

An exploration of Focusing-oriented Therapy for
Addictions

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ABSTRACT

This study aims to provide the first systematic explication of focusing-oriented therapy for clients with addiction. It begins with basic principles from the Philosophy of the Implicit – experience, interaction, focaling and carrying forward – outlining their significance in psychopathology and therapy. General focusing-oriented therapy is examined in terms of five client tasks and four therapist responses. A focusing-oriented view of addiction is then developed in terms of phenomena that, socially and personally, deal with unacceptable experience through ‘process-skipping, ‘flailing’ and the use of a ‘carapace.’ Three core tasks of focusing-oriented therapy for recovery are proposed. These help a client stand aside from the addictive carapace, carry forward underlying existential dilemmas and discover a new way of being-in-the-world. Five further recovery ‘avenues’ are identified using experiential aspects of mainstream treatments for addiction and experiential recovery tasks are suggested for them. These understandings of addiction and focusing-oriented therapy for recovery are illustrated in two substantial case studies of therapy in a mainstream drug and alcohol treatment agency. Proposals are made suggesting a greater significance for experiential therapy in addiction treatment.

CONTENTS

Abstract	2
Preface.....	9
Acknowledgements.....	11
Chapter 1 – Research Questions & Methodology.....	12
1.1 Rationale, questions and immediate constraints.....	12
1.2 Methodology Principles	14
1.2.1 Realistic scoping and a broad perspective.....	14
1.2.2 Embodied exploration.....	16
1.2.3 Development Cycles.....	18
1.2.4 Meaningful micro-processes.....	19
1.2.5 Clarity and Life	20
1.3 Research Ethics	23
1.4 Methodology	28
1.5.1 Phase 1 - Embodied exploration	28
1.5.2 Phase 2 - Development Cycles	29
1.5.3 Phase 3 - Clarity and Life	31
1.5 A note on triangulation.....	32
1.6 Structure of the thesis	33
Chapter 2 - A Philosophical Framework.....	35
2.1 Introduction	35
2.1.1 A ‘not so quiet’ revolutionary	35
2.1.2 Origins and Influences.....	38
2.2 Experience and Existence	40
2.2.1 Internally differentiable	41
2.2.2 The linguistic somatic.....	43
2.3 Interaction and Encounter.....	44
2.3.1 Ecological.....	45
2.3.2 Intersubjective	47
2.3.3 Parallels	48
2.3.4 Only together	50
2.4 Focaling and Value.....	50
2.4.1 Right direction.....	51
2.4.2 Focaling	53
2.4.3 Human Agency	54

2.5 Carrying forward and Authenticity	56
2.5.1 Symbolization & Zigzag	57
2.5.2 Living a situation forward	59
2.5.3 Pause and dialectic tension.....	61
2.5.4 'Abstand' - Standing aside from conflation	63
2.6 A note on the self	64
Chapter 3 - Psychopathology	67
3.1 Experience and Existence	70
3.1.1 Philosophy and Psychopathology	70
3.1.2 Structure Bound.....	71
3.1.3 Frozen Whole	73
3.1.4 Conflated living	74
3.2 Interaction and Encounter.....	76
3.2.1 Philosophy and Psychopathology	76
3.2.2 Isolation.....	77
3.2.3 Autistic	79
3.3 Focaling and Value.....	80
3.3.1 Philosophy and Psychopathology	80
3.3.2 Defensive.....	82
3.3.3 Flailing to escape.....	84
3.3.4 The 'inner critic'	87
3.4 Carrying forward and Authenticity	91
3.4.1 Philosophy and Psychopathology	91
3.4.2 Standing aside from the blockage.....	91
3.4.3 Reconstitution - Connection with what is alive	92
3.4.4 Articulating the idle running	93
Chapter 4 - Experiential psychotherapy.....	95
4.1 Focusing-oriented Therapy and Avenues	95
4.1.1 Origins in person-centred therapy.....	95
4.1.2 Relationship to other methods	97
4.1.3 'Experientializing'	100
4.1.4 Avenues.....	102
4.2 Overview of the therapy.....	106
4.3 Client tasks.....	109
4.3.1 Experiencing/existence	110
4.3.2 Interaction/encounter	112
4.3.3 Focaling/value	116

4.4 Therapist responses.....	122
4.4.1 Creating an intersubjective space.....	122
4.4.2 Felt meaning.....	124
4.4.3 Articulations	126
4.4.4 Living Toward	128
4.5. Tasks and responses	130
Chapter 5 – Addiction & Recovery	131
5.1 Addiction theory and discourse.....	131
5.1.1 Competing paradigms of addiction theory	131
5.1.2 Dominant views of addiction and recovery	133
5.1.3 Discourses of addiction and recovery	138
5.2 Views consistent with the Philosophy of the Implicit	148
5.2.1 Experience and Existence.....	148
5.2.2 Interaction and Encounter	150
5.2.3 Focaling and Value	151
5.2.4 Carrying forward and Authenticity	152
5.2.5 Overcoming paradigm incompatibilities.....	154
5.3 Existing focusing-oriented views	159
5.3.1 Gendlin’s Reference	159
5.3.2 Experience and Existence.....	160
5.3.3 Interaction and Encounter	163
5.3.4 Focaling and Value	166
5.4 Focusing-oriented views of addiction and recovery	168
5.4.1 Addiction – Themes and Observations	169
5.4.2 Proposed view of addiction	170
5.4.3 Recovery – Themes and Observations.....	171
5.4.4 Proposed view of recovery	172
Chapter 6 – Focusing-oriented therapy for Recovery.....	173
6.1 A core model.....	173
6.1.1 Experiencing and Existence.....	173
6.1.2 Interaction and Encounter	174
6.1.3 Focaling and Value	175
6.1.4 Carrying Forward and Authenticity.....	176
6.2 Leading treatment orientations	178
6.3 Avenues of focusing-oriented intervention.....	179
6.3.1 Avenue A - Emotional regulation and self-as-perspective	180
6.3.2 Avenue B - Waiting upon a carrying forward	187

6.3.3 Avenue C - Stirring up ambivalence & opposition	192
6.3.4 Avenue D – Releasement (Gelassenheit) and self-identification	200
6.3.5 Avenue E – Concrete carrying forward	206
Chapter 7 – Case Illustrations – Core Model.....	211
7.1 Introductions to each case	212
7.1.1 F26.....	212
7.1.2 M35	215
7.2 Recovery Task 1 - Standing aside from the carapace	219
7.2.1 The ‘fugg’ (F26)	220
7.2.2 Self-harm (F26).....	224
7.2.3 Alcohol dependence (M35).....	228
7.2.4 ‘It’s so difficult’ (M35)	232
7.2.5 Recovery task, evidence and therapist roles	234
7.3 Recovery Task 2 – Carrying forward existential dilemmas.....	237
7.3.1 Relationships and a Bear (M35).....	237
7.3.2 Shrug, smile and the ‘face’ (F26)	242
7.3.3 Recovery task, evidence and therapist roles	245
7.4 Recovery Task 3 - Finding a new way of being-myself-in-the-world.....	248
7.4.1 ‘Getting me’ and the Willow (F26).....	248
7.4.2 Steps toward wholesomeness (M35)	256
7.4.3 Recovery task, evidence and therapist roles	262
Chapter 8 - Case Illustrations – Therapeutic Avenues	265
8.1 ‘Avenue’ A - Emotional regulation, and self-as-perspective	265
8.1.1 Sitting on the floor and Rumi’s field (F26).....	265
8.1.2 Tolerating the fugg (F26).....	267
8.1.3 Out-of-body experiences (M35)	269
8.1.4 Recovery task and evidence.....	271
8.2 ‘Avenue’ B - Waiting upon a carrying forward	272
8.2.1 Dysfunctions of living – Patterns and gaps from the past	273
8.2.2 Dysfunctions of living – A trapped present.....	274
8.2.3 Life working its way out – Flailing to get free	275
8.2.4 Life working its way out – An energy from nowhere.....	276
8.2.5 Recovery task and evidence.....	278
8.3 ‘Avenue’ C - Stirring up ambivalence & opposition.....	279
8.3.1 Sensing together and differently - Resonating Board (M35/F26)	279
8.3.2 Socratic Questioning/Abrasion (F26)	282
8.3.3 Two-chair - Tom/Jerry (F26).....	283

8.3.4 Recovery task and evidence.....	286
8.4 'Avenue' D - Releasement (Gelassenheit) and self-identification.....	286
8.4.1 Getting a grip (M35).....	287
8.4.2 'I-may-wake-up-one-day' (M35)	287
8.4.3 Choice and an 'inch taller' (M35)	290
8.4.4 Choice and employment (F26).....	292
8.4.5 Recovery task and evidence.....	295
8.5 'Avenue' E – Concrete carrying forward.....	295
8.5.1 Dwelling in safety - home and body (M35).....	296
8.5.2 Tactics & Objectives (M35)	300
8.5.3 Alcohol free days and runs (M35).....	303
8.5.4 Tangible issues of a different kind (F26)	304
8.5.5 Recovery task and evidence.....	305
8.6 Evidence of addiction and recovery	305
8.6.1 Addiction	305
8.6.2 Recovery.....	306
Chapter 9 - Discussion	307
9.1 Research questions.....	307
9.1.1 Theoretical Background	307
9.1.2 Addiction and Recovery	309
9.1.3 Focusing-oriented therapy?	311
9.1.4 Conclusion.....	317
9.2 Strengths and limitations.....	317
9.2.1 Study strengths	317
9.2.2 Study limitations	318
9.2.3 Strengths of results	320
9.2.4 Limitations of results.....	321
9.3 Comparison with existing knowledge.....	322
9.4 Implications for practice	325
9.4.1 Felt senses of addiction.....	326
9.4.2 Therapists – felt senses that open	328
9.5 Reflections on theory.....	329
9.6 Implications for research	331
9.7 Personal learning	332
Appendix 1 – List of Observations.....	335
Appendix 2 – Application for Ethical Approval	346
Appendix 3 – Informaton Sheets and Consent Forms	353
Appendix 4 - Illustrations of the Phase 1 process	358

1. List of Phase 1 Unpublished Working Papers.....	358
2. Tests of Focusing-oriented therapy	360
3. Thinking at the Edge Exercise #4.....	361
Appendix 5 – Illustrations of the Phase 2 process	370
1. First cycle hypotheses and reflections on their practice.....	370
2. Stages in the recovery process from the first cycle.....	373
3. Second cycle Task Analysis Process Map.....	375
4. Second cycle hypotheses and reflections on their practice.....	376
5. Third cycle hypotheses	380
Appendix 6 – Outline of leading Addiction Treatment Orientations	383
1. Twelve Step.....	383
2. Relapse Prevention	384
3. The ‘Transtheoretical Model’	385
4. Motivational Interviewing (MI).....	387
5. Person-centred	388
6. Gestalt.....	390
7. Somatic	391
8. Dialectical Behaviour Therapy (DBT)	392
9. Acceptance and Commitment Therapy (ACT)	392
Appendix 7 - Change Interview - F26	393
Appendix 8 - Change Interview - M35.....	407
Appendix 9 – Bibliography	423
Appendix 10 – References to client sessions	441

PREFACE

This study is ambitious. It has attempted to devise a therapy for a particular client group by combining two basic approaches – on one hand philosophy and fundamental theories, on the other empirical practice and reflection. Working in an area of therapy where there is little systematic theory, it has cross-fertilized thinking and practice, illustrating the results achieved through case studies.

At this preliminary stage the emphasis was upon bringing together key concepts in meaningful ways, rather than calibrating evidence to substantiate refined assertions. Metaphors were employed for their evocative power and ability to amalgamate material that might otherwise remain disconnected. It was hoped that such an approach might transcend some of the divisions in thinking and practice that otherwise constrain the sphere of addiction treatment.

Such theoretical and practical exploration has been long, involved and messy. A good deal of practice was needed to build a confident understanding of the dynamics of both addiction and its treatment. Only slowly could this complex sphere be related to focusing-oriented therapy, connecting to its most essential thinking. The ideas that had resulted then needed to be taken through cycles of empirical examination, each allowing perspectives to be revised and reshaped through practice. Finally a focusing-oriented view of addiction and its therapy could be proposed and exemplified in two substantial case studies.

Care is taken here to present the fruit of such intense exploration in as clear and logical form as possible, using a consistent structure for the whole thesis. A pattern of inferences is set out from philosophy through psychopathology to therapy and therapy for addiction. Diverse addiction theories and therapies are linked to this and background information provided in an appendix. A sequential structure of ‘observations’ provides a way, an additional means to navigate what can seem complicated territory.

It is hoped that this sequence of thinking may be clear to follow, that accumulated insights contribute depth and breadth, and that implicit validity may become apparent as case material speaks for itself.

Whilst involvements with drugs or alcohol have been my priority, a broader definition of addiction is presumed in much of the discussion. In these terms addiction is an,

“Overwhelming involvement with any pursuit whatsoever (including, but not limited to, drugs or alcohol) that is harmful to the addicted person, to society, or to both.” (Alexander, 2010, p. 29)

I have also found it useful to see addiction in terms of power. Key factors identified by Orford will be evident in this study – mood modification as a source of power, the power to create strong compulsive habits and the progressive amplification of powerlessness (Orford, 2013, pp. 41-56).

Having chosen to use the word ‘addiction’ as a way to understand a continuing phenomenon, I have tried to avoid the pejorative labels for those involved in it, ‘addict’ etc which imply presumptions I would not share.

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I owe a lot to Campbell Purton who taught me focusing and has been a constant inspiration to my work, particularly here as my first supervisor. I am grateful also to Anne Cockburn my second supervisor. The work set out here has been influenced by a number of colleagues whose insights and support I have greatly valued – Richard Baughan, Sarah Bean, Anna Magee and Martin Langsdon.

Above all thanks to my wife Anne without whose support and sacrifice this work would not have occurred and without whom my life would be unimaginable.

CHAPTER 1 – RESEARCH QUESTIONS & METHODOLOGY

This chapter introduces the rationale for this study and the research questions upon which it is based. I then set out the choices I have made about methodology with the issues of principle that have led me to make them. A further section explains both the ‘procedural’ and ‘practical’ issues of ethics involved.

In this and subsequent chapters, each section will bring together the conclusions reached in summary form as an ‘observation’ which will be numbered to offer a clear structure of inference throughout the thesis.

1.1 Rationale, questions and immediate constraints

The origin of this research began with a personal challenge. As a newly qualified focusing-oriented therapist I was given the opportunity to work in part of a charity supporting adults with alcohol and drug problems. Such clients demonstrated a particular and entrenched kind of stuckness that was not easily resolved. Yet experienced colleagues urged me not to be downhearted. Modest expectations for success seemed common not just within this organisation but general among those who treat such problems. It occurred to me that whilst certain approaches were well established, a fresh perspective might be welcomed if it offered a new insight into such problems and their resolution.

Focusing-oriented therapy claims an insight into the distinctive process of change that occurs within many therapeutic orientations (Gendlin, 1996). A particular kind of attention to experiencing can facilitate a person to be ‘carried forward’ (Gendlin, 1964) from a stuck way of living. The therapy was developed from principles used with very stuck schizophrenics (Purton, 2004) and it occurred to me that there might be relevance here for the stuckness of addiction. However, I soon discovered that there is a dearth of material about how to work

with substance dependent clients within the focusing-oriented tradition. As a therapist I found myself working from basic principles.

The origin of the research therefore lies with a professional need - finding myself as a focusing-oriented therapist working with clients who were stuck with a particular issue. How could I understand their predicament and develop my therapy to help them? A period of concerted action and reflection within an academic structure seemed to offer the potential for a very useful way forward and the research questions follow naturally from this:

- ***What is a focusing-oriented view of addiction and recovery from it?***
- ***How may focusing-oriented therapy support recovery from addiction?***

The origins of the research nevertheless provided both opportunities and constraints. The sphere of exploration was taken to be my existing engagement as a focusing-oriented therapist working in a particular setting with a distinctive client group. Very limited opportunities have been available to connect to other focusing-oriented therapists working with addiction. The research questions are broadly drawn, recognising the serious limitations of existing theory in this sphere. Yet inevitably, attempts to fashion a model with general application would be necessarily influenced by the particular contingencies of the clients encountered – those in a particular UK city treated under a government funded programme.

Observation 01 – The research proposal utilized the existing role of the researcher as a single therapist in a particular setting.

As such if offers depth but limited breadth. It should be judged as a first systematic view of addiction and therapy from a focusing-oriented perspective.

The context was also limited in research resources. There was no existing community of research in this aspect of focusing-oriented therapy, no precedent for focusing-oriented research in this field and no established methods to deploy. Consequently the desire to build the study on empirical foundations suggested a self-directed, broadly heuristic model. The rationale upon which this study was based presumed not just a therapist as researcher, but also a researcher able to work from very limited foundations.

Observation 02 - The research proposal presumed the ability of the researcher to generate a basic theory and therapeutic model in a field of focusing-oriented therapy with minimal research traditions.

1.2 Methodology Principles

The research rationale described so far represents the proposal made to conduct this study and the constraints implied from the start. The next section explains how I have faced the methodological issues that arise from it.

1.2.1 Realistic scoping and a broad perspective

The first issue was the lack of developed thinking in the focusing-oriented tradition about addiction and its treatment. The grounds for such an assertion are demonstrated later in a review of literature (see 5.3, page 159). At this stage the challenge can be simply illustrated by the fact that Eugene Gendlin, the creator of focusing-oriented therapy, made only one subsidiary reference to 'addiction' in 137 documents, spanning over six decades, listed in his online library (Honde, 2013). My bibliography of focusing and addiction (Tidmarsh, 2013a) also showed that no writer has connected the issue to any standard process of focusing-oriented therapy.

The literature of addiction presented other challenges. It is extensive and marked by strongly competing traditions, for example between social sciences and biomedical sciences (Weinberg, 2013). As the major compendiums of theory show (e.g. Leonard & Blane, 1999; Lettieri et al., 1980; Rotgers et al., 1996), developed research in multiple spheres is not accompanied by commonly supported integrative perspectives. One writer commented,

“These theories or 'models' of addiction conflict in every imaginable way ...

We stand individually adamant but collectively flummoxed. Under these conditions, theoretical discussions of addiction often feel less like scholarly collaboration than holy wars between champions of diverse philosophical, scientific, and spiritual assumptions that underlie the conflicting theories.”

(Alexander, 2010, p. 57)

Addiction theory is discussed at greater length elsewhere (see 5.1.1, page 131). It is important here to recognise here how such theoretical and political divisions (Courtwright, 2010) have added complexity to this study. Put simply, any agreed common ground on the subject of addiction has been hard to find.

The proposal to develop a focusing-oriented therapy for addiction therefore encountered serious challenges in relating focusing theory to a very large, complex and hotly debated sphere of addiction theory. Prudence may have suggested such a scope was simply too large. I did not agree with this, but needed to take account of these challenges in terms of the expectations for this study and its results. I considered that to establish one clear and credible focusing-oriented therapy for addiction would represent a significant step. I would need to base the study on evidence and illustrate this in its results, but more systematic testing would be outside the scope of the study.

Observation 03 - Characteristics of the of focusing-oriented and addiction literatures presented significant challenges in exploring a focusing-oriented therapy for addiction.

Consequently the empirical part of the study was limited to the exploratory and illustrative stages.

A further complication arose from the way that Gendlin's thinking stands apart from the 'unit model' which he sees as dominating scientific thinking. Later in this study the significance of this will be explored (see Ob.12, page 38). However, the important methodological issue is the difficulty of reconciling dominant 'unit model' approaches in addiction thinking e.g. the 'brain disease' theory (Ob.56, page 137) to the underlying philosophy of focusing-oriented therapy. Very early on I also became aware of how everyday terms like 'addict' and 'recovery' had a slippery quality. They seemed to bring with them philosophical and social presuppositions that would need to be unpicked if a clear relationship to focusing-oriented thinking was to be established. I recognised the need to gain some clarity about addiction from a social and anthropological perspectives and trace fundamental focusing-oriented thinking back to the Philosophy of the Implicit.

Observation 04 - Tensions in paradigms of thought suggested the need to clearly understand the philosophy underlying focusing-oriented therapy and anthropological understandings of addiction.

1.2.2 Embodied exploration

The issues and constraints detailed so far implied that gaining a firm footing during the initial period of research would be challenging. How was sense to be made across unrelated theoretical spheres and conflicting philosophical paradigms? How will the immediate demands of practice sit with such thinking and be informed by it?

One of the few focusing-oriented perspectives available to help is provided by Todres (2007) who describes qualitative research in terms of 'embodied enquiry.'

This appeared to be particularly relevant to the task at hand. Where there are major conceptual differences to be negotiated it,

“relies not just on sense-making logic, but on the sense-making experience of a person whose body holds a history of many experiences and projects.”
(Todres, 2007, p. 176)

In circumstances where there is a need to connect together apparently disparate spheres, this approach depends upon Heidegger's notion of 'Befindlichkeit' (Ob.16, page 46), the holistic sense of the interconnection of situations, supporting,

“a body-based hermeneutics in which qualitative meanings are pursued by a back and forth movement between words and their felt complexity in the lived body.” (Todres, 2007, p. 180)

This thinking suggested a cautious but confident way of dealing with conflicts and contradictions in explicit thought, allowing wider implicit insights to grow and shape a practical, embodied response. It seemed to have room for a genuine exploration,

“where we do not explain a pattern by fitting it into pre-existing concepts, but allow the pattern to change the concepts or to generate new concepts.”
(Purton, 2009b, no pages)

In Gendlin's terms this kind of stage has a comfortable 'prescientific' feel:

“the requirement that one be ‘scientific’ before one has devised variables is deadly. It means we can never extend science. It means that to get to our aim we must already be there (like the boy who says he got out of the well by running home to get a ladder).” (Gendlin, 1962, p. 20)

Gendlin's own interest in psychotherapy research led him to propose eighteen strategies that might replace established approaches. One of these commends

‘tinkering,’ or ‘playing in the laboratory,’ a substantial period of exploration of an issue before a hypothesis can be established for testing (Gendlin, 1986). This is the kind of exploration exemplified in his *Thinking at the Edge* (TAE, Gendlin & Hendricks, 2004), a method that has been developed as a qualitative research tool “*to create meaning systematically from experience*” (Tokumaru, 2011, p. 16). To me this kind of process evokes the first phase of a heuristic enquiry – immersion:

“Primary concepts for facilitating the immersion process include spontaneous self-dialogue and self-searching, pursuing intuitive clues or hunches, and drawing from the mystery and sources of energy and knowledge within the tacit dimension.” (Moustakas, 1990, p. 28)

Recognising the complexity of the theoretical and practical issues involved I chose to have a substantial exploratory beginning to the study, trusting the implicit insights of thinking and practice to grow organically. It seemed wise to spend a period of years learning what I could about addiction and practicing focusing-oriented therapy with addictive behaviour, until patterns began to emerge.

Observation 05 - Phase 1 – Embodied Exploration – The first part of the study was loosely structured to allow the implicit qualities of experience and theory to be explored to reveal connections and patterns. The period would be allowed to continue until clear perspectives began to emerge.

1.2.3 Development Cycles

Once patterns are produced a more systematic development of models was implied. How was this to be done?

Looking at spheres of learning, research and education a variety of models commended themselves, each suggesting reflexive rotations between thinking and practice. Educational theorist Jerome Bruner (1960) highlighted a spiral process

whereby concepts are revisited to add depth and breadth. In psychology Gendlin emphasises the zig-zag between the implicit and explicit (see Ob.23, page 59) as the means of carrying forward. Similarly, in a description of micro-process analysis, Greenberg describes the “*abduction*” (Hartshorne et al., 1965) whereby “*the investigator oscillates between imagination and observation guided by imagination to create a type of picture or a hypothesis to explain an observed novel finding*” (Greenberg, 2007, p. 25).

The most influential model for this came from a theory-building model of case studies in therapy (Stiles, 2007) where rich case experience is set against pre-existing configurations of theory so that insights and revisions naturally arise. Thus new concepts can be generated and in further cycles offered to be ‘proved’ against more data. As McLeod comments,

“As this inquiry cycle continues, the theory becomes more comprehensively grounded in evidence, and at the same time more differentiated.” (McLeod, 2010, p. 22)

As defined by Styles and McLeod, such a detailed process would be beyond the scope of this study. However the pattern of disciplined reflection would seem appropriate for this study. Drawing hypotheses from the embodied exploration it would be valuable to test and refine them through successive cycles of this nature.

Observation 06 - Phase 2 – Development Cycles – This part of the study generated and tested models of therapy through structured cycles of thinking and practice. Thus each model was compared with data from client sessions and revisions drafted accordingly.

1.2.4 Meaningful micro-processes

Several of Gendlin’s (1986) previously mentioned proposals on psychotherapy research potentially offer a way to focus attention during the Development Cycles.

He suggests working with 'sub-processes' and commends the approach used in two particular studies (e.g. Greenberg, 1983):

"[A] subprocess can be studied alone or in sessions where a recognizable client statement marks when therapists assign this 'patient task' (as Greenberg called it). ... The process was divided into two phases. The second phase (called 'resolution') was defined on several instruments. Promising research possibilities were thereby opened." (Gendlin, 1986, p. 132)

This idea is taken up by some focusing writers (e.g. Leijssen, 1998a) and the most comprehensive guide on this approach (Greenberg, 2007) suggests the use of 'markers' (client indications of a problem), 'tasks' (key client processes), therapist responses and 'resolution markers' (showing the achievement of a task).

Whilst planning the second phase of work I recognised the impossibility of performing the detailed steps expected in a full implementation of task analysis. However, the model of tasks and responses provided a structure to understand focusing-oriented therapy and sketch models of work with addiction. Working in this way provides data for a more developed future stage.

Observation 07 - A task analysis approach to microprocesses was chosen to understand focusing-oriented therapy and assemble hypotheses of work with addiction.

1.2.5 Clarity and Life

Two fundamental issues remain to be addressed that are necessarily intertwined – verification and presentation. How can results be expressed in such a way that it speaks clearly and authentically to a reader?

A rich engagement is used in the embodied exploration of the first phase and the cyclical developments of the second phase. They follow Gendlin's perspective on

authenticity which I will describe later, expressed in the zig-zag of carrying forward (Ob.23, page 59) and the vitality of 'lived forward connections' that are expressed (Ob.24, page 60). Todres uses the epistemological position of Bernstein (1988) to describe validity in qualitative research, an approach which aims to heal the Cartesian legacy of objective/subjective divisions:

"Within this view, when we move to inhabit or share a particular engaged perspective (practice), shared understanding proceeds and works. ... This approach therefore values an embedded validity of contingently influenced experience rather than the abstractions of 'objectivity.'" (Todres, 2007, p. 32)

He draws on Gendlin to identify a 'truth value' that needs more acknowledgement, a "*faithfulness to the bodily felt sense that opens or touches the holistic presence of the phenomenon as it is experienced*" (Todres, 2007, p. 38). This implies that questions of validity and presentation are resolved together in the nature and degree of involvement afforded to the perceiver. Understanding occurs from within, through the active and personal engagement of the participant who is enabled to "*stand before' the concreteness of the experience*" (Todres, 2007, p. 12).

During exploratory phase it became clear that, lacking more developed testing stages, validity would need to be expressed organically in this study. Just as meaning from diverse sources could be implicitly understood, so this study needed to communicate in ways that allow authentication through participation. Some of Todres' signposts for his own expression provided a ready template for this:

"It would tell us something that connects with universal human qualities so that the reader can relate personally to the themes. ... It would not attempt to exhaust the topic but would attempt to allow it to be seen more clearly: like shining a light which increases the reader's sense of contact with this phenomenon without fully possessing it." (Todres, 2007, p. 49)

The issues expressed before (e.g. Ob.03, page 15) suggested that the realisation of this study needs to have both an insight to overcome explicit constraints and a formal clarity to re-formulate well-trodden territory. Fundamental issues of philosophy need to have been resolved so that they facilitate rather than get in the way. The material presented needs to have a living reality that reaches out to the experience of the reader.

The final phase of the study is to present the material with 'clarity and life':

- **Clarity** I have chosen to use 'observations' to make interpretative conclusions clear, showing their origins and connections. A framework from the Philosophy of the Implicit has been chosen to show how therapeutic processes relate back to fundamental thinking. It is hoped that this clarity will allow the reader's understanding and to grow through the thesis.
- **Life** The study design does not allow formal methods of validation for the concepts presented, however I have chosen to provide a sizeable quantity of case material (including Change Interviews, Elliott, 1999) to allow inherent meaning to become apparent. As with facets of a TAE:

"Any instance is superior to a higher order generalization because it has internal specificity. In any real life event you can discover some complex structures which are actually there." (Gendlin & Hendricks, 2004, p. 15)

- **Life and Clarity** Work during the exploration phase illustrated how rich metaphors can evoke both life and clarity of expression and this was demonstrated during my session at an international conference (see 9.4, page 325). I have chosen to present the material in a metaphorical way to allow a personal and immediate perspective.

Observation 08 - Phase 3 – Clarity and Life – The final part of the study has been designed to express results with clarity and allow a degree of personal participation by the reader. Case material will be provided to allow a clarity and transparency of communication.

1.3 Research Ethics

The initial stage of the research naturally involved a consideration of its ethical implications and a process of planning a way of working that was responsive to them. In discussion with the management of the Matthew Project, the agency where the work was to be done, I drafted proposals which received the support of the organisation's Director. These arose from a review of the project using professional guidelines (Bond, 2004) and the more fundamental principles of autonomy, non-maleficence, beneficence, justice and fidelity (Beauchamp & Childress, 2001).

(I had anticipated also seeing research clients at the University of East Anglia Counselling Service and the initial process also involved that organization. In the event no research clients were offered by that organisation and it will not be referred to again)

An application for ethical approval was submitted to the School of Education & Lifelong Learning Research Ethics Committee at the end of January 2009 and was approved. The report is provided in Appendix 2 (page 346). Further consent was given by the Chair of the same committee in May 2012 to the use of the *Change Interview* process, which had not specifically been referred to in the initial application. All information sheets and consent forms used are at Appendix 3 (page 353).

A useful distinction in research ethics can be made between '*procedural ethics*' and '*ethics in practice*' (Guillemin & Gillam, 2004). Procedural issues are

summarized in the table below with the steps used to respond to them. Following this I will discuss the most significant issue of ethics in practice for this project.

Issue	Procedural steps
Dual role – The therapist had potentially conflicting relationships with the client – as both therapist and researcher.	The therapeutic relationship always took precedence in dealings with the client. This was considered as a matter of transparent integrity as a counsellor.
Mind of the client – As a researcher the therapist might have harmed the clients or their interests.	The possibility of labelling was identified and the need to stand back from the dangers of terms like 'addict.'
Mind of the counsellor – Clients might have unguardedly been exposed to unformed theoretical developments?	An approach analogous to clinical supervision was used to structure exploration and analysis of issues. New insights were only used as called for from the client's process in the context of the therapeutic relationship.
Recording of sessions - A safe and secure process was required.	Detailed safeguards were identified in terms of participation, temporary or permanent halts to recording, security and destruction of recordings.
Use of questionnaires - Arrangements needed to be clear and appropriate.	Procedures were agreed for this but questionnaires were rarely used in practice.
Selection of clients – A clear	Detailed arrangements were agreed to ensure

process was required.	there was no duress.
Informed consent – This was recognised as a significant issue.	Particular concerns were addressed about information, potential of clients being under the influence of drink/drugs, and opting in/out.
Confidentiality & anonymity - Appropriate safeguards were required.	Arrangements were agreed about anonymity during the project and upon publication.
Complaints – A clear and adequate process was required.	Appropriate arrangements were agreed.
Impact upon myself – Have the pressures been anticipated?	Appropriate issues were addressed

Observation 09 - Procedural ethical arrangements were agreed with the appropriate university authorities to safeguard clients' needs.

The most significant practical issues of research ethics arose from the environment in which the research was carried out. This can be illustrated in terms of informed consent.

Clients involved came for treatment because of serious issues in their lives. It was not unusual for clients to have severe financial problems, periods of homelessness, poor relationships and be known to the criminal justice system. A history of mental illness, trauma and abuse were also common, particularly for those referred for counselling. Therapeutic relationships were therefore predicated on a significant degree of vulnerability.

Power inequalities are also frequently observed in this type of work. The dominant model of change from addiction (DiClemente & Prochaska, 1998)

presumes stages of persuasion, moving a person from pre-contemplation to action and beyond (see Appendix 6, page 385) and a degree of ‘artful manipulation’ is considered legitimate (Miller & Rollnick, 2002). One recent commentator details external pressures on addiction counselling and those arising from differences of opinion within the consulting room about what is in the client’s best interests. In his view such power tensions are “*the rule rather than the exception*” with this type of work (Orford, 2013, p. 191).

The impact of such influences is perhaps evident in the ‘compliance culture’ that such clients grow to expect from agencies. I will show later how the moral component of the discourse of addiction impacts upon those dealing with it (Ob.58, page 143) and highlight research (page 147) that illustrates the instrumental response that some service users can adopt. In my experience of the many reasons that led a person to be in addiction treatment, some constraint on free choice is common. Indeed clients may sometimes seem to regain self-determination by absenting themselves from treatment, occasionally or permanently. Willing and open engagement cannot be taken for granted.

Such a context raises serious concerns for research engagement that depends upon informed consent. How can the free consent be obtained and assured? How can clients be supported to exercise or revise choices as is right for them? The following tactics were used during the research to attempt to improve the likelihood of consensual participation:

- Separating the initial information about the project from the discussion about participation to allow time for reflection.
- When clients are in a very vulnerable state in initial interviews simply choosing not to offer participation in the research.
- Portraying participation in research as something which ‘approximately half’ of clients feel comfortable doing. From this a felt sense can be taken

informally – ‘do you think you might be in the half that do this or the half that doesn’t?’

- Talking through the process informally before introducing paperwork to sense the degree of comfort from the client. If the client appears unsure offering the option of non-participation straight away.
- Confirming the overall decision to proceed once the paperwork was completed. Reconfirming this at the start of second and third sessions.
- Making an enquiry about recording during sessions and turning off the recorder if the client felt the need. (Such enquiries were made infrequently, perhaps a dozen times during the project. The client requested the recorder turned off once.)

These approaches no doubt improved the degree of consensual participation, but no entire guarantee of the subjective experience of consent could be established. In my view a greater degree of confidence can be drawn from the relationship of the research to the therapeutic relationship itself. Such ‘*relational ethics*’ (Ellis, 2007) imply a degree of ethical reflexivity (Guillemin & Gillam, 2004) that was discussed in clinical supervision. In my view the focusing-oriented offering of ‘resonating board’ responses (see 8.3.1, page 279) for the consenting participation of the client starts to offer an implicit ethical shared space.

Observation 10 - Ethics in practice particularly depended upon the situation of ethical responsibilities in the therapeutic relationship and the exercise of ethical reflexivity during supervision.

1.4 Methodology

This section records the detail of the methodology adopted in the three phases.

1.5.1 Phase 1 - Embodied exploration

This period lasted from September 2008 till June 2011 and combined four streams of exploration, each aiming to develop embodied understandings of addiction, recovery and associated therapy.

Literature exploration

During this period an intensive interaction with the literature was carried out regarding focusing-oriented therapy, the Philosophy of the Implicit, addiction, treatment orientations and recovery regimes. An anthropological perspective of addiction was pursued and parallel themes explored (see Appendix 4, page 358).

Clinical practice

Following ethical approval clients were then engaged in the research and all clients who consented were accepted as research clients. The first phase of clinical practice lasted 33 months until June 2011. During this time 24 clients consented to participate in the study, presenting difficulties with Alcohol, Cannabis, Cocaine, Heroin and Trichophilia over a total of 193 sessions. Of these 17 clients attended for less than 10 sessions, 7 attending for only one.

Engagement with the focusing-oriented community

During this period I took on the role of 'space-holder' for the subject of focusing and addiction for the international Focusing Institute in New York. As part of this I developed a bibliography of focusing and addiction (Tidmarsh, 2013a), facilitated a conference workshop and corresponded with practitioners in several countries. I presented papers on focusing-oriented therapy for addiction at three international conferences during this period – Japan (Tidmarsh, 2009), Germany (Tidmarsh,

2010) and California (Tidmarsh, 2011) and participated in an international symposium session on 'stopped processes' (Geiser, 2010a).

Thinking at the Edge

During this period 28 papers were prepared for discussion at supervision, drawing together insights from the other three streams of exploration (list at Appendix 4, 358). Thinking at the Edge (Gendlin & Hendricks, 2004) was used in various ways including several formal projects e.g. 'Tough & Tender' (TAE4), 'A sense of belonging' (TAE5), 'More stuck in addiction' (TAE6), 'Beyond conspiracy' (TAE7), 'Tussle of discovery' (TAE8). The first of these is provided in Appendix 4 (page 361) as illustration. A series of tests of focusing-oriented therapy were developed (Appendix 4 provides a Phase 1 version, page 360).

Completion

The first stage was completed when a sufficiently cohesive picture of addiction, recovery and relevant elements of focusing-oriented therapy had emerged to allow a more intense period of work to take place. This change was perhaps signalled by the warm conference reception to my third presentation, *Not drowning but waving* (Tidmarsh, 2011), which had set out a strong summary of an approach to the key issues.

1.5.2 Phase 2 - Development Cycles

The second phase comprised three cycles of hypothesis generation and testing with case studies. The principle (Ob.06, page 19) was to state clearly hypotheses that had arisen from the first phase, particularly from a micro-process perspective (Ob.07, page 20). Then experience of working with a current client would be used to provide critical reflections on the hypotheses and prompt amendments, revisions and further development. Three cycles were undertaken based upon changing hypotheses.

First Cycle

The process was piloted on one session with an existing client from the first phase (F4), a 29 year old female heroin user. Then the first cycle carried out with a single new client (F26), a 34 year old female with alcohol and self harm issues. I judged it beneficial to start with a new client and this one was the only client to be taken on at this stage. The first cycle of study lasted from June to November 2011 and comprised 20 sessions. An analysis was made (paper 31) that presented conclusions and revised hypotheses for the supervision session in January 2012. Appendix 5 lists the hypotheses of this phase and reflections on them (page 370). An initial analysis of stages in the recovery process is also illustrated (page 373).

Second Cycle

This began in January 2012 using revised hypotheses based upon a Task Analysis Process Map (Appendix 5, page 375). The first client (F26) continued into this cycle and was supplemented by two further clients - a 45 year old male with alcohol problems (M35) and a 36 year old male with heroin and alcohol problems (M36). As before these were chosen as new clients that were allocated when the cycle began. (M36 was withdrawn since he took up a 'detox' place early in the therapy and was unable to continue as a consequence.) The second cycle lasted from January to April 2012 and comprised a further 25 sessions (16 with F26 and 9 with M35). An analysis was made (paper 33a) that presented conclusions and revised hypotheses for the supervision session in April 2012. Appendix 5 lists the hypotheses of this phase and reflections on them (page 376).

Third Cycle

This began in January 2012 using further revised hypotheses (Appendix 5, page 380). As this was the final cycle an emphasis was put on developing a broad picture of work with these clients for the final phase of Clarity and Life. The two clients already involved in the second cycle were retained and a longer period of

therapy used. The third cycle lasted from April to October 2012 and comprised a further 41 sessions (21 with F26 and 20 with M35). The cycle was completed with both clients undertaking a semi structured *Change Interview* (Elliott, 1999) conducted by an independent researcher/therapist (Appendix 7, page 393 and Appendix 8, page 407).

1.5.3 Phase 3 - Clarity and Life

The third phase began in October 2012 and was completed in September 2013 with the submission of this thesis. Following the principles already discussed (Ob.08, page 23), it seeks to draw together the results of the first two phases in a way that will communicate well with a reader.

- The thesis is structured to show the connections between philosophy, psychopathology, and therapy. Connections are made with addiction theory and therapeutic practice. My interpretations can be clearly traced using the 'observations.'
- Rich case exemplifications are provided in chapters 7 and 8 allowing the reader to gain a clear view of the clients and therapy process, with direct relation to the conclusions reached.
- A limited illustration of the concepts in the form of metaphors is given in Chapter 9 to present the conclusions in a personal immediacy, as was achieved at an international conference (see 9.4, page 325).

Observation 11 - The study was arranged in three phases. The Embodied Exploration of Phase 1 built a rich understanding of addiction and therapy in explicit and implicit forms. The Development Cycles of Phase 2 used therapeutic practice to systematically test and revise hypotheses. Phase 3 is designed to present the work so as to speak to 'head and heart' with clarity and life.

1.5 A note on triangulation

A clear statement is needed in terms of the position of ‘triangulation’ in this study.

Accepted authorities on case study research recommend drawing on multiple sources of information as one of the “*key principles of a good quality systematic case study*” (McLeod, 2010, p. 78) and such various process and outcome measures are frequently used.

When originally established, this study envisaged the use of such measures (see Appendix 2, page 346) but none are presented to support the conclusions. The general grounds for this have already been explained. Theoretical challenges and the limited research traditions (Ob.02, page 14) meant the prime effort of the work is in exploring and establishing an initial theory and formal testing would be beyond the scope of the exercise (Ob.03, page 15). In reality the terms that would need to be tested were still undergoing development right up to the final phase of this work. Testing with sufficient rigour would have required a further phase after the three set out here.

This study is effectively a theoretical and empirical exploration with illustrations from clinical work rather than a case study in the normal sense.

Further, when questions of validation and presentation were considered I choose to substantiate the assertions made through a clarity of expression that will speak in a human sense rather than through using measures (Ob.09, page 25). This decision was made from a philosophical commitment to expression of implicit form and experience of its communicative strength (see 9.4.1 page 326). The *Change Interview* (Elliott, 1999) format provided valuable material for this approach.

Limited experience of trialing measures in this study showed that none were sufficiently related to the key issues (e.g. 'carapace,' existential dilemma, being-in-the-world, Ob.77, page 178) to be valuable:

- Standard 'treatment outcome profiles' (Marsden et al., 2008) used in addiction focus on the behavioural rather than existential position of clients.
- Standard measures from psychology like CORE-OM (Barkham et al., 2006) attend to general levels of psychological health rather than anything to do with addiction.
- Theory based measures like URICA for Motivational Interviewing (Henderson et al., 2004) are naturally limited to a particular framework.

The only measure with some utility was the limited employment of Personalised Questionnaires (Elliott et al., 1999) to reveal key client preoccupations. However these were not used with sufficient frequency and rigour as to be worthy of inclusion.

1.6 Structure of the thesis

The remaining chapters of the thesis are set out to demonstrate the 'clarity and life' principle:

- An understanding of focusing-oriented thinking is established at the beginning by starting with a philosophical framework (chapter 2).
- The Philosophy of the Implicit is then systematically linked to psychopathology (chapter 3) and psychotherapy (chapter 4).
- The four basic concepts of experiential psychotherapy (see Gendlin, 1973b, p. 322f) are used to provide a connecting structure in most chapters. These are experience/existence, interaction/encounter, focalizing/value,

carrying forward/authenticity. Ten years later Gendlin affirmed these as crucial to his thinking (see Gendlin & Lietaer, 1983, p. 86) and he used them in several subsequent summaries (e.g. Gendlin, 1984a, 2003, 2004a).

- Only when the focusing-oriented foundations are clear is the topic of addiction introduced (chapter 5). A broad understanding of the concept is offered, particularly using anthropology and a focusing-oriented view of addiction and recovery from it are established.
- A core model of focusing-oriented therapy for recovery is then described (chapter 6) and this is elaborated to include insights from other orientations, with rich illustrations from cases provided (chapters 7 and 8). Themes are then brought together in a final discussion (chapter 9).

CHAPTER 2 - A PHILOSOPHICAL FRAMEWORK

To provide a basis for the entire study this chapter traces Gendlin's key philosophical concepts, remarking on some of the origins of this approach and drawing some external parallels outside the focusing-oriented sphere. Gendlin's stance has a distinctive contrast with anything found in the field of addiction and therefore it is important to be clear of its foundations as early as possible. Subsequent chapters will then be able to examine the theoretical and practical tensions that result in focusing-oriented therapy for addiction.

2.1 Introduction

2.1.1 A 'not so quiet' revolutionary

These sections start to illustrate one of the recurrent issues for this study, the unresolved tension between objective, rationalistic conceptions of humanity and relativistic and subjectivist understandings, inevitably tied up with the Cartesian/post-Cartesian divide. At each level of understanding, philosophical, psychological and therapeutic, the fault-lines of such divisions will be apparent. For example we will see how Weinberg seeks a post-human view of addiction that surpasses,

“... the overwhelming tendency to conceptualise human biology and human social life dichotomously as two, and only two, wholly discrete and independently integrated ontological domains.” (Weinberg, 2013, p. 173)

We see Bourdieu's recognition of this 'most ruinous', 'artificial' divide in social science and his much criticised attempt to,

“bring to light the theory of practice which theoretical knowledge implicitly applies and so to make possible a truly scientific knowledge of practice and of the practical mode of knowledge.” (Bourdieu, 1992, p. 27)

We see Merleau-Ponty's dilemma of agency:

“The choice would seem to lie between scientism's conception of causality, which is incompatible with the consciousness which we have of ourselves, and the assertion of an absolute freedom divorced from the outside.”
(Merleau-Ponty, 1962, p. 507)

Speaking of the scientific understanding of the sense of smell, Latour points to how the interesting functions of how the body reacts in situations may be replaced by an empty sense of the body as a thing:

“Either we have the world, the science, the things and no subject, or we have the subject and not the world, what things really are.” (Latour, 2004, p. 208)

I will show the place Gendlin has in such company. Like each of these he strives for an immediate human conception of reality that transcends objective divisions. The 'body' will be central to this and it is important to distinguish his position from contemporary ideas of the embodied mind that still retain a representational and mechanistic foundation. His position is akin to one of 'participational agency' (Spackman & Yanchar, in press).

Gendlin described himself as a “*not so quiet!*” revolutionary (Gendlin & Lietaer, 1983, p. 97) and Levin encapsulates his lifelong battle and achievements in the following terms:

“Gendlin remains neither with the Enlightenment conception of the individual as a self-contained, self-sufficient monad whose essence is a purified rationality, nor with the conception of the individual as a mere product of culture, the current view that there is no human nature, but only a variety of culturally constructed natures. Although he grants that the cultural conception went deeper than rationalism, a still deeper understanding of the individual emerges in his work.” (Levin, 1997, p. 44)

Such an endeavour necessarily involves the generation of a discourse outside traditional demarcations. Existing ways of thinking are uncomfortably pressed into service beyond acceptable limits and new language and practice displayed. Necessarily the resulting assertions may be sometimes tentative, ambiguous and yet bold.

As will become apparent, the term ‘unit model’ deserves a particular mention in this work, a term used by Gendlin to refer to what he sees as a quasi-mechanistic perspective in natural science, able to describe anything using divisions – atoms, particles etc. (Gendlin & Johnson, 2004). He challenges the Cartesian divisions evident in modern science as dividing the indivisible:

“Today the most common ineffective attempt to help oneself inside is what we now call ‘vivisection.’ One is very active ‘upstairs’ in one’s mind, drawing maps and attempting to understand one’s trouble, thinking this, and thinking that, but instead of merely intellectualizing, one feels in one’s gut every move one makes upstairs!” (Gendlin, 1984a, p. 81, my emphasis)

Such artificial divisions miss the immediate, rich, intricate process which encompasses,

“environmental interaction, body life, feeling, cognitive meanings, interpersonal relations, and self.” (Gendlin, 1964, p. 134)

Gendlin’s position consequently contradicts the common contemporary view:

“Most of the world thinks and acts in terms of formed things, patterns, units, entities. What is not formed is considered disorder, ‘excess,’ flux, or at best a whole that allows no precision. We claim, instead, that what is not already formed is a greater order, more finely differentiated than any forms and concepts, and yet also unfinished.” (Gendlin, 2004a, p. 5)

Observation 12 - Gendlin seeks to challenge the 'unit model' - the Cartesian divisions in the way living systems are understood and the reliance on abstract patterns and forms.

2.1.2 Origins and Influences

Gendlin studied philosophy at the University of Chicago in the 1940s. As an undergraduate he found that he had the capability not merely of expressing ideas in competing conceptual frameworks, but could discern a visceral sense of them so as to transcend forms. Consequently,

“... when I had a point to make, I did not need to frame it in one of the systems already existing. I learned that I could create a quiet space within me and let my own words come. ... ‘Oh... yea! ... that’s what I was about to say!’ And that ‘that’ was charged with implicit language, but was not a set of words.” (quoted in Levin, 1994, p. 346)

He developed an interest in the way experience and concepts interact (Gendlin, 1989a), writing an MA thesis on Dilthey (1950). His doctoral dissertation (1958) was completed on *The function of experiencing in symbolization* and by this time he had begun work with the University the of Chicago Counselling Centre, exploring experiencing in therapeutic terms. Gendlin lists the philosophers of existentialism as precursors of his thinking - Kierkegaard, Dilthey, Husserl, Heidegger, Sartre, and Merleau-Ponty. Each of these are noted for the extent to which they open up the possibility that the experiential present is fundamental in, and essential for, an understanding of structures and concepts. They contributed to the post-modern deconstruction of forms and realities, leading to a relativist and subjectivist world. Yet, whilst questioning the ascendancy of form and emphasizing the changeable multiplicity of experiential reality, Gendlin emphasises the reliability of implicit intricacy rather than its relativity. To him it is far from arbitrary, indeed it is imbued with more meaning than any symbolization

can express. He criticizes the deconstruction of Derrida not for what it does, but for where it stops, and considers himself “*post-post-modern*” (Gendlin, 1994, p. 386), finding meaning in experiencing that is otherwise denied.

It is this positive relationship with the pre-structured implicit that is the distinctive contribution of Gendlin. It is why Merleau-Ponty is so important to him, emphasizing the centrality of the body as the source of precise meaning. Philosophical understandings of ‘existence’ can too easily become a paradoxical and negative abstraction for Gendlin, who emphasises the importance of what one *is* and *lives* - that one *feels* one’s existing (Gendlin, 1973b). This question of the manner of experiencing becomes the touchstone of authenticity.

It is worth pausing to recognise the philosophical stance regarding psychology that is implied in this position. It recognises the deficiencies of two broad approaches to psychology current in the 1950’s and 1960’s. The ‘repression paradigm’ concerned with blocked material and the unconscious and the ‘content paradigm’ implying a need to change particular elements of the psyche (Gendlin, 1964). By working from immediate experience a focusing-oriented approach attempts to avoid the traps of these approaches. It has led to the preference for “*process variables*” (Gendlin et al., 1968) and ‘content-free’ research, i.e. looking at ‘how’ material is worked with rather than ‘what’ is in contention (Gendlin, 1963). For example when needing to have an understanding of the self the approach has adopted a process orientation:

“To the extent that experiencing does implicitly function, the individual may respond to himself and may carry forward his own experiencing. This interaction of the individual's feelings with his own (symbolic or actual) behavior, we term ‘self.’ A more exact term: self-process.” (Gendlin, 1964, p. 131).

A self is an entire system,

“not so much ‘what one is,’ as how one carries oneself forward in further living, further feeling and self-responding, and further interpersonal relating.” (Gendlin, 1973b, p. 333)

In basic terms, Gendlin asserts a view of self-in-process, remaining largely agnostic and contingent about what its contents may be.

Observation 13 - Gendlin’s philosophy emphasises the implicit experience of meaning underlying symbolisations. It takes a process orientation towards psychology and the self, largely avoiding assertions about content.

2.2 Experience and Existence

Experience is the key concept in Gendlin’s work - philosophy, psychology and therapy. Early on he comments that:

“Existentialism succeeds if we equate ‘existence’ with ‘experiencing.’”
(Gendlin, 1966a, pp. 235-236)

He emphasises the *quality* of experience and existence, tending to swap these concepts interchangeably:

“Existence is preconceptual and internally differentiable. ... One exists one’s concrete experiencing and this is not equal to concepts, conceptual patterns, definitions, or units of any kind. Patterns and units can be made from experiencing, but experiencing is never equal to what words say, or to any ‘what,’ which one might define. This is what is meant by the word ‘preconceptual.’” (Gendlin, 1973b, p. 322)

Gendlin’s earliest philosophical work identifies seven ways that felt meaning functions together with symbols. The most fundamental is that of ‘direct reference’, (*“the felt datum of an individual’s inward direct reference in his*

phenomenal awareness" (Gendlin, 1962, pp. 243-244)) i.e. an internal experience of the particularity of sense, unconstrained by particular symbols that point to it but do not contain it (Gendlin, 1962).

It would be hard to overemphasise the significance of this concept of the implicit for Gendlin. As has been explained, he sought to oppose dominant traditions that reserved meaning to externally accessible explicit formulations and structures. Instead he asserted the prior significance of implicit understanding constantly being brought into expression and then further expression from the inexhaustible wealth of pre-conceptual meaning. At this stage two elements are significant - the degree to which the implicit is internally differentiable and the linguistic aspect of its somatic sensing.

2.2.1 Internally differentiable

Implicit experiencing precedes reflective understanding and is 'internally differentiable' - "*the life of the body as felt from the inside, 'your sense of being your living body just now'*" (Gendlin, 1973b, p. 322). This gives rise to a new sense of 'feel', visceral but not limited to the sense of a chair against the body, more an encompassing and rich sense of the particularity of life in a moment:

"That pre-separated multiplicity functions in the coming of your thoughts and actions. You act and think with it. It functions in a highly orderly way. In most situations you would be lost without it." (Gendlin, 1989b, p. 204)

Initially this may simply be an unclear body sense, something that for a long time may remain potential but unresolved. Attending to it permits a sequence of intricate experiential process-steps. At each stage there is a reference to a felt sense, the 'direct referent.' This can be crudely characterised as a checking for the whole sense of living, as if the whole of an implicit sense could be made explicit. However, the sensing may be found to have a multiple quality, both sequentially

and simultaneously. In sequential terms the connection with a felt sense opens up novel possibilities,

“making happen’ the further experiencing process which then has even further felt meanings leading still further.” (Gendlin, 1967b, p. 191)

In simultaneous terms there is a need for discernment because there is always more implicit meaning than can become explicit:

“The myriad facets of any experiencing which could be differentiated are not simply lying side by side, but are ‘focaled’ - they all function to imply one next step which would carry forward.” (Gendlin, 1973b, p. 327)

So there is a need to differentiate in the moment, perhaps giving attention through ‘clearing a space’ or through a more definite step of allowing an otherwise blocked sense. Carrying forward begins with the sensing and a bodily release follows which changes again:

“A shift is felt, something in the body is released, there is no doubt that saying this is not just words. ... Thus, when one symbolizes one’s experiencing (in words or other symbols), that is itself a further experiencing, a carrying forward of the experiencing being symbolized and hence a change in it. To say what one feels changes it.” (Gendlin, 1973b, p. 235).

Thus a series of steps may be needed for a felt meaning to be explicated, each bringing forth nuances and associations of its inherent rich multiplicity (Gendlin, 1962). For this reason a live process is always closer to the reality than any particular explicit form.

Thus the process of attending to and differentiating the felt sense is a fundamental of philosophy and living.

Observation 14 - The pre-reflective, somatic sensing of experience is the heart of meaning for Gendlin. Its pre-separated multiplicity can be differentiated as distinct from particular explicit forms. The implicit provides a touchstone of reality, always richer and more complex than any particular expression.

2.2.2 The linguistic somatic

Strangely in a philosophical tradition, meaning is discerned through a bodily process (1993b). Yet 'body' means more than flesh and blood. It is effectively extended to include both the somatic and the whole, undivided life of the person. It might be better understood as 'embodiment', the reflection of living interaction:

"Our bodies are such that they absorb all the training, all the language, all the social forms, all the culture, everything we read and then they still imply more." (Gendlin, 1990, p. 214)

Living and meaning are intertwined, body and mind are indivisible and existence always arises in a social and cultural mesh. A distinctive facility with and understanding of language therefore exists at a somatic level:

"Implicit meaning does not exist before or without language. ... The 'coming' of words is bodily, like the coming of tears, sleep, orgasm, improvisation, and how the muse comes ... language is implicit in the whole human body (not only in our brains). Language is implicit in our muscular movements and in every organ. (Gendlin, 2004b, p. 132)

Words consequently are only understandable in terms of living situations that they imply:

"They bring their own situations into our sentient situational mesh now, so that they say something here now." (Gendlin, 1994, p. 385)

Setting out this way of understanding Gendlin is attempting to build upon the work of phenomenologists such as Husserl and Dilthey, and set out a philosophical way that a ‘more-than-logical’ process works. He sets out a detailed philosophical argument (Gendlin, 1962) for a ‘nonnumerical’, ‘multischematic’, and ‘interschematizable’ integrated order which is not dependent upon ‘cut’ explicit structures, and open to precise, yet creative steps (Gendlin, 1973a). Thus at a philosophical level the foundation is built for the ‘body’ (or embodiment) to be offered a central place in a ‘more than logical’ means of experiencing and understanding.

Observation 15 - The ‘direct referent’ demonstrates a somatic absorption of cultural life and linguistic patterns. Its ‘more-than-logical’ process discerns the immediate situation - physical, social and historical interconnections.

2.3 Interaction and Encounter

As I am starting to show, interaction is an essential element of all living. Gendlin’s (1997b) concept of ‘interaction first’ means that what are commonly perceived to be separate entities are only to be comprehended as an interconnecting system, a ‘self-organizing process’ (Gendlin, 1993b), where the nature of each depends upon pre-influence of the other. Thus the most significant understanding of an environment (“En#2”^a), is defined in body/environment terms where a person is always a ‘being-in-the-world,’ so that human beings,

“are encounterings in the world and with others. What one feels is not ‘stuff inside,’ but the sentience of what is happening in one’s living in the

^a A *Process Model* identifies body and environment as one inseparable event, an “reflexively identical environment” which is “identical with the organism’s living process” (Gendlin, 1997b, p. 1). This is termed *En#2* to distinguish it from the environment viewed by a spectator (*En#1*), the accumulated tangible results of *En#2* process (*En#3*, see Ob.30, page 72 below) and a future aspect *En#0*.

outside. ... A person, at some moment, is an interacting-with, a fearing-of, a hoping for, an angry-at, a trying-for, an avoiding-of.” (Gendlin, 1973b, p. 323)

These fundamental interactions of a person can be understood from two perspectives - the ecological connection of a person and environment and the intersubjective connection of person with person (c.f. Gendlin & Johnson, 2004).

2.3.1 Ecological

The situational relationship of persons is expressed by Gendlin through various metaphors, describing them as having ‘situational bodies’ which, “*always sense themselves in sensing anything else*” (Gendlin, 2004b, p. 129). Biological metaphors are used to refer to humans as having “*plant bodies*” (Gendlin, 1993a, p. 24) that can sense the environment in a way beyond the five senses. This relates to the wholistic sense of self-in-environment that is maintained by living creatures and the constant responding to it that occurs through visceral body-environment interactions:

“Life process is always interaction with the environment. When the proper environmental objects occur (and note, not just any object is a fitting one for respiration, digestion, or reproduction - only certain objects fit the body interaction), then interaction is carried forward, and the momentary condition (which we called the ‘felt meaning’) is thereby changed.”

(Gendlin, 1967b, p. 190)

A plant turns toward the sun without a conscious process of discernment and a human being has a sense of what is behind them without an immediate act of perception. This kind of “*being-knowing*” (Gendlin, 1993b, p. 34) of contextual interaction redefines what are normally understood as interior process:

“Experiencing is not ‘subjective,’ but interactional, not intra-psychic, but interactional. It is not inside, but inside-outside. Again, just as with body

and psyche, experiential theory does not merely assert this unity of inside-outside.” (Gendlin, 1973b, p. 324)

The term ‘situation’ has a significant and multiple understanding in Gendlin’s writings.

“It is not a perceived object before you or even behind you. The situation isn’t the things that are there, nor something internal inside you. Your intricate involvement with others is not inside you, and it is not outside you, so it is also not those two things together. The body-sense is the situation. It is inherently an interaction, not a mix of two things.” (Gendlin, 2003, p. 104)

A situation is a whole mesh which is ‘carried’ in the body (Gendlin, 2003) and includes an imperative to be ‘met’ in a particular way (Gendlin, 2009). As I have shown, cultural forms like language are only comprehensible in terms of the situations which ‘cross’ them so that situations ‘colour’ or ‘cook’ words (Gendlin, 1997a). The concept of *Befindlichkeit* from Heidegger, translated as ‘situatedness,’ is significant. This has a great richness including the moody disclosure of being-in-the-world, the essential process of a person (not a ‘thing’) and the constantly inherent potential for articulation (Gendlin, 1978/79). In this sense the world is not merely abstractly present-at-hand but is ‘ready-to-hand,’ imbued with particular meaning, encountered as needed (Heidegger, 1967). I feel justified to assert that the self is always self-in-situation.

Observation 16 - Interaction precedes all other aspects of human life and living can only be understood in terms of ‘situations’ – interconnected environmental responding. Humans have an ecological ‘being-knowing’ (Befindlichkeit), a constant contextual interaction with a world that is ‘ready-to-hand.’ Their self is always a self-in-situation

and different selves arise naturally in responses to different contexts.

2.3.2 Intersubjective

Human to human connections are unsurprisingly central to ‘interaction first’, so that the inherently inter-subjective “*being-with*” (Gendlin, 1978/79, p. 62) is a fundamental aspect of being-in-the-world. Living cannot be other than social and historical, it is always connected with and toward another human being:

“Just as my foot cannot be the walking kind of foot-pressure in water, we occur differently when we are the environment of each other. How you are when you affect me is already affected by me, and not by me as I usually am, but by me as I occur with you.” (Gendlin, 1997b, p. 30)

The inter-human process, crucial to a view of therapy, is shown by other focusing-oriented writers to have existential origins. A paper by Madison (2001) takes us back to developmental principles in Merleau-Ponty that put intersubjectivity at the origin of a human life. However much we may avoid the fact,

“emotional ties between people are only possible because we continue to primarily live in the other’s gestures and responses.” (Madison, 2001, p. 6)

Lynn Preston’s Focusing Oriented Relational Psychotherapy sets out this clearly in a paper on *Two Interwoven Miracles* – ‘tapping into’ the felt sense and ‘authentic heartfelt interaction’ (Preston, 2005). When interviewed four years on from this paper she comments:

“I’m thinking back on the article that I wrote, the two interwoven miracles, and then recently Gene and I have been saying it’s really not two miracles, there’s one miracle, right! It’s not two interwoven miracles but there’s one miracle of what we would call focusing as relationality.” (Preston & Prengel, 2009)

There is a crucial significance here for focusing, which can sometimes be perceived as an act of personal interiority, something that more ‘accompanied’ than ‘shared.’ If being-in-the-world is always relational and there is only one ‘miracle’, then focusing is an intersubjective process. As Preston comments, “*we find the uniqueness of our own feeling selves with and through the particularity of the feelings of the other*” (Preston, 2005).

Observation 17 - ‘Being-with’ is the bedrock of human life, so that the most personal and individual processes, including focusing, are also a feeling-with and feeling-toward others.

2.3.3 Parallels

The fundamental logic of this philosophy is enriched by parallels from other writers:

For example, Bourdieu’s (1992) notion of ‘habitus’ aims to understand the personally embodied, socially shaped milieu which each person inhabits and through which they express their individuality. This is,

“... an active residue or sediment of his past that functions within his present, shaping his perception, thought, and action and thereby moulding social practice in a regular way. It consists in dispositions, schemas, forms of know-how and competence, all of which function below the threshold of consciousness.” (Crossley, 2001, p. 83)

Merleau-Ponty’s analogy of a football player also vividly illustrates the richness and immediacy of embodied being-in-the-world. In any moment, a player’s movements reflect an immediacy of visceral sensation, positioning on the pitch in relation to the movement of others, the rules, traditions and tactics of the game and the individual’s capabilities and skills.

“The field itself is not given to him, but present as the immanent term of his practical intentions; the player becomes one with it and feels the direction of the 'goal', for example, just as immediately as the vertical and horizontal planes of his own body. It would not be sufficient to say that consciousness inhabits this milieu. At this moment consciousness is nothing other than the dialectic of milieu and action.” (Merleau-Ponty, 1965, pp. 168-169)

Anthropologist Tom Ingold presents a pre-objective, pre-ethical ‘sentient ecology’ of life, a learned ‘ontology of dwelling’ where he sees,

“the human condition to be that of being immersed from the start, like other creatures, in an active, practical and perceptual and engagement with constituents of the dwelt-in world.” (Ingold, 2011, p. 42)

Cultural commentator Berlant catches the implied quality of a situation in the conventions of a ‘situation comedy’ or the police procedural:

“The police conventionally say: ‘We have a situation here.’ A situation is a state of things in which something that will perhaps matter is unfolding amid the usual activity of life. It is a state of animated and animating suspension that forces itself on consciousness, that produces a sense of the emergence of something in the present that may become an event.”

(Berlant, 2011, p. 5, emphasis original)

This sense has also been recognised by a contemporary philosopher with no connection to focusing but who nevertheless speaks of situationally informed ‘existential feeling’ (Ratcliffe, 2012).

Observation 18 - Gendlin’s thought is complemented by writers from various fields who describe the immediate interaffecting of life. Significant among these are concepts of the encompassing ‘habitus’ and embodied

understandings of the 'sentient ecology' of life and its learned 'ontology of dwelling.'

2.3.4 Only together

A challenging corollary arises from such an understanding of interaffecting. Early on *A Process Model* (Gendlin, 1997b) points out the way that processes may be sometimes considered independently but, as will be seen in the concept of 'eveving' (see Ob.21, page 54), there is a more fundamental interconnection too:

"In our new model the processes are originally and inherently coordinated.

In phases when a process is resumed, the rest of the body occurs only together with it. Whenever that process is stopped, the rest of the body lives without it. So the other processes have phases during which they are always together with this one process, all one with it, not differentiated from it, and other phases during which they have gone on and formed without it." (Gendlin, 1997b, p. 20, emphasis original)

The consequence of this is that change is never just a separate process, one that in a manner of speaking can occur in a corner. As I will explain later (Ob.23, page 59), a change in occurring leads to a change in implying so that a whole system is not quite the same. As a consequence a change in one part may be held back by a stopped process elsewhere.

Observation 19 - The interaffecting of processes implies that to some extent change in a particular place or with a particular person depends upon changes in other parts and can be thwarted by them.

2.4 Focaling and Value

Gendlin has a particular view of the implicit direction within reality. Anything that occurs also carries within in the potential of a next step, an implying, something

that is always greater than what does occur (Gendlin et al., 1984). This is present in the simple processes of life, e.g. hunger implies eating. In muscular terms, bodies are always getting ready for the next action through a “*patterned readiness*” (Gendlin, 1964, p. 114). As a bird knows how to build a nest (Gendlin, 1993a), we can sense the right next step, or be ‘thrown’ into a purposeful ‘being-possible’ (Gendlin, 1978/79).

Such direction is not discerned cognitively, through a process of deduction, it is related to as a felt sense, through the body, our plant bodies:

“The body totals up the circumstances it has and then implies the next step, whether it is relativity or inhaling. This has not been well understood. The living body always implies its right next step.” (Gendlin, 1993a, p. 31)

Two parts of this need to be clearly understood - the sense of a right direction and the process of focalizing:

2.4.1 Right direction

The sense of direction and rightness here is important and easily misunderstood. What does it mean to recognise a right direction? Does this entail some deterministic teleology at work or moral judgement? Certainly some understandings of a ‘stopped process’ might suggest this i.e. the ‘right’ process waiting to be restarted, with or without an ethical overtone:

“The very existence of bad feeling within you is evidence that your body knows what is wrong and what is right. It must know what it would be like to feel perfect, or it could not evoke a sense of wrong.” (Gendlin, 2007, pp. 86-87)

However, a more fundamental meaning is implied that includes both the most basic biology and the accumulations of history and culture:

“Every living body implies the next steps of its life-process. The plant implies that the sun will come out, and it implies its photosynthesis with the sun. ... Our own plant bodies have also taken on language, mathematics and physics. Now they can imply a right next step in situations that include those. When life is stopped – when we sense a problem – our bodies imply a next move (whether or not we can shape it and enact it).” (Gendlin, 1993a, p. 30)

The right direction is not arbitrary (like 'north' painted on the ground, Madison & Gendlin, 2012) but the one that is fitting for the whole situation (Madison & Gendlin, 2012), not one part at the cost of the rest. Discerning the right may take several steps, checking against the response of different elements, till a resonance is found. It is evident in the continual process of resonating the accuracy of symbolisations based upon what uniquely fits. This distinguishes an authentic process:

“By ‘process’ is meant exactly that a bit of experiencing is an implying of further environmental interaction, and when such actually occurs it carries the process forward into that special change which is also a continuity because it is something like what was implied.” (Gendlin, 1973b, p. 326)

Such a rightness of direction can include something entirely novel, even though it may have been implied in the situation for many years (Gendlin, 1984a). To live “*beyond structures*” (Gendlin, 1962, p. 313) is a key part of human freedom:

“Our bodies can total up years of all kinds of experience and at any moment give us something new, a new more intricate step.” (Gendlin, 1992b, p. 206)

This sense of direction is understood to have a “*life-forward*” quality (Gendlin, 1996, p. 259), a concept akin to Rogers’ (1980) ‘actualizing tendency’ so that experiential “*steps are in the direction of growth*” (Gendlin, 1996, p. 24). Here

Gendlin's perspective implies a tendency toward the interaffecting growth of the system, rather than Rogers' more individual sense of self-actualization.

Observation 20 - There is an inherent growth-full direction and 'patterned readiness' in situational inter-affecting, which can include the entirely novel. Discerning a 'right' direction is therefore about an attunement of implicit relations.

2.4.2 Focaling

One idiosyncratic understanding of direction and 'rightness' is worth unpicking - Gendlin's special term 'focaling.' This is used to express the fact that meaning is something inherent even in a complex inter-relating system. It arises in a particular way from the interactions, not added to them. Gendlin provides an analogy in his story of learning to repair and retune 'Intermediate Frequency' radio receivers whilst serving in the navy (Gendlin, 1997b). It offers an analogy for the way purpose arises through a series of sensitive adjustments made to an interacting mesh. There is no perfect position for any one element in abstraction from the others. The directionality that is implicit, must be actively discovered through successive steps of tuning and re-tuning. It is something that requires attention, adjustment and symbolization:

"If one lets oneself sense the whole feel of now, a sense of direction emerges, if it is sought. ... It is not just any release from any pressure, but a whole body sense of one's life or specific situation which is used implicitly, without having to separate out all its many facets. ... It is the whole of one's living, which shapes this direction." (Gendlin, 1973b, p. 327)

There is a significant point here about the variety of elements that participate and that each does so in an active mode, many meanings being encapsulated in one focaling. The somewhat perplexing language Gendlin invents to express this,

including the idea of “eveving” (the interaffecting of everything by everything, Gendlin, 1997b, p. 38), potentially obscures the fruit of the philosophical model here. The interaction of elements to carry forward in a ‘right’ direction “*does not form just any event whatever*” (Gendlin, 1997b, p. 48) because it depends upon ‘relevance’, an existing interconnection. An implicitly rich and interconnected meaning is engaged when attending to the felt sense. Doing so opens up an endless potential:

“Many factors are indeed relevant, and do indeed have a part in the shaping of what occurs. But in participating in the next formation, they open and cross. They do not do it as themselves, but as already crossed with whatever else participates in shaping the next event.” (Gendlin, 1997b, pp. 47-48)

Wallulis (1997, p. 282) remarks on the “*considerable capacity for coherence*” here and Levin celebrates a,

“priceless hermeneutical gift, because it lets us think (into) a spacing, an openness, that is both vague and precise, both more determinate and less determinate than the conceptual structures which, on paper, appear to surround and control it.” (Levin, 1994, pp. 344-345)

Observation 21 - ‘Focaling’ points to the implicit capacity for coherence and purposeful direction within situations. The interaffecting of everything by everything allows many factors to ‘cross’ and a meaning to emerge over many small steps.

2.4.3 Human Agency

It is valuable to observe the very distinct, situated sense of human agency that is the corollary of the interaffecting view of life and self-in-situation (Ob.16, page 46). The free individual is far from the idealised sense of a disconnected, arbitrary

will, or the presumption that the freest choices are the most uncommitted. Rather the idea of freedom is an embodied, environmental and purposeful perspective. It is something which is recognised in some contemporary views which see agency as the:

“means of which actors enter into relationship with surrounding persons, places, meanings, and events. Viewed externally, agency entails actual interactions with its contexts, in something like an ongoing conversation.”

(Emirbayer & Mische, 1998, p. 973)

For purposes here it can be briefly illustrated with views from Merleau-Ponty (1962) who demonstrates how human commitments invest reality with significance, *“a sort of sedimentation of our life”* (p. 513), so that,

“far from its being the case that my freedom is always unattended, it is never without an accomplice, and its power of perpetually tearing itself away finds its fulcrum in my universal commitment in the world. My actual freedom is not on the hither side of my being, but before me, in things.” (p. 525-6)

Merleau-Ponty sketches an embodied, interconnected way of being that resonates with the focaling perspective of Gendlin:

“I am free, not in spite of, or on the hither side of, these motivations, but by means of them. For this significant life, this certain significance of nature and history which I am, does not limit my access to the world, but on the contrary is my means of entering into communication with it. It is by being unrestrictedly and unreservedly what I am at present that I have a chance of moving forward ... I can miss being free only if I try to bypass my natural and social situation by refusing to take it up ...” (p. 529)

Observation 22 - Gendlin points to a distinct view of freedom and agency seen in terms of embodied interaffecting and

commitment. It suggests that fulfilment comes from discovering and realising the potential of one's ecological and interpersonal situation rather than acting outside of it.

2.5 Carrying forward and Authenticity

The significance of interaffecting between apparently independent items is paralleled in Gendlin's thinking in temporal terms by the concept of 'occurring into implying.' It is fundamental to his view that all reality can only be understood as a process, a non-mechanistic 'functional cycle' by which events always imply further change and arise out of an implied process:

"Any occurring is also an implying of further occurring. And, each bit implies something different next." (Gendlin, 1997b, p. 8 emphasis original)

This arises from the essential unity of an entity and its environment and, whilst the process is unavoidable, this is not a repetition but a constantly-evolving novelty:

"Occurring is change; something happens. Occurring into implying can change the implying. The occurring sequence is also a sequence of changes in the implying. So the sequence is not determined from the implying in one event. The process is a changed implying all along the line. We can go a step further: Since implying implies a next occurring, and since occurring changes implying, therefore implying implies a change in implying."

(Gendlin, 1997b, pp. 10-11 emphasis original)

The next step that takes place is more than a simple logical inference or any change that might have occurred abruptly or by accident. As was seen in the analogy of the Intermediate Frequency radio receiver (2.4.2, page 53), it is something to which all parts of the system make a contribution. Yet precisely what happens, or indeed how it happens, could not be predicted in advance.

There is consequently a paradoxical quality of “*continuity-in-change*” (Gendlin, 1973b, p. 235), something genuinely new which, nevertheless, fits with what there was before.

Several themes are important to explore at this stage - the zigzag of symbolisation, the tangibility of living forward, the place of choice, the dialectic pause and the move from conflation to ‘Abstand’:

2.5.1 Symbolization & Zigzag

Symbolisation is philosophically important to Gendlin’s view of carrying forward (Gendlin, 1964) and is significant in the person-centred tradition. A zigzag of reciprocal responses is necessary between what is implied and statements or actions (Gendlin, 2004b). Carrying forward, then,

“is the characteristic continuity we experience when new sentences and then new concepts articulate and explain what we have understood only implicitly.” (Gendlin, 2008, p. 4).

A linguistic accuracy is sometimes described as a prerequisite of carrying forward i.e. just the ‘right’ words (Gendlin, 1967b) and focusing is referred to as what precedes it - a sense of something on the tip of the tongue (Lou, 2008) or what cannot be quite understood or remembered. Focusing is thus,

“a matter of giving attention to one’s sense of what one might be able to say beyond what one currently says.” (Purton, 2011, p. 13)

Whilst linguistic symbolisation is perhaps the most frequent way that carrying forward is recognised, it is to be distinguished entirely from a rigid process of semiotic representation, equation (Gendlin, 1964), or copying of a blank (Gendlin, 1993b). It should more appropriately be understood as a fluid process of action and change. As well as with words, carrying forward can be stimulated and expressed by,

“... images, dance steps, roles played, other people's reactions, all these are perceived as feedback, and can have the carrying forward zigzag effect, which action has.” (Gendlin, 1969, p. 8)

Significantly, Gendlin himself points to an experiential zigzag that is more about action than words, and may not be restricted to his method:

“I must also say that experiential focusing may not be the only mode of the basic zigzag method I am discussing: To reflect on the feel of what one is up against is one way. One can also guide his actions, moment by moment, with an experiential zigzag. Perhaps in that way one seems less explicitly conscious (or verbally conscious) of how he guides himself. A zigzag of feeling and actions might work as well as a zigzag of feeling and words. The basic question is whether one engages in a constant zigzag movement between felt meaning, on the one hand, and any sort of patterned steps he uses—either words and concepts or acts and roles.” (Gendlin, 1967a, p. 150, my emphasis)

Following Purton, my suggestion at this stage is that whilst carrying-forward clearly involves a new step of living, and whilst this may need to find fulfilment in an explicit form, the identification of linguistic symbolisation with this process may be unnecessarily restrictive. Recent focusing-oriented theory suggests, for example that perhaps the term would be more appropriately ‘articulation’ rather than ‘expression’:

“Focusing is not primarily concerned with ‘the body’ but with one’s situation, and with the articulation of one’s responses in the situation. Our responses are often there before they are articulated, and we need to give our attention to them, but the extent to which they involve bodily feelings is very variable.” (Purton, 2013, no pages)

Observation 23 - Carrying forward points to the constantly recurring cycle of 'occurring into implying.' It explains how both novelty and continuity are present in the formation of new structures from the implicit. The many patterned steps of a zig-zag between implicit and explicit forms are necessary to allow accurate articulation in symbolic and tangible forms.

