Psychotherapists have always emphasized that effective psychotherapy requires something more than the individual's cognitive explanations and his reports about external situations. "Intellectualizing" and "externalizing" are well known to be ineffective modes of behaving in psychotherapy. It has long been known in all orientations that patients who "intellectualize" or "externalize" tend to fail in therapy.

Despite this unanimity concerning these two ineffective sorts of interview behavior, we have lacked a good description of what sort of behavior is effective. What does one do if one is not intellectualizing or externalizing?

An individual in a therapeutic interview frequently describes external situations, and almost constantly employs concepts to understand himself, that is, engages in intellectual behavior. As he is always concerned intellectually and situationally, what more must be involved, so that we don't call his approach to therapy "intellectualized" or "externalized"?

If we could positively identify and measure what more is involved, we would have defined a mode of patient activity which the many schools of psychotherapy all call effective, in their (otherwise different) therapies.

The present sequence of research studies took place in the client-centered frame of reference and its findings must be considered as limited to it. But, for a number of reasons, it is likely that the positive patient process is the same in all orientations. If so, some grounds for a universal theory of psychotherapy may be extrapolated.

What then is this positive process? What must be present in addition to intellectualizations and event descriptions? One way to put the answer is "feelings." The patient should work not only with cognitive explanations or event descriptions but also with his feelings. But we must be more specific than this word. By feeling here we do not mean an emotion. And we do not mean, simply, that the individual must talk about feelings.

For example, the psychoanalytic way of describing this positive process involves three specific elements. It involves (a) free association, leading to (b) blockages which are concretely and directly felt, and are then (c) worked through. Thereby, new material emerges to consciousness directly from these concretely felt blockages encountered in free association. If this is to happen, if the patient is to work through such directly encountered blockage, he has to be willing and able to center his attention on what he has thus run into, feels, and can't yet formulate clearly and explicitly. To work it through, he has to engage in a concrete experiential change or release.

The client-centered way of defining this positive process sounds different, but involves the same basic process. Here the therapist's main mode of responding is "reflection of feeling." The client may tell of events, or seek to explain himself cognitively, but the therapist will respond to the feelings the client implied.

Such feelings include not only emotions, for example, "You feel angry . . ." but also such feelings as "You feel you shouldn't put up with this, but you don't feel able to do anything about it." The therapist calls the client's attention to an as yet unclear partly cognitive and situational complex which is concretely felt by the client. The client must then be willing and able to focus his attention directly on this felt complex so that he can concretely feel and struggle with it.

If the patient or client reacts to this therapeutic task by failing to attend to his present feeling (conceptually it is not yet clear), if he fails to "focus" on it and carry it forward, if instead he stays with general explanations, or talks only again about the external situation—then he is intellectualizing or externalizing.

In the present series of studies the word focusing names the positive mode of behaving in therapy interviews. Specifically, it names the individual's focusing on his not yet conceptually clear, but directly felt, experiencing (Gendlin, 1962, 1964). Therefore we will also call it the "experiential" manner of interview behavior.

In the sequence of research described here we have devised measures of this experiential manner of interview behavior, and applied them to tape-recorded psychotherapy interviews. We have found that this mode of behavior does indeed characterize the interviews of eventually successful clients, and not of those who eventually fail. These research studies support this experiential theory of psychotherapy.
However, we also found that those clients who begin therapy in a very intellectualized or externalized manner usually don't ever develop a more experiential manner, and hence fail in therapy. Thus, their failure is predictable almost from the beginning.

Now that we can define the sort of interview behavior which eventuates in success, it no longer seems right to let failure-predicted modes of behavior simply continue for years to their eventual failure. What can be done? We have embarked on a new avenue of research, in which we will attempt to "teach" this "focusing" manner of process to clients. By applying our measures to the clients' subsequent interviews, we can test the effectiveness of such a procedure.

But, prior questions are: if the ability to engage in the experiential mode of process doesn't come from therapy (as we had always thought), what parts of the general population have this ability? Is it related to personality traits? Social class? Adjustment? Genetics? We will report a study in which we found personality traits associated with focusing ability.

If focusing ability is such an important problem-resolution skill, ought we not to teach it in school, to everyone? Would it be a possible means of preventive psychology? Is it teachable to anyone? At what ages? Can we measure the ability in the laboratory (since we are speaking of the general population, not psychotherapy patients only)?

Finally, we ask: is focusing ability a factor in that broader ability called "creativity"? We will discuss why it seems that it is. We will report one study which supports that prediction.

In the following we will first briefly discuss the theory of experiencing and how it has altered the sort of variable we measure (from earlier analyses of verbal content—which is said, to a new type of variable: differences in manner of process).

We will then present an overview of the findings in a new encompassing analysis, showing that high levels of the experiential manner of interview behavior do characterize effective psychotherapy. This analysis will enable us to examine and evaluate the problem of predictability more informatively. Is this experiential manner of behavior never taught effectively by therapists to individuals who begin without having it already?

We will then present two studies from the new series of laboratory focusing studies.

**THEORY**

**Feeling Is a Process**

It is important to note that directly felt experiencing is a process. We cannot explain personality change with the sort of theory that considers experiences as entities, and personality as a container full of entities or contents. Such theory may have many other uses, but it cannot formulate personality change.

Thus, we consider experiencing as a process. We also consider the related word feeling as a process. We mean, not the noun: a "feeling of . . ." but the verb, the feeling activity.

Feeling as something focused on occurs only in an activity of reflective attending. But even in psychotherapy one does not always reflect upon ones feelings. One might be fully involved in what one is doing in the situation, or how one is responding to another person, paying no reflecting attention to ones feeling. Whether there is reflecting, or interacting, there is always some ongoing process.

In this theory we do not make feeling into something that could be found separately as an entity; either it is part and parcel with attending, or it is part and parcel with words and behavior in an interacting manner of process.

Can we more exactly define that manner of process which involves such ongoing feeling (and change), as against intellectualizing and externalizing? We want to define it well enough to make it measurable. We want to describe it sufficiently clearly so that, if you listen to a tape recording of a few minutes of interview behavior, you would be able to say fairly definitely which manner of process is occurring in it.

**Four Phases of Focusing**

The manner of process called focusing has been described (Gendlin, 1964) in terms of four phases: (Phase 1:) **Direct Reference** is the individual's attempt to carry forward a concrete feeling process by attending to what he directly and internally feels. Sometimes (when successful) such a process leads to a "felt give," a yielding or release, a shift in the concretely felt. We call that (Phase 2:) **Referent Movement**. At such a time the individual may exclaim "Oh! . . ." well before he has had time to formulate words for the shift which has just occurred in the felt concreteness. Referent movement occurs first as a felt shift. After a few seconds he may employ many words. It is one bit of felt shift, yet thereafter, many details of what he was wrestling with will appear different, new facets will now seem relevant, different things will occur to him.

In successful therapy, individuals never deal only with what they talk about, but with the experiencing involved in it. The experiencing is "overdetermined," that is, it contains, in an implicit way, thousands of facets of the individual's living in his situations. When such a felt experiential concreteness is carried forward so that it shifts or eases even slightly, all these thousands of implicit facets have changed.

Therefore, after such a concretely felt "referent movement" there is often (Phase 3:) **Wide Application**, as many new facets and relevances to other situations come to mind. Often the individual says "and another thing is . . ." or "Oh, and this also tells me why I do so and so in that other kind of situation . . ." All these would not have occurred, nor have been relevant before. They arise after the felt
Finally, (Phase 4:) Content Mutation names the fact that (along with the verbalized variety of wide application) the main problem he was speaking of has also changed. If before he struggled with "why does it make me so angry?" he now says: "I'm not really angry so much as . . . ashamed that I can't do anything in that kind of situation." (And . . . after another sequence of direct reference and referent movement he will probably experience further content mutation: he may say "Oh . . . It isn't so much that I'm ashamed—rather it's that I won't let myself relax because then I'll just avoid the whole thing. I keep myself at least trying to deal with it some way, by not getting over being upset about it.")

