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Coming Home: A Recovery-Oriented Intermodal Focusing Group for Adults With Mental Illness. Development of a Method.

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Abstract

The recovery model in mental health treatment promotes hope, resiliency, empowerment and agency of the client. All too often these principles are overlooked in favor of a focus on pathology, symptom management, and medication. The focusing method, which was created during the humanist movement of psychology, offers a step-by-step guide to accessing the innate resiliency that lies within an individual's somatic experience. This paper explores the focusing method as an intervention for recovery-oriented treatment with a group of ten adults ($N = 10$) living with mental illness at a day program. An intermodal design was applied to establish scaffolding and containment of the intervention, as well as adapt focusing for use in group work. Clinical observations concluded that intermodal focusing can be useful in enabling clients to connect to their somatic experience and ultimately with the recovery-oriented principles of hope, resiliency, empowerment, and agency.

Introduction

The recovery model (RM) of mental health began in the early 1990's, establishing a new philosophy towards mental illness. Rather than a focus on pathology, symptom management, and external directive from providers, the RM aims to empower individuals to take an active and collaborative role in their treatment and work towards living fulfilling lives despite their diagnosis (Anthony, 1993; New Freedom Commission of Mental Health, 2003). Recovery operates on the principles of hope, resiliency, empowerment, and person-centered treatment, and research has shown that the mental health professional must convey these principles to the client in order for treatment to be effective (Lietz, Lacasse, Hayes, & Cheung, 2014; Borg & Kristiansen, 2004; Davidson, 2003).

Focusing, a six-step method created as a person-centered approach, provides a natural engagement of an individual's "life forward direction" (Gendlin, 1981) by connecting them to their somatic experience. Person-centered therapy, developed in the 1940s, is considered the foundation of the humanistic school of psychotherapy, drawing on the client's capacity for self-direction and development. Although created long before the RM, focusing is an effective intervention for promoting the principles of consumer empowerment, resiliency, collaborative care, and strength-based treatment.

A two-part method was developed that combines Gendlin's six-step focusing method (1981) and expressive arts therapy for adults with mental illness at a recovery and rehabilitation day treatment program. The purpose of this inquiry is to explore the effectiveness of focusing as a tool in building awareness through the mind-body connection and engaging the client in recovery-oriented treatment. It also aims to

examine the usefulness of multiple expressive arts modalities in implementing the focusing method. A review of the current literature will discuss the link between the RM, focusing, and relevant expressive therapy modalities.

Literature Review

The Recovery Model in Mental Health

Recovery is described as a deeply personal, unique process of changing one's attitudes, values…and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations cause by illness.

- Anthony, 1993, p.19

The established philosophy of mental health services in the United States up until the 1990s has been one of little hope for patients diagnosed with mental illness (Lietz et al., 2014). Treatment focused on psychopathology with the primary goal of managing symptoms (Anthony, 1993; Lietz et al., 2014). When speaking about her experience with the mental health system, Deegan (1995) stated, "many of us who have been psychiatrically labeled have received powerful messages from professionals who in effect tell us that by virtue of our diagnosis the question of our being has been already answered and our futures already sealed" (p. 92). Providers who operate without humanity can have a harmful affect on the consumer including over-diagnosing, over-medicating, coercion, disrespect, and hopeless attitudes (Lietz et al., 2014; Rockwell, 2012).

Starting in the 1990s, a new dialogue began that emphasized recovery rather than pathology. Anthony (1993) outlined six areas of focus for mental health services that reached beyond impairment (treatment of symptoms and crisis intervention). These areas

included: case management (access), rehabilitation (role functioning), enrichment (self-development), rights protection (equal opportunity), basic support (survival), and self-help (empowerment). This new vision of mental health service gained influence, and in 2003 The New Freedom Commission of Mental Health called for an overhaul of the current system and then adoption of a recovery-oriented model.

The RM facilitates consumer engagement with activities of life and the community, so that not only do individuals live fulfilled lives but society also benefits from their contributions (New Freedom Commission of Mental Health, 2003). This is especially important because of the growing prevalence of mental illness in the United States. According to the National Institute of Mental Health (2016), approximately one in six adults or 44.8 million people experience mental illness in a given year, and almost half of adults will meet the criteria for a mental disorder in their lifetime (Kessler et al., 2005). It is critical that our mental health care system empowers rather than suppresses these individuals.

Tse et al. (2016) conducted a critical review of strength-based interventions, a subset of the overarching RM that emphasizes the same principles of self-efficacy, sense of purpose, resiliency, and hope. Seven studies were analyzed for data on how such interventions contributed to recovery for adults with severe mental illness. Results found that strength-based interventions a) reduced the length of stay at hospitals; b) increased service satisfaction; c) improved attitudes of self-esteem, self-efficacy, confidence, hope, and life satisfaction in patients; d) increased goal attainment, and; e) increased utilization of services.