2.5.2 Living a situation forward

As already indicated (page 45), Gendlin uses the idea of 'inside-outside' to show the inter-connection of what may sometimes be portrayed as separate. This is most evident in the active processes of living forward:

"Experiential body process is carried forward by action and feedback. As one acts, one perceives one's own acting. This is then a new experiencing which can again lead to an action which is again experienced and leads to another action. This 'zigzag' between body sense and visible action is such that each carries the other forward: the action is itself experienced again, and this experiencing again leads into a new action." (Gendlin, 1969, p. 8)

In visceral terms this can be traced back to the fundamental action-oriented nature of the human body which, in Gendlin's view, shows an,

"... implying of their next bit of life-process. A plant or animal body projects (entwirft, structures, organizes, enacts, expects, is ready to go into, implies) its own next step. The concept: A living body implies its own next step." (Gendlin, 1993b, p. 34)

This ties in with the constant vigilance of living beings, as we have seen (Ob.16, page 46), always preparing for the next action through attention, attunement and sensorimotor anticipation (Ogden et al., 2006). Through such whole-body processes the motion of human life is maintained. As Whitehead (1938, p. 217)

commented, “from the moment of birth we are immersed in action, and can only fitfully guide it by taking thought.”

It is important to keep in mind the situational emphasis of Gendlin in this. His language can sometimes seem to indicate a magic quality in the physical body - the body “can fill itself in”, it “knows how to heal” and generates “missing interactional events” (Gendlin, 1996, pp. 282, 281). A recent development in theory rightly emphasises the significance of the situational interaction here as the key element. A German word for ‘utterance’ (*Äusserungen*) is borrowed from Wittgenstein, emphasizing the spontaneous, non-linguistic responses to a situation. This re-emphasizes that carrying forward is a situational living:

“What is needed is to keep our attention on our situation as a whole (through not letting ourselves be distracted by over-familiar aspects of it), and to allow our responses to become more articulated. This procedure is not well characterised as a change in how one describes one’s ‘feelings;’ it is a matter of a change in attitude, in how one is living. One finds new words, but these words are not reports of new bodily feelings, they are new Äusserungen – new responses, new deeds in the form of words. It is in that sense that we can say that focusing-oriented therapy goes ‘beyond the talking cure.’” (Purton, 2013, no pages)

Such deeds are appropriate in the practical articulation of an organism that needs to act and respond to survive. Embodied and interaffecting life therefore needs to be ‘lived forward.’

Observation 24 - Carrying forward arises from a responsiveness between person and the mesh of their environment. Organisms constantly anticipate coming action and prepare by attunement to the environment. Situations are ‘lived forward’ in these terms though new responses (Äusserungen).

2.5.3 Pause and dialectic tension

One important parallel for carrying-forward is identified in an approving passage by Levin:

“Gendlin’s new concept gives us, beyond the seemingly ‘unavoidable’ dilemmas of postmodernism, a reformulation of the Hegelian ‘Aufhebung’, the Hegelian ‘sublation’ that both transforms and preserves. It is, then, a major contribution to a use of language beyond postmodernism.” (Levin, 1997, p. 42, my emphasis)

Whilst the full philosophical significance cannot be pursued here, the reference to ‘sublation’ is significant, pointing to the distinctive moment of preservation, yet transcendence. The reference to the dialectical process raises questions about the methodology adopted by Gendlin.

His early paper (Gendlin, 1966b) reveals a confident position on the dialectical method, showing how Plato illustrates the significance of the direct referent. Concepts are defined for the philosopher through a process of teaching and then, through examples, their veracity is tested to destruction, the point where there is no alternative but to assert an opposite. This process would be an empty game without the presence of a live person who is prompted to remark that the essential qualities of what was being asserted have somehow been lost in the process:

“I have now also discussed the three other elements of this activity called dialectic: the role of contradiction, the forced choice of our respondent, and his pre-defined knowledge, the fact that he meant to define something in the first place, he had some sense of this, whatever it was, which he wanted to define.” (Gendlin, 1966b, p. 5)

From this Gendlin is able to assert the significance of the implicit knowledge that, paradoxically, both knows something but doesn’t quite know it:

“Dialectic is controlled by and within nature’s order. This is an order which controls concept-formation. So it isn’t itself concepts. Rather, it includes activity, pre-defined, experiential knowledge, wanting and choice, and it controls what leads even our best definitions to contradict themselves as more aspects of the world are drawn in.” (Gendlin, 1966b, p. 12)

Significantly the formal processes of assertion and contradiction are key in forcing a shift forward so long as a connection with implicit intricacy of the situation is maintained. (This is reminiscent of the third step in *Thinking at the Edge* (Gendlin & Hendricks, 2004) where ‘no word fits.’)

“The key to dialectic is to see exactly how the negativity – the faults found with statements – is specific information which can lead to a new statement. A new statement also will later be overthrown, but the specific information which led to it will never be abandoned.” (Gendlin, 1970, p. 4)

This provides a template of focusing, suggesting two processes that strike me as very significant - the moment of carrying forward when new meaning becomes apparent and, before it, a *constructed tension* where existing forms of the explicit are tested to destruction. It does not seem too strong to suggest that the space for the former to arise is a direct consequence of the discomfort of the latter.

We will see later how the dialectic process described by Gendlin has parallels in a variety of therapies and may be very significant in an addiction setting (Avenue ‘C’, Ob.82, page 199).

Observation 25 - Focusing can be seen as a dialectic process of carrying forward when existing explicit forms are demonstrated to be inadequate. A constructed tension (Aufhebung) has the potential to release the implicit and shape a new form.

2.5.4 'Abstand' - Standing aside from conflation

By extension this view offers an explanation of why symbolization is an action and never a mere representation (see page 57). Meaning arises as a process, a way of standing apart from a moment to discern the distinctiveness of a living reality.

Early in his writing Gendlin gives us the principle of something becoming an 'instance of itself' ('iofi'):

"The 'iofi' principle asserts that one may consider any specified meaning as an instance of a kind of 'experiencing procedure.' One may ask, 'What kind of experiencing procedure do I find here?' and thus create (specify) new methodological meanings." (Gendlin, 1962, p. 183)

The emphasis is not on an object or 'content', but a process:

"... the given statement - rather, our having of it, i.e., the Direct Referent - can be an illustration or example of countless generalities, new categories."
(Gendlin, 1997b, p. 248)

Until that point no distinction is possible, the person and process are one (see conflation, Ob.32, page 76). Now a very distinctive, even 'revolutionary' (Hendricks, 2003) pause can permit attention to the direct referent. With it the ability arises to distinguish the process, live situation, from the living being:

"in attending inwardly in focusing-way, there is always a difference between the self and whatever is there. Because a small distance - Abstand, breath between, space - is made as the body forms the whole sense of the problem, there is an experience of: 'I am here and this is there; yeah, I sense it.' And a new 'I' comes there." (Gendlin & Lietaer, 1983, p. 90)

Recognising an 'iofi' permits the simplest and yet most significant experience of an 'I' that is not conflated with the processes or 'contents.' Symbolization in these terms is therefore more an action than a labelling.

This personal move is necessarily also a moment of sharing. It is the essential turn from an isolated individuality to the intersubjective experience of being-in-the-world (Ob.17, page 48). The gap created depends upon the warming space that another can bring, perhaps a kind friend:

"What we are doing when we 'put something at a distance' is imaginatively stepping back from ourself, and seeing ourself as though from outside, from the sort of distance a kind friend might see us. We are not stepping back from the problem exactly (I am not sure how to understand that), but from ourself." (Purton, 2002)

The space created should be described as a "*shared implicit relational ground*" (Depestele, 2008, p. 9).

Observation 26 - Making a pause (Abstand) a person has the potential to find a shared space, to stand aside from a situation and encounter an immediacy of self.

2.6 A note on the self

It is beyond the scope of this thesis to set out an account of Gendlin's view of the self. However, it would be valuable to briefly recognise some of the assertions he makes on the subject, and more importantly, those he resists. Four positive assertions have effectively been made so far:

- **Self-in-process** – Gendlin sees self primarily as a process rather than an entity. (Ob.13, page 40).

- **Self-in-situation** – Gendlin sees the self primarily in terms of inter-affecting. (Ob.16, page 46)
- **Self-in-relation** – Gendlin sees the self as constantly engaged in inter-subjectivity. (Ob.17, page 48).
- **Self-in-immediacy** – Gendlin emphasises the distinctive sense of self that arises in immediate experiencing. (Ob.26, page 64).

To these we can add some negative assertions, perhaps little more than corollaries of these:

Self as not a thing, not content – Gendlin rejects reification of the self:

“We reject the old notion of one internal, subjective self-thing, which has the thing-continuity of a brick or a stone.” (Gendlin, 1985, p. 146)

“... the ‘I’ has no content; it is always again there, and cannot really ‘change’ to ‘be’ the content.” (Gendlin, 1985, p. 149)

“This is not to say that there is no separate, individual, self-based personality, but only that personality is not a thing.” (Gendlin, 1966a, p. 230)

Self as a multiplicity of patterns – Gendlin constantly struggles with attempts to limit living intricacy in explicit forms (Ob.12, page 38) and this principle is particularly applied to the person:

“The self shows many patterns subtler than the usual kinds of schemes. I propose that we do not reduce these patterns to simpler ones, but let them stand, and let each function philosophically to undercut the others.”
(Gendlin, 1985, p. 148)

Self as contingently one and many – Gendlin does not allow intricate immediacy to be constrained by concepts of self. His dogged defence of the implicit carefully avoids both a dialogical and a unitary assertion:

“... the multiplicity of entities is still better than the scheme of just one. Why is anyone tempted to reduce this variety and intricacy to some single pattern? The temptation arises because of the belief that nothing exists without an imposed form of ‘unity.’ The variety seems to imply that there is no self, no person. Someone will ask: ‘Isn’t each of us still one person?’ Our answer would be: ‘Certainly - but not in every way.’ This answer is ambiguous because the oneness of a person is ambiguous as a generality. Here is a better answer: A person ‘is’ and ‘is one’ in many ways that are not in the mathematical unity-form.” (Gendlin, 1987, p. 286)

The issue of self will be returned to later (Ob.32, page 76, Ob.50, page 119).

Observation 27 - Gendlin sees ‘self’ in terms of immediacy, relating, situational inter-affecting and process. He resists the reification of the self and fixed views which might deny the rich multiplicity of its patterns.

CHAPTER 3 - PSYCHOPATHOLOGY

In this chapter I will look at the particular concepts of psychopathology that arise from the Philosophy of the Implicit before outlining key elements of focusing-oriented therapy itself. Doing so I need to recognise Gendlin's characteristic reluctance to rely too much on explicit explanations in this field:

"I have nothing to say about different kinds of pathology. I still think it is right that what the pathology is, is not as important as how one moves that." (Gendlin & Lietaer, 1983, p. 94)

As with his philosophical approach, Gendlin's view of psychopathology does not fit simply within the standard divisions of science i.e. physiological, social, psychological. For example he identifies valid explanations of schizophrenia in each of these spheres but then rejects the exclusivity of such interpretations since:

"a person, whether called schizophrenic or something else, is bodily, and social, and psychological. To study the person apart from the community, to conceive of 'personality' as purely internal machinery, are errors."
(Gendlin, 1973b, p. 330)

An experiential view of psychopathology attempts to sidestep barriers associated with conflicting systems of interpretation by seeing problems as fundamentally about the interacting process of a person in situation. A 'neurosis' can thus be understood both as social and a narrowing of the experiencing process:

"Experiential theory does not yield a classification of neuroses, nor a catalog of pathological experiences - not what is experienced, but how one proceeds from it, determines whether anything was optimally human or a malady. What is a malady, is living in routines, by the values of others, without even being in touch with one's own flow of life and feeling enough

to sense one's felt complexity, from which alternatives can be devised."

(Gendlin, 1973b, pp. 331-332)

Gendlin quotes existential therapists with approval including May's (1958) broad category of 'existential neurosis.' It is,

"an inability to have a sense of oneself and of life as lived from one's own inside sense and zest. The difficulties in this pattern of 'existential neurosis' are the inability to 'own' one's own life and conduct, to be 'autonomous' and 'authentic,' to have direct access to an inner basis and source of actions and choices." (Gendlin, 1973b, p. 331)

He similarly also affirms Hora's (1962) view of the inauthentic, defensive strivings of 'existential anxiety' (Gendlin, 1973b). Malfunctioning arises out of the interconnections of living, to be understood in terms of the process, since,

"to be 'afraid of people' is not just a fact, a datum to be correctly described. As a felt meaning it is the present condition of an interactive organism. ... For to be 'afraid of people' is a stopped version of personal interaction (just as hunger is a stopped version of digesting food)." (Gendlin, 1967b, pp. 190-191)

Throughout his career Gendlin opposed conceptions of the self and human problems that depend upon imposed abstractions, the use of concepts to suggest formative contents in human living such as symptoms and psychoses. Such an approach would be misleading because,

"... the content of experience is generated by the process of experiencing. The kind of content one will find depends upon what manner of process is happening." (Gendlin, 1962, p. xx)

Systems of therapy (such as the psychoanalytic) that depend upon a particular view of content are also likely to be misleading (Gendlin, 1973b). Concepts that

have a content emphasis are consequently to be redefined in terms of experiencing e.g. congruence (Gendlin, 1959) and neurosis (Gendlin, 1967a):

“Human nature is not a set of contents (and neither is mental health).

Human nature is the experiential process in which biological and cultural contents are carried forward.” (Gendlin, 1967a, pp. 151-152)

Conventional understandings of psychopathology are therefore reversed.

Normally there would be a perusal of a person's experience (symptoms) to identify patterns that can be aligned with abstract forms (diagnosis). Understanding of a psychiatric complaint using a diagnostic manual depends upon the accumulation of such evidence. By contrast Gendlin argues that the therapeutic process defines what health is:

“... if there is such a thing as ‘health’ for the human person, then it will not be statable as any one of the variety of finished and conceptualized concepts of health which we find or formulate. Rather, what is universal is the concrete process (not my particular conceptual formation of it), which I have called experiencing ...” (Gendlin, 1967b, pp. 193-194)

Such an intention to preserve a process experiencing view of psychopathology is important for Gendlin but may not always be achieved in practice. Prouty observes that the phenomenological language can start to imply content:

“Gendlin’s phenomenological description of the hallucinatory Structure Bound ‘state’ yields the problematic of how to turn a Non-Process Structure into a Process Structure.” (Prouty, 1994, p. 26)

In the remainder of this chapter there may occasionally be times when adverbs assume the qualities of adjectives, or nouns and descriptions appear to imply the existence of internal objects, a practice which Gendlin elsewhere derides.

Observation 28 - Gendlin avoids describing psychopathology in terms of 'content', preferring to view it as a process problem connected with the interacting system or the process of experiencing.

3.1 Experience and Existence

3.1.1 Philosophy and Psychopathology

The previous chapter set out strong philosophical assertions which reverse accepted views about the explicit and implicit. It portrayed an understanding of reality where meaning is not reserved to concepts or symbols that are applied to living (Ob.12, page 38). Rather it is found in the pre-separated multiplicity of the implicit (Ob.14, page 43), to be discerned by returning to the bodily, experiential processes of life, the 'direct referent' (Ob.15, page 44).

Such a view naturally leads to a psychopathology which is attuned to implicit vitality and explicit constraints. Pathological living is thus the way that the processes of life can become thwarted or blocked, particularly when one element in an interaffecting process is absent. The concept of a 'stopped process' is one that is frequently found in Gendlin's writings, particularly in *A Process Model*^b:

"If such an aspect of en#2 is missing, we can speak of 'a' process that is separated and stopped. Now there is a stopped process - separable from the whole process." (Gendlin, 1997b, pp. 12-13, emphasis original)

Stoppages are not to be viewed as necessarily negative, but they are seen in repetitive and frozen behaviour patterns where explicit forms are continually repeated. They are particularly found where a person loses the capability to attend to the direct referent and their practical sense of self becomes indistinguishable from forms and structures:

^b See note on En#2 page 34.

“When ‘ego’ or ‘self-system’ are said to ‘exclude’ some experiences from awareness, usually it is assumed that these experiences nevertheless exist ‘in the unconscious’ or ‘in the organism.’ Our discussion, however, leads us to the conclusion that they do not. Something exists, to be sure, but it is not the experiences as they would be if they were optimally ongoing. Rather, what exists is a felt and physiological condition which results when, in some regards, the body interaction process is stopped -i.e., is not occurring.” (Gendlin, 1964, p. 137)

This potential error which confuses structures with the living process of existence is at the heart of Gendlin’s thinking and will be important for a view of addiction.

Observation 29 - The idea of a process stoppage is used by Gendlin to refer to the experience of a psychological dysfunction more than to its aetiology. It draws attention to what is not occurring – presumed often to be the process of experiencing.

3.1.2 Structure Bound

One of the earliest insights Gendlin contributed to in the Chicago University Counselling Centre (Gendlin & Zimring, 1955) concerned the significance of ‘process experiencing.’ It could be distinguished from a ‘structure bound’ manner of experiencing - reacting to the present as if it were an item from the past. Whilst authorities like Freud referred to the content of perceptual distortion from a ‘repetitive compulsion’ (Freud, 1936), Gendlin saw the manner of experiencing as more important, passive rather than active :

‘There is experiencing of structures and patterns instead of the richly detailed immediacy of present events’ (Gendlin & Shlien, 1961, p. 69)

Such experience is also described as ‘structure bound’ because parts of the person are perceived as not in process and appear constrained. Structure bound

processing is equated with what other theories describe as "unconscious," "repressed," "covert," "inhibited," and "denied," and with extreme forms "psychosis" (Gendlin, 1964, p. 130).

"If neurosis can be considered a being out of touch with one's potentially rich ongoing experiential flow, then psychosis is an even more radical narrowing of this flow." (Gendlin, 1973b, p. 332)

By contrast to a live process, in a structure-bound manner,

"... one ends by experiencing the past all over again. But this past is only a repetitive pattern or structure, framework, screen." (Gendlin & Zimring, 1955, p. 17)

"My experiencing is structure-bound in manner, when I experience only this bare outline and feel only this bare set of emotions, lacking the myriad of fresh detail of the present." (Gendlin, 1964, p. 128)

In terms of a broad philosophy such repetitive structures resemble the residue of old living that subsists in tangible form, like the beaver's tree, the mollusc's shell, the spiders web (En#3, Gendlin, 1997b)^c. It is as if existing forms are used because the stoppage prevents new forms being made. Gendlin characterizes an extreme structure bound process of a schizophrenic where "*felt experiencing becomes rigid (not in process) or 'literal'*" i.e. "*the lack of functioning of other meanings which should inform our interpretation of a given set of words or events.*" (Gendlin, 1964, p. 141).

Observation 30 - A stopped process leads to structure bound processing where an individual is not in touch with their experiencing and repeats patterns from the past. Such

^c See note on En#3 page 34.

*behaviour can lead to the repetitive structures of nature
- the spiders web or mollusc's shell.*

3.1.3 Frozen Whole

The same early paper introduces the idea of a ‘frozen whole.’ It arises from the phenomenological recognition that healthy experiencing has a rich, intricate, meaningful quality which can easily be obscured by explicit forms if it is not apprehended with immediacy and freshness:

“Opposed to this fluid utilization is the case we call ‘frozen’: an old experience inserts itself into a present situation. It arises as a whole unit ... forcing you to think of or feel the whole old experience. By calling it ‘frozen’ we express that it is incapable of internal differentiation.” (Gendlin & Zimring, 1955, p. 6)

This is not uncommon, happening to some degree to anyone, evident in situations that lead to tension and may lead to behaviour that one finds incomprehensible and perhaps deplorable:

“... aspects of one's experiencing are ‘frozen together,’ and respond as a whole structure.” (Gendlin, 1973b, p. 332)

Fresh living is ‘blocked,’ and old experiencing ‘freezes together’ to make a substitute way of being. There is now a “*frozen place*” (Purton, 2007, p. 67), a sequence which,

“may ‘go off’ as a result of being ‘cued’ by present events, but it is not an interpretation of, or response to, present events.” (Gendlin, 1964, p. 142)

It is interesting to observe here terms that would not look out of place in contemporary (Relapse Prevention) descriptions of addiction – compulsive behaviour as ‘cued’ by triggers (Appendix 6, page 384). The individual may repetitively respond to the frozen whole, but cannot interact with himself or

others. In fluid experiencing the old is present in a seamless mass from which the present is carried forward (Gendlin, 1973b). However, the living of frozen wholes is very different.

It is also tempting to notice in the descriptions of them as examples of negatives that Gendlin (the philosopher/therapist) would least like to have encountered. To a thinker who argued for the implicit richness of living, a frozen whole is shown when we,

“speak of contents or ‘experiences’ as if they were set, shaped units with their own set structure” (Gendlin, 1964, p. 128)

To a person-centred therapist a frozen whole is revealed as something which interferes with the unstructured self-experiencing that is essential to offer empathy to others.

“Unless my experiences implicitly function so that I can newly understand you, I cannot really understand you at all.” (Gendlin, 1964, p. 128)

Focusing-oriented practitioners have illustrated psychopathology increasingly in content terms of stuck experience e.g. ‘narrow places’ where parts of a person *“do not answer to fresh and new inputs, they meet life with stereotype reactions, there is no ability or willingness to respond otherwise”* (Geiser, 2003).

Observation 31 - Contrasting with the fluid intricacy of the direct referent, the idea of a ‘frozen whole’ highlights undifferentiated blocks of living, whole structures that may be ‘cued’ by particular events.

3.1.4 Conflated living

One of the less emphasized themes in Gendlin’s psychopathology concerns the position of the self in pathological states. We have seen above that Gendlin sees self in terms of immediacy, situational inter-affecting and process. He resists the

reification of the self and fixed views which might deny the rich multiplicity of its patterns (Ob.27, page 66).

When he speaks about the loss of self in psychopathology he is not referring to an entity but to the immediate process of existence which is personally and viscerally experienced:

"When the interaction process is greatly curtailed (as in sleep, hypnosis, psychosis, and isolation experiments), the inwardly felt experiencing is thereby curtailed. The individual then lacks the implicit function of felt experiencing and loses both his sense of 'self' and his capacity to respond to and interpret present events appropriately." (Gendlin, 1964, p. 139)

A later description of psychosis has the disconnection and sense of external agency which are reminiscent of addictions:

"in psychosis so often the patient complains: 'I didn't do that. Something made me do it;' ... The hallucinations, voices, and things in his head are not felt to be his own. He lacks the sense of self. If he does have a sense of self (an 'intact ego'), this felt sense does not inform the hallucinatory phenomena. In regard to these, he has no sense of self that implicitly contains their meaning. This loss of self is due to the missing felt functioning of experiencing." (Gendlin, 1964, p. 141, my emphasis)

Here we have a very significant corollary of Gendlin's situated sense of self. If identity and the ability to live authentically arise only through interaffecting, then to lose such connections is to lose self. Decontextualised, a person misplaces meaning, coherence and direction. Reactions and responses may occur but they can become arbitrary, disowned or as if controlled by another:

"When the interaction process is greatly narrowed, not only do psychotic-like experiences occur, but the sense of 'self' is lost. The felt process to

which there can be self-response becomes static and the individual has un-owned perceptions.” (Gendlin, 1964, p. 142)

Later we see a powerful model that describes loss of self as a breakdown in personal relating, where the human sense of ‘I-Me’ is replaced by an instrumental ‘I-It’ (Ob.71, page 166). Focusing-oriented writers illustrate how the weakened self becomes confused with frozen patterns of response, conflated with the shapes of their own affliction:

“So, we meet a person in our therapy room who has been living for a long time with pain and inhibition and all sorts of symptoms. There is no more space between her and her symptoms; she has become identified with them and this mode of living.” (Geiser, 2010b, p. 102)

“By ‘entrapment’ I mean to refer to all those cases where we are submerged, overwhelmed, caught in our feelings; where our feelings are living us rather than we living our feelings.” (Purton, 2000, no pages)

Observation 32 - Restricted ability to connect with experiencing can lead to a loss of sense of self and agency. An individual can feel indistinguishable from their affliction and in the hands of another.

3.2 Interaction and Encounter

3.2.1 Philosophy and Psychopathology

The previous chapter introduced Gendlin’s fundamental understanding of interaction as the essential element of all living. This was shown to have an ecological aspect (Ob.16, page 46) an inter-subjective one (Ob.17, page 48) and to be enhanced by complementary views of a learned ‘ontology of dwelling’ (Ob.18, page 49). A view of psychopathology naturally follows on from this.

Psychopathology as a dysfunction in interaction provides a very meaningful view of a stoppage. If, as Gendlin's philosophy holds, a human being is essentially an interaction from start to finish, then a disruption or truncation of this connection will have a devastating effect. As Gendlin comments, based on this theory, interacting change is the constant reality of a person. Consequently it is something of a conundrum to understand how and why a person stops interacting:

"If the essential nature of human beings is conceived of as a being-with and a being-in, then it is most easily explainable that people change when their surroundings change, that people are different when they are with someone different. If there is a puzzle, it is how we avoid being alive in new ways, how we repeat patterns that are not a being affected by the situation or person, here, now." (Gendlin, 1966a, pp. 229-230)

Nevertheless, a disconnected person will inevitably lose the energy that an environmental reciprocity would replenish and the security of orientation that comes from recognisable landmarks:

"It is a basic concept of experiential theory that human existence or experiencing is an interactional process with the environment. Therefore in isolation, experiencing must be much narrower than in interaction. ... in isolation one also loses this capacity to interpret what words and events mean. Along with this is lost one's sense of self and sense of ownership of one's own body. A narrowed ongoing interactive flow of experiencing therefore also involves depersonalization, and inability to interpret."

(Gendlin, 1973b, p. 332)

3.2.2 Isolation

The broad human experience of isolation is potently evoked through a simple metaphor of its extreme, schizophrenia:

“My conception of the illness: It is not so much what is there, as what is not there. The interactive experiential process is lacking, stuck, deadened in old hurt stoppages, and in disconnection from the world. It cannot be ongoing, except in and toward someone and in the world. If a toaster is unplugged, would you take it apart to find out what is wrong inside of it?” (Gendlin, 1966c, p. 12)

An attribution of dysfunction within a person may overlook more significant process disconnections. Later Gendlin speaks elsewhere with some passion about such isolation:

“I think schizophrenics suffer from being disconnected from the world. Being in a hospital, particularly a state hospital, is a late, visible, physical dramatization of their being disconnected from the world - and this is the disease we try to treat in the hospital!” (Gendlin, 1972, p. 333)

Whilst the problem may be interpreted as psychological, its origins may be interactional, particularly where there is interpersonal isolation:

“How we live toward the world and others, how we sense ourselves in situations and referred to by others, that is us. If there is nobody there to refer to me personally and if I have not somehow learned in other relationships to respond to myself personally, or cannot now do so, then I am not there, and everything gets very flat, very strange and very weird.” (Gendlin, 1972, p. 334)

An experiential therapist who works with trauma victims describes it well:

“When people lose contact, their ‘experiencing’ stops. It happens to prisoners when they are isolated from people and the outside world. Many become ‘crazy.’ They lose contact with themselves, their feelings and bodily felt awareness of experience. Their mind goes in circles, which they cannot stop. They don’t realize any more that they are thinking, are

anxious or hungry. Their experiencing becomes frozen or 'structure bound': they function in a stereotyped way." (Coffeng, 2002, p. 155)

A focusing-oriented therapist identifies dysfunctional behaviour patterns as thwarted attempts to relate:

"Self-limiting, repetitive behavior patterns can be seen as 'stuck interactions.' The problematic feeling state has not been 'answered' and so it 'asks' again and again, 'Am I special?' 'Is it all my fault?' 'Is it ok for me to be successful?'" (Preston, 2005, no pages, my emphasis)

3.2.3 Autistic

The interpersonal quality of the disconnection also comes out in his particular use of the term 'autistic' to describe a distinctive isolation:

"When a person feels regressed, sleepy, or alone and autistic, or rejected or put upon or constricted, then the contents - what the person finds inwardly - will also tend to be negative. Contents are results of the quality of ongoing process. Our inward psychic data are not just things inside, they are aspects of experiential process. This process is our interaction with the universe, with the situation, with others." (Gendlin, 1974, p. 237)

An autistic mode of responding is devastating for the client:

"Instead of steps of carrying forward into living by action and interaction, the person supplies all the responses. The results are not the same! ... It is thus a very serious charge, when I say that most therapists leave their patients inwardly alone. It means also that what most needs to change, will not change." (Gendlin, 1974, p. 217)

By contrast a client-centred response, even toward a client in autistic modes of response, can have a profound effect:

“For the patient, a few minutes can be of crucial help. The experience of making sense to another person and living less autistically, even for a few minutes, may provide something the patient can keep and work with for weeks.” (Gendlin, 1972, p. 354)

Observation 33 - In experiential terms psychopathology is an isolation from essential interrelation with the environment and other people, thereby losing sustenance and meaning. Gendlin sees this as often resulting in an ‘autistic’ inability to relate to oneself.

3.3 Focaling and Value

3.3.1 Philosophy and Psychopathology

The previous chapter described the implicit direction within reality and the ‘patterned readiness’ that is an intrinsic part of human life (Ob.20, page 53) . Focaling was introduced, the way that the interaffecting of everything by everything provides a mesh and capacity for coherence (Ob.21, page 54).

This section looks at the psychopathological corollary of this. Where the stoppage is human, the body which lives on despite it, does so differently because of the stoppage and so ‘carries’ it:

“A stopped process is an unchanged implying carried by a changed occurring. It is carried by the process that does continue, by how that process goes on differently.” (Gendlin, 1997b, p. 18).

This carrying is a dynamic, not static reality. The whole system responds to the missing element, holding and even amplifying the unfulfilled need, yet finding a way forward that still works in a compromised way. A repetitious quality arises in thwarted attempts to move forward:

“At the point where the process cannot continue, the last bit which can happen repeats. This is frequently found. We can also think of this repeating bit as the first bit of the process which cannot go on. Only this bit can, and then it repeats over and over.” (Gendlin, 1997b, p. 75)

Some parts of the process may be carried forward by intervening events, producing some release and satisfaction. However, whilst the entirety remains unresolved there will always be a striving for completion:

“But can we still call it ‘stoppage,’ when not only other processes, but the supposedly ‘stopped’ one seems also to go on? We might call them ‘stop/ons,’ since they are part of the process that cannot go on as usual.”
(Gendlin, 1997b, p. 79)

Gendlin uses some obscure terminology and yet expressive metaphors for this kind of situation, for example the image of ‘leafing’:

“By leafing, the organism stays in the field of the stoppage. It remains at the spot, and under the conditions, of the stoppage. It would have spent only a moment there, if the process had not stopped. Now new events might form with the environment, which could not have formed before the stoppage.” (Gendlin, 1997b, p. 78 emphasis original)

“The leafings reiterate the stoppage. ... These new elaborations are not themselves going anywhere. Or, we could say, they go into the blue. They are like the fingers of a river that is stopped and spreading out. They go as far as they can; they occur and reiterate since the stoppage remains. So they are again implied. They occur again in so far as they can occur, but slightly differently for having just occurred.” (Gendlin, 1997b, pp. 85-86, emphasis original).

Morotomi expresses this in the more tangible terms of repeating ‘suffering bits’:

“Something new is implied in the ‘suffering bits’ themselves. Any suffering pattern repeats again and again, but never in quite the same way. Never quite the same! Here is grounds for hope for suffering people.” (Morotomi, 2010, no pages)

In the following section we will explore two tendencies discernible in the actions of a stop/on - the establishment of a defensive structure and the increasing pressure to find resolution.

Observation 34 - The image of ‘leafing’ is used by Gendlin to express the way that stopped processes are discernibly ‘carried’ in continuing physical and behavioural patterns. Notwithstanding frustration, the process repeatedly makes steps intended towards resolution.

3.3.2 Defensive

Defensiveness is observed in the degree to which apparently dysfunctional patterns of living can be aggressively resistant to change. One focusing-oriented approach uses the metaphor of ‘guard dogs’ to describe the backlash or setback that can occur when an important change is contemplated:

“The guard dog is protecting the status quo; it is protecting the structure bound process from opening to life. Also implicit is the notion that the guard dog may be protecting you from a premature change in a deep structure, the new supports may not yet be in place so that the ‘bearing wall’ (another key piece of my approach) can be dismantled.” (Lee, 2010, p. 1)

The defensive and denied structure of a stopped process was identified in the ‘Treasure Maps’ development of focusing-oriented practice. It arose from the observation that *“repetitive and habitual reaction sequences can become individually identifiable as they persist over time”* (McGavin & Cornell, 2008, p. 45).

Described as an ‘addiction’, this pattern was found not to be amenable to currently understood focusing procedures:

“It became clearer than ever that we couldn’t simply do focusing as we had learned it; i.e. Focusing with what we could already find in our bodies. We realized that, in the alcoholic drinking, Ann had been acting from a part of her that she could not feel, yet which was extremely powerful. We needed a way to make focusing work more effectively with this complex kind of process if these problems were ever going to change - for us.” (McGavin & Cornell, 2008, p. 41)

As we will see later (Ob.72, page 168), three configurations were discerned in this pattern - one that was weak and compromised, one that sought to dominate and control and one that was defending and protective. Whilst these configurations interlocked, it was felt best to work with them as entities or ‘partial selves.’ The authors identify the role of a ‘defending partial self’ who is constantly,

“trying to save your life and maintain your integrity — at the same time ... you may feel overwhelmed, emotional, rebellious ... disconnected, depressed, embarrassed, ... compulsively people-pleasing, compulsively antagonistic, escapist, exhausted ...” (McGavin & Cornell, 2008, p. 52)

This picturesque language identifies the tendency for blocked living to become entrenched and defended. The resulting frustrations invoke negative judgements but some psychopathologies see a fundamentally positive energy involved (see also Gendlin’s ‘reconstitution’ approach, Ob.39, page 93). In person-centred theory, as well as evidence of disturbance, ‘conditions of worth’ are a manifestation of actualization,

“acting to the individual's benefit in that they serve to guide the person's behaviour away from the possibility of further 'hurt' or psychological damage.” (Merry, 2003, p. 85)

“Whilst the actualising tendency may be urging the individual to experience novelty to enable growth to take place, the self-actualising tendency of that same individual may inhibit this motivation because the new situation is perceived as being too risky.” (Merry, 2003, p. 87)

The resulting defensiveness can be harsh and self-destructive. The more a person finds themselves trapped in threatening and unmanageable circumstances, the more extreme will be the coping response like a frostbite strategy, sacrificing the non-essential to protect the core:

“When a need message is chronically thwarted, the energy loss must be stopped if the child is to survive. In this sense, addiction mimics the frostbite strategy - sacrificing a non-essential part so the core survives. In addictive movement, the body impulse to send the normal need message occurs, and somewhere along the path of action the normal sequence is stopped and a stereotypic gesture shows up, which effectively restrains the body from going further in the sequence, instead sending it in an automatic, predictable and soothing alternate direction. It could be articulated as ‘I long, I begin to reach, I chew my nails,’ or ‘I long, I slump, I eat.’” (Caldwell, 2001, p. 220)

Observation 35 - Defensive patterns may be observed in an entrenched stoppage which resist interventions, yet encapsulate a positive intention. These may be understood as representing a ‘frostbite strategy’ where non-essential parts are sacrificed in favour of survival of the majority.

3.3.3 Flailing to escape

One of the other tendencies of a stopped process is only partially expressed by Gendlin, but I will argue, will be significant in an understanding of addictive behaviour. This is the tendency for dysfunctional behaviour to be exacerbated

until a resolution is precipitated. Speaking of leafing, Gendlin offers us the metaphor of an insect trapped in a room:

“The insect hits the window pane again and again, beginning to fly out to the light only to hit the glass painfully. But after a while it makes little tries, bzzz, bzzz, bzzz, bzzz, but these are no longer those awful first few hits when the bug smashed into the window pane as its body implied flying out to the sun. Now they are little rhythmic starts, almost continuously, along the window surface, as if exploring, maximizing the chance of finding an opening if there is one.” (Gendlin, 1997b, p. 77)

This suggests that the apparently stopped process is active in seeking a resolution. It is reminiscent of the psychodynamic understanding of ‘acting out’ where a particular preoccupation expresses itself:

“The patient does not remember anything of what he has forgotten and repressed, but acts it out. He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it.”
(Freud, 1958, p. 150, emphasis original)

Also in Freud’s attention to verbal forms, there are,

“numerous little slips and mistakes which people make - symptomatic actions, as they are called ... I have pointed out that these phenomena are not accidental, that they require more than physiological explanations, that they have a meaning and can be interpreted, and that one is justified in inferring from them the presence of restrained or repressed impulses and intentions.” (Freud, 1959, pp. 45-46)

My view is that the apparently destructive behaviour of some clients can be an expression of an unresolved ‘stop/on’ and an attempt to achieve resolution. Gendlin suggests generally that the apparently ‘negative’ can be considered a stopped but positive process:

“Another way to respond to negative and self-defeating ways of relating is to think of them as positive ways that are as yet incomplete, stopped, or twisted back on themselves. Therapists might ask themselves: What life-forward direction might conceivably be implicit here? The client may already be going in that direction but it is inhibited, partial, or turned in. The therapist can respond to that right intention, as if it were obviously there. Whatever the actual life-forward direction is, it may then emerge.”

(Gendlin, 1996, p. 293)

Such obscured rationality is perhaps akin to that which Gendlin observes when setting out the characteristic sequence of steps to be expected during a focusing process:

“Such steps do not follow by logic, and yet they make sense - we can follow them. They have a certain kind of order, different from logic and from irrationality, something deeper, more exact, more specific, more intricate; maybe not every time but often.” (Gendlin, 1990, p. 211)

I have suggested elsewhere (Tidmarsh, 2011) that this is a valid expression of the implicit, not ‘drowning but waving’ and the image of ‘flailing’ occurred both during a Thinking at the Edge exercise and recently during a conference presentation (see 9.4.1 page 326). Whilst there is sometimes the tendency for such expressions to reduce in intensity over time (as Gendlin implies in the analogy of the trapped fly), the opposite also occurs. I observe such expressions growing in size and scope (although with depleted frequency) as if that which is ignored makes increasingly desperate efforts to be heard.

As a footnote it is interesting to see the recognition in some quarters of the addiction community that apparently irrational expressions of addiction have a positive origination:

“Jede Sucht hat einmal als Suche begonnen” - Each addiction once began as a search. (Attributed to Andreas Tenzer, Cologne)

Observation 36 - A certain kind of order may be observed in the apparently irrational expressions of energy constrained by a stopped process. There can be a crescendo in such ‘flailing’ as, with an apparently costly irrationality, a person may precipitate their own release.

3.3.4 The ‘inner critic’

Before leaving this section it is valuable to highlight a particular example identified in focusing-oriented and other therapy – the ‘super-ego’ or ‘inner critic’. Gendlin is interesting in appearing to adopt this concept directly from Freud. He does not seem to see the need to question or explain it, merely describing how it speaks and how to respond to it. The most common picture is of ‘the inner authoritarian’, a voice that attacks:

“This is the voice that attacks us, tells us that what we feel is probably wrong, anything we try will probably fail. It tells us something along the lines of: ‘You’re made out of bad stuff.’ It attacks most of us pretty constantly and assumes a tone we would not tolerate from another person.” (Gendlin, 1984b, pp. 191-192)

There is a subtle distinction between the self and this apparently alternative configuration:

“People usually think that their superego attacks are part of themselves. And of course, in some sense it is they who are attacking themselves, because it is certainly no one else. But in another respect, when thought of as the manner of experiencing it is, the superego is inherently ‘not me.’ What we call ‘me’ pulls back, defends itself, hides, and becomes constricted under the attack.” (Gendlin, 1996, p. 250 emphasis original)

The literature shows four kinds of response to the ‘inner critic’ which to me show increasing subtlety and insight:

Rejection and abhorrence

Gendlin’s simple advice is in the negative - “*do not respect your critic*” (Gendlin, 1981, p. 113). This leads to ways to cope with attacks including immediate strategies like disbelief, putting down with humour, waving off, role reversal – ‘you stop that!’ Such techniques have a basic motivation – “*it comes down to simply bypassing the superego’s attack*” (Gendlin, 1996, p. 257).

Attention but without endorsement

A ‘long range’ approach includes a more sensitive appreciation of the fear and hysteria caught up in an attack. Can its protective intentions be heard and recognition given to ingrained patterns of shame, humiliation and guilt? This can start to address the bifurcation so that,

“*owning one’s evil* from inside lets one be whole, rather than the passive victim of an active part of oneself that is split off.” (Gendlin, 1996, p. 257)

Cornell and McGavin also show compassion:

“*There may be a grain of truth in what the Critic is telling you ... The Critic may represent an unhealed part of you that has been cut off from love and acceptance.*” (Cornell & McGavin, 2002, p. 38)

Müller (1995) suggested identifying the ‘inner critic,’ hearing but disregarding it and changing the focus from Criticizer to Criticized i.e. attending to its needs. Leijssen’s (1995) book in Dutch (quoted in Langeveld & de Bruijn, 2008) apparently distinguished between internalized critical parent and more protective intentions, something seen in the ‘Treasure Maps’ development of focusing-oriented practice as a ‘partial self’ (McGavin & Cornell, 2008). Without overemphasising such personification the critical intention may be recognised as “*a helper out of control*”

(Langeveld & de Bruijn, 2008, p. 9). Fundamentally this kind of approach is not about rejection but listening.

Relating and accepting

Cornell suggests a significant further step in the ability to recognise ownership of a rejected tendency:

"As with all blocks, identifying the Critic is more than half the battle. Try saying, 'That's my Critic,' and see if that is enough to make it lose most of its power." (Cornell "The Focusing Student's Manual" quoted in Langeveld & de Bruijn, 2008, p. 5)

McGavin (2005) provides a very personal illustration of this kind of process in her paper on *Focusing with the Part that Wants to Die*. Problematic experience in childhood led her to an enduring partial sense that wanted to die, something she considers to be the result of receiving an attack from the 'inner critic.' Focusing had an immediate dramatic effect – *"almost right away there was this sense of a me that was OK, not my problems, not my shit"* (McGavin, 2005, p. 65). It revealed to her the unhelpfulness of either identifying with the 'inner critic' or its victim and the greater unhelpfulness of putting the feelings to one side. In a moving passage McGavin recognises the need to provide unfettered space to an abhorrent expression:

"This is hard to say, because there is a part of me that would like you to feel differently, but I promise you that you can stay just the way you are for as long as you need. I will not pressure you to change, or feel differently or be different in any way. I will do my best to make a space where you can change, when and if you are ready in the way that you want to and hear what you need heard and support you in the ways that you need."
(McGavin, 2005, p. 67)

This approach offers a relationship with the ‘inner critic’ from a stance that is not it or its victim. It proffers a valuable space for resolution to naturally occur, not needing to understand but being willing to accept and demonstrates a standing beside that I see as very significant (Ob.49, page 115).

Active expression through opposition

An entirely different tradition also provides an approach that would be consistent with focusing-oriented principles. Emotion focussed therapy identifies self-evaluative and self-coercive splits as significant grounds for conflict. They developed the two-chair process from the Gestalt tradition where conflicting aspects of a person’s living are given voice, building a dialogue by physically switching between them:

“This process of active expression vividly brings experience into awareness and brings opposing aspects of experiencing into direct contact thereby creating the possibility for the construction of a new organization. In the experiential search process, the experience of a particular side is developed by attending inward to the internal experience of that side in order to symbolize what is experienced.” (Greenberg et al., 1993, p. 192)

This approach will be explored more later (Ob.82, page 199). At this stage this perspective adds to that of McGavin and others, showing an empathetic facilitation and articulation of problematic, but unclear senses. The existential reality of contrasting senses of being-in-the-world is sharpened by the process of dialectic tension (Aufhebung, Ob.25, page 62), following the same principle by which an ‘incorrect’ handle word can bring out a more developed felt sense.

Observation 37 - The ‘inner critic’ provides a model of denied agency that can inform an understanding of addiction and its treatment. Whilst its form may be painful and destructive, the positive intention caught up in it may

be recognized and an accepting space offered where change may occur.

3.4 Carrying forward and Authenticity

3.4.1 Philosophy and Psychopathology

The previous chapter outlined carrying forward as related to the cycle of 'occurring into implying', demonstrated in the zigzag of symbolisation (Ob.23, page 59) and living a situation forward (Ob.24, page 60). But what happens where the carrying forward is blocked? How is articulation sought even where it cannot be fully achieved? How can thwarted processes be reconstituted? These themes of psychopathology follow directly from the philosophy.

Leaving aside extreme forms, therapeutic practice shows evidence that the tendency of carrying forward to seek meaningful articulation can be present, even during a stoppage. The focusing-oriented tradition shows three kinds of response to this challenge – a standing aside from the stuck responding, a connection with live responding and attention to the thwarted articulation.

3.4.2 Standing aside from the blockage

An earlier discussion suggested that carrying forward might depend upon the 'Abstand' of focusing, the ability to stand aside from a conflating pattern (Ob.26, page 64) and Gendlin recognises the problems of penetrating stuck patterns of experiencing. To find a resolution there is a need to connect with an interacting process, yet,

"So long as the manner of experiencing remains structure bound, the structures themselves are not modifiable by present occurrences."
(Gendlin, 1964, p. 129)

The experience of a stopped process is primarily that of repeated behavioural patterns that do not carry forward. The more they are repeated as they stand the more they are entrenched. A focusing-oriented pause therefore presents a ready first step in resolution.

Observation 38 - Carrying forward from a stoppage depends upon the ability to stand aside from the structure bound patterns that block the interacting process. Standing aside is discovered in the pause (Abstand) where a moment of living beyond the pattern may be experienced.

3.4.3 Reconstitution - Connection with what is alive

It therefore follows that connection can only be sought through aspects of the person's living that are still in process. In terms of Gendlin's theoretical approach the 'law of the reconstitution of experiencing process' applies, which differentiates between process that is still active (needing merely to be carried forward) and that which is stopped (needing external reconstitution):

*"If contents are viewed as process aspects - that is to say, as implicitly functioning aspects of ongoing experiencing - then the law of reconstitution implies that certain contents (process aspects) must be symbolized before certain other contents (process aspects) can thereby become process aspects that are capable of being symbolized." (Gendlin, 1964, p. 131
emphasis original)*

The second focusing-oriented response of to a stopped process is therefore to attend to what is immediately alive even though it may be far from the core of a problem. Gendlin's (1972) description of working with schizophrenics has many examples of this - patiently attending to the minutiae of immediate living to establish a way to connect to the life of the person, letting him 'travel his own road.'

This is also illustrated in Wholebody Focusing terms with the significance of 'gestural leads' in therapy as expressions "*as an incipient form of bodily implying of a life-forward direction, a tacit indicator of right next steps*" (Fleisch, 2009, p. 178).

Observation 39 - Carrying forward from a stoppage depends upon the ability to relate to the immediate living of the client outside the structure bound patterns. This may mean attending to the immediacy of gestures or unrestricted experiencing elsewhere. This facilitates a growing experience of wholeness away from the stoppage.

3.4.4 Articulating the idle running

Gendlin says that a person carries a stoppage in the body and this is no better expressed than in the idea that,

"every moment the person's body is like a monument, a statue, representing the situations that are wrong in its twisted-up inward muscles and stomach tightness." (Gendlin, 1978a, p. 343)

Consequently anxiety and guilt are not dysfunctions to be eradicated, but signs of existential issues begging for resolution:

"Anxiety is not what stops one, but exactly the opposite. It indicates an opening for radical change. Therefore, Heidegger and others elevate anxiety almost to a defining principle of what it is to be human - namely, how being human is not ever an established entity ... Guilt, like anxiety, can speak; it marks missed opportunities, violated sensitivities that ought to have been part of holistic focal valuing and carrying forward." (Gendlin, 1973b, p. 334)

Suetake has a particular awareness of the potential caught up in such contortion, what he calls 'idle running':

"Some modes of psychopathological experiences, for example, splitting in object relations, having delusions and hallucinations, and repeating stereotyped behaviors may be some kind of leafing in bodily process. But in these modes of experience, the thoughts, images and behaviors keep idle-running, while the bodily implying continues to imply the same without carrying it forward." (Suetake, 2010, p. 123)

I would propose that the third focusing-oriented response to a stopped process is therefore to attend to the felt sense of the idle running, the issue knotted up in it, that which prompts what may nevertheless be an intolerable response. Gendlin recognises Freud's assertion that the energy of a defence comes from the repressed and from Rogers that it is most therapeutic to take a person's intended felt-meaning at face value as a starting point (Gendlin, 1964, p. 132 footnote).

"One must respond to the functioning experiencing, not to the structure."
(Gendlin, 1964, p. 132).

The example of the inner critic explored earlier (see Ob.37, page 90) shows the advantages of offering an accepting space for change. The personal tone used (McGavin, see page 89) is significant, indicating the intra-subjective I-Thou orientation involved.

Observation 40 - Carrying forward from a stoppage depends upon an articulation of the stoppage and the 'idle running' energy caught up in it. To do this implies a personal encounter with the positive intention behind what may be intolerable experiencing and a willingness to allow a resolution to take its own course.

CHAPTER 4 - EXPERIENTIAL PSYCHOTHERAPY

In this chapter the principles and practice of focusing-oriented therapy will be set out in two parts. The first will introduce the therapy, its origins and relationships with other methods. In particular the idea of 'experientializing' will be described and the connection this has to therapeutic avenues in Gendlin's thinking. After this an overview will be given of the therapy and its elements. Therapeutic issues of carrying forward will from now on be dealt with under the other headings.

4.1 Focusing-oriented Therapy and Avenues

4.1.1 Origins in person-centred therapy

In initial statements Gendlin called his therapy 'experiential', referring in a 'gut-sentience' way to what existentialists meant by "concrete existence" (Gendlin, 1966a, pp. 233-234) although its origins were clearly in the person-centred tradition being established by Carl Rogers in 1950's Chicago. Speaking of his early period with Rogers, Gendlin identified two core themes in the practice of this early client-centred group:

"Well, from the very beginning they always had this emphasis on a contact between the therapist and the client, in such a way that every moment the therapist checks his understanding of the client. ... And then, when you get it completely right, then there is a strong impact on the person. ...

The second thing I think is that: when one takes and receives and checks, so that one really has heard what the person is trying to say, in that silence which comes then, something deeper moves in the person and that is really the essential change process." (Gendlin & Lietaer, 1983, p. 79)

Several times he argues that the field of psychotherapy has not sufficiently learned the crux of this way of working and adds two additions to the tradition - an

emphasis upon exact specificity and an instruction to check a reflection inside (Gendlin, 1974). Gendlin points to his early work with Zimring as influential on Rogers' 'Process Scale', which was later developed into the Experiencing Scale.

"The change from self-concept, as he had called it before, to the process of responding to one's experiencing, that came from me, or perhaps even through me since there is a philosophical background to that notion."
(Gendlin & Lietaer, 1983, p. 81)

And it is this experiential perspective that has dominated, so that 'focusing-oriented' therapy is really client-centred therapy with this emphasis:

"my rendition of client-centered therapy ... is really a reformulation of it in experiential terms. As so reformulated, it ought to be a part of every therapist's way of working." (Gendlin, 1974, p. 211)

This position is not accepted by all of the person-centred community, some even asserting that *"focusing is not necessary for therapeutic change in client-centered therapy"* (Brodley, 1991, p. 5). Yet, using Hart's (1970) analysis of the development of client-centred therapy, Friedman (2000) convincingly demonstrates Rogers' work culminated in a fully 'experiential' therapy after the earlier 'reflective' and 'non-directive phases.' A personal communication from Gendlin illustrated the developmental world into which he stepped:

"I found that Rogers and his group were not very clear in their own minds just what in the client they were responding to. It was the client's 'message' or 'feelings' ... Rogers and others encouraged my theoretical efforts to pin this down. People said things like 'Gene, we're glad you're working on these ephemeral things.' ... When it correlated with success in therapy while other variables did not, people began to try to understand it more seriously." (quoted in Friedman, 2000, p. 47)

Observation 41 - Gendlin played a role in the creation of person-centred therapy and the focusing-oriented tradition can be seen as an attempt to capture the experiential essence of Rogers' approach.

4.1.2 Relationship to other methods

The structure of philosophy and psychopathology already reviewed make an experiential emphasis in Gendlin's therapy unsurprising (e.g. Ob.14, page 43). However, when combined with his reticence to become attached to any explicit structure of interpretation, this leads to an integrative approach. Whilst not entirely agnostic about theory, it is clear that in his view, even the best theoretical understanding can only encapsulate second order, relative meaning:

“According to the experiential method, theories are neither true nor false. They are not true because the kind of entities they assert do not actually exist in concrete human experiencing. But they are not simply false. Because they sometimes enable people to locate experiences they would otherwise have missed. The reality of what it brings out would remain even if it were to dismiss the theory.” (Gendlin, 1996, p. 2)

For this reason any orientation can get in the way of relating to the person's experiencing:

“All orientations and procedures interfere with psychotherapy insofar as they are held to tightly. Priority must always be given to the person and to the therapist's ongoing connection with the person. Like procedures, all theories can be destructive, if we think that a person is what a theory says.”
(Gendlin, 1996, p. 172)

This leads to an open acknowledgement of the significance of experiencing in all therapies and a desire to enhance them with its use. Client-centred reflecting is proposed as a baseline for using any other approaches (Gendlin, 1990), the

touchstone of their success (Gendlin, 1973b) and shows why relating to the implicit undercuts all other methods (Gendlin, 1974). An analogy of focusing being a motor to power a car brings him close to the kind of 'necessary and sufficient' claim that Client-Centred therapy makes. Wheels and chassis don't move without it. Yet he draws back:

"This analogy overstates the case for focusing. No single way can be the only way for human beings. It also overstates the need for other methods; one can go far with focusing alone. But let us always ask, 'What can we learn from the other method?' as well as 'How would that method work better with focusing?'" (Gendlin, 1991, p. 265)

So Gendlin makes plain he is not proposing that focusing is 'sufficient' for therapeutic change but sees it as an essential sub-process (Gendlin, 1969). The heart of his proposal is its combination with other approaches:

"In a real sense focusing misses every other useful avenue of therapy. It needs to be combined with them all. ... On the other hand, if we use only focusing by itself, we lack almost everything. I have never proposed focusing as a method of therapy by itself." (Gendlin, 1991, p. 264)

Purton (2004, p. 154) quotes an exchange showing Gendlin is a long way too from a dogmatic claim that focusing is 'necessary' for therapeutic change. In a philosophical exchange Hatab says,

"I can imagine anxiety being resolved, by uncovering early childhood traumas, by bootstrapping or coping skills, by the grace of Jesus, by Buddhist emptiness, or even by some success or a little good news."
(Hatab, 1997, p. 245)

Notwithstanding the lack of experiential rigour Gendlin approves and responds, "*I love Hatab's list of what might alleviate anxiety, including 'a little bit of good news.'*" (Gendlin, 1997c, p. 251). He largely sustains an un-dogmatic commitment

to seek and follow what works for a person, accepting his limitations, constantly inviting corrections, recognising the unfathomable complexity to which/whom he is trying to connect. Friedman approves of an assertion made by Gendlin:

“The therapist should keep in mind that focusing is one way to carry implicit bodily experiencing forward, but there are other ways. ... No one has the right to claim that there is only one way for human beings to grow, in therapy, in personal development, or in anything.” (Friedman, 2007, p. 22 which quotes Gendlin, 1996, p. 108)

Friedman wryly suggests that Gendlin would have done well to be consistent in this position in his writings. He illustrates points of overstatement including ones which seem to dictate what a therapeutic response ‘always’ aims at (Gendlin, 1968, p. 213), progress ‘only’ being associated with referent movement (Gendlin, 1968, p. 216), and the ‘necessity’ of experiencing for the possibility of personality change (Gendlin, 1962, p. 39). He sums up:

“I would say that my aim in therapy is to give a therapeutic response. A therapeutic response is one that helps the client. Help can take many different forms. An experiential response is one very special kind of therapeutic response. It is very powerful. Focusing and listening are specific methods that provide an experiential response and thus facilitate client movement. They are not the only ways to get such movement. Nor is such a response the only kind of response that is therapeutic. Where Gendlin says that focusing is what successful clients do in therapy I would prefer to say that focusing is one of the things successful clients may do in therapy. Focusing is very powerful and not always necessary.” (Friedman, 2007, p. 24, emphasis original)

I am not convinced by Friedman’s stance which seems to beg the question as to what ‘help’ means. Many interventions might have a positive impact upon a client’s situation including those that the client might find unacceptable or

intrusive. Gendlin may be guilty of overstatement, but his dogged persistence in exploring and systematically explicating a hitherto confusing area of human experience has produced considerable results. At this stage it is sufficient to recognise the careful modesty, to value the insights of focusing-oriented therapy and their systematic expression, and to notice the open and respectful statements which counterbalance occasional hyperbole. This research aims to explore a particular therapeutic approach for a certain client group. Arguments of exclusivity, such as those that have bedevilled the Client-Centred community are not required. I am content at this stage to agree with Purton's modest affirmation:

“All this is undeniable: focusing is not the only source of help there is, but it is one of the few resources which are available, however impoverished, or lacking in grace, the external world may at times seem to be.” (Purton, 2004, p. 155)

Observation 42 - Gendlin holds to theories lightly, preferring the client's experience and a therapist's relationship with them. He offers client-centred reflecting as a baseline for other approaches, with focusing as a way they may be improved and not something to be offered on its own. Notwithstanding theoretical differences, he is open to all ways that bodily experiencing may be carried forward.

4.1.3 'Experientializing'

So where does Gendlin's psychotherapy sit? Does he have a theory or no theory? As Purton points out, the resulting approach is not,

“an anti-theoretical stance. Theories are important, but not in the sense of ‘corresponding with reality;’ they are important in the impact which they can have on clients.” (Purton, 2004, p. 129)

His philosophy recognises the undivided multiplicity of life, of clients and their problems, of the process of therapy itself (Gendlin, 1996). He looks to the experiential effectiveness of different means of engagement (i.e. ‘avenues’) and their deployment notwithstanding therapeutic divisions. As we will shortly see, the importance is not to reach an explicit logical accommodation, but to deepen experiential sensitivities through varied practice:

“Since any avenue can lead to a felt sense, and any other avenue can carry it forward, the felt sense provides a juncture between avenues. Our sensitivity to many avenues enables us to modulate what we do on any one, so as to respond uniquely to the intricacy of each situation with each client.” (Gendlin, 1996, p. 171)

The formality of orientations and procedures is accepted as a necessary part of the work of a therapist but needs softening. We have seen how a personal facility to ‘translate’ between opposing theoretical systems was one of the inspirations for Gendlin’s philosophical explorations (2.1.2, page 38). He demonstrates this skill in his writings on psychotherapy, showing how apparently incompatible thinking can lead to surprisingly compatible practice. For example:

“while the psychoanalytic theory of the unconscious differs in many ways from client-centered theory, that unconscious to which an effective interpretation refers is exactly what I term ‘implicit felt meaning.’”
(Gendlin, 1968, p. footnote 4)

Nevertheless he proposes no false theoretical synthesis:

“The felt sense that arises from inside the client enables us to work, not within orientations (although we belong to them), not with fixed

procedures (although we may learn two or three on each avenue), not with avenues (although we become familiar with each avenue as such), and not with the felt sense (though it brings change steps and junctures among the avenues), but always with the person in front of us.” (Gendlin, 1996, p. 171 emphasis original)

As we shall see later, the imperative to put aside theoretical presumptions echoes the ‘bracketing’ of a therapist’s immediate concerns. It is essential to ‘put nothing between’ client and therapist and this applies to theories as much as anything else (Gendlin, 1996).

So Gendlin suggests that it is necessary to value different orientations through a synthesis of practice, not just eclecticism (Gendlin, 1969, p. 8), a process he originally calls ‘experientializing’:

“We must define each method by the specific experiential steps and momentary effects in the patient, which they produce. To do so, we must define much more exactly what the therapist actually does, which has these experiential effects.” (Gendlin, 1969, p. 9)

Observation 43 - Focusing draws attention to the experiential process within the work of different orientations and discerns commonalities of practice among them. Such experiential ‘avenues’ may be used freely as prompted by the needs of a client.

4.1.4 Avenues

Focusing-oriented psychotherapy: A manual of the experiential method (Gendlin, 1996) sets out a developed understanding of experientializing, evident in the structuring of the book. There are two parts - first one about ‘focusing and listening’ and then one about ‘integrating other therapeutic methods.’ Chapter 11 which begins the latter, sets out an approach that would allow engagement with

orientations, but with the ability to value differences and what is held in common.

It proposes four moves (Gendlin, 1996, pp. 170-171):

- To unpack orientations - recognising that a large number of therapeutic approaches share a more limited number of procedures. Therefore to work with the smaller pool of procedures.
- To consider how a procedure is used. The actual practice is more specific than any procedure or theory.
- When orientations and descriptions are set aside, to recognise the real differences that appear e.g. that therapy can consist of totally different kinds of experience. This therefore prioritizes avenues above fixed procedures.
- To recognise the way that focusing and the experiential method enable the use of each avenue and provide a way to move between them.

The concept of avenues is significant for this research, providing the foundation for chapter 6. It is therefore important to grasp clearly what is meant by it.

Avenues are not to be confused with orientations and the third move describes them as follows:

"Therapy can consist of totally different kinds of experience. I call these therapeutic 'avenues.' A given therapeutic event can consist of images, role play, words, cognitive beliefs, memories, feelings, emotional catharsis, interpersonal interactions, dreams, dance moves, muscle movement, and habitual behavior. These different avenues are genuine differences in the very stuff of which the therapy consists. ... We can, therefore, group procedures by avenue, despite the fact that they may be part of different orientations with different theories." (Gendlin, 1996, p. 170 emphasis original)

The avenues listed are exemplified by the topics covered in subsequent chapters of his book. Later in this chapter reference is made to *A Process Model*:

“A theory is beginning to develop (Gendlin, 1997b) that says that the avenues carry experiencing forward in different ways.” (Gendlin, 1996, p. 177 emphasis original)

This is a tantalising reference, yet obscure. The term ‘avenue’ appears in *A Process Model*, yet it seem to be used for an entirely different technical purpose there (e.g. Gendlin, 1997b, p. 79). Whilst the book speaks a great deal about the process of life, I can discern no developed argument there that different avenues carry forward in particular ways. The reference to carrying forward is perhaps clarified better elsewhere when he asserts that the different avenues of therapy carry forward different kinds of object:

“As food carries body-process forward, so also do our physical motions, interpersonal actions, words, conceptual steps, dreams and our work with them, as well as other people's words and their actions toward us. These carry the same single system forward, but in different ways. They cannot replace each other.” (Gendlin, 1984a, p. 100)

The talk of ‘avenues’ is emblematic of the kind of difficulty that arises from Gendlin’s theoretical work. His philosophy necessarily leads him to avoid dogmatic assertions and the dubious security of theoretical precision. He affirms relentlessly that everything must be subject to the experiencing of a client. This may be why categories such as ‘avenues’ are not developed further, so as to resist offering the temptation of misleading, logical structures. Yet what sort of thing is an ‘avenue’? Are these ways of relating, ways that human meaning develops, ways that things are resolved? It is interesting that Wholebody Focusing uses the term within a narrower frame:

“Many avenues for carrying forward experiencing open and inter-affect each other—such as was evidenced in the examples, including awareness of gestures, posture, movement, energy, imagery, impulses, etc. - that arise at the edge of awareness in sessions.” (Fleisch & Whalen, 2012, p. 105)

If definitional problems are put to one side there seems to be some valuable truth in the ‘avenues’ material. Different therapeutic traditions have built up ways of relating to clients that have stood the test of time. These can be grouped according to the kind of process or interaction involved for the client, perhaps how their living and experiencing is engaged. An ‘experientializing’ perspective might provide a valuable means of relating to therapeutic work in the field of addiction which is riven with silos of interpretation that perpetuate particular views. By contrast can we simply observe what carries people forward? Can we pay attention to how do they experience the process? It seems to me that an affirmative observation is appropriate here, but also a warning. The affirmation is:

Observation 44 - The experientializing method and the concept of therapeutic ‘avenues’ are sufficiently defined to be applied to the many therapies offered for addiction. They may provide a practical way to transcend some of the divisions apparent in this field.

The warning concerns the degree to which the experiential element, clearly the nub of Gendlin’s insight and method, may be lost in other parts of a therapeutic approach. For example, whilst focusing is explicitly offered in Process-Experiential Therapy (Greenberg et al., 1993), it is but one of a number of techniques used. Also, an experiential referent may be used as a subsidiary or minor part of an approach attending to other priorities, perhaps cognitive or behavioural. I can see no necessity to undertake focusing as it is traditionally practiced, but the implicit must somehow be allowed to be decisive:

Observation 45 - The experientializing method allows the establishment of therapeutic avenues where the implicit provides a determining role in therapy.

In the remainder of this chapter the fundamentals of focusing-oriented therapy will be set out i.e. Gendlin's description of the core process of therapeutic facilitation which addresses the psychopathology perspective outlined in the previous chapter. Chapter 6 will propose avenues of focusing-oriented therapy for recovery.

4.2 Overview of the therapy

This overview will start to look for patterns of therapeutic intervention between client and therapist. What is it that the client needs to do? (therapeutic task) What does the therapist do to help the client achieve this? (therapeutic intervention)

It may be useful to begin with general encapsulations of the therapeutic approach and the stages involved. An early statement uncontroversially comments that personality change is normally associated with an "*intense affective or feeling process*" (Gendlin, 1964, p. 105) and the context of a particular relationship. A little later a stronger affirmation is made about experiencing and the interpersonal encounter:

"If there is one rule which encompasses the many we are still formulating, it may be: Let us conceive of the individual as not fully formed sentient experiencing, and pay attention to it, respond to it, refer to it, and make room for it, even when silent and without shape. Then let us respond from our own persons in whatever way is immediate and plainly real for us, but quickly again make room for attention to the newly moving experiencing in him which we thereby create." (Gendlin, 1966a, p. 245)

A third statement affirms an experiential position by a rejection of positions taken elsewhere:

“Existential psychotherapy holds that one makes and changes oneself in present living. ... Experiential psychotherapy works with immediate concreteness. One’s sense of immediate experiencing is not emotion, words, muscle movements, but a direct feel of the complexity of situations and difficulties.” (Gendlin, 1973b, p. 317)

Gendlin’s *Focusing-oriented psychotherapy: A manual of the experiential method* includes a whole chapter debating when the word ‘therapy’ should be appropriately used and includes the following assertion on the last page of the book (and then immediately goes on to debate the ‘difficult philosophical problems’ with the concept):

“‘Focusing-oriented therapy’ is not therapy that includes brief bits of focusing instruction. Rather, it means letting that which arises from the focusing depths within a person define the therapist’s activity, the relationship, and the process in the client.” (Gendlin, 1996, p. 304)

Friedman quotes an undated personal communication from Gendlin which touches on the underlying structure at work:

“Experiential therapy focuses on the inchoate - the felt sense that someone’s words come out of. Therapeutic movement (as against mere self-observation or knowing oneself) comes in the act of attending to, responding to, and for seconds being with what is sensed under what is clear.” (Friedman, 2000, p. 48, emphasis original)

So these statements give some indication of what is to come. They exemplify the origins of the therapy in the Client-Centred tradition and emphasise the particularity of a core process of experiencing and its inter-subjective heart. Notable is the stance which, following Rogers, stood aside from medical efforts to

‘treat’ a person (rendering them from a person to an object) and, under the ‘medical model’ abstract them from the business of “*making oneself in one’s living situations with others in society*” (Gendlin, 1973b, p. 345). Gendlin necessarily stands with those who reject labelling and objectification of psychological problems and treating people according to category.

Before looking at the detail it is useful to see how the process of focusing has been variously described over the years. Originally it was analysed in four phases:

“Phase one, direct reference to a felt meaning which is conceptually vague but definite as felt; phase two, unfolding and the symbolizing of some aspects; phase three, a flooding of global application; phase four, referent movement, and the process can begin again with phase one.” (Gendlin, 1964, p. 122)

A few years later there were still four phases described in very similar terms but with the order slightly different (Gendlin et al., 1968, pp. 219-220):

- Direct reference
- Reference movement
- Wider application
- Content mutation

This document also included a newly revised Focusing Manual, providing instructions on what to do and a *Post-Focusing Questionnaire*. The list of instructions was repeated in various documents, but, when Gendlin wrote *Focusing*, his 1978 book that gave a popular introduction to the topic, the manual was expanded and referred to six ‘focusing movements’ (1978b, pp. 58-71):

- Clearing a space
- Felt sense of the problem
- Finding a handle
- Resonating handle and felt sense

- Asking
- Receiving

These have been promulgated in a very similar form for therapeutic use since (e.g. Gendlin, 1984a, 1996). One distinctive element introduced here are the ‘split-level’ instructions:

“Try to apply our instructions as exactly as you can, but the moment they seem to do some violence in you, stop, don’t run away, instead: see directly, what you have there.’ On one level, ‘please follow’, and on another level, ‘please don’t follow’ the instructions.” (Gendlin, 1984a, p. 88)

These illustrate graphically the prime position of the client – even when performing a therapeutic task, the client’s sense of what is right for them is still paramount.

Observation 46 - General summaries of focusing-oriented therapy emphasize the attentive space offered to the client’s feel for their situations and problems. A series of stages have been identified in focusing and developed over years. Nevertheless, the ‘split level’ instructions stress the precedence of the client’s process.

The methodology chosen to develop a model of focusing-oriented therapy for recovery uses a task analysis approach and attention to microprocesses (Ob.07, page 20). The next part of the chapter will use this approach with generic focusing-oriented therapy.

4.3 Client tasks

In this part of the chapter the tasks of the client will be reviewed first, followed by the kinds of intervention expected from the therapist.

4.3.1 Experiencing/existence

The previous chapter set out a psychopathology consistent with the Philosophy of the Implicit. This characterised process stoppage as the heart of many problems (Ob.29, page 71) where an individual loses touch with their experiencing. Patterns from the past are repeated in the ‘structure bound’ way (Ob.30, page 72) of a ‘frozen whole’ (Ob.31, page 74). A person loses an immanent sense of self and in various ways, structures of identity are substituted for it (Ob.32, page 76).

Experiencing

The key client task is to connect to their immediate experiencing. This is perceived as the core process that will release frozen and repetitive behaviours and allow stopped processes to be carried forward. Gendlin sums up the imperative simply as a “a shutting up.” (Gendlin, 1969, p. 4):

“The rule for focusing - a rule to be applied inwardly to oneself - is ‘Keep quiet and listen!’ Then, by referring to the concretely felt referent, it will unfold; the sense of its meaning, and then the words, will come into focus.”
(Gendlin, 1964, p. 125)

Friedman expresses the imperative poetically and intersubjectively:

“Someplace inside, someplace deep inside, we all want someone to listen to our heart’s song. We want to sing an aria of our pain, a ballad of our love, a medley of joy. We want to give voice to what is inside each and every one of us: the particular ways we have been blessed and hurt by life. We all long to be heard.” (Friedman, 2000, p. 91)

The focusing steps are expected to have an impact upon the manner of experiencing of the client in three forms (Gendlin, 1964, p. 127):

- Immediacy – contrasted with disassociation or a postponement of affect.

- Presentness – the sense of responding to what is happening *now* rather than a familiar, repetitious pattern.
- Freshness of fine detail – any moment's experience has more details than can be symbolised.

There is such richness that any symbolisation is only explicated through a series of steps (e.g. Ob.14, page 43) which allow a multiplicity of understanding and tolerance of continuing incomprehension:

“The client's inner ‘therapist’ (his conscious self) must shelve a lot of knowledge and surmise, must refrain from many interesting interpretations, and prefer instead to wait, silently, while for some time nothing much comes.” (Gendlin, 1984a, p. 84)

We have already noted the ‘shutting up’ described as a shared pause (Abstand) which stops the constant symbolisation of the known (Ob.26, page 64). The unknown needs a space to be created for it to form:

“To allow a felt sense to form, one must stay quiet, and one must let it form. The letting part is only half of it. Another half of this process is (very deliberately to make room for it) like holding a frame over the dark, so that then something can be let to form within that frame.” (Gendlin, 1974, p. 242)

Like sleep, tears or an orgasm the felt sense comes from the situation in its own way and time (Gendlin, 1993a). It may be bidden but not commanded and is deeper and wider than an emotional response. Finding a felt sense there is a need to stand back to “*the right distance*” - *where one can feel ‘the whole thing’*” (Gendlin, 1991, p. 269 footnote). As was observed before (Ob.26, page 64), this involves an intersubjective space.

Observation 47 - Client Task 1 – Experiencing - To encounter the immediate felt sense through a shared pause (Abstand), that frames what is yet unclear and fragmented.

4.3.2 Interaction/encounter

The previous chapter set out the psychopathology of interaction and encounter. Having seen human life in terms of interaffecting, both ecological (Ob.16, page 46) and intra-personal (Ob.17, page 48), pathology was shown to arise where that sustaining interaction was disrupted or destroyed, condemning the individual to isolated, 'autistic' existence (Ob.33, page 80). The consequences of this were seen at various levels including the profound disturbance of schizophrenia.

Concrete Sentience

A second task follows from the client's initial relationship with experiencing and broadens awareness. Here the existential origins of the therapy are clearly shown, particularly in Gendlin's use of the word 'concrete.' The process is down-to-earth and immediate, something tangibly felt in the body and living, yet it is also one discerned through the interaction of people and the feelings toward things and each other that they experience. References back to Heidegger perhaps express this most completely:

"Existentialism defines human beings as being 'in the world.' It defines subjective or individual experience not as something within, but as 'in the world.' It defines the individual human as a being here (Dasein). This means he is concretely sentient. Existence is always yours, mine, his. It is the concrete ongoing living we feel and are. It implicitly contains how we are alive and geared into our situations. Other persons are perhaps the most important aspect of the world and the situations we live in. Human beings are always a 'being-with.' (Loneliness is no exception; in fact we can

feel lonely only because being-with is an essential aspect of human beings.)" (Gendlin, 1966a, p. 227, my emphasis)

It seems to me that clients arrive in therapy because of an ecological mismatch – their living and their environment are out of alignment. A shift in relating needs to happen, and may have been postponed for a long time. Society may diagnose a psychological ailment for an inter-human predicament. Dysfunctions, even those in apparently extreme categories, are expressions of living inhospitably or in a fragmented way. Consequently, the ability to attend holistically is significant:

"Whether one attends to a whole situation or to some tiny aspect of it, the bodily felt sense of that will be a whole. ... It is always the whole bodily living of... This wholeness is a characteristic of the felt sense." (Gendlin, 1984a, pp. 80-81)

Paradoxically, a fragment can be related to in a way that reveals its essential interaffecting. Purton uses Hua Yan philosophy to evoke this interpenetration of all things in the image of *Indra's Net* – an image of a suspended infinite network of jewels, each polished to reflect all of the others (Purton, 2009a). In *Thinking at the Edge* terms it would be a 'facet' (Gendlin & Hendricks, 2004), or in philosophical terms an 'iofi' (see 2.5.4, page 63). The key issue is not in partial understanding but an integrated 'ontology of dwelling' (Ob.18, page 49), a holistic inhabiting:

"The body is wiser than all our concepts, for it totals them all and much more. It totals all the circumstances we sense. We get this totaling, if we let a felt sense form in inward space." (Gendlin, 1974, p. 236)

'Concrete relating' reveals the background feelings of life (de Fréminville, 2008), the situations that shape how one can act and react. To relate to the whole sense opens up freedom and agency:

"The very nature of finding oneself concretely seen, felt, connected, and one's every feeling and motion responded to constitutes finding oneself no

*longer helpless, hopeless, no longer isolated, unloved, lost in weirdness.
The concrete mode of living is already different.” (Gendlin, 1966a, p. 216)*

***Observation 48 - Client Task 2 – ‘Concrete Sentience’ - To attend to a
sense of the interaffecting in the whole situation,
ecological and intersubjective.***

Being-with

A third task relates to the disconnected, ‘autistic’ quality of a stopped process (Ob.33, page 80) which can tend to reduce the ability to relate to both self and others. The significance of the therapeutic relationship is well recognized in opening up a client’s personal isolation and the focusing-oriented approach to that will be highlighted later (Ob.55, page 129).

The distinctive step here is to accord a personal welcome to what might otherwise be understood impersonally. A welcoming ‘focusing attitude’ (Leijssen, 1998a) is offered to whatever comes and I have discussed the need to cope with interventions of the inner critic (Ob.37, page 90). The felt sense should be accorded the same acceptance as would be offered to a client :

“We try to receive whatever comes from a felt sense. We let it be, at least for a while. We try not to edit it, change it, or immediately push it further. Neither do we agree with what first comes from a felt sense. We know there will be further steps. We develop an attitude of welcoming whatever comes, even if it seems negative or unrealistic. We know that further steps can change it. Such steps can come only if we first receive and welcome what is now here.” (Gendlin, 1984a, p. 84)

The interpersonal style of welcoming implied by this attitude is evident in all sorts of focusing work. We are invited to practice hospitality to felt senses with the tolerance of a ‘guest house’ proprietor (see Jelaludin Rumi quoted in Lawrence, 2004). It also helps perhaps to,

“Imagine the felt sense as a shy child sitting on a stoop. It needs caring encouragement to speak. Go over to it, sit down, and gently ask, ‘What’s wrong?’” (Friedman, 2007, p. 39)

We can speak to the felt sense like a person:

“Maybe you’re worried about something,’ I check with it. There’s a sense of yes, it agrees with that. It is worried, concerned. It’s concerned about me. What I will get into, what will happen to me.” (Cornell, 2005, p. 27)

Whilst there is a danger of reification here, this kind of language encapsulates an attitude of tolerant acceptance that is prepared to live alongside a pain or aberration to allow it to carry forward in the way it chooses. Earlier we saw an eloquent example of McGavin allowing tolerant space to a sense in her that wanted to die (page 89). The tensions that arise from such forbearance are recognized and the practice of ‘standing it’ recommended, neither ‘identification’ nor ‘dissociation’ but a generous being-with mixed feelings (Cornell, 2005). We will see later how the heart of this intra-subjective encounter has been recognized, a Buberian ‘I-Thou’ orientation toward the multiple ways of being-in-the-world rather than the objectification and rejection that are commonplace (Ob.71, page 166).