In therapy, we depend upon this experientially based "content mutation." If "contents" existed in us as such, and not merely as aspects of ongoing experiencing, then we wouldn't be able to change them. We know of no way to change a personality content or feeling, except by feeling it through, by carrying experiencing forward. But, how is experiencing carried forward? By attention, words, actions or other responses of ones own or from others.

**Observable Definitions**

- 1. Can we definitely recognize (on tape recordings) whether this focusing attention is occurring?
- 2. Can we also definitely recognize whether a carrying forward type of words and of interaction is occurring?
- 3. Can we distinguish these from intellectualizing and externalizing?

In practice there is no difference between Questions 1, 2, and 3. On a tape recording, one does not directly observe the carrying forward effect of the individual's silent attention. Rather, we hear only words, actions and responses of patient and therapist. Thus, we really measure only 2—words and responses carrying forward the feeling process or not doing so. If not, then it is intellectualizing or externalizing (or dead silence—which again we can differentiate from focusing silence only by what the individual says before and after such silences).

Thus, there is only one question and one measurable dimension: to what extent do the individual's words and actions refer to, or freshly phrase his ongoing felt experiencing, and to what extent are they rather "mere" words, not involving and carrying his felt experiencing any further? For our purposes here, let us call that whole experiential manner (carrying forward) focusing, including all four phases and including both when it is internal attention and when it is words and interactive behavior, that do the carrying forward.

This variable (focusing) also clarifies what the therapist (of any orientation) seeks to respond to. There has been no clear formulation of what the therapist responds to. To call it feeling makes many therapists think only of emotional contents ("you feel angry") or of a mere repetition of what the client said ("He did such and so, and then you did such and so?" . . . "Yes, that's what I said."). Despite this ambiguity in the notion of feeling, therapists respond to what can be felt and is implicitly complex, like "You feel you shouldn't put up with this, but you don't know what to do." Such statements are neither mere emotions like "angry," nor mere repetition of what the client explicitly said in words. The directly felt, implicitly complex experiencing is what all therapists really seek to respond to.

This formulation can therefore be universal. Whatever the words (Freudian or Jungian, self-concepts or power drives, interpersonal patterns, etc.)—not these different words but whether they are used experientially is the basic variable of success or failure in the therapies.

The research question now is: Can this experiential manner of verbal behavior be picked out observably, operationally, reliably?

[Page 221]

**FROM CONTENT TO PROCESS VARIABLES**

To measure differences in manner of process, involves a new type of research variable. The usual variables concern "content," what is done or said. We are concerned with how it is done or said.

Process variables are (so to speak) "second-order" variables, obtained by a kind of "rotation," to use an analogy with factor analysis. How does one move from a "content" type of variable to a "process" variable?

In the preceding discussion we first mentioned a content type of variable: the individual talks about feelings. This concerns only what he talks about. But, in discussing psychoanalytic working through, and client-centered responding, we found that concretely felt blockage and concretely felt implicitly complex meanings must be attended to, and concretely worked with. The variable we really want is not whether he talks about feelings, but how he talks.

Thus, a process view of feeling and experiencing is different not only in theory. It leads one to pick out and measure something quite different.

Let us lay down a general procedure for moving from a content to a process formulation of a variable.

Let us use a different example: Say we want to measure "resolution of authority problems."

The first step is to note that the usual way of measuring the variable would be to classify (and then count) different sorts of contents—for instance, verbal contents: in our example: what does the patient say about authority figures?
As predicted, the first set of scales again showed no findings, while the second set correlated with success on the outcome measures. For example, intensely experienced feelings, and to what extent does he rather express them?

The third step is to notice that by "really"—as against merely verbally—we always mean "experientially." Rather than mere verbal solutions, we want to recognize "real," that is, experiential solutions. (This is the sort for which we predict the later behavioral differences we imply by the term "solution.")

But the same verbal contents can occur "merely" verbally, or they can occur as part of a "really" experiential process. The fourth step is to ask: how, behaviorally, is the "really experiential" recognizably different from a "merely verbal" version. This question asks for operational marks for picking out different manners of process, different ways of how the speaking or acting can occur.

For example: the patient may say insightful (solution-like) things about authority figures, without having resolved anything. But, conversely, he may only rarely say a little about it, yet be resolving his authority conflicts. How would we recognize this? By the manner of his interactions with us (or on the tape recording), his present use of choice and autonomy. Has he ceased doubting what he feels whenever the therapist does not immediately grasp it? Does he still wonder, on each topic, how he ought to feel and what he ought to wish? Does he still find it so difficult to speak freshly, without first previewing and censoring what he is about to say? Does he lean right into speech and action, where before he did not act or speak in that manner? These are process differences which might indicate more validly whether he has resolved his authority conflicts. Or, if we are in the midst of therapy, then struggles around such concrete details and such concerns may indicate that he is now experientially working through, what—in content terms—would be called his authority conflicts.

In speaking of authority problems, we purposely used an example we have not researched into. (Another example we did actually carry out is mentioned on p. 231.) We wanted to illustrate the difference between content and process variables, and how to move from one to the other, before mentioning the actual sequence of research studies on process variables.

We believe that the method of reformulating a content variable as a process variable, is of general importance. Operationally, one then measures something entirely different, and more related to what one really wanted to study. Variables are at first usually formulated in content terms because our language and older theories still tend to give them to us in content terms.

THE SEQUENCE OF PSYCHOTHERAPY RESEARCH

Early Studies of Therapy Interviews

In using the word process for our type of variable, we should recall that there is an older use of the word process research in psychotherapy. The term was used to refer to any studies of the interviews over the course of therapy.

But the early process studies (Cartwright, 1957) usually analyzed verbal content. Classification systems were developed for content analysis of what the client said. Interviews were tape-recorded, statements were classified. An exemplary finding was: Early in therapy there are more statements referring to other people. Self-referring statements tended to be negatively toned. Later in therapy, there are significantly more self-referring statements and these are significantly more often positively toned.

This early type of process research laid the methodological foundation for analyzing tape-recorded therapy interviews, and relating the results to independent pre- and posttherapy psychometric tests. However, today, I call them "content" studies, because they concerned verbal content. [1]

Two Content Variables Remeasured as Process Variables

The first reformulation of content variables into process variables began with two verbal content scales which had proved disappointing: "Does therapy, for this client, focus chiefly on his problem, or does it focus chiefly on his relationship with you?" and "To what extent do the problems focus in the past?" (Seeman, 1954). The lack of correlation of these scales with outcome was disappointing, since focus on the relationship and on the present were thought vital to therapy. To move from content variables to variables of the manner of process, Gendlin, Jenney, and Shlien (1956, 1960) repeated the old scales and added two new ones:

"How important to the client is the relationship as a source of new experience?" [2] and "To what extent does the client express his feelings, and to what extent does he rather talk about them?"

The second test of scales is not affected by how much the client talks about the therapist ("How old are you?" or "You are client-centered, so you probably won't answer my question.") or whether he talks about the present ("my boss left for a week, yesterday . . ."). The new scales interpret focus on "relationship" as manners of experiencing with the therapist which one could not have before with anyone, or alone. It does not matter whether this is verbalized as being about therapist or about self. Focus on the present was reinterpreted in the new scales as concrete present experiencing during the interview—as to content it might well be about a past event, for example, intensely experiencing sadness now, about events of long ago.

