago. Hospitals used to keep patients in longer--those out for some time would naturally have a longer stay when last hospitalized. Finally, length of last psychiatric hospitalization correlated -.52 with paranoid-nonparanoid diagnosis: That is, patients diagnosed paranoid tended to be in the hospital for a shorter period of time the last time they were hospitalized. Since paranoid patients tend to be less disorganized than nonparanoids (Chapman & Chapman, 1973), perhaps hospital staff tended to discharge them more readily.

Implications for Research

Comments About the Experiment

This section will deal with aspects of the experiment warranting comment but not stemming directly from the data discussed to this point.

Screening of potential subjects. Since only non-focusers were to be included in the experiment, 30 subjects scoring 3 or 4 on the Post-Focusing Questionnaire were screened out of the study from 62 potential subjects tested.

Thus, it cannot be concluded that outpatient schizophrenics are uniformly bad focusers.

Many of the subjects scored as focusers were in individual psychotherapy, and it may be that the referring therapists tended to choose as individual therapy cases those patients showing more awareness of their feelings. Or it may be that experience in psychotherapy had actually helped some of these patients learn to focus, contrary to Gendlin et al.'s (1968) findings. If some of the patients had learned to focus, it might be attributed to differences in the populations treated. VA patients might be expected to have a better premorbid history than patients in a state hospital, such as those discussed by Gendlin et al. Further, patients used in the present study were successfully functioning as outpatients, rather than being inpatients like those in Gendlin et al.'s research. Another difference is that patients in the present study, including those screened out, were motivated to participate in psychotherapy and had volunteered to participate in the research project.

Looking over the Post-Focusing Questionnaires on those subjects screened out, it appears that some of the subjects excluded were writing about their emotions rather than their felt sense of their problems or life situations. Perhaps then some of the patients screened from the study were not focusers. The initial screening

was done by a judge who was trained before the method for training judges was refined, as is discussed in Appendix M. Perhaps an expansion of the rating scale would help to impress the difference between "emotion" and "felt sense" in the minds of future judges used in focusing studies (see Appendix L).

Comments about the training. Patients included in the study had chosen to participate, and had chosen to be in psychotherapy. These patients had failed to learn to focus despite a large amount of time many of them had spent in psychotherapy (see Table 1). The difficulty in training these subjects to focus was a contrast to the ease with which staff members at the hospital and potential judges wishing to learn focusing were taught to do so. The author has rated five posttraining questionnaires from staff and eventual judges and scored each of them as 4's. With these individuals, scores of 6 and below were attained by four of them, and a score of 7 for the other, on the Post-Focusing Checklist after training. This indicates again the checklist's differing reliability for college educated normal subjects as opposed to high school educated schizophrenic veterans.

Programmed training manual. The programmed training manual devised by the author was effective in teaching staff and judges and some of the patients the basic concepts involved in focusing. For most of the patients,

however, the manual seems to have been incomprehensible without further explanation. With these patients the trainer found it necessary to go over each page of the manual carefully, eliciting the responses called for in the manual.

Used with these subjects, it seems that for the manual to be more useful it would be necessary to simplify the language in it and to greatly shorten it.

On the other hand, the manual was useful with the trainer available to explain its contents, because it served as a concrete stimulus to help hold the patient's attention, and it provided cues for remembering which aspect of focusing to discuss next. It also helped to break up the temptation for the trainer to carry on a monologue about focusing. The structure calling for the subject's response to items in the programmed manual helped involve the subject in the training process.

The trainer found that knowing something of the background of many of the subjects was very helpful in coming up with examples from their lives, which seemed to help the patients to understand the ideas being presented. With several of the patients it was necessary to explain what a "feeling" was with examples from the person's life, for instance, "Remember how angry and helpless you were when your money was stolen last week." Results might have been less (or more) successful with a different trainer,

one who was completely unfamiliar with the patients.

Comments concerning the patients. Some patients seemed readily able to recite descriptions of old feelings, but new ones seemed unavailable to them or appeared to be just over the edge of awareness. For others, strong feelings seemed available to them, such as anger, but they seemed unable to grasp the idea of a felt sense of a problem.

Some patients denied having any problems. In order to elicit their cooperation it was necessary to have them try to focus on a pleasant feeling, concerning, for example, an upcoming enjoyable activity. These subjects seemed out of touch with their feelings to the trainer. Some patients described a feeling briefly and then quickly denied it. For example, one patient said "I'm glad to help you because I like you and I have a feeling for that right here," and later said, "You know I was just kidding when I said I had that feeling, don't you?"

Other patients expressed fear of looking at their feelings, fear of what they might find. One patient said that he was afraid it would make him hear voices. It took courage for these patients to try to face their feelings. One patient had tears in his eyes after focusing on a painful part of his life.

One patient kept repeating several sentences, apparently unrelated to the training, over and over again

during the session. He frequently makes the same statements in talking with persons he meets at the hospital.

Patients' reactions to the experiment. Some of the reactions of the patients to the training and to the instruments were very positive. One individual said that the training session and the pre- and posttesting sessions were a lot like therapy and were interesting. He said that it helped him to "formulate things from my life."

Another individual said of the training that "It helped." One person said, "It helped straight me out a little bit."

After the training, one patient said that he was better able to know what his feelings were, and better able to describe them, than he had been able to do in group therapy previous to the training. He said this was because the training was more private and less distracting.

Other comments were more negative. One person had to be screened from the study because he refused to fill out the questionnaires after the initial focusing instructions. He said that it "called to mind problems that I don't want to talk about."

Several patients, including some in both the experimental group and the control group, said that they were bored during the focusing instructions because they couldn't follow the directions. One person said he felt inadequate

after the focusing instructions because he couldn't concentrate.

In response to the Post-Focusing Checklist two patients complained that the items were too clear cut to answer one way or the other.

A therapist working with a patient to teach him focusing could eliminate these problems by going at the patient's pace and being careful to answer any questions carefully which the patient might have. The therapist could also tailor the language he used to best suit the patient's level of education and understanding.

Implications for Future Research

Considering that psychotherapy with schizophrenics is widely practiced, and that the results of this endeavor are frequently fruitless (May, 1975), the need for additional research in this area of improving the psychotherapeutic process with schizophrenics is apparent. The present study provides exploratory data in this direction.

A programmatic series of studies could be conducted which would increase knowledge about experiential focusing and its relationship to psychotherapy with schizophrenics. This could begin with research on the instruments used to assess focusing. Then studies relating to the present one, with gradually increasing scope, could be initiated. These could consider the effects of medication on focusing,

the relationship of subtypes of schizophrenia and focusing, the amount of training necessary to teach a high level of experiential focusing, and ways of maintaining focusing behavior over time.

Research on the assessment of focusing. As has been discussed, problems were found to exist with the instruments used to assess focusing. Using the Post-Focusing Questionnaire, for example, rating the items one at a time as opposed to rating the questionnaire as a whole, one can find differing results. The Post-Focusing Checklist can yield results with a low correlation to the questionnaire either way the latter is rated, at least when used with schizophrenics. The language in either instrument tends to be difficult for a less verbal patient to understand. Finally, neither of these instruments has been experimentally linked to the Experiencing Scale.

Rating of Focusing. The guidelines which were developed in this study can aid judges to reliably score the Post-Focusing Questionnaire. A change of increasing the range of possible ratings might further enhance reliability, however.

Increasing the range of possible ratings on the scale would increase its variance, thereby improving reliability. Perhaps it could also serve to make experiential focusing more understandable to judges. Expanding

to a seven-point scale would serve to make it more comparable to the Experiencing Scale, and help to make comparisons between the instruments more meaningful. The comparison of the instruments would be more precise if they could be matched on mean, standard deviation, and shape of distribution.

One such possible focusing scale could be the one shown in Appendix L. This scale adds items which make it better able to differentiate questionnaires such as those of the schizophrenic veterans in the present study, while also differentiating higher levels of focusing one might expect to find in therapy interviews with a highly successful client. This scale could be used to rate segments of psychotherapy interviews as well as questionnaires, and could be compared to the Experiencing Scale in making these ratings. This could help to better tie in the concept of focusing with the body of research existing in which the Experiencing Scale has been used.

Before adopting the use of a revised scale, however, it would need to have gained acceptance by researchers in focusing, such as Eugene Gendlin and Gary VandenBos. Otherwise results found in the research would not be readily comparable to the ongoing body of research on focusing as it develops.

Post-Focusing Questionnaire. The finding in the present study that rating the Post-Focusing Questionnaire

either as a whole or item-by-item can lead to different results suggests that both ways of rating the questionnaire be used in research. Perhaps after more complete guidelines for making the ratings are developed this could become unnecessary. The rules given in Appendix F are a start towards improved guidelines for judges.

One possibility in further refining the rules would be along lines suggested by Ivey (1971). In a factor analytic study of typescripts (Crowley & Ivey, 1976), from a study of the skill of direct, mutual communication (Higgins, Ivey, & Uhlemann, 1970), Crowley and Ivey found what kinds of words were most facilitative to interpersonal interaction. These were "feeling" words and words embodying "content specificity." A study of words from questionnaires representing various levels of focusing might be conducted in a similar way. One might expect to find, for example, that on questionnaires rated as representative of a high level of focusing, words denoting internal experiencing would be accompanied by qualifying words, ones which indicate that the word used to express one's internal experiencing does not quite describe it. Gendlin (1964) has indicated that as a person tries to explain a vague but concrete bodily felt sense of a problem, he often says, for example, that "It is kind of like...", or similar statements indicating that the words the person uses do not quite accurately describe his felt

sense.