Critical to the RM is an emphasis on the relationship between the practitioner and the client, as well as between the client and her peers and community. Lietz et al. (2014) interviewed 16 participants (N=16) who had been diagnosed with a severe mental illness (SMI) and who considered themselves to be "functioning well," or were living in recovery from SMI (p.165). Interviewees were asked which experiences with mental health services aided their recovery. Several themes emerged including services that a) established safety; b) facilitated self-determination and incorporated the client's opinions; c) offered an individualized and humanizing approach; d) fostered hope; e) validated experiences including trauma history; f) promoted positive thought patterns and self-esteem, and; g) were grounded in shared experience. Consumers primarily spoke about attitudes of and interactions with providers, rather than specific interventions or treatment methods.

Borg and Kristiansen (2014) found a similar emphasis on the attitudes of mental health professionals. In interviews with 15 service users (N=15), these researchers found that providers who conveyed hope, empathy, shared power, respect, availability, and flexibility of services were the most helpful in aiding recovery. In his research on patients with schizophrenia, Davidson (2003) also identified the presence of hope in the provider as the most helpful part of the recovery process.

In her address to the mental health student community, Deegan (1995) also emphasized the power of hope. "Hope is not just a nice sounding euphemism. Hope and biological life are inextricably intertwined. When animals and men learn that their actions are futile and that there is no hope, they become more susceptible to death" (p.94). Although much of the mental health literature stresses the importance of hope from both

the practitioner and the client, specific studies on its effects remain elusive, particularly in

the United States. Rather than study its positive effects, much of the existing research

explores the complexity of hope and the dichotomy between hope and hopelessness. In

Lietz et al. (2014) providers described their struggle over the balance between giving

hope and providing false promises.

In a review of qualitative and ethnographic studies in sociology and anthropology,

Graaf (2016) attempted to understand how hope could be used in health settings. The

research illuminated three themes: 1) the practice of hope and taking action to create and

maintain hope; 2) how the practice of hope is linked to notions of space and time, and; 3)

the ambiguity and tensions connected to hoping based on the "potential danger to be

disappointed" (p.605). The author also stated that recent scholars have begun to define

hope as a practice or action rather than a passive emotional or moral state, emphasizing

that it can be utilized as a tool to cope with life's uncertainties.

Person-Centered Therapy

Although created decades before the recovery model, client-centered, later called

person-centered therapy had a sweeping impact on the mental health field and influenced

many of the current practices (Joseph & Murphy, 2013). Born out of the framework of

humanistic psychology, Carl Rogers (1061) developed person-centered therapy based on

the idea that in every human is a biological tendency towards growth, development, and

autonomy. Rogers called this the actualizing tendency. In *On Becoming a Person,* Rogers

(1961) wrote:

 The curative force in psychotherapy [is] man's tendency to actualize

himself. By this I mean the directional trend which is evident in all organic

and human life—the urge to expand, extend, develop, mature—to express

and activate all the capacities of the organism or the self. This tendency

may become deeply buried under layer after layer of encrusted

psychological defenses; it may be hidden behind elaborate facades which

deny its existence; it is my belief however, based on my experience, that it

exists in every individual, and awaits only the proper conditions to be

released and expressed (p.351).

According to Rogers, the process of "becoming a person" enables one's capacity

to be open to experience and enables the discovery that one's own organism is

trustworthy (Rogers, 1961, p.121-123). This idea of trust in the individual is congruent

with the idea that the consumer best understands what they need in terms of treatment,

and encourages providers to form a collaborative, respectful, and strength-based

relationship, tailored to the consumer's individual needs (Lietz et al., 2014).

Focusing

Focusing is a process of mindfully tuning inward and connecting to the

whole body's inner experience (Gendlin, 1981). Philosopher Eugene Gendlin

(1981, 1996) developed it while working at the University of Chicago alongside

Carl Rogers, who at the time was establishing his theory on client-centered or

person-centered therapy. Gendlin found that the most significant variable correlated

with success in therapy was the client's ability to speak from a place of embodied

knowing; in other words, the ability to speak from a place of awareness and

connection with their present bodily experience (Rappaport, 2009; Wagner, 2006).

Before Gendlin developed focusing, he created a seven-stage process scale, later known as "the experiencing scale" (Klein et al., 1969), which measured the client's ability to connect to their bodily experience (aka felt-sense) according to seven different levels. Those who placed high on the scale were likely to have more success in therapy, and those who placed low were not. Out of this discovery, Gendlin developed the six-step focusing method to teach individuals how to connect to their somatic experience, which would ultimately enable progress in therapy. The six steps of the focusing method are 1) clearing a space (setting aside any issues present), 2) choosing an issue and felt sense (bodily experience), 3) finding a handle/symbol: a word, phrase, image, gesture, or sound (to describe the felt sense), 4) resonating (checking if the handle feels right) 5) asking (the felt-sense), and 6) receiving (listening with openness) (Gendlin, 1981).