As predicted, the first set of scales again showed no findings, while the second set correlated with success on the outcome measures.
Measurement of Experiencing during Psychotherapy

The reformulation of client-centered concepts in terms of the experiencing process occurred over the years 1955-1958. It was deeply grounded in Rogers’ earlier work, and in turn influenced his later work (Rogers, 1951, 1959, 1961, 1967).

In 1955, Gendlin and Zimring first presented a theoretical formulation of the experiencing process and a research proposal. Then came the just mentioned rating scale study (Gendlin, Jenney, & Shlien, 1956) and a theoretical formulation (Gendlin, 1957). Then Rogers reformulated his theoretical definition of the “self.” It had been a more content-like conception; self was defined as a “conceptual pattern of perceptions of characteristics” (Rogers, 1951). Now he defined “self is primarily a reflexive awareness of the process of experiencing . . . It is not a structure to be defended, but a rich and changing awareness of the internal experiencing” (1959).

We thought that such an experiential self would be characteristic of the optimally adjusted individual, or of the successful client late in therapy. Before therapy, the neurotic individual would still show “personal constructs” that “are extremely rigid” and seem to him to be “solid guides,” and he would have no recognition that “an inner referent does exist.” Rogers’ Process Scale characterized the interview behavior which would mark the stages of this continuum. In a scale using seven different (but closely related) parameters, each scaled over seven stages, Rogers drew together the earlier work on experiencing.

The scale moves from such descriptions as those on the left to those exemplified in the column on the right.

<table>
<thead>
<tr>
<th>The individual is very remote from his experiencing and unable to draw upon it to symbolize its implicit meaning.</th>
<th>His experiencing is used as a referent to which he can turn again and again for more meaning.</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is . . . expression about self as an object.</td>
<td>The self exists in the experiencing of feeling. At any moment, the self is the experiencing.</td>
</tr>
<tr>
<td>Problems are perceived as external to self.</td>
<td>The individual is living some aspect of his problem in his experiencing.</td>
</tr>
</tbody>
</table>

In the research studies using this scale, 4-minute segments were randomly selected from the first and third one-third portions of early and later interviews. These segments were rerecorded and coded, so that early or late period of time, therapist, and nature of case could not be recognized. The segments were presented to raters in a random order. Using the scale, several raters rated these segments without communicating with each other. Reliability between ratings was established. (In different studies reliability ranged from .47 to .95.) Ratings were then averaged and used in the research.

"Success" and “failure” in therapy are always defined in terms of change on independent pre- and posttherapy psychometric measures.

In a series of studies (Tomlinson, 1959, 1962; Tomlinson & Hart, 1962; Walker, Rablen, & Rogers, 1959) the Process Scale (or the later, more specific Experiencing Scale) was applied to tape recordings of neurotic clients.

In all these studies, the finding was that the more successful clients showed significantly higher levels on the Process Scale both early and late in psychotherapy. The meaning of the finding is that the Process Scale measures a manner of interview behavior which eventuates in a successful outcome of psychotherapy.

The same finding was again arrived at with hospitalized schizophrenic patients at Mendota State Hospital, in Wisconsin (Gendlin, 1966; Matarazzo, 1965; Rogers, 1967; Truax, 1963). Again, the successful group of patients (about half) were higher, throughout therapy, on the process measures than were the failure cases.

Meanwhile, in the Wisconsin research, we revised the Process Scale. At first we found that the seven strands were more reliably rated when rated separately (van der Veen, 1960).

In developing better scales we found that the observable aspects of interview behavior needed to be more specific. The original Process Scale had many stage-descriptions which described no specific behavior, but consisted only of a phrase, such as "more than at the preceding stage." The next higher stage was then again described as "still more." Instead, we sought specific observable aspects to differently define each stage.

Only four of the seven original parameters were really different enough, so that observable cues clearly belonged to one or the other. These four scales correlated so highly with each other (Tomlinson, 1962) that one was deemed sufficient. This was the newly specific Experiencing Scale, used in our final study on schizophrenics. Thus, in the following, the findings from schizophrenics employed the EXP Scale, while the studies of neurotics used the Process Scale in all but one instance. The same basic variable, and much the same interview behavior aspects are being measured in all these cases.

The finding each time was that experiencing ratings of a few 4-minute segments predict success or failure with a high degree of
statistical significance. We can now measure, while it is still going on, whether an effective mode of therapy behavior is occurring. We need no longer wait some years for the outcome measures to tell us!

The implications for clinical practice and for future research strategy are quite momentous. Both practice and research procedures can now be instituted and tested by rating the subsequent interviews soon after whatever one does. In the past, each psychotherapy research study was condemned to require many years, until outcome measures were available, and each patient had to be left to continue whatever he was doing, since there was no objective way to evaluate if his present therapy process was of an effective sort.

From a theoretical point of view, also, these findings are a fruition and a turning point. The findings establish that success depends on a certain mode of in-therapy behavior, namely that mode characterized by high levels of experiential attention and involvement. This finding can be applied and tested in any orientation to psychotherapy. Although using different words and conceptions, the different orientations—when successful—probably involve one and the same experiential process in the individual. But whether this experiential process is indeed universal is now a perfectly testable question! The research design and measure need only be applied to answer the question.

**ARE SUCCESS AND FAILURE PREDICTABLE FROM THE START?**

An Analysis of 50 Cases

We must now discuss a much less happy implication of our findings, which has recently led us into a new avenue of research. The disturbing implication is that success is predictable from the start. [5]

It will be recalled that we had predicted not only that highly experiential behavior (focusing) would characterize the eventually successful client's therapy behavior. We had also predicted that this mode of behavior itself would develop and increase over the course of therapy.

In some of our studies the successful clients do increase their experiential manner of therapy behavior more than failure clients do. In other studies the difference was not significant. But even when statistically "significant," the increase was so small as to be psychologically insignificant. The overall implication is that the experiential type of behavior is not developed as a result of therapy. One either has it very nearly from the start, and so succeeds, or one lacks it and fails in therapy. So much effort and devotion by both patient and therapist over so very many hours and years—and failure was quite predictable from the start?

It is especially discouraging that therapy does not develop the ability to focus and interact in an experiential manner. We had always thought that therapy develops exactly this capacity in individuals who lacked it—in fact, we had thought that only therapy can develop it.

It seems now that we have two distinct factors here: (a) Engagement in an experientially focusing and involved manner of interview behavior produces change and problem resolution. (b) Development of this mode of behavior in individuals who lack it seems not to occur in psychotherapy. It seems to be a prerequisite for therapy, not something to hope for from therapy.

We are inclined to take another look at our data. Is it really the case that no client gets this ability during therapy? Do all the successful ones have it at the outset? How many exceptions? Are there no therapists who know how to engender it in a client who at first lacks it? Or is this finding only an overall group trend, perhaps showing that relatively few therapists know how to engender it, but perhaps (on closer examination), will we find that some do? What degree of predictability is there? Is it nearly sure that those low in EXP at the start will fail, or are their chances merely somewhat greater, statistically?

To answer these questions and to give a total picture, we present here a new analysis of all 38 neurotic cases from which data is available. We also present separately, data from 12 schizophrenic cases with regard to predictability.

Data of 38 neurotic cases from four studies were combined (Tomlinson, 1959, 1962; Tomlinson & Hart, 1962; Walker, Rablen, & Rogers, 1959). The data consist of ratings on the original Process Scale, except in Tomlinson, 1962, where four of that scale's seven parameters were rated on four separate scales. Ratings of early and late in therapy were compared. Ratings by different judges were averaged, and where different portions of an interview were rated separately (e.g., segments from the first 1/3 and the third 1/3) these were averaged. Finally, in the instance where four separate subscales were employed, these ratings were also averaged, yielding overall ratings.