Another area needing development through research on the Post-Focusing Questionnaire is a rewording of the questionnaire for less verbal patients, or perhaps a standardized explanation of it to precede its use with a less verbal population. A more tedious but perhaps more accurate manner of obtaining answers to the items might be to tape record and then transcribe for judges an interview with the patient after focusing instructions, using the questionnaire as a basis for structuring the interview. Research could also be done comparing such interviews to written questionnaires with the same subjects.

Post-Focusing Checklist. The present research found this instrument to have a low correlation with the Post-Focusing Questionnaire when used with a less verbal schizophrenic population. Items on the checklist were confusing to these subjects. The items need to be reworded or fully explained to subjects such as those in the present study, and then the results need to be compared to findings from the Post-Focusing Questionnaire. Certainly in future research with schizophrenics the checklist should not be used without comparison with the questionnaire until it can be shown to have a high correlation with the questionnaire, perhaps through further development.

The range of scores (0 to 28) and the normal distribution found in the present study make the checklist a promising instrument, however, especially when used in conjunction with scores from the Post-Focusing Questionnaire.

Physiological measures of focusing. Gendlin and Berlin (1961) found that when undergraduate students were asked to focus on their felt experiencing, and reported being able to do so, there were fewer GSR's (Galvanic Skin Responses) and a greater resistance rise than when subjects were asked to think about disjointed problems. These measures indicate a reduction of physiological tension. In studies of schizophrenia, Galvanic Skin Responses tend not to be significantly higher for schizophrenics than for normals (Lang & Buss, 1965), though other physiological measures such as respiration rate, cardiovascular measures, and measures of muscle tension indicate a higher than normal state of arousal for schizophrenics. Studies also indicate that as schizophrenic "pathology" decreases, these measures reflect a lower level of arousal more like that of normal subjects.

These studies suggest a relationship between physiological measures and focusing, which might be especially important in the study of schizophrenia, therefore warranting further research. Physiological measures could supplement other measures of focusing utilized in a study.

Physiological measures might one day help a researcher of focusing to better determine whether a subject has actually focused or has instead merely answered questionnaires in such a way as to make himself look good to the experimenter, or has answered in such a way as to attempt to please the experimenter.

Comparison of schizophrenics with normals. Gendlin et al. (1968) reported findings indicating that focusing is essential for a client to be successful in psychotherapy, but that focusing ability is not in itself a measure of adjustment. Gendlin et al. (1968) have suggested that many normal individuals are nonfocusers, such as approximately half of the high school students in their study. Yet if focusing ability corresponds with level of experiential process, then according to Rogers (1958, 1961, 1975), a higher level of experiential process is hypothesized to evolve from successful therapy. Rogers' (1961) view of a fully functioning person is one whose level of experiential process is high--a person able to attend to his experiencing easily and to describe it. A lower level of experiencing, with more rigidity and less awareness of feelings, could then be expected in a person manifesting severe psychopathology.

A study comparing normal subjects to schizophrenics might help to resolve this issue. Subjects could be matched on age, educational level, social class, sex,

and race, perhaps by using nurses aids or maintenance personnel as normal subjects (Chapman & Chapman, 1973). The focusing measure would be standardized to show a normal distribution with the normal subjects. Then schizophrenics who were off medication for at least four weeks could be assessed for focusing to determine if there was a difference in level of experiencing between them and the comparison group of normal subjects.

Outcome studies. Studies determining the effects of training in focusing on psychotherapy outcome would be of special interest to psychotherapists working with schizophrenics and with other patients. Cross-sectional studies such as the present one are helpful, but longitudinal studies would permit an analysis in more depth. Important areas could be explored, such as the relationship between focusing (and higher experiential level) and outcome variables, including length of hospitalization, success in finding employment, and success in relationships with other people. Most importantly, the hypothesis could be tested that experiential focusing is a necessary prerequisite for successful psychotherapy outcome.

Training of psychotherapists. Ivey's (1971) success in teaching skills of counseling to beginning counselors suggests that microtraining could be used to teach beginning counselors to focus on their own experiencing and to recognize experiential focusing when it was occurring

with their clients. Since a high level of experiential process is necessary for successful psychotherapy (Gendlin et al., 1968), this might be considered an especially important skill for a beginning counselor to develop.

Beginning counselors could also be trained in teaching experiential focusing to their clients, either directly through microtraining or indirectly by responding only to focusing behavior. The therapists could be trained to respond in such a way as to shape the behavior of the client towards a discussion of his ongoing experiencing.

Experiencing in relationships. It might be speculated that a factor drawing people together in intimate relationships, such as marriage, is the ability of one person to help carry forward the experiencing of the other person. Gendlin (1964) describes psychotherapy as a process in which a helping person responds to a person seeking help in such a way as to enable the second person to carry forward his experiencing. Perhaps because of a similar process, persons when they become close find that new areas of felt meaning are opened to them, so they feel more "fulfilled" and "alive."

It might also be that in relationships which were once intimate, but have become unsatisfying, this carrying forward of experiencing is no longer taking place. Perhaps

successful marriage counseling takes place when the counselor is able to help reengender this process in a couple. This would have implications for the training of marriage counselors in ability to recognize levels of experiential process, and in the development of techniques for facilitating it in relationships.

Research could be done asking engaged couples and newlyweds questions such as whether they had feelings in this relationship that they had never had before. Another approach might be to have each person focus and then examine whether they were focusing on an aspect of their relationship with the other person. They could also be asked to focus on an aspect of their relationship with their spouse in which they were aware of feeling something new, but were not yet aware of what exactly the feeling was, or what brought the feeling about.

Implications for Theory

Microtraining

The results of the present study were mixed. On some measures only the microtrained patients demonstrated significantly improved focusing ability, while on other measures both groups showed improvement. To the extent that both groups showed improvement, the elaborate framework of microcounseling would appear to be unnecessary. During each assessment, the patient was led step by step

through the skill of focusing. Modeling and feedback, however, were not directly involved in the contacts which the control group had with focusing. Perhaps these elements of the microtraining process are less essential for learning than has been postulated by Ivey (1971).

On the average, microtraining was not effective in teaching a high level of focusing to these patients, although some patients learned to focus according to the measures taken in this study. Perhaps microcounseling lacks power in teaching certain skills to some types of individuals, such as some of the patients in this study who did not improve in their focusing ability. In working with some of the patients it appeared obvious that the training would never help them learn to experientially focus.

Another possible explanation of the low average level of focusing these patients attained after training is that focusing might not be a unitary skill. The scoring of focusing implies at least three skills: (a) staying with one problem or situation important to the person, (b) obtaining a felt sense of that problem as a whole, and (c) ability to remain with that felt sense and to regain it despite distractions, for a long enough time that a felt shift can occur. Although attending to one's ongoing experiencing, or felt sense, is the central skill involved, it might be necessary to teach focusing in a series of discrete steps for patients such as those in the present

study. Ivey (1971) has stressed the importance of a single-skill approach in microtraining.

Experiential Focusing

Gendlin's theory is broad enough that it could be used to encompass post hoc nearly any of the results possible from the present study. For example, Gendlin's theory of psychopathology suggests that it is the amount of "frozen experiencing" which differentiates degrees of psychopathology, which classifies Gendlin's theory as a continuity theory of psychopathology. That some non-focusing patients were not able to learn focusing from this training, while others were, implies the possibility of a difference in capacity to learn, which might be a basic differential deficit inherent in some subtypes of schizophrenia. This differential deficit might not be explainable by "frozen experiencing" any more than impairment because of brain damage could be explained as "frozen experiencing."

Yet Gendlin could explain varying capacity to learn by saying that the microtraining was only effective in carrying forward the experiencing of those patients whose structure of experiencing existed in such a form that it could be carried forward by the training. An analogy would be that only a child whose developmental capabilities had reached the point where he/she could coordinate his/her muscles sufficiently, would be able to learn from training

how to play the piano. This would imply that another type of developmental step other than microtraining would be necessary to carry forward the experiencing of those patients who failed to learn to focus in this experiment. Because of the encompassing ability of Gendlin's theory to explain results, it lacks the specific predictive power which would let it be readily tested.

A more specific problem with Gendlin's (1969) formulations stems from the positive results of this experiment: Some of these nonfocusing patients apparently did learn to measurably focus from the brief training provided. This finding raises questions as to the value of focusing as a predictor of therapeutic outcome. Outcome predictions for some of these patients who were predictable therapeutic failures on the basis of focusing ability would have to be altered because of the brief training provided. One control subject measurably learned to focus during just the two assessments of focusing ability.

Gendlin et al.'s (1968) formulation that success in psychotherapy could be predicted from experiential level assessed during the first three sessions of therapy was based on studies in which the therapists were working from a limited variety of therapeutic orientations, such as the client-centered orientation. These therapists were not trying to directly teach experiential focusing. Further, even in the research presented by Gendlin et al. (1968),

some therapists appeared to teach their patients how to raise their experiential level. In the present study a direct attempt was made to teach focusing, and some subjects responded by increasing their level of experiential functioning. Gendlin's contention regarding the predictive power of experiential level on therapeutic outcome may have to be limited to a therapy setting in which focusing is not directly taught (VandenBos, 1973).

It might be pointed out that Gendlin (1969) uses the Focusing Manual both for teaching and for assessing focusing. Because of this it is impossible to make a distinction between individuals able to focus before testing, and those that learned to focus because of exposure to the Focusing Manual. That both the experimental and the control group showed improvement in the current study may reflect this problem of assessment, since focusing ability with no training at all cannot presently be measured. A method of assessing focusing without use of the manual would help to solve this dilemma. In previous research in which focusing has been assessed and compared with other variables, perhaps rather than focusing per se it was ability to learn very quickly a skill such as focusing which was compared with the other variables.