My assertion is that this ability to stand alongside unresolved and mixed senses of being-in-the-world is a significant focusing-oriented step that opens up ways to dwell with the unpalatable, to be able to say ‘*That’s my critic*’ (Ob.37, page 90).

Observation 49 - Client Task 3 – ‘Being-with’ - To stand as a human alongside senses of being-in-the-world, beginning to find ways to relate and the potential for habitation.

4.3.3 Focaling/value

The previous chapter set out a psychopathology consistent with the Philosophy of the Implicit. Focaling points to the essential meaning and direction that can be experienced in life (Ob.20, page 53) and to the necessity of attunement and adjustments through focaling (Ob.21, page 54). It is evident in the way that a stoppage is ‘carried’ by patterns of ‘leafing’ – repeated steps that seek resolution (Ob.34, page 82). Defensive patterns may be observed and, in a ‘frostbite strategy’ non-essential parts are sacrificed in favour of survival of the majority. A certain kind of apparently irrational order is observed as the process ‘flails’ toward resolution (Ob.36, page 87).

This section will look at two therapeutic tasks – ‘coming home’ and ‘dwelling.’

Coming home

In previous sections we have seen how Gendlin emphasises the importance of the immediate sense of self as process (Ob.27, page 66), recognizing how estrangement from this can lead to trap people in explicit forms of identity (Ob.32, page 76). His *Eight Characteristics of Process Experiential Steps* suggest that steps bring one closer to being ‘oneself’:

“As one comes to have a sense of this whole as an object there comes to be a difference between oneself and that sense. ‘It is there. I am here.’ There is a concrete disidentification (that is one way of putting it). ‘Oh ... I am not that!’ A felt sense lets one discover that one is not the felt sense. When one has a felt sense, one becomes more deeply oneself.” (Gendlin, 1996, p. 21, emphasis original)

A fourth client task has three aspects, the first is to permit increasing senses of self to be recognised and accepted. This occurs perhaps first in the recognition of another person during therapy and slowly the possibility of accepting oneself, warts and all, becomes possible. In both senses this is a process, an experience,

where something partial and fragmented is carried forward to find a more comfortable place, that allows ambiguities. I am reminded of Cornell and McGavin's parable of an estranged dog that eventually was enticed home (Cornell, 2005).

The second aspect is one of valuing. With the implicit sense of self comes a re-awakened connection to what really matters. Values arise from the live sense of a person-in-situation, rather than being imposed upon it:

"We do not first adopt value-conclusions from some system and then apply them to choose between different possibilities. First we must confront and differentiate experienced meanings (felt meanings). Then we find that these now differentiated felt meanings have a significant feel of good or bad, resolved or conflicted." (Gendlin, 1967b, p. 185)

To connect to values is to recognise one's place in the whole mesh of human relating, affirming what is most important and true. It requires a living process to feel at home both with a place and with the connections implied by it.

The third aspect is the renegotiation of a more comfortable way of being with the immediacy of "*self which is not any content.*" (Gendlin, 1996, p. 24). As we have seen, this is not to be confused with a 'thing-like' entity that stands apart from the world. Depending as it does upon inter-affecting, the process is a focalizing, discovering a way of being-with and being-in the world that carries the whole situation forward. Finding a supportive way of dwelling in society provides a way to be 'deeply oneself' and 'at home' despite ambiguities:

"Within the context and relative permanence of home, one can experience the co-existence of seemingly irreconcilable opposites and this experience creates a special feel of containment that is not usually consciously appreciated. Regardless of how 'dysfunctional' families may be, homes can provide that deep and fundamental sense of space where all these

opposites and contradictions can be contained and held together.”

(Papadopoulos, 2002, p. 14)

In Magee’s terms an opportunity for existential shift occurs, for the heart to open:

“To feel deeply, completely and unconditionally ‘received’, recognised, ‘known’ and respected by another is also to have the opportunity to ‘come home’ to the self.” (Magee, 2013, no pages)

An immediate sense of self is viscerally present but, discovers its own agency in transcending explicit forms:

“We ‘interrogate’ ourselves inwardly to discover what we feel, wish, are. This ‘self’ we interrogate is not an ‘inhabitant’ inside. In one respect it is ‘present’ (our directly-felt bodily concreteness), in another respect it is ‘absent.’ ... To say how I feel is a living process that ‘surpasses’ what was given when I began to talk. And, to tell you how I feel is, of course, a different being-in-the-world, than to say it to myself or some other person.”

(Gendlin, 1966a, p. 232)

It is useful to try and catch the sense of self being referred to here, distinct from an external self-concept, more all-encompassing than ‘self-as-perspective,’ something necessarily contingent and in process, yet viscerally experienced as an embodied continuity. It is perhaps Harré’s ‘sense of identity’:

“I distinguish the socially defined fact of personal identity, in which the particularity of personal embodiment plays a central part, from the personal sense of identity through which a person conceives of him or herself as a singular being with a continuous and unique history. The latter is a necessary condition for the acquisition of a theory of the self, which is experienced as the sense of identity.” (Harré, 1984, p. 27)

Observation 50 - Client Task 4 – Coming home – To permit the self to be recognised and ‘received’, finding value in the sense of self-in-situation.

Dwelling

The final client task relates to the focaling concept of a right, growth-full direction being at the heart of reality (Ob.20, page 53) and the idea of a constant ‘implying’ always waiting to be carried forward (Ob.23, page 59). Embodied action is not something artificially attached to the process of therapeutic change but naturally arises from the zig-zag of experiencing and symbolisation. Action leads to a new experiencing, an implicit awaiting more articulation.

A tangible zig-zag can suit those of an active disposition, allowing practical steps to follow each other, building confidence and direction through meaningful achievements. At heart all therapeutic process will be carried forward in practical terms as a person’s being-in-the-world changes.

Three spheres are significant in a tangible zig-zag process – direction, choice and self-investment. Each works in an opposite direction from that expected by the ‘unit model.’ Usually discerning the right way to go is understood to depend upon an objective, ‘rational’ appraisal which is then applied in particular circumstances. However a focaling approach begins with the embodied sense of what the whole situation implies allowing a sense of direction to arise from it.

“the direction of one’s next psychotherapeutic step is always implicit in one’s present experiencing, it isn’t a matter of choosing goals, as if the direction could be anything, and is added on from the outside to present experiencing.” (Gendlin, 1973b, p. 326)

Stepping forward from a stopped process therefore depends upon an experiential and practical sensitivity:

“Only in a person's directly felt experiential sense can there be a sense of an own direction, an owned sense of a need for change which gives such a direction. Searching into such a sense of needed change, such a sense of malaise, or pain, or constriction and unlivable living, one senses the expansion which would come from living more freely.” (Gendlin, 1973b, p. 341)

Where there is a matter of choice Gendlin cautions against the false dichotomies of explicit options (e.g. X or Y). If neither the X and Y options appear to be right at the moment it would be better to wait for a more encompassing sense of the implicit:

“... just say 'I want something else' and then you can begin to sense for new possibilities. Many more choices open up from the bodily living in the situation ... But I wouldn't say you ever want just the one or the other. I would always have liked to be able to say 'I want whatever's right', which is a lot like the old tradition of 'whatever is God's will, I'll do that.'”

(Madison & Gendlin, 2012, p. 93)

There is a strong existential quality to this stance, a recognition of contingent struggles of actual living compared with false abstractions. A renewed engagement may allow a hitherto unrecognised avenue to open up. Yet the existential challenge of implicit options is not underestimated. Gendlin is very clear about the way that carrying forward can be blocked by,

“forgetting it, by saying the wrong thing and letting it shrivel. One can also let it keep hanging there unsatisfied and go to bed. One can wipe it out with a little alcohol, or talk it away.” (Gendlin, 1994, p. 385)

As Purton comments, a tangible zig-zag therefore offers the challenge of self-investment:

“We open ourselves to the whole complexity of the situation, new ways of experiencing it emerge, but we are still faced with the choice of what to give our heart to ... There has to be something of the nature of will or agency, in which the person identifies themselves with the new way of seeing things.” (Purton, 2000, no pages, my emphasis)

Later he notes the way that having choices about choices is a core capability of a human being (Frankfurt, 1971) and points to a different kind of choosing (see Ob.84, page 205):

“Given all that, there comes the point where we have to decide, or to put it another way we have to discover among our many wants, what we really want. What we really want, I have suggested above, is on a different level from what we just want, but we can't get to it without fully experiencing all our relevant feelings.” (Purton, 2000, no pages)

It is hard to do justice to the ‘interacting first’ in these concepts of direction, choice and self-investment. They each have an arbitrary, chopped up feeling that misses the inherent connectivity that needs to be expressed. Anthropologist Tim Ingold (2011) provides an elucidation of a ‘dwelling perspective’ which distinguishes the intricate, interdependent human process of living from the artificial process of construction of houses – building. He follows Heidegger - “only if we are capable of dwelling, only then can we build” (Heidegger, 1971, p. 160) . The articulation of the final client task depends upon a discovery embodied sense of fitting with a place and building that arises from it.

Observation 51 - Client Task 5 – Dwelling - To articulate experiential steps that arise in tangible choice and self-investment.

4.4 Therapist responses

Focusing-oriented Therapists recognise the tasks that clients undertake and facilitate them through four generic responses.

4.4.1 Creating an intersubjective space

The therapist's role to support a client's experiencing was originally set out in ten rules (Gendlin, 1968) and then subsequently in seven techniques for engendering process steps (Gendlin, 1996). As was commented above, this is Client-Centred Therapy but with a particular discipline and discernment. The first therapist task is to establish a space for focusing to occur. The right steps and attitudes are taught in how the session is conducted:

“it is not helpful to teach focusing during therapy. It is preferable that the therapist models the more general focusing attitude of waiting in the presence of the not yet speakable, being receptive to the not yet formed,” (Leijssen, 1998b, p. 132)

Demonstrations of Gendlin working with a focuser show the dedication and precision he deployed in listening to them and checking accuracy:

“Whatever I say or do in therapy is instantly checked against the client's inward response. It means I rarely say or do two things consecutively without a client expression between. ... I always give priority to the client's own step. Whatever else I can do must wait.” (Gendlin, 1984a, p. 89)

This approach requires the therapist to make responses that 'point' (Gendlin, 1968) and also encourage contradictions from the client when a reflection or understanding does not quite catch the nuance involved:

“To get the steps, we have to reflect exactly; I am not saying those forms are not there. I am not saying those forms do not matter. I am saying:

Something here which is very, very exact and formed, is also not just formed but gives rise to steps. That is the kind of order and model I want to talk about.” (Gendlin, 1990, pp. 211-212)

The Philosophy of the Implicit gives a particular meaning to this precision – carrying forward is here expressed as inter-personal knowledge - grasped by someone else and responded to through their living – ‘to understand exactly, although differently’ (Gendlin, 1997d). Gendlin tells the story of a friend eager to pass on a particular insight, who would not be content to hear his own words parroted back to him. To be confident of being really understood he would prefer to hear his ideas relayed back ‘exactly’ to show subtlety of understanding, yet in different terms to show a human understanding from another person’s life.

The ‘although differently’ part of the process depends upon the therapist’s authentic sense of the situation at hand and how their reaction has changed. As Gendlin (1969) points out, the trick is to respond to the felt meaning the client just had, not something else, but to do so as a different person-in-situation. Letting go of any explicit sense of ‘who I think I am’ (Moore, 2003), the capability in the room to discern, connect and respond is expanded. Yet a dissonance in resonance is also inevitable, allowing a little triangulation or perspective, the acceptance of many subtleties and differences. The shared quality reasserts the non-autistic quality of living (Ob.33, page 80) and the intersubjective holding of the self (Ob.17, page 48).

Observation 52 - Therapist role 1 – Creating a space - To facilitate a shared space where the client can relate to their immediate experiencing and be heard accurately (exactly though differently).

4.4.2 Felt meaning

The therapist offers a special attention to implicit material presented in the room, seeking wherever possible to facilitate further steps:

“The therapist must attend not only to the client's words, but to how they are said, and to how the client is living right in this moment, in saying this. This means observing the person's face, body, voice, gestures, and taking the person in much more broadly than verbally. But not only such nonverbal cues are important, one must also ask oneself: what is the client doing or trying to do in saying this? What is the client's approach to the problem?” (Gendlin, 1973b, p. 338)

Thus the therapist responds both to the client and the ‘client's client’, their implicit experiencing. The form of that response and the theoretical structure that may lie behind it are almost immaterial so long as the experiencing is caught:

“The directly felt, implicitly complex experiencing is what all therapists really seek to respond to.” (Gendlin et al., 1968, p. 220)

It can be helpful to respond to a client who is not focusing, as if they were, to the felt sense behind the words:

“... it makes all the difference if the therapist, in responding, points at a felt sense that is really more complex. No matter how precise and clear what the client says may be, we must always assume and refer to a concrete felt sense.” (Gendlin, 1968, p. 211)

An extension of this is the therapist's use of their own felt sense to help the experiential process when it is challenging. This is what the Gestalt tradition refers to as a kind of ‘resonating chamber’ (Polster & Polster, 1973; Sideroff, 1979) and the person-centred approach sees as ‘integrative impressions’ (Villas-Boas Bowen, 2002):

“Most clients need a long period (months) of persistent therapist response to exactly what the they feel, perceive, and imply. During such periods the therapist's use of his own feelings is for the purpose of imaginatively sensing the client's felt meanings.” (Gendlin, 1968, p. 221)

Naturally the senses perceived by the therapist will include those about the process between the participants (transference). These provide a very fruitful opportunity:

“The therapist pays attention to his own reactions and explicates them to himself before he states them.” (Gendlin, 1968, p. 223)

“Thus, feelings of difficulty, stuckness, embarrassment, being manipulated into a spot, resentment, etc., are essential opportunities for the relationship to become therapeutic. But this cannot happen if the therapist knows only how to ‘control’ these feelings in himself (i.e., force them down). Of course he can control them, since usually they are not very strong. On the contrary, the therapist must make an extra effort to sense them in himself.” (Gendlin, 1968, p. 223)

Four specifications are given for therapist self-expressions (Gendlin, 1964, p. 143 footnote):

- They are expressed explicitly as the therapist's own,
- The therapist spends a few moments focusing on the feeling he might express,
- The phrasings and meanings which arise in us are very strongly influenced by our overall feeling toward the person to whom we speak,
- When the client expresses himself, a response to that is needed.

These four types of intervention demonstrate the process driven quality of focusing-oriented therapy. The shape and outcome of the session are always in the hands of the client, and that only as experiential steps lead.

Observation 53 - Therapist role 2 – Felt meaning - To offer a special attention to felt meanings, using self as a 'resonating chamber' for what may be present.

4.4.3 Articulations

Both of the client tasks identified within the Focaling perspective (Ob.50, page 119; Ob.51, page 121) depend upon the ability to use an embodied felt sense to carry forward beyond existing limitations. The therapist response needs to look to these potentials beyond and within the immediacy of flailing. The problem holds the secrets of its solution:

"We have also implied that any negative 'hung up' condition or problem carries within itself implicitly the directions for its own positive solution, even if that solution must be created and cannot merely be 'found.' Thus, a therapist must pay very close attention to the possible positive aspects incipient in maladjusted negative behaviors and feelings." (Gendlin, 1968, p. 216)

That which is positive must be engaged by the therapist, but in a way that sidesteps the inherent negativity.

"There is always a positive tendency which we can 'read' in the negative behavior. ... Whatever is being defeated in the client's usual behavior and interaction pattern must not be defeated here, in this interaction with the therapist. It must instead be carried further and beyond the usual self-defeating pattern. It must succeed here, whereas it usually falls elsewhere." (Gendlin, 1968, p. 224)

Hints at a life-forward direction may be very physical:

"Therapists need to recognize and respond to life-forward movement when it happens. At first it may be shy, or only implicit. We also need to sense

where it might come, so that we can look for it there. So we need to know what it looks like. ... We need to look for and respond to new health, a belly laugh, shy bits of trying something new ...” (Gendlin, 1996, p. 259)

The crucial quality of this therapeutic step lies in the ability a client has to choose. However impossible this may seem to be the therapy holds to this right and responsibility. Someone who has no sense of self, no agency in the world, who feels themselves ensnared by a malevolent force, still has both the capacity and responsibility to choose:

“An existential therapist is committed to aid the patient to articulate life and thereby accords the patient full responsibility and validity for any choice, sense of significance, for the unique way of construing anything which is this person. This has a freeing effect which aids one to move on through false constraints, securities, and imposed values to which one fearfully clings.” (Gendlin, 1973b, p. 342)

As we will see later (Ob.84, page 205), whilst generally under-expressed in the focusing-oriented community, the question of choice and investment remain crucial.

One practical matter is not mentioned by Gendlin and should be considered here – an explicit invitation to choice and action. Standard focusing responses include enquiries about what a felt sense wishes to express or what it may need (Leijssen, 1998a). An extension of this are enquiries designed to subtly open up a space for a carrying forward that may be sensed in the room but remains elusive. ‘What next step might be implied by all of this?’ ‘Where does this seem to be pointing?’ A therapist has an opportunity, perhaps even a duty to invite a client into their next step. ‘What action might be needed now to carry this forward?’ ‘What choice is almost made in this?’

Observation 54 - Therapist role 3 – Articulations - To attend to and invite articulations of carrying-forward in gestures, actions, values, flailing and experiences of self.

4.4.4 Living Toward

At a basic level the significance of the therapeutic relationship is warmly acknowledged so that focusing steps are recognised as an “*interactional process*.” (Gendlin, 1990, p. 213). Early on the relationship is a rare and precious commodity:

“Personality change is the difference made by your responses in carrying forward my concrete experiencing. To be myself I need your responses, to the extent to which my own responses fail to carry my feelings forward. At first, in these respects, I am ‘really myself’ only when I am with you.”
(Gendlin, 1964, p. 136)

The humanity of the therapist is perhaps very significant in the sense that, putting “*nothing in between*” (Gendlin, 1990, p. 206):

“Then I am just here, with my eyes, and there is this other being. If they happen to look into my eyes, they will see that I am just a shaky being. I have to tolerate that. They may not look. But if they do, they will see that. They will see the slightly shy, slightly withdrawing, insecure existence that I am, I have learnt that that is O.K.” (Gendlin, 1990, p. 205)

The therapist is therefore primarily important as a person:

“It is of little importance how good, wise, strong or healthy the therapist is or seems. What matters is that the therapist is another human person who responds, and every therapist can be confident that he can always be that. To be that, however, the therapist must be a person whose actual reactions are visible so that the client's experiencing can be carried further by them,

so the client can react to them. Only a responsive and real human can provide that.” (Gendlin, 1968, p. 221)

This reconstitution depends upon the life established between two persons, interactive not merely reactive:

“If my feeling is relevant to what we are now doing, I must respond from it. My reactions are part of our interaction. I owe it to the client to carry further that part of our interaction which is now occurring in me. If I don’t, we will both be stuck in that respect.” (Gendlin, 1968, p. 220)

Living-toward another (Ob.17, page 48) demonstrates a unique restorative process:

“One also wants to live with one’s patient in ways that are not felt, but would be, if the patient were lived with. Completion of life-enhancing action is implied in all pathology. The concept of reconstituting asserts the great power of either individual in an interaction. It holds that if one lives toward another so as to complete that person’s life-enhancing implications, these latter will then appear to have been implicit.” (Gendlin, 1973b, p. 336)

Observation 55 - Therapist role 4 – Living-toward – To respond as a human ‘other’ to shared implicit meaning with the client, ‘putting nothing between.’

4.5. Tasks and responses

In summary five client tasks are identified in focusing-oriented therapy:

1. Experiencing - To encounter the immediate felt sense through a shared pause (Abstand), that frames what is yet unclear and fragmented. (Ob.47)
2. 'Concrete Sentience' - To attend to a sense of the interaffecting in the whole situation, ecological and intersubjective. (Ob.48)
3. 'Being-with' - To stand as a human alongside senses of being-in-the-world, beginning to find ways to relate and the potential for habitation. (Ob.49)
4. Coming home – To permit the self to be recognised and 'received', finding value in the sense of self-in-situation. (Ob.50)
5. Inhabiting - To articulate experiential steps that arise in tangible choice and self-investment. (Ob.51)

Four therapist responses are identified in focusing-oriented therapy:

1. Creating a space - To facilitate a shared space where the client can relate to their immediate experiencing and be heard accurately (exactly though differently). (Ob.52)
2. Felt meaning - To offer a special attention to felt meanings, using self as a 'resonating chamber' for what may be present. (Ob.53)
3. Articulations - To attend to and invite articulations of carrying-forward in gestures, actions, values, flailing and experiences of self. (Ob.54)
4. Living-toward – To respond as a human 'other' to shared implicit meaning with the client, 'putting nothing between.' (Ob.55)

CHAPTER 5 – ADDICTION & RECOVERY

Addiction is a huge topic and a comprehensive survey of it is well beyond the scope of this thesis. Yet it is important to understand the nature of the field to see where a focusing-oriented view might fit.

A brief indication of the problems associated with completing paradigms regarding addiction was given in the first chapter (1.2.1, page 14). This chapter aims to broaden this perspective in four main parts. Firstly, dominant views of addiction and recovery are described and social/anthropological themes relating to these are set out. Secondly, views consistent with the Philosophy of the Implicit are explored, ending with three views which seem most in tune with this philosophy. Thirdly, existing views of the addiction from the focusing-oriented literature are summarised. Fourthly, having revisited resonances with focusing-oriented psychopathology (chapter 3) focusing-oriented views of both addiction and recovery are proposed.

5.1 Addiction theory and discourse

5.1.1 Competing paradigms of addiction theory

Reference has already been made to the strong divisions and many sub-divisions of thinking within the literature of addiction and the difficulties these would pose to integrating a focusing-oriented view (see 1.2.1, page 14). The vivid metaphor of “*holy wars between champions of diverse philosophical, scientific, and spiritual assumptions that underlie the conflicting theories*” (Alexander, 2010, p. 57) is matched by another writer who suggests that,

“Despite this long history of conceptual acrobatics, the complexities of drug-using behaviors continue to defy rigorous categorization under the heading of addiction-as-disease. ... In this sense, addiction-as-disease may

be a little like the Loch Ness Monster: the indigenous faithful swear they have seen it and know exactly what it looks like, but skeptical outsiders have only seen shadows of something for which they have no more compelling explanation available.” (Reinarman, 2005, pp. 312-313)

The standard conception of addiction as a personal affliction is also subject to serious critique from those who see good evidence of individuals exploited in a power field that such an understanding obscures. The presumption that ‘responsible consumption’ should be easily possible for any adult ignores the considerable industry designed to establish and profit from addictive patterns. A major authority on the subject recently argued that,

“addiction can be viewed as a form of disempowerment, even oppression. But, arguably, the most oppressive thing about it is the way in which those who become addicted and those closest to them are only dimly aware of how they are being exploited for others’ profit and how circumstances of disadvantage have conferred vulnerability on them.” (Orford, 2013, p. 215)

Thus, any focusing-oriented therapy view of addiction would need to respond not merely to a voluminous and conflicting literature, but to the passionate incompatibility of theoretical constructs used. Indeed there needs to be a sensitivity to the entrenched positions upon which such views are based, the ‘epistemic trajectories’ deployed (Raikhel & Garriott, 2013) and depend upon the way the concept has been moulded in a social context through a process of ‘historical ontology’ (Hacking, 2002). A way to transcend the incompatibility of worldviews or paradigms (Kuhn, 1970) is required. To me this may point to an advantage of an embodied enquiry beyond post-modern relativism and eclecticism.

5.1.2 Dominant views of addiction and recovery

Reference has been made before to Gendlin's fundamental critique of the 'unit model' that he sees as dominating scientific thought and is in many ways anathema to the interaffecting basis of the Philosophy of the Implicit (Ob.12, page 38). Leading views of addiction adopt this kind of orientation, largely looking at the behaviour of a person in isolation from their situation and emphasising physiological causes as the heart of the problem. This can be illustrated by a brief look at three internationally authoritative views of addiction from the USA – those of the American Psychiatric Association (APA), the American Society of Addiction Medicine and the National Institute on Drug Abuse:

Diagnostic and Statistical Manual

The APA's *Diagnostic and Statistical Manual*, which gives the most influential current definition of *Substance Dependence* (DSM IV - TR), includes two factors that distinguish physiological dependence (tolerance and withdrawal) from five other factors (APA, 2000):

- Increased use over time
- Inability to cut down use
- Preoccupation with obtaining/using/recovering
- Giving up of other activities in favour of use
- Continued use despite obvious harms

It is as if the physiological factors represent the core of the problem whilst other factors are amended over time. A diagnosis of *Physiological Dependence* requires either the tolerance or withdrawal criteria being satisfied. *Psychological Dependence* requires neither the tolerance or withdrawal criteria being satisfied. A further category of *Substance Abuse* (in DSM IV-TR) and would be satisfied by meeting one or more of four criteria concerning recurrent substance abuse:

- Failure to fulfil major role obligations
- Use in hazardous situations
- A recurrence of substance related legal problems
- Continuing use despite recurrent social or interpersonal problems exacerbated by it.

The guide indicates that both substance dependence and substance abuse cannot be satisfied at the same time (APA, 2000).

Consultation has been going on for some time about a new edition of the *Manual* (DSM V) and this is due for release during 2013. This is reported to combine the categories of 'dependence' and 'abuse' into a single disorder, but divided by type of substance e.g. 'alcohol use disorder,' 'stimulant use disorder' etc. Law enforcement elements have been removed from a list of eleven symptoms and craving added (APA, 2013).

So this continues the mixture of criteria used for the definition of this psychiatric disorder, combining the apparently physiological elements of withdrawal and craving with social and legal considerations. Whilst the new proposals apparently aim to clarify and tighten the criteria they demonstrate clearly a behavioural perspective of an individual abstracted from his or her environment

Brain disease and its detractors

A distinctive view is provided by the American Society of Addiction Medicine whose short definition makes it plain that it is a problem of brain circuitry with individual and social consequences:

"Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or

relief by substance use and other behaviors.” (American Society of Addiction Medicine, 2011, p. 1)

This position is the result of a substantial period of research and political influence by the American National Institute on Drug Abuse (NIDA) who have positioned addiction in the medical field of brain science (National Institute on Drug Abuse, 2008). The concept of a chronically recurring brain illness (Leshner, 1997) claims to establish “*a unified framework for a problem-based field in conceptual disarray*” (Campbell, 2007, p. 200), despite pressures among key stakeholders - police, medicine, social science and politicians. Courtwright observes the unresolved tensions:

“Another way to say this is that both social scientists and neuroscientists still live in their own gated academic communities, that they engage in vigorous boundary maintenance, and that they champion their own disciplinary and sub-disciplinary master variables. There is a lot more at stake in the brain disease debate than our understanding of addiction. At bottom, it is really a high-stakes argument about how we ought to understand human behavior, motivation and pleasure - and about what policies we should adopt to regulate it.” (Courtwright, 2010, p. 144)

He concludes his analysis by comparing the NIDA research process to that of NASA which has used scientific spinoffs to justify very expensive programmes that otherwise fail to meet major objectives:

“Although it is too soon to pronounce judgment, it seems possible that NIDA’s own brain disease research will follow a similar trajectory. That is, it can fail in its central political objective - the medicalization of a treatable disease - and yet still succeed in winning scientific converts and sparking innovations in other fields. It would not, after all, be the first time that policy and science went their separate ways.” (Courtwright, 2010, p. 144)

More critical voices observe the way that concepts like 'addiction as a disease' have been reworked over time, but

"not in the direction of greater focus and precision as is typically the case with other diseases." (Reinarman, 2005, p. 311)

This leaves open the question of how much 'ontological gerrymandering' (Woolgar & Pawluch, 1985) is really involved, so as to generate understandings that serve powerful interests. In simple terms there would seem to be room for some way to transcend the incompatibility of paradigms that are evident in this discipline.

A pragmatic view

A recent book by a leading authority provides three simple tenets that explain the process of addiction, spanning the spheres of biology, behaviour and environment and also distinguishing the attractions of immediacy from entrenched compulsions:

- *"Those objects of consumption which have the greatest addiction potential are those which have the capacity to bring about a rapid, rewarding change in a person's mood – using that word in a broad sense to mean 'state of mind or feeling.' They generally come in appetising 'pieces' (pints, fixes, bets) and the act of consumption can be repeated, with suitable 'rests', often and almost endlessly.*
- *They therefore possess the capacity to create, under the right circumstances, habits of consumption which are strong and not easy to break. Addiction is essentially a disorder of habit.*
- *Such habits change over time. Unless checked they entrain processes which serve to amplify and change the habit, rendering it yet more harmful and difficult to curtail."* (Orford, 2013, p. 41, my emphasis)

This characterisation usefully describes the distinctive quality of certain substances and processes in a way that can still relate to a human context.

Choosing direction

It is not surprising that Orford provides this summary within a broader enterprise. He argues that the individual perspective of this affliction needs to be seen in the context of power and powerlessness. His work seems to illustrate an implicit direction that this study is taking that needs to be openly stated and acknowledged.

Like Orford I acknowledge the significance of leading approaches to the subject that emphasise well established physiological, neurological, and behavioural characteristics. Orford's tenets above seem to sum up for me well the wisdom of them. Yet my practical experience suggests the advantages of other perspectives too. Gendlin's philosophy and therapy offer understandings of humanity and its afflictions that work from different presumptions to the 'unit model' and can be shown to have validity. They inspire me to stand aside from the medical definitions of addiction and brain disease interpretations and see how far a focusing-oriented view might go.

The choice of this study is to work from this perspective, retaining a respect for other views, drawing on them in the process. Developing an understanding of addiction as an expression of being-in-the-world I largely choose not to dwell upon chemical, neurological or other understandings. This is a pragmatic way forward for this study and should not be taken as a misguided argument to refute all other interpretations.

Observation 56 – Current views of addiction reflect competing theoretical paradigms with the dominant 'brain disease' perspective operating from a 'unit model' view of psychology. Ways are needed to transcend the

incompatibility of paradigms that may be involved. This study chooses to adopt an experiential orientation, drawing on other perspectives as appropriate.

5.1.3 Discourses of addiction and recovery

Before looking further at models of addiction that attune with the Philosophy of the Implicit it is valuable to observe the significant philosophical, cultural and ideological presumptions that are caught up in the concepts of addiction and recovery from it.

Addiction as a cultural tool

Addiction as currently understood is a modern invention, the first recorded use of 'addict' as a noun dating from 1909 (Brodie & Redfield, 2002). It encapsulates a theory of social order based on individual inhibition that became popular in middle class circles (Levine, 1983) in response to the pressures of the Industrial Revolution in Britain (McCormick, 1969) and in America, the rise of western capitalism (Valverde, 1998). It distinguishes and supports a particular ideology of individual responsibility and freedom to match the evolving roles of producer and consumer in a mass market:

"In the history of power relations in liberal and democratic regimes, the government of others has always been linked to certain ways in which 'free' individuals are enjoined to govern themselves as subjects simultaneously of liberty and of responsibility - prudence, sobriety, steadfastness, adjustment, self-fulfilment, and the like." (Rose, 1996, p. 12)

Consequently, the freedom of subjects within such a system is a precious necessity:

"Subjects are obliged to be 'free', to construe their existence as the outcome of choices that they make among the plurality of alternatives. ...

And for those selves unable to conform to the obligations of the free subject, unable to choose or anguished by the choices they have made, dynamic and social therapies offer technologies of reformation ...” (Rose, 1996, pp. 78-79 emphasis original)

The discourse of addiction provides a rich cultural resource, supporting the dominant mode of economic activity, denigrating those who cannot or do not play a valid part in it and explaining away dysfunctions of the social structure as failures of individuals and their morals. Reith sums it up well:

“Ironically, it is this intense valuation placed on freedom that sows the seeds for its undermining. The promotion of the ideology of consumer sovereignty – as a subjective state, as well as a mode of governance – is the fertile soil out of which the shoots of ever more ‘addictions’ grow. This, then, is the fetishism of addiction – an apparently individual pathology that disguises the deep tensions that arise from the ambivalence of freedom as a form of control.” (Reith, 2004, p. 298)

The apparently individual affliction of addiction therefore has a social utility. Its ideological and cultural significance is amply illustrated by the increasing categories of everyday human living that can stray into proscription - eating chocolate and shopping (Bailey, 2005), playing computer games (Cover, 2006), physical exercise (Cole, 1998), even falling in love (Earp et al., 2013):

“What is startling is the rapidity with which it has now become a commonplace that, precisely, any substance, any behavior, even any affect may be pathologized as addictive. Addiction, under this definition, resides only in the structure of a will that is always somehow insufficiently free, a choice whose volition is insufficiently pure.” (Sedgwick, 1992, p. 584)

The treatment of addiction thus needs to be sensitive to its cultural role, a discourse which bolsters a dominant view of correct living by pathologizing areas

of deviance in very individualistic terms. In cultures that see consumption as a form of identity (Du Gay, 1996) addiction is its obverse (Reith, 2004) and perhaps a distraction from fundamental dysfunctions:.

“This type of categorization both de-contextualises behavioural patterns and has an overall disempowering and dehumanising effect in terms of denying the user any kind of independent agency, while simultaneously diverting attention away from the larger social forces which influence drug taking trends” (Åslid, 2007, p. iv).

Observation 57 – The discourse of addiction highlights the significance of consumption in contemporary experiences of identity and may obscure social tensions around freedom and choice. Disregarding other common compulsions, it tends to proscribe deviant consumption where the role or self-regulating producer/consumer is compromised.

Addiction as a splitting

The discourse of addiction has a distinctive role at a personal and societal level – to split legitimate living from the illegitimate, providing a degree of security to the former by stigmatising the latter. This works through a strong perceptual distinction between the two categories (Klein, 1988) and in addiction is frequently associated with a deterministic view of biological dependence, even though scientific investigation shows this division is anything but clear (Davies, 1997). Splitting ghettoizes individuals and groups within society and at a personal level it reifies and projects so that repugnant living becomes the responsibility of a shadow persona – the drunk or druggie self. The concept of ‘others inside’ has been usefully coined to represent this combination of cultural and personal estrangement:

“In contemporary publicly funded treatment systems, the others inside people, understood and managed as insanities and addictions, are uniformly construed as profoundly mysterious nonhuman agents that exert their influences in a staggering variety of ways, but always so as to strain the tenability of sufferers' membership within their respective local, state, and national communities.” (Weinberg, 2005, p. 92)

Social split

The social split is observed by Derrida (1995) who remarks upon the term's inherent rejection - 'ad-diction.' Whilst one may speak positively of compulsive activity, for example a saint's zeal for holiness (Alexander, 2010) or reader's passion for literature (Cover, 2006), it would be inappropriate to speak unambiguously of a 'positive' addiction. An inherent interdiction exists to bolster up the fundamental values of society, proscribing those who step outside the self-determination expected of all citizens.

As with other social patterns of practice that 'scapegoat' some members of a social group to retain the purity of the majority (Douglas, 1984), so "*those mechanisms deployed to 'fix' the deviant simultaneously stabilize the norm*" (Cole, 1998, p. 267). This is evident in the counselling of a methadone treatment programme where the moral status of an 'abject other,' can underlie well-intentioned therapy:

“Thus, in the very process of abjection, the counsellor also (re)constitutes herself as a subject, and is subordinated to a social and symbolic order in which 'the junkie' (and numerous others) are 'abject.' The fear or threat associated with those constructed as 'dangerous' others, thus, is fundamentally related to our own becoming and being a subject.”

(Bergschmidt, 2004, p. 69)

Historical studies of the concept of addiction also point to the use of the term to distinguish between acceptable overindulgences of the middle classes compared with the intolerable excesses of the poor and ethnically marginalised (Weinberg, 2005).

Orford usefully explains the multiple power relations inherent in addiction and discerns five discourses that support the status quo and enhance the position of those who benefit from addictions through increasing liberalisation. The first three imply that activities inducing addiction are no more than harmless leisure pursuits, provided through legitimate businesses that contribute to the nation's economic capital. The last two discourses imply that,

“Citizens should be free to choose how to use their leisure time, including being free to drink or gamble as they wish.

Consumers have a responsibility to protect their own health and well-being and that of others close to them, by drinking sensibly or gambling responsibly.” (Orford, 2013, pp. 154-155)

These portrayals of freedom of choice and personal responsibility serve to obscure the insidious social impact of addictive substances and activities. Producers are largely absolved from ethical considerations and these are loaded onto the consumer. Problem behaviour is attributed to a marginal group of 'irresponsible' people (e.g. 'binge drinkers') and the discourse seeks to obscure less palatable facts, such as those portrayed in an American Medical Association comment:

“The individuals the [alcohol] industry seeks to blame for problems with its products are also their best customers, and the industry’s marketing budgets, which dwarf its expenditures on educational programs, are tailored to reinforce and encourage heavy drinking behaviour.” (AMA 2002, pp. 8-9, cited by Singer, 2008, p. 103)

In summary, what may often be described in medical and behavioural terms as the dysfunctions of an individual can also bear an equally significant social and moral burden.

Observation 58 – The discourse of addiction appears to stabilize norms

by regulating social inclusion. It increases the marginalization of some groups and protects the position of others by providing a means to both explain and distance aberrant behaviour. For some groups, recovery may consequently involve overcoming inherent social exclusion.

Recovery in these terms is constrained to imply the capability to exercise a particular kind of agency through ‘free’ choice in a socially acceptable manner.

Personal split

The personal utility of this split, is observable in the way that individuals use the ‘otherness’ of addiction to understand and manage themselves. People often start to express themselves as addicted particularly in *retrospective* explanations of apparently irresponsible behaviour, e.g. facing financial problems from gambling debts (Oldman, 1978) or a moral censure of drug use (Orford, 1985). Invoking the split allows a person distance from responsibility and censure. This kind of function was observed in the ‘otherness’ of neurosis by Carl Rogers. With slight adjustment, his words could equally refer to addiction:

“My life would be noteworthy”, says the neurotic, ‘were it not for the fact that my neurosis prevents me and excuses me from attempting to live it”
(Rogers, 1942, p. 283, my emphasis).

Such ability to stand apart from a sense of personal agency, allocating responsibility elsewhere is observed in a variety of modern processes of ‘decentering the human subject’ (Hacking, 1995). Individuals can feel themselves

compelled into behaviour which they may not usually condone, always through means beyond their comprehension. This is something that has been characterised as a kind of “*secular possession*” (Room, 2004, p. 230) or fetishization, whereby objects appear to assume the potency of personal and social reality. As we will explore later (Ob.63, page 152), the utility and precision of such a distinction is observed in some drug rehabilitation programmes, particularly where social inclusion is at stake:

“It was only insofar as program members learned to distinguish behaviors caused by insanities and addictions from those authored by sufferers themselves that insanities and addictions could take form as discrete others inside people rather than rendering them completely other and beyond the pale of moral community.” (Weinberg, 2005, pp. 27-28)

Without underestimating the physiological dependencies induced by certain chemicals, it is valuable to see the problematic agency of addiction within the broader context of other deniable behaviours. Bateson sees being problematically wilful as,

“an unusually disastrous variant of the Cartesian dualism, the division between Mind and Matter, or, in this case, between conscious will, or ‘self’ and the remainder of the personality.” (Bateson, 1972, p. 313)

Davies (1997) describes it as a kind of ‘learned helplessness’ that parallels other social techniques of evasion and obfuscation. For example it can be compared with the divisions between an ‘apparently normal person’ and a problematic one observed in those coping from shell shock (Steele et al., 2005). In very different terms, humour provides a parallel discourse that enables taboos to be addressed and failures shrugged off within the safety of deniability (Kane et al., 1977).

Understanding such social and personal splitting has given me sensitivity to address personal dislocation as part of therapy and confidence in relating to

different 'parts' of those dealing with addiction. To use a metaphor from literature, connection is to be made not just with Dr Jekyll but also Mr. Hyde (Cooper, 1999). This is explored further below (Ob.63, page 152).

Observation 59 - The discourse of addiction uses disease and other explanations to project responsibility for aberrant behaviour onto the non-human agency of 'others inside.' Consequential self-alienation is managed through socially negotiated attributions. Recovery in these terms implies the discovery of viable senses of self that do not depend upon such divisions.

'Recovery' as a common but unclear notion

The term 'recovery' is used extensively in the drug and alcohol field to indicate the process of release from an addictive behaviours and later I will use it in descriptions of focusing-oriented therapy. It has a ready, frequently emotional connotation among those who have undergone addiction treatment and can lead to a warm fellow feeling. The term has also been appropriated by governments and treatment organisations and it is useful to understand the issues that may surround its use.

From the perspective of the current government it represents a re-assertion of the idea of abstinence as a goal of treatment. The previous UK Drug Strategy (Home Office, 2008) allowed for a period of prescribed medication (e.g. methadone or Subutex) to be offered as part of treatment, anticipating that over time it would assist clients to become free of all substances. However such 'scripts' may often endure for many years, perhaps achieving crime reduction objectives at the expense of personal change (White, 1996). Such strategies have also been criticised as having the "*cosmic solecism of treating those addicted to psychoactive drugs with more psychoactive drugs*" (Self, 2013, p. 3).

In December 2010 the coalition government suggested an alternative strategy:

“We will create a recovery system that focuses not only on getting people into treatment and meeting process-driven targets, but getting them into full recovery and off drugs and alcohol for good. ... Recovery involves three overarching principles – wellbeing, citizenship, and freedom from dependence.” (Home Office, 2010, p. 18, my emphasis)

However, despite the rhetoric, the new strategy does not drive for abstinence in the way that ministers may have desired. As the Guardian observed, allowing the ‘recovery’ to include maintenance regimes:

“Plans for an ‘abstinence-based’ drug strategy and to cut benefits for problem drug users who refused treatment, which were championed by Iain Duncan Smith and the Tory right, have been shelved. The coalition’s first official drug strategy, published today, includes plans to pay drug treatment providers ‘by results,’ but it acknowledges the difficulties of treating chronic users by talking of ‘recovery’ rather than abstinence.”

(Travis, 2010)

Ambiguities between the aspiration of abstinence and the pragmatism of maintenance treatments illustrate a government coping with the complex reality of addiction. A society where compulsive behaviour is common, and in many modes of consumption is actively encouraged, will have difficulty drawing lines between the problem and its resolution. This ambiguity is evident in the idea of recovery being a life-long process (including periods of lapse) and debates about the status of ‘less harmful’ drugs like cannabis and the status of ‘legal highs.’ (Nutt, 2012) Some caught up in addiction will take a hard line and see abstinence the only sustainable resolution. Others want to plot a path for their own life that may encompass occasional use or the use of less harmful substances.

I am struck by the existential quality of personal accounts of recovery. Whilst a moral rhetoric may be adopted, individuals are speaking of the struggle to grasp and sustain a whole life, a viable way of being-in-the-world. Such a broader view, starting to allow flexibility about when and how abstinence is used has been increasingly championed in the recovery community. This is evident in two recent definitions of recovery - the first from an influential consensus group in Britain, the second attempting to span both addiction and mental illness:

“The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.” (UK Drug Policy Commission Recovery Consensus Group, 2008, p. 6)

“Recovery refers to the ways in which persons with or impacted by a mental illness and/or addiction experience and actively manage the disorders and their residual effects in the process of reclaiming full, meaningful lives in the community.” (Davidson & White, 2007, p. 113)

Ambiguities about recovery can prompt treatment agencies to work according to their own recovery agenda, seeking to recruit users to it and sometimes tending to impose limited and surface compliance. A recent study (Carr, 2010) demonstrates how disempowered clients play back to an agency the discourse that is expected, performing linguistically and practically so that crucial personal needs (e.g. retaining custody of a child) are met.

Recovery is therefore both a highly personal issue for those engaged in it and an ideologically driven concept. Focusing-oriented therapy looks to the existential meaning which each client defines for themselves.

Observation 60 - 'Recovery' is a widely accepted term used for the process of release from addiction, but there are tensions over interpretation, particularly regarding the place of abstinence. Nevertheless, it can have a profound existential meaning for those engaged in it – representing the personal recovery of a whole life.

Later in this chapter a focusing-oriented view of recovery will begin to be formed.

5.2 Views consistent with the Philosophy of the Implicit

The second part of this chapter will illustrate views of addiction and recovery that resonate with focusing-oriented psychopathology (chapter 3). Unfortunately there is only space here to illustrate major trends, rather than to do them justice. I will use the fourfold structure previously employed, beginning each section with a short summary of previous conclusions. At the end the question of transcending paradigms will be explored.

5.2.1 Experience and Existence

Focusing-oriented psychopathology identified issues of experiencing as frequently significant in human dysfunctions. Problems can arise from a 'stopped process' (Ob.30, page 72), or 'frozen whole' (Ob.31, page 74), producing rigid and repetitive attempts to live without the experiential essence that makes life possible.

This perspective resonates with the substantial literature in the addictions field that links it with difficulties in expressing and tolerating emotions and the phenomenon of alexithymia (e.g. Kauhanen et al., 1992). The psychodynamic tradition suggests that the distress and suffering of addiction and alcoholism is:

"closely linked with the complex ways in which individuals with these problems experience, tolerate, and express their feelings, or affects. They

seem to suffer in extremes, either feeling too much or feeling too little.”

(Khantzian, 1999, pp. 49-50)

This leads to a substantial view, that anecdotally seems to be shared by many practitioners, that much excessive drug and alcohol use is self-medication and is supported by research evidence (Khantzian, 1999). In similar vein we are told that “*Drug use ... is pharmacologically induced denial of affect*” (Wurmser, 1984, p. 44) and alcohol is used as a “*chemical lobotomy*” (Laing, 1971, p. 101).

Yet, ideas of denial in addiction can seem to have both existential and moral overtones. Observations that “*client denial distinguishes addiction*” (Rasmussen, 2000, p. 114), or that addiction is itself a “*disease of denial*” (Paolino, 1991, p. 219) may be more a moral censure rather than existential observation. This view is also reflected in a critique of the socially constructed view of the affliction:

“The heuristics of addicted denial and sober insight are both so central to American addiction therapeutics and so firmly rooted in cultural ideologies of language that one can hardly imagine an alternative.” (Carr, 2013, p. 174)

Such indications provides a salutary reminder to look for the basis of experiential avoidance rather than rush to judge its moral inadequacy. For example the evidence of trauma among substance abusers is high (Druley et al., 1987). Nevertheless there is adequate academic and practical corroboration to suggest that experiential/existential avoidance, ‘process-skipping’, remains significant in many addictions.

Observation 61 - Experiential avoidance is widely recognised as a major factor in addiction, seen both as a cause and result of its effects. Recovery consequently implies the ability to engage with experiencing.

5.2.2 Interaction and Encounter

Focusing-oriented psychopathology (chapter 3) identified issues of interpersonal and ecological disconnection as crucial (Ob.33, page 80). In interpersonal terms a close link is frequently made between addiction and attachment disorders, so that addiction is,

"the result of unmet developmental needs, which leaves certain individuals with an injured, enfeebled, uncohesive or fragmented self. ... Since painful, rejecting and shaming relationships are the cause of their deficits in self, they cannot turn to others to get what they need or have never received."

(Flores, 2004, p. 83)

In ecological terms the famous study of opiate use among enlisted US soldiers in Vietnam (Robins, 1974) showed how contingent drug use can be upon environmental factors. A significant proportion (45%) of those returning home in 1971 were opiate users with one fifth of these recorded as physiological dependence. The study was surprised to find that upon returning home most stopped using drugs, with only 2% continuing drug use thereafter. Whilst many factors might be considered important here, it would be hard not to observe that environmental factors have significance in the framing and sustenance of serious drug addiction (Robins & Slobodyan, 2003).

Whilst there is no room here to review the literature of addictive aetiology, there are solid grounds to point to a correlation between interactional breakdown and addictions.

Observation 62 - Relationship difficulties and attachment disorders are recognised as frequently significant in addictive behaviour. Addiction has been observed both to be a response to particular environments and strongly influenced by them. Personal change from addictive

behaviour may thus imply both interpersonal and environmental change and reconnection.

5.2.3 Focaling and Value

Focusing-oriented psychopathology (chapter 3) recognised an ambivalence within pathological behaviours, showing how stopped processes still demonstrated a life forward tendency (Ob.34, page 82) and that the apparently dysfunctional activity evident in defence (Ob.35, page 84) and flailing (Ob.36, page 87) both had positive origins. This kind of view is substantiated in detailed work to understand how the discourse of 'others inside' (Ob.59, page 145) was used in drug treatment programmes for comorbid clients, i.e. those with both addictive and mental health difficulties (Weinberg, 2005).

Detailed observations showed a precision and subtlety and 'social negotiation' used by participants when describing their own behaviour and that of their fellows. When called to account for a wrongdoing, both participants and staff could choose either to invoke a discourse that would attribute wrongdoing to the addiction (the 'other inside') or to the agency of the person him or herself. It demonstrates that "*the empirical forms taken by insanities and addictions are always thoroughly affected by social history and socially situated human activity*" (Weinberg, 2005, p. 127). The study concludes that,

"the boundaries between those personal behaviors for which residents were held responsible and those that were attributed to others inside them were not decided on the basis of an ethically, ontologically, or otherwise fixed dichotomy between 'the human' and 'the nonhuman.' Instead, they were perpetually negotiated in and through the conduct of routine program practice." (Weinberg, 2005, pp. 140-141)

The authors consider this behaviour to demonstrate a contextualised understanding of meaning and do not see in it the grounds for joining with those

who debunk the phenomena of addiction as merely a social illusion (e.g. Szasz, 1972). What this demonstrates is the experiential mixture of personal and socially constructed meaning in addictive behaviour and its potent mixture of agency and dis-agency in the choice and use of discourses.

Observation 63 - The discourse of 'others inside' is observed to be a significant way that those with addictive behaviours manage their immediate living and, through social negotiation, effect change. Recovery implies the ability to transcend a discourse which divides self and agency.

5.2.4 Carrying forward and Authenticity

The Philosophy of the Implicit (chapter 2) suggested that carrying forward arises from a new responsiveness between person and the mesh of their environment (Ob.24, page 60) and Focusing-oriented Psychopathology (chapter 3) showed it occurring as a person is able to relate to their immediate living outside the structure bound patterns (Ob.39, page 93).

Parallels to this approach are paradoxically illustrated in studies of how people move on from addiction without the intervention of professional treatment. Findings reported by Harvard Medical School (1995) suggest that 80% of all alcohol-dependent persons who recover for a year or more do so on their own. Names like 'natural recovery,' 'spontaneous recovery,' 'spontaneous remission,' 'maturing out' are applied to processes that combine 'avoidance-oriented' and 'approach-oriented' factors (Walters, 2000).

On the avoidant side are the 'pushes' from negative consequences of a drug or alcohol habit including the notorious 'rock bottom' of the twelve step tradition. The 'pulls' of approach-oriented reasons can be significant, helping individuals to 'drift out' of misuse in order to invest more in conventional life (White & Cloud, 2008). A three stage model starts with finding good reasons to quit, making public

pronouncements of resolve and in the third phase developing assets to support and making greater connections and investment outside the substance using world (Stall & Biernacki, 1986).

Gradually the perspective of research has shifted from the investigation of factors that influence termination of substance abuse to the broader social context in which a change occurs. Bourdieu's social science concept of social capital starts to be recognized as significant, defined as:

“the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition.”

(Bourdieu & Wacquant, 1992)

From this perspective a 'community-reinforcement approach' (Hunt & Azrin, 1973) and latterly the concept of 'recovery capital' have been developed. Recovery capital is,

“... the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe alcohol and other drug problems” (White & Cloud, 2008, p. 22)

The concept of recovery capital has led to particular screening activities and aggressive programmes of community outreach. Early assessment of a client's recovery capital can usefully help shape a recovery intervention to meet and support inherent capability and resourcefulness.

Observation 64 - Studies of 'spontaneous recovery' and 'recovery capital' highlight the importance of environmental connections in finding release from addiction and illustrate the significance of spontaneous personal change.

This brief review of the addiction literature has demonstrated that the key elements of a focusing-oriented perspective are paralleled in addiction research and practice. I recognise that I do not have the depth of expertise in addiction literature to develop a complete argument to indicate the focusing-oriented place in this field.

5.2.5 Overcoming paradigm incompatibilities

We observed earlier that there is a need to transcend the paradigm-related incompatibilities of the addictions field (Ob.56, page 137). This section will illustrate three contemporary strands of thinking that may offer this possibility. At the end I suggest that the Philosophy of the Implicit may have a value in these terms.

A multi-factor approach

A fruitful way forward is to consider the various explanations of addiction not as completing aetiologies, but as potential elements of a complex system. An example might be Moss and Dyer's (2010) model which identifies a 'dual systems process' in human life (a conscious effortful process and a habitual, automatic one) and kinds of factors that act upon this – biological, psycho-behavioural and socio-environmental. This has many parallels with other multi-factor models like the 'biopsychosocial' model (Marlatt et al., 1988) and the 'complex systems' view (Larkin & Griffiths, 1998).

Effectively these approaches, whilst operating from a 'unit model' scientific paradigm, are attesting to the complex mesh of interaffecting that is the heart of a focusing-oriented, existential understanding of reality and particularly addiction. An application of the philosophy of Gilles Deleuze to addiction illustrates the value of such a 'bio-psycho-socio-cultural' perspective that can,

"understand life in terms of interactions between things. Alcohol and other drugs not only cause changes in the brain and physiological organisms, but

also involve complex settings that form assemblages. Instead of alcoholics, for example, we have different alcohol assemblages that affect bodies and biopsychosociocultural realities ...

We lack the understanding that addictions and other mental problems relate to the social settings in people's lives. ... people do not live in a laboratory and there are ways to affect brain activity by changing habits, routines and procedures in everyday life." (Oksanen, 2013, p. 65)

Such a position opens up the possibility of a view which is respectful of the scientific foundations of addiction research yet is also open to understandings of the fundamental interaffecting of persons and reality.

Observation 65 - A 'bio-psycho-socio-cultural' perspective identifies the multiple physical, social and human factors that are expressed in addictive behaviour and suggests it is a way of responding to challenges of living.

A 'dislocation' view

A systematic response to this kind of analysis is provided by Alexander (2010) who sets out a Dislocation Theory of Addiction dependent upon three principles:

- Psycho-social integration is a necessity for individuals and society. People need to belong to develop identity and meaning and the lack of such belonging is fundamentally destructive.
- Globalising free-market society undermines psycho-social integration. Free markets depend upon an individualistic and unencumbered orientation of individuals and incorporates processes that disrupt psychosocial integration.
- Addiction is a way of adapting to sustained dislocation. In this view it,

“is neither a disease nor a moral failure, but a narrowly focused lifestyle that functions as a meagre substitute for people who desperately lack psychosocial integration.” (ibid. p. 62)

In these terms dislocation is a necessary but not sufficient cause of addiction.

Whilst conventional wisdom explains addiction in maladaptive terms, pointing to malign hidden causes, dislocation as predicament of living demonstrates an adaptive intention and effect. Addiction is one kind of existential response identified to ‘get by’ with dislocation. This theory predicts:

- (i) *“The individuals who are the most dislocated within any society, no matter what the cause, will be the most prone to addictions;*
- (ii) *Addicted individuals within any society will be using addiction as a functional way of adapting to their dislocation, either consciously or unconsciously; and*
- (iii) *Individuals should be able to overcome their addictions if their psychosocial integration is restored.” (ibid. p. 153)*

This systematic analysis provides a valuable exposition of the place of addictive behaviour as a response to the whole experience of being-in-the-world. It again underlines the significance of seeing addictive activity as part of a broader pattern of living for an individual, one including much striving and struggling, perhaps tackling issues that are ultimately beyond individual resolution. In these terms individuals are to be accorded credit for attempting to behave adaptively, whatever the actual consequences.

Observation 66 - Addiction can be demonstrated as a partially adaptive response to the existential issue of dislocation that arises in free-market societies. In these terms recovery may inevitably represent an incomplete individual

solution to enduring dysfunctions in the social structure of life.

A 'post-humanist' view

A recent study reviewed the fundamental divisions in science between biomedical and social explanations of addiction, concluding that there has never been a successful meeting or adequate explanation for the core issue of loss of control (Weinberg, 2013). The author proposes a view based upon the idea that human nature is,

"dynamically and diversely constituted through different configurations of practice within which actors, human or otherwise, mutually shape one another." (ibid. p. 177)

Thus a person (a 'situationally created multiplicity') interacts with an environment, inhabiting it by finding means of its own articulation, being affected in the process and learning to be affected:

"Addictions take form as bodily articulations – that is, learned embodied sensibilities and felicities that tend to bind us to the worlds within which they are acquired and can be availed." (ibid. p. 179)

Such binding,

"entails the development of embodied tastes and talents for myriad aspects of the worlds in which drug use figures, of tacitly learning literally to inhabit them or engage and be engaged by them. ... Neither felicitous and performance-enhancing nor distressing and performance-debilitating drug use can be adequately understood in artificial isolation from the specific practical and relational contexts within which pleasure and pain, personal ease and dis-ease, competent and incompetent performance, receive their genuine measure." (ibid. p. 179)

Consequently,

“the sense of a loss of self-control is heavily informed not only by the dyadic biological relationship between user and drug but by the wider and more various constellations of practical and relational contexts one has come to inhabit and within which one feels compelled to live.” (ibid. p. 179)

Such an embodied, interacting and developing view of addiction resonates strongly with the Philosophy of the Implicit and will influence the conclusions drawn.

Observation 67 - A ‘post-humanist’ view sees the compulsive behaviour of addiction as a form of somatic articulation in response to wider ‘practical and relational contexts’ of living.

The implicit transcends paradigms?

At the start of this chapter reference was made to the variety of competing theoretical paradigms in the field of addiction. The need was identified to transcend the incompatibility of worldviews to bring together an integrated view of the issue (Ob.56, page 137). In these terms addiction might be used as a rich example of unresolved tensions between objective, rationalistic conceptions of humanity and relativistic and subjectivist understandings, inevitably tied up with the Cartesian/post-Cartesian divide.

Previously I noted Gendlin’s desire to challenge the divided perspectives of the ‘unit model’ (Ob.12, page 38) and his assertion of an implicit experience of meaning underlying symbolizations (Ob.13, page 40). His philosophical explorations began with an undergraduate ability to speak the ‘languages’ of different paradigms based upon the implicit felt sense (2.1.2, page 38).

Three models are set out in this section. The first offers an integrative ‘bio-psycho-socio-cultural’ perspective yet acknowledges our inability to relate human living to models of neurotransmitter activity (Ob.65, page 155). The other two see addiction as a response of interaffecting in the broader contexts of life – a way of coping with social dislocation (Ob.66, page 156), a form of somatic articulation (Ob.67, page 158).

Perhaps it is not too fanciful to suggest that these three attempts to transcend the entrenched divisions in addiction thinking are pointing to the inherent meaningful connection that exists at the level of the implicit. Further, Gendlin’s reticence about the ‘truth’ of explicit theories and the validity of asserted psychological ‘contents’ seems to be borne out.

Observation 68 - The Philosophy of the Implicit may offer a way to transcend divisions of understanding in addiction theory by reference to the interconnected richness of implicit meaning.

5.3 Existing focusing-oriented views

The third part of this chapter brings together existing focusing-oriented views of addiction and its treatment using the structure deployed in previous chapters. A summary is provided for each heading. It begins with Gendlin himself.

5.3.1 Gendlin’s Reference

To my knowledge there is only one reference to addiction in Gendlin’s extensive writings:

“Now we see that the body implies not just more, but a right next step. This kind of ‘right’ does relate to the ethical kind, but in a complicated way. The body can also become addicted which uses but subverts its right next-step implying. There is also a direct sense of error, of unsoundness. There are

many other complications which are very much worth studying because knowing those lets us more effectively use the body's right next-step implying." (Gendlin, 1993a, p. 30, my emphasis)

This tantalisingly appears to recognise the significance of addiction, but to describe it in almost an everyday manner, as a compulsion which just happens. Without further explicit references from Gendlin, it is necessary to look to other focusing-oriented writers for a view.

5.3.2 Experience and Existence

This section will look at the dominant, experientially based term for addiction in the focusing-oriented world and see how it is expressed in spiritual terms, as reflecting both an upward and downward spiral and as a key to respond to addiction related to trauma.

Process-skipping - Turned off experiencing

The most distinctive expression of addiction theory in explicit terms within the focusing-oriented community surrounds the idea of process-skipping originally set out in Gendlin's *A Theory of Personality Change*:

"In the structure-bound manner the experiencing process is, in given respects, missing. By 'missing' we mean that from an external viewpoint we may notice that the implicit functioning of experiencing ought to be there, but there is only the process-skipping structure, and the experiencing surrounding it and leading up to it. Thus we say that structure-bound aspects are not in process."

(Gendlin, 1964, p. 129)

"However, to the extent to which we respond to our own feeling so as to skip or stop the process rather than carry it forward, to that extent we need others to help us be ourselves." (Gendlin, 1964, p. 135)

This idea is taken up by Campbell and McMahon who approach process-skipping and addiction from the perspective of Christian spirituality. They see a lot of people in society avoiding difficult feelings and trying to escape or numb them:

“That’s what process-skipping is all about. It’s the way we bounce off, skip away from, and try to control uncomfortable feelings that are actually our very best doorway into our felt senses. This troublesome experience is precisely where the potential for inner growth and change lie waiting to surprise us.”

“Psychological addiction involves a ‘substitution’ of one behavior, feeling, or attitude in place of another, rather than becoming congruent with and ‘processing’ what is real, thereby allowing it to unfold and tell its story so the body-feel of it can be carried in a different way.” (Campbell, 2011, no pages)

Another book takes an even more spiritual view of addiction:

“By addiction, here in this context, we mean the use of any action, person, group or thing as a substitute for growing into a more truthful relationship within myself, with the world around me and within God.” (McMahon & Campbell, 2010, p. 181)

Campbell’s description of tensions with his mother illustrate this broader sense of addiction:

“Quite literally, I became addicted to visiting mother as a way of numbing and therefore controlling the feeling of guilt. I substituted this distracting activity in place of entering into and through my feelings into my body’s felt-sense of it all, thereby failing to dispose and open myself to receive the untold story hiding beneath the feelings.” (McMahon & Campbell, 2010, p. 182)

Growth toward wholeness

A short but clear summary of how change happens involving addiction is provided by Ann Marie Wyrsc (2010), following in the tradition of McMahon and Campbell. This contrasts an operational definition of a growth cycle (Awareness → Acceptance → Allowing → Action → Live Consciously and Choicefully) with one of an addictive response (Act Automatically → Experience Relief of Anxiety → Live on 'Automatic Pilot'). The model expresses the cumulative power of each step in terms of a spiral.

Overwhelming emotions of trauma

Anita Bhat's focusing-oriented work with addicts with PTSD symptoms demonstrates the significance of addiction as a response to overwhelming emotion and the potential for reconnection from the focusing-oriented practice of 'clearing a space':

"I have found Focusing to be the most powerful therapeutic approach for recovering substance addicts. Once addicts become sober, they tend to experience a flood of overwhelming emotions and distressing bodily sensations that feel unbearable, and with no tools like Focusing to regulate their internal states, are at risk of relapsing to numb out the pain. ... My research demonstrates how Clearing a Space could help substance-addicted women with PTSD to reduce trauma symptoms and improve quality of life and well-being through finding the 'right' distance from past trauma (e.g., neither too close to traumatic stimuli, which could trigger overwhelming affect and PTSD symptoms, nor too distant from traumatic or any emotional stimuli, which could trigger dissociation)." (Bhat, 2009, no pages)

These accounts offer some beginnings of a focusing-oriented therapy view.

Observation 69 - 'Process-skipping' offers a focusing-oriented account of addiction – the use of repetitious avoidance to substitute for unpalatable experiencing. Focusing-oriented therapy for recovery can offer a way to overcome process-skipping.

5.3.3 Interaction and Encounter

This section will look at the terms for addiction in the focusing-oriented world concerning interaction and encounter. It refers to focusing in the twelve step tradition and 'loving at the edge' which has grown out of it. A parallel is provided with an intra-subjective perspective on Buber's 'I-It.'

Focusing and the twelve step tradition

The twelve step tradition (Alcoholics Anonymous, 1952) is taken in its entirety in two applications of focusing-oriented therapy to addiction. Suzanne Noël (2010) has developed a model which uses focusing to enliven work on each of the twelve steps (see example page 208). When each of the 'steps' is addressed, the aim is to open up the rich interaffecting connections that would otherwise be missing. In very simple terms the model prompts and supports a process of reconnection:

"As we sense into our bodies, textures, shapes, images, gestures will slowly begin 'symbolizing' the inner feel of each aspect of each Step. This personal inner feel allows us to experience the Step, to live it. By doing so, we have a concrete, bodily-felt knowing of it. We have a personal relationship to it. It is no longer an abstract concept. It has become part of our living." (Noël, 2010, p. 136)

Similarly Stephen Crawford (1999) has developed an application of twelve steps and focusing to bring out the parallels with particular emphasis on the integration of disconnected parts which leads to personal growth and ultimately spiritual development.

Loving at the Edge

What is particularly significant in Noël's work is the use of groups and the emphasis on personal interaction in encounter. A scattering of quotations from a long passage may provide some sense of how focusing and love fit together in her view of recovery from addiction:

"I do believe that loving is our natural state. ... I do believe love is seeking itself even if it is in all the wrong places and in all the wrong ways. ... Focusing is giving me a deep, satisfying sense of that, and, best of all, a way to access, stay with, and enjoy this enlivened state of lovingness so that it won't fade into being a distant thought or memory. ... For me, this is the best gift of Focusing: this vibrant, live connectedness with ourselves, others, and the universe. ... This is what is so important to bring to addiction: the comfortable, safe companionship; the attentive contact; the desire to sense the other." (Noël, 2010, p. 139)

"Loving at the Edge means we are willing to let the other, the Focuser, fall into our heart until they can fall into theirs. It's as simple as this. ... We are working toward having our being be an inclusive, loving space for others – our open heart wisely self protective, honouring and caring for itself as much as for others." (Noël, 2010, p. 140)

This approach builds from the 'logic of loving' in Domain Focusing (Lee & Prengel, 2009) and in a characteristically poetic and passionate way, evokes both the personal isolation that can accompany addiction and the openness of her heart. In a profound way focusing-oriented therapy offers a 'being with' to counterbalance the 'being without' of addiction (Tidmarsh, 2010).

Observation 70 - Relational focusing emphasises the inter-human isolation involved in addiction and the recovery significance of a 'loving encounter.'

The 'I-It' orientation

An external perspective can be found in the approach of a person-centred and existential therapist in work that does not relate to addiction. Mick Cooper sets out a relational approach to the functions and dysfunctions of agency drawing on dialogical psychology (Hermans et al., 1992) and psychologists who “*have argued that a close correlation exists between an individual’s attitude toward him or herself, and his or her attitude toward others*” (Cooper, 2003, p. 143). He sees the wholeness, respect and validity of Buber’s (1958) inter-subjective ‘I-Thou’ relating as paralleled in intra-subjective ‘I-I’ connections. Experiencing *oneself* as a person to be encountered and known is essential for encountering others, and vice versa.

Cooper sets out the instrumental alternative to relating in these terms - Buber’s intersubjective ‘I-It’ becoming an intra-subjective ‘I-Me’ and distinguishes the characteristics of relating to oneself in this way (Cooper, 2003, pp. 133-139):

- ‘It-ifying’ Versus Humanizing - seeing part of self as an object
- Fragmenting Versus Relating to Wholeness - seeing elements of experience as separable
- Construing as Determined Versus Acknowledging Freedom - experiencing life as mechanistic
- Experiencing in the Past or Future Versus Encountering in the Present - remaining trapped by what has happened
- Generalizing Versus Individuating - formulaic, general and repetitive patterns
- Non-confirming Versus Confirming - denying part of self the right to exist
- Relating in Fragments Versus Relating as Wholeness - a superficial knowing and connection
- Protectiveness Versus Willingness to Take Risks - part of self always held back
- Monologue Versus Dialogue - utilitarian, goal-focused interaction

Cooper makes no reference in this analysis to the subject of addiction but the qualities set out here are notable among those who seek help for substance abuse. Their living can be formulaic, repetitive and instrumental. In my experience, clients wanting to be rid of inexplicable anomalies of behaviour and are resistant to any understanding and tolerance of the broader context that may be significant. Agency is often expressed in terms of an increased need to 'get a grip' on recalcitrant tendencies.

Observation 71 - The intra-subjective application of Buber's 'I-Thou' model demonstrates the instrumental orientation associated with addiction and points to an encounter element in resolving existential problems during recovery.

5.3.4 Focaling and Value

This section will see how addiction connects to focusing-oriented work concerning defensive structures and partial selves. (see Ob.35, page 84).

Defensive structures

Robert Lee's *Macroshifting* approach includes practice to achieve 'deep change' through long term focusing projects. He identifies a variety of issues to relate to including 'ropes', 'bearing walls' and 'guard dogs.' The latter might illustrate a perspective here of defensive structures within the self that might be akin to addictive patterns (Lee, 2010). He also refers to 'bias control', a concept that Gendlin (1992a) uses in the interpretations of dreams and "consists in expecting a step from the side opposite to one's usual attitude" (Gendlin, 1992a, p. 25). Lee comments:

"Because the structure bound place is embedded in who we are, our person, our meanings, our insights, and our realizations could be skewed by this

situation and biased toward it. Deep Change can then require efforts to control bias.” (Lee, 2010, p. 3)

This is an invocation of an oppositional sense that we will see as significant later in a therapeutic avenue (Ob.82, page 199).

Partial selves

The notion of ‘partial selves’ in the ‘Treasure Maps’ development of focusing-oriented practice, arose when a celebrated exponent of focusing has a personal experience of ‘addiction’ that resisted resolution through the focusing she taught. From this came the idea that the observation that “*repetitive and habitual reaction sequences can become individually identifiable as they persist over time,*” (McGavin & Cornell, 2008, p. 45) and this led to the theory of ‘controlling’, ‘defending’ and ‘compromised’ partial selves. For example the defending partial self is seen as coping with the compromised part using the tactic of avoidance. “*A Defending Partial-Self learns many ways to soothe/numb/contain/distract a distressed Compromised Partial-Self*” through addiction, compulsive behaviour, acting irresponsibly etc. (Cornell & McGavin, 2010).

This view provides an interesting perspective. In some ways it appears to replicate the traditional splits of addiction – the ‘good’ instinct being subverted by the ‘bad.’ Yet here is a warm appreciation of the positive motivation of the ‘defending’ partial-self, absent from the twelve step tradition or Wyrsh. The ‘Treasure Maps’ writers see psychopathology as being based in the idea of a tangle, a conflict between partial selves, that arises either from a traumatic failure to meet an overwhelming situation or rejection by those who are important to us (Cornell & McGavin, 2010). Cornell uses her understanding of parts as a key element in working with addiction (and interestingly adopts the bifurcation of an ‘addict part’ in the process):

“My own experience with working with addictions includes the assumption that ‘the part that wants to do the behaviour’ should have a turn to speak and communicate about what it has been trying to do for the person. It may take quite a while to arrive at the place where it is possible to have this conversation, because it is only the person as Self-in-Presence that the ‘addict’ part will trust enough that it will speak honestly about its motives.”

(Cornell, 2013, p. 169)

The resulting dialogical theories of self have not been without criticism within the focusing-oriented community (Purton, 2000) and I have already expressed reservations about falling in with the traditional bifurcation of addiction (Ob.59, page 145), yet there are some significant lessons here which will be picked up in later chapters.

Observation 72 - Macroshifting and Treasure Maps applications of focusing identify the significance of defensive structures in addiction and suggest their resolution during recovery may need more than a standard therapeutic process.

5.4 Focusing-oriented views of addiction and recovery

In the final part of the chapter the key perspectives on addiction from various sources will be summarised and a proposal made of a focusing-oriented view. The same process will be followed for ‘recovery’, the process of healing from addiction. Images of a ‘carapace’ and ‘flailing’ are used. Both arose from a Thinking at the Edge exercise and recently demonstrated their evocative power during a conference presentation (see 9.4.1 page 326).

5.4.1 Addiction – Themes and Observations

Four themes have emerged – splitting, process-skipping, a carapace and flailing.

Observations from this chapter are grouped below in these themes:

Addiction as a splitting – A term used groups and individuals and social groups to explain and excuse unacceptable behaviour associated with loss of agency and control.

- The discourse of addiction proscribes deviant consumption. (Ob.57)
- The discourse of addiction appears to stabilize norms by regulating social inclusion. (Ob.58)

Addiction as a process-skipping – A disruption or dysfunction in a person's ability to relate to their own experiencing.

- Experiential avoidance is seen as both a cause and result of addiction. (Ob.61)
- Relationship difficulties and attachment disorders are significant in addictive behaviour. (Ob.62)
- 'Process-skipping' offers a focusing-oriented account of addiction. (Ob.69)
- Relational focusing emphasises the inter-human isolation involved in addiction. (Ob.70)

Addiction as a carapace – A stuck pattern of repetitive, instrumental and defensive living.

- The discourse of addiction projects responsibility for aberrant behaviour. (Ob.59)
- The discourse of 'others inside' is used to manage living. (Ob.63)
- An instrumental orientation is associated with addiction. (Ob.71)
- Defensive structures are evident in addiction. (Ob.72)

Addiction as a flailing – A pattern of apparently inexplicable and uncontrollable behaviour which ineffectively responds to an existential dilemma.

- A 'bio-psycho-socio-cultural' view suggests addiction is a coping response. (Ob.65)
- Addiction is a response to social dislocation. (Ob.66)
- Addiction is a form of somatic articulation. (Ob.67)

5.4.2 Proposed view of addiction

A view of addiction is proposed that arises from these themes:

Observation 73 - In focusing-oriented terms addiction is therefore:

- *A term used by individuals and social groups to explain and excuse unacceptable behaviour associated with loss of agency and control.*
- *A process-skipping – A disruption or dysfunction in a person's ability to relate to their own experiencing.*
- *A carapace – A stuck pattern of repetitive, instrumental and defensive living.*
- *A flailing – A pattern of apparently inexplicable and uncontrollable behaviour which ineffectively responds to an existential dilemma.*

In sum, addiction is a pattern of experiential estrangement and compulsive behaviour which provides a way of coping with existential dilemmas.

5.4.3 Recovery – Themes and Observations

Four themes have emerged from discussions of recovery – carrying forward life, standing aside from the carapace, finding ways to respond to existential dilemmas and discovering a self. Observations from this chapter are grouped below in these themes:

Recovery is carrying forward the whole of life in a way that is meaningful for the individual.

- ‘Recovery’ is appropriated widely yet can have a profound existential meaning. (Ob.60)
- ‘Spontaneous recovery’ and ‘recovery capital’ highlight the importance of environmental connections in recovery. (Ob.64)

Recovery is standing aside from an addictive carapace and attending to experiencing.

- Recovery implies the ability to engage with experiencing. (Ob.61)
- Therapy can overcome process-skipping. (Ob.69)

Recovery is finding ways to live with their existential dilemma.

- Interpersonal and environmental change and reconnection are essential in recovery. (Ob.62)
- Defensive structures need more than standard therapy. (Ob.72)
- Dislocation theory implies that any recovery will be a partial and ongoing solution. (Ob.66)

Recovery is discovering a new self, a way of being-in-the-world.

- Recovery implies the ability to transcend a discourse of ‘others inside.’ (Ob.63)
- Recovery implies a self that is not divided. (Ob.59)

- Recovery needs an inter-human encounter. (Ob.70)

Gendlin's concept of carrying forward seems to fit the implicit meaning of recovery well. Facing the intransigence of addiction these themes suggest an implicit possibility of movement - occurring-into-implying can always change further implying (Gendlin, 1997b). Yet some degree of realism or pessimism is implied by the scope of interaffecting involved, individual change is essentially achieved only through a broader process of change (Ob.19, page 50). This ties in with the significance of power relations in addiction (see page 142). Recovery within an unchanged power structure is an achievement against the odds and may easily be limited and partial.

5.4.4 Proposed view of recovery

A view of recovery is proposed that arises from these themes:

Observation 74 - In focusing-oriented terms recovery is therefore:

- *Carrying forward the whole of life in a way that is meaningful for the individual.*
- *Standing aside from an addictive carapace and attending to experiencing.*
- *Finding ways to live with existential dilemmas.*
- *Discovering a new self, a way of being-in-the-world*
In sum, recovery is a personal process of carrying forward where, through experiential engagement, alternative ways of living open up.

Yet it must also refer to broader constraints:

Observation 75 - Recovery within an unchanged environment may be limited and partial. Power constraints may undermine individual resolve and lead to lapse or relapse over time.

CHAPTER 6 – FOCUSING-ORIENTED THERAPY FOR RECOVERY

This chapter will first review the material so far to build a focusing-oriented therapy for addiction. A core model of therapy for addiction recovery will be proposed, setting out the tasks that appear to be central. After this a brief summary of leading treatment orientations for addiction will be provided and then Gendlin's 'experientializing' method (Ob.44, page 105) will be used to identify five treatment 'avenues' that build upon the experiential approach of other orientations. The avenues provide a further model of focusing-oriented therapy for addiction recovery.

6.1 A core model

In this section the focusing-oriented view of addiction and recovery (Chapter 5) will be compared with core elements of focusing-oriented therapy (Chapter 4) to establish an integrated view of therapy for recovery. Key issues from this will be discussed.

6.1.1 Experiencing and Existence

Chapter 5 concluded that in terms of Experiencing and Existence:

- **Addiction** is a process-skipping – A disruption or dysfunction in a person's ability to relate to their own experiencing. (Ob.73, page 170)
- **Recovery** is standing aside from an addictive carapace and attending to experiencing. (Ob.74, page 172)

Chapter 4 identified one client task of focusing-oriented therapy relating to Experiencing and Existence:

- **Client Task 1 – Experiencing** - To encounter the immediate felt sense through a shared pause (Abstand), that frames what is yet unclear and fragmented. (Ob.47, page 112)

These chapters have established a strong theme that builds from the understanding of experiencing as the key issue in the Philosophy of the Implicit. Addictive behaviour exemplifies this in terms of a carapace of avoidance and the first client task of focusing-oriented therapy is designed to respond to needs in this area. Considered together a first core task of focusing-oriented recovery therapy can be identified as:

- **Recovery Task 1** – To assist a client to stand aside from their addictive carapace and attend to their own experiencing, however limited it may be.