For the 38 neurotic cases there is significantly more increase on the scale for the success cases than for the failure cases. However, the increase is only half [Page 226] a stage on the seven stage continuum (17 success cases move up an average of .592 of a stage; 21 failure cases move not at all -.055 p < .004). Thus successful individuals do increase in this mode of behavior, but by no means can psychotherapy for the group be characterized as a movement from low to high levels on the continuum.

**TABLE 1**

<table>
<thead>
<tr>
<th>Neurotic Cases: Distribution of Process Change Scores (Late-Early) by Starting Level and Outcome</th>
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<tbody>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>-1.0 &amp; below</td>
</tr>
<tr>
<td>-.9 to -.5</td>
</tr>
</tbody>
</table>
Might this be due to a downward movement of some individuals, masking an upward movement of others? Only 3 of 17 success cases show a decrease (see Table 1). Without them, the average increase for the success group would, of course, be somewhat higher (.82 of a stage) but still unimpressive. Two of the three were very high starters, and even after their drop, they still show a high level of experiential behavior. Thus, they too support the view that psychotherapy is not always the development of experiential interview behavior. Effective therapy is associated with the level of experiential involvement, rather than the trend. A sufficient degree of that mode of interview behavior is effective therapy, whether accelerating over time, or not. Only 2 of the 21 failure clients move even as much as half a stage upward.

Turning to Table 2, we see that the schizophrenic group began lower on the scale than the neurotic group, and remained lower throughout. Differences between successful and failure cases were smaller, though still significant. In Table 2, we have chosen improvement on the MMPI schizophrenia scale as our independent outcome variable, because the findings vary somewhat, depending on which outcome criterion, or weighing of criteria, one uses.

Despite all these findings, however, we must examine Tables 1 and 2 directly to evaluate the predictive force we have been discussing. While all of the new neurotic patients who start at a high (4.0) process level are successful, predictability is less impressive at moderate and lower levels. We see from Table 1, that nearly half (18 of the 38) begin at Stage 3, and here the success and failure ratio is nearly balanced (8 successes, 10 failures). Thus, for half the patients, no prediction is possible at the start. We also note that of the 16 who begin at Stage 2 (failure predicted) five are successful. Thus, from the levels early in therapy, 15 of the 38 follow the prediction and chiefly account for the predictability of the group. This is less than half the individuals.

Especially noteworthy are the five eventual success cases who begin quite low on the scale. We can conclude that less than one-third of those who start low are successful, but still, it is incorrect to conclude that this never occurs!

Table 2 presents comparable data for 12 schizophrenics, divided into success and failure groups on the basis of outcome on the MMPI Sc subscale. Several things are striking for this group. The schizophrenic group as a whole falls lower on the EXP scale than neurotics. The differences in overall EXP levels between success and failure cases are statistically significant but not as great as for neurotics. Finally, schizophrenics do not show even the small differences in process movement from early to late in therapy which were found between more and less successful neurotics.

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In regard to these findings, some qualifications are relevant: First, the EXP scale has not been tested for the reliability of very small differences or movement over very small intervals. Second, Table 2 presents data from interviews occurring very early and very late in therapy, ignoring interviews at intermediate points. In our more detailed research with schizophrenics we have found that the course of process is more uneven than is the case for neurotics (Rogers, 1967). Neurotics change in process in a fairly orderly, linear fashion over time, but schizophrenic curves are more complex and uneven, with periods of sudden spurts and periods of backsliding. Hence, the average EXP level over therapy is higher for the success cases than the Table can reveal.

For both neurotics and schizophrenics there is a strong relation between overall EXP level and outcome.

A closer look at Table 2 allows us to evaluate more specifically the predictive value of the initial EXP factor. For schizophrenics, initial EXP level predicts success or failure much more strongly, but there are important qualifications, and again, there are exceptions.

Table 2 could be read to show that five of the six patients starting below 1.75 are failures and that five of the six who start above this point are successes, a very good level of prediction. But, we have no evidence to show that such small scale differences are meaningful or reliable.
Even with this qualification, the predictability of the schizophrenic from initial EXP is impressive, but even here two cases are exceptions. The one success patient who does start low (below 1.75 where most fail) shows a substantial increase in EXP, one that brings him to the level of other successes. It is quite striking that when success cases start low, they almost always change positively, while this is not necessarily the case for failure.

In short, these tables show that there is a fairly strong relationship between initial EXP level and case outcome, but there are enough exceptions to warrant consideration. While most of the schizophrenics and about half the neurotics (especially those who start at the extreme high and low points) are quite predictable as to outcome, there are some who start fairly high and fail, and perhaps even more important theoretically, some who begin very low on the scale and who do manage to move up to higher experiential levels in therapy and to eventual success by outcome criteria. There may be two patterns. In some people, effective therapy behavior is present all along. In others, a good outcome occurs because they do develop their experiencing capacity as therapy proceeds.

**What Does Predictability Imply?**

The findings imply that we must distinguish two aspects of the experiencing variable in psychotherapy:

1. The extent to which the client *engages* in the behavior which the scale defines: A higher level of this mode of behavior is associated with outcome (average level for neurotics, successes: 4.05, for failures: 2.93). The level is an index of ongoing effective therapy.
2. The extent to which the client *increases* this behavior over the course of therapy; such an increase would mean that, later in therapy, the successful client's interview behavior is therapeutically more effective than it was at the start. That is so, but it is not a large increase.

We must alter our thinking. We had rightly thought that the individual in therapy changes *as a result* of an experiential process. The trouble is that we also thought that his ability to engage in such a process was itself equivalent to health, and hence had to result from therapy. It was as if we said: "How did the boy get out of the deep hole he fell into? He ran home and got a ladder."

We had thought that only psychotherapy itself can teach focusing, and that an inability to engage in it is simply maladjustment. High level of experiencing, we had thought, was equal to high adjustment. But, perhaps we had only wrongly identified "ideally adjusted person" with "good client!" Psychologists could well make such a mistake since they know so much more about troubled people than they know about people who never come in contact with psychologists.

It seems now, rather, that focusing is indeed quite an important skill, but not one that defines adjustment. Many quite maladjusted people (e.g., beginning [Page 229] clients) turn out to have this ability under certain circumstances. Others may, perhaps, be quite well adjusted, but be unable to focus their attention and communicative behavior in this experiential mode. It may be that such individuals in their ordinary interactions do carry their experiencing forward, but cannot do so very well with reflective attention, or in interactions relating to their areas of difficulty. If they do run into personality difficulties, then indeed they would have trouble since they lack the skill at that manner of behavior which appears definitely necessary for therapeutic change.

Thus, it seems that focusing ability doesn't define adjustment, but is necessary to move from maladjustment to adjustment.

Now, if one doesn't already have this ability, how does one come by it?

We may still hold that psychotherapists sometimes (at this time, rarely) teach this ability. As we saw, this did occur in 5 out of 38 cases. Apparently some therapists do know how to engender this ability. Perhaps they are so rare only because we have not had even a rough definition of this preconceptual felt experiencing which therapists seek to respond to (and seek to teach their patients to attend to, and speak from). We called it feeling, but as we saw, this term is open to the misunderstanding that it is sheer emotional tonalities, or affect contents within, rather than the ongoing preconceptual concretely felt sense of the individual's meanings and situations. As it becomes empirically established what therapists seek to respond to and teach their patients to attend to, we can expect to become much more effective in teaching therapists how to teach this to their patients.

But, if this ability to engage in this manner of behavior is indeed such a vital problem-resolving skill, then we ought to teach it to patients directly. Until now, even during therapy, we have been reluctant to teach it directly. Perhaps it is no wonder that therapists have failed to teach it. Aside from often not knowing it clearly, they often also held it to be against their principles to teach it directly. Psychotherapy as a whole was thought to be the only way to learn it.