The present study adds a practical, real dimension to research on focusing. Previously research on focusing had been done primarily with college students, rather than

with individuals seeking help through psychotherapy. The present study adds the dimension of research with patients, and not hospitalized patients in an institution, but patients who are free to choose to participate or not to participate both in psychotherapy and in the research itself. The present study reveals that psychologists can quickly modify the experiential level of at least some of the schizophrenics with whom they work in their day to day clinical setting, and in doing so possibly make psychotherapy more effective with those patients (Gendlin et al., 1968). The present study demonstrates that Gendlin's abstract theory can be applied to a real clinical setting.

That some subjects were able to learn focusing supports Gendlin's (1969) contention that focusing can be taught, and that focusing training can be effective in a short period of time. That some patients diagnosed as schizophrenic learned to focus supports Gendlin et al.'s (1968) contention that focusing ability is independent of psychological adjustment. It must also be noted, however, that some patients did not change in focusing ability. Therefore, the general conclusion that experiential level is easily altered is not accurate.

Schizophrenic Deficit

The results from the present study shed some light on the area of schizophrenic deficit. To obtain an accurate picture of schizophrenic deficit, it would be

necessary to contrast schizophrenic performance on a given task with the performance of a comparable group of normal subjects. This was not done in the current study. Nevertheless, there are few studies examining schizophrenic deficit with outpatients, which adds some weight to the relative importance of the present research.

We might first note that in the current research over half of the subjects screened were rated as being able to focus at a level necessitating their being eliminated from the study. As has been explained previously, this may be a consequence of the care received by these VA patients, through psychotherapy and medication (Chapman & Chapman, 1973). It is also possible, however, that schizophrenic impairment with a population such as that in the present study does not extend to focusing ability. Additional research would be necessary to clarify this issue.

An area of concern is schizophrenic impairment in learning ability (Chapman & Chapman, 1973; Lang & Buss, 1965). The results of the present study indicate that at least some patients previously unable to engage in the skill of experiential focusing were able to do so after brief training. In considering schizophrenic outpatients, perhaps learning deficit is not as pervasive as with schizophrenic inpatients. This may be because schizophrenic outpatients have less of the type of impairment which would

result in their being hospitalized, including perhaps more ability to adapt in a variety of situations. The improvement in focusing ability may also reflect a compensatory effort towards learning which has been made by schizophrenics functioning as outpatients. Medication may play a part in helping these outpatients to learn more readily than unmedicated patients which are more frequently examined in research.

In terms of the thinking disorder manifesting itself in schizophrenia, the current study provides evidence that at least some patients can measurably improve in their ability to appropriately center their attention on a topic and to hold it there for several minutes. Again, this may reflect a less pervasive thinking disorder with these outpatients (Chapman & Chapman, 1973; Cohen et al., 1974) than with inpatients more typically studied, or it may be an effect of the medication readying the patients for improvement. But, there is the alternate explanation that a form of psychotherapy teaching a higher level of experiential process could aid in modifying schizophrenic thought disorder. Additional research on this point could possibly help to justify efforts at psychotherapy with schizophrenic outpatients.

Summary

Psychotherapy is often attempted with schizophrenic patients, and has often met with failure (May, 1975).

Gendlin and his associates (Gendlin et al., 1968) have attributed this failure to the low level of experiential process taking place within schizophrenic patients during the course of psychotherapy, and to the failure of therapists to teach patients to increase their level of experiential process so that they can benefit from therapy. Gendlin and his associates developed the Focusing Manual to help patients learn to focus on their ongoing experiential process, but evidence exists that these instructions alone are not sufficient to teach the skill (VandenBos, 1973).

A potent method of teaching counseling and other skills was initiated by Allen (1967) and developed by Ivey (1971)--microtraining. In this method a person's level of ability in a specific skill is assessed, a model of the skill is provided, practice in the skill is encouraged, feedback is given, and then the person's level of ability in the skill is reassessed. Microtraining has been used successfully to teach a wide range of skills (Ivey, 1971)

Schizophrenics, however, typically show a deficit in nearly any skill as compared to normal subjects (Chapman & Chapman, 1973), and slow learning in both simple and complex situations (Lang & Buss, 1965). Microtraining, however, had met with some success in teaching specific skills to schizophrenics (Ivey, 1973).

The present study was an attempt to teach experiential focusing to a group of schizophrenics using the micro-training paradigm. The subjects were all male outpatients in psychotherapy at a Veterans Administration hospital. All were receiving psychotropic medication. Only subjects volunteering for the study were included. Of twenty subjects, half were randomly assigned to training and half to a no-training control.

Although because of the small number of subjects this must be considered an exploratory study, some improvement in focusing ability was found across a variety of measures. On some measures the trained group improved more than the control group, and on other measures both groups showed improvement. The effect of the training generalized to the patient's psychotherapy session following training.

The patients did not learn to focus with a high level of skill; however, they did improve significantly. On the average the patients showed increased ability to remain on one topic, and some increase in awareness of feelings and expression of feelings. This ability to stay on one topic may indicate an improvement in the thought disorder, if as some theorists indicate (Chapman & Chapman, 1973; Lisman & Cohen, 1972), schizophrenic thinking involves a failure to edit out irrelevant or inappropriate associations.

These results were integrated with research and theory in the areas of experiential psychotherapy and microtraining. Suggestions were made for future research in microtraining in experiential focusing and in related areas.

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APPENDIX

- A. Focusing Manual
- B. Post-Focusing Questionnaire
- C. Post-Focusing Checklist
- D. Rating Scales
- E. Example for Judges of the Post-Focusing Questionnaire and for Therapists Rating Focusing
- F. Improved Guidelines for Rating the Post-Focusing Questionnaire
- G. Supplementary Instructions for Rating Single Items of the Post-Focusing Questionnaire
- H. Programmed Manual for Teaching Experiential Focusing
- I. Practice Post-Focusing Questionnaires for Training Judges
- J. Tukey's HSD Source Tables
- K. Sample Post-Focusing Questionnaire with Scoring
- L. Proposed New Rating Scale for the Post-Focusing Questionnaire
- M. Development of Procedures for Training Judges of the Post-Focusing Questionnaire
- N. Post-Focusing Questionnaire Rating Guidelines from Mellett and Coblenz (1966)

APPENDIX A: FOCUSING MANUAL

This is going to be just to yourself. What I will ask you to do will be silent, just to yourself. Take a moment just to relax...(5 seconds). All right---now, just to yourself, inside you, I would like you to pay attention to a very special part of you....Pay attention to that part where you usually feel sad, glad, or scared. (5 seconds) pay attention to that area in you and see how you are now.

See what comes to you when you ask yourself, "How am I now?" "How do I feel?" "What is the main thing for me right now?"

Let it come, in whatever way it comes to you, and see how it is.

.....

30 seconds or less

.....

If, among the things that you have just thought of, there was a major personal problem which felt important, continue with it. Otherwise, select a meaningful personal problem to think about. Make sure you have chosen some personal problem of real importance in your life. Choose the thing which seems most meaningful to you.

.....

10 seconds

.....

1. Of course, there are many parts to that one thing you are thinking about--too many to think of each one alone. But you can feel all of these things together. Pay attention there where you usually feel things, and in there you can get a sense of what all of the problem feels like. Let yourself feel all of that.

.....

30 seconds or less

.....

2. As you pay attention to the whole feeling of it, you may find that one special feeling comes up. Let yourself pay attention to that one feeling.

.....

1 minute

.....

3. Keep following one feeling. Don't let it be just words or pictures--wait and let words or pictures come from the feeling.

.....

1 minute

.....

4. If this one feeling changes, or moves, let it do that. Whatever it does, follow the feeling and pay attention to it.

.....

1 minute

.....

5. Now, take what is fresh, or new, in the feel of it now...and go very easy. Just as you feel it, try to find some new words or pictures to capture what your present feeling is all about. There doesn't have to be anything that you didn't know before. New words are best but old words might fit just as well. As long as you now find words or pictures to say what is fresh to you now.

.....

1 minute

.....

6. If the words or pictures that you now have make some fresh difference, see what that is. Let the words or pictures change until they feel just right in capturing your feeling.

.....

1 minute

.....

Now I will give you a little while to use in any way you want to, and then we will stop.

APPENDIX B: POST-FOCUSING QUESTIONNAIRE

Please answer the following questions with a minimum of one sentence per item in such a way as to describe the nature of your focusing experience. You need only talk about the specific topic to the extent needed to convey the nature of the process you experienced during the focusing. Be sure to use at least one complete sentence in your description.

1. Without saying what you thought about, describe in two or three sentences what was happening for you during this time.
2. Describe what happened when I said: "Try to get a sense of what all the problem feels like. Let yourself feel all of that."
3. What happened after I said: "As you pay attention to the whole feeling you may find that one special feeling comes up"?
4. Describe what happened when I said, "Keep following that feeling and let words and pictures come from it."
5. Did the feeling change or move (if so, describe that)?

6. How is this different from what you normally do?
7. What surprised you most about doing this?
8. What about this was the best thing for you?
9. What was the worst thing about it?