The felt sense is a physical phenomenon that encapsulates the whole of your experience. Gendlin (1981) stated, "[a felt sense] is an internal aura that encompasses everything you feel about a subject at a given time…a great musical chord…a big round unclear feeling" (p. 32). Once one has accessed a felt sense they often feel what is called a felt shift, or change in internal experience. This shift often first comes as a feeling of relief or as a release of tension and is the result of consciously acknowledging the body. Such relief or release allows internal energy to move in what Gendlin called the life-forward direction, which he defined as the body's innate tendency to move in the direction of healing and of life (Rappaport, 2009). Also essential is the focusing attitude, which brings a friendly and welcoming attitude to the inner experience regardless of pain, suffering, or discomfort. This is described as "keeping company", "saying hello",

"friendly curiosity", or "welcoming" the felt-sense, which allows the person to maintain a safe and open relationship with his or her inner experience (Rappaport, 2009, p. 27-28).

Extensive research has been done to explore the correlation between connection to the felt sense (aka. experiencing) and therapeutic outcome (Rappaport, 2009; Hendricks, 2001; Klein et al., 1969). Hendricks (2001) reviewed 27 research studies across various therapeutic approaches and diagnostic categories, and found that all but one study showed a correlation between a high level of experiencing and successful therapeutic outcome. Outcomes were measured by therapist and client reports, and external evaluations. Hendricks also found 39 studies showing that training or therapy in focusing led to raised levels of experiencing, confirming that focusing can "teach" an individual to connect to present somatic experience. However, some studies found that increased experiencing was not maintained once training or therapy concluded.

In this meta-analysis, Hendricks (2001) discussed Leijssen's study in which over 800 therapy sessions from 26 different clients were recorded and analyzed for content. Sessions were divided into two categories: positive and negative evaluations from client or therapist. To qualify as a positive evaluation, the client had to comment on his or her perceived helpfulness of the session without prompting from the therapist. Results showed that 75% of positive sessions contained an element of focusing, whether it was the client or therapist who initiated. Focusing has been found effective for a wide range of uses including psychosis, depression, stress reduction, chronic pain, and addiction, and with diverse populations including prison inmates, inner-city adolescents, the elderly, and cancer patients (Hendricks, 2001; Wagner, 2006; Rappaport, 2009; Klangsbrun et al.,

2005). It has also shown success across cultures and therapeutic modalities (Hendricks, 2001).

Focusing and the Expressive Therapies

Focusing has been understood in the literature as a tool to enhance any therapeutic modality including psychodynamic, cognitive-behavioral, brief therapy, and the expressive therapies (dance/movement, drama, music, art, and expressive arts). It is also used across the globe in different fields such as medicine, education, bodywork, fine arts, writing, and conflict resolution (Rappaport, 2009).

The most prominent integration of focusing with other modalities is focusing-oriented art therapy (FOAT). Art therapist Laury Rappaport (2009) developed FOAT after realizing the practice she did before making art (described as sitting quietly and accessing an inner sensation to guide her process) was actually focusing. According to Rappaport (2009), focusing and art therapy go hand in hand and act to strengthen each other. "Focusing provides mindful access to the inner resources of the bodily felt sense while art therapy carries its rich source of imagery and wisdom into an outward visual artistic expression" (Rappaport, 2009, p.88). Integration of the two can involve connecting to the felt-sense and then externalizing it through art, or vice versa, making art and then connecting to its felt-sense. FOAT is flexible and can be used in a myriad of ways depending on process.

The most researched aspect of FOAT is the initial step called clearing a space, which involves connecting to a difficulty and then setting it aside. McGrath (2013) designed a mixed methods study aimed at examining the effectiveness of clearing a space with art in decreasing anxiety, depression, stress, and pain level, and increasing mindful

awareness in adult women ($N = 8$) living with chronic pain (three months or more). The study was carried out over three focusing sessions of 90 minutes. Results showed a slight decrease in depression of 14.6% according to the depression, anxiety, and stress scale (DASS) and a slight increase of 11.18% in mindful awareness according to the mindful attention awareness scale (MAAS). It also showed a decrease in self-reported pain levels in the majority of women with a mean score of 25% decrease. Seven of the eight women described the art making process as relaxing or releasing, and 88% said art making was a useful tool in their pain management.

Chidanand (2014) found a similar decrease in depression in a 4 weeklong quantitative pilot study on online interventions of FOAT with South Asian women ($N = 16$) suffering from PTSD symptoms of depression, stress, and anxiety. Participants were guided through the six-step focusing method online with a period of reflective journaling post session. 47% of subjects found a significant decrease in levels of depression. Also interesting was that neither study found a notable decrease in anxiety or stress level of participants. The small sample size of both studies could be a factor for this, and length of time for the former study. The results of the latter study could be an indication that person-to-person contact is necessary to facilitate focusing, and that online interventions are ineffective in treating anxiety and stress.