We cannot yet be sure that this skill can be taught, but we can now deny the main reason we have had for thinking that it cannot: it is not the case that only psychotherapy itself can teach it. Psychotherapy does not usually teach it, and those maladjusted individuals most often succeed who begin by already having that skill.

This finding is reminiscent of many other findings, that those most likely to fail are those who are worst off at the start. The less well adjusted, the less ego strength, the lower socioeconomic class, and so forth, the less the likelihood of success in therapy. However, the present findings do not concern outside measures. They concern in-therapy behavior variables. This time we have a hold of exactly what these individuals do, or do not do, in the therapy interviews to succeed or fail.

The other findings concern inherent aspects of a person which cannot be changed, whereas the present findings concern a manner of behaving. While related to personal attributes (see next section) the finding does not merely distinguish positive and negative prognostic groups. The finding implies instead: by what procedures can we enable the presently failure-predicted individuals to do what they now don't do?
It might be thought that these findings, and this experiencing variables apply only in client-centered therapy. The same measure has not yet been applied to other orientations—although it should be noted that the measure is “content-free,” hence, can be applied just as well to psychoanalytic or any other patients.

[Page 230]

But there are very striking analogies between the here reported sequence of research and that undertaken by Bordin concerning free association. One need only substitute “ability to free associate” for “focusing ability” to interpret his results. Bordin (1963) described and undertook a research in which he predicted that individuals’ ability to free associate would be an index of their adjustment. His reasoning was well grounded in psychoanalytic theory, and is perfectly parallel to our own. Psychoanalytic theory, too, held both that this ability is an index of adjustment, and that it is the mode of behavior necessary to engage in effective psychoanalysis!

Psychoanalysis was held to be the change from a condition in which the attempt to free associate runs into almost immediate blockage, to a condition in which the individual can very easily and continuously engage in free association.

The work of psychoanalysis consists in attending to and working through the concretely felt blockages to which the attempt to free associate gives rise. Patients who cannot even attempt free association are simply not good candidates for psychoanalysis.

But Bordin (1966) found that the ability to free associate is not highly correlated with adjustment. Here, too, it seems (though Bordin does not so interpret it) that the well-adjusted person had been wrongly identified as the good patient.

**FOCUSBING IN THE LABORATORY: TWO PILOT STUDIES**

**Focusing Ability and Personality Traits**

Since we are ultimately interested in studying whether focusing ability can be taught, we devised a brief set of focusing instructions to the subject. We preferred not to use therapy-like interviews as a measure of focusing ability because quite extraneous factors would determine whether an individual who can actually would engage in such intimate expressive behavior with an experimenter. Also, as mentioned, our reasoning has led us to the conclusion that even therapists hesitate to attempt direct teaching of this mode of attention, but that the reasons against such direct teaching have fallen away. Hence, direct teaching instruction for a silent focusing process on the part of the subject seemed best. Afterwards we ask the subject not what he thought about, but how, in what manner, he proceeded during the silence.

We had reason to expect this method to succeed, because once before we produced focusing in the laboratory with brief and direct instructions. Gendlin and Berlin (1961) found significantly fewer GSRs and greater resistance rise during periods of silence after a tape-recorded instruction to focus in regard to a personal problem. Similar patterns were found during a nonthreatening memory task. On the other hand, opposite patterns (many GSRs and resistance drop) occurred after instructions to choose an “important personal problem,” as well as after instructions to think about many different unthreatening things that happened that day. The old content variables: threat versus non-threat showed no GSR differences. We found differences for our reformulated process variables: two different manners in which to think and feel: “continuous focusing” versus an external and discontinuous manner.

In that research our very simple (tape-recorded) five-line instruction had been effective. We cite it here. It was given after an instruction to select a personal problem (and the period of silence allowed to do that).

[Page 231]

(b-1) Again in this next instruction, please just think silently to yourself. Please just to yourself, choose some situation or problem about which you have some strong troublesome feelings. When you have decided which problem feelings to choose, please wait until you hear how I’d like you to think about it. All right.

(a-1) OK Please think about some one specific aspect of the problem. As you think about it, try to feel it as specifically as you can. If you find yourself thinking about many different things, please again choose one feeling from among these and continue thinking about one feeling as much as possible. All right.

In that GSR research we did not need to decide which individual subjects did focus. Overall differences in autonomic correlates occurred for the two process variables, that is, after the different instructions. The instructions were sufficient operational definitions in themselves. But, we did notice that we could easily decide from what some subjects afterwards voluntarily said whether or not they had been able to carry out the focusing instruction. Since there are, today, no well-established terms for that manner of process, the colorful, newly invented descriptions some subjects are forced into quite credibly indicate that the subject is trying to describe something he has gone through. In contrast, what other subjects say leaves one in no doubt that they could not understand or follow the instruction.

**The Focusing Manual and the Post - focusing Questionnaire**

Adapting this experience for our new, longer and much more detailed “Focusing Manual” (see Appendix A), we devised a questionnaire (PFQ) to administer afterwards. Open-ended questions (see appendix) ask the subject for the sort of description we had found so indicative before.

Through numerous revisions, we piloted different versions of instructions and analyzed pilot results, adjusting our version to avoid quite
A large number of routine misunderstandings.

A 2-page Focusing Manual was finally devised, consisting of specific instructions with silent periods in which to carry them out. The instructions need to be heard and attempted to be appreciated. The subject is asked to choose a personal problem of life importance to him. It is pointed out that he knows many more facets of this problem than he could possibly think of separately and specifically. He would have to think of each, one by one. But, he can feel them all as a feeling of "that whole thing." He is instructed to pay attention to the concretely felt sense of "that whole thing," and to let some directly felt facet emerge—perhaps the strongest or most important felt facet of that whole problem. Further instructions then ask for the sort of attending which permits the felt give or carrying forward we term "referent movement." Finally, he is asked to phrase to himself freshly, in words, however he feels the facet now. If phrasing has the effect of again shifting the feeling, he is asked to attend to it and again freshly to phrase it.

On the nine item Postfocusing Questionnaire, afterwards, subjects write a few sentences in response to the open-ended questions.

The core issue from a measurement point of view involved the question of whether or not one could reliably ascertain the degree to which any subject had, or had not, followed the instructions and had engaged in a focusing process.

Ratings by judges have high reliability. The range of the scores is great. Roughly half of the subjects can follow these instructions. It may seem surprising that simple instructions should elicit a distinct feeling process in subjects.

Our choice of population was determined by the eventual hope to teach focusing ability in schools. We first chose a senior high school population.

**Procedure**

Two groups of high school students \( N=47 \) were the subjects. The Focusing [Page 232] Manual (FM), the PFQ and the Cattell High-School Personality Questionnaire (HSPQ) were administered. The data were treated as follows:

- 1. Ratings of the PFQ—a group of 11 graduate students (not psychology) were presented with a set of rating instructions which defined the process of focusing, and included an example of what the successful process involves. Without discussion, they then rated the transcribed responses of all the subjects to one question at a time. The raters used a 4-point scale, with the high end of the scale representing the judge's firm conviction that the response is indicative of a subject having focused, and the low end of the scale representing the judge's conviction that the response being rated indicates that the subject could not possibly have focused. The above procedure would have resulted in 4,653 judgments, had all 47 subjects responded to all of the nine questions and had all 11 judges been able to rate all the responses. As it turned out, we were forced to drop three subjects due to many unanswered questions, and execute the reliability analysis by individual items, using only those subjects which were rated by all 11 judges on that particular item.