6.1.2 Interaction and Encounter

Chapter 5 concluded that in terms of Interaction and Encounter:

- **Addiction** is a carapace – A stuck pattern of repetitive, instrumental and defensive living. (Ob.73, page 170)
- **Recovery** is finding ways to live with existential dilemmas. (Ob.74, page 172)

Chapter 4 identified two client tasks of focusing-oriented therapy relating to Interaction and Encounter:

- **Client Task 2 – ‘Concrete Sentience’** - To attend to a sense of the interaffecting in the whole situation, ecological and intersubjective. (Ob.48, page 114)
- **Client Task 3 – ‘Being-with’** - To stand as a human alongside senses of being-in-the-world, beginning to find ways to relate and the potential for habitation. (Ob.49, page 115)

Another central view of the Philosophy of the Implicit concerns breaches in the fundamental need for interaffecting, both in ecological and intersubjective terms. The consequential distancing effects environment, human connections and self-relating. Addiction exemplifies this in the repetitive defended carapace that substitutes for living connections. The second and third client tasks of focusing-oriented therapy address experiential needs in this regard. Considered together a second core task of focusing-oriented recovery therapy can be identified as:

- **Recovery Task 2** – To assist a client to address and carry forward the existential dilemmas which concern them.

6.1.3 Focaling and Value

Chapter 5 concluded that in terms of Focaling and Value:

- **Addiction** is a flailing – A pattern of apparently inexplicable and uncontrollable behaviour which ineffectively responds to an existential dilemma. (Ob.73, page 170)
- **Recovery** is discovering a new self, a way of being-in-the-world. (Ob.74, page 172)

Chapter 4 identified two client tasks of focusing-oriented therapy relating to Focaling and Value:

- **Client Task 4 – Coming home** – To permit the self to be recognised and ‘received’, finding value in the sense of self-in-situation. (Ob.50, page 119)
- **Client Task 5 – Dwelling** - To articulate experiential steps that arise in tangible choice and self-investment. (Ob.51, page 121)

The focaling theme in the Philosophy of the Implicit illustrates the inherent capacity for meaning and direction that exists. Psychopathology shows how thwarted patterns of behaviour constantly attempt to bring such resolution. The

compulsive behaviour of addiction illustrates this ‘flailing’ very clearly. Recovery is naturally therefore a matter of releasing this potential in a new way for the individual to relate to the world, accompanied by a new sense of self. The fourth and fifth client tasks of focusing-oriented therapy show that this needs a process of reconnecting to values, finding identity and a ‘home.’ Tangible actions lead to the opportunity for choice and self-investment, each a token of a ‘dwelling’ perspective. Considered together a third core task of focusing-oriented recovery therapy can be identified as:

- **Recovery Task 3** – To assist a client to discover a new way of being-myself-in-the-world.

6.1.4 Carrying Forward and Authenticity

Chapter 5 concluded that in terms of Carrying Forward and Authenticity:

- **Addiction** is a splitting – A term used by individuals and social groups to explain and excuse unacceptable behaviour associated with loss of agency and control. (Ob.73, page 170)
- **Recovery** is carrying forward the whole of life in a way that is meaningful for the individual. (Ob.74, page 172)

Chapter 4 did not identify client tasks of focusing-oriented therapy relating to Carrying Forward and Authenticity, although the four therapist roles could be understood in Carrying Forward terms:

- **Therapist role 1 - Creating a space** - To facilitate a shared space where the client can relate to their immediate experiencing and be heard accurately (exactly though differently). (Ob.52, page 123)

- **Therapist role 2 – Felt meaning** - To offer a special attention to felt meanings, using self as a ‘resonating chamber’ for what may be present. (Ob.53, page 126)
- **Therapist role 3 – Articulations** - To attend to and invite articulations of carrying-forward in gestures, actions, values, flailing and experiences of self. (Ob.54, page 128)
- **Therapist role 4 – Living-toward** – To respond as a human ‘other’ to shared implicit meaning with the client, ‘putting nothing between.’ (Ob.55, page 129)

Throughout this study the Carrying Forward theme has pointed to the fulcrum of change for the whole. Core features of the Philosophy of the Implicit include ‘occurring into implying’ and the zig-zag of symbolization that depends first upon a pause (Abstand) (Ob.26, page 64). Psychopathology identified the key principles of ‘reconstitution’ that articulates implicit energy seen in ‘idle running’ (Ob.40, page 94). Carrying forward can be seen in the existential steps of those undergoing recovery – changes that arise from personal ‘life-forward’ investments. This reclaims agency and represents the obverse of addiction. Focusing-oriented therapy includes carrying forward as a part of all client recovery tasks and it would be inappropriate to attempt to separate it out. The four therapist roles each exemplify activity designed to assist the carrying forward of the individual in their situation but essentially supplement a person’s own process:

Observation 76 - Recovery is a life process, in the hands of a person as they inter-affect with many influences. Like other orientations, focusing-oriented recovery therapy therefore offers a contribution to carrying forward.

In summary, a core model of focusing-oriented therapy for recovery can therefore be proposed:

Observation 77 - Three core Recovery Tasks are identified in focusing-oriented therapy for addiction:

- *Recovery Task 1 – To assist a client to stand aside from their addictive carapace and attend to their own experiencing, however limited it may be.*
- *Recovery Task 2 – To assist a client to address and carry forward the existential dilemmas which concern them.*
- *Recovery Task 3 – To assist a client to discover a new way of being-myself-in-the-world.*

6.2 Leading treatment orientations

Of the many treatment orientations used for addiction, nine are perhaps the most prominent in current use. There is not space in this study to detail them but an outline of each is set out in Appendix 6. In simple terms the significance of each can be summarised as follows:

- **Twelve Step** (see page 383) This is a self-help tradition that remains the dominant treatment orientation across the world e.g. Alcoholics Anonymous. Members work through a standard series of steps to achieve change and join an ongoing community.
- **Relapse Prevention** (see page 384) This is the most developed cognitive-behavioural approach and widely used in mental health settings. It provides a rational way to understand and respond to lapses and relapses in overcoming addiction.
- **The ‘Transtheoretical Model’** (see page 385) Sometimes referred to as the ‘stages of change’ model, this is a widely accepted understanding of the cycle of change commonly encountered with clients moving from ‘pre-

contemplation', through 'contemplation' and other steps to 'decision' and 'maintenance.'

- **Motivational Interviewing (MI)** (see page 387) This is a widely used series of tactics designed to enhance and harness the ambivalent attitude demonstrated by many who wish to make changes.
- **Person-centred** (see page 388) This is a major orientation that approaches addiction problems in the context of the whole life of the person.
- **Gestalt** (see page 390) This is another well established orientation focusing on the whole person. It has been applied in a systematic form to addiction treatment and a valuable literature has resulted.
- **Somatic** (see page 391) Whilst this approach is not widely used, the limited exploration of body work with addiction shows a significant perspective.
- **Dialectical Behaviour Therapy (DBT)** (see page 392) This is one of two orientations that include a mindfulness-based approach with other methods. Elements from the cognitive behavioural tradition are also incorporated.
- **Acceptance and Commitment Therapy (ACT)** (see page 392) This also uses a mindfulness-based approach in a multi-faceted regime. It aims to enhance a specific kind of self-acceptance which transcends the dominance of addiction.

6.3 Avenues of focusing-oriented intervention

The previous chapter explained Gendlin's method of 'experientializing' to be able to relate focusing with other 'avenues' of therapy avoiding common divisions between orientations (Ob.43, page 102). It emphasises attention to experiential

processes (Ob.44, page 105). The final part of this chapter will look for connections between focusing-oriented therapy and orientations dealing with drug and alcohol problems through exercises in ‘experientializing.’ Five clusters of activity suggest avenues of focusing-oriented therapy for recovery.

6.3.1 Avenue A - Emotional regulation and self-as-perspective

One kind of process notes how addictive practices are used to manage emotional burdens. It is the basis of a psychodynamic approach to addiction and its ‘self-medication’ properties:

“The degree to which individuals can tolerate distress and find relief from human suffering is proportional to the degree they have been able to develop and internalize capacities to regulate feelings, to establish and maintain a healthy regard for self and others, and to take care of themselves. These capacities are incorporated as mental structures and functions in our personality organization and reflect our ego capacities and sense of self.” (Khantzian, 1999, p. 48)

Other approaches also speak of the challenge of ‘affect regulation’ (Gross & Thompson, 2007), see developmental origins to the problems (Flores, 2004) and make connections with alexithymia (e.g. Kauhanen et al., 1992).

Relapse Prevention – self regulation muscle

A cognitive view suggests that regulation problems occur because of an unwarranted emphasis on emotion or inadequacy in monitoring and managing it. Using a muscle analogy the research takes the view that,

“self-regulation operates as a limited resource, akin to strength or energy, especially insofar as it becomes depleted after use - leaving the depleted self subsequently vulnerable to impulsive and under-controlled behaviours (including increased consumption of alcohol).” (Baumeister, 2003, p. 281)

Research has sought ways to strengthen the ‘muscle’ and it is not surprising that restorative measures include sleep, a positive emotional experience and regular exercise (Baumeister, 2003, p. 283).

The entire emphasis of Relapse Prevention is about avoiding and managing high risk situations, both substance use and underlying emotional pressure. An example of the mixture of these is the technique of ‘urge surfing’:

“Clients are taught to visualize the urge as an ocean wave that begins as a small wavelet and gradually builds up to a large cresting wave. As the urge wave grows in strength, the client’s goal is to surf the urge by allowing it to pass without being ‘wiped out’ by giving into it. I tell clients that urges are often conditioned responses triggered by cues and high-risk situations. Like a wave, the conditioned response grows in intensity until it reaches a peak level of craving. Giving in to the urge when it peaks only serves to further reinforce the addictive behavior. Not acting on the urge, on the other hand, weakens the addictive conditioning and strengthens acceptance and self-efficacy.” (Marlatt, 2002, p. 47)

Gestalt and somatic contact cycle

‘Organismic self-regulation’ is key in Gestalt thinking that has implications for addiction treatment. The self,

“is the contact boundary in action perpetually forming figures and grounds and constellating their field. The self (addicted or not) is always responding to its internal sensations and the field in which it exists, attending to emerging needs as they arise and adjusting behaviour to meet those needs by organismic self-regulation.” (Leung, 2010, p. 26)

Addiction consequently implies the restriction and truncation of the contact cycle presumed to be a fundamental in human interaction. Part of the therapeutic

response is therefore to stimulate ways that this cycle can be refreshed to fulfil its whole purpose and objective. To this end,

“the drug experience is clarified so that it can be assimilated into global experience in a way that results in full contact with needs and that leads, eventually, to withdrawal from a stereotypic and repetitive cycle of functioning and how this clarification results in a reorganization of the field so that the person is engaged in a more meaningful life experience.”

(White, 1999, pp. 147-148)

Somatic techniques are used at different stages in the recovery cycle, for example at the action stage there is a somatic exploration of alternative tasks to substance use:

“The therapist will encourage this exploration by urging both proximal (figural) and distal (grounded) alternatives. Proximal alternatives include awareness of shallow or desperate breathing patterns, of body armor, of fascinating thoughts aligned with the use of the drug and include substitute behaviors; distal alternatives include activities of actual or potential interest to the client that reside in ground (e.g., exercise, making love, working, etc.).” (White, 1999, p. 152)

The therapy methods here have a strong resemblance to somatic therapy for addiction which attends to the ‘movement tag’ which is both a boundary marker for dissociation between states and ‘the leading edge of recovery.’ The client is carefully awakened to the marker, first raising awareness and curiosity about it and its associations, then owning it in a positive way. The next phase,

“called Appreciation, shows up when we come to the natural end of the original sequence, and the opportunity for natural pleasure arises. I feel complete, satisfied. I am safe! I get a sense that How-I-Move-Gets-Me-

What-I-Want. In the Appreciation phase, it becomes crucial that I welcome and allow myself to feel the pleasure.” (Caldwell, 2001, p. 227)

The last phase is also very significant,

“Called the Action Phase, it operates on the principle that I am never truly complete until I apply my new movement sequences back into my environment, my daily life. In this phase, I find how the accurate original movement sequence wants to live in my current situation.” (Caldwell, 2001, p. 227)

Mindfulness and Acceptance and Commitment Therapy

Mindfulness related to drug use can have contrasting effects – both sensitisation and desensitisation:

- **Sensitisation** – A ‘decentred’ perspective brings awareness to the automatic responses to relapse triggers (Palfai et al., 1997). *“In the context of addictions, mindfulness might mean becoming aware of triggers for craving ... and choosing to do something else which might ameliorate or prevent craving, so weakening the habitual response”* (Groves & Farmer, 1994, p. 189). This allows the adjustment of habitual behaviours, perceptions and understandings and provides the opportunity to make conscious choices.
- **Desensitisation** – Helping the individual cope with adverse states that might otherwise trigger drug use. From a conditioning point of view, conscious attention to stimuli provides a form of covert exposure. Being with a stimulus without reacting in a predetermined way is a form of ‘response substitution’ where the normal triggers are experienced but not responded to (Breslin et al., 2002, p. 288).

Acceptance and Commitment Therapy sees suffering as arising from needless struggles with the world as structured by literal meaning. ‘Self-as-perspective’ provides a primary way out of this:

“teaching the client how to be aware of content, to be aware of the awareness of content, and yet not to be preoccupied with content or attached to it as a matter of personal identity. ... To notice when thoughts and feelings are present from a perspective of self-as-context, without objectifying these events or mistaking them for ‘self’ in this deeper sense.”

(Hayes et al., 1999, p. 187)

Three goals are involved in this process. First there is a need to undermine attachment to the ‘conceptualized self’ by showing how attachment to both positive and negative self-concepts is at times detrimental. Secondly, an awareness of *self-as-perspective* is created by distinguishing consciousness from its content, appreciating the continuity of consciousness compared with the changing nature of content. Thirdly, the conceptualized self is contrasted with the *self-as-perspective* to undermine strivings for coherence in feeling, thinking and acting, and revealing the arbitrariness of content (Hayes et al., 1999, p. 189).

Metaphors and practical exercises are used to build awareness of the observing self and success is judged when the client reports the sense of looking at private experience, rather than being caught up in it, also being able to laugh at oneself ‘in earnest’ (Hayes et al., 1999).

Cornell makes some useful distinctions between mindfulness, the felt sense and her concept of ‘Self-in-Presence.’ She observes that discussions of mindfulness omit the potential for living beyond a problem that is intrinsic in a felt sense:

“The idea that a new kind of felt experience of the problem can form only in this spacious state, and that this new kind of experience is itself the organism living beyond the problem, is an idea brought in by Focusing.

Another difference is that Self-in-Presence feels more like a good parent, with a warm acceptance rather than a neutral observational tone. From Self-in-Presence we are not just observers of our emotional states; we are compassionate.” (Cornell, 2013, p. 87)

Experientializing reflections and observations

In summary this avenue demonstrates approaches that:

- See direct connections between clients’ inability to deal with enhanced levels of arousal and their dependence upon drugs and alcohol.
- Consequently encourage attention to means of regulation.
- Develop the facility of *self-as-perspective* (compared with ‘self-as-content’) in order to ride the ‘waves’ of feeling that may arise.
- Seek a resolution of an affective cycle through its completion.

Turning to the ‘experientializing’ approach there would seem to be a major compatibility between practices here. Elements are very reminiscent of Wholebody Focusing (McEvane & Fleisch, 2008) and focusing-oriented practice in general. Several conclusions can be drawn –

- First, here is the conscious work with emotional regulation and its somatic expressions. Focusing-oriented therapy does not normally pay attention to such matters explicitly, although it is recognised in reflections of focusing and neuroscience (Ellis, 2012) and one person’s work with PTSD survivors (Ob.69, page 163). A focusing-oriented approach could provide a dual responding - allowing the exploration of meaning to sit alongside and enrich explicit support to regulation.
- Second, there is somatic working with gestures, tags and the completion of implied meaning. Focusing-oriented approaches are used to working with the body and with completion of gestural forms including ‘bodying forward’, the carrying forward by inter-body connections (Geiser, 2010b).

- Third, the self-as-perspective view is consistent with focusing practice and may be the origin of the widely used concept of 'self-in-presence': *"a state of self that is witnessing and compassionate towards one's own inner aspects and process"* (Cornell, 2013, p. 85). Focusing is distinctive in looking to the carrying forward inherent in a mindful attention.
- Fourth, focusing-oriented therapy potentially offers an advanced perspective where the meaning of emotional overload ('self-in-situation', Ob.50, page 119) is addressed in the immediate context of practical measures to cope with it.

Focusing-oriented therapy appears to be able to offer complementary and enhancing capabilities to this avenue. The view of a person as an interaffecting being-in-the-world may add richness to the tendency to speak in terms of stimulus-response.

Observation 78 - Avenue 'A' commends careful attention to 'emotional regulation' whilst working with addiction. A dual responding is appropriate – both to find steps to 'complete' gestural coping mechanisms and to relate to the implicit meaning involved in them. Such dual sensitisation/desensitisation can also be linked to the experience of 'self-as-perspective.'

The avenue suggests a recovery task to complement those of the core model:

Observation 79 - Recovery Task A – To assist client's 'emotional regulation' through dual-responding, encouraging self-as-perspective and linking practical issues to implicit meaning.

6.3.2 Avenue B - Waiting upon a carrying forward

Whilst not usually the most striking initiative presented, many orientations accept that resolution will take its own route. As a matter of principle change cannot be pre-engineered or chamfered to fit.

Stages of change - MI/Transtheoretical

Motivational Interviewing, one of the most dominant ways to work with addiction, has a results-oriented, focused quality (see Appendix 6, page 387). That said it is easy to overlook its underlying essential threefold 'spirit' – a *collaborative* and client-centred approach, an *evocative* method of working and an honouring of the client's own *autonomy* and self-determination (Arkowitz et al., 2008). Put together there is a recognition here that moments of change are subject to the interconnectedness and idiosyncratic motivational disposition of individuals. In these terms the characteristic 'rolling with opposition' is not so much a tactic as an affirmation of sovereignty.

A similar modesty is recognised in the highly influential 'stages of change' model (see Appendix 6, page 385), pointing to whole person orientations (stages) and the need to make distinctive interventions depending upon the person's own sense of reality at a particular time. The way the stages are presented may obscure the recognition that the process is as much natural as contrived. The initiatives depend upon the ability of a person to know a good thing when it is seen.

Both approaches therefore depend upon the concept of an individual as a situated, interacting identity, an entity that cannot be predicted.

Work with the actualising tendency - Person-centred

The person-centred tradition is open in its opposition to the perceived dominance of the "*politics of helping*" (Mearns & Cooper, 2005, p. 97), whereby the 'problem' rather than the client is the major focus of attention. Such an approach is resisted

in favour of a phenomenological perspective, as is exemplified in a noted case study concerning addiction:

“Any 'problem-centred' way of working would not have got to that existential significance - in fact, it would still be working on the wrong 'problem!' ... The struggle with Dominic was to help 'Dominic the drunk' have a credible voice.” (Mearns in Mearns & Cooper, 2005, p. 97)

As I observed before (Ob.35, page 84), a person-centred view of the actualising tendency significantly suggests that it is at work within addictive behaviours and needs to be supported to come to a whole resolution for the person.

Consequently, whilst the ‘cycle of change’ may track a common journey, each individual travels in their own way and therapy should not direct the client into a particular direction nor imply that particular recovery goals are inherently the right answer (Bryant-Jeffries, 2001). This person-centred belief in the client and their actualizing tendency may be seen by some as rare and shocking in much drug and alcohol work which may operate from very different presumptions (Wilders & Robinson, 2012).

Defences as care strategies - Gestalt/Somatic

We have already seen how organismic self-regulation is recognised to be one of the key principles of Gestalt working (page 181). Defences that interrupt this are nevertheless seen as ‘*care strategies*’, always to be understood, never denigrated (Buchbinder, 1986, p. 55). Among these ‘retroflection’ is the re-absorption of feelings and unmet needs, turning onto oneself what would be intended for something outside the self (Perls et al., 1958). Forms of exterior expression can therefore be a release:

“After developing an awareness of the retroflection, the therapist might ask the patient to ‘do outwardly what you are doing to yourself.’ The alcoholic is then directed to express his feeling: to the therapist; to a group member

or members, or to the appropriate significant other in the 'empty chair.'"

(Buchbinder, 1986, p. 64)

This view expresses recovery as the facilitations of a natural process, the recommencement of a stopped process.

Relapse Prevention – situational dynamics of new model

It is interesting to see how the new model of Relapse Prevention, whilst retaining a practical and mechanistic orientation, has become more refined. It sees the complex interaffecting between person and environment as the focus of attention:

"The consideration of how these factors may interact within a high-risk situation ... and how changes in proximal risks can alter behavior leading up to high-risk situations will enable clients to continually assess their own relapse vulnerability. As Kauffman one of the pioneers in the study of complex systems, stated, 'The internal portrait, condensed image, of the external world carried by the individual and used to guide its interactions, must be tuned, just so, to the ever evolving complexity of the world it helped create'" (Witkiewitz & Marlatt, 2004, p. 231)

This implies that whilst pragmatic interventions are appropriate to deal with high risk situations, the whole mesh of connections is also key.

'Maturing out'

Whilst there is considerable concern about the increasing influence of drug use in our societies, there is also continuing evidence that in a number of fields, a majority of recovery occurs without professional help and may be linked to age (Kessler et al., 2005). An analysis of studies leads a recent academic to favour a 'choice' model rather than a 'disease' model for addiction, observing that,

“the correlates of quitting include the absence of additional psychiatric and medical problems, marital status (singles stay addicted longer), economic pressures, fear of judicial sanctions, concern about respect from children and other family members, worries about the many problems that attend regular involvement in illegal activities, more years spent in school, and higher income.” (Heyman, 2013, no page)

This connects addictions to the whole process and drama of life, shaped by inequalities of power (Orford, 2013) and prompted by choices inherent in it (Room & Collins, 1983). It might allow addictive dysfunctions to be seen as part of the tight-woven fabric of living, to be understood and resolved as part of that lattice.

Summary and experientializing reflections

In summary this avenue demonstrates approaches that:

- Depend upon the responsiveness of a whole person to their situation, emphasising choice and engagement in the world as much as addictive compulsion.
- Suggest that motivation to revise behaviour connects to the whole mesh of an environment and therefore changes in relation to it e.g. related to age and personal commitments.
- Imply that addiction might be part of the process of human living, a care strategy with disadvantages. Thus a response to the whole person-in-process is most appropriate.
- Point to the inherent potential in a human being that can heal itself.

Together these approaches imply that addiction is resolved through the development of a life situation, as much as through disconnected interventions on individual behaviours. From an experientializing point of view, the philosophical basis of focusing-oriented therapy is important here, recognising the inherent

potency of carrying forward, the implicit rightness of the life forward direction. This suggests an orientation that is not directed:

“One can decide to want ‘whatever should happen’ or ‘whatever would be right,’ leaving open what that is. This has a large effect in the body. If one says this and the body responds to it, one is no longer conflicted. One no longer plays one thing against another. Instead, one is all in one piece in one’s wanting. It gives one a breath, one’s whole body straightens. Experiencing moves on past the stoppage. Then, from the further experiencing, a new way can later be formulated.” (Gendlin, 1996, pp. 271-272, emphasis original)

I am reminded of a connection between focusing-oriented therapy and Buddhist concept of Inter-dependent Origination. If I understand correctly a profound patience and trust is implied:

“The inter-dependence origination cannot be predicted, however, the error is usually inevitable when the counselor is assisting to create it. The core idea is that the inter-dependence origination is open to any ongoing activities. As long as the counselor avoids to be arbitrary and keeps an open attitude, error could be corrected so that the situation turns out to be proceeded in a right direction and the negative dependent origination stops getting worse.” (Xu, 2011, p. 4)

This avenue therefore is somewhat esoteric, standing for an implicit capability, something to be cooperated with, not thwarted, but remains uncontrollable.

Observation 80 - Avenue ‘B’ identifies a power in the implicit which is associated with the ‘right’ carrying forward and no less. It advocates a combination of embodied engagement and tolerance that is uncommon in treatment regimes that stand apart from their clients. The process of

wanting ‘whatever should happen’ provides a powerful way to relate to experiencing.

The avenue suggests a recovery task to complement those of the core model:

Observation 81 - Recovery Task B – To assist clients to attend to implicit meaning and wait upon the ‘right’ carrying forward.

6.3.3 Avenue C - Stirring up ambivalence & opposition

Various orientations apply a variety of approaches to the business of dislodging a dominant and defensive structure, a ‘carapace’ which protects and constrains the person’s whole existence. In experientializing terms they connect to the idea of focusing as a dialectic process and the carrying forward that can arise from a constructed tension (Ob.25, page 62).

Motivational Interviewing

One of the prominent elements of Motivational interviewing is the objective of “*exploring and resolving ambivalence*” (Miller & Rollnick, 2002, p. 25) through a distinctive inter-personal process:

“This departs somewhat from the popular notion that motivation is internal, residing within the individual as a personal state or trait.

Motivation for change can not only be influenced by but in a very real sense arises from an interpersonal context.” (Miller & Rollnick, 2002, p. 22)

Interventions are based on Festinger’s (1962) theory of ‘cognitive dissonance’ summarised in three ideas – ‘change talk’, ‘rolling with resistance’, ‘developing discrepancy.’ They see change as dependent upon increasing the tension between present experience and a desired goal so that change is impelled by discomfort.

‘Change talk’ is motivational speech about a significant discrepancy that needs to be resolved, where *the client* voices the disadvantages of the status quo and

advantages of change. The therapist avoids directive or confrontational interventions, that might aim to push a client in a practical direction but clarifies the client's disposition, elaborates through open questions and affirms change talk (Miller & Rollnick, 2002). Rebuttal is not opposed or confronted but, in a kind of 'psychological judo', the resistance can be turned ('agreeing with a twist') and reframed to create a new momentum for change (ibid. p105).

This description may give a quasi-mechanical feel or a sense that influencing skills are almost being used coercively (Orford, 2013). This tendency could be counterbalanced by a sensitivity to the significance of deeply held values for a person:

"[A man] dates his quitting [smoking] from a day on which he had gone to pick up his children at the city library. A thunderstorm greeted him as he arrived there; and at the same time a search of his pockets disclosed a familiar problem: he was out of cigarettes. Glancing back at the library, he caught a glimpse of his children stepping out in the rain, but he continued around the corner, certain that he could find a parking space, rush in, buy the cigarettes, and be back before the children got seriously wet. The view of himself as a father who would 'actually leave the kids in the rain while he ran after cigarettes' was ... humiliating, and he quit smoking." (Premack, 1970, p. 115)

Developing discrepancy empathetically can mirror unclear, unsettled conflict at the heart of the client's self-experience and identity, so that a profound self-discovery can take place (Wagner & Sanchez, 2002). (This may well link with the 'releasement' (Gelassenheit) identified in Avenue D, see Ob.84, page 205.) Perhaps an interpersonal congruence is key, so that "*the resolution of ambivalence is promoted by accurate empathy alone, and it tends to resolve in a positive direction without directive help from the counselor*" (Miller, 2004, slide 32).

Socratic Questioning

This kind of technique has similarities with Socratic Questioning (e.g. Overholser, 1993) a Cognitive Behavioural practice aimed at changing a client's beliefs. Initially this was transparently concerned with demonstrating the logical flaws in a client's thought process - 'one-two three-aha!' As this method was seen to be inconsistent with lasting change then refinements were made, making the process collaborative and empirical, so that the therapist is not always heading in an already planned direction. Engaging the client is recognised as dependent upon an open process aimed at empowering their choices. One writer defines Socratic Questioning as asking the client questions which:

- *"The client has the knowledge to answer,*
- *Draws the client's attention to information that is relevant to the issue being discussed but which may be outside the client's current focus,*
- *Generally move from the concrete to the more abstract, so that,*
- *The client can, in the end, apply the new information to either re-evaluate a previous conclusion or construct a new idea."* (Padesky, 1993, p. 4)

There are interesting emphases here on guiding discovery rather than highlighting deficits and bringing attention to specific instances which are not in awareness. Therapists are told to listen for idiosyncratic words and metaphors that seem oddly placed in the sentence. Summarising should frequently occur, which feeds into synthesising or analytical questions, bringing the whole exploration back to the original issue at hand.

Gestalt - Frustration used to push

The Gestalt tradition has recognised the advantage of constructive frustration in therapy. This was originally expressed by Perls and colleagues as follows:

"In the process of growing up, there are two choices. The child either grows up and learns to overcome frustration, or it is spoiled. It might be spoiled

by the parents answering all the questions, rightly or wrongly, it might be spoiled so that as soon as it wants something it gets it. ... Without frustration there is no need, no reason to mobilize your resources, to discover that you might be able to do something on your own, and in order not to be frustrated, which is a pretty painful experience, the child learns to manipulate the environment.” (Perls, 1969, pp. 34-35)

An approach to therapy with addiction consistent with this theory observes the ‘inadequacy impasse’ where clients express inability to undertake simple steps and respond almost reflexively with ‘I can’t’ or ‘I don’t know.’ These are seen as attempts to evade responsibility and there is a technique of inviting the client to rephrase ‘I can’t’ into ‘I want you to do it for me’ (Passons, 1975, p. 146). Another therapist responds to ‘I don’t know’ with ‘try knowing’ or ‘I don’t know right now and I am open to learning’ (Coven & Blackhawk, 1978, p. 431).

A common approach in addiction treatment recognises substance use as a way of avoiding frustrating situations. Whilst offering warm empathy for the person, neither judging nor criticizing, the Gestalt therapist withholds support for self-defeating behaviour. The client is not protected from the difficulties of the situation within the consulting room and, in a structured way, assisted to endure ambiguities and insecurities with safety:

“The therapist needs to be careful not to do for the patient that which he is capable of doing for himself. Before the patient can be more direct in expressing a need, he must feel it is okay to not know or to make a mistake. The therapy situation can provide the alcoholic with a relatively safe arena in which to rehearse new behaviors. ... In order to make an impact on the patient the therapist must possess the ability to frustrate.” (Buchbinder, 1986, pp. 63-64)

The whole approach is well summed up by White:

“The client is constantly experiencing the existential dilemma of being torn between the comfort of his existing integrity and his need to change. The aim in therapy is to shift the ‘inner conflict’, that between impulse and the counter-attacking resistance, into an open, aware conflict.” (White, 1999, p. 151)

Two chair

As has been mentioned above, whilst not common in a drug and alcohol setting, two-chair facilitation provides a means of articulating and working through different aspects of a person. I am aware of no application which uses this approach for the most obvious bifurcation in drug and alcohol work, between the ‘normal’ and ‘addictive’ selves. It is interesting that the one account that gets closest to it, attempting ‘multidirectional partiality’ through separate relations with drunk and sober selves, then moves to a challenging (‘relational depth’) engagement with the whole client (c.f. Mearns & Cooper, 2005, p. 77). Whilst it is important to keep out of the split of the addictive discourse (Ob.59, page 145), a presence that is ‘counter’ also seems significant (Schmid, 2002).

Greenberg and colleagues differentiate two therapeutic tasks that might call for the approach:

- Self-evaluative splits – the internalization of societal standards and attitudes to the point that the person loses the capability to discriminate their own needs within constraining ‘shoulds’ and ‘oughts’ (Greenberg et al., 1993, pp. 186-187).
- Self-interruptive splits – the interruption of emotional experience and expression in terms of activity. *“The processes involved in self-interruptive splits emphasize interruptive activity against the self as opposed to evaluation or use of coercive power against the self.”* (Greenberg et al., 1993, pp. 216-217, emphasis original)

I have shown how social pressures relate to the bifurcation of 'others inside' in addiction (Ob.59, page 145). Here there is a inspiration to work with split realities for a client, albeit the primary existential dilemmas to which addiction may provide a secondary expression.

Standing up to addiction

Reference has already been made to the significance of the social and practical environment in the process of recovery, and the importance of recovery capital (Ob.64, page 153). The response of the immediate social circle to a person's addictive behaviours can be extremely significant and interventions like Social Behaviour and Network Therapy seek to mobilise support for change (Copello et al., 2002). Many challenges are offered to those who live with or care for people with addictive behaviours. In simple terms the 'coping dilemmas' can be reduced to three options - tolerance, engagement or withdrawal (Orford, 2012).

Active engagement through 'standing up to' addiction can be significant. From an employment perspective, 'supportive confrontation,' a mixture of support and firm discipline is recommended (Trice & Sonnenstuhl, 1990). However, the domestic counterpart, 'Tough Love,' can present formidable personal challenges and is not without controversy (Orford, 2012). A broad appraisal of the power relations in addiction acknowledges the odds against a carer in such circumstances but commends examples of collective action to stand up to addiction, transforming private suffering into a matter of collective responsibility (Brent, 2009).

Such initiatives point to the imperative of an ethical 'alterity' reminiscent of Lévinas (1981), an 'other' often disenfranchised in the individual orientation of much addiction treatments. The position, voice and accountabilities of other stakeholders in the process will be significant, though often ignored.

Summary and experientializing reflections

Turning to the ‘experientializing’ approach there would seem to be a major compatibility between a focusing-oriented or experiential approach and one that sensitively supports a client in the challenge of decision making. The emphases in Socratic Questioning on empirical evidence, working with questions ‘the client has the knowledge to answer’, yet ones which ‘may be outside the client’s current focus’, can suggest a fruitful exploration of implicit real life experience. A more-than-logical process does not need to lack structure and rigour (as TAE demonstrates).

The Motivational Interviewing example emphasises that, *“ambivalence is not really an obstacle to change, rather, it is ambivalence that makes change possible”* (Miller & Rollnick, 2002, p. 23) and it is good to see this as an experiential reality. Focusing-oriented therapy is used to relating to contrasting and contradictory senses. As with Socratic Questioning, there are clearly ways that an experiential orientation would enhance the validity of the exploration and the likelihood that a resolution is sustained.

The Gestalt use of frustration is pertinent to the challenge of working with alcohol and drug clients. Two extremes are normally strenuously avoided – the opprobrium common in society towards extremes of addiction or the easy evasion that users offer to each other. The therapist wants to hold space for a full appreciation of what might be avoided, but without judgement or censure. From a focusing-oriented point of view the sense of frustration is the unclear but creative edge.

The reference to ‘standing up to addiction’ suggests the need to take account of the place, interests and responsibilities of other stakeholders. This is something that arises when child protection issues are involved, but is an unacknowledged dynamic of alterity in most therapeutic work.

In summary, the ‘stirring up of ambivalence’ challenges focusing-oriented practice in three particular ways.

- Firstly, it emphasises the therapeutic advantage of the abrasion between senses of self and inconsistent behaviour. Focusing-oriented therapy is usually less robust and clear about seeking out and facilitating ambivalence. The Gestalt two-chair technique described in the discussion of the Inner Critic (Ob.37, page 90) has a similar oppositional quality which is not compatible with an experiential approach.
- Secondly, Motivational Interviewing points here to ambivalence with fundamental values. The relativism of focusing-oriented therapy may easily rob it of relationship with this key fulcrum. As we will see later the sense of values and of position relating to them may be important.
- Thirdly the use of discomfort emphasises that the clarity and acceptance of a focusing-oriented approach does not imply an easy-going process in the consulting room. As with TAE, the discomfort of that which ‘does not fit’ has a crucial value.

Observation 82 - Avenue ‘C’ advocates an abrasive edge in experiential responding when dealing with the ambiguities of an addictive carapace. Therapists are invited to explore the empathetic felt sense of ambivalence, ‘Socratic Questioning’, frustration and the alterity of two-chair process.

The avenue suggests a recovery task to complement those of the core model:

Observation 83 - Recovery Task C – To assist clients to engage with abrasive experiences of the felt sense and its ambiguities.

6.3.4 Avenue D – Releasement (*Gelassenheit*) and self-identification

The question of values arises distinctly in a number of therapeutic approaches, particularly where calculative living is highlighted. In a variety of ways these seem to relate to *Gelassenheit* (Heidegger, 1966), a non-willed openness or radical acceptance that might also be translated as 'releasement' (Bolling, 1995).

Acceptance and Commitment Therapy (ACT)

ACT is significant in highlighting the importance of values, working with them, yet distinguishing them from goals.

"One reason clients get stuck is that they believe attaining goals is the key to happiness and life satisfaction." (Hayes et al., 1999, p. 219)

It distinguishes values and purpose as different from judgements:

"For valuing to occur, it is critical that values not be confused with judgments - values must instead be choices. A choice is a selection among alternatives that may be made with reasons (if reasons are there) but not for reasons. Choices are not explained, justified, linked to, or guided by verbal evaluations and judgments." (Hayes et al., 1999, p. 212)

Values are in these terms elements of fundamental orientation of life, chosen for their implicit meaning and significance for a person. They are not contingent, dependent upon an appraisal of circumstances and advantages. Acting according to values is a choice of self-investment that may run counter to self-interest in a judgemental sense:

"If an action is based on reasons, and the reasons change, then the decision itself logically must be altered. In some deep sense this means that true commitments are better done as choices than as judgments. Reasons often

point to things that a person cannot control directly. This means that judgments are linked to things a person does not control, and thus one's level of commitment can potentially be undermined." (Hayes et al., 1999, p. 218)

To make this orientation explicit, clients are invited to contemplate what they would like to see inscribed on their tombstone, or participate in an intense and intimate 'horizon setting' exercise to clarify values. The embodiment of values is known as 'willingness' the discovery of an over-arching purpose independent of goals and their contingent achievement.

Twelve step – powerless/higher power

The 'powerless' orientation of the twelve step tradition is challenging and central. The first two 'steps' identify the impotency of the individual and the need for the intervention of a higher power. Whilst the language clearly has religious origins, the tradition is that the 'higher power' does not have to be God or a religious figure, it can be an animate or inanimate object, even a thought or idea. The importance is the relationship this has with the person's life – in some way external, unmarred by the impotence, and embodying a potency that the person lacks. In theological terms this is a fundamental act of repentance and reorientation (metanoia), a distancing of self from broken living hitherto.

There is a fundamental paradox here which has been much debated and it is useful to see it in the light of existential philosophy (Miller & Kurtz, 1994). In these terms the first two steps require the adherent to recognise their essential limitations and finitude, abandoning the imperative and illusion of human control based upon Cartesian dualism (Kurtz, 1979). In these terms A.A. offers an extreme version of the existential paradox connected to *Gelassenheit*, not subduing reality but letting it be what it is. Kurtz suggests that an alcoholic needs to give up attempts to will what cannot be willed, i.e. applying a utilitarian grasp to existential reality where only orientation and means can be chosen, not outcome:

“In the A.A. understanding, the drinking alcoholic drinks alcohol in an effort to achieve control – absolute control over his feelings and environment; yet his drinking itself is absolutely out of control.” (Kurtz, 1999, p. 194)

The strangely theological but non-dogmatic language of AA therefore invites an existential choice:

“A.A., both in its suggestion of a ‘Higher Power’ and in the dynamic of its meetings, invites and enables the living out of this mutuality between human dependence and personal independence.” (Kurtz, 1999, p. 206)

“Because of essential limitation, to be fully human requires the acknowledgment of both limited control and limited dependence; and it is the embrace of each that enables the attainment of its apparent opposite.” (Kurtz, 1999, p. 207)

Gestalt – being what one is

There is a degree of similarity between such twelve step change and that described in a Gestalt approach – *‘change can occur when the patient abandons, at least for the moment, what he would like to become and attempts to be what he is’*:

“I will call it the paradoxical theory of change, for reasons that shall become obvious. Briefly stated, it is this: that change occurs when one becomes what he is, not when he tries to become what he is not. Change does not take place through a coercive attempt by the individual or by another person to change him, but it does take place if one takes the time and effort to be what he is - to be fully invested in his current positions. By rejecting the role of change agent, we make meaningful and orderly change possible.” (Beisser, 1970, p. 77)

The difference is between a perception of self and an experience of self. Working with explicit perspectives or public representations of the self a person can sit

lightly to reality, using selective attention to construct an artificial whole. Leaving this aside to a degree allows carrying forward to occur in a way that arises from the implicit 'given' qualities of a person-in-situation. Attending in a less blinkered manner can allow the challenge to arise, not to strive after a constructed ideal, but to live authentically where one is. There is a parallel here too with *Gelassenheit*.

Stages of change – 'self-liberation'

The work that led to the creation of the 'transtheroetical model' (see Appendix 6, page 385) identified ten common change processes that were perceived to be helpful in the treatment of addiction. The one that was rated most significant by participants was 'self-liberation,' understood in terms of confidence in an ability to make a change. It was related to identity and values so that,

"the ordeal of undergoing unpleasant procedures either reflected or increased ... personal commitment." (DiClemente & Prochaska, 1982, p. 141)

This simply illustrates the distinction between calculative thinking which might have re-appraised a difficult procedure with the further involvement that arises from values.

Summary and experientializing reflections

In summary this avenue demonstrates approaches that:

- Identify a distinction between a mode of utilitarian control in living (where means and ends can be chosen) and an existential mode (recognising the limitations and finitude of existence) where orientation and means can be chosen but not control.
- Highlight the need to distinguish personal values as of a different order to utilitarian judgements. Values depend upon a self-investment, an embodied willingness, a choosing beyond calculation of means an ends.

- Show addiction as an orientation that attempts to achieve satisfaction, or relieve discomfort, by inappropriately attempting to maximise control.
- Suggest the attainment of agency and meaning through a process which relinquishes coercive attempts to change reality – a ‘releasement’ (*Gelassenheit*), living more authentically with what is.
- Commend recovery as an existential action based upon the accumulated weight of personal meaning - associating self with a particular direction/need/value.
- Attend to self-investment as a key values-driven step, providing a distinct perspective on an everyday, contingent experience of choice that may be the subject of attention in addiction therapy.

Turning to the ‘experientializing’ approach, these avenues bring a significance to the issue of values that may not be emphasised in experiential work. It endorses and enhances the limited focusing-oriented therapy material about choice that was set out above (Ob.51, page 121).

In summary this avenue identifies three sub-steps – standing aside from the illusion of control, attending to values through self-identification, moments of choice that affirm the new reality in tangible terms. Each provides an opportunity for focusing-oriented development:

- Firstly, focusing-oriented therapy provides a means to stand aside from attempts to control living and the problems associated with it. It allows the person space to attend to the whole existential issue and provide an understanding and accepting attitude that supports existential exploration. Maintaining a stance in the implicit allows too simplistic tendencies toward judgement and fixing to be avoided.

- Secondly, focusing-oriented therapy is aware of a rich source of material from which a reorientation of value can be developed. Clients can be assisted to discover the significance of implicit fragments from their life in different times and contexts. Particularly they can be assisted to build an 'I-Thou' relating to what matters to them even in behaviour that otherwise might be abhorrent.
- Thirdly, focusing-oriented therapy can assist with the key issue of turning a reorientation of value into practical change. The experiential method can allow multiple senses of self-in-situation to be recognised and valued, avoiding coercion externally or internally. Thus moments of choice can be highlighted as experiential experiments, where the individual waits on their own carrying forward.

This is a significant avenue for focusing-oriented therapy for recovery. The material suggests ways that the unique capabilities of focusing-oriented therapy can be exercised, yet calls for greater clarity in doing so.

Observation 84 - Avenue 'D' contrasts utilitarian modes of 'controlled' living from those based on values and acceptance (Gelassenheit). It characterises the choices in recovery as acts of value-driven self-investment rather than calculation. In these terms focusing-oriented recovery depends upon carrying forward through 'releasement.'

The avenue suggests a recovery task to complement those of the core model:

Observation 85 - Recovery Task D – To assist clients to make choices based on values and 'releasement' (Gelassenheit) rather than 'controlled' living.

6.3.5 Avenue E – Concrete carrying forward

This avenue looks at the behavioural interventions that are considered significant in addiction treatment and the structural shells that may be developed to support them. In theoretical terms Avenue ‘E’ develops further the suggestion that the zig-zag of carrying forward can take tangible rather than linguistic form (Ob.23, page 59) and the fifth client task, ‘dwelling’ (Ob.51, page 121). Gendlin’s use of the terms ‘concrete’ and the client task of ‘concrete sentience’ are also relevant (Ob.48, page 114).

Relapse Prevention – Structured self-assembly

In a quasi-technical way Relapse Prevention has taken the addictive behaviour process to pieces and established strategies that target each particular element to reduce the probability of impact/recurrence and cumulatively increase likelihood of desired action. These include interventions to respond to urges/cravings, rationalisations/denials, high risk situations, lapses and the responses to them (‘abstinence violation effect’) (Larimer & Palmer, 1999). The subject of these interventions is encouraged to almost be a fellow technician, observing malfunctions in a system and making practical adjustments to deal with them.

Such an overall orientation underlines the way that, whatever the larger motivational and psychological factors that may be caught up in addiction, its resolution depends upon engagement with the particularity of contingent reality – circumstances, pressures, attitudes, judgments. The individual is supported to move in a particular direction as accumulated blockages are systematically removed and supporting structures assembled. Whilst treating core competencies, this approach eschews a blueprint for resolution. However it expects each participant to be engaged in an active process of contingent self-assembly – subjecting prototypes of change to constant refinement through repeated practical trial and error. It builds a pragmatic appraisal of what helps and heeds recovery.

Recovery Capital – Investment in life

Recovery capital refers to the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe alcohol and drug problems.

It builds on a ‘biopsychosocial’ (e.g. Griffiths, 2005) view of addiction. If changes are made to the situation that supports the addictive behaviour, change in living may follow. A hierarchy of needs are recognised starting with the physiological, safety and relational, and then building to esteem and self-actualization (Maslow, 1954). It is exemplified in research which shows that the key issues of recovery are *“the avoidance of their former drug-using network and friends and the development of a set of non-drug-related activities and relationships”* (McIntosh & McKeganey, 2000, p. 189).

At a deeper level this refers to the ties that connect an individual to the ecological and inter-personal resourcefulness of their context. What opportunities are present to build a viable way of life in a particular place, to make meaningful relationships with others and establish ties of reciprocity? The opportunities of participating in the social and ecological space are accompanied with matching responsibilities (White & Cloud, 2008). Addiction is normally associated with skill deficiencies in building such a physical and human habitation and there is a need to overcome the frayed life chances involved.

The implicit imperative to participate in life as it is lived, to invest in life in a particular place, represents a major source of resources and stimulation toward recovery.

Twelve step – using a structure

The twelve step tradition is notable for having a developed structure of principles that are passed on through generations. For example the steps offered as the key tasks for all adherents have not changed since 1939 (Alcoholics Anonymous,

1952). However, the paradoxical quality about the fellowship is the way that unchanging tenets of faith and practice are nevertheless expected to be embodied in a very personal and idiosyncratic process. Considerable scrutiny is offered about the degree and sincerity of ‘working’ the steps that an individual performs. The process must have a real existential quality.

Working from a focusing-oriented basis, Noël (2009) provides examples of participants using a felt sense to connect to their ‘Higher Power’ in very personal terms:

J: *“I see a superior being with a long cape. This cape is made up of the universe, and seems alive. It feels majestic. This majestic being has his back turned, but as if saying, ‘follow me.’”*

L.: *“I see Jesus, but Jesus is supporting my back, gently nudging me along, saying ‘Go ahead.’”*

C: *“I see a hole, something small on the horizon, toward which I am moving. As I go up to it, it opens up into a big space where all is well. It feels good.”* (ibid, no pages)

So whilst having a strict structure of involvement, the dogmatism effectively provides a structure for the revision of a highly personal approach to life:

“For most AA members, who do not identify as being religious in any traditional sense, this new orientation is specifically achieved through reclaiming the right to personalised faith by creating one’s own religiosity and rejecting the theological teachings of organised religion.” (Medina, 2012, p. 123)

A combination of a rigid structure with a requirement for a personal process seems to be one of the keys to the success of this tradition.

Summary and experientializing reflections

In summary this avenue demonstrates approaches that:

- Indicate the recovery advantages of attending to the detail of practical contingencies associated with a shift in addictive behaviour. Thus, alongside the personal and motivational changes, practical steps aimed at addressing the risk factors are seen as advantageous.
- Identify the significance of the broader context in providing a fruitful sphere in which recovery can take place. This is true both at the low levels of a hierarchy of human needs and also at the higher level where the potential for ecological and interpersonal engagements is important in motivation.
- Offer a strong structure to direct, coach and support a person in recovery, yet with an emphasis on personal investment to perform the duties of the structure in a self-invested way.

Turning to the ‘experientializing’ approach these avenues identify emphases usually outside the normal sphere of focusing-oriented therapy. They beg questions about the degree that the zig-zag of carrying forward in recovery can take a concrete rather than linguistic form (Ob.23, page 59). How much can the practical constraints and supports described help a person give expression to implicit reality as it carries forward? How much can they stimulate an existential encounter that mere linguistic shifts may not bring to fruition?

The previous avenue advocated the application of explicit dissonance to stimulate expression of the implicit. Such opportunities are amply provided in the immediate moment-by-moment choices of a person seeking to live forward his/her problems in changed behaviour. From an ecological perspective such tangible expressions represent precious opportunities to reconnect to the implicit mesh of interaffecting, the responses (Äusserungen) that can sustain and

empower change (Ob.24, page 60). As the client makes improved physical connections, often renegotiating tangible obstructions (Ob.19, page 50), he/she relates to the implicit coherence within their situation (perhaps through small steps Ob.21, page 54) and the interaffecting carried forward in the fifth client task ('dwelling,' Ob.51, page 121).

Observation 86 - Avenue 'E' highlights the zig-zag between concrete expressions and the implicit as a key process in recovery. It points to the carrying forward that can arise from the explicit through practical steps of reordering and the use of tangible supports.

The avenue suggests a recovery task to complement those of the core model:

Observation 87 - Recovery Task E – To assist clients zig-zag between the implicit and tangible forms to carry forward their concrete situation.

CHAPTER 7 – CASE ILLUSTRATIONS – CORE MODEL

This chapter and the following one set out an account of two cases to illustrate the models proposed. This chapter concerns the core model of focusing-oriented therapy for recovery (Ob.77, page 178) and the following one concerns the five ‘avenues’ identified (A-E e.g. Ob.79, page 186 etc.).

They provide the opportunity to see the impact of a range of tasks and methods on two very different subjects. Client M35 was an externally-oriented client who wished to pursue the practical changes necessary to release him from a pattern of addictive living that he could not control. By contrast client F26 was an internally-oriented person with various ‘psychological’ problems which she attempted to relieve with alcohol and self harm. Both therefore had ‘internal’ and ‘external’ problems and both showed markedly different dispositions toward their resolution.

By way of introduction an overall summary of each case is set out separately, showing the process of therapy and the key issues presented. Material is then presented concerning each of three core recovery tasks (Ob.77, page 178) of the core model. At the end of each section a summary is given according to the core recovery task, the relevant understanding of addiction (Ob.73, page 170), the relevant client task of focusing-oriented therapy (e.g. Ob.47, page 112) and the four therapist roles for focusing-oriented therapy (e.g. Ob.52, page 123). Material is then set out to illustrate each of the five recovery tasks associated with the ‘experientializing’ avenues (A to E, e.g. Ob.79, page 186 etc.).

Detailed references are provided for quotations of client sessions that are mainly intended for the author’s use only. However, to illustrate it may be helpful to understand that M35/07/C10 refers to the 7th session of client M35 and the 10th response of the client in the excerpt transcribed. Excerpts from therapy sessions

are included and, to retain anonymity names and other identifying features are obscured e.g. <husband>, <quotes time and date>.

7.1 Introductions to each case

7.1.1 F26

This first case refers the first sixty-three sessions of therapy. They were undertaken by me at a substance misuse charity and formal consent was given by the client to use for research purposes. All sessions but the first were recorded.

The client was a 32/33 year old female and records showed that she was referred by a Substance Misuse Nurse at the NHS Alcohol and Drugs Service because of alcohol problems associated with her psychological issues. At that time she had engaged with the NHS service for 'several months', had completed a Relapse Prevention course and 'has used the skills acquired to very good effect.' According to the referral, counselling was chosen as she 'has identified several issues from her past that she may need some help resolving.'

The referral form indicated she used between $\frac{1}{2}$ - $1\frac{1}{2}$ bottles of wine daily and had been using alcohol problematically for 2 years. The psychological health section indicated that she was receiving mental health services from a community mental health team with references to a consultant psychiatrist for reviews of medication. Medication was listed as Escitalopram (an antidepressant), Depakote (a bipolar treatment) and Propranolol (a beta blocker). She was listed as having anxiety and had received a diagnosis of Borderline Personality Disorder. Self-harming was significant and suicide had been considered with plans made.

The notes refer to the client being an identical twin. Her parents separated when she was 10 years old and the client had lived with her mother. At the age of 16 she began to suffer from depression without apparent cause. The referral stated

that 'alcohol has been used since age of 18 to self medicate and dampen down anxiety levels.' She had undertaken Cognitive Analytic Therapy.

Core Problems

When she began therapy with me she identified four topics she wished to pursue in therapy:

Problematic Drinking

There was a pattern of using alcohol relatively indiscriminately as a means of dealing with psychological states, social pressures and the inability to cope. This was often combined with medication:

"The night before you know I took some tablets and a bottle of wine, well last night it was 2 bottles of wine and more tablets. About 200 mg of Diphenhydramine [an antihistamine] I think. Enough with the wine to knock me out and trip. I saw sock puppets. The end result, as you know, was feeling like I was made of lead the next day.¹

Depression

The depression the client feels was associated with a mental state she has described as the 'fugg.' This was a mixture of tension, anxiety and depression. It was so intolerable that it led her to want to relieve the tension in whatever way fell to hand. She was torn between two extremes as to what she might do at such times. One would be to smile and shrug and say things were all going to be fine. The other would be to curl up in a ball and cry or 'punch the life out of something.'

An Inner Critic

The client suffered from intense critical self-rejection,² an ability to force herself through things that are painfully wrong³ and used a facade behind which her needs may be hidden.⁴ The critical voice considered that she was selfish and needy and showed a pathetic weakness that rendered her as bad as those she abhorred.⁵

SelfHarm

The client had an established pattern of self-harming both as a way to respond to everyday tensions and as an extreme measure. The former normally involved cutting and the latter had led to a broken wrist due to hammer blows. Hitting her head against a wall had also been used.

The process of therapy

The process of therapy showed recurring patterns of behaviour based upon the entrenched issues. As will also be seen, a general trend of improvement was evident during the period of the therapy, punctuated by lapses. The therapy cannot therefore be divided into clear stages, rather by significant events within and outside the therapy that marked the path followed.

During the first part of the therapy I took trouble to attend to the client's feelings. At the start she found even the thought of them abhorrent. I was introduced to the 'fugg', first by report and then as the client began to display a fugg state during sessions. Having attended to this I began to assist the client to shift her experience of it.

Suicide occurred as an issue particularly after the tenth session, where I consented to an impromptu additional session to address her immediate suicidal state. The client had prepared stockpiles of medication. The issue of suicide reoccurred several times later during the therapy. On these occasions the client absented herself from work and, under the influence of medication, considered walking out into the traffic on a main road.

Self-harm and alcohol use were regularly addressed as a barometer for the client's psychological problems and also a cause of anxiety within her family. After significant two-chair processes the client started to use a plaster cast or 'pot' on her arm as a way of dealing with this. Attempts were made to regulate drinking with some effect, but the focus was on the person rather than this behaviour.

The client's repeated sickness absence from work led to occupational health scrutiny and steps towards dismissal. The stress from this and responses to it were significant in the therapy too.

During a *Change Interview* upon the completion of the research period (see Appendix 6, page 393), the client was asked about what she might like to change about herself and admitted that a year ago she would like to have changed all of herself⁶ but subsequently did not wish to change any.⁷ Among the changes that had occurred she included "*I am able to accept (I still hate the word), accept my feeling,*"⁸ and "*I don't think I hate myself as much anymore.*"⁹ She described the therapy as significant:

*"It was just the only way I was going to be alive. I couldn't carry on for the rest of my life like it, that's for certain. It was the only way I was going to be able to move anywhere."*¹⁰

Emails and Text Messages

An unusual characteristic of the therapeutic relationship was the use made of text messages for therapeutic purposes. Shortly after the third session the client started to occasionally text me with a report of her felt sense and the circumstances surrounding it. Special agreement had been reached about boundaries because both sides thought there may be an impact on psychological extremes and destructive behaviour if the client could experience herself as 'heard' in a focusing-oriented way.

7.1.2 M35

The second case refers to the first thirty sessions of therapy. They were undertaken by me at a substance misuse charity and formal consent was given by the client to use for research purposes. All sessions but the first were recorded.

The client was a 45/6 year old male who self-referred because of alcohol problems after therapy elsewhere, including couple therapy. The referral assessment was that he most likely was physically dependent on alcohol. The form described him as a successful businessman living between two properties, a flat and a house shared with his partner. It records an association between where he lived and alcohol use. He regularly went back to the flat to drink during the day. He considered himself to have an 'avoidance disorder' and felt that "*the alcohol issue is probably the first five metres of the ocean and what's below it is this avoidance.*"¹¹

Core Problems

When he began therapy with me the client was presented with a provisional model of therapy that differentiated stages and asked him to describe his current state ('where am I now?') and envisage a step forward ('what would *under way* feel like?') in terms of tangible achievements, experiencing skills, 'daemons' and 'blocks' and support. Edited examples of his responses are set out below:

Table 7.1 - Initial issues for M35

	Where am I now?	What would 'under way' feel like?
Tangible achievements	<ul style="list-style-type: none"> • I allow myself to be in position where I can drink at will • I want to be in control and to want to control it • I'm not in control when I'm alone 	<p>To have goals that I achieve:</p> <ul style="list-style-type: none"> • Not to drink before midday • Not to exceed daily recommended guidelines • To give myself 2 alcohol free days per week • To drink only socially <p>To be clean would be:</p> <ul style="list-style-type: none"> • To run faster and further • To feel brighter • To sleep well • To be more effective at work • To control and not be controlled
Experiencing skills	<ul style="list-style-type: none"> • I'm drinking too much • I'm not in control of my own drinking • My drinking has a negative effect on my home life and my work • I'm concerned that my drinking will have long term detrimental effects on my health • I drink at inappropriate times of the day • I don't give my body/liver the time it needs to recover 	<ul style="list-style-type: none"> • To have more control over my drinking • To monitor and measure my drinking and learn from that • To have a plan • To give myself time for my body to recover • Not to drink so that I can't communicate with my partner or clients • To really understand the long term health dangers • To drink within certain times of the day - not first thing or with breakfast

Table 7.1 - Initial issues for M35

	Where am I now?	What would 'under way' feel like?
Daemons and Blocks	<ul style="list-style-type: none"> • I drink when I can • I'm always drunk a little • I want to drink • I drink when I am on my own • I don't need to be down • I've always used alcohol/smoking as a way of relaxing after work • Going down to my flat triggers use • I don't know why I drink 	<ul style="list-style-type: none"> • To not always want to drink when I have the opportunity to • To recondition my head so that drinking starts to become a social not an individual pastime • To move back to my other house with my partner and away from 'the cave' and all that it now stands for
Support	<ul style="list-style-type: none"> • My partner supports me, we have now moved to a place where we can talk properly about alcohol and I don't need to hide if I've had a drink. • It makes a huge difference not having to hide when I've had a drink. • I have the support of my counsellor. 	<ul style="list-style-type: none"> • I could be more honest with my family and friends. Although I don't know if this would help.

The process of therapy

The therapy followed a repetitive pattern from the beginning. At the start of each session the client would provide a breakdown of his drinking during the intervening week and allowed a discussion of the circumstances of it. From this there were suggestions from me about themes to pursue and practical measures to appraise.

During the therapy the client underwent a major shift in his personal life, eventually splitting up from his partner. At the start there was a significant pressure on the therapy to assist the resolution of the client's drinking problems so that he could be permitted to take up marriage and family life. As time went on the prospect of this way forward became increasingly difficult and eventually, a

decision was taken to terminate the relationship. The influence of this on reducing his drinking behaviour was significant.

At the same time the client had been struggling to establish a more viable life for himself without dependence on alcohol. He set himself targets both in terms of alcohol-free days and running. He completed two public 10k runs and improved his drinking to match.

At the end of this period the client was celebrating the longest period of unbroken sobriety since he was 14 years of age. He had established himself securely after the relationship breakup and achieved significant milestones in his running, homebuilding and alcohol use. During the *Change Interview* upon the completion of the research period (see Appendix 8, page 407), he described the therapy as 'educational':

*"I learned more about myself. I learned more about the reason why I was doing what I was doing. I learned different tools to try and deal, on several levels."*¹²

Asked how significant the changes achieved in therapy had been the client replied:

*"Huge, massive. To be honest there isn't anything that is more important. At some point I would have lost my license, probably lost my job. ... You read about guys that used to be director of whatever, fell off, became an alcoholic and ended up selling the Big Issue. And you think, there but for the grace of God ..."*¹³

7.2 Recovery Task 1 - Standing aside from the carapace

In this part four groups of material will illustrate the recovery task in practice. At the end a summary will bring together conclusions about this task and its consequences.

7.2.1 The 'fugg' (F26)

An addictive avoidance

The 'fugg' was a major difficulty for client F26. It described a compulsive existential state that engulfed her and, within which her sense of agency was hugely constrained. The fugg, her name for a mentally and emotionally overloaded state of incapacity, was both the cause of other 'addictive' behaviour and a compulsion in itself:

- She related to 'fugg' and anxiety as being an 'it.'¹⁴
- The fugg was "*an unmanageable mess in my head and I don't know how I feel, how I can react or anything about any of it. I just want to open the door in the back of my head, reach in, pull it out and be done with it.*"¹⁵ It was a feeling of 'mush' in the head, 'thinking through treacle'¹⁶ and was associated with panic attacks and 'pure fury.'¹⁷
- Once triggered the fugg grew in intensity "*it just opens the door for everything else to come flooding in then.*"¹⁸ The fugg was described in an analogy of a Blackpool ballroom:

*"The door opens and somebody comes in and starts screaming at you. Then somebody else comes in the other side and starts shouting that person down and arguing with that person so that the other person shouts back. Gradually more and more people come in and start arguing with each other, and try and analyse each other and try and figure everything out. Till you reach the point where you are stood on the balcony looking into the ballroom and you haven't got a clue what anyone is saying. There is just a mass, a cacophony of noise."*¹⁹

- She felt that the fugg must be fought and this exhausted all of her capacity
 - *“Don’t know what I want other than for it to stop, cos fighting it is so tiring it hurts. I don’t want to do it anymore, but I’m afraid to give in to it cos it’s so strong at the mo I worry where it’ll take me, nowhere safe ...”²⁰*
- However bad, the fugg was also familiar and comforting in lots of ways - *“I don’t want to allow myself anything other than that.”* This appeared to be because it allowed little capacity to deal with anything else.²¹
- A suggestion was made that the ‘fugg’ represented some material that needed to be experienced and expressed. Therefore fighting this would not be useful and the client should try to survive and hear it insofar as this was possible²² but this appeared impossible to her.
- The fugg was seen as making it difficult to take responsibility, or even to move about and do things.²³
- Statements from the client illustrated the importance of giving-in as part of the fugg (and I would say ‘addictive’) experience:²⁴

“It’s almost by, kind of like by me giving into that excuse provided, that then kind of gives the fugg that foothold to just kind of get in there and ... Someone’s comes up toward you and says ‘you don’t like having to deal with expectations do you really?’ So just, you know, you go off at home. You do not like having to get up and deal with people. It just gets more and more, yes, suffocating like that, really.”

“It allows that stepping yourself back from that cold, that putting-yourself-out-there. it provides an excuse to stay in that warmer, more comfortable place. It was what it was, but it allowed that fugg to come in and, for a while, for me to embrace

it, because it's a more comfortable, warmer place till it gets a bit scary."

Invitations to step outside it

There were a number of examples where the client arrived in a 'fugg' state or descended into it during the session. These illustrate the way that she was invited to step outside the configuration. One example took place in 36th session where the fugg discourse was evident in the tense, anxious depressive fog that engulfed the client. I asked her to recall the worst of it and she chose moments standing on the kerb beside a major road contemplating a step into suicide.²⁵ I attended to the sensations and begin to expand awareness to the context of her situation - positive experiences taking photographs,²⁶ our shared time of meticulously and fruitlessly tracking the fugg.²⁷ Gently the intense isolation²⁸ gave way to a more rich interpersonal connection, occasionally expressed through a gentle joke at my expense,²⁹ to the point where the client was making occasional quips.³⁰ I carefully visited the material we had worked on together, checking out where the client was e.g. including the admission that alcohol had been 'let back in' over recent weeks.³¹ The strongest turning point in this session occurred when, contrary to her perceptions, I introduced an alternative discourse by commenting: "*And I want to say that I see stability in you which you don't see in yourself.*"³² This led to a discussion of her reluctance to admit such stability, the grounds for her distaste and the contradiction involved in it. I recognised it in her distinctive smile something that felt to me like a 'flexible stability':³³ She responded,

Client Um. ... I'm so pretentious! [laughs] Maybe it's the core of me but, kind of like a willow tree ... particularly flexible, you can bend all sorts of shapes out of it. Mmm. Nice sitting under that kind of tree. You can just sit there and listen to the 'Wind in the Willows.'

The ‘willow’ metaphor became significant and is explored in section 7.4.1 (page 248).

Recognising and switching discourses

The ability to recognise and switch discourses provided a way for the client to step out of the control of addictive patterns. Another example occurred in 40th session at which point she had been absent from work for a long time on sick leave, with short-lived attempts to return to normal attendance. The session occurred on a Monday afternoon where she had failed again to return to work, even knowing that the following day would bring a formal hearing that, at best, would lead to a final written warning justifying dismissal if she was absent again. The client was open about this, the heavy drinking she did the evening before and a ‘black hole in her stomach that “*if I allowed it, could just suck everything into it.*”³⁴ I observed that she was very close to losing her job and potentially (as major breadwinner) her home too. The client nevertheless perceived herself to be entirely impotent.³⁵

Whilst longwinded at times the approach then used by me fits within the Socratic challenge described in the ‘avenues’ and has the following characteristics:

- A choice not to participate in the discourse of the ‘black hole’ or ‘fugg.’ Normal opportunities to express empathy are ignored e.g. sympathy for self pity.³⁶
- A decision to repeatedly bring the client’s attention to harsh immediate reality e.g. things are sliding,³⁷ the likelihood that she would lose her job.³⁸ However, there was no moralism or censure. She talks of making excuses and others being disappointed with her, but I do not even acknowledge this language.
- A repeated enquiry about parts of the picture where the client could exercise a choice. Whilst the difficulties of the client’s position were acknowledged, I did not see these as invalidating the possibility of active

choice. I used the quantity of wine drunk and the possibility of walking into work as illustrations of real choices not taken.³⁹

- The direct reminder of “*another sort of <client’s name> that I know.*”⁴⁰ I suggests that somehow the client toggles between senses of herself (discourses) at the snap of a switch. When the client commented that she could not maintain the other sense of self, I respond that I was “*not asking you to maintain it but I’m asking you to have space in the world for it to be. And not to be kicked out by this marauding ...*” [configuration].⁴¹ I pointed to the client’s distinctive smile as a sign of her other self,⁴² acknowledged the sense he has that she might feel attacked or affronted⁴³ and asked her to summon up the feeling she would have in this more positive mode⁴⁴ even though it may be exhausted.⁴⁵

This material shows examples of the impact of the ‘fugg’ upon the client – a repetitive structure of interaction that would overcome her and stimulate aggressively addictive, self-harming and para-suicidal behaviour. Attempts to attend directly to this in a focusing-oriented manner proved counter-productive. Nevertheless, I demonstrated the ability to recognise the particular discourse that was engaged and showed how it could be broken away from. The capability to shift from an addictive frame was gradually learned by the client. The fugg was often experienced in the first part of the therapy, but became less frequent as the therapy progressed, except for moments of extremity.

7.2.2 Self-harm (F26)

The ability to step out of an addictive discourse was illustrated dramatically in the process that helped the client move forward regarding her self-harm. This way of responding had been a major issue for the client since the age of 19.⁴⁶ Just before the fourth session she found herself in A&E and admitted that the pattern was “*arm in plaster once or twice a year,*” “*cutting – weeks to maybe a month*

*between.*⁴⁷ The urge to self-harm was an ever present 'itch' waiting to be scratched.

Self-harm was closely associated with the fugg and the configuration reflected the same sense of being overshadowed rapidly. It had a quality of caring for herself but also there was an immense tension between the urge to inflict injury and its absolute prohibition. When asked to attend to the process in a focusing way the client responded, "*I am simply unable to know that bit because it just gets overshadowed so quickly and so completely by 'don't do it.'*"⁴⁸ Throughout the therapy I accepted the client's need to self-harm and sought to understand this rather than merely prevent it. This recognition was also offered by means of texts and much later she replies to one:

*"So anyway, I guess I wanted to say thank you, and that I like the sense of it, and that I like the sense of noticing you give me too. Hope I make sense, I am feeling a little like harming so I felt I wanted to communicate this, a connection via this strange medium might give me that caring that harming might otherwise."*⁴⁹

A two chair process in sessions eighteen and nineteen provided the means to express and stand aside from the self-harming configuration and in some sense beside it (Ob.49, page 115) in an I-Thou way (Ob.71, page 166). The two chair process is detailed elsewhere (8.3.3, page 283), but in self-harm terms it was useful to recognise the bifurcation of Topdog ('Tom') who inflicts pain and Underdog ('Jerry') who endures it. This split was distinctively more experiential than the normal division in addiction between the addictive and non-addictive personalities. It recognised the underlying needs in both positions and the requirement to facilitate encounter and even a negotiated settlement rather than denial and the simplistic win-lose of recovery.

At the end of the exchange there was a moment of carrying forward:

Topdog “But you're used to being hurt, so ... I can do what I like. [pause]

I can think of a potential compromise. But I don't know how well received it would be, or even if it is possible. ... In that if I could find it possible, a way not to get to do this [points to bandaged wrist] then I would have to find another way to listen to it, you, rather than just beat the shit out of it.

Underdog I'm not sure I quite understand that. So if you could find another way not to do that ...

Topdog If I could put this in plaster so that I wasn't able to break you anymore, or bruise you, or cut you, or anything else. Then I wouldn't be able to do any of that.

Underdog That should be lovely. But we know that the medical profession is not so good at giving away pots for nothing.

Topdog There's ways and means.”⁵⁰

The client went to hospital as an outpatient from this session and managed to arrange for a plaster cast (or 'pot') to be put on the arm that she constantly injured. On the way home she texts to me:

“... my arm is in pot with a HUGE sense of relief! To that bit of me that doesn't want to hear, from that bit of me that wants to be heard ... ‘thank you for looking after me, I feel validated and valued.’ <therapist> you can imagine the script from there on it (self loathing, uncomfortable, detestable, squirm inducing drivel) but, well, there it is.”⁵¹

She was accompanied to the hospital by her mother-in-law and, for the first time, allowed a family member to see the injuries to her arm and participate a little in her troubles. The following session acknowledged that she had not harmed

herself this week and I noticed a sense of decisiveness in this action, as much a symbolic step as a practical measure. She responded:

*"Like you say it's a sign that OK, I'm going to listen. You know, that part of me is going to listen to this part. Just kind of ... just kind of actually try and listen to it rather than drown it out."*⁵²

Speaking of the moment when the cast was put on her wrist she said:

*"Yes, that's what it felt like when it went on. The fact that it was just kind of like that ... Ok this is listening to this bit, and not trying to drown it out with hitting it with a hammer. I hope it has got a lot further than that but it felt ... Yes, it just felt sort of ... safe."*⁵³

Whilst this was a significant shift there were inevitably periods of floundering that followed⁵⁴ and the client established a way to remove and replace the cast as appropriate. Thus she could wear it when there was a need to protect herself, but leave it off at other times. The changing perspective on self-harm was illustrated in a text:

*"I'm confused! As you know I've been wanting to harm more at the mo[ment]. Well I've been struggling with it. I've found myself not being able to as much as I want (hence why I still haven't got it in cast) and not knowing what to do with that feeling. The actual act of doing it doesn't seem to come as easily nor serve the purpose as much and it's driving me nuts! I want to, I can do and to a certain degree I am, but it feels weird. I'm kind'a lost or challenged with the feeling I'm left with."*⁵⁵

A changed relationship had occurred with this configuration with a degree of insight, as was illustrated by responses in the *Change Interview* at the end of this period of therapy:

Client *"Society expects you to not go round doing some things. Society sees that you do these things and thinks that you must be a certain way. To me it offers too much for me to be without it. Other people just see it as a weakness. 'Oh she must be ... you know, struggling with things. She obviously can't cope if she is doing that.'*

Interviewer *What's your understanding of it?*

Client *At the moment that it provides me with a way of caring for myself. But other people see it as a way of destroying myself. Which in hindsight I might have thought in the past but now I understand it differently."*

These examples provide a contrasting illustration of an addictive pressure to articulate something which was unacceptable and incomprehensible to the client herself. The addictive pattern of harm had been a regular pattern of life for over 13 years. Through a 'dual responding' (Ob.78, page 186) the client was assisted to stand aside from the repetitive stopped process and, finding an alternative articulation, she discovered some relief. The client became able to reach a relationship with this addictive pattern, stepping out of its control in the process. Starting to recognise its patterns she deployed the expedient of the arm plaster to keep herself safe. As with other addictive patterns, the self harm reduced in regularity and severity over the course of the therapy, whilst re-appearing at moments of crisis.

7.2.3 Alcohol dependence (M35)

The 'impossibility' of change from alcohol dependence

Client M35 provides a more traditional story of alcohol addiction and a process to break its habitual form. When he referred himself to the counselling agency he reported both the ability to have heavy drinking bouts consuming perhaps three

bottles of wine in a day (30 units) and the constant habit of using small Gin & Tonics regularly during the day to “*take the edge off.*”⁵⁶ He spoke of drinking alcohol before going for a morning run at the gym and of indulging heavily when arguments have taken place with his partner.

From the start the client was disappointed by his inability to resolve the drinking problem and chastised himself with the idea that “*You could say that actually, ‘grow a pair’ and it could finish today. You don’t need to have another drink. If that’s what you want to do.*”⁵⁷ This view was recalled in the *Change Interview* at the conclusion the research. The client reported performance in his drinking at the start of every session and commented during the *Change Interview* that he had worried about having a positive story to tell.

I guided him through a series of steps that could be part of a traditional Relapse Prevention process (see Appendix 6, page 384). He agreed to keep a drinks diary⁵⁸ and first went through a process seeking to restrain his drinking till after 9 am or 10 am. When this was only partially successful⁵⁹ I asked, “*Can we reach agreement on something, that even if war is declared tomorrow, I am still not going to drink before 9 am because I have decided to do so?*”⁶⁰ This achieved more, even though he admitted to pouring a gin and waiting for the radio ‘pips’ to give him clearance to drink it.⁶¹

Allowing a momentary sense of self

A tension was evident between the client’s eagerness for results and the ineffectiveness of resolutions made in the counselling room. The therapy was at that point aimed at assisting the client to connect to the felt sense of himself in situations. I invited him to check with himself often offering ‘resonating board’ responses to assist the process (Ob.53, page 126). When a compulsive impulse arose I encouraged him to make practice making choices based upon an immediate intuitive sense of himself and what was ‘right’ for him (Ob.85, page 205). I improvised a scorecard for him to identify moments of choice and his felt

senses, but without pressure for a particular outcome. The process linked a reassuring clarity of structure (a tangible task) with a more challenging self-acceptance and understanding. He responded well:

"It's changing that, 'I need a drink', it's changing that '<client's name> you are beating yourself up because you are drinking.' And it is taking those negative things. And I know, that's a really good idea because I know I will come back here next week and that will be filled out. Because as soon as I get one I will want to get the next one, and so on ... Should I need any encouragement? Rubbish this is really serious, I should not need it! But you giving me a little card, a bit of a challenge and a bit of something tangible ... Something tangible could be, don't go for a drink this lunchtime just go off and do some work. Then it is lost in the mists of time, whereas if I go off and do some work and I can tick that box, <quotes time and date>, that's exactly it.⁶²

The next week the client was able to report a period of 48 hours without alcohol. He had not done this of his own volition for five years or more. The scorecard process enabled him to notice moments of choice and take them. Multiple occasions were identified where he had noticed an opportunity to drink and exercised the choice not to. He reported feeling so much better, and a little taller.⁶³

Stepping beyond the addictive self

A continual preoccupation for the client was the sense of inadequacy he felt in the face of addiction. In a real sense he felt his manhood compromised and the need to expend more macho energy in 'getting a grip' or 'growing a pair.' The discrepancy between this expectation and his repeated incapacity regularly tied the client in knots of frustration.

I noticed that outside the conflict of addiction, he was nevertheless a successful self-employed businessman, able to handle complex entrepreneurial challenges with a light touch rather than an absolute need for control.⁶⁴ Over several sessions I invited him to have a sense of himself in this different setting, exercising capable flair in life. Could he imagine the felt sense of himself beyond the barrier of his addiction, confidently able to look back? He responded:⁶⁵

“Mmm, yes. And you describe it very accurately, in the sense that it’s almost like there is something I need to walk through to get to the other side. And when I walk through to get to the other side, and I put my new jacket on that I haven’t actually worn yet because it’s now a bit tight, it won’t be. I will be running 26, 27 minutes [for a 5k run] instead of a 32 or 33. I will have that feeling that maybe I will feel an inch taller because I have gone through this very difficult thing. And I’ll be in control of the beast, rather than the beast being in control of me.”

Several times he was invited to identify ‘handle words’ for the sense of himself and the sensing sequence goes from ‘more solid’, through ‘stronger’, ‘less niggles’, ‘harder’, ‘lighter’ and ‘fitter.’ He was invited to remember the feel of a moment when he had this sense and he starts to,

“describe the feeling after giving up smoking. It was 2nd August about seven years ago and, as a smoker, particularly a very heavy smoker I’d leave home with my car keys, my mobile phone, a couple of packets of cigarettes and my lighter. Bearing in mind this is August, the feeling of walking outdoors, sticking my phone in my back pocket, wearing a tee-shirt because I don’t need pockets, because I haven’t got any fags. That is liberating, it’s a weight that is lifted off you, that’s where this image of being an inch taller comes from I guess. I am seeing the two things as being very closely related, in the sense that ‘I’ve done it, I’ve beaten it.’”⁶⁶

As will be seen later, this sense of a capable sense of self, '*Mr Assured*',⁶⁷ was significant in the way that he conceived of a self-agency that was not dependent upon intensity of grip and control, a step towards a more 'wholesome' living.