APPENDIX C: POST-FOCUSING CHECKLIST

Following is a list of statements and questions which have been used to describe the experience of focusing. Please read each item and decide whether or not it describes your focusing experience. Please make your decision on the basis of your experience, NOT what you think it should have been. Since each person's experience is somewhat different, there are no "right" or "wrong" answers.

| | YES | NO |
|--|-------|-------|
| 1. The feeling was very concrete but hard to put into words. | _____ | _____ |
| 2. Did you struggle and not find any object for your feelings? | _____ | _____ |
| 3. Everything is exactly as it was before. | _____ | _____ |
| 4. It was not one whole feeling, but little ones scattered all around the problem. | _____ | _____ |
| 5. I found better words for what I was feeling than I had before. | _____ | _____ |

- | | YES | NO |
|---|-------|-------|
| 6. Did you find out what was behind the feeling you got? | _____ | _____ |
| 7. I know I was missing the main point but tried to keep up with what I was supposed to be doing. | _____ | _____ |
| 8. Was there a sense of having worked something through? | _____ | _____ |
| 9. I tried to concentrate and keep an idea focused. | _____ | _____ |
| 10. Words or pictures seemed to come from the feeling. | _____ | _____ |
| 11. The feelings began to make sense and fit in with other things. | _____ | _____ |
| 12. The words or pictures had old or familiar elements put together in a new way. | _____ | _____ |
| 13. Things definitely changed, but not in words or pictures. | _____ | _____ |
| 14. Focusing put things into a new perspective. | _____ | _____ |

- | | YES | NO |
|--|-------|-------|
| 15. I got to a place where my problems didn't touch me. | _____ | _____ |
| 16. Did the things you thought of seem trivial or inconsequential? | _____ | _____ |
| 17. Had you seen these words or pictures in the same light before? | _____ | _____ |
| 18. The process seemed to get deeper and more engaging. | _____ | _____ |
| 19. Did you have a sense of I've thought all this before and it's stale? | _____ | _____ |
| 20. The words I use to describe the feeling are the same but mean something different now. | _____ | _____ |
| 21. I began to see how I could make things different. | _____ | _____ |
| 22. Not much was happening but I did find something to think about. | _____ | _____ |
| 23. Did you see now something you hadn't thought of before? | _____ | _____ |

- | | YES | NO |
|---|-------|-------|
| 24. Were you eventually able to sense clearly the main feeling? | _____ | _____ |
| 25. Was there a sense of wholeness to what you thought about? | _____ | _____ |
| 26. Did your feelings seem to take on new applications or consequences as you explored them? | _____ | _____ |
| 27. Was it rather like daydreaming about what had happened or could happen? | _____ | _____ |
| 28. Were you eventually able to see more clearly the interrelation of the things making up the feeling you had? | _____ | _____ |

APPENDIX C (CONTINUED)

ANSWERS TO POST-FOCUSING CHECKLIST

Score = number of items which disagree

Score of 6 or less = clear focuser

Score of 18 or more = clear nonfocuser

- | | |
|---------|---------|
| 1. Yes | 15. No |
| 2. No | 16. No |
| 3. No | 17. No |
| 4. No | 18. Yes |
| 5. Yes | 19. No |
| 6. Yes | 20. Yes |
| 7. No | 21. Yes |
| 8. Yes | 22. No |
| 9. No | 23. Yes |
| 10. Yes | 24. Yes |
| 11. Yes | 25. Yes |
| 12. Yes | 26. Yes |
| 13. Yes | 27. No |
| 14. Yes | 28. Yes |

APPENDIX D: RATING SCALES

1. Does therapy, for this client, focus chiefly on his problem, or does it focus chiefly on his relationship with you? (This scale separates relationship from problems, regardless of the qualities of either.)

| | | | | | | | | |
|-----------------------|---|---|---|---|--------------------------------|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Focus on his problems | | | | | Focus on relationship with you | | | |

2. Do what extent does the client talk about your general characteristics such as age, sex, looks, beliefs, background, school of therapy, et cetera?

"You're young so I doubt if you'll understand me."

"You're nondirective so of course you won't answer me."

| | | | | | | | | |
|-------|---|---|---|---|---|---|--------|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Often | | | | | | | Rarely | |

3. To what extent does the client find that his relationship with you is an important instance of the difficulties he has generally?

"I feel guilty when I want to be dependent. And I feel that way with you also."

"I'm uncomfortable about your opinion of me. Come to think of it, I'm always worried about what others think of me."

| | | | | | | | | |
|------------|---|---|---|---|--------------------|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Not at all | | | | | Very significantly | | | |

4. How important to the client is the relationship as a source of new experience?

"I've never been able to let go and just feel dependent and helpless, as I do now."

"This is the first time I've ever really gotten angry at someone."

| | | | | | | | | |
|------------|---|---|---|---|--------------------|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Not at all | | | | | Very significantly | | | |

5. To what extent do the problems focus in the past.
(Childhood or earlier years.)

| | | | | | | | | |
|------|---|---|---|---|---------|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Past | | | | | Present | | | |

6. To what extent does the client express his feelings, and to what extent does he rather talk about them?

(This scale differentiates direct expression from report about one's feelings, regardless of whether the feeling is past or present.) Examples follow:

Report of feeling

"I have this feeling of hate and its for you."

"I was scared last night."

"Often I feel depressed."

(No indication of present feeling in either words or voice.)

Expression of feeling

"I hate you."

"It comes to me now how scared I really was last night."

"Gee, I feel low."

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|

Talk about feeling past or present

Express feelings of the moment

APPENDIX D (CONTINUED)

From the psychotherapy interview, we want you to make a judgment as to whether the client behaved in such a way as to indicate that he was or was not focusing.

Scoring

- 4 -- Focused with experiential effect
- 3 -- Focused on a specific felt meaning and obtained some words or images, but did not refocus.
- 2 -- Thought about a problem, but did not gain a clear bodily felt sense of the problem.
- 1 -- Did not focus, had random thoughts about problems or other matters.
- X -- If the behavior noted is irrelevant or absolutely insufficient to make ANY judgment HOWEVER UNSURE, as to whether the subject focused or not.

APPENDIX E:

EXAMPLE FOR JUDGES OF THE POST-FOCUSING QUESTIONNAIRE
AND FOR THERAPISTS RATING FOCUSING

You are asked to rate the questionnaire answers on a 4-point scale. What you are attempting to assess is whether the person who answered the question did or did not focus on his feelings during the experiment he participated in prior to answering the questionnaire.

What is it to focus on one's feelings? It is a kind of introspection, in which one attends to inner events of thought which cannot be known directly to any other person but oneself. However, focusing does not apply to as broad a spectrum of inner events as does introspection. Introspection can be of emotions, of ideas, or memories, or transient sensations. Focusing implies attention to a particular kind of inner event which is somewhat different from all of this.

The inner event which one focuses upon has been called "one's felt experiencing," "one's felt meaning of what is happening to him in the world," and "one's implicit sense of experience." Central to all these definitions is that this inner event is felt, that it is a process, and that it is occurring at the present time. In these ways it differs from an idea, emotion, memory, or sensation, which are perceived as more static units occurring outside time, and can be looked at apart from the way

they make us feel. (When we do look at the way they make us feel, we are focusing.) But all this is best understood in an example:

I am a student, in company of a teacher for whom I have conscious feelings of great respect. I am accustomed to feeling pleasure when I am in his company--he is so intelligent, so interested in helping me to understand. I am with him now, and I am thinking how much I admire him, how this is the sort of experience for which I came to the university, how I know now that I did the right thing. But, as I pay attention to my felt sense of what is happening between us now, I notice that I feel a little uneasy. How can this be? A barrage of thought continues to tell me how much I like this great teacher, what a fine man he is, and so forth, but I ignore these thoughts and concentrate on my felt sense of uneasiness. As I attend to it, it changes and sharpens into a feeling of disgust, and now I notice that I am greatly repelled by his habit of chewing tobacco while he is talking to me. In a little while I am amused by my new feeling of repulsion toward this side of my teacher, and the feeling of uneasiness is gone. I feel relieved.

Notice from this example that the student's conscious formulations derived from past experiences with this teacher are not adequate to explain the feeling he has toward him now. Only by paying attention to what he has now, can he understand this feeling of relief--as if he has solved a problem. The formulation "disgust" which comes out of his focusing on his present feelings is a satisfactory one. IT IS THE ACT OF PAYING ATTENTION TO ONE'S PRESENT FEELINGS AND COMING TO A NEW, FELT-TO-BE MEANINGFUL FORMULATION ABOUT THEM AS A RESULT OF PAYING ATTENTION TO THEM WHICH IS THE ESSENCE OF FOCUSING.

APPENDIX F:
IMPROVED GUIDELINES FOR RATING
THE POST-FOCUSING QUESTIONNAIRE

General Instructions

1. Be able to point to something written in the material to be rated, a specific phrase upon which the rating is based. Go by what is written on the questionnaire over your own intuition in making these ratings.
2. When evaluating a response please refer to the question on which it is based.
3. Refer to the chart below as a general guide to making the ratings:

| Rating: | <u>Person's Reported Experience</u> | | |
|---------|-------------------------------------|--------------------------------|------------------------|
| | Concentration on one thing | Concentration on felt sense | Shift in felt sense |
| 4 | Present | Present | Present |
| 3 | Present | Present | Absent |
| 2 | Present | Absent | Absent |
| 1 | Absent | Absent | Absent |

4. In making the ratings, refer to the following criterion.

4 -- FOCUSED WITH EXPERIENTIAL EFFECT

The person describes definite feelings about a problem or about a situation important to him (see 3 rating)

PLUS at least one of the following:

- a. The person is aware of something being new or different from what it was before.
- b. Person describes a sense of having worked something through.
- c. Person's feelings begin to make sense to him and to fit in with other things--he has a sense that there is a relationship between his feelings which he has not seen before.
- d. Person describes being able to see things in a different way, having a different perspective on his problem as a consequence of attending to his felt sense.
- e. Person describes feeling relief at the end of the experience, or a feeling of well-being stemming from attending to his feelings about a problem.
- f. Person describes awareness of a new feeling, one that emerged as a result of his focusing and that he was initially unable to describe with words and pictures.
- g. Person describes arriving at a conclusion based on insight into the significance of his feelings. This insight must include a shift in his felt sense.
- h. Person describes attending to his felt sense, even if the subject of these feelings he is attending to and attempting to clarify is unclear to him or not stated. The person must make it clear that he was continuously referring to his felt sense. Plus he must describe an experiential effect, as in (a) - (g) above, coming about as a result of focusing on his feelings.