Rather than focus on stress reduction or symptom management, Klagsbrun et al. (2005) created a study to explore the use of focusing as a session opening for the art making process with female cancer patients ($N = 20$). This occurred during two one-day retreats, two weeks apart. Participants were led in clearing a space in groups as a precursor to expressive arts therapy activities, finding it to be an effective warm up.

Researchers wanted to study clearing the space over a period of time, so participants were guided over the phone before the actual groups took place. Participants also practiced clearing the space with a partner between sessions. In total, participants cleared the space four times within the study. Results showed that participants' ability to clear a space grew significantly with repeated practice, and the process of turning their attention inward enabled participants to speak in metaphors about their emotional and physical states, which facilitated the art making process. Many participants also reported using the combination of focusing and expressive arts therapy after treatment ended.

Writing as a therapeutic tool

Working with the expressive therapies can be an overwhelming experience, and when not properly contained can lead to harmful implications (Knill, Levine, & Levine, 2010). Rappaport (2009) emphasized the use of writing with FOAT as a tool for grounding, especially when working with clients with severe mental illness or in the early stages of trauma recovery. The use of concrete tools such as journals, containers, boxes, envelopes, or sandtray can help create safety and containment for felt sense energy.

Writing has been shown as an effective tool for re-integrating psychic material that surfaced with one's personal narrative or ego state. In a study comparing non-verbal expression and writing, Krantz and Pennebaker (2007) found that students who danced to express their trauma for ten minutes a day and then wrote about it for another ten minutes showed measured improvements to health and higher grade point averages than those who only danced to their trauma. Pennebaker (1986) studied psychology students ($N =$ 46) who had been reporting major health issues such as cancer, high blood pressure, ulcers, flu, headaches, and earaches. Participants were asked to recall a traumatic

experience. They were divided into three groups: the first group wrote about the current events of their lives, the second group recounted the details of the traumatic event, and the third wrote about the details and also about their emotions about it and how they felt the trauma impacted their lives. He found that students who not only wrote about the details of their traumatic experiences but also about their feelings and the trauma's emotional impact showed a 50% decrease in doctor visits compared with the other two groups. Pennebaker concluded that behavioral inhibition could have somatic implications, and that writing could be a useful mode of catharsis and self-disclosure.

Studies have also shown writing as an effective tool in promoting the recovery principles of resilience and hope. In an attempt to explore the ability of poetry to foster resilience, Tegner, Fox, Philipp, and Thorne (2009) designed a pilot study that examined twelve female cancer patients ($N = 12$) over a six-week period. Results found an increase in emotional resilience and a decrease in suppressed emotions, most significantly anger. Tegner et al. concluded that poetry was an effective outlet for participants to express and explore anger related to their cancer diagnosis while simultaneously building on resiliency.

Existing research supports focusing as an effective intervention for building somatic awareness and increasing success in therapy. It can also be used as a tool for symptom management based on its effects on stress reduction, relaxation, depression, and chronic pain. By enabling the life-forward direction, focusing puts into action the principles of empowerment, hope, and strength-based care. The use of focusing with expressive arts modalities such as FOAT and writing is useful when working with mental illness because it serves to concretize and externalize elements such as the felt sense or

clearing the space. This helps make it possible for those with severe mental illness and/or significant trauma responses to find agency and guide their own direction in treatment.

Method

With the principles of recovery-oriented treatment in mind, an intermodal focusing method was designed to facilitate recovery-oriented treatment at an adult day treatment program. Focusing helped group members raise their level of personal awareness and engage somatically with their recovery. The integration of expressive arts therapy and focusing enabled distancing from material and grounding of the intervention. It also served in adapting focusing for use in a group format.

Participants

This intermodal, six-step focusing group was implemented at a recovery and rehabilitation oriented day treatment program for adults with a range of mental illnesses. It took place during an established group aimed at exploring the mind-body connection. This group had been meeting once a week for eleven weeks before the following intervention took place; therefore safety and group cohesion had already been established.

Group participants consisted of ten adults ($N = 10$) ranging in age from 27 to 80 years old, with an equal ratio of male ($n = 5$) to female ($n = 5$). Diagnoses of group members included Bi-polar II, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, and Post-Traumatic Stress Disorder. Four group members had co-occurring substance use disorders ($n = 4$), and seven group members

had a history of complex trauma ($n = 7$). All ten group members were Caucasian and lived in the North Shore area.

Materials/Space

The group took place in a carpeted room with no windows, lit by two standing lamps. Chairs lined the walls and pillows were provided for those who wished to sit on the ground. Writing materials included colored index cards, pens, and clipboards. Since the room did not have a table, sink, or trash cans, art materials were chosen for their easy application and minimal clean up. These included white drawing paper, colored pencils, colored pens, markers, and oil pastels. An ipod and portable speaker were also utilized.

