Wolfgang Klooss (Ed.)

Wor(l)ds of Trauma

Canadian and German Perspectives

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IRTG Diversity
Mediating Difference in Transcultural Spaces

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www.waxmann.com
info@waxmann.com

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Introduction

Wolfgang Klooss

With "trauma" the essays collected in this volume explore a topic, which for decades has received wide attention in the public and the academic world, and add comparative German and Canadian voices to the conversation. At the beginning of the volume Winnipeg writer and critic Dennis Cooley sets the tone for the following scholarly investigations with poetic contemplations on his own traumatic experiences during an extended period of hospitalization. In *departures* which was first released in April 2016, he talks about "the vulnerable body as it passes through the world's stubborn alchemy."

It is not surprising that scholars have been discussing "trauma" intensively in recent years, considering that (collective) experiences of traumatization have not ceased in the 20th or the 21st century. "Trauma" can be experienced individually, collectively (in groups, ethnicities), nationally and globally. The Holocaust, Hiroshima, and Nagasaki still serve as reminders and symbols of large-scale destruction and human suffering. Both globally and locally, conflicts derived from (religious) intolerance, poverty, enforced migration, and resistance to refugees continue to contribute to narratives. Racialized and class-conscious societies have come to reveal the dark sides of humanity. At the same time, there has been a growing focus on the physical and mental consequences of traumatic events on people.

The volume centers around problems and challenges that have received widespread attention, such as the treatment of First Nations and Métis in Canada, cultural genocide, deportation, family destruction, physical and mental abuse by educational, state and church institutions. The forceful relocation of Canada's Japanese population after the attack on Pearl Harbor or the rejection of immigrants from Punjab in Vancouver, also known as the *Komagata Maru* incident, could serve as further historical examples that tell stories of victimization and suffering.

The essay collection offers contributions to the general theme of "trauma" by not only looking at physical-psychological phenomena in personal as well as collective forms of suffering, but also at socio-cultural understanding, whereby a comparative, if not cross-hermeneutic approach, generates both Canadian and German perspectives on the problems. With the exception of one comparative analysis dealing with literary treatments of apartheid and genocide in (South) Africa, case studies focus on Canadian and German issues, while papers with a theoretical orientation exceed this geographical realm. Since this volume is interdisciplinary in scope, it includes contributions from clinical studies and psychology (Kristin Husen, and Wolfgang Lutz), from the social (Martin Endress) and political (James Fergusson) sciences,

Native studies (Hartmut Lutz), literature (Konrad Gross, Ralf Hertel, Martin Kuester, Markus M. Müller, Laurie Ricou, Susanne Rohr, and David Staines), cultural studies (Adam Muller, Robert Schwartzwald, Struan Sinclair, and Andrew Woolford), media and visual studies (Stephan Jaeger, Uli Jung, and Katherine E. Walton).

The essays which are sometimes case studies of an exemplary nature are assembled thematically and do not follow a disciplinary arrangement. Occasionally, academic analysis and personal reflection are combined. This gives some of the contributions a particularly individual tone, allows for different narrative styles, and reflects different disciplinary practices.

For intrinsic reasons post-traumatic stress disorder (PTSD) is repeatedly addressed even in articles from the field of literary criticism,[1] while the act of voicing/writing trauma is often attributed with a therapeutic function. On the thematic level it does not come as a surprise that Germany's severest traumatic experience, the Holocaust, is reiterated in contributions across disciplines. In contrast, several essays with a Canadian focus thematize Native trauma as, for instance, experienced in the Residential Schools that tried to deprive Native children of their indigeneity. It is also due to the thematic scope of the volume that the *Canadian Museum for Human Rights* in Winnipeg, which opened in November 2014, plays a prominent role in a few contributions.

Among the most repeatedly referenced research are studies conducted at Johns Hopkins University in Baltimore, namely Cathy Caruth's *Trauma: Explorations in Memory* (1995), and *Unclaimed Experience: Trauma, Narrative, and History* (1996), as well as Dominick LaCapra's *History and Memory after Auschwitz* (1998), and *Writing History, Writing Trauma* (2001).