3 -- FOCUSED ON A SPECIFIC FELT MEANING AND OBTAINED SOME WORDS OR IMAGES, BUT DID NOT REPORT AN EXPERIENTIAL EFFECT AND DID NOT REFOCUS.

No experiential effect stems from the focusing (as described under the section for a 4-rating). This can be clarified by reference to any or several of the following criteria:

- a. Person describes attending to his felt sense, even if the subject of the feeling he is attending to and attempting to clarify is unclear to him or not stated. The person must make it clear that he was continuously referring to this felt sense.
- b. Feelings as described here include not only emotions, e.g., "I feel I shouldn't put up with this, but I don't feel able to do anything about it."
- c. The person experiences a feeling or feelings, he is able to maintain his attention on his feeling, and the feeling is related to a problem or situation important to him.
- d. The person describes his feeling as real, but hard to put into words.
- e. The person describes getting a feel for the whole situation.
- f. Person describes having felt this way before-- no element of newness.
- g. Person describes being able to sense clearly the main feeling.
- h. Person directly states that he was attending to his feeling, even if his manner of describing his feelings is intellectualized.
- i. Person describes staying with the feeling until it becomes clear to him what the feeling is.

- j. Person describes moving from one feeling to another but gains no sense of relief, nor of different perspective; and the feelings were related to one another or to a central situation or problem.
- k. Person describes the feelings as being represented or symbolized by pictures, nor words.
- l. Person describes exploring one aspect of self-image involving many feelings and their potential relationship.
- m. Person communicates what it is like to be him in terms of his feelings about himself or about a situation.
- n. Person is briefly distracted, but attempts to continuously focus, and was mostly able to stay with his felt sense.
- o. Person expresses feelings about his feelings.

2 -- THOUGHT ABOUT A PROBLEM, AND STAYED WITH IT, BUT DID NOT GAIN A CLEAR BODILY FELT SENSE OF THE PROBLEM

This may be clarified by reference to any or several of the following criteria.

- a. The person describes his thought as being concentrated on one problem during the instructions, but is not able to center his attention on felt aspects of the problem.
- b. Person may have briefly become aware of immediate feelings about a problem or situation important to him, but moves quickly to a rational consideration of the problem, and does not return to its felt meaning.
- c. Person describes thinking about different aspects of a problem, with these discrete thought-about elements having a unifying central theme.
- d. Person might describe the experimental situation as being relaxing, but not describe a felt sense of the situation or problem he is considering, though he does concentrate on one problem.
- e. With "schizophrenic ambivalence" he may admit to having feelings about a problem or situation, and then deny having the feelings.
- f. Person indicates that he became aware of a feeling about a problem and then purposely tried to avoid or change the feeling.
- g. Person uses the word "feeling" in describing a situation or problem, but there is concrete evidence that he is referring to thoughts in using it.
- h. Person describes himself as "thinking about" a feeling in reference to a situation or problem, but there is no evidence at all that he experienced the feeling.
- i. Person describes physical sensations which have no connection with the problem or situation he is concentrating on.

- j. Person concentrates on the problem of not having feelings.
- k. Person is briefly distracted, but attempting to continuously stay with a problem, and was mostly able to do so.
- l. Person consistently concentrates on the utility of the method.

1 -- DID NOT FOCUS, HAD RANDOM THOUGHTS ABOUT PROBLEMSOR OTHER MATTERS

- a. There is an expressed inability to shut out external stimuli and engage in any type of introspection.
- b. Person states that his mind was wandering or that he was unable to follow the instructions.
- c. Person states that he was unable to think of anything important to him. He directly denies having any problems to think about.
- d. Person consistently denies having any involvement in the process.
- e. Person describes his entire experience as one of fantasy rather than as one of attending to feeling.
- f. Person consistently denies any feelings, and does not refer to a problem or to a situation important to him.
- g. Person briefly becomes aware of immediate feelings about a problem or situation, but blocks, loses interest, or becomes distracted, and does not return to either the problem or the felt sense of the problem.
- h. Person describes having a variety of feelings about problems, but moves from one discrete thought to another without any apparent relationship between them, without returning to any one problem or situation.
- i. Person shifts from feeling to feeling in a confused way, and does not attempt to determine what they are about.
- j. Person indicates directly that the feelings to which he is attending are unimportant to him.
- k. Person's thoughts move from problem to problem without connection between them.
- l. Person tries to stay with the exercise, but is unable to concentrate on one thing.

APPENDIX G:

SUPPLEMENTARY INSTRUCTIONS FOR RATING SINGLE ITEMS
OF THE POST-FOCUSING QUESTIONNAIREGeneral

Try not to let a less educated manner of expression (e.g., poor grammar) effect your judgment of the person's focusing. Again, make your judgment on the basis of what is written.

Specific

Rating

- | | |
|---|--|
| 4 | Person describes a change in his felt sense |
| 3 | Person indicates an awareness of his feeling state |
| 2 | Person describes trying to feel something but does not describe actually experiencing a feeling. |
| 1 | Person says "I don't know," which is taken to indicate confusion about the task. Person answers "nothing" to Questions 1, 2, 3, 4, or 8. Person states that he was confused. |
| X | Do not use X to avoid making a difficult judgment, but do use X if there is insufficient information to render a judgment, however uncertain. For example, if a person left a question blank or answered just "yes" or "no" without any elaboration, a rating of X would be given. Similarly, if in answering Question 5 (Did the feeling change or move?), the person indicates that "nothing changed," but there is no evidence to indicate whether the person ever had a feeling, and no elaboration, X would be given. Or in Question 6 (How is this different from what you normally do?), if the person says that "It was different" or "It wasn't |

different" with no elaboration at all, X is given because it is impossible to tell if he had a feeling or was merely referring to a cognitive state. Similarly for Questions 7 and 9, rate X if the person says "nothing" without elaboration. Rate X if person attends to a strictly physical sensation (e.g., muscles twitching), or says he was relaxed, without evidence that it was tied to his focusing on a problem or situation.

If the person does elaborate, or phrases his reply so that more can be inferred from it, then rate the reply 4, 3, 2, or 1.

APPENDIX H:
PROGRAMMED MANUAL FOR TEACHING EXPERIENTIAL FOCUSING

The form of the Programmed Manual as presented to the trainee was one new item per page, in a booklet, with the answer to the item from the previous page being at the top of the page and with the next consecutive item being at the bottom of the page.

An example of a page would thus be:

21. is not

22. Focusing (is, is not)
thinking about a situation.

PROGRAMMED MANUAL

1. As you read this booklet, you will notice that it has questions for you to answer. Your answers should be very short--usually only a word or two long. Guess at the answer, even if you get it wrong, and it will help you to remember what is in the booklet.
2. This booklet deals with a means of understanding yourself which will help you in psychotherapy. This booklet should help you learn a method of _____ yourself.

2. understanding

3. You just tried out this method of understanding when you followed the instructions read to you. It is called focusing. Did you feel you were able to do what it said?

3. Whichever answer you gave is fine.

4. We will now make _____ more understandable to you. It involves getting a bodily feeling for the whole meaning of a problem.

4. focusing

5. This feeling for the _____ meaning of a problem might be better understood if first approached by starting with single feelings, and then working towards experiencing several feelings.
-

5. whole

6. One example of a _____ might be anger, and what it means to you. Let's take a specific situation in which you interact with another person and consider feelings which might go with that relationship.

6. single feeling

7. Take for example your relationship with your psycho-therapist or with another member in your therapy group. Commonly a person would have conflicting feelings about a relationship. List two positive and two negative feelings which you might have about your relationship with this person.

7. You may have included these possibilities:

Positive: a. warmth or liking
b. a feeling that he usually understands you

Negative: a. anxiety about what he might think of you
b. anger that sometimes he is sarcastic

8. Now take each of the feelings you listed, and feel for yourself what each feels like, one at a time. Have you successfully done this?

8. If yes, go on to #9. If no, please try to feel each one separately again. If you have trouble, feel free to talk with the person sitting there about it.

9. Now try to imagine experiencing at least one of your positive feelings and one of your negative feelings

at the same time, together.

Usually a person feels some vagueness or slight confusion when trying to do this. This is perfectly all right, as it is often part of the bodily feeling of two or more feelings together.

Were you able to feel two or more feelings together?

-
9. If yes, go on to #10. If no, please try again to bodily feel two or more feelings together. If you have trouble, feel free to talk to the person sitting there with you about it.

-
10. This bodily sense of two or more feelings at the same time is what is meant by "feel all of the problem."

Just as you made up "the whole feeling" from its separate parts, it is also possible to pick out the separate feelings about a situation from the "whole feeling about it." This is what was aimed at in the instructions which were read to you at the beginning of this session.

Can you think of an example where you might have a "whole feeling" for a situation and then pick out separate, more specific feelings about that?

-
10. If yes, go on to #11. If no, an example of a general feeling might be your generally positive feeling about your relationship with a friend, on an occasion of doing something together. Specific aspects of this include your pleasure at doing things with that person, your enjoyment of his joking around, and so forth. Now try to form a fresh example of this from your own life.

If you have trouble, feel free to ask the person sitting with you about it.