Procedure

The intervention was implemented during two group sessions, each 1.5 hours long, with a 15 minute break after the first 45 minutes. Due to absences eight group members ($n = 8$) attended the first session, and all ten members ($n = 10$) attended the second session. Before each session, the group facilitator sat in a quiet room for five minutes to clear the space (step one of the focusing method) with self-directed imagery. The intention was to help the facilitator be open and neutral to group members and material.

Both sessions began with brief psycho-education about focusing. The philosophy behind person-centered therapy (Rogers, 1061), Gendlin's observations of the correlation between experiencing and success in therapy (Hendricks, 2001), and tangible examples of the felt-sense were provided. A short discussion about times members had been aware of a felt sense was encouraged. Group members were then invited to help their bodies get

comfortable. Wagner (2006) suggested taking care of physical needs, such as putting on a layer if cold, or scratching an itch that is needed.

In the first session, members were asked to check-in using a word or phrase accompanied by a gesture to describe how they were feeling. This was used to get an inventory of the participants' mental and emotional states at the beginning of focusing and to observe the connection or disconnection between their verbal statements and body language. In the second session, the facilitator skipped this initial check-in, which could have affected several aspects of the outcome. This will be discussed in more detail later.

Step One: Clearing a space.

Rappaport (2009) emphasized how clearing the space through writing could offer a safer and more concrete holding place than non-directive modalities. In this case participants used colored index cards (members chose what color), a pen, and a clipboard. They were first asked to imagine feeling 'all fine'. This could be a body sensation or an image of a safe place. They were instructed to write down anything that was between them and feeling 'all fine'. This could be things in the moment or an 'always' feeling, like worry or hopelessness. Next they were offered a communal box to put their cards in. This presented a tangible way to set their problems aside. They could also keep the cards if they preferred.

Step Two and Three: Connecting to a felt sense/finding a handle.

Members were then asked to turn their attention inward and sense, "What's inside right now?" or "how am I on the inside right now?" (Rappaport, 2009). This could come as an image, a word or phrase, a sound, symbol, or gesture (the handle) (Gendlin, 1981). They were encouraged to be friendly to whatever emerged (the focusing attitude). When

group members had trouble identifying a handle, time was spent exploring and identifying a handle for the felt sense through one-on-one dialogue.

Step Four: Resonating and Art Making.

Once every participant had a handle for their felt sense, they checked it against their body to determine if it felt right (resonating). The participants were then given 15-20 minutes to make art about their handle for the felt sense. After art making, a 15 minute break was offered.

Step Five: Asking.

During the break, the facilitator set chairs adjacent to those of group members. Participants were then asked to place their art facing them and observe it with curiosity and friendliness. They were given three questions to ask their art: "who are you," "what do you need," and "what do you want me to know?" Index cards were distributed to record answers.

Step Six: Receiving.

Members were asked to reflect on what they had written. This was followed by a period where members could share reflections and/or artwork. To close the session, members where asked to say something they were taking away from the session, and/or something to leave behind.

Record Keeping

Brief notes were taken during the session, and a full narrative was written four hours post-session. The narrative first covered salient aspects of the group as a whole, and then broke down into a chronology of each participant. Artwork and index cards from the asking step were collected and analyzed for content. The facilitator also did the

intermodal six-step focusing method at a later time and setting as an artistic response to both sessions.

Ethical Considerations

This six-step focusing method required several sessions dedicated to creating rapport and group cohesion before delving into deeper and more personal material. Any future implementations would require the same warm-up period. The structure of the intervention was also designed to properly descend into the focusing method in a safe and contained way that avoided flooding or overwhelming group members.

Results

In this section, results from each of the focusing steps will be presented. The content of the results primarily focused on the felt shift: if it occurred and how it manifested. The second focus was to identify themes in the artwork and content from the asking step. The third was to observe the process of connecting to the felt sense. Differences in group dynamics for both sessions were also observed.

Clearing a space

During the first session the majority of people asked questions like, "are we writing one thing on each card? Or all on one card." They were encouraged to sense what felt right for them. "Maybe there is a problem that feels big and needs its own card. Maybe others feel okay to be all together." Several times members asked if something "counted", for example, "like my brother's death?" One group member who regularly emphasized how content, grateful, and peaceful she was struggled to identify anything

bothering her. She eventually named the "always" feeling of missing her husband who had passed away.

In the second session members requested significantly less clarification, partly because eight of the group members had participated in the first session. During both sessions the vast majority of group members filled up multiple cards and wrote for several minutes. In the first session, one member stated, "I'm just now realizing, I don't think I've ever felt content, maybe in my whole life." In the second session a member stated, "It's amazing how I feel like I could just keep writing down things that bother me. I feel like I could keep going forever."