Since most of the essays are based on papers delivered at a partnership conference of the University of Manitoba and Trier University (Trier, May 2016), many articles are by scholars from Winnipeg and Trier. Further essays by colleagues from other Canadian and German universities, such as the universities of British Columbia, Montréal, Ottawa and Toronto as well as Greifswald, Hamburg, Marburg, and Kiel enlarge the scope of contributions.

Wor(l)ds of Trauma ends with a brief commemoration (Hartmut Lutz) of Jo-Ann Episkenew, a respected Métis elder and scholar from the *Indigenous Health Research Institute* at the University of Regina. She had agreed to enrich this voulume with a contribution titled "Letting Go of Trauma: Indigenous People and Brainwave Neurofeedback," but died unexpectedly at the beginning of 2016.

Special thanks go to Lutz Schowalter for his editorial suggestions and meticulous proofreading of the manuscript.

Note

1 PTSD is a psychological disorder characterized by severe handicaps in patients' everyday life. Prevalence rates for women are four times higher (3.6%) than for men (0.9%).

Part I
Trauma Poems

From *departures* (with an Introductory Note)

Dennis Cooley

For years I had written about the wayward and mysterious body. Sometimes it appeared in anguish, sometimes in petulance. Often it behaved in comical ineptitude or recalcitrance. One book, *Bloody Jack* (1984), ended with a passage on the appendix – the book's appendix and Cooley's very own. The body figured in yearning and desire and joy. Always it was wondrous. A later book, *soul searching* (1996), played with the tug between mind and body. In another poem the body protests against Cooley's mistreatment and takes its revenge on him. I was always on the side of the maligned and neglected and miraculous body.

Then one day the body – my body – broke out in full rebellion. An exploded appendix in 1995 delivered me to the hospital where I languished in fever and hallucination. Voices spoke to me – very clear and distinct voices. The world was running down, on the verge of extinction, and acrobatic figures swung through bottomless dark trying to mend it. A man pretending to be a painter walked through a door, wiping blood from a cloth he was carrying. Another man, a stick man, leaned terrifyingly over the hospital bed, jerking and flailing. A case perhaps of how close poetry and schizophrenia can be.

When I was finally able to sit up, the heels of my hands were sore and my vision had blurred. I clumsily wrote a raw record of that time – memories of a heat and grinding that went on and on in gritty textures and dust; impossible dreams about parents and grandparents and friends and family and colleagues. I suspected just about everyone of neglect and conspiracy. The dreams included visions of water, glowing plants just up there, up the steps that weren't there; noted the sweetness of air blowing over snow rotting in spring, thoughts of my wife's family home where I might find refuge. I wrote as best I could remember what had happened. I had no idea in what order most of the events had occurred and I had no pattern of them in mind. This was in February.

By that fall I had begun a book. It would be a long poem. It would be long and disjointed to reflect the experience and to situate it as postmodern. I did some research and wrote up more notes. Over the next two decades I worked on other books, but I kept coming back to the manuscript. I kept adding passages, constantly revised what I had, moved parts around. Gradually I became aware of larger and more varied contexts within which I could amplify the story. I wrote still more notes, drafted more pieces. I drew in information that seemed apt and exciting – stuff about the

appendix; the chemical constitution of the body; the swoops and loops of the earth, the moon; the rhythms of agriculture; the story of human evolution; the amazing mechanics of DNA; stories of my own family and childhood. I made more notes, drafted more passages, revised everything. The manuscript got bigger and bigger.

I knew the poem would not be simply narrative. It would draw a conglomeration into the gravitational pull of the event. A lot of the added information came from Bill Bryson's astonishing book *A Short History of Nearly Everything* (2004) and, still later, Diane Ackerman's *An Alchemy of Mind*: *The Marvel and Mystery of the Brain* (2005), a poet's memorable account of our strange brains. The writing quickened with a sense of what could be said, what removed, what altered. The record, I began to see, was thickened with circles and whorls and cycles and descents. I recognized the reassuring sense of a bird in a tree, the implications of desiccation and thirst, and I began to see where those details might take me. The material became less medical, less obsessive. I took up new leads, including what I had written outside of *departures* (2016), and sometimes before it. I wanted to lift the weight of an oppressive sweltering that clung to the notes. The poem steadily became more embedded in larger patterns. It also became more lyrical, more meditative, more extended, more personal, more comical.