11. When you focus on your whole feeling for a situation, you must first stop talking silently to yourself to let a feeling for that situation emerge. First in focusing you must stop _____.

11. talking silently to yourself.

12. As you are carefully quiet, you can let the whole experience of a situation or interaction with another person come to you. You let yourself feel the _____ experience of it.

12. whole

13. Words or images may come to you when you focus on the whole feeling of a situation, but let them pass unless they have an effect on the feeling. Hold onto the words or images if they make the feeling more intense, or cause it to shift, or bring a sense of relief. Let words or images pass unless they _____ on the feeling.

13. have an effect

14. You may find that a specific feeling then comes up. This _____ will seem like the main part of the whole feeling.

14. specific feeling

15. Focusing is a shift from "telling yourself about a problem" to getting a "bodily feeling about a problem." Words and meanings can arise from this _____.

15. bodily feeling.

16. This bodily feeling is a feel for the richness of a "whole situation," not just an emotion like anger, depression, or joy by itself.

The bodily feeling is not a simple _____ by itself, but would always include the meaning of the emotion.

16. emotion

17. You may find your mind going blank or wandering during focusing. If this happens, start freshly and focus on the whole feel of right now. If your mind goes blank, start freshly with a _____ of the _____ thing for you now.

17. feel.....whole

18. You are successfully focusing if at first you can feel more than you can understand, when what is there is more than words and thoughts. Sometimes your feeling is more than _____ and _____.

18. words...thoughts

19. Focusing and letting a feeling come is different from letting anything at all come. It is different, for example, from letting "voices" or other weird things come. Focusing involves "how you now feel" about some problem of living. Since focusing is different from letting _____ thoughts come, it helps one to control them. It feels safe and different to focus on what one feels now.

19. weird

20. Underline one of the answers for each of these:

Focusing (is; is not) letting a feeling of the whole thing come to you.

20. is

21. Focusing (is; is not) letting anything at all come.

21. is not

22. Focusing (is; is not) thinking about a situation.

22. is not

23. Focusing (is; is not) getting a bodily feeling for a situation.

23. is

24. Focusing (does; does not) involve staying only with those words or images that have an effect on your feeling.

24. does

25. The following example is of a person who (is; is not) focusing.

"I went to the movies yesterday and a big guy cut in line in front of me. I just stood and stared at him, but didn't do anything about it."

-
25. is not This was just a description without feelings and their meaning.

-
26. Here is another example: The person (is; is not) focusing.

I am a student, in company of a teacher for whom I have conscious feelings of great respect. I am accustomed to feeling pleasure when I am in his company. I am with him now, and I am thinking how much I admire him. But as I pay attention to my felt sense of what is happening between us now, I notice that I feel a little uneasy. How can this be? A barrage of thoughts continues to tell me how much I like this great teacher, what a fine man he is, and so forth, but I ignore these thoughts and concentrate on my felt sense of uneasiness. As I attend to it, it changes and sharpens into a feeling of disgust, and now I notice that I am greatly repelled by his habit of chewing tobacco while he is talking to me. In a little while I am amused by my new feeling of repulsion toward this side of my teacher, and the feeling of uneasiness is gone. I feel relieved.

-
26. is

-
27. Write down a brief example of not focusing in the space below.
-

27. Your example might include thoughts about a situation, but not your feelings about it and what those feelings mean to you.

28. Now look at the essay you wrote after listening to the focusing instructions at the beginning of this session. Were you focusing then?

28. Now you are just seeing if you can recognize whether it was focusing.

29. It is time to talk with the person in the room with you.

APPENDIX I:

PRACTICE POST-FOCUSING QUESTIONNAIRES FOR TRAINING JUDGES

Questions from old form of questionnaire
(Instructions were given by tape recorder in a classroom)

1. In no more than four sentences (one short paragraph), please describe what was happening to you, and what you have experienced while listening to the instructions which were given to you during the last ten minutes.
2. Subjects 1 - 34: Did the feeling change after you got the words or picture?

Subjects 35 - 68: How did the feeling change after you got the words or picture?
3. What was the best thing about doing this?
4. What was the worst thing about doing this?
5. What surprised you most about all this?
6. Subjects 1 - 34: Was thinking this way different from the way you usually do it?

Subjects 35 - 68: How was thinking this way different from the way you usually do it?
7. Many people get lost near the start and then the rest doesn't make sense. Did something like this happen to you?

Person #1

1. When the instructions were given I would listen and try to concentrate. Many times my mind would wander before the speaker came back on.
 2. I kept wondering what the reasons were behind the questions.
 3. Getting time to think about the thing I had to think about. These things caused my mind to wander too much.
 4. Wandering mind.
 5. The surprise will come after I find out the reasons for the questions.
 6. ?
 7. Yes
-

Person #2

1. This experience was something that I have never experienced before. At first, I felt very relaxed and then the voice (same tone) kept guiding my thoughts and making them become clearer and more defined. Troubles, sadness, joy, etc., were all felt at different times, and it was as if somebody was listening to all of my thoughts. Instead of the scattered and partially thought-about daydreams, this experience was helpful in that it gave me ten minutes to myself. I think people should be able to do this at least once every day. We are all in too much of a rush to truly sit down and think over our feelings and thoughts.
2. It made the feeling more intense when there were words to describe it.
3. It was relaxing and gave the time needed by everyone to think about personal problems and emotional reactions to them.
4. It brought to the front of my mind certain things that have been repressed.

5. It was an experience that I have never had before-- where your thoughts and feelings are guided by a voice.
 6. Usually my thinking is all mixed up. Everything and anything enters consciousness. Here it was sort of guided.
 7. No
-

Person #3

1. I began thinking at the beginning of the tape, but couldn't bring out any one experience too clearly. Afterwards I lost track and couldn't follow the procedures with the words and pictures. I feel I would like to hear the tape again. The voice on the tape seemed pleasant and relaxed.
 2. ?
 3. --
 4. You have to be able to relax completely. I think I lost the procedure by not doing so.
 5. --
 6. Before I just thought, and never realized the procedure of the whole thing.
 7. Yes
-

Person #4

1. I'm not sure what has happened. I had many experiences and feelings "running" through my mind. I did put my thoughts on a personal problem at one time during the recording but couldn't seem to follow through with the same problem throughout the entire session.
2. None, I knew how I felt in the beginning.
3. It was a new experience.
4. Not being able to concentrate fully.

5. How it helped the listener to delve into his own thoughts.
 6. My own thinking isn't quite this organized. I don't really sit down and probe at my problem.
 7. I seemed partially lost through the entire session.
-

Person #5

1. During the last ten minutes, I almost forgot about the world around me. Many thoughts were flowing through my mind at the same time--thoughts of mixed emotions. I was almost surprised to realize I could feel so many different things concerning one subject area. This flow of feelings was in one way relaxing and in another disconcerting. At one time I felt at ease and the next, bothered because my thoughts kept jumping around so. As an end result, however, it was a soothing type of experience.
 2. The feeling seemed stronger and more clear.
 3. It seemed to somewhat clear the mind.
 4. It made you realize the subject involved many different sides and not all happy.
 5. The number of mixed emotions that seemed to be involved.
 6. You had time to devote to just one subject and not many.
 7. No
-

Person #6

1. The feeling was one of complete relaxation and no inhibitions--a feeling of a near hypnotic state where I was very responsive to the suggestions of the voice in the recording. My thoughts were taken to a conflict I have not been able to resolve in my life but which seemed less serious after listening to the recording. I began to experience some logical thinking occurring.

2. The problem I am confronted with did not seem as serious.
 3. More logical sequence of thought processes.
 4. A feeling of drowsiness.
 5. The feeling of relaxation and the fact that one started to think more logically.
 6. The feeling of relaxation is not usually with me when I am thinking about a serious problem that confronts me.
 7. No
-

Person #7

1. My thoughts center around my mother who is seriously ill--I tried to think of what procedures I would follow so I would spend as much time as I possibly could--what measures I would follow to help make her more comfortable. My thoughts center on what a wonderful person she has always been--and the way she has accepted this illness.
 2. I wanted to do more to make her comfortable.
 3. It gave me time to help work out a problem.
 4. --
 5. That I don't organize my time very well.
 6. --
 7. No
-

Person #8

1. During the past ten minutes I was reviewing, with anticipation, my job in athletics. The anticipation of which I speak is that of obtaining another job in the area of athletics, but a question of ethics enters into my mind in two ways. The job I am interested in acquiring is one that has been offered

- to me previously. However, I refused this job when offered, because of a previous verbal agreement with another school. The present job presents a dim outlook for athletics and I wonder, will I be asked to resign if things don't improve and therefore be left without a job in athletics or should I move on to greener pastures? I asked myself should I stand by my players and hope they will respond with success or should I forget about their respective futures and say the hell with ethics?
2. I felt that I will try to acquire the other position and not worry about the boys that I am leaving.
 3. I felt that I can help the new boys, because of a better environment which will brighten their outlook on the athletic situation.
 4. The thought of leaving all my associates in athletics, with the thoughts that they will think I wasn't worth hiring in the first place.
 5. The way I felt I could forget about my ex-players and associates after thinking deeply about it.
 6. I usually try to feel concerned about others besides myself--but it's a "cutthroat game."
 7. No

Person #9

1. If this recording had been played in complete privacy, it would have been more effective. Other people's movements were distracting to me. Also some preparation for this type of mental examination would have been helpful. It took quite a while for me to concentrate my thoughts; the abrupt change from school chatter to depth thinking was not stimulating.