Here the two parts of the first recovery task are clearly illustrated – attending to experiencing and standing aside from an addictive carapace (Ob.74, page 172). They show the same process but in small and large scales. In the first the invitation was to notice the immediate, contingent sense of self when an addictive pattern arose. What was it like to be in this moment? The second invited the client to find a sense of being-in-the-world outside the addictive pattern. Both depended upon the pause (Abstand) and felt sense (Ob.26, page 64), standing aside (even a little 'beside'), avoiding judgemental or coercion. The first had immediate impact upon the client's drinking practice, the second began foundations for the longer term.

7.2.4 'It's so difficult' (M35)

Another way that the client was enabled to stand aside from his addictive patterns was through work on the bodily felt sense of his drinking. He was invited to repeat the physical gesture of reaching for the habitual 15 ml Gin & Tonic, around which life was structured. Through a focusing exercise there was a feel of tension and the metaphor of driving a car when:

*"something is getting tighter and tighter inside and then, the same way that you push down the clutch, and it's almost like the car going 'fwhoosh' [releasing exhalation] from not being driven. It's a similar thing. It's that drink that is 'fwhoosh', and that tension or tightness, like something being twisted inside, like a rubber band or whatever, and then its 'fwhoosh,'"*⁶⁸

I noticed a hand gesture with the sound, a kind of 'release, a flinging' and from this there was recognition that whilst the tightening was self-inflicted, the release appeared to come from elsewhere. To the client it was similar to the physical

gesture of ‘release’ that he knew from shutting the door and smoking: “*It’s like a valve being turned and then air escaping, and [chuckles] pressure, a pressure valve.*”⁶⁹ This related to many things, including the sense of buried gunpowder within him, waiting for somebody to pull the trigger.⁷⁰ Such pressure was also released in physical assaults to inanimate objects in his flat, a broken door, doorpost and kitchen furniture, and also occasionally released in a physicality with his partner that he found abhorrent. During the session it was expressed in physically hitting the chair,⁷¹ in the exclamation “*for fuck’s sake,*” the less vehement coda, “*It’s so bloody difficult. And it shouldn’t be this difficult,*”⁷² and the feel that it “*sounds like a school report, ‘could try harder.’*”⁷³

The need for release naturally led attention to the whole sense of being-in-the-world where it was building up. It connected to judgements others were making of him to which he assented – that he was ‘emotionally retarded,’ with ‘Avoidant Personality Disorder’⁷⁴, and should be seen as responsible for the depression of his partner and the negative state of their relationship.⁷⁵ (Only reluctantly, twice in thirty sessions, did he briefly mention what might have fuelled these tendencies - a father who left home and largely disappeared when he was ten and two previous relationships that included elements of bullying.⁷⁶) I consistently encouraged him to attend to the sense of these problems outside the configuration that he has been trained to adopt, to stand beside himself with them. For example I noticed the degree to which he opened himself up to criticism and suggested that he may have learned early the habit of regulating the emotional surroundings of others.⁷⁷

This process was long and difficult but culminated in the final session of this series, where he reported having been able to deal with his former partner with equanimity. He had become aware that the empty feelings associated with that would normally lead to drinking. Such moments had become less difficult but were still there. Talking to him I noticed how he was now separating two

elements that had previously been inextricable – moments of vulnerability and the compulsive resolution of them through drink.⁷⁸

This work shows another example of assisting the client take a step toward awareness of his experiencing and away from the addictive stopped processes that had become almost unavoidable for him. Working with physical gestures proved very successful to allow the whole mesh of his being-in-the-world to be brought into awareness and gradually symbolised. The ability to put aside normal self-censure and to stand alongside the addictive behaviour with understanding and compassion, allowed the client perspective and stability, the first step of recovery. This again illustrates two significant themes – standing beside the addictive process (Ob.49, page 115) and showing compassion through an I-Thou encounter (Ob.71, page 166).

7.2.5 Recovery task, evidence and therapist roles

Chapter 5 concluded that in terms of Experiencing and Existence:

- **Addiction** is a process-skipping – A disruption or dysfunction in a person's ability to relate to their own experiencing. (Ob.73, page 170)

Illustrations above showed clients using a variety of patterns to avoid experiencing – For F26 this involved the 'fugg' (7.2.1), self harm (7.2.2). For M35 there was alcohol dependence (7.2.3) and emotional overload (7.2.4). The process-skipping behaviour was both connected to 'addictive' substances and shown elsewhere.

Chapter 4 identified one client task of focusing-oriented therapy relating to Experiencing and Existence:

- **Client Task 1 – Experiencing** - To encounter the immediate felt sense through a shared pause (Abstand), that frames what was yet unclear and fragmented. (Ob.47, page 112)

Clients were invited to pause addictive behaviour and encounter an immediate felt sense – F26 was permitted a self not constrained by the ‘fugg’ (7.2.1), an encounter with Topdog and Underdog (7.2.2). M35 had a momentary sense of self (7.2.3) and an appreciation of self under pressure (7.2.4).

Chapter 6 identified:

- **Recovery Task 1** – To assist a client to stand aside from their addictive carapace and attend to their own experiencing, however limited it may be. (Ob.77, page 178).

The significance of being able to stand aside from a discourse of ‘others inside’ (Ob.63, page 152) was illustrated in several ways – F26 found release from the fugg and the ability to engage in employment again (7.2.1), overcoming self-harm to an extent (7.2.2). M35 found change from alcohol not to be ‘impossible’ (7.2.3) and a self not subject to an ‘Avoidant Personality Disorder’ (7.2.4).

Chapter 4 identified four therapist roles in focusing-oriented therapy:

- **Therapist role 1 - Creating a space** - To facilitate a shared space where the client can relate to their immediate experiencing and be heard accurately (exactly though differently). (Ob.52, page 123)

These illustrations showed me offering a space for the expression behind patterns – F26 related to experiencing beyond the fugg (7.2.1) and started to listen to the sense of beating herself up (7.2.3). M35 was enabled to follow a trial of senses of self beyond the barrier of addiction (7.2.3).

- **Therapist role 2 – Felt meaning** - To offer a special attention to felt meanings, using self as a ‘resonating chamber’ for what may be present. (Ob.53, page 126)

The considerable benefit of ‘resonating board’ responses is well demonstrated in these examples (7.2.2).

- **Therapist role 3 – Articulations** - To attend to and invite articulations of carrying-forward in gestures, actions, values, flailing and experiences of self. (Ob.54, page 128)

Articulations were evident in various parts of this material. I asked about the felt sense of F26’s choices about work (7.2.1) and listened to implicit meaning in her self-harming (7.2.2). M35’s the ‘successful’ life of a client outside drink was explored (7.2.3) and he was invited to repeat gestures of drinking to attend to their felt meaning (page 232).

- **Therapist role 4 – Living-toward** – To respond as a human ‘other’ to shared implicit meaning with the client, ‘putting nothing between.’ (Ob.55, page 129)

These cases show a rich interpersonal connection with client F26 despite the fugg state (7.2.1) and during two-chair process I assisted by playing a part myself (7.2.2, see also page 283). M35 received a proposal of agreement ‘even if war is declared tomorrow’ (7.2.3).

Observation 88 - Case evidence supports the assertion of Recovery Task

1 – to assist a client to stand aside from their addictive carapace and attend to their own experiencing, however limited it may be. It also supports the general application of the four generic therapist roles in this work.

7.3 Recovery Task 2 – Carrying forward existential dilemmas

In this part three groups of material are presented showing elements of therapy that illustrate the recovery task. At the end a summary will be made, bringing together conclusions for this task and showing its consequences.

7.3.1 Relationships and a Bear (M35)

Whilst attending therapy for alcohol problems, a major task for client M35 concerned his partner. When outlining the dimensions of the therapy at the start of the *Change Interview*, the first perspective he mentioned was the “*painful breakup*” with his partner⁷⁹ and, though he was preoccupied with alcohol, this was the first change that he identified.⁸⁰ Problems in this area had been growing for two years, but came to a head and started some resolution during the therapy. The following lengthy section attempts to show the dynamic of this change and the painfully slow process of self-discovery that accompanied it. As a man with a marketing background the client frequently repeated catch-phrases that summed up his sense of self and being-in-the-world. Shifts in these catch-phrases illustrated the movements he made which, as will be shown later, related to major shifts in his use of alcohol.

At the start of therapy the client had an established relationship with a partner, with the expectation of marriage and children. They had been renovating and decorating a house where she lived, notwithstanding the retention of a flat as a base for his business, his “*bolt-hole*”⁸¹ and predominant residence. The client’s prevarication about commitment resulted in him being told that he was very selfish, denying his partner what she wanted - marriage and children.⁸² He reported a holiday which had good periods but also one where she “*threw something into the mix that really upset things*”⁸³ e.g. being clear about taking up full time residence with her. The client had “*a problem saying what I want in a*

*relationship in a normal grown up way*⁸⁴ and felt he must overcome this by leaping into commitment as if it were a bungee jump⁸⁵ or religious conversion.⁸⁶

A regular catechism (or 'sales slogan'⁸⁷) was deployed in therapy, enumerating her advantages (e.g. she was tall, she was good looking, she was arty) and affirming "*if I can't have you I don't want anybody else because what else would I want?*"⁸⁸ Over time this expanded to include his defensive "*if I can't have you I don't want anybody, and I just want to be alone.*"⁸⁹ Later at his darkest moment it was the symbol of his self-induced hopelessness.⁹⁰ The client used this phrase to reflect on change during the *Change Interview*:

*"I really couldn't see the wood for the trees. And I think that ... I say it was inevitable ... I go back to the phrase that really used to annoy <therapist> about 'if I can't do it with her I can't do it with anybody.' You know, 'woe is me' and I thought that reaching 46 I had found this person that I was going to spend the rest of my life with. I think probably that I had tricked myself, and sort of thought it was going to be easier than it was, and I didn't really see some huge clues along the way. [Interviewer: But you tried quite hard to make it work.] I did, and then I thought, well actually I don't want it, and I sort of want to be alone. And I think that I couldn't see that at the start of the year and I was sort of stumbling back and forth and back and forth."*⁹¹

During the fifth session the turmoil with this partner was connected to his history of being with girlfriends for a few months and then parting from them⁹² and in the following session it linked to the childhood loss of his father.⁹³ The client saw something inside himself as amiss and blamed himself for problems with a previous girlfriend and business partner.⁹⁴ He was ambivalent about the tenacious efforts his partner has made to keep the relationship going,⁹⁵ including her capability to "*just ask the same questions eight times till she got an answer that she wanted.*"⁹⁶ Pressures mounted on the client to make the necessary commitment. "*The gunpowder is in there buried just waiting for someone to pull the trigger.*"⁹⁷ As a person that avoided arguments, confrontation⁹⁸ and

aggression⁹⁹ he was appalled to realised that, under the influence of drink, he had grabbed his partner's wrists and bruised them.¹⁰⁰

The pattern of therapy paralleled the escalating pressure of the relationship with his partner. Her increasing desire for commitment was met with matching blocks from him, and with an inability to stand aside from a mutually unsatisfying relationship. During this time the I noted and affirmed 'configurations' of the client that assisted his growth (e.g. an 'assured' sense of self¹⁰¹) but these held no sway compared with his sense of an Avoidant Personality.

Yet the pattern slowly, almost imperceptibly shifted. He became able to notice the expectation he always had that he should regulate the emotions of others¹⁰² and the right outcome for him started to be "*a sense of acceptance that we can't go on any longer.*"¹⁰³ The client appropriated a minimal felt sense of what he most wanted in life, summed up in the quasi-sardonic yet partially defiant words "*I just want to be alone.*"¹⁰⁴

The concept of 'alone' was raised in the first configuration of how he felt in the flat¹⁰⁵ and was used as a symbol of retreat, "*I just want peace and quiet and to be left alone and ... I just want peace and quiet.*"¹⁰⁶ Worries about isolation in old age were now acknowledged,¹⁰⁷ but so also some pride over a viable single life over sixteen years.¹⁰⁸ The experience of his 46th birthday (see page 287) provided a grim edge to the sense of being alone - the feeling 'that-I-may-wake-up-one-day' i.e. not on a 46th birthday but a 66th or 76th still not further forward.¹⁰⁹ He struggled with 'self-pity' but also began to recognise an authentic sense of grieving for a relationship that did not reach fruition,¹¹⁰ and an understanding of the change taking place "*what I am going through is actually quite big.*"¹¹¹

Alongside the turmoil of the relationship it became possible to distinguish emotionally reactive patterns of drinking from an everyday self-comforting which was proved more straightforward to address.¹¹² Notwithstanding everything going

on he started to amass evidence of shifts in his drinking, achievements that were down to him and nobody else:

*"I recognise all of the things we have said over the past few weeks about <partner>, and not about <partner> and all the things. Maybe it's like that getting out thing, and the sluggishness and the lethargy, and actually saying to yourself - 'don't beat yourself up over it, there is something bigger going on here as well, in terms of the alcohol.' That's not going to be with you forever, that you are winning, you are beating it, you are there, you are turning the corner."*¹¹³

The self that was able to live a better life could be contrasted with the negative discourse he received from his partner,¹¹⁴ the interminable conversations with her he could not escape, leaving him with 'guilt' and the sense of being 'wounded.' Sitting with this feeling there was a 'raw' sense and he was reminded of a song that referred to a 'man with a black heart.'¹¹⁵ He felt his own 'vulnerability' and propensity to lash out (e.g. in drink) when the opportunity presented itself.

The image that occurred to me was of a chained bear (a medieval practice now seen in pub signs) - a strong, noble animal deprived of its right habitat and liberty and then baited. It resonated with the client and he recollected similar feelings in relation to a former partner and his former business partner¹¹⁶. The image of the bear occurred later when he was in the eye of the storm with his partner,¹¹⁷ and two months later the client used it as a way to acknowledge and accept the pressure he was under.¹¹⁸



The next session the client spoke of the cage disappearing for the bear and the animal emerging into the freedom, wandering around, a little unsteadily.¹¹⁹ Two sessions later he spoke about the desire to find a 'wholesome' place for the bear

and there were various indications that the bear was nosing around to find the right way to be.¹²⁰

Thus a parallel process developed. On one side highly emotional and confrontational interactions continued with his partner. These were characterised by long phone calls and her making uninvited acrimonious visits to his flat. Later he described a day that included six hours on the phone to her followed by an uninvited visit and another six hour conversation.¹²¹ In the twenty-first session he accepted that the relationship was reaching a point of no return and that the clash of energy between them would tear it apart, almost regardless of their intentions. The personal investment he had made was associated then with a lot of pain.

Yet in parallel to the turmoil another side developed, one with perspective and the ability to relate to himself with some compassion. Despite occasions where he shouted and lost his temper,¹²² he recognised ways to resist being “sucked in to *lowering myself*” and then end up “*beating myself up about it.*”¹²³ He started to see a pattern of energy transfer, where his partner’s frustrations are taken on by him and inflicted on the kitchen door.¹²⁴ It became clear that he could not control, only endure the mayhem.

When the harassment started to abate a breakthrough occurred for both partners.¹²⁵ He reported that she had begun to accept the need to move on and was making steps.¹²⁶ Listening to the felt senses there was a general sense of sadness, in his words ‘mourning’ for the relationship that was over.¹²⁷ Yet when he encountered her by accident he was able to notice the sadness it evoked and found himself able to resist the temptation to be nice to her in ways that would have “set me back a month.”¹²⁸

The therapy thus provided a structure within which the relationship could work itself out with much flailing and pain. Therapy did not solve it but provided a way that the client could carry forward from a stuck place. The resolution of the

existential dilemma paralleled the resolution of the ‘addictive’ pattern - both carrying forward in an interactive shape.

7.3.2 Shrug, smile and the ‘face’ (F26)

The physical manifestations of a client’s avoidance of experiencing have been significant in the therapy for F26, providing a means of self-recognition and opening up elements of the protective processes involved. The notes from the initial (unrecorded) session indicate the recognition and intransigence of the problem: *“Ability to show acceptable face to hide the pain inside. Very avoidant of feelings and emotions – does not even like the use of these words.”*¹²⁹ During the second session I invited the client to sense herself in the present and enquired about her smile - *“I need to be wary of your smiles don’t I?”* I commented before the end *“I don’t believe the smile is just a pretention. There is a bit of you in there as well”*¹³⁰

During the sixth session the client reported recent problems with sickness absence from work and I noticed her smiling and shrugging gesture. There was a recognition from her that her ‘barriers’ go up – smiling and shrugging things off¹³¹ yet the cost of this deception was made clear:

*“It’s that part of me, you know everybody just believes that I’m ok. It’s very easy to dismiss it. Part of me just wants to scream. I can smile and get on with the job but they have no idea how hard it is to be able to keep that up! Even when it does come without trying, it’s not going to be ok.”*¹³²

I compared the situation to a Relapse Prevention one with a drug person for whom ‘harm minimisation’ was the key – teaching skills to recognise places of risk and choose evasive action. Could she use similar strategies to avoid pressure? This was inconceivable to the client,¹³³ yet two sessions later she admitted awareness of such a facade and a temporary ability to resist using it.¹³⁴

The significance of such physical expressions of resistance only begin to be explored during session twelve, which followed an unplanned session associated with a suicide attempt by the client. I had met the client and addressed her suicidal intentions, in the process setting explicit boundaries to our relationship. However, the most significant element of the discussion had been prompted when she brought out the medications she had secreted. She recalled how I revealed an unguarded discomfort and irritation. I was,

“... so cross that you could hit me. ... Actually I think it hit home to me that I was in quite a serious position. I don’t know that I realised that I was in a particularly serious position. I kind of knew that I was but perhaps didn’t realise till afterwards that I was in a scary place.”¹³⁵

I recognised the ironic voice which, on that occasion, went with the smile and a shrugging shoulder, to enable her to express a desperate place as if she wasn’t quite serious. When the medications came out of the pocket there was a shock that punctured the irony. It hurt.¹³⁶ Talking about it afterwards we recognised that the boundaries negotiated between us about suicide were also an (intersubjective) challenge to the ironic voice – my dogged, not clever presence working from the feel of ‘I know this is right, I’m going to keep doing this.’¹³⁷ The client commented,

“When you say about the boundaries that we agreed on, to me it was just like you were there! ... That sense of you being there was perhaps what enabled me to listen to things.”¹³⁸

From that session three elements (being heard, boundaries and this ‘looking after yourself’) are identified as “*an antithesis of the ironic voice.*”¹³⁹ At the next session she returned to this which seemed to have “*hit the nail on the head,*”¹⁴⁰ stayed with her and led her to try and change her behaviour. She was encouraged to be neither inflexibly present nor absent, but to notice and take appropriate care. The ‘shrug and smile’ terminology became a recognised way of reflecting her struggles

with experiencing.¹⁴¹ I offered an accepting attitude to it, recognising the usefulness of a protective mechanism in difficult circumstances,¹⁴² encouraging her to use it consciously in therapy sessions if needed.¹⁴³ This acceptance perhaps gave her the confidence to choose an alternative to the shrug:

*"I can't just shrug things off like I/they don't matter. At least not without recognising it might matter (I'm still doubting, might?). Not sure how to do that yet, if indeed it's even possible, or even if it's true, but today helped. I've never really had kindness without feeling the need to reciprocate in order to prevent pain or discomfort for the person giving the kindness, (maybe that's a type of kindness itself). Or even had a kindness and caring that was genuine and undistracted, being really listened to (that feeling of being stabbed in the heart). The freedom I'm recognising in allowing your kindness in, (not shrugging it off and being genuinely heard) meant I feel strangely uncomplicated tonight and the lights shone brighter driving home."*¹⁴⁴

The shrug response was recognised as a sign that important matters were being touched on¹⁴⁵ and I suggested that if the sense of something can be genuinely touched even for a moment, it can be let go with a shrug.¹⁴⁶ When I challenged the client about her avoidance on sickness absence I noticed her shrug,¹⁴⁷ remarked on her physical demeanour (shuffling, high pitch of voice, anxious gestures) and the sense of her feeling affronted. She was pleased to be sensed and accepted, even though challenged:¹⁴⁸

Client "To sense a level of caring about whether I make an effort. Not just being told it. There is a warmth there that is more encouraging. Rather less, it's like you say, slightly affronted, almost, you know, feeling of having a finger waved in my face, told off kind of thing. To a gentle hand between my shoulders giving a gentle push to, make a choice I guess, [Therapist: Yes.] rather than you must do this.

Therapist It seems like a choice that is being made by default.

Client Or it is not being made at all. Like you say, by default ... that's going to happen, that's going to be the thing unless I choose to actually, actively, go down another path.

Therapist It is the shrug again isn't it. It feels like the shrug. It feels like 'what could I do.' Perhaps it isn't.

Client I know what I could do. I know what I must do. It's just whether I can allow myself to do it. That's how it feels whether I can allow myself to be that positive person. You know, let some of that in. I don't know, I keep punishing myself, I guess."

This small example of F26's shrug, smile and avoidant patterns show the therapy providing a place where her existential issues can be addressed, however painfully. Accepting the client and recognising that there is no 'right' answer, the therapist's role is nevertheless to be an active participant in the tussle, not content to stand by while the client drifts. Over time this 'living toward' (Ob.55, page 129) is what the client relies upon.

7.3.3 Recovery task, evidence and therapist roles

Chapter 5 concluded that in terms of Interaction and Encounter:

- **Addiction** is a carapace – A stuck pattern of repetitive, instrumental and defensive living. (Ob.73, page 170)

These cases show clients who have become entrenched in defensive patterns. M35 was enduring an untenable relationship and used drinking, retreat into a 'bolt hole', aggressive outbursts and self-denigration as ways to manage it (7.3.1). F26 adopted various expressions of a false self to defend herself (alongside use of alcohol and self harm) – the 'face,' shrug, smile and ironic voice (7.3.2).

Chapter 4 identified two client tasks of focusing-oriented therapy relating to Interaction and Encounter:

- **Client Task 2 – ‘Concrete Sentience’** - To attend to a sense of the interaffecting in the whole situation, ecological and intersubjective. (Ob.48, page 114)
- **Client Task 3 – ‘Being-with’** - To stand as a human alongside senses of being-in-the-world, beginning to find ways to relate and the potential for habitation. (Ob.49, page 115)

In this material we see clients who are unable to face untenable situations being assisted through stages to relate to them. M35 began by endorsing his partner’s condemnation of his avoidance, but then began slowly to attend to his sense of the reality – the gunpowder waiting to be exploded, ‘being sucked in’, ‘I just want to be alone’, the chained bear (7.3.1). F26 was enabled to attend to the feelings hidden under repetitive responses, so that she could begin to accept kindness and show it to herself (7.3.2). Both clients moved from starting to attend to the felt sense of their situations to the point where they could stand alongside them.

Chapter 6 identified:

- **Recovery Task 2** – To assist a client to address and carry forward the existential dilemmas which concern them.

Both case study clients worked hard to resolve longstanding unresolved issues. M35 came to different terms with a failing relationship to the point that he could establish a viable alternative life for himself (7.3.1). F26’s issues were encountered in a suicide conversation and another about the potential loss of her job over sickness absence. She was enabled to take a step forward with both that would otherwise have been inconceivable (7.3.2).

Chapter 4 identified four therapist roles in focusing-oriented therapy:

- **Therapist role 1 - Creating a space** - To facilitate a shared space where the client can relate to their immediate experiencing and be heard accurately (exactly though differently). (Ob.52, page 123)

The importance of a safe space for the implicit is clearly significant to both clients, notwithstanding entrenched patterns of avoidance – I listened for M35's relationship beyond his labelling (7.3.1) and offered a degree of kindness and warmth that F26 denied to herself (7.3.2).

- **Therapist role 2 – Felt meaning** - To offer a special attention to felt meanings, using self as a 'resonating chamber' for what may be present. (Ob.53, page 126)

These cases show how focusing interventions are significant for resonations that clients do not perceive themselves – for M35 the chained bear (7.3.1) and for F26 the sense of a decision about employment that was being taken by default (7.3.2).

- **Therapist role 3 – Articulations** - To attend to and invite articulations of carrying-forward in gestures, actions, values, flailing and experiences of self. (Ob.54, page 128)

A variety of powerful articulations are illustrated here – for M35 the destructive and aggressive expressions of the client in relationship, counterpointed by hiding himself in his bolt-hole (7.3.1.), for F26 the physical gestures of dismissal offered by another client to the world and herself (7.3.2).

- **Therapist role 4 – Living-toward** – To respond as a human 'other' to shared implicit meaning with the client, 'putting nothing between.' (Ob.55, page 129)

These cases illustrate the distinctive steps that can be achieved through interpersonal encounter with clients. This was vividly illustrated in the fulcrum moment of F26's suicide conversation (7.3.2.) when the client was struck by my human response to seeing the prepared medications.

Connecting to M35's 'chained bear' image (7.3.1), I opened an understanding that was initially anathema to the client, one based upon a depth of compassion and kindness.

Observation 89 - Case evidence supports the assertion of Recovery Task

2 – to address and carry forward existential dilemmas.

It also supports the general application of the four generic therapist roles in this work.

7.4 Recovery Task 3 - Finding a new way of being-myself-in-the-world

In this part two substantial groups of material will be presented showing elements of therapy that illustrate this recovery task. They will show the evolving impact of therapy as expressed in growing senses of self-efficacy. At the end a summary will draw together conclusions regarding the task and its consequences.

7.4.1 'Getting me' and the Willow (F26)

The crucial issue for client F26 was the degree to which her sense of whole self can be seen and accepted by others, seen and accepted by herself and find expression in her own sense of living. Thus the process of therapy first tried to provide space for all of her and alternative configurations to be accepted, then facilitated some dialogical debate for herself and finally encouraged living out of senses of her own agency.

Getting me

It was important to her that I could listen without saying ‘but you shouldn’t feel like that.’¹⁴⁹ This listening provided safety,¹⁵⁰ reassurance,¹⁵¹ relief¹⁵² (and prevented her lying to herself¹⁵³). It enabled her to attend to emotionally difficult material without losing control¹⁵⁴ and, as we have just seen, was one of the key strengths of the special conversation about suicide.¹⁵⁵ On many occasions I listened to what was going on for her and when there was a particularly accurate and perceptive observation it stays with her:

“I think that what stuck with me was what you said at the end of the session ... It just kind of got me a bit, you’d just kind of got what was there.”¹⁵⁶

This became the basis of a more mutual understanding, albeit tenuous:

“I have been able to hear the fact that you can ‘get me’, hear what is going on. We get this weird kind of understanding or connection. But um, that sort of thing can be potentially lose/lose, and shut the barriers right down again.”¹⁵⁷

Her sense of self by comparison with her family, particularly her mother and sister, were crucial to the client. They were noted for not taking any account of the real sense of herself and displaying a self-centred view of the world which the client found abhorrent:

“I don’t want to ever be seen as self-centred. I suppose that’s where the judgement comes from. I never want to be anything like a self centred, selfish person. I can hate myself for that.”¹⁵⁸

There was consequently a particular tension between being seen and missed for the client and this was mirrored in her tendencies for exposure and concealment. Allowing others to care for her was also significant such as when her mother-in-

law accompanied her to hospital about self harm¹⁵⁹ or her husband took responsibility for her medications.¹⁶⁰

Relating to myself

The issue of an inner critic (see Ob.37, page 90) was identified for the client from the beginning and was associated with certain non-negotiable elements of the client's self-image that must be maintained:

- She was desperate to be a good person¹⁶¹ and to avoid letting others down.¹⁶² She was the strong member of the family, the diplomat who must hide any sense of need.¹⁶³ It became clear that this was a strong reaction against the selfishness she perceives in their family¹⁶⁴ and the habit of saying things without sincerity.¹⁶⁵
- A harsh judgement was apportioned by the client to herself. Thus attempts to offer a generous acceptance to those parts of her that have been hurt are stifled,¹⁶⁶ met with a cringing reaction.¹⁶⁷ Attempts to relax are sabotaged¹⁶⁸ because they represented 'weakness and negativity.'¹⁶⁹
- The client felt unable to relax, there was always a negative critique:

*"I hate being that. I hate being ok. I don't allow myself to be. I'm never happy being that. I'm always aware that if I'm laughing and joking and feeling ok, I'll feel guilty for it. So whilst I am all of that and that is real because it needs to be, get on with everyday life, blah, blah, blah, it's never just that. There is always this, there's always a guilt and a weight that is dragging it down, it never is allowed to be just that."*¹⁷⁰

- Following a resonating suggestion from me, some advantage of the critic was recognised. Whilst it has the abusive qualities of relationships encountered in marriage guidance sessions,¹⁷¹ strangely it was felt to

protect her from the abuse of others¹⁷² (being harsher to herself than they might be).

Through the critic we see the most distinctive characteristic sense of self for the client - a splitting. Experience was strongly divided between herself and other people, between herself and the fugg, a quasi-demonic possession. It enabled her to survive by radically rejecting the unpalatable or cutting herself off from her process with others or herself. It established entities which appeared immutable but which were inherently untrustworthy, seeming to require a particular response, but actually with a manipulative eye elsewhere. The most immediate lesson was somehow to distrust not the vitality of life caught up in such representations, that was heart-rendingly real, but the structure within which it was presented. Significance lay not in what was illuminated but also in what the shadow obscured.

The most useful divisions of understanding in the therapy process appeared to be the personifications of 'Tom' and 'Jerry' that arose during the two-chair processes (see also page 283). At first sight Tom might seem relatively close to the abusive dominance well known to the client and sympathy might have seemed appropriate for Jerry as the unloved victim. Focusing-oriented typologies might recognise here a 'controlling partial-self' and a 'compromised partial self' in these voices (Ob.72, page 168).

Yet on closer examination the voices represented frozen expressions of unresolved need, suspended processes rather than substantive entities. Tom expressed discomfort with experiences of vulnerability and 'selfishness' which are "abhorrent,"¹⁷³ "disgusting,"¹⁷⁴ "needy and weak and just pathetic,"¹⁷⁵ "loathsome."¹⁷⁶ Jerry squeals to be heard,¹⁷⁷ for "consideration",¹⁷⁸ "recognition;"¹⁷⁹ and the cessation of abusive treatment,¹⁸⁰ particularly through self-harm.¹⁸¹

Whilst the intra-psychic conflict can appear to be the crux of the matter, both voices can be perhaps more usefully understood as encapsulations of a response to elements of the environment. The process of presentation obscures the contextual impetus that has given birth and succour to these tendencies. For a moment it was too easy to forget that when not describing her existential traumas, the client speaks of her revulsion at the uncaring selfishness of family and how unheeded abuse replaces the love she might otherwise enjoy. By accepting the limited horizon of psychological trauma I could potentially miss the heart of the problem, it was not an issue with being, but one with being-in-the-world.

Session twenty (immediately after the two-chair processes) demonstrated the power of the bifurcation, rendering experience repetitively incomprehensible. After the stormy tussles of the recent sessions the client had discovered a calm, disengaged, rather lost place. She was surprised to notice herself not beset by excesses from the fugg or the constant attentions of the critic. Moments that would have dragged her into an emotional wobble had somehow been accommodated.¹⁸² The immediate and pervasive sensation however was not so much relief at this achievement but sorrow. She could not see a step forward but, a little sheepishly, mourned the loss of something so familiar¹⁸³ and comfortable.¹⁸⁴ These kinds of bifurcations had provided an intense and clear reality to her life, one that has shaped the person she was. Whilst concerned not to be ungrateful, she was disconcerted by the flatness that arose in their absence.

The willow

Alongside such tussles, the sense of a new ability to be was also experienced by the client, initially most strong when she was disconnected from many of the constraints that normally beset her. For example, after the twenty-fourth session she texts:

“So last night I was laid in bed listening to my music and being carried away in the escape it offered me, much the same as my last txt to you. I was considering the feelings evoked in me (still cringing at the word by the way) and power I felt and the sense of it all. It’s almost physical in a sense of having someone reach into my chest and squeeze and pump my heart for me increasing its strength, enabling me to breathe in the power of nature and emotion and those around me, and wanting to then explode, pouring out and spreading the feeling of it all. It came to me, last night and again this morning, that the explosion I feel inside me isn’t just from the positives of nature and love etc, though they are very keenly felt there, but I also felt as though I could expel the anger in me, the sadness and frustration, hurt, loneliness.”¹⁸⁵

This sense of being “grounded” and able to be “more myself”¹⁸⁶ had consequences in practical terms, such as the ability to resist suicidal actions:

“On a long walk with my music on loud. Car had to go in the garage. I’ve just walked past the entrance to the slip road onto the <major road> Ordinary in itself, other than a few days ago I might have walked up there and along the central reservation. Not today thought I really am swinging from one thing to another hey!”¹⁸⁷

Steps forward for the client were associated with this different sense of her own self. After a difficult period including suicidal intentions, she chose to invite her husband to take over her medications, thereby avoiding the potential of inappropriate use. This handing over of responsibility was, paradoxically a responsible, empowering act. She associated it with preoccupations about being seen as a whole person.¹⁸⁸ There was a real sense of being looked after even though she had arranged it herself.¹⁸⁹ I pointed out that the normal sense of responsibility was burdensome and inescapable. Yet now this was seen as a place where she could make choices.¹⁹⁰

Session thirty-six provided an illustration of the way that my affirmation of something perhaps a little outside the client's awareness led her to be able to symbolise a sense of self that took on a growing significance. I noticed a sense of stability in the client which I checked out with her as she did not recognise it herself. She notices a reluctance to admit it, feeling it to be "dirty", or "arrogant," something to be shrugged off.¹⁹¹ I was emboldened by her recognition of the shrugging off gesture, an indicator of something on the edge and was able to notice the ambivalence of both being avoidant yet wanting to be recognised:¹⁹²

Client So I shrug it off.

Therapist That sounds good [Client: Yes.] Must be in a good place.

The more you feel like shrugging the more we are on the right track. [Client: Yes.] So there is something in stability, the arrogance of stability, [Client: Mmm.] You don't want to be arrogant. [Client: Mmm-hmm.] You just want to be better than the rest! [Client laughs: That's the one.] The person who did not want to play goal but would play centre forward.

Client Because I'm a runner!

Therapist There's a kind of an interesting contradiction there, isn't there. [Client: Mmm, I'm a walking contradiction.] Because arrogance is distasteful to you, viciously distasteful, because it smells like those people we don't mention. [Client: Mmm.] And yet, you are better than the rest and are quite prepared to show it, [Client: Mmm.] in the right sort of way. [Client: Mmm.] So I say to you, can you feel some stability in yourself?

Client Somewhere.

Therapist Underneath your toes perhaps.

Client It's got to be there because it comes out every now and then. [Therapist: Mmm-hmm.] I do feel more like that is me. It just gets drowned out.

Therapist And I want to say that the smile is to do with that as well. [Client: Yes.] That the stability is associated with the inherent 'flexibility' or 'capability', the part of you that can [Client: Mmm.] see and smile at things and see things from a variety of perspectives very easily. [Client: Mmm.] So it's not stability as in a lead weight, but as in an ability to adjust and bob around.

Client Um. ... I'm so pretentious! [laughs] [Therapist: You're so pretentious?] Maybe it's the core of me but, kind of like a willow tree ... [Therapist: Mmm.] particularly flexible, you can bend all sorts of shapes out of it. [Therapist: Yes, live and flexible and dappled.] Mmm, nice sitting under that kind of tree. You can just sit there and listen to the 'Wind in the Willows.'

The client grew up in an area with tidal rivers and warmed to the idea of willows' ability to survive in flooded areas¹⁹³ remembering a large one from her childhood that was cut down.¹⁹⁴ The image was returned to in the next session, and was connected to a sense of her "grounding",¹⁹⁵ and was evoked as a symbol of her whole self during the combative session forty where she confirms,



"That <client's name> that you talk about is there and capable of noticing that sense of self in me and, you know, when I saw that willow tree

*yesterday I thought I could feel like what we were saying about. But I can't maintain it.*¹⁹⁶

The willow sense was connected to a poem (Anon, 2012) and the wearing of a particular ring.¹⁹⁷ At a point where she was finding work very difficult she,

*"printed out a small print of the willow tree picture I took and stuck it to the back of my ID badge. It serves as a reminder that you can see the strength in me, that core of the tree and the roots that keep me myself!"*¹⁹⁸

The willow was connected to the image of Rumi's field (see page 265)¹⁹⁹ and to the intersubjective experience of acceptance:

*"Yes. ... In my mind's eye it just ... it feels like sitting at the base of [laughs] let's say a willow tree shall we! Just looking out on this really calm and peaceful field or view, and it's quiet, and there is nothing there apart from that, apart from yourself. There is nobody else around, that you don't have to be anywhere at a certain time, you don't have to do anything, nobody wants anything from you, you are just there. Just there. And it's just quiet. Kind of allowed, to recognise you I suppose, that sense of who you are. No not even a 'who', because who you are is almost kind of made up of relationships with other people and everything else isn't it. (Therapist: Mmm.) It's just the ... you know, it's just recognising you on your own, just that ..."*²⁰⁰

These are personal steps toward finding a sense of who the client is. The process with her is slow and tenuous. Unlike M35 she held back from the practical element of giving tangible expression to the new self.

7.4.2 Steps toward wholesomeness (M35)

The progress made by M35 can be tracked by reference to the way he changed his ability to relate to himself – from internalised judgements, through stumbling

recollections, to configurations that appeared to grow and blossom as they were carried forward. Each was particularly associated with physical senses of himself (e.g. a strong chest), senses of situations that were meaningful to him (e.g. flying solo, Mr Able) and senses of way of being to which he aspired (e.g. wholesome). Two assertions are made here. Firstly that the generation of such senses of self was an essential task in the process of recovery. Secondly that focusing-oriented work provided the way for him to discover configurations that were distinctive, strong and developing for him. It can be shown that none of these senses was dominant nor decisive, each allowed him to engage with something that was part of a changing process, each carried him forward to meaning that only arose in the fresh moment.

Flying solo

The ninth session with client M35 illustrated the potential sense of himself as an assured, able, confident person - something he did not express so clearly when with others, even his partner: "*I am at my most self-assured and in control when I am flying solo.*"²⁰¹ With his partner and in the addictive frame of reference this degree of capability reduced, till the capable business-man felt no more than a 'naughty boy.'²⁰² I invited the client to distinguish the problematic situations of his life from suggestions made to him that he was the heart of the problem.²⁰³ He was able to point out similarities in his experience and patterns that might connect to them.²⁰⁴ In doing so he began to distinguish capable senses of himself that were not constrained by the common negative understandings.

Assurance as antithesis of 'getting a grip'

As we have seen, one of the presumptions made by client M35 about his drinking was that it would be solved by exercising control and getting a grip. He associated his alcohol habit with loss of control so that to be 'underway' in treatment would be to rectify this i.e. "*to control and not be controlled.*"²⁰⁵

Interestingly attention to the early sessions reveals ambiguities in this rather binary notion and illustrates how much agency can be entwined with a sense of self-in-environment. He spoke of his flat as "*a completely different universe, everything is standing on its head,*"²⁰⁶ as if there were a great feeling of safety within the flat which was absent in the hostile outside world. Some of his drinking habits were, as he said, socially disapproved of and presumably a matter of shame. Yet it would seem that nevertheless being in the flat provided a sense of agency that remained valid even though he might be apparently 'out of control' in the eyes of the world and, sometimes, himself.

*"when I walk back through the front door at [location of flat] I feel ... safe, home, alone/solitude/peace, in control (which goes against being out of control because I'm drinking but the feeling I have is that I am then in control ...), able to do what I want. I seem to walk differently."*²⁰⁷

Nevertheless a common kind of statement was made in the ninth session, "*when I am sitting here sometimes I mentally kick myself saying 'get a grip, what's the problem?'*"²⁰⁸ In the session I proposed an alternative view of strength and capability by highlighting a sense of the "*assured, able person ... perhaps a pretty common sense of self as being an assured operator in a business, being able to go anywhere, do anything and not be phased.*"²⁰⁹ In his business capacity he was used to fulfilling responsibilities, manipulating difficulties, setting overall objectives and finding pragmatic ways to achieve them. In that environment it would be strange for him to have narrow rigid targets (of the sort that he was trying to set for himself with his drinking). Rather he would be using all of his skills and flexibility to get the job done as easily as possible. Could he have targets that are expressed in the terms of this 'assured control sphere,' i.e. "*playing to your strengths?*"²¹⁰

A similar discussion takes place two sessions later about getting a grip:

“... you say you want to get a grip of this. [Client: Mmm.] You started by saying I need to get a grip of all sorts of things. Actually, it isn’t all sorts of things, that you’ve got to get a grip on, [Client: Mmm.] you can manage your life perfectly well most of the time, 98% of the time, without getting a grip, [Client: Mmm, yes.] by using a light touch and the right ... [Client: Yes.] So you’re not a person that needs to manage life by getting a grip at all, you’ve got much more flair and energy, more savoir faire. This is not the jackboots getting a grip. [Client: Yes.]”²¹¹

Here an experiential exploration opens up a much richer sense of self than the one the client brought to therapy. It suggested to him that ability was not the same as control and invited him to have a live sense of self to replace the explicit patterns that beset him. The fruit of such existential senses is set out below.

A strong chest

Focusing on significant issues and moments with client M35 frequently brought attention to his chest. As we have already seen (7.2.4, page 232), a release in the chest was recognised as part of the physical ritual of drinking. Yet, for a 46 year old man, struggling to achieve at exercise and running, the sense of becoming athletically stronger and harder also had resonance. There was a constellation of feelings associated with stepping forward, and we have seen how this was associated with memories of doing so having given up smoking (see page 231).

In the session after completing the 10k sponsored run and a period of alcohol free days he focused on this sense and identifies a “*strong chest*” and as being like a rolling snowball.²¹² Three sessions later this association has extended across his life - repairing the house for sale, taking a difficult leading role in a residents group, even thinking of the vegetables he would grow next year. In each he found a sense of the strong self (in the chest) similar to the one before a race.²¹³ This recurred a week later and was connected to the sense of things getting how he wanted them (including tomatoes going red).²¹⁴ Three sessions later the ‘strong

chest' was identified as one of the four key strategies that were significant in his recovery, albeit one that could not yet be summoned reliably.²¹⁵

Personal Best

Given his athletic efforts it was not surprising that the idea of a Personal Best was also used. I pointed out that a famous *Tour de France* winner gained success not from 'growing a pair' but from managing small matters to improve his potential.²¹⁶ The client commented that he had heard a five times Olympic gold medal winner remark that while all Olympic athletes could not win, all could rightly be expected, after years of training and preparation, to deliver a personal best (PB) at the games.²¹⁷ The prospect of achieving a 'PB' in terms of alcohol free days became a motivator for the client²¹⁸ as he comments in the *Change Interview*: "*I sent a text on Tuesday "PB - Personal Best." Tuesday was longer than I have been sober probably since I was 14.*"²¹⁹

Wholesome habitation and herbal teas

The *Change Interview* also revealed the significance of a broad concept for the client in embodying the life that was opening up for him.

"And I've been banging on to <therapist> for the last three or four sessions about wanting to be 'wholesome.' It seems an apt word to use. I now want to go home and look after myself and care for myself. I want to eat good food. I was rather shocked to see that I was 12 stones 12 pounds and I should be tipping just on the 12 stones really, which also helped a few weeks ago. There is a real ... be alone, just look after myself, be calm ...

„220

He had spoken earlier of wanting to find a "wholesome place for the bear."²²¹ The origin of this sense can be discerned six months before during a discussion of how his girlfriend and ex-business partner criticise the client for "not pushing things forward."²²² Pausing he recognises that he could do these things if he were on his

own but with these people was prevented because he was “*not able to be myself.*”²²³ Various instances are discussed such as booking a holiday or wanting to plant out seedlings at the shared house.

The thought may have been given energy from a moment of desolation on a lonely birthday - pictures of the *Boulevard of Broken Dreams* and thoughts that “*I-may-wake-up-one-day ...*”²²⁴ It was evident in the struggle of days such as the one related shortly after:

*“Working again but from home today. Up at 4.30 as couldn’t sleep, no wine, now 11.30 and meeting <partner> in a pub for lunch, unsure of what to drink, Guinness or Orange Juice? – Drank Orange juice, another long talk. Decided strategy for the rest of the day, buy one bottle and no drinking after 7.00 pm as I have a long run tomorrow morning. Cooked and watched Jubilee concert with Peppermint Tea and water. Was close to being another alcohol free day so annoyed with myself but pleased with the control.”*²²⁵

Certainly various sorts of tea were significant in his changes of life²²⁶ so that he boasts in the *Change Interview* of a moment of ‘craving’ for green tea.²²⁷ But more significant was the recognition that his centre of gravity at home has shifted, “*gravitating away from the kitchen,*”²²⁸ where he would stand and drink wine:

*“I said last week, I love my home, I am using all of it now, I’m actually using the living room. [Interviewer: That’s a beautiful change, I love that change. You’re actually occupying your house!] Yes all of it. Not just standing there waiting for somebody to turn up ... [Interviewer: Yes, not on sentry duty. There’s a wonderful sort of physical manifestation of a psychological freedom.] Yes and the thing is, it’s a really nice feeling, walking around the place with a cup of green tea.”*²²⁹

Such senses of himself grew and developed as he did, providing ways to relate to the changes as they occur. The progression from 'flying solo', through 'assurance', a 'strong chest', a 'Personal Best' to 'Wholesome' habitation, almost nest building,²³⁰ showed the fluidity and vitality involved. It also had very tangible connotations as illustrated by the purchase of an 'Indiana Jones' style hat at a music festival during the summer.²³¹ The Interviewer commented that perhaps the hat was an important expression of his liberation and linked it to the accepting therapeutic relationship.

7.4.3 Recovery task, evidence and therapist roles

Chapter 5 concluded that in terms of Focaling and Value:

- **Addiction** is a flailing – A pattern of apparently inexplicable and uncontrollable behaviour which ineffectively responds to an existential dilemma. (Ob.73, page 170)

Both clients in these case studies lived within structures of dissociated personal agency that had profound impact upon their lives. For F26 there was an inner critic, a sense of splitting in 'Tom and Jerry' and the semi-psychotic attacks of the 'fugg' (7.4.1). M35 had an apparent incapability to control his use of alcohol, or to 'get a grip' on what was most challenging to him (7.4.2). Both of these respond to unresolved existential issues that undermine their sense of agency.

Chapter 4 identified two client tasks of focusing-oriented therapy relating to Focaling and Value:

- **Client Task 4 – Coming home** – To permit the self to be recognised and 'received', finding value in the sense of self-in-situation. (Ob.50, page 119)

Both clients gradually permitted senses of self that did not confirm to long established explicit judgments that had constrained them – for F26 the image

of a willow was used to 'ground' herself and enables her to resist urges toward suicide (7.4.1), M35 used a series of senses of self ('flying solo', 'strong chest', 'personal best') to relate to an implicit sense of wholesomeness that arises (7.4.2).

- **Client Task 5 – Dwelling** - To articulate experiential steps that arise in tangible choice and self-investment. (Ob.51, page 121)

The clients provide mixed illustrations of this task. M35 was carried forward as developing senses of himself are given tangible expression in lifestyle changes, athletic engagement and renovations to this accommodation (7.4.2, see also 8.5 page 295). However, F26 was disoriented by a major step forward. Whilst she achieved a new sense of self she failed to make the 'dwelling' (7.4.2).

Chapter 6 identified:

- **Recovery Task 3 – To assist a client to discover a new way of being-myself-in-the-world.**

The discovery of a new way of being-myself-in-the-world was important for both clients in these studies. For F26 it was the flexible, grounded sense of the 'willow,' associated with the capability to accept herself (7.4.1), for M35 a new sense of agency was expressed in images of strength and wholesomeness, renovations to his flat and even the purchase of a new hat (7.4.2). Experiential carrying forward was a very different process than coercive attempts to 'get a grip' (7.4.2).

Chapter 4 identified four therapist roles in focusing-oriented therapy:

- **Therapist role 1 - Creating a space** - To facilitate a shared space where the client can relate to their immediate experiencing and be heard accurately (exactly though differently). (Ob.52, page 123)

The creation of a space of acceptance and understanding for the felt sense was again important in these illustrations. F26 felt the significance of my 'getting' her and this recognition supported the two chair process (7.4.1). M35 was provided with a space that welcomes constantly shifting senses of self with subtlety and respect (7.4.2).

- **Therapist role 2 – Felt meaning** - To offer a special attention to felt meanings, using self as a 'resonating chamber' for what may be present. (Ob.53, page 126)

Once again 'resonating' responses assisted significant progress – for F26 the advantages of the inner critic, and the client's sense of stability (7.4.1), for M35 the assured business man (7.4.2).

- **Therapist role 3 – Articulations** - To attend to and invite articulations of carrying-forward in gestures, actions, values, flailing and experiences of self. (Ob.54, page 128)

In this material I attended to M35's gestural rituals of drinking (7.4.2) and F26's shrugging off and her need to be better than others (7.4.1).

- **Therapist role 4 – Living-toward** – To respond as a human 'other' to shared implicit meaning with the client, 'putting nothing between.' (Ob.55, page 129)

Subtle and contrasting illustrations of living-toward are shown here – relating in a particular way to F26 through the image of 'Rumi's field (7.4.1, see below) and adopting a businesslike shared enquiry mode with M35 (7.4.2).

Observation 90 - Case evidence supports the assertion of Recovery Task

3 – to discover a new way of being-myself- in-the-world.
It also supports the general application of the four generic therapist roles in this work.

CHAPTER 8 - CASE ILLUSTRATIONS – THERAPEUTIC AVENUES

In this chapter evidence from the case studies relating to the five therapeutic avenues is presented.

8.1 'Avenue' A - Emotional regulation, and self-as-perspective

The material above shows the capability that focusing-oriented therapy has to assist both clients to relate to emotionally demanding material by establishing a perspective that is beyond it. This has many similarities with the self-as-perspective approach set out in the discussion above (Ob.78, page 186).

To begin with, examples from one client illustrate how in a focusing-oriented therapy approach, the foundation of emotional regulation is a sense of self that is somatic, meaningful and particularly, intersubjective. A dual responding takes place – relating both to gestures and their implicit meaning:

8.1.1 Sitting on the floor and Rumi's field (F26)

The safety of the place provided by therapy was very important to the client F26. It found tangible expression in the fifth session when, after a period which affirmed that 'being with' (client, felt sense) was significant and sufficient in itself, I noted a shift of posture from the client and offered the option to sit on the floor which was taken up.²³² Later she described sitting on the floor as 'enough' because it was 'safe'²³³ and this option was taken in several more sessions, particularly at moments of difficulty²³⁴ After a session she could recall the sense of herself in that place:

"I think I'm a little calmer, sore but still confused as to what to do about the work stuff. It helps to notice the me from yesterday, sat on the floor with

*you. I think I can revisit that feeling of safe and (perhaps) not judged. It's certainly a calmer and less angry place to be.*²³⁵

The ability to summon up the sense of this was used when the client was facing difficult conversations at work:

*"At this moment <therapist>, I can sit in the quiet, eyes shut and recognise a sense of the me that sits with you, the one that sees you. I can sense the connection there and safety and warmth of it. I hope you can notice it too, notice me, and also the sense of you that sits with me. It's nice."*²³⁶

On one occasion the floor position was connected to a Rumi description of meeting in a field “*between wrongness and rightness*” (Jelaludin Rumi quoted in Lawrence, 2004) and the reference helped to summon up this felt sense.²³⁷ It was a ‘Tardis’ (a reference to a science fiction drama where the space-ship was larger on the inside than the outside), a place she could pop into for relief after a funeral,²³⁸ into which confusion could be offloaded.²³⁹

This sense of place arose intersubjectively and somatically, from a sense that someone “*gives a shit about my stuff*,”²⁴⁰ that “*someone genuinely cares*.”²⁴¹ The ability to sustain difficult levels of emotion therefore came from the Intersubjectivity that was tangibly felt. Time after time the ability to shift the client from a stuck place (e.g. a semi-suicidal isolation²⁴²) arose from an experience of an abrasive human reaction that provided a counterpoint to professionalism. Such sharpness allowed a direct sense of both being seen and seeing that mattered a great deal:

"I was able to notice you as in the room at <charity address>. While in that place, I noticed how you see me, how you accept me for just being. I could see you cos I was aware of you seeing me, which meant I was aware of you too. It felt peaceful, quiet, safe, warm and secure. The only way I could

*think to describe the sense I had/have of myself (and equally you as for me to be aware of it) is that I felt real!"*²⁴³

8.1.2 Tolerating the fugg (F26)

Over the therapy this client slowly began to be able to anticipate the arrival of the fugg and take compensatory action. An example of small shifts in the fugg problem occurred before the 57th session in an email in which the client described herself as "*simply feeling overwhelmed.*" There is,

*"so much noise, so much emotion it reaches a point of deathly silence, of unfathomable, unbearable tension with no way of pinning anything down. It feels cold and painful, it's the pain that's most unbearable ..."*²⁴⁴

She referred to a previous email from me:

*"I guess that's what reading you email offered me. A way of noticing immediate sensations, of breaking things down a little to offer a little more clarity ... I had a shower, (actually I sat in the shower for an hour) and noticed the spray on my face and the way some jets of water hit me harder than others. Slowed things down. I thought of maintaining your eye contact and noticing you there, that even though you are a way away and busy you care enough to take time out to help me. In that moment attempting to pause it all. Just then is a little clarity. I can notice some of Tom and Jerry, of the guilt, of the anger etc."*²⁴⁵

"Just now, I am feeling a little overwhelmed again. It all becomes such a muddle it hurts, I can't untangle it all. I want to reach out for a hand to stop me getting sucked in. I feel desperate, it's like drowning, with no individual wave knocking me under, but lots. ... Hopefully you get the primary issue of being overwhelmed, the feeling of loneliness with it then when I do break free to gasp the air. During the drowning all I can see around me is the dark waves of anger, guilt etc. Even being able to see

them is a relief from the drowning sensation I feel. So, meeting your gaze, sensing you there and noticing a connection, just now feels warm in the cold of it all.”²⁴⁶

I responded with a careful observation of the sense her email had given and commend the precise observation of physicality, and the sense of the interconnection:

“It will not be possible a lot of the time, nor in a big way. But perhaps there will be ways to maintain something of the sense of yourself having this experience and the particular way it is in each moment. The more you can do that the better. ... I hope today goes better - that you can take care of yourself and maybe even manage a little distraction”²⁴⁷

The client replied:

“This morning after I read your reply I laid in bed and noticed where I was and where I am today. Sat here just now my heart is racing a little and I can sense a tension in my arms and across my chest.

The feel you get of the fugg hadn't occurred to me but it seems correct, with one noticeable difference. The fugg previously had always felt grey in colour and feel. The sensation of the fugg just now is much the same, not being able to escape it, overwhelming, suffocated, but different in that if I were to assign it a colour it feels white not grey, I can see more of it. It's a little less dark, though not to say any less scary.

This morning, with a little more clarity ... I can, as you say, see the waves. I can notice them and they way each of them make me feel. Being able to look above the surface of the water and see what's around is like a breath and I can feel a sense of relief in my chest even though what I can see is less than inviting. ... Just now, I can notice the waves of anger, guilt etc. But strangely I can allow them to be there. I can say that I am justified in

feeling them, that there are real and not just a selfish creation of my own making. This I can bear. The anger I can tolerate, it feels like it is outward in direction and not inward. If I were in a kick boxing ring just now I wouldn't want to come up against me, there is a burning in me that feels like it's bubbling under.

*But I feel justified in reaching out a hand <therapist>. That there's enough of the real me here worth saving. There is a confusion of the sense of the real me as I am not sure what is the real me and what is shaped by past painful events. I don't know who I am.*²⁴⁸

This indicated the elements that have been involved in the process of self-regulation – intersubjectivity (to provide a safe space), attention to the felt sense and to body sensations, a degree of allowing and tolerance.

8.1.3 Out-of-body experiences (M35)

M35 entered therapy in a very embattled place. He was under pressure from his partner both to give up drinking and to commit to marriage. His failures to undertake either were considered to be entirely his fault and, courtesy of the internet, a diagnosis of an 'avoidant personality' was offered by his partner and apparently endorsed by the marriage guidance counsellor they have seen. His partner visited him unannounced and uninvited for long sessions of debate and he reported regularly having similar conversations by phone for several hours at a time. It was after these conversations that his urge to drink felt unavoidable and he could become uncharacteristically aggressive, breaking furniture and fittings in his flat.

During the sixth session he talked about not liking to be told he was wrong when he was not, he could not let things go.²⁴⁹ He described the feeling of being trapped in a long conversation with his partner which he knows would pressurise him and turn out badly:

“it’s almost like … having an out-of-body experience in terms of … I can see the potential dangers of this conversation. I can see that it could spiral from something which is really silly up to something which is really damaging and going to last for days. But is almost like I can’t stop it.”²⁵⁰

Further on in the therapy session I checked out the sense that in such conversations the client may be conversing at a rational level but, through the ‘out-of body’ experiences also sensed something more – the feel of the situation. Could he pause and ask himself ‘what is the feeling I’ve got here?’²⁵¹ Later the client related to his father leaving the family home when he was young and losing contact over thirteen years. He related the story but finds it difficult to connect to the feeling.²⁵²

Five sessions later the issue of his avoidant personality was again important. I invited him to observe his behaviour and the environment he was working with rather than take any external judgement. He was constantly having arguments with his partner but was standing a little apart from them mentally. He was perhaps a little tuned in to the out-of-body sensations and now more protected:

Client “… they’re not arguments, they’re just so emotionally … well I was going to say, depressing. It is depressing, it’s tiring and it’s, I can feel my head turning off, or my brain is saying ‘I don’t want to do this anymore.’ And, ‘you could go on as much as you like but it isn’t going in any more.’

Therapist Your remember saying about how there was a point where you had an out-of-body experience. [Client: Yes] There’s another one. That is, kind of, another part of you holding up its hand and saying [Client: Yes] ‘I want out of here’ or ‘Let’s do something different’ or whatever. That’s lovely. Sorry, I am sure it did not feel lovely at the time. [Client: No] But it is a sign of something quite, positively [Client: Controlling.] I would call it a

kind of survival mechanism. To actually notice what is good for me and what is not. [Client: Yes] If I put my hand in the fire that same survival mechanism will say [Client: Yes] get me out of here quickly.

Client I think that's a thing as well. I walk round the <flat> and there's holes in doors, missing doors where over the last couple of years, missing knuckles (Therapist: Mmm.) where I've punched and kicked and thrown things and how the TV's working, I've no idea after, there's a great chunk out of the wall behind it where I've kicked it so hard. Um, but that seems to be less of a worrying feature now, over the last few weeks. I don't know if that's a sense of, I'm putting it down to this control thing that we talk about here and at hypnotherapy as opposed to, I suppose what the other sense of relegation. Relegation's not the right word. Sense of acceptance that we can't go on any longer so I can't get so frustrated, I'm certainly putting it down to the feeling a bit more in control as well. ²⁵³

In many ways that client remained stuck in his emotional predicament for many weeks. Two things help him shift – the achievements he was notching up in management of his alcohol use and the crisis realisation that occurred on his 46th birthday (see 8.4.2 page 287). Yet his ability to respond to the 'out-of-body' content of experience shifts by the way his life carries forwards in practical terms.

8.1.4 Recovery task and evidence

Chapter 6 identified the following recovery task:

- **Recovery Task A** – To assist client's 'emotional regulation' through dual-responding, encouraging self-as-perspective and linking practical issues to implicit meaning. (Ob.79, page 186)

This evidence showed clients who have difficulty managing issues of emotional regulation and were assisted to come to a different relationship with themselves. In both senses there was a dual-responding (Ob.78, page 186) where the attention was both given to the expression of difficulty in its own terms (e.g. physical experience and felt sense) but also to the sense of the person-in-situation that could be discerned. The two elements were followed and offered through a secure relationship so that some of the insecurity can be tolerated and the individual discovered more able senses of self. This evidence shows F26 learning to manage the fugg and observe herself coping with it. M35 was shown using the feeling of 'out-of-body' experiences as a barometer of immediate pressures and his way of managing them.

Observation 91 - Case evidence supports the assertion of Recovery Task

A – to assist client’s ‘emotional regulation’ through dual-responding, encouraging self-as-perspective and linking practical issues to implicit meaning.

8.2 ‘Avenue’ B - Waiting upon a carrying forward

This avenue (Ob.80, page 191) is distinctive in representing the natural process of change at work within a client, associated with the presumption that elements of addiction are more about the situation a person is in and their process of living, than anything else. The role of a therapist is consequently to work with the grain of the wood, recognising elements of the same story on different canvases. At this stage two kinds of evidence can be sketched out – one showing how addictive practice is a dysfunction of living, the other showing that recovery is life working its way out.

8.2.1 Dysfunctions of living – Patterns and gaps from the past

Each client demonstrated experiences in the past that have a direct bearing on their ability to sustain their current being-in-the-world. Such deficiencies in experience and capability can be shown to directly influence addictive behaviour and show themselves in repetitive patterns of deficient living.

F26

- The client came from a family which split up early and she ended up comforting her mother through the crisis even though she was still a child.
- The client had a history of dysfunctional relations with her mother and (twin) sister.
- From her early life the client adopted an abhorrence of too close intimacy from family and others, finding emotionality unacceptable.
- Isolated from others, the client began self-harming as a teenager.
- In adult life the client has established a robust, fragile, perfectionist persona, presenting as entirely capable at all times.

M35

- The client's father left the family without further contact when he was 10.
- The client adopted a persona as a child where he accepted responsibility for the emotional regulation of others and felt the need to perform as a 'manly' man.
- The client had practiced avoidant behaviour since teenage years, being christened by his first employer as 'Mr-Yes-but.'

- The client has had a string of short term relationships with females where he sought to avoid commitment. One girlfriend tried to get him to accept marriage by booking the wedding ceremony without his knowledge and hoped to gain his consent from the *fait accompli*.
- Being self-employed in a media job, the client established a heavy drinking professional and personal lifestyle in youth and middle years, with a ‘bachelor’ independence.

8.2.2 Dysfunctions of living – A trapped present

Each client faced particular challenges in the present which appeared to be beyond their capacity to respond. Coping patterns and ‘work-arounds’ have been evolved which tend to be repeated, but may not develop and evolve fast enough. Such problems were exacerbated by a combination of commitments and habits that made the position appear inescapable.

F26

- The client had a highly structured and demanding job suited to her persona but unconnected with other aspects of herself. She felt unable to do it outside the perfectionism.
- The client was married and had financial commitments which made it inconceivable that she would be able to leave her job, even though it was increasingly unfulfilling.
- The client was tied into a tight structure of personal, practical and emotional responsibilities to her extended family which she found intolerable but unavoidable.

- The client had a circle of friends but found it very hard to have more than superficial relations with them. Consequently she felt isolated and 'invisible.'

M35

- The client came to counselling after both marriage guidance counselling and personal counselling feeling guilty that he had an 'avoidant personality' and incapability in making personal relationships.
- The client was being pressurised by a partner whom he financially subsidised who wanted early commitment to marriage and children, both of which he had repeatedly declined.
- The client lived separately from his girlfriend, with whom he endured long emotionally laden phone calls and meetings reviewing his failures and inadequacies in her terms. He felt incapable of refusing these conversations but constantly sought to avoid the commitments required.
- The client believed that the girlfriend must be the perfect person for him and often commented that if he did not have her he would have nobody.

8.2.3 Life working its way out – Flailing to get free

Each client engaged in behaviour that was seen as unacceptable by themselves, those they care about and society at large. This appeared to show two functions. Firstly, it articulated the tension that has built in their personal system, providing a means of some expression and 'flailing' to force some resolution, often increasing in severity. Secondly, it provided some immediate, but short-lived relief from the difficulties.

F26

- The client has denied emotional needs and used self-harming, alcohol and drugs as ways to manage herself and the pressures she was under.
- Occasionally the self-abusive patterns took extreme forms leading to serious para-suicidal events.
- A sequence of events had led to hospitalisations and a very poor sick record at work which left her constantly on the edge of losing her job.
- Repeated steps took her to the brink of such personal disasters, but she appeared to construct matters so that the worst outcome was always narrowly avoided.

M35

- The client drank throughout the day, regularly making trips home to top up with a Gin & Tonic to 'take the edge off.' In afternoons and evenings he drank several bottles of wine.
- The client drank heavily after difficult meetings with his partner, broke furniture and fittings in his anger and frustration. To his horror, found he could be verbally aggressive with the girlfriend.
- The client's bachelor accommodation became his 'cave', a place of retreat with sets of reassuring and self-comforting rituals, defended against the world.

8.2.4 Life working its way out – An energy from nowhere

Each client's recovery showed a process where a resolution of their major life issues was matched by a reduction of dysfunctional behaviour. Resolution depended upon a variety of uncomfortable 'crunch points' where some part of the

fundamental configuration of the person's life shifted. Changes in dysfunctional behaviour also did not follow a smooth progression but included steps forward, backward and even sideways.

F26

- Despite her inability to relate emotionally the client had found herself able to relate well in counselling.
- The client has found herself able to consider entirely unprecedented moves such as the prospect of starting a family.
- The client has built a relationship with her self-harm and now managed it largely with success. However, more infrequent 'para-suicidal' events became more serious.
- The client found energy to reduce drinking and avoided it at all but the extreme moments of crisis.
- The client admitted that a major shift in her life was necessary but had yet to bring it to full implementation.

M35

- The client failed in early attempts to change his drinking habit, even to restrict alcohol to after 9am. The more effort he expended the more frustrated he became.
- During the therapy process the relationship with the girlfriend was brought to a head and he slowly separated himself from personal and financial responsibilities to her.

- During this time he expanded a gym regime to include regular 5k and 10k runs. He used these to structure alcohol use and introduce alcohol free days which were marked as great achievements in his diary.
- The client started to have a vision for his accommodation, turning the cave into a stylish *Pied à Terre*. Renovations and furniture purchase allowed him to create a special ‘alcohol-free’ space.
- The client has a sense of a ‘wholesome’ life that he was moving into and various images of his strong, capable and relaxed life that he was taking up.

8.2.5 Recovery task and evidence

Chapter 6 identified the following recovery task:

- **Recovery Task B** – To assist clients to attend to implicit meaning and wait upon the ‘right’ carrying forward. (Ob.81, page 192)

This overview summary of the two cases showed a remarkable consistency of shape to two lives that otherwise are radically different. They illustrated the inter-affecting between life and ‘addictive’ behaviour, showing that shifts in the overall being-in-the-world of a person can release energy that changes their dependence upon addictive behaviours. It would be foolish to make too strong assertions from what was necessarily the external judgement of the researcher, not explicitly checked with the clients. However, the patterns set out do give some justification for the strategy of attending to the overall ‘focaling’ mesh of a client’s being-in-the-world and the way that this was responsively carried forward (Ob.24, page 60), rather than attempt to re-engineer elements of the client’s psyche.

Observation 92 - Case evidence supports the assertion of Recovery Task B – to assist clients to attend to implicit meaning and wait upon the ‘right’ carrying forward.

8.3 'Avenue' C - Stirring up ambivalence & opposition

The approaches set out in this avenue (Ob.82, page 199) demonstrate the significance of client ambivalence as something to be enhanced and worked with. In this section evidence will first be presented of a small step already mentioned, my use of a felt sense to develop a dissonance in the room from which a greater perspective can form. After this 'resonating board' approach there will be evidence of Socratic Questioning within an experiential process, prompting relationship with experience that was uncomfortable for the client to address. Finally, the two-chair process used with one client was set out, showing that where the traditional (yet secondary) 'addict'/non-'addict' bifurcation was avoided, there was valuable place for a primary process which allows underlying ambivalence to be addressed.

8.3.1 Sensing together and differently - Resonating Board (M35/F26)

When describing the therapy during the *Change Interview* client M35 emphasised the educational and practical aspects. However, turning to the 'feeling half' he described a characteristic shape of events in the counselling room:

*"I think I probably would have led it in the sense of ... I have come in and said it's been a good week or a bad week or whatever. Then <therapist> would sit there and say, ok shut up and let me take this in, then take it from there."*²⁵⁴

Commenting on this the interviewer said that this was where I was potentially doing what the client was (still) not very able to do, this was the deeper layer of the collaboration with me 'taking it in' and reflecting deeply on what was found there, using my body to help the client learn to use his own.

The two elements of a resonating board approach were very evident here (Ob.53, page 126). First there was the ability to facilitate the session simply by expressing a felt sense which the client does not quite catch for himself. Examples of this are a 'self-contained' quality about the client,²⁵⁵ the sense of the client constantly having to try,²⁵⁶ some drinking 'being prepared' as one might use the toilet before a long coach trip.²⁵⁷ Second there was the ability to offer a resonation that contrasts with, even contradicts what the client would discern. Examples of this include the perception of a broad 'assured' capability in the client (to contrast with more anxious box-ticking tendencies),²⁵⁸ later a sense of capability that contrasts with 'getting a grip.'²⁵⁹ I discern in 'if I can't have you I don't want anybody else' not moral weakness nor backsliding but a significant "*something in your gut that doesn't want to do this.*"²⁶⁰

When a focusing process was taking place with M35 I sometimes slowed things down with lengthy summary statements, checking at each point that I had the feel of the client just right.²⁶¹ This happens particularly at the end of the seventh session with many affirmative/adjusting comments from the client, even though he had sensed a moment before that he, "*Maybe don't want to hear it.*"²⁶² The summary statement adopts a highly engaged, slightly theatrical mode of expression which was uncomfortable to read in retrospect. However, it illustrates several qualities:²⁶³

- A way of holding the conversation at a crucial point, slowing it down and highlighting implicit elements.
- A more emotive summation of what has been heard - the gesture that:
"... contains the anger and the sadness, the desperation of a person for whom it is so ..."
"That why couldn't I just, why is it, why isn't it that I'm alright and acceptable as I am but that I always have to kind of, [Client: Yes.] fit in with those others?"

- An openness about my reactions to the material:
"And it brings tears to my eyes to think about that person ... So I feel desperately, ooh, as we say in the trade 'welling up.'"
- Affirmation of the client's experiencing that might be difficult for him:
"... That's not the gesture of a bruiser or of a violent Pratt, that's the gesture of someone at his wit's end, that just deserves to be able to relate in a way that he can do, that doesn't require him to constantly try and put himself out and rethink..."
"... like the painting in the hallway and think, oh yes. [Client: Yes.] That's just me, something that I have done, [Client: Yes.] and I like it! [Client: Yes, and if you don't like it that's fine.] It doesn't matter if you don't like it or not [Client: So long as I do.] ..."

The client's comments during the *Change Interview* show that this kind of interaction were valuable facilitators of the therapy.

With client F26 I frequently used my intuition to discern unclear felt senses, offering the results to the client (Ob.53, page 126):

- I checked out with her a desire not to hurt people,²⁶⁴ a sense of her as younger.²⁶⁵ I used a focusing-oriented sequence (summarising felt sense, offering, handle words and checking) to give a structure for the process. This step by step noticed first one 'something' then another, but not seeking any logical connection or explanation,²⁶⁶ sometimes drawing the elements on paper.²⁶⁷ I offered my own felt sense to carry on a process when the client faltered through the pressure, though I paused frequently to check with her.²⁶⁸
- I enquired about gestural expressions of the client – her distinctive smile,²⁶⁹ the pugilistic feel,²⁷⁰ biting her inner lip,²⁷¹ her tensed posture,²⁷² the physical energy of a hurricane.²⁷³

- I offered observations that contradicted the standard (often self-critical) interpretations the client had of her experiencing – that she did not have sensitivity,²⁷⁴ was always ‘black and white’,²⁷⁵ that her desire to help others was insincere,²⁷⁶ that she was selfish with her husband.²⁷⁷ I wished to meet the part of her that can be nasty when drunk.²⁷⁸
- I encouraged the client to accurately hear my responses²⁷⁹ and to notice the difference there may be in perception.²⁸⁰ The client was invited to allow the differences to be present - her hearing parallel to my hearing of her.²⁸¹

Later illustrations of process that involved a divergence arise when I offered the client reactions relating to material that arose between us. On several occasions I encouraged an open understanding of dynamics of our relationship, based upon the necessarily different felt senses we each have. This arose from a discussion of ‘ulterior motives’,²⁸² another about the application of boundaries in our relationship²⁸³ and was evident in the extreme conversation about suicide²⁸⁴ which was later recognised as offering both participants a different sense of themselves.²⁸⁵ As will be seen later, the client’s recognition of me as a different person with a very different (though not imposed) being-in-the-world was perhaps the key factor in a very challenging process.

8.3.2 Socratic Questioning/Abrasion (F26)

I have already referred at some length to the conversation that took place with client F26 during her fortieth session (see *Recognising and switching discourses*, page 223) and will not repeat it. The elements of choice in it will be referred to later (8.4.4, page 292).

However this presents evidence of a socratic process:

- My choice not to participate in her discourse.

- A decision to repeatedly bring the client's attention to harsh immediate reality.
- A repeated enquiry about parts of the picture where the client could exercise a choice.
- The direct reminder of another sense of her that I have experienced.

This approach was necessarily one drawn out by the significance of the circumstances and draws upon work in previous sessions e.g. the sense of self as willow tree.²⁸⁶ However, the process perhaps illustrates a mode of focusing-oriented attention to the implicit both obscured and expressed in the 'idle running' (Ob.40, page 94) and its carrying-forward. The session had a direct impact on the client's behaviour regarding work. A hint of the personal impact was given in an email the evening of the session:

*"I feel a little like I lost sight of me, willingly or otherwise. That realisation, that I lost sight of me and the allowing of it via slack decisions etc. However hard it gets leaves me feeling I haven't looked after me and that maybe I need to. ... I feel now like by noticing that I can care for me a little."*²⁸⁷

8.3.3 Two-chair - Tom/Jerry (F26)

A two chair process with client F26 in sessions eighteen and nineteen provided a dialogical means to express and stand aside from a self-harming configuration. The client gave expression to a critical voice and an oppressed underdog, later characterised by association with cartoon characters as 'Tom' and 'Jerry.' In the first of these sessions the critical voice expressed feelings like:

"Stop putting all of your issues onto other people. They are not going to see you as what they need." "Get over yourself" "You're needy and you are as bad as them." "You're wanting to cause the same sort of hurt. And that

*makes you abhorrent,” “disgusting,” “needy and weak and just pathetic,” “loathsome.”*²⁸⁸

The oppressed side expressed feelings like:

*“I need some consideration as well” “I don’t want everything I just want some recognition;” “You don’t give a damn about me do you?” “You don’t see me do you? ... And it’s not just them that craps on me it’s you that craps on me more than they do.”*²⁸⁹

During the second session some of the same conflict was expressed, but at a much reduced animosity. This time the client can voice both sides and expressions include:

- When under scathing attack (“Who do you think you are?”) the underdog, Jerry, was able to say *“I’m the bit you said you would try and listen to”* and further asserted *“I want to say ‘and I’m me.’”*
- The “disgust” of Tom for Jerry was voiced. When invited by me, Tom was enabled to both feel the disgust and listen to Jerry. This led to a request from the topdog, *“I kind of want to say – where’s the give and take in it?”* And, *“I’ve got to sit here and listen to all the nasty, uncomfortable, disgusting stuff that Jerry has to say. Well, where’s the give and take?”*
- Whilst wanting to react to the need to listen to the topdog after the abuse of the past, Jerry acknowledged the benefit of being heard and *“Jerry sort of concedes that there may need to be some ... give and take.”*²⁹⁰

At the end of the second two chair process the abusive pattern was increasingly associated with the physical damage of self harm. The underdog was voiced by me and, as the topdog, the client was able to discover a compromise that steps outside the abusive pattern:²⁹¹

Underdog You can be so hard.

Topdog Yes but you are used to it aren't you.

Underdog You mean I like it?

Topdog Yes. [unclear]

Underdog Don't you smirk at me. It hurts.

Topdog But you're used to being hurt, so ... I can do what I like. [pause]

I can think of a potential compromise. But I don't know how well received it would be, or even if it is possible. ... In that if I could find it possible, a way not to get to do this [points to bandaged wrist] then I would have to find another way to listen to it, you, rather than just beat the shit out of it.

Underdog I'm not sure I quite understand that. So if you could find another way not to do that ...

Topdog If I could put this in plaster so that I wasn't able to break you anymore, or bruise you, or cut you, or anything else. I wouldn't be able to do any of that.

Underdog That should be lovely. But we know that the medical profession is not so good at giving away pots for nothing.

Topdog There's ways and means.

The client went to hospital from this session and manages to arrange for a plaster cast (or 'pot') to be put on the arm that she constantly injures. While this two-chair process substantially followed normal practice (see page 196), it showed a marked contrast from normal process either in focusing-oriented therapy or work with addictions. Effectively it offered the focusing-oriented way of connecting to the implicit with respect for the evanescent parts that may arise. It linked this to a

dialogical muscularity, asking the client to feel both the different elements but also the tension between them.

8.3.4 Recovery task and evidence

Chapter 6 identified the following recovery task:

- **Recovery Task C** – To assist clients to engage with abrasive experiences of the felt sense and its ambiguities. (Ob.83, page 199)

This evidence showed the combination of attention to the implicit (in a trusting dialogical space) and various styles and levels of practice designed to facilitate the abrasion of explicit forms. In each approach dissonances in the explicit undermined its accepted authenticity and lead to a renewed encounter with the implicit. It is important to observe that the bifurcations used avoided stereotypical divisions (e.g. drunk self/sober self) common in traditional addiction discourse. Significant benefits are demonstrated to both clients.

Observation 93 - Case evidence supports the assertion of Recovery Task

*C – to assist clients to engage with abrasive experiences
of the felt sense and its ambiguities.*

8.4 'Avenue' D - Releasement (Gelassenheit) and self-identification

Three sub-steps were identified regarding this avenue (Ob.84, page 205) - standing aside from the illusion of control, attending to values through self-identification, moments of choice that affirm the new reality in tangible terms. Focusing-oriented work with these is illustrated in the following examples.