In the end (which is to say, by the time I would have to let the book go) I could see that I needed to jettison a lot of what I had hauled into the manuscript at one time or another. Now, twenty years after the event, more focused and radically shortened, the poem tells of the vulnerable body as it passes through the world's stubborn alchemy.

from *departures*:

€

sits at the end of the ward
at the end of the world
it is very cold

.winter squeezes
.through the windows
.at the end of the hall
.at the end of it all

february, his feet cold. always cold.

a horrendously distended stomach fastened to a machine
Sits in an orange robe
he will lose in Kraków.

Could be a squash growing from a pole.
Could be a pumpkin among dead vines.
Could be king of the gourds.

a long tuber
fatter than earth
no softer than
a white radish
a spaghetti squash
feeds from the shining tube
they hold him under
drop him from
would be a plant drinking from the window
the glass a shine of water
its cold clear wetness

he will die in the high cold night

€

they say wind cannot dry it
fire cannot consume it
water cannot wet
nor earth rot

our days yes are fields
are as the fields of grass
we are made to lie down in
but to lie together in them
smell the crushed grain & flowers
the small dust of their perfume
fallen dust of the world

the sweet bundles of flesh
we have only now to touch

€

genetics is we can agree
what most matters
to you is postmodern

there being dissonance
in such matters generally
it is generic of a kind unkindly

yet in gestation generous & in generation
plenty of noise in the system
stray chunks & trays of broken pieces
in odd places add
nothing it seems to the whole

no one knows what
it is doing there or what
it does it doesn't
do much of anything
as far as we can see
what good is it

a few strands
with no discernible purpose
or intelligible affect
and an awful lot of garbage

€

the shouts & whispers
the body vibrates
the illicit romance
every clasp and spasm
the endless chemical gossip
gabba gabba gabba
working the gaps
its small & inaudible gasps

psst ppstt presses the doors
in yeas & nays slamming
/open and shut

speaks surprise & yearning
Heraclitus heard and knew
was the world spinning

€

Thursday 700 am
a gauze mask on the earth's face
the fields numb from sleeping
morning bleak with february

Cars drag themselves across the parking lot
nudge over sheets of dirty metal
clench against the cold.
All turn to face the same
way, watch through their
lights where they wait to enter.

Hunch against the wind, try to
keep their breath close, their
exhalations from freezing in the air.

Their lights spray onto the air
shove the cold through the glass
he watches through. The cold
presses him into the chair.

€

7 years for the body
to replace it
self completely new
except the same
old self everyone can tell
it's you & yet
it's not
you you are no longer you the same

things have changed and you are now not you
even though you are the same
bump where the finger broke
same slicing up & across
same long
boney feet same madness
for rhyme & pun same black
hair only grayer
you:
entirely different all the same

is it really you
you will say when i replaces me
where then will you be when
i get a new me & you you too
get a new me also a new you
how can i say i knew you
then we too who knew
who could believe are new again
who will we be when we are new

who knew you will say
who knew who could poss
ibly know or passably say
how we could know
one another now
and then
€

passes across the world
a sheet of piss-yellow
they tear & wrap
around bodies

long slow nights
every car pulls
the sheet up
yanks it
\down

€

Something more is called for, some thing for which a gentleman would give his last farthing. Farting like an old dray horse would seem what's needed. It seems such a fair thing, in the end a far better thing, if he were to produce at least one single ting, a near or far ting. That would not be asking too much, surely. That would be perfectly reasonable.

Heads bowed, in solicitation prayerful, in genuflection solemn, in hope beseeching. A tingling. A tin ting, a tintinnabulation. That the pneuma might pass them over, and the spirit dwell among, they bend and peer, stand and listen. An elision in time, the world's lesions. Kyrie Eleison, morning noon and night time too.

All this have they done for him. How in the final analysis can he let them down? Has not he, like them, fallen out of the fiery comets and the storming gasses?

All they ask is a fart or two.
Are you hungry?
No, he isn't.

G., a burly man, huffles in, thick-sweatered. Seems faintly baffled. Hey, hi, pleased to see him, laughs when G. arrives to report. They're holding steady, steady as she goes. Waiting for gas.