My only thoughts were that I could feel no definite feelings. We keep our feelings so repressed that in ten minutes I couldn't find a definite thought. My foremost thought was that my feelings are very regimented, suppressed and that I'm a fairly unemotional person. Fortunately, I had no grave personal problems that were bearing on my mind. This helps to prove that I am frequently blase about things and do

not react to them. The words that came to mind were suppressed, "Schedulist" and feelingless.

No pictures came to my mind. And my thoughts did not develop or expand.

2. They didn't.
3. For a moment I thought about what feelings are inside of me.
4. You were not completely free to concentrate or "let yourself go" because you were aware of others.
5. The entire thing. I was expecting to analyze someone else, not myself.
6. Completely different. I usually let things "come as they may" and show or feel very little. However, my feelings are easily hurt probably because I hide them.
7. Yes

Person #10

1. Confusion, after taking thirty minutes to set up tape I lost all interest in what might be on the tape. However, once the tape started I became confused, I kept looking for a more direct approach to whatever we were to do, other than relaxing. Having had a headache, I drifted from thinking about work, food, sex, voltage regulators, to the soft voice which drifted into my thoughts, not interrupting in my thoughts, but re-directing or reinforcing areas of thoughts.
2. No change in feeling. I kept trying to think of what I was expected to think about--underlying theme of tape but never materialized.
3. Relaxing
4. Confusing--difficult to really see or feel the expected --after 8 hours of work it is extremely difficult to choose one item to think about for any one period of time.

5. The approach--adjustment of microphone, speaker's voice, speaker's unconcern for time, directives.
6. Didn't require a lock-step situation where a lesser problem is solved--then a more complex problem, etc.--locked order.
7. Yes

Person #11

1. I didn't understand fully what the instructions were on the tape. I had a difficult time following the procedure to use. I found myself thinking about my problems which in the course of the ten minutes seemed to be all related. I could not keep my mind on one particular thing or feeling. I kept relating one feeling to an occasion or incident which in turn would cause another feeling.
2. It was constantly changing.
3. Actual thinking time allowed.
4. I couldn't concentrate because I didn't fully understand.
5. Nothing--I didn't understand it.
6. It was much more complex.
7. Yes

Person #12

1. I experienced a period of quiet yet confused thinking. I went from a previous period of happy thoughts to some personal problems which tended to be depressing. I didn't focus my thinking on one problem or thought throughout this instructional period.
2. Freer feeling.
3. Relaxation and time for personal thoughts.
4. Tended to be depressing.

5. The lack of motivation or explanation.
 6. Rather directed and channeled.
 7. No
-

Person #13

1. In the beginning, everything was vague. Exactly how do you muster up a feeling. When instructed to deal in specifics it was easier to relate this to normal thinking procedures. Most of the problems were problems that were thought of before without coming to any conclusions. My thoughts were channelled to the most pressing thought on my mind, but I found it difficult to do any real thinking in a group situation. Waiting for the next instructions also hampered the train of thought. It was more or less a rehash of thoughts of plans in the future, trying to decide if I really want to go through with my plans without coming to any definite conclusions.
 2. It was more tangible. It was easier to think about and made it easier to really relate it to what was on the mind.
 3. It gradually brought you to thinking about a problem and problem was not so overwhelming.
 4. I thought about things I decided were not worth worrying about anymore.
 5. Nothing surprised me.
 6. It was more a gradual way of coming to a feeling.
 7. No
-

Person #14

1. During this time period I was able to resolve a problem which was bothering me. I was able to look at the problem objectively and see both the negative and positive aspects. I was more relieved once I thought about the problem knowing that I could resolve it by thinking in this calm, relaxing atmosphere.

2. The feeling made me more happy than being sad.
 3. I was able to resolve this problem and came to some tentative conclusions.
 4. It was a very good representation of helping me to resolve and eventuate myself.
 5. The technique which was used in helping me to think in a better mind about problems of the inner self.
 6. I usually jump to conclusions and become upset over trivial matters. My problems tend to be exaggerated.
 7. No
-

Subject #15

1. Pictured how I did feel in comparison to how I'd like to feel. After realizing that I felt tired and, at the same time, anxious, I started visualizing a carefree floating atmosphere--one of no worries and problems. My ideas, however, were vague and in no specific order or pattern.
 2. Began picturing atmosphere I'd like to be in now.
 3. Made you realize what you actually could visualize if you gave yourself enough time.
 4. It was hard to visualize more than one picture or actual thought.
 5. The length of time given for each idea.
 6. I never really sit down and ask myself "why."
 7. Yes
-

Subject #16

1. At first, I felt as though I was being hypnotized--the voice was so slow and mysterious. I couldn't think of a feeling but then it came. I felt like I was going to fall asleep and was daydreaming. I never had an experience as such before, to actually

- find something to think about.
2. I didn't have any change in feeling.
 3. It was very quiet and I could think about my personal problem, without interruption.
 4. I was free to think, but I wasn't sure of what my solution would be.
 5. I was surprised to find I thought clearly about the problem.
 6. I usually don't concentrate on the one subject as I did now. I think many different things and get confused.
 7. Yes
-

Person #17

1. It took me a long time to get the many problems of today out of my mind and to begin thinking limitlessly. Once on this trend, I seemed to be feeling a quietness of well being. I was not chasing this feeling but allowing it to push me. There was no ups or downs but a flood of easy movement. Very relaxing; however, music has produced this same experience in the past. This to my knowledge is the first time someone has talked me into this mood of expression. The voice itself was pleasant enough.
 2. To easiness.
 3. Relaxing after a period of time.
 4. To get started or in the right frame of mind.
 5. How quickly I got caught up in this once I got started.
 6. Most thinking done within limits or patterns.
 7. No
-

Person #18

1. The mind seemed to be very deep and all the emotions seemed as if they were in a deep well. Gradually, they came upward and swam around in confusion. Finally, the mind settled on one emotion but not fully. Soon, it turned to another--the extreme opposite of the first. Soon after, it changed to still another and this time with great awareness of the feeling I felt change in my body. Blood seemed to flow more rapidly, and I became warmer. Soon pictures and other words came to mind.
 2. Became more broad a feeling. Still concentrated on the feeling but with under scope.
 3. Being fully relaxed and realizing the small corners of the mind.
 4. If thinking of grief--could be quite depressing.
 5. That a feeling of change came over my body and the feeling or emotion my mind settled on.
 6. Usually in thinking of something many other points come to mind. This was complete concentration on 1 point.
 7. No
-

APPENDIX I (CONTINUED)

Expert Ratings of These Practice Questionnaires

These ratings are averaged for five judges from the present study and rounded off to the nearest whole number. The questionnaires were each rated as a whole.

| | | | |
|----|---|-----|---|
| 1. | 1 | 10. | 1 |
| 2. | 4 | 11. | 1 |
| 3. | 1 | 12. | 1 |
| 4. | 1 | 13. | 2 |
| 5. | 4 | 14. | 2 |
| 6. | 4 | 15. | 1 |
| 7. | 2 | 16. | 2 |
| 8. | 2 | 17. | 3 |
| 9. | 1 | 18. | 4 |

APPENDIX J: TUKEY'S HSD SOURCE TABLES

| | <u>q</u> | <u>p</u> |
|---|----------|----------|
| Post-Focusing Questionnaire rated as a whole--inverse transformation | | |
| Comparison of Pretest with Posttest | 6.35 | .01 |
| Post-Focusing Questionnaire rated item-by-item | | |
| Comparison of Experimental Group with Control Group at pretest | 1.87 | NS |
| Comparison of Experimental Group with Control Group at posttest | .71 | NS |
| Comparison of Pretest with Posttest for experimental group | 4.09 | .01 |
| Comparison of Pretest with Posttest for control group | .31 | NS |

APPENDIX K:
SAMPLE POST-FOCUSING QUESTIONNAIRE WITH SCORING

Rated as a whole:

Judge A: 3

Judge B: 3

Rated item-by-item, mean ratings:

Judge A: 2.33

Judge B: 2.50

1. Question: Without saying what you thought about, describe in two or three sentences what was happening for you during this time.

Answer: While focusing my thoughts tended to drift from one emotion to another. I thought that my mind was set of a certain viewpoint then inexplicably I would find myself being influenced by a different feeling.

Ratings: Judge A: 3; Judge B: 3

2. Question: Describe what happened when I said: "Try to get a sense of what all the problem feels like. Let yourself feel all of that."

Answer: I weighed all the possible alternatives to the situation on which my mind was focusing on.

Ratings: Judge A: 2; Judge B: 3

3. Question: What happened after I said: "As you pay attention to the whole feeling you may find that one special feeling comes up"?

Answer: The solution that is most pleasing to me dominated my thoughts.

Ratings: Judge A: 2; Judge B: 2

4. Question: Describe what happened when I said: "Keep following that feeling and let words and pictures come from it."

Answer: The benefits and end results which would undoubtedly occur flashed through my mind.

Ratings: Judge A: 2; Judge B: 2

5. Question: Did the feeling change or move (if so, describe that)?

Answer: Yes it did. I became aware of the unavoidable consequences and as a result my feeling being focused drifted toward another emotion.

Ratings: Judge A: 4; Judge B: 3

6. Question: How is this different from what you normally do?

Answer: I usually don't take time to think of both sides of the coin and the various end results that a certain situation can end up at.

Ratings: Judge A: 2; Judge B: 2

7. Question: What surprised you most about doing this?

Answer: It was a deviance from my norm.

Ratings: Judge A: 1; Judge B: X

8. Question: What about this was the best thing for you?

Answer: It enabled me to become more aware of ways of tackling feelings. I decided not to be swayed by what you consider the most enjoyable result but to weigh all possible roads the feeling may lead to.