- 2. Reliability of ratings—two approaches to the reliability of ratings analysis were utilized, both employing analysis of variance with one entry per cell. The first method, Ebel's formula (Guilford, 1959) yielded average interjudge correlations and the standard alpha coefficient for reliability of ratings of all eleven judges. The average interjudge correlations ranged from .108 to .482, and the alpha coefficients ranged from .570 to .910. The second method was a cumulative homogeneity analysis of reliability (Fiske, 1963) which is independent of the number of subjects and judges. The question in which the highest proportion of the total variance is accounted for by the variance of persons is the question which offers the highest degree of discrimination between subjects, in contrast to other variance components.

The ratings on Questions 4, 5, and 6 discriminated and were reliable, with ratings on Questions 3 and 7 being somewhat less so. Ratings on Questions 1, 2, 8, and 9 were neither discriminating nor reliable. The above results were almost identical for both methods used.

- 3. Correlation of focusing ratings with personality measures—for each subject, a mean focusing rating score was determined for the five most reliable questionnaire items, and also a mean score for the whole set of nine items. The above two scores were correlated with the 14 personality factor scores obtained on the HSPQ. Ten scores from the HSPQ were utilized in the correlations. See Table 3 for the correlations of mean focusing scores and the personality factors (14 first-order factors and 3 second-order factors).

<table>
<thead>
<tr>
<th>Factor</th>
<th>5 item mean</th>
<th>9 item mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>-12</td>
<td>-08</td>
</tr>
<tr>
<td>B</td>
<td>36*</td>
<td>40**</td>
</tr>
<tr>
<td>C</td>
<td>44**</td>
<td>45**</td>
</tr>
<tr>
<td>D</td>
<td>-52**</td>
<td>-49**</td>
</tr>
<tr>
<td>E</td>
<td>-27</td>
<td>-19</td>
</tr>
<tr>
<td>F</td>
<td>-34*</td>
<td>-23</td>
</tr>
<tr>
<td>G</td>
<td>32*</td>
<td>25</td>
</tr>
<tr>
<td>H</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>I</td>
<td>37*</td>
<td>35*</td>
</tr>
</tbody>
</table>
### TABLE 3

Correlations between Mean "Focusing" Scores and Personality Factors

<table>
<thead>
<tr>
<th>Personality Traits</th>
<th>J</th>
<th>O</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extrov.</td>
<td>-.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td>-.58**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurot.</td>
<td></td>
<td></td>
<td>.24</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. —Decimal point omitted.

*p ≤ .05 level

**p ≤ .01 level.

### Personality Traits

The findings concern a correlational analysis between Cattell's personality descriptions of subjects and their "focusing ability" scores. Inspection of the correlation matrix shows that 9 out of the 14 first-order personality factors correlated significantly with the mean focusing score for the five most reliable items. Among these, five correlations were significant beyond the .05 level of significance and four at the .01 level. The focusing score was also correlated with Cattell's second-order factors; resulting in one significance (Table 3).

The correlations between the focusing measure and the personality factors imply that what is being measured is a meaningful variable. The relationships between rated focusing and the complex personality factors offer the initial phase of establishing construct validity for the concept of focusing ability.

Focusing ability did not correlate with Cattell's adjustment score.

An inspection of the factors correlating with focusing (we had made no specific predictions) indicates that for the most part focusing ability, is associated with just such traits as are akin to focusing thus giving a meaningful picture. Such traits as "silent and introspective" (F-), "subjective" (1+), as well as the schizoid rather than the manic type (C-, F1, Q41) are examples.

Subjects high in focusing ability (in Cattell's words) are: More intelligent, abstract thinking, bright, controlled, socially precise, self-disciplined, compulsive, effective leaders, steady; conscientious, persevering, staid, rulebound, good organizers of thought, persistent; deliberate, not mind wandering, not distractable, not restless, not impulsive; sober, prudent, serious, taciturn, secretive, daydreaming, no extrovert, no mood swings; tender-minded, dependent, overprotected, sensitive; emotionally stable, face reality, calm; relaxed, unfrustrated, not irrationally worried and tense; not overfatigued by excitement, not lonely, not autistic.

### Focusing and Creativity

Our second avenue of research was also determined for us by the eventual possibility of teaching focusing to normal individuals in school. We think that focusing ability is useful, not only for the resolution of personality problems and for ones ability to aid others in doing so (preventive psychology), but also for creative thinking in general. Since this is also of great importance for a normal population, and more directly involved in the chief aim of education, we want to test whether focusing ability and creativity are indeed related as we predict.

The theoretical rationale for this prediction is clear:

The ability to focus on concretely felt, but preconceptual aspects of the situation or problem one is presently experiencing is obviously necessary if one wishes to move beyond the definitions, constructs and interpretations one already has. Without employing something as yet preformulated, one can only remain within the formulations one already has, one will obtain only whatever follows from these. Thus, most definitions of creativity emphasize the individual's ability to let go of the constructs and interpretations he already has. But this is only a negative definition (like defining effective therapy behavior as being not merely intellectualizing and externalizing, that is, as the ability to *let go* of the intellectual forms and ways of construing which one has been using.) But "let go" of these—in favor of what?

And, by use of what else?

Many definitions of creativity involve freedom from being "stimulus bound," that is, the individual's ability to hold his constructs "loosely," to be able to perceive a given problem or situation not only in the first way he happens to see it, or the conventional way, but also in further ways.

A difficulty of this way of defining creativity is that one tells the individual only what *not* to do (not to cling to his constructs too tightly) but not what to do. No matter how loosely he wishes and tries to hold to his way of seeing something, no matter how willing and eager he may be to see it some other way—how is he to do that?

Creativity involves turning ones attention from the well-articulated explicit form in which one interprets something, to ones as yet
unformulated felt sense of the whole situation—exactly what effective psychotherapy involves. The creative individual is the one who doesn't scorn his vague impressions, who can stand a few moments of attention to his—conceptually vague—but concretely felt impressions, and who formulates these. Through a series of steps he develops his felt impressions from being merely felt in the situation, through initial (often un-promising-sounding) versions, toward the evolution of a meaningful statement, question or specific perception. We thus predicted that positive focusing ability would correlate with a test of creativity (the Hidden Figures Test) which its author (Gottschaldt, 1926) discusses in negative terms, very like the above.

Procedure

The subjects were 22 college sophomores enrolled in a course in introductory psychology. They were given a series of three tests in a group situation; total testing time was 1 hour.

The first test given was Part I of the Hidden Figures Test, an adaptation of the Gottschaldt Figures Test. The task involves deciding which of five geometrical figures is embedded in a complex design. There are 16 items on this part of the test; testing time is 10 minutes. Score is number right (minus 1/5 number wrong) in the 10-minute period.

Immediately following this test the subjects were asked to listen to a recording of the Focusing Manual. The subjects were then asked to fill out a questionnaire (PFQ).

In a third test (TAT productivity score) subjects were asked to look at a series of pictures on a screen by means of an opaque projector. (Two stick figures drawings, and TAT cards, 3BM, 13MF and 10 were used.) The subjects were asked for each picture to: “write as many different stories as you can. You need not write down complete stories, but give me enough information so I know what you a talking about.” Each was exposed for 3½ minutes. The total sum for all pictures was obtained. The Hidden Figures Test scores were compared to both the Focusing Manual as well as the TAT productivity score.

Results

Focusing ability is associated with the ability to do well on the Hidden Figures Test.

The TAT ability taps a different aspect of the Hidden Figures Test, since it was also found related to it, but was found unrelated to focusing ability.

On the basis of PFQ ratings, the group was separated into 10 focusers and 12 non-focusers. The mean score for the Hidden Figures Test was 4.79, the median 4.8. Two subgroups were formed, 12 high in this ability (4.8 or above) and 10 who were low (4.7 and below) (see Table 4).