8.4.1 Getting a grip (M35)

Section 7.4.2 (page 257) provided evidence of M35's initial and repeated imperative to 'get a grip', or 'grow a pair' as a means of constraining his aberrant tendencies. This will not be repeated except to observe the significant distinction demonstrated between calculated living and 'releasement.'

8.4.2 'I-may-wake-up-one-day' (M35)

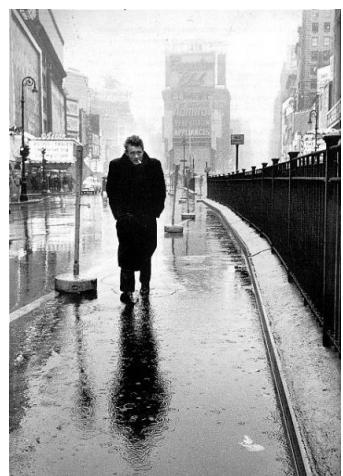
Client M35 was prompted to relate to his values and sense of himself by two distinctive moments of desolation during the course of the therapy. The first was described by the client as the lowest point:

*"I remember laying on the sofa at home, watching 'The King's Speech' on DVD. It was chucking it down with rain, it was a Wednesday afternoon. I had the hangover from hell and I had broke a glass the night before and I found a little bit of glass on the floor and pricked my finger, which wouldn't stop bleeding. I just lay there and cried."*²⁹²

The second was a month later, the client's 46th birthday where, despite some steps forward in his morning use of alcohol, he had spent it alone consuming three bottles of wine. Speaking about the feeling he said:

*"there is some sort of internal angst between actually going out and doing what I say I want to do and, almost an apathy ... It's not apathy, it's not laziness, it's, I suppose, more of a sluggish, sluggishness if that's a word ..."*²⁹³

When this was attended to he connected to a sense of being 'weighed down' with something 'holding me back.'²⁹⁴ I noticed a sense of 'grieving' in the way he was expressing things. The client was reminded of the image of James Dean in 'The Boulevard of Broken Dreams' (see photo).²⁹⁵



The various feelings were identified in turn - a frustration and intolerance with himself, a sense of grieving (if he could not have this girl he could have none) and a need to shield himself.

In the latter part I asked him to relate to the uncomfortable sense he had endured on his birthday and afterwards - this was eventually identified as the feeling 'that-I-may-wake-up-one-day' i.e. on a 66th or 76th birthday still not further forward²⁹⁶. This moment of painful sense of his life prompted a realisation that things were changing for him, but if he did not choose something different, his life might stick in the same place, year after year. A series of exchanges occurred which explored the felt senses of 'I-may-wake-up-one-day' – one remorseful, another responsive. In particular I (over 10 years older than the client) suggested some unfettered, non-judgmental space was given to 'I-may-wake-up-one-day', allowing the whole sense of it, for it to be as it was:

Therapist "... It's a very lucky man who gets to the end of his allotted span without a knowledge of, and some personal encounter with 'I-may-wake-up-one-day.' To have some space for that, to allow it as part of living, not denied, not a foreign body, [Client: Mmm.] it's actually just part of being a human being.

Client A bit like Frank Sinatra.

Therapist Yes, 'regrets, I've had a few, but then again ...' That's an acceptance of the frailty of life, the happenchance of it.

Client I think also I tend to forget about the alcohol in some way, and fail to recognise the fact that what I am going through is actually quite big. It's not cancer, it's not life-threatening in that sense but it is a big thing.

Therapist A turning point in your life. [Client: Yes, absolutely.] If you don't turn now you could wake up in 20 years time standing in your kitchen.

Client Absolutely. And then coming in to see you.

Therapist Sorry, I don't wish that to be ...

Client No, but it is right. It is right and at the end of the day it has to be respected and remembered, obviously by myself. I recognise all of the things we have said over the past few weeks about <partner>, and not about <partner> and all the things. Maybe it's like that getting out thing, and the sluggishness and the lethargy, and actually saying to yourself - 'don't beat yourself up over it, there is something bigger going on here as well, in terms of the alcohol. That's not going to be with you forever, that you are winning, you are beating it, you are there, you are turning the corner. Don't beat yourself up. Yes you are going to feel shit because you ran in 35 minutes, there is a reason for that.'

Therapist Yes, it's very important to kind of park the morality there a bit, right/wrong, and allow yourself just to notice, 'well here I am and during the fateful Thursday there was a sense of I-may-wake-up-one-day. I'm going to allow that to be there so that it informs.' That in a sense is your big, in a split second your big appraisal of just where I am. As the world turns you for a moment allow yourself to [Client: Yes.] get a feel for it all. And it may not be the right appraisal, perhaps there are lots of things missing from it, but to allow that moment of appraisal to touch you ... I am still arguing that it is the existential sense of you that is going to make this shift, that if we invent artificial motivation [Client: Yes.] and stuff, then it will not be strong

enough. [Client: Yes.] But actually it is being able to touch ... I notice just now I am crying, because for me the moment of the thought, that you could be waking up 20 years time, struck me very strongly. That's my stuff. Can you see what I am saying that the energy for change comes from touching the vitality of life within you rather than the artificial structures of [Client: Yes.] intention?

Client I agree totally and oddly, I am not getting upset, which is really odd because normally I would do.”²⁹⁷

This begins to refer to the existential sense of values highlighted by that avenue. Moments of desolation prompted a thoughtfulness that might easily have led to self-chastisement or despair. An experiential openness was stimulated that allowed multiple senses to be related to and, interestingly, a culmination that attended not to their particularity, but to the whole feeling of it. The client did have positives he could reflect upon, but he was able to be with these moments of distressing actuality in a kindly and aware way. The richness of this carried him forward not to an agenda for change, but to a process of growing, as will be seen in the next section.

8.4.3 Choice and an ‘inch taller’ (M35)

This avenue shows the process of choice arising from accumulated stimuli that tend toward the need for change. It illustrates both the process of self-identification and the third sub-step of tangible symbolisation through action.

During the thirteenth session I invited the client to notice the opportunities he was presented with during the day to make a choice. Using the analogy of athletic muscle building, I suggest that every small event was a free choice that he can make for himself and build capability for others. An illustration was the Friday

night meeting where a friend bought him a glass of wine. I ask him to think about where he was at that point, where his desired hardness is to be found:

“That is it the moment where a simple hardness might have held the line. [Client: Yes, I guess it’s weak.] Kind of flabby. [Client: Yes, alright then.] It was the goal that didn’t quite come off, [Client: Yes.] the cross came and we were a bit slow. [Client: Yes, finished up in row Z] So I am wanting to say ‘cobblers to all of this’, that life is presenting you with choices that you are not noticing for the achievements, or the muscle building [Client: Yes.] that might be produced. [Client: Yes.] If you had said ‘no’ on Friday you could have walked out a centimetre or a millimetre taller. [Client: Yes.] And that every time an opportunity arises there is a kind of a shrug - ‘yes alright.’ It is resisting that shrug.”²⁹⁸

I proposed a simple scorecard to record the moments of choice the client exercised during the day regarding his drinking. I pointed out:

“to me it as significant to me that you are doing the noticing, not stipulating rules and regulations. [Client: No.] You are actually noticing the moments when choice could be made [Client: Yes.] and you are noticing the sense of yourself in making those choices. That is the gold seam in it.”²⁹⁹

“I’m saying where the moment of shrug [Client: Mmm, yes.] which would have involved alcohol [Client: Yes.] and you say to yourself that there is a choice here. If I don’t exercise a choice at this point I will have a glass in my hand. [Client: Yes, that’s good.] And I actually want you to put a tick in the box or a date in the box so that we can notice the change. I want to say that there is a millimetre, I don’t know what twelve millimetres look like, is that an inch? [Client: It’s 24.5 millimetres in an inch, so half an inch.] Half an inch. So this will be half an inch taller.”³⁰⁰

The following week the client reported 48 hours without alcohol. He had not done this of his own volition for five years or more. The 'blue card' process had enabled him to notice moments of choice and take them. Multiple occasions were mentioned where he had noticed an opportunity to drink and exercised the choice not to. He reported feeling so much better, and a little taller.³⁰¹

8.4.4 Choice and employment (F26)

As we have already seen (see *Recognising and switching discourses*, page 223), during the fortieth session with client F26 I addressed the question of investment and choice directly in terms of her employment. She recognised she was not exercising a choice in most parts of life, demonstrating very little capability to do things from her own volition. She says:

*"... it takes so much to make the right choice and do what is expected of me. It's just so hard. It's exhausting and it's tiring! All of that is just an excuse isn't it, for not doing it. It's going back to how I feel today which is just an out and out failure."*³⁰²

I challenged her with my felt sense that

*"of you being buffeted around by the winds of circumstance but I don't see any rowing or, swimming or whatever people do when being buffeted in the winds of circumstance. That your ability to do things seems to have been reduced down, in my experience, to taking photographs."*³⁰³

I referred to the other side to her that I also knew - a capable, confident person who seemed almost absent. (There was a connection to the image of a willow tree from a previous session.) Could the space between us be structured to ensure this person was supported and not elbowed out?

Therapist

"... there is something very important here. There is something very valuable that potentially is slipping

through our hands. Um, and it is not about morality and all of that sort of <a local expression for dung> but it is about, is there some way that we could have this interpersonal space, the degree of caring, that can sustain you through making a few of these choices that gets you to the right place? Your job may be the wrong job, you know, but if it's going to mean the difference between you having a mortgage or not, etc., etc.

So what's the feel now? What's the feel of listening to me? Old and boring? [The client chuckles and smiles. The therapist smiles and points to it.] Do you see, yes, do you see. That I can relate to that other, that even when you are being, yes, [Client: Yes.] really awful, I can relate to that other side of you [Client: Yes.] at the same time, yes!

Client *I can feel that.*

Therapist *So don't give me that rubbish that it's not here.*

Client *I just can't sense it myself.*

Therapist *You just did!*

Client *Only because you did.*³⁰⁴

After some time the client acknowledged feeling the presence of this capability and saw the need to be good to herself, to allow herself to choose that positive person. At the end we agreed the seriousness of the situation and the need to maintain support and for her to restrict alcohol intake at the moment to a half bottle an evening. As a consequence of this session she achieved a different

connection with her work and overcame the potential danger of dismissal. An email later showed the experiential difference:

"I wanted to let you know, I think I am proud of myself for today.

This morning was hard as you know, but I stopped and thought about our discussions and noticed some obscured decisions but then made some harder but ultimately better decisions.

Deciding not to isolate myself at work (easy familiar option) ... Proved to lift my mood as people didn't ignore me, in fact talked to me and included me.

Deciding to just get on, even though I felt low, and not limiting myself to a limited workload (thinking I can't do it) ... The variation of work also lifted me and the working under pressure focused me more and I felt less like an invalid with issues.

Deciding not to leave work early (not to hide) ... I felt positive at having achieved a full day and not giving in Deciding to address a situation and not enter into it (possibly destructive-definitely confusing) ... I feel lighter.

*All in all, I feel a lot lighter than I did this morning, I have become more aware of my sense of strength and can find my smile I think ...*³⁰⁵

These kind of choices also connected to other choices about her emotional regulation and self harming. A month later she texted:

*"... I think I needed few tears at work today. I needed to allow myself to recognise that the situation at work upsets me. I have been trying to keep it so together for everyone else's sake, so they don't have to deal with me, but I needed to actually allow myself to recognise the pain of that. I was much more composed and able to work afterwards."*³⁰⁶

8.4.5 Recovery task and evidence

Chapter 6 identified the following recovery task:

- **Recovery Task D** – To assist clients to make choices based on values and acceptance (Gelassenheit) rather than ‘controlled’ living. (Ob.85, page 205).

This evidence showed clients relating to their personal values as a counterbalance to calculative living – M35 had a birthday reappraisal associated with thoughts of his own mortality (8.4.2) and came to accept the implicit power of ‘wholesomeness’ as more significant than ‘getting a grip’ (8.4.1). F26 recognised a sense of her own fundamental value and capability as a different value to set alongside her crisis with employment (8.4.4). Both clients experienced moments of choice in the sense of self-investment – for F26 this led to practical steps forward in a faltering employment relationship (8.4.4) and for M35 it allowed him to take practical steps and sense being ‘an inch taller’ (8.4.3). For both the process of change had personal and practical elements which was further evidenced in the *Change Interviews* (Appendix 7, page 393 & Appendix 8, page 407).

Observation 94 - Case evidence supports the assertion of Recovery Task D – to assist clients to make choices based on values and acceptance (Gelassenheit) rather than ‘controlled’ living.

8.5 ‘Avenue’ E – Concrete carrying forward

The avenues discussion (Ob.86, page 210) identified three ways in which structure and practical considerations might be significant in focusing-oriented work with addictions and this approach might relate to existing orientations. These were:

- Attention to the elements that contribute to addictive behaviour and making practical interventions that might match a motivational determination in a particular direction.
- Consideration of the contextual connections of a person in recovery to build the ecological and interpersonal foundations upon which recovery was known to succeed. Also here was a recognition of the motivational stimulation and energy that such connections can offer.
- Recognition of the need for those in recovery to have a structure to work in, albeit one that also demands their idiosyncratic personal involvement. Structure to hold a person seems to be the early challenge of recovery.

The two clients in this study were substantially different in their response to these matters. M35 was a results-oriented person from the beginning of therapy. Three sets of material are presented below which illustrate this – first the tracking of his recovery in tangible terms of his surroundings, a kind of physical symbolisation. Secondly a summary of the variety of practical tactics that were evolved and practiced with him during the process. Thirdly the way that he set store by alcohol free days. Some indications of the evidence for this are provided in summary form.

The position of F26 was however different. She underwent a variety of significant personal changes during the therapy (as detailed in the *Change Interview*) yet struggled with practical matters. A discussion of this with some evidence is provided regarding her. At the end of both there is a summary.

8.5.1 Dwelling in safety - home and body (M35)

After the number of alcohol free days he had accomplished, perhaps the most distinctive expression of change identified by M35 during the *Change Interview* concerned where and how he lived. The Interviewer made the following remarks from their conversation:

“... for me a particularly significant reported ‘change’ was the experience he described of ‘feeling safe in his house’ ... It occurred to me that this is a lovely metaphor, or even a corollary for the - rather new - possibility of living more comfortably or responsively in his body. His evident enjoyment of new creative projects planned and underway in terms of his house had a similar feel to them.”³⁰⁷

The issue of dwelling was important throughout, his ability to dwell securely in either of the houses he owned, how that shifted during therapy and what evidence there was for the Interviewer’s supposition that there was a symbolic connection here to his embodied living.

The client owned two properties when he started therapy. One, a house was owned with his partner and there had been longstanding activity to turn this into a comfortable home for both of them. Nevertheless she lived there and, for the most of the week the client returned to a flat that he had owned for a long time. (They had been together for four years and three months and had bought a house and moved in together just over two years later. Yet and within four months the client had moved back to his flat.³⁰⁸)

The client felt a particular affinity with the flat (“*my cave, my sanctuary*”³⁰⁹) even though his time there was often “*alcohol related*,”³¹⁰ the place he could sneak back to during the day for surreptitious Gins³¹¹ (perhaps as much about a physical reminder of security as the alcoholic intake). The flat had the faded familiarity of “*an old pair of jeans*” encapsulating a lot of his past. He could have walked blindfold among its rooms and “*when I walk back through the front ... I feel ... safe, home, alone/solitude/peace, in control.*”³¹²

At the start of therapy he had recently he decorated the hallway and put up prints of his own photographs. This provided a continuing feel of satisfaction, but the kitchen had an ambivalent feel. On the one hand standing in the kitchen provided a sense of pleasure, relaxation. It was “*just a completely different universe,*

*everything is standing on its head and I will stand in the kitchen, listening to <a radio sport programme> and drinking a bottle of wine, and enjoy doing it.*³¹³ Yet it was “battle-scarred, because I keep punching bloody doors which is stupid, and the door in the kitchen is off its hinges and leaning up against the wall.”³¹⁴ He had punched the kitchen furniture and fittings as a way to cope with the frustration of long phone calls from his partner and it was to avoid her that he stood as a sentry, just in the place in the kitchen where he can see cars arriving in the car park.

By contrast the house was a domain where his partner appeared to have the upper hand. It was “*history waiting to be made, I know that I need to leave the past behind in terms of <the flat> and move on.*³¹⁵ At the beginning he accepted that in some way he was “*fighting not to move on, different life, commitment to family, one partner for ever.*” Furniture choices symbolised the lack of fit - In his flat he had new bedroom furniture but, “*every time I walk past it I think, ‘I really like that’ but it’s not going to fit in the [house with partner].*³¹⁶ There was a Jekyll and Hyde split between the flat and the house.³¹⁷

The challenges of moving into a closer relationship with his partner have been set out previously. Coming back from a long weekend away he recognised himself at a “shit or bust” moment³¹⁸ when she wanted a timetable from him about when he will permanently move in with her.³¹⁹ His turmoil and ambivalence was expressed in tangible terms - planning how to implement a closing down of the flat and moving in with the partner but in a moment’s pause, finding himself also planning improvements to the flat. He recognised that somehow he wanted to have two lives.³²⁰

The tensions of his position continued to be vented on the furniture and fittings of his kitchen.³²¹ The pattern was being established where his partner came to the flat to “*get me*” and “*I go to that safe place and I stay there, maybe too long before I sort of venture out.*³²² He had tangible longings for individuality in terms of place (booking a holiday or planting out seedlings)³²³ and looked for ways perhaps to create a den for himself at the new house or broker a looser

relationship "*I think it's called 'living together apart...'*"³²⁴ Whilst making tangible investments in the relationship he found evasions about marriage also appropriate - "*I was always going to put that one off until I had got into, maybe, I don't know, different territory.*"³²⁵

The client felt physically invaded on a regular basis with his partner making combative visits and he has been known to leave the house to avoid her.³²⁶ The client's strongest sense of himself was that "*I just want to be alone*",³²⁷ and this desire became a repeated refrain.³²⁸ As the relationship storm subsided, the client and I looked for a physical sense of the positive way forward he was taking. Gardening was mentioned, eating his own tomatoes, but this was not quite right.³²⁹

The client's wellbeing was strangely symbolised in terms of the window blinds planned for his flat. Early in the therapy the broken, catching blinds were described to illustrate the familiar disarray of his retreat.³³⁰ In the middle of the process the unresolved blinds symbolised his impotence and the step forward that was tantalizingly close:

*"... there is stuff all over the place, you want to sort it out, you want to make it nice, you haven't got the balls to make it nice because you don't want to put the new blinds up because you know <partner> is going to come round and she is going to go ape!"*³³¹

*"... I don't have the balls to go out and do what I want to do, just in case it upsets somebody that I no longer live with and have been going through sheer hell with for two years. I know that when I bought the bedroom furniture I felt great. I know that when I started clearing out the <flat> again it felt great. I know that putting new blinds up would make me feel really good. ... And it is almost like I am getting there, I can see out of it, it is just tearing it apart enough to step through it and say (exhales) I'm there!"*³³²

His triumph was therefore trumpeted during the *Change Interview* in terms of blinds and shutters:

"Physically, I got a mate round after going for a run yesterday to measure up to get the blinds done for the windows. I bought new bedroom furniture. <Previous partner> went absolutely crazy. The idea that I wanted bedroom furniture meant that I was moving back to <house owned with previous partner> and everything else. So I've been hanging on and hanging on. I want to get the blinds sorted out. I want to paint the living room. I want to get new furniture. ... And it is almost like 'nest-building' is the word that was used ...³³³

"It was so exciting yesterday, I've got French doors going out onto the patio and it has got some lead lights above it, the original colour glass. And the friend that came round and measured up for all of the blinds, talked about shutters on the outside. And I got so excited about shutters on the outside of the door. And that is worth a dozen bottles of red wine."³³⁴

This activity was more than a symbol, it was a tangible expression of the fact that, after a long time of abuse, now he could actually feel safe in his own house,³³⁵ arguably feel safe in his own life. This section has demonstrated the significance of embodied living for this client - he attended to himself by attending to the physicality of his body and the physicality of his habitation.

8.5.2 Tactics & Objectives (M35)

The client's practical nature and desire for achievement in his alcohol use led to a considerable variety of tactical ideas being tried with him:

- Keeping a drinks diary indicating both the quantity and circumstances of drinking.³³⁶

- The setting of a time in the morning before which he will not drink alcohol e.g. 9 am.³³⁷ This was enhanced by an agreement that it will be followed “*even if war is declared tomorrow, I am still not going to drink before 9 am because I have decided to do so?*”³³⁸
- Proposing that he only purchases one bottle of wine at a time. So if he wishes to drink two in a day he would need to make two trips.³³⁹
- Deciding not to keep alcohol in the flat over night, so that when he woke in the morning it would not be there to drink.³⁴⁰
- The client’s suggestion that he might try reducing the quantity and increasing the quality of wine he bought.³⁴¹
- Differentiating drinking that results from emotional anxiety from other drinking. Thus offering some understanding to himself when the overload session occurred - trying to stem the habit when the tension was great was like trying to reason with a boiling kettle to avoid the steam.³⁴²
- Recognising the precautionary use of small Gin & Tonic doses as a way of bolstering a sense of wellbeing. Some were found to be ‘being prepared’ as one might use the toilet before a long coach trip.³⁴³
- The scorecard where he was invited to notice the moments of choice that arise for him regarding alcohol. Thus he could notice when he drives on a route close to a supermarket where he habitually buys drink. He could notice the moment when he could have chosen tea not beer in a friend’s house etc. The tactic was not to issue a prohibition but to notice, consult the felt sense and choose,³⁴⁴ something the Interviewer notices during the *Change Interview* .

- I asked what gambling odds he would give on having a couple of drink free days the next week. Discussing this the client offered £100 to £10 that he would succeed.³⁴⁵
- Connecting drinking patterns to his desire to perform in running and lose weight.
- The entirely impractical suggestion from me to buy a week's worth of wine at the same time.³⁴⁶

At an advanced stage in the therapy (session 28) I summarise the four strategies that could have been significant in his recovery:³⁴⁷

1. The 'grow a pair' determination that was effective occasionally, but usually best in the 'heat of battle'. (I did not share the clients vitriol when this did not work.)
2. The 'strong chest' that was very good but could not yet be summoned reliably.
3. The practical steps (e.g. not alcohol in house overnight, and not buy more than one bottle of wine at a time) that were effective to a limited degree but were sometimes honoured in the breach. (I admitted feeling that this might be a better foundation for a bottom line.)
4. Kindness to the 'something a little bit empty' on the basis that this would not normally be attended to and could be easily neglected.

This list was endorsed by the client in discussion. In reality the evidence for the benefits of the 'growing a pair' determination was sparse.

8.5.3 Alcohol free days and runs (M35)

M35 entered the therapy with a view to come to a different relationship with his drinking but not to be abstinent. Nevertheless he viewed an alcohol free day as an important milestone in his recovery. Such days were highlighted with a marker in his diary and the accumulation of larger spells was a matter of pride as evidenced in the *Change Interview*.

The client visited the gym regularly and had an involvement with a group that organised 5k runs on a Sunday morning in a local park. He signed up for more organised runs including a longer one in London which he did as a sponsored run. The longer runs required a period of training in advance and some days of abstinence beforehand. The client used these events as motivation and structure to help him achieve alcohol free days.

The following table shows some of the alcohol free days mentioned by the client during the therapy, showing the elapsed week of therapy when the report was made and giving some indication of the connection to formal running events.

Week	Description
1	Start of therapy. To be 'underway' would include "to give myself 2 alcohol free days per week."
16	One alcohol free day
19	Two alcohol free days
21	Four alcohol free days
23	Three alcohol free days + several one off days
24	Three alcohol free days
26	Completed the 10k sponsored run and had enjoyed a period of just short of a week alcohol free in the process
28	One alcohol free day, some one bottle days, several two bottle days, no three bottle days
32	Two alcohol free days
37	One alcohol free day and only one 'wobble' away from a one bottle a day regime
38	10k run and twelve alcohol free days - <i>Change Interview</i> "I sent a text on Tuesday - Personal Best - Tuesday was longer than I have been sober probably since I was 14."

I did not keep detailed records of alcohol free days because, although they were significant for the client, they were not an objective of the therapy. As the previous section illustrates, the prime target of the therapy was to build a different relationship between the client and his pattern of life, albeit including alcohol.

8.5.4 Tangible issues of a different kind (F26)

Reviewing the evidence for client M35 provides a clear correlation between his change of life and his behavioural patterns. Indeed, as will be discussed later, there was evidence here that the client was combining the experiential therapy with practical measures to develop a tangible symbolisation to parallel (and sometimes replace) the verbal symbolisation.

The process with F26 has been of a different kind. The issues she brought into therapy were problematic drinking, depression, an inner critic and self harm. The evidence presented above suggests that the drinking and self harm were behavioural manifestations of the broader existential issues represented by the depression and inner critic. In later stages self-harm and drinking were largely under control. This came from a use of the plaster cast instigated after the two chair session and the interventions of the client's husband when excessive drinking was likely. However both problems had less frequent but more intense moments of crisis which are described above in terms of 'flailing,'

It could well be argued that the 'psychological' problems of this client are more interface issues about her being-in-the-world. She has not developed the tools to address the world and has not built a sense of self or interface that can enable this to be done effectively. Her 'mental' problems will not be resolved until the landscape changes.

8.5.5 Recovery task and evidence

Chapter 6 identified the following recovery task:

- **Recovery Task E** – To assist clients zig-zag between the implicit and tangible forms to carry forward the concrete situation. (Ob.87, page 210)

This section has reviewed sharply contrasting evidence. M35 had been assisted to make structural and practical changes to his life. Indeed it could be argued that the making of these changes were been used by him to cement the change that was occurring in his personal life and sense of self. There are good grounds to hold that the two spheres have evolved together. However, whilst F26 has made a series of significant personal steps have been recorded in the therapy (see *Change Interview* , Appendix 7, page 393), including positive steps on drinking and self harm, tangible shifts in her situation have not been achieved. These differences will be discussed in the next chapter.

Observation 95 - Case evidence supports the assertion of Recovery Task E
– to assist clients zig-zag between the implicit and
tangible forms to carry forward the concrete situation.

8.6 Evidence of addiction and recovery

8.6.1 Addiction

The case illustrations (chapter 7) provide evidence of the characteristics of addiction in practice. Both clients showed experiential estrangement – F26 through the direct avoidance of feelings and adoption of a ‘fugg’ pattern, M35 through frequent use of alcohol and a frequent ‘I-it’ orientation. Both performed patterns of compulsive behaviour which varied from the suicidal extreme, though aggressive outbursts, self harm to the ‘shrug and smile.’ Both revealed underlying

existential dilemmas that were being partially managed through such patterns – for one a key relationship, for the other both a relationship and a work commitment.

8.6.2 Recovery

Similarly case illustrations (chapter 7) provide evidence of recovery, particularly as seen in the *Change Interview* discussions. Both clients showed patterns of change that could not have been predicted in advance, but were idiosyncratically their own. F26 became able to relate more directly with her experiencing and expressed the benefit that this had brought her. She endured a variety of interpersonal and work challenges during the course of the therapy, gradually finding that alternative ways of living opened up. When the period of study finished she had yet to make the overall move in her existential dilemmas that was needed. By contrast M35 made significant shifts in his way of living, opening up a new sense of comfortable habitation. His experiential process was symbolised more in practical terms than verbal, although the case material records a sequence of senses of himself that were significant over time.

CHAPTER 9 - DISCUSSION

9.1 Research questions

This section will review evidence presented in relation to the research questions identified for this study (chapter 1). The questions were:

- How may addiction and recovery be understood from a focusing-oriented perspective?
- How may focusing-oriented therapy be offered to relate to this understanding?

After a summary of the theoretical background, the evidence in response to these questions will be reviewed in turn.

This chapter aims to bring the material from previous chapters together in as clear terms as possible. For the most part, it will therefore avoid repeating bibliographical references indicated before.

9.1.1 Theoretical Background

The thesis has used Gendlin's (1973b) analysis of experiential psychotherapy to provide a structure to understand the focusing-oriented position. From experiential theory this identified four basic concepts that have become the enduring themes of my work – existence/experiencing, interaction/encounter, focalizing/value, carrying forward/authenticity.

My theoretical exploration began (chapter 2) with a review of the philosophical framework for these four themes. This emphasised the significance of lived experience as an 'internally differentiable' reference point where that which is most tangibly somatic is also culturally expressive of linguistic forms. Ideas of the essential interconnectedness of life are at the heart of this approach, both in

environmental and inter-subjective terms. A sense of direction and value is consequently implicit in reality as every action that occurs is itself an implying of further steps. The term 'focaling' is used to point to the intricate, living mesh that arises as a consequence. Thus development and change occur through an inherent process of carrying forward, a tangible realization of what is implied, particularly seen in the zigzag between symbols and implicit reality.

Gendlin sees himself as a revolutionary and much of his work takes a stand against the 'vivisection' of Cartesian divisions (mind/body, person/person etc) which are presumed in much scientific thinking and the 'unit model' of reality. His key concept of the felt sense remains largely unrecognised in mainstream philosophy and psychology and this will be shown to have direct consequences for understandings of addiction and its therapy.

This philosophical framework is shown (chapter 3) to suggest understandings of psychopathology based upon the concept of a human being as an interaffecting process of profound intricacy. The experiential theme shows how the rich immediacy of human process can be thwarted, leaving people to rely upon 'structure bound' responding and the repetition of 'frozen wholes.' Pathology becomes a matter of 'autistic' living, in isolation from the rich streams of connecting that sustain and direct existence. Such problems are revealed distinctively in defensive structures of interaction and apparently irrational manifestations of tension as the person struggles to find a resolution. Notwithstanding such restrictions the person endlessly seeks to articulate a carrying forward and reconstitute the live process that was stopped.

The tasks of a therapeutic response to such predicament (chapter 4) reflect the four recurring themes. A client needs to relate to the rich immediacy of their present experiencing, the 'direct referent' and therapist interventions are all designed to facilitate that awareness. A second task responds to a client's isolation by helping them gain a sense of self-in-relation (ecological and inter-subjective), particularly the interaffecting with existential issues that may be

pressing. A third task concerns the ability to establish structures of self that appropriately articulate implicit interconnected reality. The fourth element is evidenced when the client is carried forward in their living.

This approach is clear about process and largely agnostic about theoretical understandings of the human personality. Neither is it constrained by the application of particular techniques or methods. It suggests that a wide array of therapeutic practice can benefit from 'experientializing' i.e. the use of the felt sense as the guide to their normal application. Consequently whilst it is clear about experiential process steps, the approach also encourages the identification of 'avenues' which cross with other therapeutic orientations.

9.1.2 Addiction and Recovery

The limited review of addiction possible in this study (chapter 5) showed that the scientific community has no common view on the phenomenon. Rather perspectives are drawn from the 'gated communities' of scientific disciplines and theoretical orientations within them. Dominant views are substantially incompatible with Gendlin's philosophy, representing what he describes as the 'unit model.' These emphasise chemically induced tolerance and withdrawal and the concept of a brain disease. This study chose to adopt an approach to the subject which is respectful of current theories and practices but works from a substantially different philosophical basis than that normally adopted.

Anthropology illustrates the socially constructed nature of addiction, particularly its ambiguous relationship to the role of individual as consumer. It observes how the discourse of addiction involves both a self alienation and a societal one, in both instances morally censuring to allow a more limited integrity to be protected.

A variety of views on addiction are nevertheless identified which resonate with the focusing-oriented perspective being developed. These include views of addiction as self-medication and a problem with affect regulation. The 'dislocation' view

and ‘attachment disorder’ views illustrate interactive dysfunctions and a substantial study of detoxification facilities illustrates how the discourse of addictive ‘others inside’ is used as a tool. Traditions of ‘spontaneous recovery’ and ‘recovery capital’ also illustrate a sense of carrying forward. Overall, a ‘post-humanist’ view reflects in the most developed form, a perspective sympathetic to the Philosophy of the Implicit – that of addictions as bodily articulations.

The limited focusing-oriented perspectives available emphasise ‘process-skipping’ and the significance of defensive structures such as ‘partial selves.’ Taking these into account with the views of addiction and focusing-oriented psychopathology listed above, a focusing-oriented view of addiction is proposed:

Addiction is a pattern of experiential estrangement and compulsive behaviour which provides a way of coping with existential dilemmas.

(Ob.73, page 170)

The case illustrations (chapter 7) provide evidence of the characteristics in practice. Both clients showed experiential estrangement – one through the direct avoidance of feelings and adoption of a ‘fugg’ pattern, the other through frequent use of alcohol and a frequent ‘I-it’ orientation. Both performed patterns of compulsive behaviour which varied from the suicidal extreme, though aggressive outbursts, self harm to the ‘shrug and smile.’ Both revealed underlying existential dilemmas that were being partially managed through such patterns – for one a key relationship, for the other both a relationship and a work commitment.

The description of focusing-oriented therapy, when taken with this concept of addiction and generic information about recovery suggest a matching focusing-oriented view of recovery:

Recovery is a process of carrying forward where, through experiential engagement, alternative ways of living open up. (Ob.74, page 172)

Similarly the case illustrations (chapter 7) provide evidence of this in practice, particularly as seen in the *Change Interview* discussions. Both clients showed patterns of change that could not have been predicted in advance, but were idiosyncratically their own. F26 became able to relate more directly with her experiencing and expressed the benefit that this had brought her. She endured a variety of interpersonal and work challenges during the course of the therapy, gradually finding that alternative ways of living opened up. When the period of study finished she had yet to make the overall move in her existential dilemmas that was needed. By contrast M35 made significant shifts in his way of living, opening up a new sense of comfortable habitation. His experiential process was symbolised more in practical terms than verbal, although the case material records a sequence of senses of himself that were significant over time.

The theoretical objective of this study is therefore accomplished. Building from philosophical and psychological principles and taking into account views of addiction inside and outside the focusing-oriented community, an understanding of addiction and recovery has been proposed.

9.1.3 Focusing-oriented therapy?

Having reviewed focusing-oriented therapy in general terms (chapter 4) an overview of popular treatment orientations for addiction was made (chapter 6, see also Appendix 6, page 383) so that the key principles were established. This showed a wide array from 12 step facilitation, through behavioural 'Relapse Prevention' and Motivational Interviewing using the 'transtheroetical' model of change. These approaches emphasise the person's orientation toward drugs or alcohol and practical steps to make a difference. Alongside these are orientations that work more with the whole person – person-centred, Gestalt, mindfulness and ACT.

Three core tasks of focusing-oriented recovery were identified from Gendlin's basic concepts that have shaped the thinking throughout. These develop views of

psychopathology and therapy taking into account perspectives on addiction set out above.

Recovery Task 1 - Standing aside from the carapace

This recovery task was identified (chapter 6) as:

Assists a client to stand aside from their addictive carapace and attend to their own experiencing, however limited it may be. (Ob.77, page 178)

The case illustrations (7.2, page 219) show considerable evidence of this task being undertaken by both clients and the interventions from me associated with it. F26 is assisted to stand aside from the engulfing 'fugg' experience, recognising and switching discourses. A two-chair process assisted her to stand aside from her self-harm and the drinking that was associated with it. M35 was enabled to stand aside from a pattern of alcohol dependence that he had hitherto found impossible to change. This he perceived as stepping beyond his addictive self to offer an exceptional kindness. This kind of change resulted from a twin responding approach from me – responding empathetically to the felt sense behind the addictive pattern (rather than the pattern itself) and attending to the functional experiencing of the client outside of this.

In summary, the evidence (Ob.88, page 236) supports Recovery Task 1.

Recovery Task 2 – Relating to the dilemma

This recovery task was identified (chapter 6) as:

Assists a client to address and carry forward the existential dilemmas which concern them. (Ob.77, page 178)

The case illustrations (7.3, page 237) show considerable evidence of this task being undertaken by both clients and the interventions from me associated with it. M35 attended to the abusive relationship that he has sustained for several years and to

his habitual pattern of accepting blame and feeling disempowered. He was enabled to attend to himself as a ‘tethered bear’, to find empathy there and began to reshape his own priorities and the way he related. Both clients evidence their pattern of being-in-the-world through distinctive gestures that are meaningfully worked through in therapy. F26 had a ‘shrug’, ‘smile’ and protective ‘face’ that presented an alienated sense of self. During the course of therapy she discovered several alternative ways to connect to a growing sense of her own experience, even in previously abusive relationships. These kind of shifts followed two particular interventions by me – firstly seeking out the implicit sense of their existential dilemma in habitual actions and gestures, secondly relating to the whole of their being-in-the-world that was consequently revealed.

In summary, the evidence (Ob.89, page 248) supports Recovery Task 2.

Recovery Task 3 – A new way of being-myself-in-the-world

This recovery task was identified (chapter 6) as:

Assists a client to discover a new way of being-myself-in-the-world.

(Ob.77, page 178)

The case illustrations (7.4, page 248) show considerable evidence of this task being undertaken by both clients. The process by which F26 discovered a new way of being-in-the-world began early in therapy, relating to my ability to connect to obscured parts of herself. Different configurations were gradually explored of a self very different to the face presented to the world. The picture of the ‘willow’ was significant in allowing small steps of practical achievement. At the completion of the therapy this client had yet to make the more significant steps implied here. By contrast M35 showed a large process of steps moving toward a ‘wholesome’ sense of himself. These included practical adjustments to his pattern of life and home accommodation as well as major changes to his use of alcohol.

In summary, the evidence (Ob.90, page 264) supports Recovery Task 3.

Avenue A - Emotional regulation and self-in presence

This task relating to this recovery avenue was identified (chapter 6) as:

Recovery Task A – To assist client’s ‘emotional regulation’ through dual-responding, encouraging self-as-perspective and linking practical issues to implicit meaning. (Ob.79, page 186)

Whilst the two clients in this study were very different people, both showed considerable challenges in emotional regulation and the ability to stand aside from self to find some perspective in their experiencing. Evidence in the case illustrations (chapter 8) show both being enabled to tolerate uncomfortable experience and relate to it from a self-as-perspective position. The shifts are associated with my modelling and repetitively invoking a focusing attitude at key occasions.

In summary, the evidence (Ob.91, page 272) supports Recovery Task A.

Avenue B - Waiting upon a carrying forward

This task relating to this recovery avenue was identified (chapter 6) as:

To assist clients to attend to implicit meaning and wait upon the ‘right’ carrying forward. (Ob.81, page 192)

The key sense of waiting in this avenue is perhaps a little strange as an intervention, yet is key to the Philosophy of the Implicit and focusing-oriented process. The case illustrations (chapter 8) provide evidence in terms of the overall shape of experiencing presented by the clients. Four stages are discerned where dysfunctions in the past lead into a trapped present, then a flailing to get free and the arrival of new energy and direction. The focusing-oriented intervention is to discern and to respond to the overall pattern with patience.

In summary, the evidence (Ob.92, page 278) supports Recovery Task B.

Avenue C - Stirring up ambivalence & opposition

This task relating to this recovery avenue was identified (chapter 6) as:

To assist clients to engage with abrasive experiences of the felt sense and its ambiguities. (Ob.83, page 199)

Case illustrations (chapter 8) show a variety of interventions within this avenue.

At one extreme is the repeated way that M35 benefited from resonating board interventions, as he remarked in the *Change Interview*. At the other extreme is the two chair work with F26 and the Socratic Questioning used in her sessions.

The interventions depended upon explicitly checked felt senses that have abrasive characters. Both clients show evidence of shifts that arguably would not have been made had a less assertive and oppositional approach have been used.

In summary, the evidence (Ob.93, page 286) supports Recovery Task C.

Avenue D - Releasement (Gelassenheit) and self-identification

This task relating to this recovery avenue was identified (chapter 6) as:

To assist clients to make choices based on values and acceptance (Gelassenheit) rather than 'controlled' living. (Ob.85, page 205)

This avenue emphasises the ability to make choice and self-identification, something not normally emphasised in focusing-oriented therapy. Case illustrations (chapter 8) show M35 was enabled to address a particular sense of his own mortality and the passing of time to relate to his fundamental needs and values. In a different context he was able to connect to explicit choices of his own fundamental direction. For F26 the felt sense of her ability to choose was powerfully evoked at a key moment relating to her employment. Both depend upon my having an eye for the key ACT distinction between instrumental appraisal and the existential moment of self-investment (page 200).

In summary, the evidence (Ob.94, page 295) supports Recovery Task D.

Avenue E – Concrete carrying forward

This task relating to this recovery avenue was identified (chapter 6) as:

To assist clients zig-zag between the implicit and tangible forms to carry forward their concrete situation. (Ob.87, page 210)

This avenue is illustrated (chapter 8) in the tangible symbolizations of M35 – establishing himself in a new, safe way of dwelling at home, deploying tactics and objectives to match his felt sense. He finds himself working toward alcohol free days and using fun runs as a spur to achieving them. This tangible symbolisation matches his practical demeanour and depends upon the evocation of successive carrying forward of the felt sense. A similar process is demonstrated in a lesser form with F26 in using her plaster cast of the arm as self protection. In both instances I worked experientially and learned to recognise the significance of concrete carrying forward.

In summary, the evidence (Ob.95, page 305) supports Recovery Task E.

Therapist roles

Four generic therapist roles in focusing-oriented therapy (chapter 4) which might be applied in focusing-oriented recovery therapy:

Role 1 - Creating a space - *To facilitate a shared space where the client can relate to their immediate experiencing and be heard accurately (exactly though differently).* (Ob.52, page 123)

Role 2 – Felt meaning - *To offer a special attention to felt meanings, using self as a ‘resonating chamber’ for what may be present.* (Ob.53, page 126)

Role 3 – Articulations - *To attend to and invite articulations of carrying-forward in gestures, actions, values, flailing and experiences of self.*
(Ob.54, page 128)

Role 4 – Living-toward – *To respond as a human ‘other’ to shared implicit meaning with the client, ‘putting nothing between.’* (Ob.55, page 129)

No attempt has been made to review the implementation of these in detail. However, the evidence of the three core client tasks of focusing-oriented recovery therapy reviewed above also supported the general application of these therapist roles to the work (Ob.88, Ob.89, Ob.90).

9.1.4 Conclusion

An earlier part of this chapter (9.1.2) concluded that the first research question had been answered. This part of the chapter has summarised how the core model of focusing-oriented recovery therapy (three recovery tasks 1-3) and the ‘avenues’ model (five recovery tasks A-E) have been demonstrated within the case illustrations.

Thus both research questions have now been answered.

9.2 Strengths and limitations

The strengths and limitations of this work can be divided between those relating to the study itself and those connected with the suggestions for theory and practice it identifies.

9.2.1 Study strengths

This study (chapter 5) has shown that, to date focusing-oriented therapy literature and practice has only engaged with the sphere of addiction in a limited way. The most substantial and systematic work, linking focusing to the 12 step approach ,

does not step outside the perspectives of that orientation. Whilst successful in its own sphere it does not provide a general application of focusing outside that tradition. Other focusing-oriented engagement has been outside the psychotherapeutic sphere and, whilst informative, has been limited. The most significant theoretical connection between addiction and focusing has been in the sphere of spirituality and has had no therapeutic expression.

This study has consequently attempted to begin to put the relationship between addiction and focusing onto a firm footing. It has worked from principles of the Philosophy of the Implicit, drawing theoretical themes through experiential psychopathology and psychotherapy. It has explored principles and practice of focusing-oriented therapy as it might apply to the problem and compared these with therapy for addiction from other orientations. A view of addiction and recovery has been set out and a model of working in this area has been developed that covers both key therapeutic tasks and processes that 'experientialize' practice from other orientations. The model has been tested and validated through practical work as set out in a case illustrations.

The key strength of this study therefore lies in its largely successful attempt to systematically address largely unexplored territory and propose the basis of a therapeutic approach.

9.2.2 Study limitations

The major limitations of the study arise from three areas – the relatively modest review of a complex field, the minimal research traditions in this area and limitations on the practical testing done.

The study (chapter 5) has indicated the substantial literature that exists in the field of addiction and the great divergences of view found within it. The concept of addiction has been shown to be in considerable dispute between the 'gated communities' of the police, medicine, social science and politicians. A plethora of

theories and interpretations of the phenomenon exist, based upon fundamental philosophical and scientific divergences, as do traditions of treatment.

Anthropological analysis consequently emphasises the 'epistemic trajectories' of this category, emphasising the validity of competing understandings according to constantly changing contexts. An interlocking 'historical ontology' is suggested which takes addiction to be a large family of phenomena and points to the reflexive way that individuals and groups appropriate and mould meaning in whose sphere they exist.

This conception of meaning as arising through a multifaceted human process is appropriate to an investigation based on the Philosophy of the Implicit, but necessarily would disappoint those seeking positivistic solutions. The author has not sought a definitive solution to the problem but has emphasised validity as it is experienced with a particular client group, encountered in a particular place at a particular time. The perspective offered is one from within the tradition of the Philosophy of the Implicit and does not seek to resolve understandings beyond this. Consequently the view of addiction presented will be limited to one with validity from within this perspective.

As has been mentioned, the dearth of previous scholarship in this area provides both a spur to endeavour and a challenge on depth and breadth. Having undertaken a preliminary investigation, the author found himself without a choice of precedent, needing to establish a theory of addiction and a method of working from first principles. This approach therefore proceeded slowly and by use of broad analogies (e.g. in early investigations parallels between addiction and somatoform complaints and trauma dissociation were informative). The resulting conclusions are consequently broadly drawn and limited. They are suggestions about the phenomenon of addiction, the core therapeutic tasks to be undertaken and avenues of work to be developed learning from other orientations. The conclusions of this study cannot justify more definitive assertions.

Further the case illustrations of the conclusions reached also shows methodological limitation. Clients were selected from among those applying to the drug and alcohol agency for treatment and were allocated to the author in an arbitrary manner. They were among those who consented to participate in the study and are distinctive because they provided a significant period of engagement at a point when theoretical work had produced hypotheses to be pursued. Whilst they both have alcohol problems at least one could be understood as perhaps emphasising psychological problems more than simple addiction (although such comorbidity is not uncommon in the field).

The research was further limited by the capability and disposition of one therapist, the author, and clearly each case would have proceeded differently if another therapist had been involved. The case studies would have been further strengthened had appropriate 'triangulation' data been available. Consequently the evidence arising from them is illustrative of the model generated rather than providing definitive evidence of its validity. It suggests approaches that deserve to be further tested and no more.

9.2.3 Strengths of results

The results of this study have the advantage of providing clear proposals for understanding and practice in a challenging therapeutic area where focusing-oriented therapy has not seriously been examined before. Therefore at this point the study can claim to be unique, the only other academically established study being primarily about Post Traumatic Stress Disorder with connotations of addiction.

The study also has the advantage of revealing an understanding that is compatible with a mainstream drug and alcohol agency and clients that had received standard treatments (e.g. Relapse Prevention). The approach has its own understanding of addiction but prioritises an 'experientializing' stance, thereby being compatible with other orientations in the field. The approach was developed during a period

of practice with clients using Heroin, Cocaine, Crack Cocaine, Marihuana and Alcohol and demonstrated positive results across different substances of choice. Such clients were among the more dependent and entrenched drug and alcohol users that the agency serves.

The approach developed has the advantage of responding in a whole person way to the clients engaged with it. Rather than address merely addictive symptoms, the needs of the individual are recognised in a comprehensive way and clients are enabled to work with their whole sense of being-in-the-world. As has been demonstrated, the clients in this study particularly appreciated this kind of involvement, contrasting as it does with the instrumental orientation that can be perceived by clients in some drug treatment contexts.

9.2.4 Limitations of results

Standard practice accepts that no treatment regime is appropriate for all clients and, in line with other methods, the approach necessarily reflects interventions that are advantageous to some clients in some circumstances. Necessarily it will be more attractive to those clients who are willing (or become willing) to consider and address existential issues rather than those who seek a mechanistic solution for addictive behaviours without reference to other aspects of life.

The approach challenges two fundamental perspectives on addictive behaviour – that the problem is either seated in the chemical properties of a substance or in a deficiency of the individual e.g. the ‘chronic, relapsing brain disease’ hypothesis promulgated by the United States government. The approach does not deny the physiological and psychological influence of chemicals upon the person, but offers a means to work with the entire being-in-the-world of the person. As such it can sit alongside pharmacological and other interventions but it does suggest that experiential and existential considerations must be addressed to reach a thoroughgoing process of recovery. Some dominant orientations may find this position untenable.

The approach does not adopt a judgmental approach to addictive behaviour, seeking to relate to the heart of it rather than consider it merely a malfunction to be rejected. Abstinence is considered to be a useful option for some clients but is not offered as a necessary outcome for every client in treatment. This position, whilst not inconsistent with certain stances of addiction treatment may be uncongenial to dominant approaches such as the 12 step tradition.

The approach suggested from this study implies a sustained period of engagement between client and therapist which may substantially exceed the 12 week limitation that some agencies impose. The resource implications of this approach would need to be addressed in a widespread application of this approach through counselling. Such limitations might be substantially reduced if the approach were adopted by drug and alcohol treatment staff as well as counsellors (see below).

9.3 Comparison with existing knowledge

The substantial body of this approach follows the principles of focusing-oriented therapy as set out in the literature. Also the experiential practice it recommends is close to that well known in the focusing-oriented tradition (e.g. 6 steps). Innovations in focusing-oriented theory and practice are suggested from two directions – other therapies within the experiential tradition and ‘experientializing’ other addiction treatment traditions.

The work set out here has drawn freely from the theory and practice of other experiential therapies. Gestalt therapy is significantly more developed in its relation to work with addictions and it provides a rich foundation in theory and practice to be used. Thus understandings of the expressive nature of addictive behaviour have their foundations in Gestalt thinking, as do ways of working with the growing sense of self capability. Gestalt techniques are obviously present in two-chair and other oppositional working. Similar connections are present with somatic therapy for addiction, mindfulness treatments and the significant stance adopted in person-centred practice.

In a more challenging sense this work has drawn from experientializing approaches found in the mainstream traditions of addiction work – Relapse Prevention, Motivational Interviewing, 12-step etc. As was made clear, these operate from theoretical understandings that may be considerably different to the focusing-oriented view. However, an experiential ‘crossing’ not only produces fresh ways of working, but opens up significant areas for focusing-oriented thinking.

It is my contention that the focusing-oriented perspective represented here is distinctive from existing positions in three particular ways – intersubjective focusing, the carrying forward orientation and the exploration of novel focusing-oriented practice.

Focusing-oriented therapy is distinctive from the person-centred tradition in suggesting a legitimate role for the felt sense of the therapist in the process. This builds from Gestalt ideas of using self as a ‘resonating chamber’ and person-centred ideas of ‘integrative impressions.’ However, focusing-oriented therapy takes this further, ‘living-toward’ a client in a way that shares implicit meaning with them, ‘putting nothing between.’ The case illustrations show this as particularly valuable with addictive behaviours and there is a special element here as the difference of the therapist from the client’s frame of reference becomes a valuable gearing in the therapeutic process.

The carrying forward and focalizing elements derived from the Philosophy of the Implicit suggest a second distinctive contribution – a combination of detailed attention to the living immediacy in an encounter and depth of personal trust in the life forward direction (actualizing tendency). The latter element is the most distinctive contribution of the person-centred approach in this field, a dogged attention to the actualizing of even the most perverse behaviour. To my mind the precise emphasis on implicit meaning from focusing-oriented therapy combines with a profound trust in carrying forward to offer a special place for the client.

This allows an immediacy of opportunity to be experienced without the moral pressures common in the field.

The final distinctive contribution of this approach concerns the way that experientializing three avenues from addiction therapy open up new avenues for focusing-oriented therapy both in this field and more generally:

- **Avenue C** – This deploys attention to the implicit, but used in situations where an ambivalent or oppositional quality is encouraged e.g. through two chair work or Socratic Questioning. The ability to constantly refer back to the felt sense adds depth and security to what might otherwise be an insidious process. Addictive behaviours benefit from the moments when oppositional elements are brought to the fore, something that is not common in focusing-oriented practice.
- **Avenue D** – Heidegger's concept of releasement (Gelassenheit) provides a valuable distinction between calculative living and values driven self-identification which again is not a core process in focusing-oriented therapy. An emphasis on an experiential orientation (rather than instrumental) is inherent in focusing work, but this is shown to be potent when connected with the core values of the client as perceived in symbolised implicit form. The further step of seeking self-identification follows naturally in the context of addiction work, an emphasis which can be lacking more generally.
- **Avenue E** – The theory and practice of tangible zigzags from the felt sense is a theme that is not strong in focusing-oriented work. It arose as an innovation during the case of M35 only through difficulty. However, this demonstrates clearly that clients may connect to the felt sense and feel most comfortable working in practical, task oriented mode. This expression of the implicit in tangible form is also evident in the use of

supportive structures to contain fragile processes where unclear sensing needs support to form.

These illustrations draw together elements from the study as a whole. They show that the approach recommended here builds from elements in the experiential tradition and some from avenues that might otherwise be considered antagonistic to it. It suggests a renewed confidence in the experiential edge of all manners of therapy and a willingness to embrace that which would perhaps appear antithetical to its fundamental values. One might echo and adjust Roger's dictum "*the facts are friendly*" (Rogers, 1961, p. 25) to suggest 'the felt sense is friendly'!

9.4 Implications for practice

The initial work set out in this study does not make prescriptive recommendations about how therapeutic work with addictions should be undertaken. Such suggestions would be premature and recommendations are set out below as to how the insights from this work might be taken further in research.

Whilst the model of addiction and its treatment were developed in the structure of traditional therapy, there are many good reasons why it should not be restricted to this. Clients with problems of addiction are difficult to engage in traditional weekly therapy sessions, particularly those whose life is in crisis. The standard counselling response might be to say that such a person is 'not ready for therapy', and to a degree this is true. However, there is a trap in such an evaluation, since those most in need are least able to fulfil the client expectations of the process. How can a person be engaged beyond this? I am reminded of the creative approaches Gendlin used with schizophrenic patients.

My suggestions are that the therapists can be trained in the three core tasks of focusing-oriented therapy for addiction and that this might be done through standard experiential training techniques:

- Assists a client to stand aside from their addictive carapace and attend to their own experiencing.
- Assists a client to address and carry forward the existential dilemma which concerns them.
- Assists a client to discover a new way of being-myself-in-the-world.

However, alternative training can be provided via group work with therapists, drug/alcohol support workers and clients in various settings. This might focus upon experiences of 'crossing moments' that enabled the experience of a felt sense to be evoked and worked with in dyads.

A workshop in a focusing conference (Tidmarsh, 2013b) demonstrated how certain felt senses from focusing-oriented therapy with addiction can be symbolised in a way that allows individuals to access them in a group setting. This is not dissimilar to focusing work in the 12 step tradition described above (page 207) but working from an independent structure. Participants are taken through a simple process of connecting to images of addictive felt senses and 'crossing' these with their own experience. The emphasis was on the continuity between normal compulsive behaviour and that of more extreme individuals. Four examples are provided below from the conference of the addictive experience and three further are suggested for use with therapists:

9.4.1 Felt senses of addiction

Standing beside the carapace

This uses the image of an addiction as a constraining but protective carapace. It is explained with reference to the inhospitable environment of a crab and the pressing need for protection and the ability to retract from the world.

The carapace is useful, even a lifesaver in those terms,



yet establishes patterns of articulation (like walking sideways) that subsequently appear to be impossible to break. The challenge of this felt sense is the ability to both stand aside from the encapsulating articulation of the carapace and stand beside it.

Attending to the unheard actualization

This uses Rogers' (1978) famous analogy of potato shoots inadvertently left in darkness and the "*bizarre, futile growth, a sort of desperate expression*" of their actualizing tendency (Rogers, 1978, p. 8). The felt sense of thwarted, neglected, heroic attempts at growth is invoked but also a recognition of the futile attenuated shapes that result when the environment is unsupportive. Whilst clients' attendance in therapy is normally a sign that they wish to reject addictive behaviour, can they be encouraged to have a felt sense of the thwarted actualization that is present within it?



Flailing response

The physical gesture of flailing is used here to invoke the felt sense of apparently destructive and irrational behaviour that clients often engage in. The more pressures mount without resolution the more a client needs to violently express the tension within and the trap of frustration that their life is caught up in. The image used is of the desperation of a bird caught on barbed wire, wounding itself in vain attempts to be free. The client is here invited to see if their felt sense of aggressive destruction can connect with this.



The road not taken

An image from a poem evokes the moment of choice when faced with two paths diverging. It evokes the existential position of clients with problems of addiction, faced with



the familiar, compulsive path, or the option of noticing “*the one less traveled by*” and subsequently realizing “*that has made all the difference*” (Frost, 1972, p. 105). It connects to a discussion with client contemplating a more onerous means of obtaining his Subutex medication, and musing that such a change might be “*something I don't want to do but it might be the better thing to do.*”

9.4.2 Therapists – felt senses that open

Resonating chamber

Further explorations of the use of self as resonating chamber in work with addictive behaviours is recommended. At one extreme this would include instances where a therapist offers and checks a moment of intuition. Another step would be the recognition of different senses of the client that are not present but have been shared between client and therapist. A further extension would be the summative, growing felt sense that has arisen and built during a session or series of sessions. Another possibility would be the recognition of a felt sense arising in the therapist that neither therapist nor client can account for.

Self investment

Further explorations of the experiential edge of value and choice (Gelassenheit) are recommended. Examples might be an ‘allowing’ experience of the choices implicit in everyday substance misuse, resonances with values that don’t quite fit, seeing how the ‘right’ way of place to be accumulates alongside addictive patterns. Particular here are moments of invitation to see if carrying forward is implicitly right or a further step awaited.

Coming home

Here a sensitivity is recommended toward fragmented and disjointed behaviour that nevertheless symbolises carrying forward and steps towards home (Ob.50, page 119). This may be expressed in dissonance, self-soothing, or unexpected and occasional abilities to stand aside from repetitive practices. Any gesture towards a viable life alongside addictive patterns however scrappy, is valuable. So is the

encouragement of persons or situations which might sustain a dissonance with it. This tangible articulation will include moments of choice that the client may evade in a dozen attempts. First a therapist then a client may be able to stand beside such fragments, in recognition but not judgement, waiting on the carrying forward.

9.5 Reflections on theory

As has been shown, theoretical understandings of addiction have been subject to debate and disagreement between competing paradigms. Dominating 'epistemic trajectories' have considered the seat of problems to lie in the chemical properties of a substance, the dysfunctions of the individual (psychological and ethical) or recently, of a brain disease. Whilst broader sociological and anthropological perspectives have been developed, their influence is limited in terms of practice and policy. What Gendlin might describe as the 'unit model', and others see as 'ontological gerrymandering' may sustain divisions of understanding between the 'gated communities' that work with this issue.

Being predicated on the Philosophy of the Implicit, this study has emphasized the essential connected interaffecting of phenomena and human existence. Gendlin's theoretical stance highlights a bodily attunement which encompasses physiological processes, ecological and human interaffecting with cultural and linguistic meaning. Notwithstanding divisions of understanding, he provides an integrated perspective fundamentally at variance with dominant theories of addiction and a practical way of working with the person that gives it effect.

This study has sought to explicate what such a focusing-oriented theory of addiction might be and to test it out in practical work of recovery. It necessarily draws upon various streams of thinking and therapy. Its distinctive contribution lies in the understanding of addiction as a existential bodily articulation, a carapace of survival and defence that reflects the inter-personal, chemical and situational realities a person faces. It shows the processes and phases of addiction

as responses to the situational mesh a person faces from minute to minute, an expedient and flawed process of survival. Perhaps the distinctive contribution it makes to theory lies in the last chapter where, notwithstanding its compulsive irrationality, the shape of two client's addictive careers was set out as a pattern of situational interaction, a meaningful if ineffective being-in-the-world. Such a concept can reflect the cultural function of the concept as well as its personal utility to explain and excuse the unacceptable ('others inside').

This kind of approach is unlikely to gain widespread assent relating to a highly politicised sphere, one increasingly dominated by a medical understanding. Yet it provides a thoroughgoing rationale for those working in the sphere who wish to look beyond existing restrictions and, as the study has shown in a modest way, offers a view that can help practical interventions be developed.

Turning to the focusing-oriented world, this study has illustrated an explication which crosses fundamental concepts with a challenging therapeutic issue. It demonstrates that the principles of 'crossing', through such processes as Thinking at the Edge and experiential practice are indeed carried forward in ways that could not have been predicted before. The aim from the start was to relate with a mainstream drug treatment environment and provide results that would be valid for those who work within it. This has only been partially successful. Whilst the practice reflected here took place within a government-funded treatment facility, it remained the work of one person and would not be followed by other practitioners working there.

Nevertheless this work has set out a development of focusing-oriented thinking about addictions, recovery and treatment at a more advanced level than has been undertaken before. It suggests a view that is not dependent upon a particular treatment regime (e.g. the 12 step method) and one that is open to further development and practice as will be proposed below. This process has revealed three key elements of such an enterprise:

- That to explicate a focusing-oriented application within a mainstream environment there is a need to wholeheartedly engage as a full member within it. Notwithstanding the tensions that have resulted, it would have been counterproductive to attempt a marginal role. Crossing requires a whole-person engagement in a context and an open orientation to whatever arises.
- That the process of 'experientializing' offers a very fruitful way to relate traditional focusing-oriented work to a particular context. This usefully sets aside ideological divides and recognises the practical viability of different approaches. It allows a cross-fertilization that can carry forward therapy in new ways.
- That such an approach suggests ways in which focusing-oriented working can step outside traditional forms such as the 6-step method, to deal with entrenched life issues. This can lead to further thinking and reconfigurations.

Several areas of focusing-oriented theory are highlighted in this study that deserve further attention:

- The idea of tangible symbolization as demonstrated by one client.
- An enhanced understanding of the place of values and choice in focusing.
- The place of focusing in relation to approaches which stir up ambivalence and use opposition in therapy.

9.6 Implications for research

The research so far has proceeded largely in a narrow way. I have developed the theoretical and practical framework over five years, using academic study, thinking at the edge explorations and repeated sequences of reflection upon practice. Four times during this period the results have been shared at an international

conference and a number of connections have resulted. As an academic exercise for a further degree there has been a need for it to proceed as a contained exercise.

There is a need at this stage to break the constraints that have so far been imposed and to see if the material generated crossed fruitfully with practice of other therapists and drug/alcohol work in other settings. Positive responses to articles, conference presentations and contacts as 'space holder' for the Focusing Institute suggest that an international cohort of interested parties exists. A model for this kind of working exists at a single geographical location. Gendlin and his partner (Gendlin & Hendricks, 1972) developed a process that provided a forum that used focusing as a mutual self-development tool – the Changes Group. The first step would be to submit this material to such a forum to see if through crossing it could be validated and could carry forward in other people's lives and practice. A process of relinquishing control and responsibility would be involved. My suggestion is that this might be undertaken as a multi-national process using virtual tools such as 'Google Hangouts.'

A second process would be to submit the material to systematic validation through a formal case study process. The most logical would be a theory building case study as set out by Stiles (2007), although the prospect of a task analysis as proposed by Greenberg (2007) and colleagues would also be attractive.

9.7 Personal learning

This project has developed through my intensive involvement as both therapist and researcher. The ethical preparation anticipated that this might provide a degree of tension, as the two roles might have conflicted. This did not arise in practice.

However the process of carrying out both roles over a protracted period was stimulating, engrossing and ultimately exhausting. The cross-fertilization of

interests allowed a rich process to develop, particularly as Thinking at the Edge exercises were carried out at various stages. Process developed as sessions were transcribed, clinical supervision undertaken, academic writing carried out and discussed with an academic supervisor and focusing sessions were enjoyed with a focusing partner. Shifts of understanding and inspiration invariably took place in the very early morning, during the period immediately surrounding waking up.

The volume and nature of literature on addiction proved a major challenge. For a long time there seemed to be a need to assimilate all of the available theories, reach a judgment on each and justify it in academic terms. Repeated attempts to do this led eventually to the strategy adopted in the document set out above. The 'gated communities' of the addiction world seemed to be the antithesis of the inter-affecting accepted as the bedrock of the Philosophy of the Implicit. Were there not sufficiently rigorous academic guidance, the project could have foundered at this stage.

A key issue was the need to retain academic rigour and develop some distance. A way to do this was suggested by models of case study research in counselling and psychotherapy that have been used widely elsewhere. These present a deceptively rational approach but which was problematic when working with an area of study with little previous attention and a large and complex literature. After many difficulties and support from an academic supervisor the approach adopted here was established.

In more personal terms three strands of learning are intertwined in this project that represent the deepest personal learning and deserve warm acknowledgement before the task is done. Each presents an imperative to stand beside as if a kind friend' (see page 64), in both 'intra-subjective' and 'inter-subjective' terms, suggesting to me that the distinction between the two is often more apparent than real. First, there are the 'others inside' (Weinberg, 2005). Working with clients I gradually realise the importance of standing beside the experience of an addictive carapace, helping clients find that capability for

themselves, recognising that need in myself (Ob.49, page 115). Then Cooper's (2003) magnificent paper challenges me to take a Buberian "*stand in relation*" to a felt sense or configuration and not be afraid of difference (Ob.71, page 166). Finally, ACT and *Gelassenheit* invite me to notice how my values stand patiently alongside, even now, offering a 'releasement' (Bolling, 1995) for clients and myself that is no calculative living (see Ob.84, page 205).

APPENDIX 1 – LIST OF OBSERVATIONS

Methodology

- Ob.01 The research proposal utilized the existing role of the researcher as a single therapist in a particular setting. As such it offers depth but limited breadth. It should be judged as a first systematic view of addiction and therapy from a focusing-oriented perspective. (page 13)
- Ob.02 The research proposal presumed the ability of the researcher to generate a basic theory and therapeutic model in a field of focusing-oriented therapy with minimal research traditions. (page 14)
- Ob.03 Characteristics of the of focusing-oriented and addiction literatures presented significant challenges in exploring a focusing-oriented therapy for addiction. Consequently the empirical part of the study was limited to the exploratory and illustrative stages. (page 15)
- Ob.04 Tensions in paradigms of thought suggested the need to clearly understand the philosophy underlying focusing-oriented therapy and anthropological understandings of addiction. (page 16)
- Ob.05 Phase 1 – Embodied Exploration – The first part of the study was loosely structured to allow the implicit qualities of experience and theory to be explored to reveal connections and patterns. The period would be allowed to continue until clear perspectives began to emerge. (page 18)
- Ob.06 Phase 2 – Development Cycles – This part of the study generated and tested models of therapy through structured cycles of thinking and practice. Thus each model was compared with data from client sessions and revisions drafted accordingly. (page 19)
- Ob.07 A task analysis approach to microprocesses was chosen to understand focusing-oriented therapy and assemble hypotheses of work with addiction. (page 20)
- Ob.08 Phase 3 – Clarity and Life – The final part of the study has been designed to express results with clarity and allow a degree of personal participation by the reader. Case material will be provided to allow a clarity and transparency of communication. (page 23)
- Ob.09 Procedural ethical arrangements were agreed with the appropriate university authorities to safeguard clients' needs. (page 25)

- Ob.10 Ethics in practice particularly depended upon the situation of ethical responsibilities in the therapeutic relationship and the exercise of ethical reflexivity during supervision. (page 27)
- Ob.11 The study was arranged in three phases. The Embodied Exploration of Phase 1 built a rich understanding of addiction and therapy in explicit and implicit forms. The Development Cycles of Phase 2 used therapeutic practice to systematically test and revise hypotheses. Phase 3 is designed to present the work so as to speak to 'head and heart' with clarity and life. (page 31)

Philosophy

- Ob.12 Gendlin seeks to challenge the 'unit model' - the Cartesian divisions in the way living systems are understood and the reliance on abstract patterns and forms. (page 38)
- Ob.13 Gendlin's philosophy emphasises the implicit experience of meaning underlying symbolisations. It takes a process orientation towards psychology and the self, largely avoiding assertions about content. (page 40)
- Ob.14 The pre-reflective, somatic sensing of experience is the heart of meaning for Gendlin. Its pre-separated multiplicity can be differentiated as distinct from particular explicit forms. The implicit provides a touchstone of reality, always richer and more complex than any particular expression. (page 43)
- Ob.15 The 'direct referent' demonstrates a somatic absorption of cultural life and linguistic patterns. Its 'more-than-logical' process discerns the immediate situation - physical, social and historical interconnections. (page 44)
- Ob.16 Interaction precedes all other aspects of human life and living can only be understood in terms of 'situations' – interconnected environmental responding. Humans have an ecological 'being-knowing' (Befindlichkeit), a constant contextual interaction with a world that is 'ready-to-hand.' Their self is always a self-in-situation and different selves arise naturally in responses to different contexts. (page 46)
- Ob.17 'Being-with' is the bedrock of human life, so that the most personal and individual processes, including focusing, are also a feeling-with and feeling-toward others. (page 48)
- Ob.18 Gendlin's thought is complemented by writers from various fields who describe the immediate interaffecting of life. Significant among these are concepts of the encompassing 'habitus' and embodied understandings of

the ‘sentient ecology’ of life and its learned ‘ontology of dwelling.’ (page 49)

- Ob.19 The interaffecting of processes implies that to some extent change in a particular place or with a particular person depends upon changes in other parts and can be thwarted by them. (page 50)
- Ob.20 There is an inherent growth-full direction and ‘patterned readiness’ in situational inter-affecting, which can include the entirely novel. Discerning a ‘right’ direction is therefore about an attunement of implicit relations. (page 53)
- Ob.21 ‘Focaling’ points to the implicit capacity for coherence and purposeful direction within situations. The interaffecting of everything by everything allows many factors to ‘cross’ and a meaning to emerge over many small steps. (page 54)
- Ob.22 Gendlin points to a distinct view of freedom and agency seen in terms of embodied interaffecting and commitment. It suggests that fulfilment comes from discovering and realising the potential of one’s ecological and interpersonal situation rather than acting outside of it. (page 55)
- Ob.23 Carrying forward points to the constantly recurring cycle of ‘occurring into implying.’ It explains how both novelty and continuity are present in the formation of new structures from the implicit. The many patterned steps of a zig-zag between implicit and explicit forms are necessary to allow accurate articulation in symbolic and tangible forms. (page 59)
- Ob.24 Carrying forward arises from a responsiveness between person and the mesh of their environment. Organisms constantly anticipate coming action and prepare by attunement to the environment. Situations are ‘lived forward’ in these terms though new responses (Äusserungen). (page 60)
- Ob.25 Focusing can be seen as a dialectic process of carrying forward when existing explicit forms are demonstrated to be inadequate. A constructed tension (Aufhebung) has the potential to release the implicit and shape a new form. (page 62)
- Ob.26 Making a pause (Abstand) a person has the potential to find a shared space, to stand aside from a situation and encounter an immediacy of self. (page 64)
- Ob.27 Gendlin sees ‘self’ in terms of immediacy, relating, situational inter-affecting and process. He resists the reification of the self and fixed views which might deny the rich multiplicity of its patterns. (page 66)

Psychopathology

- Ob.28 Gendlin avoids describing psychopathology in terms of 'content', preferring to view it as a process problem connected with the interacting system or the process of experiencing. (page 70)
- Ob.29 The idea of a process stoppage is used by Gendlin to refer to the experience of a psychological dysfunction more than to its aetiology. It draws attention to what is not occurring – presumed often to be the process of experiencing. (page 71)
- Ob.30 A stopped process leads to structure bound processing where an individual is not in touch with their experiencing and repeats patterns from the past. Such behaviour can lead to the repetitive structures of nature - the spiders web or mollusc's shell. (page 72)
- Ob.31 Contrasting with the fluid intricacy of the direct referent, the idea of a 'frozen whole' highlights undifferentiated blocks of living, whole structures that may be 'cued' by particular events. (page 74)
- Ob.32 Restricted ability to connect with experiencing can lead to a loss of sense of self and agency. An individual can feel indistinguishable from their affliction and in the hands of another. (page 76)
- Ob.33 In experiential terms psychopathology is an isolation from essential interrelation with the environment and other people, thereby losing sustenance and meaning. Gendlin sees this as often resulting in an 'autistic' inability to relate to oneself. (page 80)
- Ob.34 The image of 'leafing' is used by Gendlin to express the way that stopped processes are discernibly 'carried' in continuing physical and behavioural patterns. Notwithstanding frustration, the process repeatedly makes steps intended towards resolution. (page 82)
- Ob.35 Defensive patterns may be observed in an entrenched stoppage which resist interventions, yet encapsulate a positive intention. These may be understood as representing a 'frostbite strategy' where non-essential parts are sacrificed in favour of survival of the majority. (page 84)
- Ob.36 A certain kind of order may be observed in the apparently irrational expressions of energy constrained by a stopped process. There can be a crescendo in such 'flailing' as, with an apparently costly irrationality, a person may precipitate their own release. (page 87)
- Ob.37 The 'inner critic' provides a model of denied agency that can inform an understanding of addiction and its treatment. Whilst its form may be painful and destructive, the positive intention caught up in it may be

recognized and an accepting space offered where change may occur. (page 90)

- Ob.38 Carrying forward from a stoppage depends upon the ability to stand aside from the structure bound patterns that block the interacting process. Standing aside is discovered in the pause (Abstand) where a moment of living beyond the pattern may be experienced. (page 92)
- Ob.39 Carrying forward from a stoppage depends upon the ability to relate to the immediate living of the client outside the structure bound patterns. This may mean attending to the immediacy of gestures or unrestricted experiencing elsewhere. This facilitates a growing experience of wholeness away from the stoppage. (page 93)
- Ob.40 Carrying forward from a stoppage depends upon an articulation of the stoppage and the 'idle running' energy caught up in it. To do this implies a personal encounter with the positive intention behind what may be intolerable experiencing and a willingness to allow a resolution to take its own course. (page 94)

Focusing-oriented Therapy

- Ob.41 Gendlin played a role in the creation of person-centred therapy and the focusing-oriented tradition can be seen as an attempt to capture the experiential essence of Rogers' approach. (page 97)
- Ob.42 Gendlin holds to theories lightly, preferring the client's experience and a therapist's relationship with them. He offers client-centred reflecting as a baseline for other approaches, with focusing as a way they may be improved and not something to be offered on its own. Notwithstanding theoretical differences, he is open to all ways that bodily experiencing may be carried forward. (page 100)
- Ob.43 Focusing draws attention to the experiential process within the work of different orientations and discerns commonalities of practice among them. Such experiential 'avenues' may be used freely as prompted by the needs of a client. (page 102)
- Ob.44 The experientializing method and the concept of therapeutic 'avenues' are sufficiently defined to be applied to the many therapies offered for addiction. They may provide a practical way to transcend some of the divisions apparent in this field. (page 105)
- Ob.45 The experientializing method allows the establishment of therapeutic avenues where the implicit provides a determining role in therapy. (page 106)

- Ob.46 General summaries of focusing-oriented therapy emphasize the attentive space offered to the client's feel for their situations and problems. A series of stages have been identified in focusing and developed over years. Nevertheless, the 'split level' instructions stress the precedence of the client's process. (page 109)
- Ob.47 Client Task 1 – Experiencing - To encounter the immediate felt sense through a shared pause (Abstand), that frames what is yet unclear and fragmented. (page 112)
- Ob.48 Client Task 2 – 'Concrete Sentience' - To attend to a sense of the interaffecting in the whole situation, ecological and intersubjective. (page 114)
- Ob.49 Client Task 3 – 'Being-with' - To stand as a human alongside senses of being-in-the-world, beginning to find ways to relate and the potential for habitation. (page 115)
- Ob.50 Client Task 4 – Coming home – To permit the self to be recognised and 'received', finding value in the sense of self-in-situation. (page 119)
- Ob.51 Client Task 5 – Dwelling - To articulate experiential steps that arise in tangible choice and self-investment. (page 121)
- Ob.52 Therapist role 1 - Creating a space - To facilitate a shared space where the client can relate to their immediate experiencing and be heard accurately (exactly though differently). (page 123)
- Ob.53 Therapist role 2 – Felt meaning - To offer a special attention to felt meanings, using self as a 'resonating chamber' for what may be present. (page 126)
- Ob.54 Therapist role 3 – Articulations - To attend to and invite articulations of carrying-forward in gestures, actions, values, flailing and experiences of self. (page 128)
- Ob.55 Therapist role 4 – Living-toward - To respond as a human 'other' to shared implicit meaning with the client, 'putting nothing between.' (page 129)

Addiction/Recovery

- Ob.56 Current views of addiction reflect competing theoretical paradigms with the dominant 'brain disease' perspective operating from a 'unit model' view of psychology. Ways are needed to transcend the incompatibility of paradigms that may be involved. This study chooses to adopt an

experiential orientation, drawing on other perspectives as appropriate. (page 137)

- Ob.57 The discourse of addiction highlights the significance of consumption in contemporary experiences of identity and may obscure social tensions around freedom and choice. Disregarding other common compulsions, it tends to proscribe deviant consumption where the role or self-regulating producer/consumer is compromised. (page 140)
- Ob.58 The discourse of addiction appears to stabilize norms by regulating social inclusion. It increases the marginalization of some groups and protects the position of others by providing a means to both explain and distance aberrant behaviour. For some groups, recovery may consequently involve overcoming inherent social exclusion. (page 143)
- Ob.59 The discourse of addiction uses disease and other explanations to project responsibility for aberrant behaviour onto the non-human agency of 'others inside.' Consequential self-alienation is managed through socially negotiated attributions. Recovery in these terms implies the discovery of viable senses of self that do not depend upon such divisions. (page 145)
- Ob.60 'Recovery' is a widely accepted term used for the process of release from addiction, but there are tensions over interpretation, particularly regarding the place of abstinence. Nevertheless, it can have a profound existential meaning for those engaged in it – representing the personal recovery of a whole life. (page 148)
- Ob.61 Experiential avoidance is widely recognised as a major factor in addiction, seen both as a cause and result of its effects. Recovery consequently implies the ability to engage with experiencing. (page 149)
- Ob.62 Relationship difficulties and attachment disorders are recognised as frequently significant in addictive behaviour. Addiction has been observed both to be a response to particular environments and strongly influenced by them. Personal change from addictive behaviour may thus imply both interpersonal and environmental change and reconnection. (page 150)
- Ob.63 The discourse of 'others inside' is observed to be a significant way that those with addictive behaviours manage their immediate living and, through social negotiation, effect change. Recovery implies the ability to transcend a discourse which divides self and agency. (page 152)
- Ob.64 Studies of 'spontaneous recovery' and 'recovery capital' highlight the importance of environmental connections in finding release from

addiction and illustrate the significance of spontaneous personal change. (page 153)

Ob.65 A ‘bio-psycho-socio-cultural’ perspective identifies the multiple physical, social and human factors that are expressed in addictive behaviour and suggests it is a way of responding to challenges of living. (page 155)

Ob.66 Addiction can be demonstrated as a partially adaptive response to the existential issue of dislocation that arises in free-market societies. In these terms recovery may inevitably represent an incomplete individual solution to enduring dysfunctions in the social structure of life. (page 156)

Ob.67 A ‘post-humanist’ view sees the compulsive behaviour of addiction as a form of somatic articulation in response to wider ‘practical and relational contexts’ of living. (page 158)

Ob.68 The Philosophy of the Implicit may offer a way to transcend divisions of understanding in addiction theory by reference to the interconnected richness of implicit meaning. (page 159)

Ob.69 ‘Process-skipping’ offers a focusing-oriented account of addiction – the use of repetitious avoidance to substitute for unpalatable experiencing. Focusing-oriented therapy for recovery can offer a way to overcome process-skipping. (page 163)

Ob.70 Relational focusing emphasises the inter-human isolation involved in addiction and the recovery significance of a ‘loving encounter.’ (page 164)

Ob.71 The intra-subjective application of Buber’s ‘I-Thou’ model demonstrates the instrumental orientation associated with addiction and points to an encounter element in resolving existential problems during recovery. (page 166)

Ob.72 Macroshifting and Treasure Maps applications of focusing identify the significance of defensive structures in addiction and suggest their resolution during recovery may need more than a standard therapeutic process. (page 168)

Ob.73 In focusing-oriented terms addiction is therefore: (page 170)

- A term used by individuals and social groups to explain and excuse unacceptable behaviour associated with loss of agency and control.
- A process-skipping – A disruption or dysfunction in a person’s ability to relate to their own experiencing.