In the first session, six out of eight people tore up their cards and put them in the communal box. Two people kept the cards on their person. Without prompting, half the group members (four out of eight) expressed feeling better after having torn up the cards and putting them in the box. In the second session, all but one person (nine out of 10) chose to put their cards in the box. One person put it in whole and the rest tore them up. Some threw the pieces in angrily and others placed them in gently. Several members again expressed satisfaction at tearing up their problems and putting them in the box.

Opening vs. closing statements

In the first session, group members said a word or phrase to describe how they were feeling at both the beginning and the end of the session. These statements were compared to examine if a felt shift had occurred over the course of the intervention. All eight members had a shift in content between the beginning and the end of session. Six of the closing statements indicated a shift in a positive/goal-oriented direction, and two

statements indicated a shift in a negative direction. Table 1 displays the shift for each member.

Table 1

Session One: Opening and Closing.

Member	Opening	Closing
#1	Aggravated	Calm
#2	Gratitude	Hope
#3	Curious	At peace
#4	"I can't remember how I feel"	Determined
#5	Comfortable	Grateful and delighted
#6	Aggression	"I'm still going"
#7	Tired	Anxious
#8	Good	Tired

In the second session members did not give an opening check-in. In the closing, they were asked to name one thing they would be taking from the session and one thing they would leave behind. At this point in the intervention, several members had become tearful and expressed themselves emotionally. Two group members identified hope, three group members identified taking compassion or empathy, and two group members took something for the future, including "a good meditation," and a "good conversation starter with my therapist". Only one group member identified taking something negative. Three group members chose to leave nothing behind. This could be because they were taking something meaningful from the group as a whole. It is also interesting to note themes in language used. Hope, compassion, good, and stress were all used twice. These statements are summarized in Table 2.

Table 2

Session Two: Taking and Leaving (Closing remarks).

Member	Taking	Leaving
#1	Hope that I'll see my kids again	
#2	Hope	Hope
#3	I wish I could take all your burdens	Compassion
#4	Empathy and identification	Empathy and identification
#5	Compassion	Stress
#6	Stress	Stress
#7	A good meditation	
#8	A good conversation starter for therapy	
#9	I don't know, I have to reflect	
#10	Pass	Pass

Accessing the felt sense

Members were asked to tune in and ask, "how am I on the inside right now?"
(accessing the felt sense). They were then asked to identify a handle (a word, phrase,
image, gesture, or sound) to describe their felt sense. In the first session five of the
members needed help in identifying a handle. Several members felt something complex
but struggled to find words or images for it because it felt like so many things at once. All
participants eventually found a metaphor that accurately described the essence of what
they felt. One member said he just felt "stuck". When asked what that felt like, he stated
he had so much anger in his chest but the outside felt hard. He then confirmed that the
image of anger stuck in his chest was an appropriate handle for his felt sense.

In the second session, only two out of ten people needed help accessing a felt
sense. With the exception of these two members, no one shared their handle until the art

making process was complete. This was different than the first session, wherein every

member shared his or her handle before making art. Both the sharing and withholding

happened spontaneously without prompting from the facilitator.

Artwork and Asking

Members were then asked to depict the handle through art or writing on paper

using the provided materials (pens, markers, colored pencils, and oil pastels). Most of the

members worked quietly in a focused and diligent way for the majority of the allotted

time. In the first session seven members chose multiple colors and one group member

used pen only. This member worked quickly and set his drawing aside face down.

Similarly, during the asking portion when members set their artwork at a distance and

asked, "Who are you? What do you need? And what do you want me to know?" he

quickly wrote a single sentence and set his card aside. Another group member also

worked quickly, depicting a blue tornado for both sessions. In the first session he labeled

it a "relaxed" tornado. In the second session he labeled it a "stress" tornado. The line

quality of his drawing was identical in both sessions. In the first session he expressed

confusion about the asking process. A group member attempted to clarify the instructions

by saying, "what is the tornado saying to you?" He looked at his image and then grabbed

his head and yelled, "I don't know!" He appeared frustrated and bewildered and did not

write anything on his card. In the second session, he looked at his image and wrote, "I am

a stress tornado." He then set his image and card aside and lay down on the ground. It

was common for this group member to lie down, and he regularly fell asleep during

groups. This time he lay awake, staring at the ceiling until the next directive was given.

In the fist session, artwork produced themes of nature, weather conditions, and

transportation vehicles. Two images referenced specific memories. Three images

depicted members' hearts, two broken and one in water. The asking process produced

hopeful or empowering messages for half the group members. Three other members

identified current desires or anxieties. Table 3 summarizes data from the artwork and

asking steps of the intervention.

Table 3

Session One: Artwork and Asking.