<table>
<thead>
<tr>
<th>Focusing Ability</th>
<th>Focusers</th>
<th>Nonfocusers</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(5.5)</td>
<td>(6.5)</td>
</tr>
<tr>
<td>Low</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>(4.5)</td>
<td>(5.5)</td>
</tr>
</tbody>
</table>

Note.—$\chi^2 = 6.53$, significant beyond the .02 level ($df = 1$).

The null hypothesis is rejected.

The TAT was then compared to the Hidden Figures Test. A Spearman rank correlation of .44 was obtained between the two sets of ranks which was significant beyond the .05 level.

Finally, the TAT ability was compared to the Focusing Manual ability. The Mean score on the TAT test (total of all stories) was 16.82, the median was 16.5. Two groups were formed, high (16½ and over) and low (16 and lower) (see Table 5).

<table>
<thead>
<tr>
<th>Focusing Ability</th>
<th>Focusers</th>
<th>Nonfocusers</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAT</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>(5.5)</td>
<td>(5.5)</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>(5.5)</td>
<td>(5.5)</td>
</tr>
</tbody>
</table>

Note.—$\chi^2 = .16$, ns.

Therefore both the Focusing Manual and the TAT productivity seem to be tapping distinct aspects of the skill that enables one to do well on the Hidden Figures Test.

These early findings on creativity can be interpreted as follows: The sort of "creativity" operationally defined by the Hidden Figures Test (and the very similar Embedded Figures test) has a good deal of research behind it (Gottschaldt, 1926; Guilford, 1959; Thurstone, 1944). According to its authors, the test measures [Page 235] the individual's ability to "flexibly" adapt patterns, that is, to "let go of"
constructs or configurations when no longer appropriate to the situation. Witkin (1962) also termed this ability “field-independence,” the capacity to free oneself from a given constellation or to make “divergent transformations” with ease. Witkin reports association between the Hidden Figures Test, and the “Rod-Frame Test.” In that test the subject is placed in a darkened room in which only a luminous rod and frame are visible. He is required to adjust the rod to a true vertical position when both frame and the chair he is sitting in are tilted.

While we have not yet run this “Rod-Frame Test,” it is striking here, as elsewhere, that the emphasis in past creativity studies is all on the negative, letting go of frameworks. Past thinking has missed the need for the ability to find and focus on something else, some source or guideline. In the Rod-Frame Test, obviously, the subject must focus on his experientially bodily felt sense of balance and verticality, as he has nothing else that he could go on to make the rod vertical!

In the TAT task, subjects were asked to tell as many different stories as possible—hence there they had to let go not only of a given theme, but also of their experiential sense for the picture—as that would yield the same basic story. Thus the ability to invent many different patterns without relation to ones felt experiencing is not related positively or negatively to the ability to focus on it.

It seems that focusing ability is one essential factor in the type of creativity, so often conceptualized only negatively as the letting go of given constructs.

**IMPLICATIONS**

If we have succeeded in producing this crucial therapeutic process “in the laboratory” so to speak, our next question is: is focusing (so measured) really that same capacity to show high levels of EXP in therapy interview behavior?

Since we have repeatedly found that high levels of EXP scales applied to therapy protocols predict success, we could predict success from our new measure (Manual and PFQ) of focusing ability—if we can first directly establish this presumed equation between focusing ability in the laboratory and EXP level during therapy interviews.

At this writing the Focusing Manual and Questionnaire have been administered to 10 clients in therapy, with two tape-recorded interviews before and two after the focusing administration. This will allow testing the presumed correlation between focusing ability and EXP level during therapy.

We are giving Focusing Manual and PFQ twice in succession to each subject. The first questionnaire will be used to test the correlation with EXP before focusing administration.

We can also test if two administrations “teach” focusing. If so, the taped interviews after focusing should show an increase in EXP as compared with EXP before focusing.

The present strategy allows for continuing correction, since the EXP level soon after focusing will tell us whether our procedures have been effective. If not, we will develop further teaching procedures and soon test them also.

The implications of this research model, both for clinical practice and for future research strategy could conceivably be quite great. Consider for a moment those cases, in some clinical setting, which can thus easily be measured to be quite likely to fail, given the presently ongoing patient behavior. We need no longer let the case haplessly run on for some years, to fail only after great expense and lost hope and effort. What shall be done: transfer to another therapist or a teaching procedure for the client? Whatever you suggest, its efficacy can be tested almost immediately from [Page 236] tape-recorded subsequent interviews. If your procedure has raised the experiencing level, then it seems effective. The ultimate outcome measures must then eventually confirm that. (The patient might only have learned some verbal style. Outcome tests will be required, for some time, to establish the usefulness of any seemingly effective procedure.) Or, the procedure has not worked. It is now only 5 or 6 weeks later. Something else can be attempted, and again swiftly tested.

This research method is applicable to whatever one might think would increase the patients’ ability to engage in success-predictive interview behavior; one can try that and measure subsequent EXP levels.

**SUMMARY AND CONCLUSION**

In this continuing research program each new step has opened up still more research avenues.

One main finding is that the level of experiencing measurable from a few current segments of tape-recorded interview behavior predicts eventual success or failure on independent outcome measures. This means that we are developing a convenient and reliable measure of whether or not effective (eventually successful) psychotherapy is now going on. We need not wait some years for the outcome measures.

The findings also have implications for the type of research which compares outcomes of a psychotherapy group and a control group not in therapy. It seems that psychotherapy is not really going on when the EXP level is low. In the past, two questions have been confounded: (a) Is the psychotherapy process effective if it does occur? (b) Does a psychotherapy process occur here? If psychotherapy as a certain type of patient activity can be defined, its effectiveness is a different issue from that of the people who do not now engage in it.

But, this also implies that we should not term psychotherapy (or expect effectiveness from) the mere fact of two individuals being in a
room together, and one of them claiming to conduct a professional activity. We must face the fact that a good many therapists do not know how to enable individuals who are initially low in experiential focusing ability to engage in therapy. (In our sample, less than one-third of low starters succeed.) But, where the client has, or does develop that ability during psychotherapy, its effectiveness is clearly established, since high experiencing levels correlate with success, and the success subgroup of therapy groups has regularly differed from control groups.

With increasing clarity about this preconceptual concretely felt focusing process, it can be hoped that therapists will increase their ability to point attention and to respond to it and so to aid clients in developing higher levels of this success-eventuating mode of therapy behavior.

Repeated administrations and developing further methods may eventuate in a successful teaching procedure, both for psychotherapy purposes, and generally, as preventive psychology.

At this time, we have an instrument which, in 15 minutes, gives a reliable measure of focusing ability, and appears to correlate with certain personality traits (but not with adjustment) and very tentatively with one factor of such “creativity” as the Hidden Figures Test measures.

From a broad social point of view, we have lacked a formulation (let alone behavioral measures) for the positive side of nonintellectualization and nonexternalization, as well as nonstimulus-boundness. This lack of formulation of the positive process until now, is one aspect of a society-wide tendency of silence concerning the human individual's live, sentient experiencing. But, in a free society, as has often been said, individuals must be able to free themselves of given ideas and con-[Page 237] structs, systems and roles, and must know ways to develop new ones. Nor do we mean by this just any new ones; we mean new forms which express them as individuals, as living persons. We seek social systems and forms in which the human individuals are more than replaceable parts, and do more than play preset roles. Human individuals are more than either the old definitions they are given, or the new definitions they have created. Rather, we are concerned with giving voice to the process of formulating. Novel formulating involves not only forms, but also the preformed concretely felt experiencing process on which an individual may focus, and which he can carry forward concretely and existentially toward resolutions of problems and new ideas and modes of behavior. To describe this process only negatively, only in terms of the old forms (to be let go of) or the new ones (got by magic) is not only inaccurate, it also mystifies those who lack this ability. But we need not continue to describe it as if it were a creation out of nothing. We can speak directly of live preconceptual experiencing about which silence has reigned for so long.