- A carapace – A stuck pattern of repetitive, instrumental and defensive living.
- A flailing – A pattern of apparently inexplicable and uncontrollable behaviour which ineffectively responds to an existential dilemma.

In sum, addiction is a pattern of experiential estrangement and compulsive behaviour which provides a way of coping with existential dilemmas.

Ob.74 In focusing-oriented terms recovery is therefore: (page 172)

- Carrying forward the whole of life in a way that is meaningful for the individual.
- Standing aside from an addictive carapace and attending to experiencing.
- Finding ways to live with existential dilemmas.
- Discovering a new self, a way of being-in-the-world.

In sum, recovery is a personal process of carrying forward where, through experiential engagement, alternative ways of living open up.

Ob.75 Recovery within an unchanged environment may be limited and partial. Power constraints may undermine individual resolve and lead to lapse or relapse over time. (page 172)

Recovery treatment

Ob.76 Recovery is a life process, in the hands of a person as they inter-affect with many influences. Like other orientations, focusing-oriented recovery therapy therefore offers a contribution to carrying forward. (page 177)

Ob.77 Three core Recovery Tasks are identified in focusing-oriented therapy for addiction (page 178):

- Recovery Task 1 – To assist a client to stand aside from their addictive carapace and attend to their own experiencing, however limited it may be.
- Recovery Task 2 – To assist a client to address and carry forward the existential dilemmas which concern them.
- Recovery Task 3 – To assist a client to discover a new way of being-myself-in-the-world.

Ob.78 Avenue 'A' commends careful attention to 'emotional regulation' whilst working with addiction. A dual responding is appropriate – both to find steps to 'complete' gestural coping mechanisms and to relate to the implicit meaning involved in them. Such dual sensitisation/desensitisation can also be linked to the experience of 'self-as-perspective.' (page 186)

Ob.79 Recovery Task A – To assist client's 'emotional regulation' through dual-responding, encouraging self-as-perspective and linking practical issues to implicit meaning. (page 186)

Ob.80 Avenue 'B' identifies a power in the implicit which is associated with the 'right' carrying forward and no less. It advocates a combination of embodied engagement and tolerance that is uncommon in treatment regimes that stand apart from their clients. The process of wanting 'whatever should happen' provides a powerful way to relate to experiencing. (page 191)

Ob.81 Recovery Task B – To assist clients to attend to implicit meaning and wait upon the 'right' carrying forward. (page 192)

Ob.82 Avenue 'C' advocates an abrasive edge in experiential responding when dealing with the ambiguities of an addictive carapace. Therapists are invited to explore the empathetic felt sense of ambivalence, 'Socratic Questioning', frustration and the alterity of two-chair process. (page 199)

Ob.83 Recovery Task C – To assist clients to engage with abrasive experiences of the felt sense and its ambiguities. (page 199)

Ob.84 Avenue 'D' contrasts utilitarian modes of 'controlled' living from those based on values and acceptance (Gelassenheit). It characterises the choices in recovery as acts of value-driven self-investment rather than calculation. In these terms focusing-oriented recovery depends upon carrying forward through 'releasement.' (page 205)

Ob.85 Recovery Task D – To assist clients to make choices based on values and acceptance (Gelassenheit) rather than 'controlled' living. (page 205)

Ob.86 Avenue 'E' highlights the zig-zag between concrete expressions and the implicit as a key process in recovery. It points to the carrying forward that can arise from the explicit through practical steps of reordering and the use of tangible supports. (page 210)

Ob.87 Recovery Task E – To assist clients zig-zag between the implicit and tangible forms to carry forward their concrete situation. (page 210)

Case Illustrations – Core Model

- Ob.88 Case evidence supports the assertion of Recovery Task 1 – to stand aside from an addictive carapace and attend to experiencing. It also supports the general application of the four generic therapist roles in this work. (page 236)
- Ob.89 Case evidence supports the assertion of Recovery Task 2 – to address and carry forward existential dilemmas. It also supports the general application of the four generic therapist roles in this work. (page 248)
- Ob.90 Case evidence supports the assertion of Recovery Task 3 – to discover a new way of being-myself-in-the-world. It also supports the general application of the four generic therapist roles in this work. (page 264)

Case Illustrations – Avenues

- Ob.91 Case evidence supports the assertion of Recovery Task A – to assist client's 'emotional regulation' through dual-responding, encouraging self-as-perspective and linking practical issues to implicit meaning. (page 272)
- Ob.92 Case evidence supports the assertion of Recovery Task B – to assist clients to attend to implicit meaning and wait upon the 'right' carrying forward. (page 278)
- Ob.93 Case evidence supports the assertion of Recovery Task C – to assist clients to engage with abrasive experiences of the felt sense and its ambiguities. (page 286)
- Ob.94 Case evidence supports the assertion of Recovery Task D – to assist clients to make choices based on values and acceptance (Gelassenheit) rather than 'controlled' living. (page 295)
- Ob.95 Case evidence supports the assertion of Recovery Task E – to assist clients zig-zag between the implicit and tangible forms to carry forward the concrete situation. (page 305)

APPENDIX 2 – APPLICATION FOR ETHICAL APPROVAL

The following application was considered by and approved by the University of East Anglia, Faculty of Education and Lifelong Learning, Research Ethics Committee in January 2009. (Appendices with draft documents and references to them have been deleted and the forms actually used are provided in Appendix 3.) Note that whilst the possibility of seeing clients at the university Counselling Service was referred to, this did not take place.

Introduction

The project aims to investigate the use of focusing-oriented therapy to help clients whose issues include alcohol or substance misuse, taking into account the accepted models of drug and alcohol practice in Britain. It will need a sympathetic understanding of what '*addiction*' is understood to mean in a personal and social context, as well as some diverse philosophical and practical approaches to it. In the first phase I want to explore this diversity in a personal and hermeneutic style, allowing different perspectives to speak authentically to me, particularly through my own counselling practice. Later, in a second phase I hope to see how the results of this might be formed into a practical approach. Ultimately I would like to be able to rigorously test this and offer something that was a real contribution both to the lives of those whose issues include alcohol or substance misuse and those who seek to help them.

The application relates only to the first phase of the project and has been prepared in the light of the:

- UEA Guidelines on Good Practice in Research
- UEA Research Ethics Policy, Principles and Procedures
- School of Education and Lifelong Learning Research Ethics Committee Guidance for Students and their Supervisors;
- BACP Ethical Framework
- BACP Ethical Guidelines for Researching Counselling and Psychotherapy

I am qualified as a person-centred and focusing-oriented therapist and have had UEA training in Motivational Interviewing. In the first phase I will provide voluntary counselling to clients whose issues include alcohol or substance misuse at the Matthew Project (a Norfolk drug and alcohol charity) and the UEA Counselling Service. I will record and analyse this experience and use it to explore perspectives on alcohol and substance misuse and therapeutic responses to them.

I will set out below the ethical issues associated with this. This paper has the support of the Julian Bryant (Director of the Matthew Project), Dr Judy Moore

(Director of the University Counselling Service) and Dr Campbell Purton (my academic supervisor).

1. Dual role

The key challenge is for me to deal with the dual role of counsellor and researcher and the divided loyalties that might arise. Over an extended period my counselling sessions will both stand in their own right and be the subject of my research thinking. I am clear that my prime responsibility is as a therapist and that the interests of the client shall be put first at all times. The integrity of a counsellor is a prime element of the types of therapy I practice and the entire enterprise would be jeopardised if this were compromised. I must therefore recognise and deal with concessions in the quantity and quality of data produced for the study where this dual role generates a conflict. The dual role may have an impact in the mind of the client and my own mind:

Mind of the client. I am aware that those whose issues include alcohol or substance misuse can be a very vulnerable group – to a degree out of control, and at an extreme end, socially isolated, with low self-esteem, often facing financial and accommodation problems. Whilst some clients appear to find terms like '*addict*' and '*addictive*' to be descriptive and useful, there are real issues in my mind about the potential danger of being labelled by such terms. I will therefore be careful to avoid implicit or explicit labelling. Are there other ways in which the mere fact of my research could harm these individuals? The most obvious risk arises if the sometimes slender degree of client commitment to counselling is put at jeopardy by the perception that a counsellor's interest arises from some ulterior motivation - perhaps the academic interest of the case rather than genuine concern for them. I have looked at how this might be addressed, perhaps by seeking to reduce the visibility of such a motivation, or providing an additional figure to whom the client can relate. My conclusion is that I should not do anything to reduce the quality of therapeutic relationship and the explicit, straightforward way that clients seem themselves to be treated within it. I have a good track record of building relationships with different clients and explicit recognition of the loyalty that is felt as a consequence. I believe that clients will know my motivation and this should stand me in good stead to respond to this potential risk.

Mind of the counsellor I have chosen to adopt a hermeneutic style of enquiry partly because of the significance of the dual role. Whilst I have a strong curiosity about how different philosophies and practices of counselling influence therapy outcome, my aim is to consciously avoid bringing this into the consulting room. It would be entirely wrong to subject clients to the latest technique culled from a textbook or try out half-formed theories made up the night before. It is unavoidable that my practice will develop during the period of the study. This will be influenced by many things including reading and the opportunity to consider in detail what happened in previous sessions. (This process is analogous to normal

clinical supervision.) However, as is the norm with counselling practice, my conscious aim will be to leave all of such theorising and curiosity '*at the consulting room door*' and to concentrate on responding to the client in the unpremeditated moment. Thus if the study has an impact on what happens in the consulting room it will be through an authentic change in myself as counsellor and for no other reason.

2. Relating to two organisations

I intend to carry out counselling of clients presenting with issues including alcohol or substance misuse at the Matthew Project (up to six clients per week) and the UEA Counselling Service (up to three clients per week) with appropriate clinical supervision. I am aware that both organisations have their own distinctive ethos and that these will influence legitimate client expectations. Whilst I wish to maintain some degree of common approach across the agencies it is very important also to fully integrate with how the organisations work. I will fit in my work with the normal provision of the agencies and follow their different administrative practices and different views about how long counselling is offered and when it is reviewed. Also the Matthew Project uses NHS devised forms not used at the UEA and I will appropriately follow this different practice.

3. Appropriateness of therapeutic methodologies

I have considered if the approaches I propose are in the best interests of clients. Each is well accepted and approved for work with this client group. I have already worked for over a year as a person-centred and focusing-oriented therapist at the Matthew Project. Motivational Interviewing was devised to address the problems of alcohol and substance misuse (Miller & Rollnick, 2002). The general approach of the '*Transtheoretical*' Stages of Change Model is supported by the relevant authorities in Norfolk to for the delivery of services to drug and alcohol clients (Norfolk Drugs and Alcohol Partnership, 2008).

4. Recordings of sessions

My intention is to routinely digitally record all counselling sessions within this study and (as well as issues of consent and confidentiality discussed below) I have considered the impact this might have upon clients and the therapy offered to them.

I currently record some of my Matthew Project sessions to allow me to review them and help my self-development. I am consequently aware of the varying reaction of clients to this potentially intrusive process. For example one client reacted very negatively to both the sense that his conversation would be in this way '*overheard*' and the thought that what he said might be subsequently available for judgement (e.g. by the police). At the other extreme another client has been impressed by the way that my wish to review recordings showed a depth of care for him and desire to provide him with the best possible response. This

was further enhanced when he has perceived a benefit from the additional attention his previous material had been given. I note that the remainder of the clients (the majority) appear to pay no attention to the recordings once they engage in the therapeutic process. Likewise I have not perceived myself as influenced or inhibited by the presence of the recorder and take the view that recorded and un-recorded sessions proceed in similar ways. I conclude that with the appropriate safeguards there is no inherent negative impact from the process of recording.

5. Use of questionnaires

I have also considered the potential impact for the client of the use of tests and questionnaires in the context of counselling. At this stage my intention is to invite clients to complete a total of four forms during the entire counselling relationship (at the Matthew Project this is in addition to forms required by central government).

I am aware that some Matthew Project clients have low literacy and dislike questionnaires and the formality they can introduce - the required care plan and TOP form can disrupt a session and may seem to be a distraction. Yet I also notice how surprisingly accepting clients are of intrusive requirements. For example the TOP form requires a client to set out their pattern of illegal behaviour – use of proscribed substances, shoplifting etc. I would find it very difficult to explain what benefit the provision of this information would be to a client and feel it may perpetuate an institutionalised and role power-laden relationship which is not good for therapy.

So I am generally not comfortable using forms with clients and have sought to keep their use to a minimum. However, in contrast to the government required materials, I feel some justification in only using measures designed to assess and improve the effectiveness of therapeutic sessions. (Also the use of such measures is a far less intrusive way of providing triangulation material than ones which might involve the client in working through session material at a later date). Nevertheless I think that I should exercise particular sensitivity with the use of measures planned in this project and refrain from doing so to the extent that clients explicitly or implicitly show discomfort or reservations.

6. Selection and initial involvement of clients

Whilst the organisations concerned have slightly different systems for matching a potential client and counsellor, the intention is similar. After an initial interview a decision is made as to who would be the most appropriate counsellor, bearing in mind client needs and risks, counsellor capabilities and availability. My intention is to receive client referrals within both organisations, as far as possible, precisely as such allocations are done for other counsellors.

However, there needs to be one distinctive difference in my case. My intention is that, as far as is possible, the only clients I will see at the two agencies will be those included within the study. (My existing clients at the Matthew Project will not be included so, as I finish with them, their places will be taken only by those within the study.) Consequently the allocation of a client to me will also depend upon some degree of initial voluntary consent to participate in the study.

It is clearly important that no duress is put upon clients to enter into the study with me. Therefore both organisations have agreed that the initial invitation to counselling will not come from myself and will offer the choice of counselling as part of the study or outside it. Each organisation will have slightly different ways to follow this principle. At the Matthew Project the invitation to participate will be made during an initial assessment interview. Consequently I can be allocated to the client or not as appropriate. At the University Counselling Service the information sheet (Appendix 1) will be made available to all potential clients so that the initiative to participate will have to come initially from the client themselves. Thus accepting or declining participation in the research will not influence the timing or availability of counselling, merely the counsellor used.

7. Informed Consent

Following the process detailed above I will meet those who have made an initial expression of willingness. During the first session I will explain the study using the Project Information Sheet (see Appendix 1) and seek to obtain their informed consent (see Appendix 2). If for any reason they do not wish to give consent I will nevertheless continue as their counsellor, albeit entirely outside the research process. I will assure them that this choice will not result in any detriment for them in terms of the nature or timing of counselling provided.

Information Given the type of clients involved, particularly their vulnerability and (at the Matthew Project) frequent low levels of literacy, I do not see it as appropriate to attempt to provide a great deal of information in a printed form. I feel this might alienate clients more than offering them an opportunity to engage with the issues involved. My intention is therefore to inform them primarily in conversation, using the Project Information Sheet more as an aide memoire. I have chosen to draft the Consent Form in more formal language, so that whilst it will be a framework to discuss each of the potential areas for agreement, it avoids diluting the seriousness of commitment requested.

Under the influence I have considered the possibility that clients may be under the influence of a substance when being invited to give their consent. Whilst it is not normal to counsel individuals who are heavily intoxicated or '*high*', it is not unusual for a client to attend a daytime session suffering the effects of a previous night's substance misuse, having had a 'top-up' of alcohol or being under the influence of prescription drugs such as Subutex. There is no doubt that clients' mental functions and judgement are consequently impaired - responses can be

slow and speech slurred. Nonetheless it is standard practice to continue to work with clients where possible - to require strict sobriety would substantially restrict the take-up of services and would be to the detriment of clients. Consequently great care is taken to match expectations to the level of capability of a client at any particular time, revisiting key issues as may be necessary several times. I will adopt the same working practices regarding informed consent – to proceed notwithstanding some levels of impairment, to take extra care in explaining and discussing key issues, if necessary revisiting them on several occasions to seek reaffirmation of agreement. If my judgment is that a client is not sufficiently capable to give consent then I will postpone seeking consent until a better state can be achieved.

Opting in and out Whilst the therapy offered by me will have a ‘research’ element, participants will be advised that they can refrain from the research process in part or whole, either temporarily or permanently, if they so elect. Those who have already begun sessions with me will be enabled to continue the provision of therapy by me without any reduction or pause. Clients wishes to extract themselves from the research elements will be entirely respected to the extent they stipulate. Both organisations have provisions that allow clients to change counsellor and these will not be restricted by the research process.

8. Confidentiality and anonymity

The identity of all clients involved in the project will be confidential to the client, the counsellor (myself) and the organisation where the counselling is hosted, using the confidentiality standards and practices in force at the time of the relevant organisation. All clients will be allocated a gender specific numeric alias for the purposes of the project (i.e. ‘Mr 1’, ‘Ms 2’ etc) and this will be used as identification for all purposes. Transcriptions of client sessions will use alphabetical aliases for all third parties referred to and steps will be taken to ensure that other references that might lead to identification are appropriately obscured.

9. Data security and retention

Data security Subject to the opt-out provisions above, the second and subsequent counselling sessions will be digitally recorded and transcriptions made as and when necessary. Following the existing practice of the UEA Counselling Service clients will be entitled to listen to recordings in a special meeting with their counsellor. They will be entitled to make notes but not to take away recordings of sessions. Any comments made about sessions will be noted. Similarly any transcripts will be available for viewing in a special meeting with the counsellor, and whilst notes may be taken, no copies of transcripts will be furnished.

Storage and destruction The recordings will be transferred on the same day as the session to an external hard disk drive which will be kept in a wall safe at my home. This Hard disk drive will be the data store for all confidential material related to

the project. Unless otherwise agreed, confidential material (recordings, transcriptions, schedules) shall be destroyed by me within one year of notification of final examination results or termination of registration as a UEA student, whichever is the longer.

Data protection I have sought the assistance of the University Data Protection Officer concerning the application of the Data Protection Act to this project and will abide by his/her instructions.

10. Research integrity and subsequent publishing

Working analyses of particular sessions or groups of sessions will be produced for discussion both with the academic and clinical supervisors. Whilst it would have been preferable for these to be shared with clients and their feedback secured, I believe that to do so would unnecessarily threaten the prime responsibility of the therapeutic relationship. Clients' therapeutic process is continuous and it would potentially be detrimental to open up previous sessions and debate previous events. This is a limitation of the research process and one that triangulation in a variety of ways seeks to rectify. The initial informed consent from clients provides for material to be included in the academic thesis or other published document.

11. Complaints

Clients will be advised that complaints and concerns should be raised with myself, the appropriate line manager of the relevant organisation (according to its complaints procedure) or my academic supervisor.

12. Impact upon myself

I am aware that counselling a series of very vulnerable clients in a block is already demanding for me and that I need to ensure I have adequate opportunities for rest and recuperation. This research will produce additional pressure in that my practice will be open to detailed scrutiny and analysis. The pressure to perform will be more intense. I have decided to make these issues clear to my clinical supervisor as and when they occur. I currently also have my own therapy and this will provide an additional place to address such issues if I feel it necessary.

APPENDIX 3 – INFORMATON SHEETS AND CONSENT FORMS

The following documents were used in the study as approved by the Matthew Project and University Ethics Committee.

Matthew Project Research Project : Alcohol or Substance misuse issues Information Sheet

This research project aims to help understanding of the most effective ways of counselling those whose primary concern is alcohol or substance misuse. The counsellor/ researcher is Alan Tidmarsh, a fully qualified counsellor who specializes in this area of work. If you agree to participate in the project, and your availability matches Alan's, then he will be allocated to you as your counsellor.

As part of the research Alan will ask you to complete certain forms and will also record counselling sessions with you on a digital recorder. The data will be securely stored and your confidentiality will be maintained. Any subsequent use of data either for Alan's PhD research or subsequent publication will be fully anonymized.

Care has been taken to establish the project in such a way that your needs as a client are of primary importance. Therefore:

- You have the right to opt out of the research at any stage and Alan will continue as your counsellor if you wish him to do so.
- Your confidentiality as a research participant will be protected.
- You may change counsellor if you wish to do so.

Issues you are bringing may include alcohol and drug misuse and these can be pursued with any counsellor at the Matthew Project. If you feel willing to participate in this research process then you will be invited to indicate this by signing a Participant Consent Form.

Matthew Project
Research Project : Alcohol or Substance misuse issues
Participant Consent Form

1. I have received and read Alan Tidmarsh's Project Information Sheet and have had the opportunity to ask for any information I think necessary and discuss with him any concern that arises for me.
2. I know that I can withdraw from the project at any time and have no need to give any reason or justification. If I withdraw I understand I can request any or all material relating to myself to be destroyed. I understand that I will still be eligible to continue in counselling with Alan if I decide to withdraw from the project.
3. I understand that my counselling sessions will be recorded and the recordings retained for the duration of the study and that I may listen to any of the electronic recording (or read any transcriptions made). This will be possible only in a specially arranged session with Alan and I understand that I will not be able to take away copies of any of the material.
4. I understand that any material in the project relating to myself will be anonymized and steps taken to ensure that my identity is not traceable from it in any way. I agree to anonymized material relating to myself being published in academic papers.
5. I understand that all data will be securely stored by the researcher.
6. I understand that I can contact the Director of the Matthew Project to express any complaint or concern I may have regarding the conduct of this study.

Signed (Client)

Date

Signed (Counsellor)

Date

Matthew Project
Research Project : Alcohol or Substance misuse issues
Project Conclusion Information Sheet

As you know, the Mathew Project supports a research project to consider the most effective way of providing therapy for people whose issues include alcohol or substance misuse.

Thank you for participating in this project as a research client. Recordings made during your counselling sessions have, along with material from other clients, contributed to developing theories and practical techniques in this field. Thank you also for being willing to complete questionnaires which have provided valuable background data.

This project works on the basis of the willing participation of clients. At the start you gave formal consent to take part, knowing that you could decide to withdraw at any stage. It is important that any participation is free and for you to know that the counselling and other services you receive are not affected by your taking part or not.

This research is coming to an end and as part of the final stage the possibility of asking for your feedback has arisen. It would be really useful to hear your views of the counselling you have received and what impact, if any it may have had upon you and your use of alcohol and substances.

Would you be willing to take part in a confidential and informal Feedback Interview about your experience of counselling, what you thought of it and what impact it had? Feedback Interviews would be conducted by a qualified counsellor, but not the counsellor who has been working with you. The interview would be expected to last less than an hour and cover a standard set of topics. You would be able to respond to any question as much or as little as you wish.

The views and information you choose to share would be recorded. They would be held and used with the same security, confidential and anonymity that has been agreed for material from counselling sessions. As with these sessions, the material would be destroyed at the completion of the project.

Please have a think about this. Your counsellor will be able to answer any queries you may have. If you are willing to be interviewed in this way please look at the consent form overleaf. If you are happy with this please sign the form and arrangements will be made as appropriate.

Matthew Project

Research Project : Alcohol or Substance misuse issues

Participant Consent Form - Research Project Conclusion

1. I have received and read Alan Tidmarsh's Project Conclusion Information Sheet and have had the opportunity to ask for any information I think necessary and discuss with him any concerns that arise for me.
2. I know that my participation in a Feedback Interview is entirely voluntary and that my participation or not will not influence my counselling or other services from the Matthew Project.
3. I understand that during the Feedback Interview I need only answer questions to the extent that I consider appropriate. I can refuse to answer any question and having answered a question can request that my response, or any material relating to myself to be destroyed.
4. I understand that the Feedback Interview will be recorded and the recordings retained for the duration of the study and that I may to listen to the electronic recording (or read any transcriptions made). This will be possible only in a specially arranged session with Alan and I understand that I will not be able to take away copies of any of the material.
5. I understand that any material in the project relating to myself will be anonymized and steps taken to ensure that my identity is not traceable from it in any way. I agree to anonymized material relating to myself being published in academic papers.
6. I understand that all data will be securely stored by the researcher and will be destroyed upon completion of the project.
7. I understand that I can contact the Matthew Project Director (*name, address and telephone*), to express any complaint or concern I may have regarding this study. I can also contact the academic supervisor (Dr Campbell Purton – *address and telephone*) to raise similar concerns.

Signed (Client)

Date

Signed (Counsellor)

Date

Matthew Project

Research Project : Alcohol or Substance Misuse Issues

Research Project Conclusion - Collaborator Consent Form

1. I agree to undertake Change Interviews with clients who have participated in Alan Tidmarsh's PhD research at the Matthew Project. Whilst I have been provided with the standard format of the Change Interview, I recognise that I have freedom to conduct the interview as seems most appropriate to me, making adjustments, additions or deletions to the format as I shall see fit.
2. I understand that each of the clients to be interviewed have given voluntary written consent both to being a research client and to the particular process of the Change Interview. I understand that this consent allows the participant to only answer questions to the extent he or she considers appropriate and, having answered a question, to request for a response to be destroyed.
3. I understand that each of the clients is continuing in therapy and agree to use my discretion during the Change Interview with regard to the balance between the needs of clients and the needs of the research.
4. I agree to record the sessions and that Alan will have responsibility for the security and storage of the recordings.
5. I agree to maintain confidentiality for the clients throughout the process. I will therefore not disclose any material regarding the identity of clients nor the content of interviews to anyone other than Alan. I agree to maintain the security of any papers regarding clients that are provided to me and to ensure that these, and any notes I make, are either returned to Alan or destroyed at the end of my involvement with the project.
6. I understand that if I have any concerns about this involvement I can contact Alan's academic supervisor (Dr Campbell Purton) if I fail to receive resolution from Alan.

Name (printed)

Signed

Date

APPENDIX 4 - ILLUSTRATIONS OF THE PHASE 1 PROCESS

Three documents are provided to illustrate the process during the Embodied Exploration phase – A list of working papers, a version of the *Tests of Focusing-oriented Therapy* from the end of the phase and an early Thinking at the Edge exercise

1. List of Phase 1 Unpublished Working Papers

- Paper 1 Operationalizing Focusing-oriented Therapy (Nov 2008)
- Paper 2 A Comparison of Motivational Interviewing and Focusing-oriented Therapy (Nov 2008)
- Paper 3 Research Ethics Committee Proposal (Jan 2009)
- Paper 4 Musings 1 (free writing) (Feb 2009)
- Paper 5 Musings 2 (further free writing) (Feb 2009)
- Paper 6 Analysis Template for Client Sessions - Version 1 (March 2009)
- Paper 7 Musings 3 (further free writing) (Apr 2009)

The felt sense and the journey of 'addiction': Crossing focusing-oriented therapy with drug and alcohol work – Presentation to 21st International Focusing Conference – Awaji, Japan (May 2009)

- Paper 8 Learning points from Awaji - Japanese International Focusing Conference (May 2009)
- Paper 9 Use of Awaji Scales (May 2009)
- Paper 10 Analysis Template for Client Sessions - Version 2 (June 2009)
Addiction and Discourses – A collection of material (July 2009)
- Paper 11 Case Study Review - Motivational Focusing (Sept 2009)
- Paper 12 Motivational Focusing - 12 week programme outline (Sept 2009)
- Paper 13 Motivational Focusing - Description 2nd Draft (Oct 2009)
- Paper 14 How, what and what next (Nov 2009)

Theories of addiction – unfinished summary (December 2009)

Paper 15 Mindfulness, focusing and addiction (Jan 2010)

Paper 16 Tenerife Miscellany (Feb 2010)

Paper 17 Focusing-oriented therapy and intersubjectivity (Mar 2010)

Bibliography of Focusing and Addiction – First Version (April 2010)

Being-with the being-without: relational focusing with substance misusers – Paper for 22nd International Focusing Conference - Hohenwart, Germany (May 2010)

Paper 18 Learning points from Hohenwart Conference (June 2010)

Paper 19a Tuning out – Part I – Alexithymia and Somatisation (July 2010)

Paper 19b Tuning out – Part II – Trauma and Dissociation (Oct 2010)

Paper 20 Three therapeutic tasks to carry ‘addiction’ forward – first steps, including discussion of hemispheric specialisation (Sep 2010)

Paper 21 Transfer from MPhil to PhD – Procedural Paper
TAE 4 - Tough and Tender

Paper 22 Focusing-oriented psychopathology and the fixity of addiction (Jan 2011)

Paper 23 Recovery, triage and personal investment (Feb 2011)

Paper 24 Images, symbolisation and the focusing-oriented handle (Mar 2011)

Paper 25 Affect Regulation (April 2011)
TAE 5 - A sense of belonging (April 2011)

Not drowning but waving - Focusing-oriented Therapy and the unstopped experience of ‘addiction’ – Paper for 23rd International Focusing Conference - Pacific Grove, CA., USA (June 2011, Paper 26)

Paper 27 Learning points from Pacific Grove Conference

Paper 28a Rationale and Plan for Case Studies

Paper 28b Rationale and Plan for Case Studies – Pilot
TAE 6 – More stuck in addiction

2. Tests of Focusing-oriented therapy

This version of the tests of focusing-oriented therapy is provided to illustrate a form that was used to develop a systematic understanding of the approach that could span both theoretical explorations and practical engagement.

The first version with four tests was drafted early in 2009 (paper 6a) and latest version with eight tests (paper 43c) dates from early 2013. The latest draws upon the four core concepts of *Experiential Psychotherapy* (Gendlin, 1973b) used to structure this thesis.

This version below dates from 2011 (paper 28b).

1. Focusing-oriented Therapy is present when the therapist helps the client attend to their immediate felt experiencing and repeatedly checks connection with it. It is fulfilled as the client trusts this way of self-knowledge as a reliable source of strength and identity.
2. Focusing-oriented Therapy is present when the therapist helps the client attend to painful, blocked or problematic elements of felt experiencing. It is fulfilled as the client relates to the whole of their experiencing, including such elements.
3. Focusing-oriented Therapy is present when the client focuses directly upon the felt meaning symbolizes it correctly, and feels the relief of being carried forward. It is fulfilled as the consequences of shifts are incorporated into living.
4. Focusing-oriented Therapy is present when the therapist helps the client attend to their own agency and responsibility. It is fulfilled as the client acts with confidence and potency.
5. Focusing-oriented Therapy is present when there is immediate intersubjective meeting between client and therapist. It is fulfilled as the client broadens and develops their relating.
6. Focusing-oriented Therapy is present when a therapist holds firmly to an experiential reference as the basis for empathy, in the face of alternative views and interpretations. It is fulfilled as the client experiences the empathetic challenge of that position.
7. Focusing-oriented Therapy is present when the therapist assists the client to suspend symbolisation, to attend to the implicit structure of meaning and then to stand back from experiencing to allow appropriate symbolisation. It is fulfilled as the client finds confidence in pausing, attending and standing back.

3. Thinking at the Edge Exercise #4

This full account of an early TAE exercise is provided to demonstrate the way that Gendlin's approach to theory building was used. The 'facets' (step 6) interestingly combine my own addictive experience of tobacco with that of my clients with cocaine, alcohol and heroin. This TAE exercise was undertaken in November 2010.

Step 1 – Felt sense

The focusing-oriented therapy I have been doing has been directed in a sympathetic way to the implicit. If clients have a problem that might verge on irresponsibility (e.g. not attending agreed sessions) we tend to be lenient at least for a while. Yet there always has been a harder edged approach from the old hands at the charity. They view anyone coping with addiction as a potential liar who will spin any line so long as it obtains the next fix. They say we should not stand for any rubbish.

When discussing my group work plans one of my colleagues described the process as 'hard and soft'. The soft parts are obvious – therapeutic work in the group (not necessarily easy but still sympathetic). The hard parts are setting a clear target for abstinence and calling people to account for their part in it e.g. using urine tests. I think there is something significant in this explicit accountability that may be evaded in the normal process of therapy. It feels as if the combination of the hard and soft, maybe 'tough and tender' is stronger than either on their own. Yet how do they combine?

Facet 1 - My cocaine client makes steps towards reducing/stopping use but then backtracks. He says that periods of abstinence are often precipitated by approaching urine sampling rather than therapeutic process. Somehow the kindness and trust of our relationship protects him from a more demanding expectation that change will stick.

Step 2 - More than logical

Addiction is resolved through a process that is **sympathetic** and yet must be not **sympathetic**.

Step 3 - No words say what you mean

Addiction is resolved through a process that is (...) and yet must be not (...).

Sympathetic – operating through affinity, interdependence or mutual association. Appropriate to mood, inclination or disposition. Favourably inclined, compassionate, empathetic.

Addiction is resolved through a process that is **forgiving** and yet must be not **forgiving**.

forgiving – allowing room for error or weakness. To give up resentment or claim to due payment

Addiction is resolved through a process that **evades responsibility** and yet must not **evade responsibility**.

Responsibility – moral, legal or mental accountability, burden, liability, fault

Step 4 - What did you want the word to mean?

When I say **sympathetic** I mean a generous allowing of the person to be who they are, but also a way that lets them off the hook of expectations. It is a kind of partiality.

When I say **forgiving** I mean an allowing of weakness and the giving up by the counsellor of a rightful expectation. There is a concession, a bending over towards the client that is not huge but seems a bit too far.

When I say **evades responsibility** I mean that the client slides out of reasonable burdens and somehow faults are not weighed enough.

Addiction is resolved through a process that is sympathetic, partial, forgiving, concessional, and evades responsibility and burdens and yet must be not like this.

Step 5 - Expanding what you mean, again in fresh phrases

'Addictive' clients are generally avoidant so there is a feeling that we are lucky if they turn up at all. So there is a tendency to let small irresponsibilities pass with a metaphorical shrug. Consequently a comfortable but perhaps indulgent relationship arises where a degree of challenge would be rude. However, such concessions obscure the small steps towards responsible living that clients need. They stop the adult-adult encounter and their sheen of unreality means that both of us are a little bit absent.

Step 6 – Collecting Facets

Facet 1 (from step 1) - My cocaine client makes steps towards reducing/stopping use but then backtracks. He says that periods of abstinence are often precipitated by approaching urine sampling rather than therapeutic process. Somehow the kindness and trust of our relationship protects him from a more demanding expectation that change will stick.

Facet 2 – When I was younger I tried to give up smoking. For several months I pretended to have done so but still secretly had cigarettes. It was as if my smoking was in a compartmentalized space, more kindly and forbearing, separate from harsher reality. Yet like with some of my clients, I knew this subterfuge was transitory and when it was uncovered there was a degree of relief.

Facet 3 – An alcohol client yesterday arrived in his customary mode of disaffection, anxiety, sadness. After some wallowing in this I pushed to get a real sense of what this felt sense was. This produced a strong reaction revealing a lot of anger and remorse about mistreatment as a child. The sense that the

unkindness of the world towards him was rooted so deep it was unchangeable. This step seemed to only arise from a tough challenging approach, even though at the felt sense level.

Facet 4 – My heroin client systematically slithers around talking about her drug habit and also her physical health. Whilst we both know that the heroin is a symptom, not the seat of the problem, there is a utility in this stance. We have discussed the need to break past this evasion yet it persists. There is something here about hiding away from the uncomfortable reality. I can't do it for her. It is a step of strength that requires pluck.

Step 7 – Patterns from facets

Facet 1 – Cocaine Whilst the 'tender' relationship seems real and beneficial, it often does not bring the client to the edge that matters. He can wriggle around. Yet the hard objective measure produces results. I wonder how much they are mere compliance rather than change. Yet the accountability stops him being able to slide away.

1. *The accountability is an essential element*

Facet 2 – Smoking There is a maintenance here of parallel thinking, maybe even parallel experiencing. It reminds me of the trauma idea of an apparently normal person (ANP) and an Emotional Person (EP), yet it is the other way around. Here the ANP hides in 'normal responses' and the other layer of the EP is only revealed by challenge. The two people seem to be a Normal But Avoiding (NBA) person and an Exposed Reality (ER) person.

2a. *The pretending and hiding are both necessary and wrong*

2b. *The hiding is waiting to be discovered*

Facet 3 - Alcohol It seems that the protection is an avoidance of being present in the moment. Somehow facing reality would be too hard to endure. So the NBA is a way of coping that needs to be removed but only as the pain is reduced. Challenge comes from the ability to persist in congruent reality.

3a. *Challenge comes from persisting in congruent reality*

3b. *Heartless accountability could simple be rejection*

Facet 4 – Heroin The slither is there and I need to time the moment when it is revealed. It feels too easy for me to sit in security and dangle someone over the horns of this dilemma. I need some kind of stake in it.

4a. *My stake in this evasion is both a share in the pain and my right for self respect*

4b. *Touching reality is a step of strength that requires pluck*

Step 8 – Crossing the facets leads to more patterns

Crossing 1 'cocaine' with 2 'smoking'

Cocaine says to me that 'the accountability is an essential element' in the smoking story. This is right as the smoking would not have stopped if this were not the case. Yet the moment of accountability is a moment of existential choice – a moment of learning or hurt. There needs to be an element of support to pitch this upwards and not downwards.

5. *Challenge needs to have support to pitch the choice upwards*

Crossing 1 'cocaine' with 3 'alcohol'

Cocaine says to me that 'the accountability is an essential element' in the alcohol story. Accountability seems too formal a term. It seems more like self-respect, oomph or retribution. When the anger came forward it had energy and pain in it. I was pleased to meet it, and with it a hitherto obscured part of the person.

6. *The moment of 'challenge' is really a moment of self respect when an obscured part of the person is shown*

Crossing 1 'cocaine' with 4 'heroin'

Cocaine says to me that 'the accountability is an essential element' in the heroin story. This is true but in a personal sense. It is the accountability of the person for herself that is the key.

7. *It is the accountability of the person for herself that is the key*

Crossing 2a 'smoking' with 1 'cocaine'

Smoking says to me that 'the pretending and hiding are both necessary and wrong' in the cocaine story. This is true. The necessary bit is not easy for us to relate to – we can easily see it as a malfunction, something nasty we reject. Yet also if we accept it too easily we mire ourselves further into the stuckness.

8. *We need to recognise how evasion is rich and untrustworthy – we need to know the evasion*

Crossing 2a 'smoking' with 3 'alcohol'

Smoking says to me that 'the pretending and hiding are both necessary and wrong' in the alcohol story. This is true here too.

9. *The hurt animal needs to be coaxed out of his fear*

Crossing 2a 'smoking' with 4 'heroin'

Smoking says to me that 'the pretending and hiding are both necessary and wrong' in the heroin story. This is true here too.

10. *The person knows this is happening but can't avoid it*

Crossing 2b 'smoking' with 1 'cocaine'

Smoking says to me that in the cocaine story 'the hiding is waiting to be discovered'. This is hard to see. Perhaps I want to say that there is something in the hiding waiting to be discovered – unmet need.

11. *Unmet need can be found in the hiding*

Crossing 2b 'smoking' with 3 'alcohol'

Smoking says to me that in the alcohol story 'the hiding is waiting to be discovered'. This is true here. It is a very personal affirmation and recognition that is needed. One that says the person is of value and will be stuck up for, not betrayed.

12. *The client wants to discover respect and acceptance in the therapist*

Crossing 2b 'smoking' with 4 'heroin'

Smoking says to me that in the heroin story 'the hiding is waiting to be discovered'. This seems more difficult here. The client knows that even when discovered somehow it can be evaded or will not be different. For her it is a kind of potency that is waiting to be discovered.

13. *It is a kind of potency that is waiting to be discovered*

Crossing 3a 'alcohol' with 1 'cocaine'

Alcohol says to me that in the cocaine story 'challenge comes from persisting in congruent reality'. There is a sense of 'what are we really doing here?' in this case. The week before I said that he did not seem to want to stop and maybe that is right. There is something important here about how easy it is to weasel out without censure. I can remember failing a course in my Theology degree and coming up with a wheeze that would allow me to start something new rather than painfully re-sit. My tutor didn't so easily let me off and suggested it would be better all ways round if having fallen off the bike I simply got back on and rode again.

14. *Easy cop-outs are childish not adult and should be shown up as such*

15. *There is a confidence that comes from each getting back on the bike*

Crossing 3a 'alcohol' with 2 'smoking'

Alcohol says to me that in the smoking story 'challenge comes from persisting in congruent reality'. The challenge was for me to find myself in an uncomfortable world rather than wheedling round the edges.

16. *The challenge is for the client to find himself or herself being able to live in an uncomfortable world*

Crossing 3a 'alcohol' with 4 'heroin'

Alcohol says to me that in the heroin story 'challenge comes from persisting in congruent reality'. From time to time with this client I feel a lack of my own size. I want to pull myself up to my full height and say 'this isn't getting us anywhere. Yet I have done this a couple of times and she says 'it is getting there, don't push me'. Whilst this may be to some degree a cop out, it also seems to be allowing her a sense of responsibility and a valid appraisal of her own hurt and ability to shift. There is something important here. Perhaps I should very carefully distinguish my

perspective from hers. The question should be in her frame of reference (as Motivational Interviewing attests) 'is this getting you where you want to be?'

17. *Challenge is not a shove. It must be in a client's sphere or responsibility, control and felt sense - 'is this getting you where you want to be?'*

Crossing 3b 'alcohol' with 1 'cocaine'

Alcohol says to me that in the cocaine story 'heartless accountability could simple be rejection'. It feels like the client would tend to agree with the negative judgement of this assessment.

18. *It is important for the client to be able to find a positive carrying forward in himself or herself not just a criticism of their weakness.*

Crossing 3b 'alcohol' with 2 'smoking'

Alcohol says to me that in the smoking story 'heartless accountability could simple be rejection'. I feel I would have deserved it, particularly for the uncharacteristic double-dealing with my wife. The solution with her was not to reject me but also for her not to endorse the choices I was making. This is now a familiar matter in working with relatives of substance dependent people. There is a congruence in their position, not wanting to do drugs or to be brought down by them. Yet also an avoidance of censure, control, browbeating – anything that robs the person of their independence and self-responsibility.

19. *The accountability is loving and respectful – treasuring the independence of the person and valuing their freedom of self-determination.*

Crossing 3b 'alcohol' with 4 'heroin'

Alcohol says to me that in the heroin story 'heartless accountability could simple be rejection'. It certainly would be a less of a response to this client.

Crossing 4a 'heroin' with 1 'cocaine'

Heroin says to me that in the cocaine story 'my stake in this evasion is both a share in the pain and my right for self respect. Regarding the latter point, there is a large question here of the degree that the person notices and takes account of the other half of the relationship. The archetypical 'junkie' gives selfish priority to their own needs, callously ignoring the needs of their nearest and dearest. In the counselling room I am more protected by the professional role. Yet I do not value my time and inconvenience as I might do in other circumstances. Also, the agency being a charity encourages a spirit of charitable self-denial which excuses slights and plumps the ego. (This does not feel healthy.) It feels like I need to be able to offer kosher unconditional positive regard but hold a line of self-respect, even fastidious requirement to fit in with my needs. Do clients need to be taught the value of relationships by being required to value highly someone that highly values them.'

20. *An explicit part of the process might be the negotiation of boundaries so that clients value highly someone that highly values them.*
21. *The key is the investment made by the client and this links to NVC request – ‘would you be prepared to ...’*

Yet the heroin facet also says to me that my stake includes a share in the pain. This pain is sometimes felt in my frustration and wanting to rail at the person. It is certainly there in the pain of empathy. I am not a dispassionate bystander. Should I be open about my willingness to put a stake into the process. I sense that this is respected by clients to the extent that it is a valid stake and not a romantic delusion.

22. *My stake in the pain is my caring about the process, my commitment to see the process through to a success if I can and to work within clear respectful boundaries.*

Crossing 4a ‘heroin’ with 2 ‘smoking’

Heroin says to me that in the smoking story ‘my stake in this evasion is both a share in the pain and my right for self respect’. This does not fit the story.

Crossing 4a ‘heroin’ with 3 ‘alcohol’

Heroin says to me that in the alcohol story ‘my stake in this evasion is both a share in the pain and my right for self respect’. I felt some immediate pain from the encounter with the released self. My self-respect should ensure I do not merely blub but can hold the space and provide a means for the client to work with it. In this case this means holding a clean, understanding, unpolluted space where the existential choice can be discerned.

23. *Professionalism is to offer a clean, sympathetic, unpolluted space where the existential choice can be felt and responded to, and to be content with this.*

Crossing 4b ‘heroin’ with 1 ‘cocaine’

Heroin says to me that in the cocaine story ‘touching reality is a step of strength that requires pluck. This client has constantly inspired me to try to generate small steps. I find myself sometimes spinning out possibilities for his attention. Most of these simple disappear into the ether. The ones that make sense are those where he comes up with the idea. So it brings me back to the question that Martin taught me to ask a long time back, but I do not adequately use

24. *What small, practical step might you be able to do to carry this forward a bit?*

Crossing 4b ‘heroin’ with 2 ‘smoking’

Heroin says to me that in the smoking story ‘touching reality is a step of strength that requires pluck’. I have wanted to concentrate upon the implicit action steps – ones that arise from somewhere the client does not feel aware of. I want to

emphasise the noticing of power that comes out of being carried forward.

Perhaps I could re-write the pattern -

25. *We need to notice the capability that arises from touching reality and finding oneself unharmed.*

Crossing 4b 'heroin' with 3 'alcohol'

Heroin says to me that in the alcohol story 'touching reality is a step of strength that requires pluck'. The touching of reality was not summoned forth by a step of determination. Rather, the sense of it arose from a degree of goading and crept out almost to the surprise of the client. Perhaps I should be giving credit to the oomph that arises. Maybe I should more rigorously work with that which is alive and energetic and look for this rigorously -

26. *Honour the energy that arises and touch its felt sense.*

Step 9 – Write freely

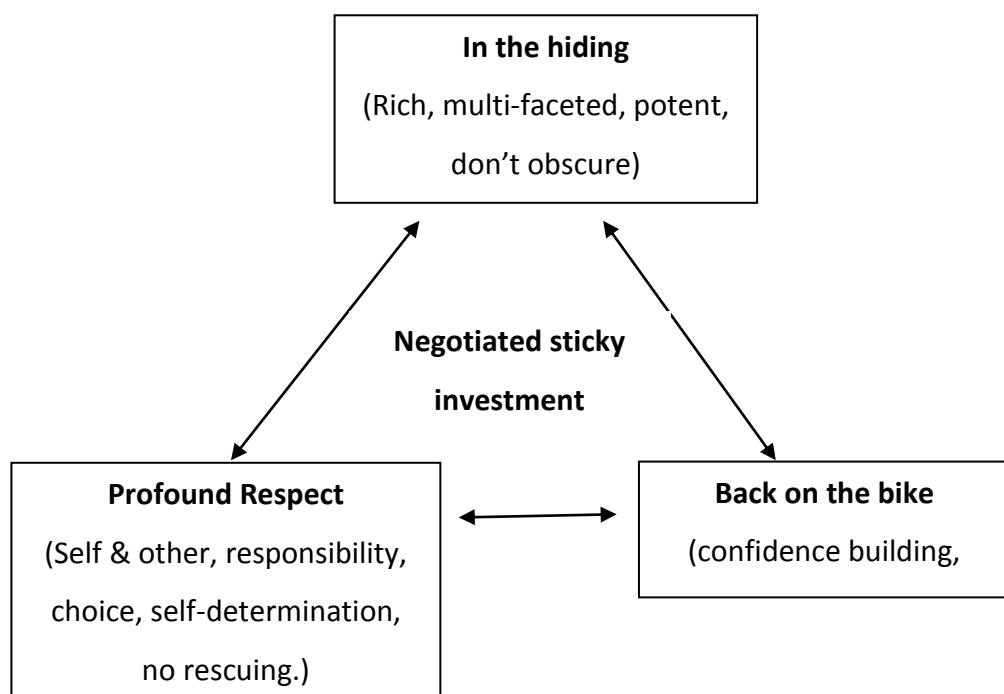
Looking at the 29 patterns there are four kinds of thing being said:

- a. The rich qualities that are to be found in the hiding. Yes here are patterns of avoidance and fear and coping out. Yet here too is a real sense of unmet need , and sometimes a hurt animal. Sometimes too there is a potency. This place seems therefore to be darkness and light, qualities and losses, to deserve the most sacred of approaches. I feel the need here to relate to this well of experiencing, to not obscure it by theories or my own fumblings, to provide a space here where the person can find themselves to be listened to and carried forward.
- b. This profound respect is a quality that seems clear here in the kind of treatment I want to demand for myself and the calling to account that is made to the client. This is not a judging, demeaning, power demand. Rather it is a recognition that the essential dignity and value of human beings – both me and him – need to be attested to. I do no good by coping out or trying to rescue the person. The choice, responsibility, self-determination is inherent in every human being. He may choose not to exercise his part, but it is still there. My profound respect for him as a big person and myself is a significant element.
- c. An existential choice is at the heart here, implicit in many moments, perhaps every moment. Sometimes all of us elide into security or avoidance. Yet growth occurs when we step forward, even in a small way, to take a step of growth. In the past I have said that such a step carries with it its own power. Perhaps the better way of putting this is to recognise that in the moment of decision, there seems no power, but once the choice is made, the power emerges. So there is a moment here of someone who has fallen off, being able to get back on the bike.
- d. In between each of these points is the idea of investment and boundaries. As a human being I need to work within boundaries. I recognise that

marriage is a boundary that keeps me out of trouble sometimes. My clients have few boundaries and easily allow themselves off the hook. Somehow the heart of all of this is the need for each human being to invest his own capital (not borrowed or donated capital from elsewhere) in a step forward. So my clients might do it by turning up regularly, by making a practical step after a session or by engaging openly in the therapy. (Other clients invest very little, it mostly comes from my side.) I am talking about a negotiated sticky investment – something freely entered into, yet not easy to slide out of, and that had a cost (however small).

Step 10 – Choosing three terms and linking them

So here is my interlocking set of terms



APPENDIX 5 – ILLUSTRATIONS OF THE PHASE 2 PROCESS

The following documents illustrate the cyclical process adopted in Phase 2.

1. First cycle hypotheses and reflections on their practice.

Paper 28b (July 2011) set out the Research Hypotheses for the first cycle under five headings, having piloted the model on one client session (F4/54). These were based upon the metaphor of process and process-skipping and are set out in the left hand column of the following table. Paper 31 (January 2012) reported the results of the first cycle, set out conclusions and summarised reflections in the right hand column of the table:

Hypothesis	Reflection
<p>a. Process</p> <p>The key image is the holistic process of being-in-the-world. This encompasses apparently differentiated elements – person/environment, explicit/implicit, self/other, mind/body, pleasure/pain. Experiencing is being carried forward by the zig-zag between these apparently separate elements.</p>	<p>This hypothesis is broadly supported by the evidence. Being-in-the-world is the key factor in therapy for addiction and the evidence would support the need for less esoteric ways to recognise and work with it.</p> <p>The apparent disconnection is significant and the findings have emphasised the person/environment connection which has a tendency to be lost. Linking to recent theory development the zigzag can now be seen as three way between a client's expressive felt sense (articulation), the empirical characteristics of a situation and symbolisations (initially derived from an addictive pattern).</p>

b. Process-skipping

Substance dependence is an extreme example of the way that this process can get stuck. It is characterised by the grasping onto repetitive forms that avoid unpalatable process and, in substitution attempt to carry forward one element at the expense of another. This process-skipping pattern becomes embedded in a way of life that will be supported by the chemical effects of substances.

This is supported by the evidence.

c. Shifts

Change occurs when a person is induced to release grip on the substitute. This happens when they have an intense undifferentiated experience of person/environment, explicit/implicit, self/other, mind/body, pleasure/pain. They connect with their immediate being-in-the-world and discover themselves carried forward by the process. The shift must be allowed/affirmed or else it will be lost.

The evidence suggests that a more significant shift is required than merely awaiting a carrying forward. This appears to involve three factors:

- a standing back (beyond mere 'intense undifferentiated experience') following a degree of internal dissonance or confrontation for the client.
- a fresh symbolisation of an alternative way of being-in-the-world (beyond mere 'carrying forward').
- an existential choice (beyond 'allowed/affirmed') to adopt the alternative.

d. Resistance

Any attempt to change a process-skipping pattern may be subject to a variety of avoidance and resistance. This response is well known in the world of addiction treatment. Interventions will need to respond to resistance, blockages and dips in motivation. Clients will need to be assisted to transcend such problems.

This hypothesis does little more than state accepted views of the issue. The evidence has shown how resistance is a fundamental expression and bifurcation of the problem, coping with life, meeting needs, avoiding the intolerable. The evidence has distinguished clearly between patterns of resistant ('stopped') experience and live experiencing. Rather than remain stuck within the addictive resistance, the client needs to attend to an immediate expression or articulation of a response to a whole situation that has triggered the resistance.

e. Therapy

Focusing-oriented therapy addresses substance dependence by facilitating a twin-track process. It supports a client encounter their undifferentiated experience of being-in-the-world and allow themselves to be carried forward beyond a process-skipping pattern. It assists a client connect the felt sense with practical elements of life change to ensure shifts are supported.

The evidence supports the hypothesis in general terms but has found the current approach to focusing-oriented therapy largely insufficient to deal with the entrenched stoppage of addiction. A developed model is required to add in learning about dissonance/confrontation, standing back, and existential choice. The evidence has also drawn attention to importance of the intersubjective relationship for therapy, but this emphasises the more muscular qualities that support shifts in experiencing compared with tendencies toward indulgence.

2. Stages in the recovery process from the first cycle

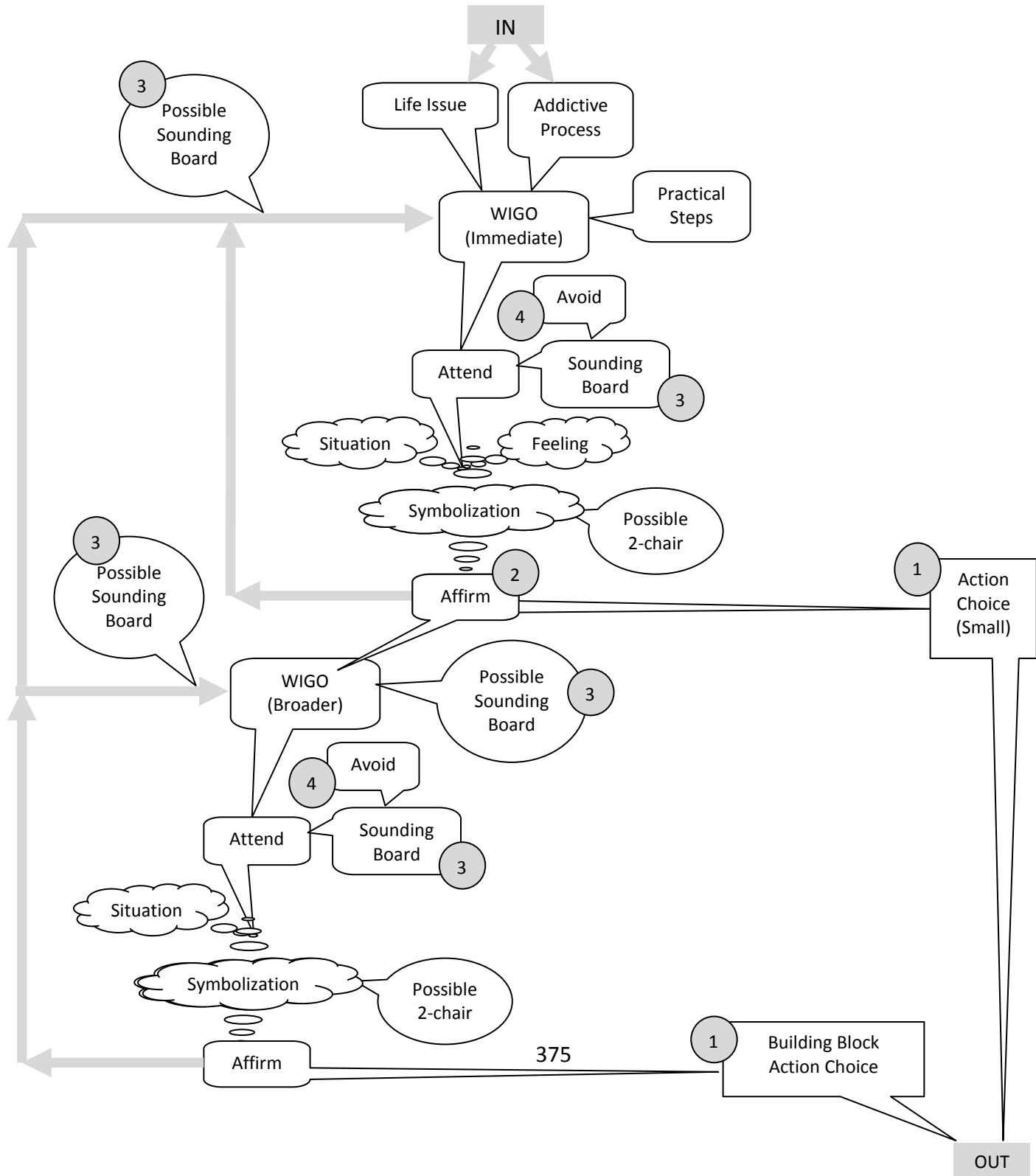
This table demonstrates an attempt to reconcile the stages perceived in therapeutic process in the first cycle of Phase 2 with a Gestalt models of recovery from addiction (Clemmens, 1997, p. 39), the Transtheoretical 'Stages of Change' model (Prochaska & Norcross, 2001) and the therapeutic Assimilation of Problematic Experiences Scale (APES, Stiles et al., 2004).

Therapeutic stage	Recovery Stage of change (SOC)	Therapeutic Recovery
First – Most interventions are in the hands of the therapist – establishing the relationship and boundaries, teaching focusing skills and safety processes. Pre-experiential grounding may be necessary. Relating to <i>what is going on for the client</i> is mostly immediate and narrow and frequently depends upon the therapist's as sounding board.	Dependent. Harm minimalization in substance use. Commits to be sober for therapy. ('Unconscious incompetence') SOC - 'Contemplation'	0 Warded off/dissociated. Either unaware of the problem, successful avoidance, affect minimal, or somatic symptoms, acting out, or state switches. 1 Unwanted thoughts/active avoidance. Client prefers not to think about the experience. Episodic, unfocused and intensely negative affect with unclear connection to content.
Second – The client can now relates to the immediate and narrow sense of <i>what is going on for them</i> . The therapist uses himself or herself as a sounding board and techniques like two chair process to the point where the client can experience and symbolise <i>what is going on for them</i> in terms of broader patterns of life. Consequences and options are made clear as increasing resourcefulness becomes apparent. At the completion of this stage the client is enabled to make resourceful choices in a new way.	Mostly Dependent. Sober for therapy and some other times. Some successful experiments with non-using periods and control. Some symbolic steps away from the pattern but with lapses. ('Conscious incompetence') SOC - 'Decision'	2 Vague awareness/emergence. Aware of a problem which cannot be clearly formulated. the problem clearly. Acute psychological pain or panic associated with the problematic material. 3 Problem statement/clarification. A clear statement of a problem is possible and can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.

<p>Third – The client takes initiative based upon the larger sense of <i>what is going on for them</i> and can adjust it based upon their immediate experiencing. Confidence grows about what is and is not possible so that resourceful choices are made about the next steps in life. From this building blocks of living are established that are not dependent upon the addictive patterns and are not vulnerable to conflict or crisis. The client still needs support but can largely operate on established lines.</p>	<p>Significantly outside dependency. Gaining confidence. Building blocks of recovery are put in place and this leads to major periods outside use. High risk triggers may still be a problem and lapses still occur. ('Conscious competence')</p> <p>SOC - 'Action'</p>	<p>4 Understanding/insight. The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (<u>a meaning bridge</u>). Affect may be mixed, both unpleasant recognition and pleasant surprise.</p> <p>5 Application/working through. The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.</p>
<p>Fourth - Most interventions are in the hands of the client, who can use the therapeutic relationship to support growth and address unanticipated issues.</p>	<p>Outside dependency Able to sustain life without use of addictive patterns. May still need to exercise some vigilance and control. ('Unconscious competence')</p> <p>SOC - 'Maintenance'</p>	<p>6 Resourcefulness/problem solution. The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.</p> <p>7 Integration/mastery. Client automatically generalizes solutions; voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e. this is no longer something to get excited about).</p>

3. Second cycle Task Analysis Process Map

A crude task analysis was reported in paper 31 (January 2012) summarised the pattern involved in therapy based upon two initial agendas from the client - a life issue or description of an addictive process. The outline shows patterns of 'what-is-going-on' (WIGO) activities (i.e. focusing relating to a sense of being-in-the-world) and potential decision points and interventions. Numbered items refer to potentially significant elements for attention.



4. Second cycle hypotheses and reflections on their practice.

Paper 31 (January 2012) set out new Research Hypotheses for the second cycle under seven headings. These are set out in the left hand column of the following table. Paper 33a (April 2012) reported the results of the second cycle, set out conclusions and summarised reflections in the right hand column of the table:

Hypothesis	Reflection
<p>a. Addiction</p> <p>Addiction is a pattern that arises when someone repeatedly avoids painful connections with what-is-going-on. It sets up a defensive knot or 'idle running' stopped process , that obscures the problem and makes do with partially met needs . Habitually part of the self-concept is depersonalised and reified in connection with a substance dependence, so that capability is undermined and the person is unable to see a way out. The heart of addiction is therefore a problem in a person's relationship with the world.</p>	<p>This statement sets out the general principles that have been developed throughout the research. This view of addiction is supported by Phase 2 evidence.</p>
<p>b. Two sides of carrying forward</p> <p>To transcend an entrenched addictive pattern a person needs to relinquish both the experiential avoidance and the habitual dependence. The process oscillates attention between the two perspectives on the same issue - growing ability in one supports steps forward in the other. Key moments of personal investment and choice are pivotal, but are not primarily the consequence of mere will power. Small steps in experiencing or change in habit intrinsically carry the person forward to release perspectives, energy and capability previously impossible .</p>	<p>The twin track view of carrying forward from addiction is supported by the evidence. The oscillation is such that the sometimes the distinction between the two parts seems minimal. The insistence upon choice, not simply seen in terms of will power has also been underlined.</p>

Hypothesis	Reflection
<p>c. Two levels of what-is-going-on (WIGO)</p> <p>Relating to what-is-going-on (focusing) is the key element of change, demanding a pause to connect both with a situation and the existential feel of it . It is perceived in two scales - the immediate sense of what it is like to be in the here and now ... and a broader sense of life as it is being lived The immediate level releases energy ... The broader level enables breakthroughs of living and symbolisation, allowing the building blocks of an alternative to be discovered. ... offers the therapist as a 'sounding board' to overcome deficiencies, particularly relating to the pre-objective somatic 'tags' of the client .</p>	<p>Whilst the two levels of focusing are evident in places, it would appear that the clear distinction of two levels is a two simplistic bifurcation of a much more entwined process. Energy is released, breakthroughs of symbolisation occur etc but within a broader process involving the felt sense, symbolisation and the situation. 'Building blocks' likewise represent a too simplistic and linear view of the process. However the understanding of a 'sounding board' process and use of somatic tags has been expanded and deepened by this process.</p>
<p>d. Transcending the habit</p> <p>Standing aside from addictive patterns means overcoming repeated avoidance ... The reified 'it' of an avoidant pattern must be distinguished from the 'thou' of a felt sense and reconstituted . The therapist's demonstrable empathy with what-is-going-on for the client combines with a clear sense of direction, confidence under pressure and resolution in neither colluding nor evading. Choices within what-is-going-on can be taken up by the client as opportunities to move forward.</p>	<p>This area has been and remains one of the most fruitful area of the Phase 2 research. Choices have begun to be seen as crucial and the roles of evasion and collusion are significant. Most interesting has been the development in understanding of 'discourses' and the application of these in releasing clients from addictive patterns. Cooper's (2004) Buberian analysis needs to be seen centrally in Phase 3. How can experiencing of the implicit and the other elements discovered and substantiated be fitted within this interpersonal and intrapersonal perspective?</p>

Hypothesis	Reflection
<p>e. Stages in a process</p> <p>The process can be seen in stages where shifts in avoidance/substance use match therapeutic changes and are reflected in reducing levels of therapist intervention ... Personal investment is maximised by explicit and negotiated expectations for each stage. Headings for these expectations include:</p> <ul style="list-style-type: none"> • Degree of dependency in substance use/avoidance behaviour. • Skills and understanding of tasks needed to be achieved. • 'Daemons' - Underlying personal/emotional issues obscured by avoidance. • Achievement of tangible changes in living. • Interpersonal support - Role to be played by relative, friend or agency mentor. <p>Regular reviews and the process of objective setting would both be supported by the use of maps ... At all times the direction and pace of the process remain always with the client's sense of what-is-going-on .</p>	<p>The cases examined indicate clients at various stages of the recovery process and the parallel development of experiential avoidance and habitual dependence is substantiated. However the structured way of working, including maps, is not demonstrated and the idea of explicit and negotiated expectations fundamentally questioned. Exploration of underlying personal/emotional issues obscured by avoidance is substantiated, although the term 'daemons' is challenged. Fundamentally whilst a broad shape of process is supported, a mechanistic application is not.</p>

Hypothesis	Reflection
f. Dialogical space and agency	<p>A particular kind of inter-human space is offered in focusing-oriented therapy, away from Cartesian isolation, which redraws distinctions between 'inside' and 'outside' processes, between one person and another. This engenders a dialogically acceptant attitude, vital to unpick the rigidly split self-concept of addiction. Focusing-oriented therapy encourages the client to tolerate discordant 'somethings' in their experience, to allow the different felt senses of a therapist, and uses 'two chair' techniques to facilitate evocation, expression and dialogue between 'voices'. This facilitates a particular intersubjective agency necessary for the client to decisively act .</p>
g. Task analysis	<p>The degree of clarity in these hypotheses suggests that the process may be open to exploration using a task analysis methodology. This would identify the fundamental pattern described here as a therapeutic task delineated by entry point ('task marker') and objective/outcome. It may permit the examination of the fundamental elements deployed and the significance of choices involved. ...</p>

5. Third cycle hypotheses

Paper 33a (April 2012) set out new Research Hypotheses for the third cycle under four headings. - Experiential Dialectic, Encounter and Otherness, Agency and Choice and the Dialogical Self Concept:

1. Experiential Dialectic

The entrenched patterns of addiction are not readily resolved through mild and gradual processes. A degree of experiential dialectic is required.

Particular characteristics of this include:

- a. **Focusing and symbolisation** - The process of attending to an implicit felt sense of a situation and bringing this into symbolisation requires a dialectic exchange.
- b. **Somatic and gestural expression** - Clients provide ready means of relating to their experiencing through somatic posture and gestural expression. As with focusing, this needs a dialectic exchange.
- c. **Daemons** - Problematic living can often be associated with longstanding patterns of experiencing and behaving. A dialectic attention to these can assist more general resolution.
- d. **Harsh reality** - Previous phases have demonstrated the fundamentally avoidant pattern associated with addiction. Part of the dialectic process is therefore to ensure that 'harsh' aspects of living are attended to, not in a moralistic sense, but so as not to conspire in evasion.
- e. **Pushing against another** - See below.

2. Encounter and otherness

One of the key elements of an experiential dialectic is seen as the interpersonal encounter that can arise in a consulting room. Therapists are encouraged to maintain a congruent individuality to complement warmth and empathy.

- a. **Pushing against another** - The therapist can provide a secure object against which the client can resonate to explore his/her experiencing. The more sincere and transparent such interventions can be the more benefit is accrued.
- b. **Sounding board** - Previous phases have demonstrated the advantages of the therapist attending to her/his own felt sense so as to offer suggestions that the client might stimulate the client's own process of focusing.

c. **Background feeling** - As with somatic and gestural expression, a valuable access point to the experiencing of a client can occur when a therapist suggests the 'background feeling' that may have begun to be evident.

d. **Personal affirmation and holding the space** - See below.

3. **Agency and choice**

A significant area of engagement in the therapy process concerns the sense of agency can experience in contrast to the disempowering perspective of 'addiction'. In particular it may be hard even to discern points where personal choice can be exercised, let alone be able to do so.

a. **Personal affirmation and holding the space** - A fundamental support to agency and choice can come from the inter/intra-subjective process and steps the therapist takes to ensure that a space is held for the client to use. Likewise the degree of personal affirmation the therapist can give the client during difficult processes is also often significant.

b. **Person-in-situation** - A commonplace understanding of addiction sees difficulties as arising from personal weakness and lack of will. By contrast a focusing-oriented approach emphasizes the contingent facts of a person-in-situation. Helping to provide experiential perspective on this also can include recognising the agency a client can exercise in other situations.

c. **Experiments with substance abuse** - Addiction treatment interventions can often put effort into setting targets for changes in substance use, expecting a cumulative and linear result. By contrast this approach recognises changes in substance use as a convenient means of exploring the client's avoidance and dependence in a practical form. An experimental form emphasises learning and change through developed understanding and confidence.

d. **Carrying forward** - This is the basic understanding that focusing-oriented therapy has about change i.e. it is not a fragmented process but one whereby the whole person and situation is carried forward. The expectation is that as such broad carrying forward occurs, the client will be enabled to make changes that are desired.

e. **Configurations and Discourses** - See below.

4. **Dialogical self-concept**

Focusing has always been able to relate to different 'senses', 'voices' or 'somethings' and this fits well with person-centred theories about 'configurations of self.' A valuable insight into addiction is provided

through a combination of this dialogical stream with Buber's influential intersubjective perspective.

- a. **Configurations and Discourses** - Previous phases have observed the significance of discourses in the field of addiction. Using configurations and discourses with clients can significantly enable them to enter a different relationship with their experience of the world as expressed through their self-concept.
- b. **New symbolization** - A common observation has been that a person is unlikely to be able to make significant steps forward in recovery unless a fresh symbolization of their self concept can occur.

APPENDIX 6 – OUTLINE OF LEADING ADDICTION TREATMENT ORIENTATIONS

This appendix provides a brief introduction to the major treatment orientations currently used with addiction.

1. Twelve Step

The Twelve Step tradition is perhaps the most dominant form of treatment for addiction in the United Kingdom and yet is a peer-support process rather than a therapeutic tradition. The tradition began in 1935 with the founding of Alcoholics Anonymous (1952) but it has grown to be a multi-national phenomenon relating to many types of addictions in many countries. Whilst it attempts to maintain an independence from other organisations, its principles have been widely adopted in mainstream treatment systems and frequently the criminal justice system mandates attendance. This led to the suggestion of a need to reform genuine groups so that they were not corrupted by a treatment ethos (Kurtz, 1999).

Those who engage in the community are invited to 'work through' their own experience of the twelve steps:

1. *We admitted we were powerless over alcohol - that our lives had become unmanageable.*
2. *Came to believe that a Power greater than ourselves could restore us to sanity.*
3. *Made a decision to turn our will and our lives over to the care of God as we understood Him.*
4. *Made a searching and fearless moral inventory of ourselves.*
5. *Admitted to God, to ourselves and to another human being the exact nature of our wrongs.*
6. *Were entirely ready to have God remove all these defects of character.*
7. *Humbly asked Him to remove our shortcomings.*
8. *Made a list of all persons we had harmed, and became willing to make amends to them all.*
9. *Made direct amends to such people wherever possible, except when to do so would injure them or others.*

10. *Continued to take personal inventory and when we were wrong promptly admitted it.*
11. *Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.*
12. *Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs. (Alcoholics Anonymous, 2010)*

The active ingredients of the Twelve Step experience have been studied with some focus on mechanisms like,

“motivational enhancement, development of 12-step cognitions (e.g., commitment to abstinence and continued A.A. participation), recovery coaching (advice), mastery of behavioural prescriptions for coping, exposure to recovery role models, enhanced self-efficacy, changes in friendship networks, and the therapeutic benefits of helping others.” (White & Kurtz, 2005, pp. 23-24)

The organization has an emphasis on spirituality and transcendence, particularly through the immediate recourse to a ‘higher power’ and the parallels between it and a religious organisation have been frequently observed (e.g. Alexander, 2010, p. 296). Perhaps it is more appropriately described as ‘Identity Transformation Organization’ (Greil & Rudy, 1984).

A systematic review of mechanisms of behaviour change in Alcoholics Anonymous concluded that:

“AA helps individuals recover through common process mechanisms associated with enhancing self-efficacy, coping skills, and motivation, and by facilitating adaptive social network changes. Little research or support was found for AA’s specific practices or spiritual mechanisms.” (Kelly et al., 2009)

2. Relapse Prevention

Relapse Prevention represents the most systematic approach toward addiction from a cognitive behavioural point of view. It has identified a phenomenon that applies across many afflictions and treatment regimes and the concept provides a valuable conceptualisation toward practical ends. The ‘natural history’ of lapses and relapses was distinguished and the various individual, interpersonal, psychological, environmental and social factors were identified (Brownell et al., 1986). A model of a person’s response to high-risk situations was developed

(Marlatt & Gordon, 1985), identifying coping measures, self-efficacy, individual outcome expectancies and including the experience of self blame over failure ('abstinence violation effect', Curry et al., 1987).

High risk situations include 'apparently irrelevant decisions' (Marlatt & Gordon, 1985, p. 49) where opportunities to breach a resolution toward abstinence are inadvertently engineered. Studies have shown the validity of the methods developed and the approach has been used in various mental health settings. A lapse-relapse learning curve is to be expected in the process of learning any new behaviours (Carroll, 1996).

There have been issues measuring self-efficacy and understanding the mechanism by which it determines outcome (Maisto et al., 2000). Individuals expectancies are shown to influence outcomes but may do so in relation to other factors and despite extensive study craving is still little understood and is a poor predictor of relapse (e.g. Kassel & Shiffman, 1992). Coping has been understood in terms of a hierarchy of 'families based on types of activity (Skinner et al., 2003), and this has identified self-reliance as significant. Self-regulation has been viewed as a kind of muscle that can be both strengthened and fatigued (Baumeister, 2003). Both emotional upset and the right type of social support have also been shown to be important (Hodgins et al., 1995).

A revision of the model was undertaken (Witkiewitz & Marlatt, 2004) to emphasise situational dynamics because seemingly insignificant changes in risk, precipitated by a minor cue can kindle a lapse. A biological metaphor of 'self-organisation' is used to understand this, with reference to the different 'states' of multiple personality disorder:

"The various states become elaborated and develop a different set of memories, affective qualities, and identities. They also become unstable and discontinuous, predisposing the individual to sudden jumps between one state and another. Unfortunately, this communication is the very thing that is needed to develop a coherent sense of self. Putnam described how the process of developing coherence involves opening channels of communication between states. This occurs through discouraging pathological dissociation and encouraging the integration of dissociated states, memories, and affects." (Barton, 1994, p. 11).

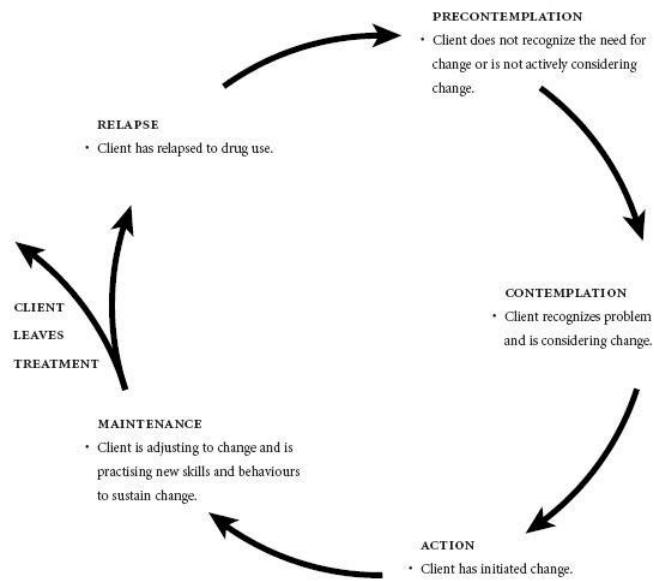
3. The 'Transtheoretical Model'

Working primarily from a Cognitive Behavioural philosophy a model was developed in the 1980's to provide a rational description of the whole process of change involved in altering behaviour, particularly recovery from addiction. It is known as 'transtheoretical' because it attempts to bring together a broad perspective not dependent upon aetiology. This model underlies the

interventions of most treatment agencies today. It emphasises the degree of readiness and motivation, the move from being unready through to contemplation, decision, action and maintenance (DiClemente & Prochaska, 1998, pp. 3-24):

- **Stage 1: Pre-contemplation (Not Ready)** Here there may be a pressing reason for change, probably health related, yet the individual may be unaware of it and is certainly unprepared to have any serious involvement with it. At this stage interventions are suggested to bring the issue into consciousness, recognise significant factors and understand the pros and cons of changing.
- **Stage 2: Contemplation (Getting Ready)** Here the person has become aware of the issue and has some assessment of the pros and cons as far as they are concerned. However they retain an ambivalence about a shift of behaviour, judging explicitly or implicitly that suggested action is inappropriate for them. The emphasis in interventions here therefore is upon opening up an understanding of what life might be like if they did change and reducing the actual or imaginary blockages to it.
- **Stage 3: Preparation (Ready)** Here the balance for the individual has shifted to recognising the issue as important to them and something they can tackle. They can establish a viable way to make the change and are clear about the desired advantages to they would gain from it. Treatment is here concerned with putting in place the final practicalities, testing elements of the shift, building support and explicit commitment among family and friends..
- **Stage 4: Action** This is where change has begun. Here interventions are needed to cope with immediate costs (that may appear prohibitive compared with longer term gains) and unanticipated difficulties. Temporary lapses are a major focus for treatment to ensure the person maintains the right direction and avoids situations that would lead to temptation. The concern is also to introduce substitute behaviours that can compensate for what may have been relinquished in the change.
- **Stage 5: Maintenance** Where the change has been achieved in a positive manner this is the final stage of stability. The emphasis is on a lifestyle that supports the new ways. The theory recognises that a major lapse may lead to an entrenched relapse and is prepared to work the cycle again to bring about a timely resolution.