Ratings: Judge A: 3; Judge B: 3

9. Question: What was the worst thing about it?

Answer: If one becomes involved in weighing the many different consequences of a feeling, he has a tendency to become confused. But, on the other hand, by focusing on a feeling one tends not to do things by impulse.

Ratings: Judge A: 2; Judge B: 3

APPENDIX L:
PROPOSED NEW RATING SCALE
FOR THE POST-FOCUSING QUESTIONNAIRE

| Score | Description |
|-------|--|
| 1 | Person expresses random thoughts or feelings, or an inability to perform the task. |
| 2 | Person is able to stay with a topic meaningful to him, but does not direct his attention to an area he perceives as a personal problem. |
| 3 | Person directs his attention to a personal problem and stays with it, but either denies feelings about the problem or fails to express them. |
| 4 | Person stays with one personal problem and expresses broad emotions about it, but does not gain a meaningful bodily felt sense of the problem. |
| 5 | Subject gains a meaningful bodily felt sense of the problem, but is unable to stay with it long enough for the bodily felt sense to change. |
| 6 | Subject is able to stay with his meaningful bodily felt sense of the problem long enough for his feelings to change, but the feelings do not change in a clarifying manner. Instead they change from |

| Score | Description |
|-------|---|
| 6 | unpleasant to pleasant, or from anxiety to a sense of relief, or from hopelessness to a sense of mastery. The subject does not refocus on this felt sense to clarify it, but avoids refocusing in order to stay with the nice feeling. |
| 7 | The subject stays with his meaningful bodily felt sense of a problem long enough for it to shift in such a way as to clarify the problem, and to enable him to see it differently and better understand it. He refocuses on his new felt sense. |

Developed from Gendlin's (1969) Focusing Scale
by Greg Swanson and Thomas Mellett.

APPENDIX M:
DEVELOPMENT OF PROCEDURES FOR
TRAINING JUDGES OF THE POST-FOCUSING QUESTIONNAIRE

It was found that thorough training was necessary to properly prepare judges of the Post-Focusing Questionnaire. Since no information has been published on training judges besides the short instructions given by Gendlin et al. (1968), a discussion of the training done in this study might be helpful to future researchers in experiential focusing.

Previous Data, Previous Rules

Data was available from a previous study conducted by Mellett and Coblenz (1966), along with an elaboration of the rules for making ratings (Appendix N), which was developed by Mellett for judging that data. The data consisted of 68 Post-Focusing Questionnaires filled out by college students, and the ratings made by the judges from that study.

Three of the psychologists at the VA hospital were asked to judge the data from the present study. All three had expressed an interest in the research project. One of these was an intern in psychology who was to make ratings on potential subjects to screen out patients already able to focus.

Each of these three judges read through the Programmed Manual (Appendix H) developed by the author to teach focusing, and discussed focusing with the author. The judges each filled out the Post-Focusing Essay Question after following the instructions in the Focusing Manual. These were judged to be representative of level "4" focusing by the present author.

For each of the 68 questionnaires from the 1966 study by Mellett and Coblenz, an average was taken from the ratings made by the judges of that study, yielding 68 mean ratings.

Each of these three judges recruited for the present study was asked to rate the 68 questionnaires, and their ratings were correlated with the mean ratings made by the 1966 judges. The three correlations of the new judges with the old mean ratings were .75, .80, and .77 using the rules for judging from that study.

Present Data, Old Rules

Of the 62 volunteer subjects for the present study, 26 were rated as nonfocusers during the screening. After the experiment was completed and the pre- and posttest data on the 26 subjects was available, it was randomized and presented to the remaining two judges. The two sets of ratings were correlated and found to be too low. The two judges correlated .29 judging the Post-Focusing

Questionnaire as a whole, .31 judging the Essay, and .37 judging the Post-Focusing Questionnaire item-by-item.

At this point the author went back to the ratings made by these two judges of the data from the previous (1966) study. Although their ratings had correlated acceptably with the mean ratings made by the 1966 judges, they only correlated .46 with each other. Upon inspection it became evident that the mean ratings made by the 1966 judges formed somewhat of a mean between the ratings made by these two new judges, thus elevating the correlation of each of the new ratings with the 1966 mean rating.

The judges were asked what they thought had happened. One of the judges who had been an author in the previous study, said that the rules for judging the 1966 data had come from an examination of that data, and did not fit the data from the present study as well. Therefore, he had been unsure of how to rate some of the questionnaires on the present data and had scored them somewhat arbitrarily.

The other judge indicated that he knew many of the subjects in the present study, and he knew that they weren't focusers. Therefore he had been "tough" in his ratings. An examination of the mean and standard deviation of his ratings on the present data bore out his statement. His mean was 1.21 and his standard deviation was .49 for rating the Post-Focusing Questionnaire as a whole, and 1.40 and .33 rating it item-by-item. In contrast, the

other judge had a mean of 2.02 and a standard deviation of .90 rating it as a whole and 2.17 and .57 rating it item-by-item.

Because the judge who had conducted previous focusing research said that the old rules did not fit the new data well, it was deemed necessary to develop a new set of rules. The old questionnaires were examined one by one, and the ratings of the judges compared to determine rules which might make scoring more reliable. This was done for the data from the 68 questionnaires of the 1966 study, for the 52 (2×26) questionnaires of the present study, and for the 26 (2×13) essays of the present study. After the rules were developed they were shown to the judge with previous experience in research on focusing (Dr. Mellett) and he helped to organize them and made some helpful suggestions. The set of rules in Appendix F were the end product of this effort.

Previous Data, New Rules

Since the two judges who had scored the present data were very busy and had already spent a great deal of time making judgments of the data, it was necessary to find two new judges. Gendlin et al. (1968) had indicated that undergraduate judges tended to be less likely to score questionnaires on the basis of preconceived ideas. Therefore, two judges who were not psychologists, and who had never met the patients in the study, were sought out.

These two new judges were warned that a good deal of time would be necessary for training them to be reliable, besides the time necessary for rating the data. They were agreeable, so the training was carried out as described in the Method Chapter.

At this point it was decided that if the new judges rated the remaining 50 questionnaires of the 1966 data, their judgments would not be comparable to the judgments made by the 1966 judges, since there were differences in the rules they would be using. Therefore a new set of "expert" ratings of the 1966 data was needed, utilizing the new rules. Dr. Mellett was prevailed upon to rate the 1966 data according to the new rules. The intern in clinical psychology who did the screening was also asked to re-rate the old data according to the new rules. First these judges and the author discussed the new rules and then went over the last 18 questionnaires from the 1966 data (Appendix I) and discussed how to apply the new rules to each one. Then they rated the remaining 50 items. The author served as a third "expert" judge on the first 50 questionnaires of the 1966 data. The correlations of the three judges with one another on the 50-1966 questionnaires, rated as a whole, were .74, .86, and .71.

These ratings were then averaged for each of the 50 questionnaires, yielding 50 mean ratings.

Since these correlations were close to the margin

of .70, the two new nonpsychologist judges were asked to be able to point to at least one specific rule in the new set of guidelines when judging the 50 items from the 1966 data. Correlating the ratings of these new judges with the mean rating of the three "expert" judges apparently again yielded somewhat inflated correlations since they were .92 and .89. With one another they correlated .82 on this data.

The two new judges and the author then had a five-hour marathon session in which their ratings on each of the 68-1966 questionnaires was discussed, and their ratings were compared to the ratings on the three "expert" judges. As a result of this discussion differences in how the two new judges were making the ratings were ironed out, and the rules for making the ratings were further refined (Appendix F represents the final set of guidelines). To insure that their ratings were more alike they were asked to again rate the 1966 data, and their new correlation was .87.

Present Data, New Rules

Data was presented to the judges one part at a time. First they were asked to rate the Post-Focusing Questionnaire as a whole. Next they were given the Essay Questions to score. Finally the judges rated the Post-Focusing Questionnaire item-by-item, with the items presented separately. Since there was less information available

from the individual items rated in isolation, some additional rules were added to help make the ratings, and are presented in Appendix G.

APPENDIX N:

POST-FOCUSING QUESTIONNAIRE
 RATING GUIDELINES FROM MELLETT AND COBLENTZ (1966)

Rating

- 4 Did Focus (Focused with experiential effect)
- Subject reports a relaxed, uninhibited attitude and seems to have moved from one felt inner event to another. Subject's feeling became sharper or changed in some way. His relaxation and feeling of well being apparently offset any fear of what he might experience. He usually described his response as being very significant and sometimes possessing a kind of "other world" quality.
- 3 Probably Did Focus (Controlled attention to feelings)
- Subject focused on a specific felt meaning and obtained some words or images but did not refocus. Subject experiences feeling but did not "let go." He may have reflected on a private, personal matter in which he is emotionally involved but, because it is either very pleasant or unpleasant, viewed the same problem in the same way throughout the experiment. Control is also inferred if the subject moves from one feeling to another but gains no sense of relief or different perspective.
- 2 Probably Did Not Focus (Interrupted attention to feelings)
- Subject thought about a problem but did not gain a clear bodily felt sense of the problem. Subject became aware of immediate feelings but blocked, lost interest or was distracted. He usually stresses the fact that he had difficulty concentrating or following instructions. However, these responses may be accompanied by expressions of a more helpful attitude toward a personal problem or better understanding of self.

Rating

1 Did Not Focus (No attention to feelings)

Subject had random thoughts about problems or other matters. There is no evidence that the subject experienced any feelings during the experiment. Usually, there is an expressed inability to shut out external stimuli and engage in any type of introspection. If the subject did refer inwardly, he was preoccupied with solving an intellectual problem or considering a situation or event which aroused no apparent affect.