The ability to focus directly on preverbalized felt experiencing and to carry it forward concretely with attention, with words, and with actions, does appear to be quite an important ability for psychotherapy, for personality, and for creativity.

REFERENCES


Appendix A

FOCUSBING 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 second 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 feelings.

1 minute

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

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POSTFOCUSING QUESTIONNAIRE

QUESTIONS

In this questionnaire we are seeking your help in evaluating the instructions which were just read to you. Please do not omit any questions. Do not report what you were thinking about.

1. In no more than four (4) sentences (one short paragraph) please describe what was happening to you in the last 10 minutes.

2. 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. 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 that happen to you?

   Yes_____ No _____

8. Some people use words and feelings. Others use pictures and feelings. Which did you find most important?

   Words_____ Pictures_____ Neither _____

9. Your age

   Sex _____ (Male)_____ (Female)_____
Your job or your father’s job

10. Eye color: Gray_____ Blue _____
    Blue-with-brown_____ Green _____
    Brown-with-blue_____ Light-brown _____
    Dark-brown _____

TO THE JUDGES

You are asked to rate the questionnaire answers on a 4-point rating scale described in the table below. What you are attempting to assess is whether the person who answered the questionnaire 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, of memories, of 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 ongoing stream of feeling,” “one’s felt sense of life,” “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 much 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 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.

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 new feeling. When he does come to understand it, he experiences a 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.

From the answers to the questionnaire, we want you to make a judgment as to whether the persons who provided these answers were or were not focusing. In most cases, you should be able to make a judgment within the range of sureness provided by the scale. In a few cases, you will find that an answer gives you no basis on which to make such a judgment. (All yes or no answers with no further comment given fall into this category.) Such unscorable answers should be scored X. You will have to judge for yourself when to use the X category. Try to make some judgment in as many cases as possible, and reserve X for those answers which are truly irrelevant to the issue of whether or not the individual focused.

**SCORING**

4—means you are SURE the subject DID FOCUS

3—means you DON’T KNOW, but think the subject PROBABLY DID FOCUS.

2—means you DON’T KNOW, but think the subject PROBABLY DID NOT FOCUS.

1—means you are SURE the subject DID NOT FOCUS

X—means the answer given is irrelevant or absolutely insufficient to ANY judgment, HOWEVER UNSURE, as to whether the subject focused or not.

**FOOTNOTES**

[1] However, Bergman’s (1951) study anticipated process variables and was groundbreaking for later developments. Bergman correlated different types of therapist response with different types of ensuing client statements. The type of client statement termed “self-
exploration occurred more frequently after one type of therapist response.

The new scale also included examples: "I've never been able to let go and just feel dependent, as I do now" and "This is the first time I've ever really gotten angry at someone." These examples make clear that it does not matter whether the client mentions the therapist verbally or not, as long as new experience is occurring by means of the relationship. The verbal classification systems still widely used, for example, in reinforcement studies, would not classify these as "T" statements because they do not mention the therapist verbally. Yet it is obvious that that does not matter, if one is concerned with the actual function of the interpersonal relationship in psychotherapy. The relationship may concretely be a vital focus of therapy without "T" being mentioned as such, and conversely, a good portion of all talk about "T" may be trivial.

The project was supported by the National Institute of Mental Health, and directed by Carl R. Rogers, Eugene T. Gendlin, and Charles B. Truax, at the University of Wisconsin and Mendota State Hospital, Madison, Wisconsin.

The final version of the EXP scale used in this research was an extension of the procedure developed by Gendlin and Tomlinson (1960); (Tomlinson, 1962). Revisions by Klein and Mathieu (in press) were made in conjunction with the development of a detailed training manual whereby clinically naive raters could be taught to rate EXP with a high degree of reliability and fidelity to the basic construct.

In 1958, Kirtner and Cartwright reported significant failure and success predictions from ratings of the first interviews of client-centered therapy. They used two main variables: does the client express affective difficulties? and does he show awareness of how his own personality contributed to his difficulties? These variables characterized differences in how clients approach therapy. The finding foreshadowed the later findings, and have been borne out.

It must also be taken into account that there is no basis for assuming equal intervals on this scale. Thus the interval from Stage 1.5 to 1.75 may well be as large as between Stages 3 and 5. The limits of reliability in rating govern our use here, rather than any factual aspect. Though reliability of ratings is high (in the .80s for intraclass), it is really not high enough to support a very microscopic use of half-stage differences. It may be that, while much harder to measure, the movement over lower ranges of the scale represents a greater or different kind of psychological change than movement at higher experiential levels.

One way to test this possibility would be to develop scales that are even more specific and refined in their observable indices than these. That is the direction of development we have taken so far, and it can be continued. It involves discussing with raters just what highly specific aspects on each bit of tape they actually notice and go by in deciding what ratings to give. When one does this, one finds that for a given stage (say Stage 2) a fairly large number of different observable details function to define a bit of tape as falling into Stage 2. The raters actually do the listening, hence they accumulate a set of distinction of their own, usually much more specific than the scale definitions they fall under. A more specific revision of the scale then builds these observable facets right into the scale (insofar as they are judged applicable as indices of the basic variable being scaled). By this method we arrived at scales certainly more specific than any previous, but probably still not as specific as one would need to stretch the continuum out enough to keep reliable pace with differences now termed one-fourth of a stage.

They are different procedures, of course, but when they work—and in their basic intent—they both involve the same process: working through of implicitly complex, directly felt blockage and its release through experiential carrying forward.

Note to Readers:

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- **Biographic Note:** Eugene T. Gendlin is a seminal American philosopher and psychologist. He received his Ph.D. in philosophy from the University of Chicago and taught there from 1963 to 1995. His philosophical work is concerned especially with the relationship between logic and implicit intricacy. Philosophy books include *Experiencing and the Creation of Meaning*, *Language Beyond Post-Modernism: Saying and Thinking in Gendlin's Philosophy* edited by David Michael Levin, (fourteen commentaries and Gendlin’s replies), and *A Process Model*. There is a world wide network of applications and practices stemming from this philosophy. Gendlin has been honored three times by the American Psychological Association for his development of Experiential Psychotherapy. He was a founder and editor for many years of the Association’s Clinical Division Journal, *Psychotherapy: Theory, Research and Practice*. His book *Focusing* has sold over half a million copies and has appeared in seventeen languages. His psychology-related books are *Let Your Body Interpret Your Dreams* and *Focusing-Oriented Psychotherapy*.
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Psychotherapy in general and focusing in particular are oriented toward expanding a person’s sense of who he is, by healing the inner split between a part of him he defines as "I" and a part of him he treats as "other;" "it" (see Welwood & Wilber,
The general goal of therapy is to help a person. Focusing ability in psychotherapy, personality, and creativity. In J. Schlien. (Ed.), Research in psychotherapy Transference focused psychotherapy (TFP) is a highly structured, twice-weekly modified psychodynamic treatment based on Otto F. Kernberg's object relations model of borderline personality disorder. It views the individual with borderline personality organization (BPO) as holding unreconciled and contradictory internalized representations of self and significant others that are affectively charged. The defense against these contradictory internalized object relations leads to disturbed relationships. Focusing ability in psychotherapy, personality, and creativity. Moreover, we argue for the creation of two tiers of professional identity within PP. Firstly, people with a master's qualification in PP might label themselves "positive psychology practitioners."