They are expecting a break-through any day now, a new lease on life.
Time for release. And an appeasing of the gods.
Something in which to be exceedingly glad.
Something big.
Any day now.

Time to fizz. Time to fizzle.
time to break out
time to break wind.

€

—

Wakes him. Wakes him from dream. Wake up she says. The one who knows in her heart he is defective. Hurries in, happy to have caught him. She has got him dead to rights. Wake up Wake up.

She has identified him as a malingerer, arraigned him for weakness. A feckless man.

Justlikeaman. Justllikeaman. Hers a strange courting.

—

wish she understood
the way the wind blows
(wish i knew)
when you are bone tired
and she is too

Time to get up,
you better wake up,
you're beginning to talk.
To yourself.

A termagant. A harridan.
A hurricane of disapprovings.

Krankenhaus the germans call it
The hospital that is and this lady
Though not german
is certainly kranken
germ to his well-being
more than a little inhospitable

snip of mouth
slice of speech
her scissored talk

oh no no no
a pleasant dream
talking with a friend David
a friend's talk

✘✕✕✘

○ now what now what
○ now what has he done now

sugar in the morning
sugar in the evening

Big Blonde bustles in dispensing
judgments with a pharmaceutical zeal

- ✓ 2 each morning
- ✓ 3 at noon and
- ✓ 1 before bedtime
- ✓

the rounds of her displeasures
sounds of the world's but mostly his failures
regularly checks the cabinet of her displeasure
resolute to keep the dispensary full
and cooley on a proper regimen

€

he has got his wish
she has taken
his body sewn
shut she has
picked it up &
taken it home

He considers the contours of things,
the symmetry of chairs,
the misshapen body,
the roundness of water.

€

Cooley re-enters
the coiled and calling world
carries with him
a slashed and bulging stomach.
recalls Megan's own incisions.

Stirs in five-toed affection.
A tad slow, a low-lying
slow-breathing cloud. A sloth.
A little root-bound.
Moves with the ease of a rutabaga.
A flat-footed platypus trying to break out.

Follows the thread all the way out of the play pen.

Newly escaped and rotund.
Definitely rotund.
Definitely not Houdini.

his appendix
has up & left him
he will not miss it
not one little bit

two large patches of white
suddenly appear in his hair
one on each side

€

He makes plans for Germany —

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Part II
Psycho-Social and Political Dimensions of Trauma

Psychological and Clinical Perspectives on Trauma

Kristin Husen and Wolfgang Lutz

1. Basics about PTSD and Treatment from the Clinical Psychology Perspective

Post-traumatic stress disorder (PTSD) is a serious psychological condition that can occur as a result of experiencing a traumatic event. The requirement of an external event as a trigger of psychological distress that potentially follows distinguishes PTSD from most other psychological disorders. According to the A criterion of the Diagnostic and Statistical Manual of Mental Disorders (DSM; see American Psychiatric Association), the DSM is the most widely accepted nomenclature used by clinicians and researchers for the classification of mental disorders. The precondition for developing PTSD involves

> exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s). (2) Witnessing, in person, the event(s) as it/they occurred to others. (3) Learning that the traumatic event(s) occurred to a close family member or friend, the event(s) must have been violent or accidental. (4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e. g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse). (American Psychiatric Association 271)

Criterion A4 is restricted, as it "does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related." (American Psychiatric Association 271) Different kinds of traumatic events can be distinguished. L.C. Terr introduced the differentiation between *Type-I* and *Type-II (or complex) Trauma. Type-I Trauma* refers to single-incident trauma that is brief in duration, e. g. a sudden and unexpected trauma, a single episode or experience of trauma, whereas *Type-II Trauma* refers to prolonged, repeated exposure, e. g. sexual abuse. Additionally, trauma can be differentiated into accidental or man-made. Examples of the four types of traumatic events that arise from these distinctions are provided in Table 1.

The key symptoms that characterize PTSD are (1) intrusions, i. e. reliving the traumatic event or frightening elements of it by means of intrusive memories, nightmares or flashbacks; (2) avoidance of trauma-related stimuli, such as thoughts, memories, people, and places associated with the event; (3) symptoms of elevated arousal, i. e. irritable, aggressive, self-destructive or reckless behavior, hypervigilance, exaggerated startle response, concentration problems, sleep disturbance; and (4) negative alterations in cognitions and mood.