Overview of Stages of Change*



*Adapted from Prochaska, J.O., and DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19 (3), 276-288.

The model has been criticized for presenting an unrealistically rational view of processes which are far less ordered, mixing understandings to provide little more than a “*security blanket for researchers and clinicians*” (West, 2005, p. 1038). A review of 87 studies on the stages of change across problem behaviours concluded that,

“Research findings suggest that the proposed stages are not mutually exclusive and that there is scant evidence of sequential movement through discrete stages in studies of specific problem behaviors, such as smoking and substance abuse. Although the stage model may have considerable heuristic value, its practical utility is limited by concerns about the validity of stage assessments.” (Littell & Girvin, 2002, p. 223)

4. Motivational Interviewing (MI)

In line with the Transtheoretical model, MI is “a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” and rather than being a set of techniques is described as a “way of being with people” (Miller & Rollnick, 2002, pp. 25, 41). It grew out of implicit principles based on intuitive person-centred practice, building on social psychology (e.g. Bem’s ‘Self-Perception Theory’ and Festinger’s concept of ‘cognitive dissonance’) but now adds in cognitive behavioural techniques such as

Socratic Questioning (Treasure, 2004). Ten years after his seminal book was published Miller still accepts that whilst there is evidence that the approach works there is less theoretical clarity about how and why it does (Miller & Rollnick, 2002, p. 26). It is much used in conjunction with other methods, but perhaps rarely used alone.

The approach is phenomenological, having a prime respect for the client's idiosyncratic world view. Miller sums up the spirit of MI in terms of '*Collaboration*', '*Evocation*' and '*Autonomy*' and '*Empathy*' as understood by Rogers, is its first principle (2002, p. 34). Self-determination for the client is very important - "*even if I wanted to make the decision for you. I could not*" (Miller, 1998, p. 125). Rapport is sought and a person-centred reflective listening is practiced (Miller & Rollnick, 2002, pp. 67-73). Both presume that there is an intrinsic positively directed energy within human beings that can be accessed and developed – the "*righting reflex*" (Miller & Rollnick, 2002, p. 20) is presumably references to Rogers '*actualising tendency*.' The individual is to be drawn forth in what MI calls '*evocation*', attending to something that is not immediately accessible or evident for the client (Miller & Rollnick, 2002, p. 76).

Reference to the actualising tendency may point to some common Rogerian understandings of what positive life is for a person – one based upon life flow and energy. MI understands a motivated state in pragmatic terms – "*motivation is getting moving*" (Miller, 1998, p. 122, emphasis original) and the approach develops a sensitivity to that state and its enhancement. '*Change talk*', expressions from the client toward the desired state, should be elicited, reflected, elaborated, and affirmed (Miller & Rollnick, 2002, pp. 85-91). This alignment with the client's energy extends to apparently maladaptive energy prompting a therapist to '*roll with*' or "*sidestep resistance by responding with empathy and understanding rather than confrontation*" (Treasure, 2004, p. 331). A therapeutic conversation is guided by the therapist away from defensiveness and toward potential for change. By contrast an unmotivated state is understood as a blockage in aligned energy flow, particularly expressed in ambivalence linked to approach-avoidance, even '*double approach-avoidance*' (Miller & Rollnick, 2002, p. 15). Faulty logic is also seen to be a problem to be overcome through consciousness raising, self-re-evaluation, weighing up the costs and benefits of change or status quo in a decisional balance (Velasquez et al., 2001). The key approach of empathetically developing discrepancy shows a sensitive understanding of emotional and value driven issues at the heart of ambivalence.

5. Person-centred

The person-centred literature is not large (e.g. Bryant-Jeffries, 2001; Farrell, 2000; Moerman & McLeod, 2006; Wilders, 1999; Wilders & Robinson, 2012). The general approach is illustrated by Bryant- Jeffries (2001) who has written extensively from his long experience as a therapist in this area. Alcohol difficulties

are seen as part of a continuum between abstinence and problematic use. Alcohol users are seen as meeting a variety of needs that arise from the whole context of social interactions. Everyone is understood to have an actualising tendency, but life (through conditions of worth) leads to the development of defensive beliefs, inconsistent with the organismic self. Configurations can develop in the self-structure as a consequence and alcohol can provide a variety of means to respond to these.

The quality of the therapeutic relationship is seen as the key to the healing process - it is a way of being, not a skill or task. This provides a way for the person to relate to their organismic needs through greater congruence. During the course of therapy there may be tension in the client between greater congruence and the urge to react and defend. Whilst the journey of recovery can be understood in terms of a standard cycle of change (DiClemente & Prochaska, 1998) the therapy should not direct the client into a particular direction and particularly not imply that recovery goals are the right answer.

Challenges for client-centred therapists can arise over questions of contact (a 'necessary condition') that may be impaired through substance use. Intoxicated clients can receive the core conditions and the therapeutic task does not change as a consequence. In this way substance users may demonstrate problems in therapy rather than discuss them. The actualising tendency is there even when the client is apparently absent in substance use or engaging in addictive behaviour which may appear to be self-defeating (Wilders, 1999).

The substance user is constantly receiving external judgements and therefore unconditional positive regard is the more important. Therapy can be compromised if the therapist is harbouring a desire to see her client give up the use of substances, then this directive attitude, even if unspoken, is likely to interfere with the therapist's ability to offer unconditional positive regard (Wilders, 1999).

A significant insight from the person-centred tradition is to view addiction in terms of the operation of a self-concept by which includes both the positive effects of the actualising tendency and influences of conditions of worth. Experience is distorted and denied when it threatens the self-concept, which nevertheless keeps trying to meet the person's organismic needs:

"It thus becomes appropriate to respect an individual's conditions of worth as evidence of the actualising tendency's capacity for self-defence and self-maintenance, as well as evidence of disturbance or incongruence." (Merry, 2003, p. 86)

6. Gestalt

The Gestalt tradition has an established literature on the treatment of addiction (e.g. Beisser, 1970; Buchbinder, 1986; Clemmens, 1997; Clemmens & Matzko, 2005; Coven & Blackhawk, 1978; Leung, 2010). Contrasting with the disease perspective, sees addiction as a “*a developed contact style, a way of managing one's experience*” (Clemmens & Matzko, 2005, p. 283):

“The Gestalt perspective of substance use is that it is a creative adjustment. Although potentially destructive, substance use facilitates a way of regulating the addicted person by creating a meaningful way to cope with unmanageable experiences. Sensations can be adjusted to enable avoidance of intolerable experiences or feelings, or confluence with others can be more easily reached. Substance use serves the purpose of desensitizing the addicted person so they can avoid the risk of experiencing themselves and others. By default, substance use diminishes the capacity for feelings, behaviours, emotions and the ability to respond appropriately.” (Leung, 2010, p. 30)

The Gestalt core concepts of field theory, organismic self-regulation and the contact processes of the cycle of experience are applied in the treatment of addiction. Relapse is shown as being a progressive regression from healthful contact functions reverting back to the inhibited sensation-action loop of substance use.

“The Gestalt approach to addiction is based on three observations: First, addiction is defined as the addict's exclusive relationship with the drug, making other relationships or contact secondary and peripheral. Second, this relationship that the addict has with the drug both serves as an avoidance of other sensations and constitutes an attempt at meaningful survival. And third, any approach to working with addicts needs to address both the meaning of the addict's survival behavior and the meta-pattern of avoiding fuller contact with the self and the environment.” (Clemmens, 1997, p. 6)

A particular understanding uses the characteristic Gestalt model of the cycle of experience, a rising energy from sensation through awareness and mobilization to a climax of action and contact, then diminution through assimilation and withdrawal. Addiction is seen as an inhibited sensation loop (Carlock et al., 1992) where a person moves quickly from sensation directly to action and then back to withdrawal, skipping and shortening intermediate steps (Clemmens, 1997, p. 10), the jumping of the cycle becomes “*like 'hot-wiring' a car*” (Clemmens & Matzko, 2005, p. 292).

Certain characteristics of substance-dependent individuals either existed prior to their drug use and/or developed through drug use (called the 'substance-dependent ground' are identified: *Overstimulation—Agitation/Anger, Limited Repertoire of Self-Soothing/Coping Skills—Fear, History of Failures and Noncompletions—Guilt, Discomfort With Self-Shame* (Clemmens & Matzko, 2005, p. 294ff).

The approach presumes an 'organismic self-regulation' by which needs are experienced recognized and met. The defences that interrupt this are interpreted as 'care strategies', never to be denigrated, always to be understood. These are projection, introjection, retroflection, confluence and deflection, each of which rob the person of essential resourcefulness. In order for the alcoholic to get his needs met, he must undo the retroflected aggression (Buchbinder, 1986).

Treatment models emphasise growth, awareness, and self-support and the 'paradoxical theory of change' where,

"... change occurs when one becomes what he is, not when he tries to become what he is not. Change does not take place through a coercive attempt by the individual or by another person to change him, but it does take place if one takes the time and effort to be what he is -- to be fully invested in his current positions. By rejecting the role of change agent, we make meaningful and orderly change possible." (Beisser, 1970, p. 77)

7. Somatic

Although a limited literature, the somatic view, based on a developmental theory of movement addiction (Caldwell, 2001) is very valuable. In ways that parallel the Gestalt cycle, this recognises the natural and meaningful sequence of reaching grasping, holding and relaxing. Various kinds of dissociation arise where needs are frustrated and attunement lost, depending on habitual cycles that substitute for needs being met by interaction.

"This habitual movement stops the original flow pattern in the body and substitutes a repetitive, stereotypic pattern in its place, which will be discussed below. The pattern is soothing, sedating and predictable. And as the child grows and becomes more socially and physically complex, the movement must mutate to fit social constraints, becoming a small gesture or expression, a 'tag.'" (Caldwell, 2001, p. 218)

The 'tag' is a physically recognisable boundary marker where the movement sequence is interrupted and dissociative living interrupts. The tag may evolve into a posture or social gesture and is repetitive, does not develop or complete and does not satisfy.

Through physical exploration the therapy raises awareness of the gestural sequence, developing a sense of owning the intention caught up in it and uncovering the original movement sequence. This enables the sequence to be completed through appropriate action.

8. Dialectical Behaviour Therapy (DBT)

Linehan and colleagues provide one of the earliest uses of mindfulness in addiction therapy, with and adaption of Dialectical Behaviour Therapy (DBT) to clients with borderline personality disorder and substance abuse (Linehan et al., 1999). This sees dysfunctional behaviour including substance abuse as a way of coping with problems in emotional regulation. The therapy simultaneously seeks to engage the client in new behaviours whilst teaching a greater self-acceptance – observing urges without being caught by them and accepting the pain of withdrawal. Mindfulness is deployed as a way of helping to extinguish automatic avoidance of emotions and fear responses (Breslin et al., 2002). Techniques from the cognitive and behavioural tradition are therefore combined with acceptance strategies adapted from Zen.

“The acceptance procedures consist of mindfulness (e.g., attention to the present moment, assuming a non-judgmental stance, and focusing on effectiveness) and a variety of validation and stylistic strategies.” (Linehan et al., 1999, p. 281)

9. Acceptance and Commitment Therapy (ACT)

Gifford and colleagues adapted Acceptance and Commitment Therapy (ACT, Hayes et al., 1999), another model that includes mindfulness, to treat nicotine-dependent smokers. ACT emphasises the need, when faced with negative emotions, to *“shape acceptance-related skills in order to reduce avoidance and increase cognitive and behavioral flexibility”* (Gifford et al., 2004, p. 691). Practical components therefore include identification of internal triggers, graduated exposure to withdrawal and practice of adaptive responses to negative emotions. Mindfulness skills are included to *“develop a safe and consistent perspective from which to observe and accept all changing inner experiences”* and *“to promote cognitive and behavioral flexibility.”* They are complemented by *“cognitive defusion skills”* which teaches clients to see thoughts *“as what they are (more or less helpful descriptors, depending on the specific cognition), and not as what they say they are (infallibly accurate reflections of reality)”* (Gifford et al., 2004, p. 696).

As with DBT, ACT provides a multi-faceted regime designed to achieve particular cognitive and behavioural outcomes, using mindfulness merely as a component. The standard application of ACT (Hayes et al., 1999) includes some more general treatment options, some of which are considered in the avenues section below.

APPENDIX 7 - CHANGE INTERVIEW - F26

What has the therapy been like for you?

02:43 'Reassuring', a lot of ups and downs. There's been periods where it has been quite hard work.

If we take a snapshot of right now - how are you doing?

03:42 'Getting there.' I wouldn't use the word 'fixed' ... I'm not where I was a year ago. I might want to go back there ... it's an easier place, familiar. Sometimes it's just easier to go back into that dark hole rather than fight your way out of it.

Does that mean it looks attractive sometimes?

04:25 Sometimes it looks like the easier option rather than having to ... move forward. Sometimes it is easier to sit back and let come what is going to come.

Easier rather than better?

04:37 Oh yes, definitely not better, just easier.

If we took a snapshot of how you are right now, it doesn't look as if you are in one of those moments [where the easier would be preferable]?

04:49 Not just right now, but equally I do have moments when they come. And I know that I will come out of it, sometimes easily enough and sometimes it's a slog. I've accepted that it's me, it is going to happen.

That sounds like a piece of self awareness ...?

05:43 Yes. But as we sit at the moment I am definitely in a better place.

And how would you describe yourself?

05:48 'Complicated', I like to think I might be a little bit intelligent, probably a little bit arrogant as well. I am the sort of person who likes to be liked and likes to be good at what I do. Perfectionist - the best at everything, or at least to be seen to be trying to be the best at everything.

06:34 When I say the best, I mean what other people would interpretation as the best, not necessarily my interpretation, what I

would consider to be perfect. Like with relationships, if they expect me to be non-confrontational I will be non-confrontation, regardless of how I might want to be.

You live up to people's expectations, or even down to them?

06:59 A way that I can be more fulfilling to other people.

Being considerate of other people at your own expense, to some extent.

Anything else if we are going to be describing you?

08:02 I like to be a bit different. I like to stand out." I like to achieve highly.

08:54 'Adventurous' ... 'creative' ... when I say 'complicated', it's a very broad word, I think a lot. People would say I over-think.

How would other people describe you? Your husband would say you are creative? And other people might think you were a deep thinker. What would your friends say about you.

10:00 Yes. 'Supportive', a good listener, friendly. Somebody they can rely on if they need it. 'Trustworthy.'

If you could change something about yourself what would it be?

11:39 I don't think I would. (pause)^d If you had asked that a year ago I'd have given a very different answer I think."

What would you have said a year ago?

11:43 All of it!

That's a pretty amazing change isn't it?

12:02 I think definitely, if not 'all of me', I would definitely have had a list of things.

Now, nothing needs to be changed. That feels like a very important statement actually, of how you are feeling right now, about you.

Two very different places. If we think about the changes, in that year since the therapy started. What have you noticed, what are you doing that's different, what are you feeling that's different? What has changed?

^d The interviewer notes that "this pause was a very significant one really ... it made room for the unspoken possibility that at that moment, F26 likes herself just as she is..."

14:03 I am able to accept (I still hate the word), accept my feelings. [Interviewer: You are grimacing when you say that.] Feelings and emotions and stuff like that. ...

14:44 I am able to notice them more and accept them for being there. And not necessarily fight it as much, or criticise it as much. It doesn't mean I like it. It's not necessarily all the time at all, [Interviewer: That you are able to notice them and accept them and let them be there.] but I don't argue with myself about them as much. Which literally used to be constant.

So you have a working relationship with your feelings

15:20 Yes. I call them Tom and Jerry. [Interviewer: Your feelings, are there only two of them?] Yes. I would be Tom and they would be Jerry and they never got heard.

That was the dynamic between you and your feelings. You were Tom and they were Jerry and they kept getting the better of you but you kept chasing them.

16:02 Yes. They were very diminutive in stature, and never got heard, and would always try and fight and were constantly getting battered down all of the time.

My memory of Tom and Jerry is that Tom tends to come off worse in the long run.

16:16 Yes. And I think that would be the thing. [Interviewer: So getting on better between Tom and Jerry is better for Tom too.]

Let's go back to the things that have changed. Let's have a look at other things that have changed.

16:55 I don't think I hate myself as much anymore. Again not all of the time. There are times when I do. Or there are times when I hate what has happened to me. ... But I don't actually think that I am necessarily a bad person. And I am a little bit more willing to accept that I'm not to blame.

Has it made a difference? What has changed because of these changes? What do these changes make possible?

18:13 I listen to Jerry. [Interviewer: Yes. Because, when you are hating yourself, and you are thinking you are a bad person, and you are thinking you are to blame. When you are believing all of that stuff ...] The moment you get any kind of feeling come up, it is just like,

'no I can't be feeling that, it's just that I'm a bad person.'
[Interviewer: it just reinforces it.]

18:47 Generally speaking if I had emotions it was because I was a bad person and I was to blame.

That was a really vicious circle. And you're not stuck in it anymore?

19:02 It just caused me to hate myself all of the time, because I am to blame for everything. It is all of my fault. There is nothing there but hate.

It sounds like the mechanism to keep putting you back into that vicious circle. It's always me. I am to blame.

Have those changes made a difference to the quality of your life. The way that you feel and what you do overall? Have they paid off in any way?

20:17 No I don't necessarily think so. I think I was able to put on a front that meant I was able to keep going with everything. It was all so internalised.

So on the outside things aren't looking much different.

20:29 No.

Is there anything else that has changed?

21:13 Probably I ought to say that right now I feel a little bit uncomfortable admitting the things that it might, just in myself it's kind of almost ... It's not as if ... That thing within me is still saying 'No, no, I'm still here.' [Interviewer: You haven't got rid of me.] Yes, if you turn round and say these things have changed ... [Interviewer: Don't get too cocky.] Yes, because I'm still here.

I completely take your point. It's important to stay grounded with the truth of what you know being about you and your experience. And that is that there are good days and bad days. That was one of the first insights that you gave me. And it felt like wisdom to me. That part of you doesn't need to get nervous. We're not going to airbrush it out of the script. It can be just taken seriously and respected as well.

22:44 It's got too much power to. [Interviewer: Too much mischief. Ok we'll let it have the other chair. And then we can include it in the dynamic of change. Because the job's not done yet. Just a kind of moment in time.]

23:31 I don't know what might have changed though generally. Just that I have a bit more insight. ... Things more clearer. I describe it as the 'fugg.' When everything goes round so quickly that you can't, like a thick fog, very grey, you can't make anything out.

That sounds really important so this thick grey fugg was a really familiar state?

24:19 Oh God yes! Really, like, all of the time.

And that's not like that all of the time?

24:30 There are moments but less so I think. I am able to reach in there and isolate something out. Just make a bit more sense of it rather than it being just a whole ... [Interviewer: A big jungley, fuggy thing.] Yes. [Interviewer: And slow it down? How do you do that? 'Reach in there' sounded like a very interesting skill that you have learned to manage this fugg.] Yes. Listen to it a bit more I think, rather than trying to fight it. I hate it and I hate myself within it, for being in that state. [Interviewer: Which would make it worse.] Yes, perpetuates the whole situation. Accept it a bit more. If it is going to be there, then accept that it is going to be there for a little while and not fight it so much maybe.

And there are times when it is not there?

25:31 Yes, like now. [Interviewer: ... goes with the insight.] Yes it does, feels like it does.

[The conversation pauses to return to the changes in sequence. In passing it considers the presence of a raisin in the interviewer's identity badge.]

I am going to ask you a series of questions about the changes we have identified.

Reference to the Tom and Jerry change - relationship with f-e-e-l-i-n-g-s. How much did you expect that to be something that changed?

27:30 Don't know about 'expect.' Hope maybe. But then I hoped it didn't as well. Because it is so familiar and comfortable to be in that situation. It was like I didn't want it to go. You know, I'd almost like to hold onto it if I felt like that arguing was getting away from me and I wasn't arguing as much and having that battle. I almost liked to bring it back as well, because it was familiar and comfortable. It might be bloody horrible but was too familiar for too long to lose.

That sounds like a bit of a 'push and pull' dynamic going on with that change.

28:20 Like when I notice it getting too far away. I'd almost engineer a situation to bring it back.

So there was a part of you that hoped it would get better, this dynamic with your feelings. And a part of you that actually didn't want it to change because it was familiar and there was something about creating sometimes a bit of drama to be able to get it back.

28:54 Yes, because I didn't want to have to deal with those things.

So are you surprised that it did overall, given the push and the pull of it?

29:09 It seemed to just happen. There have been times when I have noticed it go and then pulled to get it back again. And then, I don't know, I feel like I've been a bit distracted and just sat by the wayside a little bit and been happy to sit there, rather than me looking for it. [Interviewer: Almost under your awareness, under the radar.] Yes, I haven't even been thinking about it till just now, I haven't noticed them for that long really [Interviewer: That whole Tom and Jerry thing.] Not to the point of thinking I'm back in that situation again. There have been niggles but.

So it sound like you are quite surprised by that!

30:02 Yes. Surprised by just how it seems to have just slotted in. Rather than it being a noticeable change, or a wave a magic wand at it, and its gone. [Interviewer: You haven't had to really be on its case either.] There was a time when we did. There was a case of having to address it because I was not going to get any further until I noticed, allowed Jerry to have say. [Interviewer: To have a voice, to be spoken.] Yes. So there was a time when I had to be on his case and had to literally listen and make myself ... [Interviewer: Voice the feeling.] Yes that was quite uncomfortable. I'm quite surprised by how, thinking about it now, it seems to have just slotted in there, rather than me having to work at it so much now.

Do you think the change would have happened if you hadn't been in therapy?

31:28 No. Not at all. Not in any way, shape or form.

How important or significant for you is this change.

32:04 Pretty much up there. [Interviewer: This is one of the biggies.] Yes. I am saying that and it is saying 'I'm still here.' [Interviewer: We are not going to rush you to be where you are not ready to be, but to keep an eye on both sides is important.]

32:33 It was a very dark cloud, that place. I need to be able to get out from under that before I can do anything else. But I didn't know how to get myself out of it. [Interviewer: So for that the therapy has been really instrumental.] Yes, because I literally didn't know how to get myself out of it, because it was all, I hated what was happening, I hated what was in my head. All I wanted to do was stop them. And that was the one thing I wanted to do was stop them. And actually what I have had to do is allow them.^e [Interviewer: Talk to them, I see. And for that you needed to be able to do that with somebody.] To be safe and to be guided as to how to do it as well.

Where is the cloud now?

33:30 It's hovering, it's kind of here (indicates above head and to the left).

A similar set of questions about - 'I don't hate myself as much', 'I don't think that I am a bad person', 'I am willing to accept that I am not to blame.' Now we have to qualify these with 'some of the time I ...' How surprising, or would you have thought that was going to happen?

24:55 No I wouldn't. Because I was so entrenched with it. I think I perhaps knew that I wasn't always to blame. I wasn't willing to accept it because that meant that, if I wasn't to blame, then other people might be. And that makes me a bad person. [Interviewer: So there's the trap.] Yes. I can't think that about, about other people because that makes me a bad person. [Interviewer: That's like a catch 22.] Yes.

Whether or not you find it surprising now that you find you can see it, it seems you are not always in that trap.

36:25 I am not necessarily surprised about the part that thinks I am not to blame. But I am maybe more surprised about the fact that I don't hate myself.

What about being a bad person?

36:59 Again. Probably not so surprising. It was the whole Tom and Jerry part of me that thought I was. [Interviewer: Sounds like it was not so much of huge surprise but maybe more of a relief.] Yes.

How likely do you think that the catch 22 trap and the self-hatred would have changed without the therapy?

^e The interviewer comments that "this seem to me to be an incredible 'finding' for the client."

38:11 No. It was all linked in. It wouldn't have. Even though I had an inkling that I wasn't necessarily such a bad person. I was so tied up in this whole self-loathing that, if I even allowed myself to think for a moment I wasn't such a bad person, I was a bad person for thinking that! [Interviewer: So this is an incredibly tight little loop.] Yes. I just couldn't find a way out of it at all. [Interviewer: Certainly the therapy has been instrumental, pivotal.] Yes.

How important is this change to you? The feeling beginning to be that this is possible.

39:14 I don't know, you'll probably have to interpret that but ... because it feels uncomfortable to say it is important, because that gives it a power that I don't want to give it. But it feels like the only way I was ever going to move forward. And if you want to say that's important, then, that's important. But if I turn round and say it, then it gives it too much weight.^f

So it is kind of 'significant', rather than 'important'?

39:48 Yes. [Interviewer: Because it makes other things possible.] It was just the only way I was going to be alive. I couldn't carry on for the rest of my life like it, that's for certain. It was the only way I was going to be able to move anywhere. Everything I thought was tied into the whole thing.

There was another thing about clarity and insight. The fugg interspersed with periods of clarity. And that also you can do something with the fugg, you can reach into it. A surprise?

41:22 Yes. I didn't know how it would be possible. Because I had been trying for years and years to get myself out of it. I consider myself a relatively intelligent person. It just didn't seem entirely possible. [Interviewer: It is gratifying in that case to realise it has been a bit possible.] Yes. Quite a relief actually.

In terms of clarity and insight, I get a real sense of how these things are linked into each other fairly inextricably. In which case this question does not make an enormous amount of sense. Whether this insight and clarity would have happened without the therapy.

42:41 No. Because again I was going round in so many tight circles that there was just no way out. [Interviewer: And that was generating

^f The interviewer notes that this was an echo of the original loop.

the fugg really.] Trying to find my way out was making thoughts, that was making me angry ...

How important, significant, valuable, precious whatever, is this thing about insight and clarity to you?

43:20 Yes that's pretty important.

So let's think about the therapy in a little bit more detail. What do you think might have contributed to these changes?

43:47 Listening to myself. [Interviewer: Listening to yourself, inside and outside of therapy, in both situations.] Mmm. Yes because I consider myself to be a pretty diligent person. So if I am going to do something, I'm not going to limit it. I have these thoughts all of the time. [Interviewer: Quite, not just turning up and doing it ...] for an hour a week was not enough. [Interviewer: So you would take it away and practice it.] When I felt safe to. Because sometimes it doesn't feel very safe to do so. I might not do it or I might do it and get scared. But I try to when I can.

And that's really made a difference?

44:52 Yes. Certainly early on it would be pretty much a case of just doing it in sessions. Because it was too scary, too hard, to even hear anything, let alone listen to it.

So what was happening in the sessions that made that possible then, the scary thing? What was it exactly that made it possible for you to do something that only later became possible to do outside the therapy?

45:33 Slowing things down. Giving me a safe environment to feel was, or hear whatever it was that was being said. And ... [Interviewer: So both things - to say and to hear.] Yes. Because I couldn't isolate anything enough to be able to hear it, let alone to listen to it. [Interviewer: So that sounds like a really important two things - one is safety and the other is this skill of slowing things down and beginning to isolate them.⁸] Breaking it down rather than trying to listen to the whole thing all at once.

Anything else, either inside or outside the therapy?

47:20 Not being criticised. I think that's what, when I say 'safe environment.' Knowing that there somebody else gets it ... can actually see me, rather than saying 'don't' ... Feeling that, the

⁸ i.e. 'reaching in' to the fugg.

security and the warmth that you feel in that environment. It just makes it a much safer place to explore what might be scary.
[Interviewer: An acceptant and non-judgemental attitude, non-critical.] Yes.

So if you were going to sum up about what has actually been helpful about the therapy? How would you do that?

48:47 Being given a safe and secure environment with someone who doesn't judge you or ... I don't know, someone who can just get it. And learning, to be taught skills about slowing it down and acceptance and listening. [Interviewer: Both the sides - talking and listening, that sort of dialogue, because you started taking that and doing it for yourself when you feel safe enough.] More about the listening than the talking. Because if I start talking I start arguing.

This is important, and we need to give this, again like we will give both sides of the change thing a right to be here too, and we have got to look also at the stuff to see what's problematic. What kind of things about this therapy have been unhelpful to you, or disappointing or negative or problematic in some way?

50:30 Other people's expectations of me. [Interviewer: Other people including your therapist?] No. [Interviewer: So that's like feeling under pressure?] I have to behave in a certain way.

Is there something unhelpful about the therapy, that because you are in therapy other people expect you to be some particular way.

51:23 Yes. Trying to constantly meet up to everybody else's expectations or my expectations. Then ... I don't know ... it's a bit of a difficult one really. [Interviewer: That sounds like a mixture of an external and an internal pressure. So that you might put yourself under pressure as well, because you are in therapy.] Yes.

Have there been any things in the course of your therapy (all of it) that have been particularly painful or difficult, but might even so have been helpful?

52:22 Learning to accept things. Listening to it and hearing it is easy enough, it is doable. Actually taking heed of it and accepting it, and not arguing it back. That actually feels [Interviewer: Challenging.] Yes, not arguing it to the hilt which is what I have always done.

Has anything been missing? Have you ever thought, if only this was happening or what I need is something that isn't happening in your therapy? What's been missing there?

53:34 I don't know. More time maybe. [Interviewer: More than once a week?] We have done from time to time. You live with yourself 24/7 and one hour ... you know. It has been nice when we have had more time.

Do you have any suggestions to make regarding therapy?

54:33 No

We have just got one more piece to do and that has got to do with those things that are on your own Personal Questionnaires that you do all the time. This is the blank showing the things that you wanted to work at in therapy - self harm, inappropriate alcohol use, depression, inner critic [Client: that would be Tom and Jerry.] **We have talked about the Tom and Jerry thing changing. I want to track back to what you said that somebody looking at you externally things don't necessarily look that different so that someone watching you wouldn't necessarily know that these important things had changed. Is your therapy actually achieving changes that are important to you with these identified issues?**

55:50 Yes. You've got to start somewhere. A big part is not arguing with myself. [Interviewer: That is an underlying internal dynamic isn't it.] It is almost like, years and years and years I haven't been able to have, the 'f' word. So learning how to recognise them again and deal with them. Much like a child. [Interviewer: Like a new language, a new skill.] My feel is it is going to come in time. [Interviewer: Rather than all at once.] Yes.

So these others, obviously the mood, the depression index here, that's going to be tied in with that. Also tied in with the behaviours - there are two behaviour ones here - self harm and inappropriate alcohol use. Which I guess kind of sit on top of the internal state of affairs. Are they changing much, those external manifestations?

57:26 The actual act of, less so, but the understanding behind it is definitely.

So let me see if I've understood what you are saying there.

57:39 I'm still harming. [Interviewer: You're still harming. Maybe about the same.] Mmm. [Interviewer: So your self-harm is pretty much consistent.] Mmm. [Interviewer: And your drinking is consistent?] It has ups and downs. It feels different.

Oh it feels different. I notice that you've got two dimensions here for alcohol, so there's obviously two feelings that you have about it.

58:16 It would always be to drown everything out. And now it is not necessarily all the time needing to. [Interviewer: So you are discriminating.] I can understand maybe why I might, if I have a bad spell when I am drinking more, probably because there are things happening that are making me notice those uncomfortable things. Rather than everything just being horrible. I can reason to see [Interviewer: See what was going on.] Rather than it being just a default setting. [Interviewer: That seems like a change in itself.] Yes. [Interviewer: That your behaviour may be the same but your relationship with it and understanding of it has changed.] Yes. Sometimes I just fall back on it, because it is the easiest way. [Interviewer: Like you said at the beginning - the default, easy.] At other times I can understand it is not necessary.

When we started and I was talking about change and what you would like to change, this was the only thing that you mentioned at the time - 'actually I'd like to drink less.' Why?

59:40 Because I think I rely on it too much to cover up things that are uncomfortable. Because it is not healthy, it is expensive blah, blah, blah. [Interviewer: So there are a number of problems to using alcohol in the way that you use it.] And I don't like who I am then.^h

And just to dip back into that first question - what's still on the change agenda. That was the one you brought up, I'd like to drink less. Is there anything else that you would like.

60:20 It's difficult. Everybody else wants me to harm less. [Interviewer: Ok, it's not big on your priority list. Ok. You don't have to put it on there.] Society expects you to not go round doing some things. Society sees that you do these things and thinks that you must be a certain way. To me it offers too much for me to be without it. Other people just see it as a weakness. 'Oh she must be ... you know, struggling with things. She obviously can't cope if she is doing that.'

What's your understanding of it?

61:28 At the moment that it provides me with a way of caring for myself. But other people see it as a way of destroying myself. Which in hindsight I might have thought in the past but now I understand it differently.

^h The interviewer comments "In terms of her ongoing change agenda ... this is pretty significant."

That actually also feels like a change. That your relationship with the harming has got an insight associated with it, which is that it is a way that you care for yourself. Rather than being a symptom of not coping, it is a particular way of coping.

62:13 It's not necessarily a constructive way. [Interviewer: We're not going to make a judgement about it, we're just going to notice what it is. And that is an insight.] Yes.

We have talked a little about alcohol and the change relating to insight and discriminating in between the way that you drink. The inner critic has got a lot of change associated with it, though it doesn't necessarily show on the outside particularly, you know about it. Your mood, what is that like?

62:50 It's better. I'm not as angry. I don't think I show it as much. [Interviewer: This is a depression marker here so mood in terms of up or down.] It's not stable at all. I go through stages when I might have a particularly depressive state. And there are other times when I am not. There is medication associated with that as well that changes and goes up and down. [Interviewer: Of course and lots of things will affect your mood.] That is one thing that is very up and down. I will say one thing in general, it's better [Interviewer: Than a year ago.] Yes. [Interviewer: That feel true?] Again I have ups and downs. I wouldn't like to say. I'm not angry. That I would say. That's a very different state to being depressed. It's so up and down that I couldn't say.

And we have learned something about how your relationship with the self harm has shifted with this insight.

64:17 Yes. Very much so.

The Interviewer concludes the session, thanking the client and asking for some feedback on being questioned in this way.

Overall how was that for you?

64:51 Alright. It's been interesting. Even before coming in, being able to think to myself - what's changed - and knowing that is what I was going to be asked about. Actually yes - insightful.

Interviewer's comments.

My impression, from this interview with F26, was of that although she was clearly able (and wanting) to reflect on various aspects and contributory factors of change

– she also needed to make clear from the outset that naming those changes would not invalidate the inevitability of her ongoing process, including cycling back into difficult states. This in itself seemed to me to be an important insight that she made really early on, that she now knows herself well enough to be able to discern her ongoing occasional need for the 'problematic' behaviours. By the end of the interview she goes further and is able to articulate how she can see that her relationship with the behaviours has changed even if the behaviours themselves remain in place for the time being.

It seemed to me that it was a combination of the relational qualities of the therapy combined with certain skills – that she called 'slowing it down', 'reaching in' (to the fugg) and 'speaking and listening' – which she felt had contributed most to the changes identified.

One of the things that struck me whilst conducting this interview was to notice that on perhaps three separate occasions F26 'reminded me' of her therapist. The effect was sufficiently strong for me to ponder what it was that had seemed so familiar - and it each time it was to do with facial expressions, particularly one of pensiveness and another of an inwardly directed concentrated attention. This seemed to be an interesting physical manifestation of the relational qualities being described by F26 regarding her therapy.

APPENDIX 8 - CHANGE INTERVIEW - M35

What has the therapy been like so far as a whole? What has it felt like to be in therapy?

01:32 The first word that springs to mind is 'educational.' I first came here in <month> and at the time I was 'lost' (not quite the right word but it will do for now and things weren't getting any better. Things were getting worse on several levels, it was just alcohol there was nothing else. [Interviewer: You mean substance-wise.] Yes, and I was managing to function in my job and everything else, sort of, probably more by luck than judgement. And it has been a slow process in the sense that we are now in <month 10 months away from the start> and a couple of big wins, but I think going through it, I learned more about myself. I learned more about the reason why I was doing what I was doing. I learned different tools to try and deal, on several levels.

That's what I am hearing, yes. When you say the word 'educational', there are various dimensions to that, in terms of the learning you are describing, some of it skill-based. But overall?

03:33 Overall there are parallels with, in terms of my personal life I probably feel calmer now than I have done for a couple of years. Going through a relatively painful breakup. [Interviewer: Back in <starting month> or in the meantime?] Oh since <year, two years ago> up until probably 6 weeks ago when things started getting ... And there was a lot of to-ing and fro-ing and a lot of confusion. Yes, coming out of the other end of that now. This is now day 11 without a drink at all [Interviewer: Wow!] which is very good. I think the low point probably came in <mentions third and fourth months of therapy> where it started to get better, but then it got worse for some reason. I remember laying on the sofa at home, watching the king's speech on DVD. It was chucking it down with rain, it was a Wednesday afternoon. I had the hangover from hell and I had broke a glass the night before and I found a little bit of glass on the floor and pricked my finger, which wouldn't stop bleeding. I just lay there and cried.

So when you it got worse at that point, that sounds like on a feelings level it sounds like a real low, but was your drinking bad? Is that what you mean, that your drinking got worse, or just the whole situation and your feeling about the situation?

05:18 The whole situation, and even when I have felt good I still managed to drink three bottles of wine a day.

Ok, so your drinking has been reasonably consistent or has it changed much?

05:34 ... When I was drinking less, earlier it was due to circumstance because my partner didn't want me to drink. So when I wasn't with my partner I would make up for lost time. [Interviewer: So it was artificial external constraints on it.] Absolutely, completely manipulated. Which is why now it's really, really good because I have done it by myself for the last 10 days, whatever it is now. I've got home and I've been at home by myself and I've woken up by myself. ... I'm starting to look like a cup of green tea! [Interviewer: Fantastic! That's a really good detox programme.] It is. I said to a friend of mine that knows about what's been going on, I said 'it's really good because I had a really hard day at work <refers to some work content> and I thought I really, really want to get home and have a cup of tea.' Whereas before I would have wanted to go to the pub and have a pint of Guinness.

Amazing thing to notice, and that it was true.

06:52 Yes it is true. And I've been banging on to <therapist> for the last three or four sessions about wanting to be 'wholesome.' It seems an apt word to use. I now want to go home and look after myself and care for myself. I want to eat good food. I was rather shocked to see that I was 12 stones 12 poundsⁱ and I should be tipping just on the 12 stones^j really, which also helped a few weeks ago. There is a real ... be alone, just look after myself, be calm ...

That sounds lovely. The next question is about how you feel in general. I am going to ask it even though I am getting a real feel for how you are doing in general, even quite latterly. It feels like there is something very different happening now. What is all of this feeling like?

08:06 It feels great, to be honest it feels wonderful. I really wanted to have a glass of wine on Sunday because I was cooking. I said right from the start that I don't want to be tee total. I really enjoy wine. I just want to enjoy wine rather than wine enjoying me. And I don't want to drink ... I've got a 10k run on Sunday and if I drink now that's not going to help. And I know that the guys that are doing it will be going for a couple of pints afterwards and I don't know, I think I will probably go for the drink but just have <non-alcoholic

ⁱ 180 pounds, 81.6 kg

^j 168 pounds, 76.2 kg

larger> or something non-alcoholic, and just progress it for a bit longer. I am going to the theatre on Wednesday night and I think, if I am going to the theatre will I want a drink, a Gin & Tonic or whatever. And it is not worth breaking what will be nearly three weeks by then. So it would be nice just to ... I like wine, it was almost a hobby at one point, but it became sort of a release.

And it sounds like at the moment you're actually really liking being sober and feeling the rising wellbeing, wholesome feeling that that gives you, and not making it into a 'should', you're holding it quite lightly at the moment which sounds like an unpressured way of being. If I want to I will if I don't want to I won't.

09:57 I've got a wedding to go to on Saturday <names a distant location> and the run on the Sunday. [Client describes the down side of driving early the following morning after a bottle of wine.] I really am keen on ... We were talking on <last counselling session> and I said I would really like to do two months and I thought, actually that's putting pressure on where pressure is not needed.

I'm hearing that you're being quite careful about not pressurising yourself which feels like a nice bit of self-care. So how would you describe yourself?

11:16 I would describe myself as [pause] both selfish and not selfish. I am not selfish in the sense that I would quite happily do anything for my friends, and I am happy to drive a long way to take photographs of a wedding and drive back the next day. But I am also quite ... I probably should come with a health warning when it comes to relationships. I have lived alone the vast majority of the last 15 years. I very much like my own company and like the fact of being able to go home and shut the door and not have to answer to anybody or talk to anybody. I am probably being unfair to my previous partner but part of the problem with the drinking probably stemmed from the fact that I wasn't (I use the term loosely) 'allowed' to drink when I wanted to drink. I could have done but it wasn't worth the aggravation. So therefore I started drinking earlier in the day so it wasn't smelling on my breath. (Because I'm also stubborn at some points if someone is telling me what to do.) I work hard. I like to think I am successful at what I do. I like to think my customers think I am great, because they keep coming back. Which is nice because I'm not particularly good at getting new ones but I am good at keeping the ones I've got. [Interviewer: That says a lot in itself doesn't it.] Yes, I like to think so, I like to think I'm giving a great service, price and a really good product.

13:22 My friends ... well my best friend last night sent me a text <after and evening out at a music event> saying you're like the brother I never had. I don't have many close friends, I perhaps have six close friends that I would quite happily sit down and say, I've got a problem with. Whist people know that I come to the <name of charity where counselling takes place>, when I did my 10k run during the summer that's where my sponsorship went. The amount of people that sent me emails and text messages saying 'that's a great cause.' To the inner circle of friends I am very close. In fact my washing machine has blown up and four people have sent me text messages saying 'having you got your washing done for the wedding? Bring it round here and I will do it.'

So this is not sounding like someone who is not sociable, even though you like your own space.

14:51 No, it's not that I'm not sociable. I'm not the life and soul of the party ... I don't perform. I'd much rather have somebody round for dinner than stand in the pub with half a dozen mates and struggle to hear and struggle to be heard.

That's a bit of a 360 view, a sense of yourself and of other people's sense of you. And the more empirical evidence of your client base that are very loyal to you and clearly value your role for them. Also your friendships which feel very solid and well taken care of. If there is something that you could change about yourself what would it be?

16:14 This is going to sound very ... ('conceited' is probably not the right word) but I don't know that there is anything that I would change about myself. Would I make myself 20 years younger? Actually no I probably wouldn't. I don't know, I don't think there's ... At the end of the day you pretty much to whatever you want to do. I've had a problem, but I've done something about it (well actually <therapist> has done something about it). And I will be eternally grateful to the <charity providing counselling> for helping me. But at the end of the day I think that ... You know at the moment I've got two houses at the moment and I've got to sell one of them. Well actually I am about to get rid of the one I own with my previous partner. And I was thinking that there will be a chunk of money coming back (not as much as I paid). And I was thinking that what do I want to do? I live in a flat, a converted ground floor of an old house. Do I want to buy upstairs or would I want to buy a camper van? I think that there are two distinctly different things. I think that inside of me there is this ... ('imp' is the wrong word) sort of artist. I think if I can change myself, I think, I'll tell you what it would be, less of a businessman and more of an artist. It think that I know who I am in

the sense of, I like those photographs^k as well or else I wouldn't have brought them in. There is a bit of to-ing and fro-ing in the sense of ... [describes the detail of his business and its success, but the time demands that have been put upon him personally as a consequence.] I've taken the step to say that's been great but it's not important. I've dedicated my 30's to it and I'm not dedicating my 40's to it as well. [Further comments about the future of the business.]

Again it seems a little bit like, sort of up there with the green tea really, looking after all the different aspects of yourself.

20:46 [Describes buying an 'Indiana Jones' style of hat at his first music festival in the summer.]

Taking care of a different part of you. So in a sense we are talking all the time about change really. There is a question here about what changes have you noticed in yourself since therapy started. You have already been sort of talking about them. Maybe it would be helpful to identify them from what you have been saying. If I was to pose that question to you - how would you sum that up, about what has changed since you started therapy?

22:11 Two things I think. One is not external because it is involved. My relationship, we tried, backwards and forward and backwards and forward. When I started here it was on the back of me not going to <another county> for Christmas. <My previous partner> went down earlier. I was going down on Christmas Eve. I drank three bottles of wine and ... She came back from there on Boxing Day, lots of tears, lots of crying, and I would sit where you are and I would say 'I don't know I can't work it out, she's tall she's beautiful, she's gorgeous, she's intelligent, she's funny, she's arty.' And it was like you've got this idea of what you want, but it's not what you want, what you want to do is to be by yourself, like it or not. Whether that's <previous partner's> fault, or your fault, it's what you want to do. You want to be selfish, you want to be what you want to be, you want to drink when you want to drink. And it was very difficult. I've never had a difficulty before about leaving girlfriends, I've done it heaps of times. I don't know exactly what it was but I think there was a real ... She kept fighting to keep it all together and I think that ... And I don't know, I would ...

How old was the relationship in total, how long had you been together?

24:01 Oh it was <year, four years ago>. Not that long.

^k Referring to the selection of black and white photographs on the counselling room wall.

And it had been problematic since <year, two years ago>. [Client: Yes.¹] And you came to the <counselling charity> early <year, one year ago>. So that was when you started working on yourself but the relationship didn't start getting better till quite recently.

24:24 No, I would say probably about six weeks ago that I actually felt safe in my own house.

And did you end the relationship? [Client: Yes.] Gosh that's a pretty big change of circumstance that's happened.

24:43 Well, yes. I would say that before I came here, I went to <another, non-drug-related counselling agency in the town> for four of five months. [Interviewer: And getting counselling there, Ok, that's important.] I'm not sure what I was actually getting counselling for at the time. It was not specifically alcohol, not specifically the relationship, it was a whole combination of things. <Previous partner> round then went to <relationship counselling service> for maybe half a dozen, seven or eight times. That didn't really work out. Also during the year I tried hypnotherapy.

So you were really looking for something that was going to help.

25:48 Yes ... As well as wanting to go and shut the door and listen to chanting monks, I want to go and meditate at the Buddhist Centre and try and find more inner peace. Although I think I'm doing Ok on green tea at the moment. And also I want to become a magistrate. In terms of trying maybe to put a bit back. I think both of those have a tie in with this need to be 'wholesome.'

Is that a new thing? Or is it something that you know about from before?

26:30 I would say it's been four or five weeks since I coined the term but the feeling is probably been from <five/six months ago> time.^m It's been a definite, although there have been peaks of, 'my this is good!' You know peaks and then a trough when you come down a bit. I've sat where you are and said, "I feel really bad about coming." Some Monday mornings I've been driving in and thinking, 'how am I going to put a good spin on this?' Because I feel guilty about coming in and seeing <therapist> and saying, "Yes, I haven't really done very well over the past week." What I want to do, and

¹ Note: This is perhaps factually incorrect. The client began work with the therapist early in the current year, i.e. about 10 months ago.

^m This is perhaps a little misleading. The first time the term was coined during therapy was probably session 29 (two weeks before the interview) and the first time the sense of it was evident may have been session 24 (three months ago).

it's the same with my clients, I want to tell them something new and tell them something good. I don't like the fact that I can't come in and see <therapist> and say, "one alcohol free day or two alcohol free days." Which is why I sent a text on Tuesday "PB - Personal Best." Tuesday was longer than I have been sober probably since I was 14.

It sounds like there is a real alliance there, I mean in some ways not exactly the same as you have with your clients, although you have drawn the parallel, of wanting to ('deliver' isn't the word I am looking for actually), to engage so that there is a sense of something happening. What are you doing it for, him?

28:39 I'm doing it for me, but I think it's a team. It's not like a teacher, it's not like a manager at the football club. I don't know what financial arrangements there are. I don't know if <therapist> gets paid or anything about that side. The only thing I know is the somebody that sits there and whether, obviously he's doing his PhD and whatever else, but I can see an emotion that wants to see me get better. Because it's very personal, and there are times when I have sat there and cried and there are times when he has sat here and got upset. And I he is certainly listening to me and I have said to him on several occasions, "I feel as though I should grow a pair." There is the frustration, I want to do well I want him to be pleased so that he knows it's worthwhile talking to people like me.

So that feels a really important reflection on various qualities of this relationship. We are looking at the qualities of the therapy which contribute to change. I just want to track back for a second to the thing that I have written down here that, in your period of time have changed. (I want to hold that thought about the qualities of therapy because I'm trying to stitch the two things together.) The things that have changed - a very concrete thing is that your relationship ended six weeks ago, which had been problematic, ongoingly. In a sense your drinking wasn't because of your relationship but it certainly wasn't getting any better in the context of that relationship. And there was something else you said, that six weeks ago you felt safe in your own home. So that sounded important change, this feeling of being safe at home. And something else that felt like an emergent change was from <five/six months ago> time, this sense of wanting the thing that is getting called 'wholesomeness' in your life.

31:42 I think also just, maybe a bit of glue for those things, it's that it was almost like <previous partner> would just ask the same questions eight times till she got an answer that she wanted. We would spend so long on the phone, I think the last weekend we did this we spent six hours on the phone on Saturday. Actually after two hours I just said I needed to have a half hour break, put the phone down and went to <supermarket> bought two bottles of wine, back into

the kitchen again. The day after she came round, knocked on the door, was there for six hours. And I was living under the threat of that, if we had argued on the phone she said she would come around. And I would say that I was not going to be there. The only time that I would be over the limit and driving my car would be to sort of [Interviewer: Escape.] Yes.

Pretty invasive. So that was what you were meaning when you were saying about being safe. That this had started happening since you ended the relationship. That's not going to happen anymore.

33:09 Shouldn't happen anymore. We spoke yesterday and she said, "you sound very calm." I said well I am on day nine without any alcohol. I probably shouldn't have said that. But I am calm when she is not there. Let's say six weeks ago, then there was this period of tranquillity - busy month work-wise, then <last month but one> was great, going away with friends and having a good time. <Last month but one> was going away by myself which I like doing anyway (although I was away with friends), that was a break.

A break in this story of your relationship. I'm not looking to attribute your drinking particularly, but it does seem to be linked to this sense of being safe and able to be a bit more self-directive in every way really. That feels like an important change. Is there anything else, if you think about those changes? The relationship is external to therapy, and that's important, is there anything else that we have missed there in terms of change? You drinking has changed, the drinking pattern and amount has changed?

35:16 Certainly for the last ten days. I think so. There is (this is going to sound like a cop-out) ... It did change, in the early part of the year I could drink a bottle of wine before going to the gym in the morning. Which was just stupid. I would wake up at 4 o'clock in the morning, convince myself it was still evening and rather than morning and [Interviewer: Finish the bottle or start the bottle.] Yes. Although maybe the quantity didn't go down an awful lot, there was more of an element of control.

Ok so the way you were drinking, or the level of consciousness, the consciousness of your drinking changed.

36:25 And there was also a realisation. I've got (and this goes back to this feeling of safety again) my kitchen. You can stand in my kitchen and if you look through the dining room you can see the car park. So you can see whoever drives up in the car park. And I have actually worn the varnish where I have stood in one place [Interviewer: On watch.] Exactly, sentry duty. And I will be leaning

up against the worktop, actually I did it over there for <therapist> one day. And I can stand there leaning up against the worktop, like this, glass of wine balanced on my arm, listening to <sports radio programme> whatever. On the weekend I will go and buy the <newspaper>, take it back, same place, glass of wine. And it was ... I said last week, I love my home, I am using all of it now, I'm actually using the living room.

That's a beautiful change, I love that change. You're actually occupying your house!

37:37 Yes all of it. Not just standing there waiting for somebody to turn up ...

Yes, not on sentry duty. There's a wonderful sort of physical manifestation of a psychological freedom.

37:51 Yes and the thing is, it's a really nice feeling, walking around the place with a cup of green tea.

Really nice! I love that change it's fantastic. Ok this is a really odd set of questions about the changes we've identified. Whether you would have expected those things to have changed from therapy, or whether they come as a surprise to you? So if we started with your sense of therapy and what it could and couldn't do and would and wouldn't do. Was the change in status of your relationship a surprise to you?

38:34 No, I think it was probably inevitable.

Did the therapy help?

38:48 Yes the therapy helped. In terms of the education and the way that ... It helped in the sense that I really couldn't see the wood for the trees. And I think that ... I say it was inevitable ... I go back to the phrase that really used to annoy <therapist> about 'if I can't do it with her I can't do it with anybody.' You know, 'woe is me' and I thought that reaching 46 I had found this person that I was going to spend the rest of my life with. I think probably that I had tricked myself, and sort of thought it was going to be easier than it was, and I didn't really see some huge clues along the way. [Interviewer: But you tried quite hard to make it work.] I did, and then I thought, well actually I don't want it, and I sort of want to be alone. And I think that I couldn't see that at the start of the year and I was sort of stumbling back and forth and back and forth. And getting annoyed with myself and getting annoyed with <previous partner>, and getting annoyed with everything.

So that was something that was actually, over time, supported by the teamwork that you described.

40:24 Yes, I can say.

So that makes sense. Again this is the dimension of whether you would have or did expect this change to have happened in therapy. Did you expect therapy to affect your drinking in the way that it had. First of all with your level of consciousness and control and sort of like your relationship with drink and actually your behaviour itself?

40:57 Yes. I guess at the end of the day you don't really know what you want to happen, but you want something good to happen. I said at the start that I'd like to be in control of it, I wouldn't have thought of being tee total for the rest of my life.

Sounds like choice is really important to you.

41:11 Yes. And I would have like to have, when I was out last night, to have had a couple of pints of Guinness, but I wasn't going to because I thought it was important to get a big win under my belt.

So you are working on that at the moment. Now there's a couple of more subtle dimensions of change here. One of which is this lovely sense of occupying your house, of not being on sentry duty. And the other one, which is related to that, is the sense of being safe in your house. Are those surprises or would you have ... ?

42:03 No they aren't surprises. Because I didn't realise. [Interviewer: You hadn't identified them as particularly ...] No, not really. I had used my flat as a cave, if you like. I didn't really think too much further about it than that.

And how likely, I mean the relationship one you say was almost inevitable, there were aspects of it that seem looking back to be inevitable that would have changed. How likely do you think that these things would have changed had you not been in therapy?

42:45 I don't think it would have. I'm not sure I can say that because I don't know. Yes, I think that a better way to answer that is that it helped me understand and it helped me see. And also not just that, there were ... it's like, we were talking about the strategies, and one strategy that <therapist> came up with was, to buy a week's worth of wine at the same time. That was a really crap idea, [laughs] all gone by Tuesday, then it was OK buy just one bottle at a time. There were tools and strategies, practical things ... If you wake up at 4 o'clock in the morning and you have no wine or gin,

you are not going to drink. Then you are going to the gym, so you are getting to 9 o'clock without drinking.

That's a really pragmatic, engaged, collaborative approach. That's what I'm picking up from this teamwork idea. There's something hands-on and practical about that.

44:23 Yes, that's it. There's distinctively two sides to it - there is that very pragmatic, this makes sense, do it. Then there's the, 'well how do you feel about this', 'how does that make you feel', the other side. Definitely both levels, if you like.

Ok and if we are thinking about the qualities of the therapy that may have contributed to the changes. These are they, aren't they, the pragmatic sort of common sense engagement and that sort of softer holding aspect.

45:13 Yes and I like the idea of homework. And the first week's homework was where are you now (write this down and write that down). And I was scribbling down pages and pages. That was making sense because all of a sudden I was writing it down, I had to think about it rather than just ... Not feel sorry for myself, but rather than the angst, thinking about relationships. I was writing things down - I could see it and think, yes that's stupid or whatever.

Yes, you could reflect upon it yourself.

45:59 That was first or second week or whatever, and from there it wasn't half and half. For a month we might have talked about doing positive things, the next couple of weeks we might, there was one week I can remember saying, I just want to ban the <initial letter of previous partner's name> word. I don't want to talk about <previous partner> this week. I just don't feel it is doing any good. And there was a couple of weeks of just ignoring that element of it, well let's just try and stop you drinking two bottles of wine a day because it's not doing you any good.

So that sounds like it's been a very flexible arrangement where you have been able to decide where the priority is to a certain extent. Maybe you've both taken turns in that?

46:59 I think I probably would have led it in the sense of ... I have come in and said it's been a good week or a bad week or whatever. Then <therapist> would sit there and say, ok shut up and let me take this in, then take it from there.

You've given some examples of what you think has been helpful about therapy - the tasking, the engaging and the holding aspects of it. Has there been anything

about it that has been unhelpful or disappointing or blocking for you? It is ok to say. Frustrating or whatever?

47:53 I suppose it has been frustrating in the sense that ... But it's been a frustration with myself - I've been driving in some Monday mornings wondering how I am going to put a good spin on this? What can I say that is positive? And then I feel guilty. As I say, <therapist> said to me in the lead up to this, 'just say it as it is.' [Interviewer: You don't have to gloss it.] And I can't think of anything else that, sort of, happened. What I would say is that I stopped hypnotherapy because I thought, I was going on about this dream team. I don't know how therapy works to a degree, but it works in making whatever I was feeling a bit more full on. So if I was feeling good, it was good. If I was feeling bad it would go the other way. And I thought, I am just going to park that for the time being. When I did park it, that was when the 'wholesome' thing started to warm and come out. And I think that ... go back to the <previously mentioned other, non-drug-related counselling agency in the town>, every time I would leave the <agency> it would be 'be kind to yourself.' And I would be kind to myself by buying a bottle of wine along the way home and drink it.

49:51 But with this, I suppose I was frustrated probably ... The <first 10k> run was in early <month, four months ago> and in the week before the run I didn't have wine or any alcohol and then I finished the run and just started to go crazy. I went crazy for the next three days as well. Which is why I am very conscious about after this run on Sunday, take myself home and have some more green tea. I think probably after that I wanted to build on it, and that's what I mean by saying there is a peak and it goes right down. Just by the nature of the beast you want to just sort of, you're there and you want to go on to the next stage.

So it sounds like there still are things on your change agenda. I mean not necessarily, that earlier question was kind of about yourself. And I thought it was great that you ... you seemed to me two things. That you were currently on much better terms with yourself, actually being very much kinder to yourself, in very practical and tangible ways than previously. But that there is still this sense of wanting more change, wanting some more, not necessarily from your therapy but in general. What do you want more of?

51:27 Physically, I got a mate round after going for a run yesterday to measure up to get the blinds done for the windows. I bought new bedroom furniture. <Previous partner> went absolutely crazy. The idea that I wanted bedroom furniture meant that I was moving back to <house owned with previous partner> and everything else. So

I've been hanging on and hanging on. I want to get the blinds sorted out. I want to paint the living room. I want to get new furniture. I want to get more of those hanging on the wall.ⁿ I've just bought myself a new camera, and it's still sitting in the box. I want to embrace that. I want to ... My home is so much my home, I could walk round it with my eyes closed and still finish up with the kettle. And it is almost like 'nest-building' is the word that was used ...

Yes, they are expressions of you. This is what I am hearing.

52:46 It was so exciting yesterday, I've got French doors going out onto the patio and it has got some lead lights above it, the original colour glass. And the friend that came round and measured up for all of the blinds, talked about shutters on the outside. And I got so excited about shutters on the outside of the door. And that is worth a dozen bottles of red wine.

Oh, my goodness, absolutely. Something about that delicious playfulness actually, a playfulness and creativity that sounds like you can't get enough of it.

53:25 It is because, I have a, I really struggled to work in this team with <previous partner> on the house that we bought together. I really struggled for a long periods of time with my business partner and my business partner and <previous partner> are two of the most opposite people you might ever meet. And I know the common denominator is me, so I know it is something in here that stops me working as a team. But I really struggled because I could see so many things that I wanted to do with the <house purchased with previous partner>. And putting a new kitchen in was really painful because it was, 'why can't we decide what knobs to put on the door?' And it shouldn't have been that difficult but I knew exactly what I wanted to do and I know exactly what I want to do at <own flat>. And having that freedom to go off and do it is empowering.

It looks really energising. When you talk about it your energy really changes. That feels really important. So just bringing the focus back to the treatment of the therapy, has there been anything that you felt has been missing?

54:43 It's really hard to say. [Interviewer: You don't know what it is you haven't had.] Yes. Decent coffee.

Decent coffee! Fair point.

ⁿ Indicates some of his photographs on the counselling room wall.

54:52 It's funny actually because you ... Perhaps it's a sign that I have been coming here too long. But I turn up on a Monday morning and the ladies downstairs are all lovely and wonderful and I sit there and have a chat. Invariably I will be five minutes early and <therapist> will be five minutes late, running around whatever, and I will be down there talking. The whole thing feels really nice and it was really, I know I am going off at a tangent really but, it was really good for me to actually put something back [Interviewer: Doing the run.] Through the run.

It actually feels quite important, your engagement, with the whole of it.

55:40 It was it was important. You know, I really don't know what was missing. There wasn't anything that I got, from anywhere else that I didn't get from here. I guess the relationship, maybe if it wasn't <therapist> maybe I wouldn't have hit it off with somebody else, as well as.

Just think about it for a minute. Is there anything particular about the qualities of the relationship that you have with <therapist> that have ... ? You have touched on a number of other therapeutic contexts [refers to them]. There is something about this that has been particularly effective. Can you describe it, or what it was particularly for you in this case?

56:39 I don't know whether it's that the therapy was specifically relating to the alcohol. I think ...

Not to compare it with those, just what the qualities of this particular style of therapy and this particular relationship you have with <therapist>?

56:56 Well the style of the therapy was very similar I guess to <previously mentioned other, non-drug-related counselling agency in the town>, and going back to the <the other agency> there were times when I opened up and got very upset. It wasn't the same sort of journey in the sense that ... No it didn't last as long and it certainly didn't deliver what I am feeling specifically over the last week or whatever. If anything, did I say that around <month, seven months ago> was a real low point. You go into it and there is a, in this case there was a bit of dive. I think maybe there was a bit of a dive with the <other agency> as well but I just didn't come out of the other side of it. Because I started to go to relate or something instead.

Perhaps it may be just a pattern. That you stuck with it a bit longer this time. So there is nothing particular that comes to mind about this therapeutic approach or alliance.

58:21 It is personal because otherwise I, well maybe it's not personal. I think there's a bit of a person thing in wanting, you touched on it before, I want to do this for myself, but there is also a bit of me that thinks, I want to do it for, wherever it is as well, in terms of saying thank you, a payback. In the same way as the run. Yes maybe one of the reasons is that at the <other agency> I paid. Hypnotherapy I paid £15 every time I went. Relate I paid. Maybe if you pay for a service you don't respect it in quite the same way as if you get it for free.

Well that's an interesting idea. Sometimes it gets formulated the other way around but, there is something about that that feels ... Because you are giving, it feels like you really do give in the sense of doing the run and in engaging. There must feel like there is a nice reciprocity here.

59:36 I have said to <therapist>, after this is all over, whenever 'all over' is. And I don't know what it would be, maybe it's that I am signed up for the London run again and I will do it for them again. But if there is anything that I can do, maybe like the magistrates, having a bit of spare time.

So this extends beyond the context of the <counselling charity>. This is how you operate. Something about reciprocity that is actually quite important.

60:08 Yes but specifically for the <counselling charity> in the sense that, 'you've helped me, what can I do?'

Right well I think I've just about got through this questionnaire, not really a questionnaire. It's really looking at change, and the dimensions of change and a little bit into the qualities that have contributed to the changes that you have identified. And we have written a few of them down here. How important do these changes feel to you? How significant are they?

60:46 Huge, massive. To be honest there isn't anything that is more important. At some point I would have lost my license, probably lost my job. Last year I was driving round at 4 o'clock in the morning putting up posters for a drink driving campaign. I have breathalyzers at home and if I blow into it and it looks bad I go and clean my teeth and try again. That's extreme. You read about guys that used to be director of whatever, fell off, because an alcoholic and ended up selling the big issue. And you think, there but for the grace of God ...

Absolutely. Well we got there. I think you have touched on some really important, both particulars and generalities. So I am really grateful. That's great. Thank you for taking the time and giving back to the organisation, to

<therapist's> research. If something else occurs to you between now and the next time you meet up, you can always add it in and tell him. Otherwise we can leave it there. Thank you very much.

Interviewer's comments.

M35 presented as really happy to engage with me on the subject of his experience of therapy. He was quick to report his success in being 12 days abstinent from alcohol - something he described as a definite 'Personal Best.' His quick response to the first general question regarding what therapy has been like for him was that it has been 'educational' and his subsequent responses did seem to be quite cerebral in nature - so that examples were given to illustrate the details of the points he wanted to make about various aspects of his life and experience of therapy. It was clear that several important changes had taken place during the course of the therapy, not least his newly acquired personal best for abstinence - which seemed to be significantly related to some other important aspects of self-care.

My impression was of him trying very hard to give me what he thought was being asked for, although at times his responses, though entirely cogent, seemed to go wide of the question in such a way as to lose contact with the essence of it - at least as far as his own direct feeling referents were concerned.

I experienced my own body acquire a certain tension during the interview, possibly because of some anxiety that began to grow regarding the constraints of time given his propensity for longish answers, but I suspect that partly my felt-sense of tension was a mirroring of his own. Therefore for me a particularly significant reported 'change' was the experience he described of 'feeling safe in his house' about which he gave some interesting details including noticing that he does not now stand on 'sentry duty' at the kitchen window and can move more freely about the whole house, greatly enjoying his occupation of all of it in a much more relaxed way. It occurred to me that this is a lovely metaphor, or even a corollary for the - rather new - possibility of living more comfortably or responsively in his body. His evident enjoyment of new creative projects planned and underway in terms of his house had a similar feel to them.

APPENDIX 9 – BIBLIOGRAPHY

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APPENDIX 10 – REFERENCES TO CLIENT SESSIONS

¹ F26/T/8/02/12

² F26/9/01:50

³ F26/12/43:55

⁴ F26/8/15:55

⁵ F26/18a

⁶ F26/Cl/11:43

⁷ F26/Cl/11:39

⁸ F26/Cl/14:03

⁹ F26/Cl/16:55

¹⁰ F26/Cl/39:48

¹¹ M35/09/30:38

¹² M35/Cl/01:32

¹³ M35/Cl/60:46

¹⁴ F26/2/16:00

¹⁵ F26/3/24:12

¹⁶ F26/8/a/C10

¹⁷ F26/111/28:54

¹⁸ F26/4/32:34

¹⁹ F26/8a/C10

²⁰ F26/T16

²¹ F26/7/04:18

²² F26/7:35:21

²³ F26/37/C2-3

²⁴ F26/37/C5-12

²⁵ F26/36/C2

²⁶ F26/36/T10

²⁷ F26/36/T12

²⁸ F26/36/T2

²⁹ F26/36/T12, T15

³⁰ e.g. F26/36/C22, C27

³¹ F26/36/C21

³² F26/36/T22

³³ F26/36/T31-C32

³⁴ F26/40/08:13

³⁵ F26/40/C6-7

³⁶ F26/40/C10

³⁷ F26/40/T1

³⁸ F26/40/T3

³⁹ F26/40/T7-8

⁴⁰ F26/40/T11-2

⁴¹ F26/40/T14

⁴² F26/40/T15

⁴³ F26/40/T19

⁴⁴ F26/40/T23

⁴⁵ F26/40/T27

⁴⁶ F26/4a/C6

⁴⁷ F26/4/22:06

⁴⁸ F26/4/58:15

⁴⁹ F26/T326
⁵⁰ F26/18a/C60-C62
⁵¹ F26/T185
⁵² F26/19a/C23
⁵³ F26/19a/C25
⁵⁴ e.g. F26/ T199
⁵⁵ F26/T/18/5/12
⁵⁶ M35/02/05:18.
⁵⁷ M35/13a/C11
⁵⁸ M35/02
⁵⁹ M35/06
⁶⁰ M35/07/22:10
⁶¹ M35/08/10:34
⁶² M35/13a/C21
⁶³ M35/14
⁶⁴ M35/11a/T3
⁶⁵ M35/13a/T4-C9
⁶⁶ M35/13a/C8
⁶⁷ M35/09/ 59:40
⁶⁸ M35/04/52:09
⁶⁹ M35/04/62:09
⁷⁰ M35/07/C1
⁷¹ M35/07/C10
⁷² M35/07/C11
⁷³ M35/07/C17
⁷⁴ M35/06
⁷⁵ M35/11/ 10:40
⁷⁶ M35/06/77:29, M35/30
⁷⁷ M35/10
⁷⁸ M35/30
⁷⁹ M35/Cl/3:33
⁸⁰ M35/Cl/22:11
⁸¹ M35/02/41:56
⁸² M35/05/22:05
⁸³ M35/05/22:05
⁸⁴ M35/05/39:45
⁸⁵ M35/05/42:43
⁸⁶ M35/05/51:00
⁸⁷ M35/11a/T26
⁸⁸ M35/11a/C13
⁸⁹ M35/11a/T5
⁹⁰ M35/15a/C11
⁹¹ M35/Cl/38:48
⁹² M35/05/ 10:42
⁹³ M35/06/77:29
⁹⁴ M35/09/ 63:46, M35/Cl/53:25
⁹⁵ M35/07/C16
⁹⁶ M35/Cl/31:42
⁹⁷ M35/07/44:18
⁹⁸ M35/05/ 18:15
⁹⁹ M35/07/11:00
¹⁰⁰ M35/07/06:40
¹⁰¹ M35/09

¹⁰² M35/10
¹⁰³ M35/11/24:21
¹⁰⁴ M35/11/ 14:15
¹⁰⁵ M35/03
¹⁰⁶ M35/07/C12
¹⁰⁷ M35/05/55:00
¹⁰⁸ M35/11a/C22
¹⁰⁹ M35/15a/T17
¹¹⁰ M35/15a/C9
¹¹¹ M35/15a/C19
¹¹² M35/11/02:28
¹¹³ M35/15a/C21
¹¹⁴ M35/16
¹¹⁵ M35/19
¹¹⁶ M35/19
¹¹⁷ M35/22
¹¹⁸ M35/26
¹¹⁹ M35/27
¹²⁰ M35/29
¹²¹ M35/Cl/31:42
¹²² e.g. M35/26
¹²³ M35/23
¹²⁴ M35/24
¹²⁵ M35/27
¹²⁶ M35/27
¹²⁷ M35/27
¹²⁸ M35/30
¹²⁹ F26/1
¹³⁰ F26/2/16:45, F26/2/63:18
¹³¹ F26/6/3:30
¹³² F26/6/65:33
¹³³ F26/6/ 66:57
¹³⁴ F26/8/28:57
¹³⁵ F26/12/50:59
¹³⁶ F26/12/52:20
¹³⁷ F26/12/56:01
¹³⁸ F26/12/62:07
¹³⁹ F26/12/56:01
¹⁴⁰ F26/13/15:25
¹⁴¹ e.g. F26/T137
¹⁴² F26/16/T24-26
¹⁴³ F26/18a/C11-4
¹⁴⁴ F26/T270 - after session 26
¹⁴⁵ F26/36/T28
¹⁴⁶ F26/164
¹⁴⁷ F26/40/T15
¹⁴⁸ F26/40/C20- 22
¹⁴⁹ F26/5a/C2
¹⁵⁰ F26/ T6
¹⁵¹ F26/T12
¹⁵² F26/4/18:20
¹⁵³ F26/5/12:10
¹⁵⁴ F26/6/28:26

¹⁵⁵ F26/ 11a, 15a/T17
¹⁵⁶ F26/5a/C4
¹⁵⁷ F26/15a/C40
¹⁵⁸ F26/8a/C11
¹⁵⁹ F26/19a/T8
¹⁶⁰ F26/29/05:00
¹⁶¹ F26/2/37:00
¹⁶² F26/4/16:20
¹⁶³ F26/8a/C2, F26/8/14:48
¹⁶⁴ F26/8/8a
¹⁶⁵ F26/8/52:10
¹⁶⁶ F26/ 5/18:50
¹⁶⁷ F26/4/16:20
¹⁶⁸ F26/5/09:27
¹⁶⁹ F26/6/39:20
¹⁷⁰ F26/6/72:30
¹⁷¹ F26/10/31:30
¹⁷² F26/35:33
¹⁷³ F26/18a/C26
¹⁷⁴ F26/18a/T27
¹⁷⁵ F26/18a/C30
¹⁷⁶ F26/18a/C32
¹⁷⁷ F26/18a/T45
¹⁷⁸ F26/18a/T36
¹⁷⁹ F26/18a/T38
¹⁸⁰ F26/18a/T39, F26/18a/T42
¹⁸¹ F26/18a/T45
¹⁸² See also F26/T209
¹⁸³ F26/7/02:30, F26/14a/C12, F26/15a/C15
¹⁸⁴ F26/7/02:30
¹⁸⁵ F26/T/30/12/11
¹⁸⁶ F26/T322
¹⁸⁷ F26/T319
¹⁸⁸ F26/29/05:00
¹⁸⁹ F26/29/08:15
¹⁹⁰ F26/29/09:33
¹⁹¹ F26/36/C26, C28
¹⁹² F26/36/C28-C32
¹⁹³ F26/36/C33
¹⁹⁴ F26/36/C36
¹⁹⁵ F26/T/02/05/12
¹⁹⁶ F26/40/C14
¹⁹⁷ F26/T/27/03/12
¹⁹⁸ F26/T/3/04/12
¹⁹⁹ F26/T/29/4/12
²⁰⁰ F26/45a/C12
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²⁰² M35/09/63:03
²⁰³ M35/09/63:03
²⁰⁴ M35/09/63:46
²⁰⁵ M35/03/10:54
²⁰⁶ M35/03/12:15
²⁰⁷ M35/03/23:14

208 M35/09/42:10
209 M35/09/20:20
210 M35/09/25:40
211 M35/11a/T3
212 M35/21
213 M35/24
214 M35/25
215 M35/28
216 M35/22
217 M35/25
218 M35/30, M35/T/9/10/12
219 M35/Cl/26:30
220 M35/Cl/06:52
221 M35/29
222 M35/10
223 M35/10
224 M35/15a/C11-T17
225 M35/T/5/6/12
226 M35/11a/C25, M35/13a/C22, M35/14, M35/16, M35/30
227 M25/Cl/05:34
228 M35/30
229 M35/Cl/36:25
230 M35/30
231 M35/Cl/20:46
232 F26/5/24:50
233 F26/5/35:50
234 Explicitly recorded in sessions 7, 11, 14, 17, 19, 43, 45,
235 F26/T172
236 F26/T/2/5/12
237 F26/T/2/05/12
238 F26/T39
239 F26/T55
240 F26/ 6/1:00:00
241 F26/9/38:44
242 F26/60
243 F26/T/4/5/12
244 F26/56/tx08
245 F26/56/tx08
246 F26/56/tx08
247 F26/56/tx09
248 F26/56/tx10
249 M35/06/30:37
250 M35/06/32:15
251 M35/06/64:22
252 M35/06 /81:21
253 M35/11a/C1-2
254 M35/Cl/46:59
255 M35/06 /75:30
256 M35/07/T24
257 M35/08/
258 M35/09/ 20:20
259 M35/11a/T3

260 M35/11a/T14
261 e.g. M35/07/T17
262 M35/07/C24
263 See M35/07/T24 & T25
264 F26/3a/T3
265 F26/5/24:50
266 F26/3a/T3-T5
267 F26/5b/T7-T9
268 F26/8a/T10
269 F26/2/16:45, F26/2/01:03:18
270 F26/9/07:30
271 F26/9/15:13
272 F26/11/39:30
273 F26/12/39:48
274 F26/3a/T3
275 F26/3a/T4
276 F26/7/12:10, F26/7/17:31
277 F26/11/14:40
278 F26/8/31:50
279 F26/5b/T16
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281 F26/9/40:19
282 F26/09/29:20
283 F26/16a/T9
284 F26/11a
285 F26/12/56:01
286 F26/40/C34
287 F26/40/T8
288 F26/18a
289 F26/18a/T42
290 F26/19
291 F26/18a/T57-62
292 M35/C1/03:33
293 M35/15a/C4
294 M35/15a/C5-C6
295 M35/15a/C11
296 M35/15a/C14
297 M35/15a/T17-C22
298 M35/13a/T16
299 M35/13a/T21
300 M35/13a/T18-T19
301 M35/14
302 F26/40/C10
303 F26/40/T11
304 F26/40/T15
305 F26/T/05-04-12
306 F26/T/02/05/12
307 M35 Interviewer's comments
308 M35/07/28:58
309 M35/02/50:11
310 M35/03/32:40
311 M35/04/30:20
312 M35/03/23:14

³¹³ M35/03/12:15
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³²² M35/07/C17
³²³ M35/10
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³²⁵ M35/11a/C12
³²⁶ M35/Cl/31:42
³²⁷ M35/11/ 14:15
³²⁸ M35/07/C12, M35/11a/C15, M35/15a/C4, M35/22,
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³³⁰ M35/03/23:14
³³¹ M35/15a/C11
³³² M35/15a/C16
³³³ M35/Cl/51:27
³³⁴ M35/Cl/52:46
³³⁵ M35/Cl/24:24
³³⁶ M35/02
³³⁷ M35/11/ 00:51
³³⁸ M35/07/22:10
³³⁹ M35/17
³⁴⁰ M35/23
³⁴¹ M35/24
³⁴² M35/09/55:28
³⁴³ M35/08
³⁴⁴ M35/13a/T17
³⁴⁵ M35/25
³⁴⁶ M35/Cl/42:45
³⁴⁷ M35/28