Image	Asking
Abstract swirls with the words "Alice can."	Alice is happy and okay. You are okay, and you CAN do this.
Fuzzy image of the participant in a boat loaded with supplies (Member described the image as "out of focus like [his] brain").	I want control. I want access to my own supplies. I want more…
A caretaker carrying the participant. The participant has tears streaming down her face.	Artwork: I am the many who carry you. You need to know you are being carried by so many.
	Participant: Are you going to drop me again? I'm afraid.
Symbol of heart with a crack down the center. Underneath are the words, "My broken heart."	What do I need? I need my family back in my life.
A huge blue wave cresting over a small red heart.	I need you to know that despite this churning wave inside, you are okay. You can be at peace.
Slanted lines representing "chaos", a rocket with a Tessla car launching into the sky, and an anatomical heart with a broken valve.	I feel hope for the first time in a long time that I will make it through. This rocket and Tessla car is proof that the impossible is possible.
Her late husband's farm with farm animals, and the two of them working outside.	You are at peace.
A "relaxed" Tornado	This member was unable to identify a message.

In the second session, members were again asked to represent the handle for their felt sense through art or writing using the same materials. The majority of members worked quietly and diligently for the duration of the time allotted. Three group members drew images using multiple colors, five group members drew images including words, and two members wrote words only. The same group member chose to use pen only and completed his image quickly, setting it aside face down.

Members were again instructed to set their artwork at a distance and ask, "Who are you? What do you need? And what do you want me to know?" This asking process produced noticeably darker themes of impending death, frustration, and control vs. helplessness. Hopeful themes of compassion and empowerment were also present. A discussion commenced about frustrations at life's difficulties. One member became very tearful and stated, "No matter what you do, it all ends the same. In death." Several members commiserated over the struggle of not giving in to hopelessness and defeat. As group members vented, the conversation took on a resilient tone. One member had said, "Why do I even try? What's the point? Obligations never end." She then said, "I guess the point is, I'm not going to just lay in bed and let the world crash down around me. That's why I get up every day. Whether I like it or not, I do care." Another member then said, "It may all end the same but what we do along the way matters."

Several group members became very emotional and expressed empathy and compassion for what others were saying. Sentiments included, "there is so much courage in this room. Thank you for sharing," "I wish I could take away all of your pain, because I know how that feels, but at the same time it's nice to know I'm not alone," and "I feel a lot of empathy and identification in what other people are saying."

Common themes across both sessions included: mortality, higher power, compassion/empathy, gratitude, hope, insecurity, affirmation, peace, acceptance, and choice. Table 4 describes the content of artwork and the asking from the second session.

Table 4

Session Two: Artwork and Asking.

Image	Asking
Lush green tree growing in grass with blue lines swirling around it.	I am your higher power. Your inner strength, your intuition. I need you to stay connected to me. I need you to know that I'm always here inside you. All around you.
The participant splayed out on a bed with the words "worn out..."	Who are you: Someone who's gone without so many basics for so long. I need to grant myself the right to give myself what I need. What do you want me to know: You're going to be okay. You're not alone. You've done a tremendous job. The universe will keep moving forward.
A blue tornado.	I am a stress tornado.
A brown tree in autumn. All the yellow leaves have fallen to the ground except one.	Don't be afraid to let go!
A self-portrait of the participant eating the head of another. Fire and smoke come out of her head. There are the words, "Angry. Frustrated and more impatient than I used to be (leads to shame)."	I must retrain the long-term vigilance.
A stream of consciousness about the participant's sister who is undergoing surgery. She is worried but knows her sister is strong.	I am a healer. Meditation for my sister—sending healing to her everyday. Peace to her!
"The end. Catastrophe. Disaster. Destruction. OR The beginning. Success. Quiet orbit. Peace. Silence. Debris. Emptiness. Void. Letting and expanding into infinity. Cold dark nothing. Complete."	Who are you: Nature. The great I Am. What do you want me to know: Inevitability, quiet and dead, the end of all effort. What do you need: Acceptance, a scary place.

A large flame surrounding three stick figures lying at the bottom of a box. The words, "Nervous and insecure."	What do you want me to know: That there is no such thing as security. What do you need: To help me feel secure. I feel insecure about everything.
An empty pitcher.	What I need in my life? My daughter Lauren and son Christian.
A self-portrait of the participant with a black hole in the center of his stomach. Black matter bleeds out from the hole in smoky wisps.	My stomach holds all my pain. This black hole is the result of stuffing things down. I need to stop doing this. Because I know where it leads.

Feedback from members

Several group members offered positive feedback on the focusing sessions without prompting from the facilitator. Half of the group members mentioned discovering something they hadn't been aware of. One member said doing the focusing helped him realize something he needed to bring up with his therapist. Another member stated, "I wasn't sure why I wasn't feeling well, but you brought it up like an ice cream soda. It just floated to the top." Other sentiments were, "this was a very special group," "thank you for offering me the space to be emotional," "this group was really hard but really cathartic," and "this work is very sensitive to each individual."

Summary of sessions

In the first session all eight group members experienced a felt shift, exhibited by changes in sentiment from the opening to closing statement. The majority of members found clearing the space helpful and all eight members were able to access a felt sense with help from the facilitator. Themes from artwork and asking included hope, positive affirmations, and identifying needs. Several members offered gratitude to the facilitator at the end of the session.

In the second session group members did not begin with an individual check-in, which could have raised levels of group cohesion. A discussion commenced about feelings of frustration, insecurity, and helplessness about life that evolved into the topic of resiliency. Four out of 10 members expressed feelings of empathy, identification, and compassion. Themes of hope also emerged, including inner strength, healing, and self-discovery.

In both sessions all group members were able to connect to a felt sense, find a handle, and externalize it through art. Similar themes of hope and resiliency emerged from the asking process, however the second group also produced themes of mortality, frustration, and death. In both groups, several members expressed gratitude towards each other and the facilitator for the space to connect to themselves and to each other.

Discussion

Research has shown that focusing can enable clients to connect to their bodily experience, allowing for deeper levels of insight and ultimately better outcomes in therapy. Focusing can also can facilitate a felt shift of physical, emotional, or mental energy in a life forward direction. Additionally, focusing is a helpful intervention when used in recovery-oriented treatment, as it serves to engage the principles of resiliency and self-directed care.

An intermodal focusing method was found effective for group work with adults at a recovery-oriented day program. Results showed that the intervention was effective in facilitating connection with a felt sense, thereby prompting a felt shift for the majority of participants. Themes of hope, resiliency, positive affirmations, and reassurance were

present in both sessions. However, in the second session themes of mortality and existential frustrations also surfaced. These began with a hopeless tone, such as, "why should I even try? No matter what I do, it all ends the same—in death." As the sharing portion of the session continued, the tone became more empowered as the group rallied around the idea that the journey *is* important even if the end is the same. One member who began by saying, "Why do I even try? What's the point? Obligations never end." then said, "I guess the point is, I'm not going to just lay in bed and let the world crash down around me. That's why I get up every day. Whether I like it or not, I do care*"* (connection to the life forward direction).

The second session also generated themes of empathy, identification, and compassion, and members grew visibly emotional. This was an unexpected shift but is congruent with the RM's emphasis on the importance of clients connecting with their peers and community. Because the second session did not begin with an individualized check-in but rather began with a group discussion about focusing, it is possible that this enabled more cohesive group engagement from the beginning and allowed members to operate as a unit rather than as individuals. It was interesting to observe how the group as a whole acknowledged the felt sense of frustration and despair, which then enabled a shift in the life forward direction.

In both sessions, half of the group members discovered something they hadn't been aware of before. This supports the focusing idea that by connecting to an inner experience one can gain better insight into what he or she needs. One group member said, ""I wasn't sure why I wasn't feeling well, but you brought it up like an ice cream soda. It

just floated to the top." Another stated, "When I asked the art a question, I didn't think an answer would come. But then something poured out of me."

Research has often explored the ambiguity and complexity of hope. Lietz et al. (2014) reported that practitioners often don't want to give their clients false hope regarding treatment, and Graaf (2016) discussed the tension regarding hope and the possibility of being disappointed. Despite this, the literature repeatedly pointed to the importance of hope in the process of recovery from both mental and physical illnesses. Results of the focusing intervention showed hope as a prominent theme during both sessions, therefore intermodal focusing could potentially be an effective way of engaging clients with hope on a somatic level, and therefore could have less potential for ambiguity and tension.

Using the concrete method of clearing a space with writing also had primarily positive outcomes. Half of the group members reported feeling better after having torn up the cards and putting them in the box. It was also interesting to note that during the break and art making time people brought up topics that were applicable to their mental health. In the first session, members discussed how perfectionism stifles creativity. In the second session, they talked about the importance of positivity in changing their perspective. This was all unprompted by the facilitator.

Results of this intervention showed promising outcomes for further applications. Although this group was designed for adults with mental illness at a day treatment program, adaptations could be made to address various topics across populations in both individual and group therapy. Potential uses could incorporate additional directives specific to certain themes. For example, rather than ask, "how am I on the inside right

now," one could ask, "When I think about my mental illness, how do I feel on the inside?" Directives could also focus on places of tension or safety within the body.

Although positive therapeutic outcomes could not be measured specifically for this intervention, results have demonstrated potential for facilitating progress within and outside of a recovery-oriented framework. Intermodal focusing has exhibited important therapeutic elements such as hope, resiliency, insight, group cohesion, and awareness of somatic experiences. This writer encourages more research on the effects of intermodal focusing for growth and movement in the life forward direction for any and all populations.

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