Table 1: Types of Traumatic Events

	Accidental Trauma	**Man-Made Trauma**
Type-I (Mono) – Short-Lasting	Traffic Accidents	Criminal & Physical Violence
	Industrial Injuries	Sexual Abuse/Rape
	Natural Disasters (Short)	
Type-II (Poly) – Long-Lasting	Long-lasting Natural Disasters	Sexual & Physical Abuse in Childhood
	Technical Disasters	War Experiences
		Torture, Political Imprisonment

PTSD is a complex condition that is associated with significant morbidity, disability, and impairment of life functions. Furthermore PTSD is oftentimes accompanied by an array of other psychological disorders such as anxiety, depression, obsessive compulsive disorder, substance abuse, mood disorders, somatoform disorders, dissociative disorders or personality disorders. Comorbid disorders commonly develop due to dysfunctional strategies a person suffering from PTSD uses to cope with PTSD symptoms. The disorder is associated with a distinctly increased risk of suicide.

The lifetime prevalence of PTSD is approximately 5% to 8% for men and 10% for women. The conditional probability, i. e. the risk of developing PTSD after a traumatic event, is 8% for men and 20% for women. Differences in conditional probabilities can be explained by the fact that events vary considerably in their probability of precipitating PTSD (see Norris and Slone). The spontaneous remission rates of PTSD within the first year after a traumatic event are at 50% – a fact that speaks against certain types of interventions such as Critical Incident Stress Debriefing (CISD) (cf. Mitchell). Debriefing is a psychological first aid intervention strategy, which is provided to small groups of trauma victims typically within 24 to 72 hours after the traumatic event. Reviews of debriefing have shown no effects with regard to helping prevent the onset of PTSD or reducing psychological distress (see Rose, Bisson, Churchill and Wessely). On the contrary, some studies have identified counterproductive effects of debriefing, i. e. increased PTSD risk. These negative effects may be due to the setting in small groups, which facilitates mutual destabilization during the acute phase of emotional instability and lability. The goal of psychological emergency aid should be pacification and alienation.

Protective factors against PTSD encompass for instance a good sense of coherence, social support, high socio-economic status and functional coping strategies. Risk factors are subdivided into pre-, peri-, and post-traumatic risk factors. Among the pre-traumatic risk factors are for example lack of social support, poverty of parents, female gender, prior mental disorder(s) or a family history of mental disorders. Peri-traumatic factors encompass e. g. length, extent and repetition of traumatic impact, subjective experience of threat, other connected traumatic events, peri-traumatic emotional reaction and peri-traumatic dissociation. Post-traumatic

factors are for instance lack of social support, continuous negative life events, lack of recognition as a victim and secondary stress factors (see Maercker).

During traumatic experiences information processing is disturbed. This leads to traumatic memory, which differs from usual memory, because the memory consolidation process seems to fail. Therefore, the traumatic memory trace stays predominantly located in subcortical and primary perceptual areas, leaving it tightly coupled to its autonomic and perceptual markers, and lacking appropriate integration into autobiographical, cortical memory networks. Subsequently the result of exposure to a trauma trigger is a solely involuntarily retrieved memory trace (intrusion) that is very hard to verbalize, often fragmented in time. It consists, for the most part, of primary sensory information (images, smells, sounds) that are linked to physiological fear symptoms. Due to the lack of autobiographical context, the memory is relived as if things were happening in the present. Thus, the failure to properly consolidate and thus emotionally process potentially traumatic memories may form the neural basis of key PTSD symptoms such as unwanted memories, intrusive flashbacks, nightmares, hyperarousal, and dissociation. Reduction of PTSD symptoms can be achieved by successfully transferring trauma memory to pre-existent, cortical memory circuits (cf. van Hein).

This later aspect has immediate consequences for treatment guidelines. Trauma treatment is usually divided into different phases: (1) Stabilization; (2) Confrontation; (3) Integration. The first phase includes the establishment of the therapeutic relationship and frame for treatment, the provision of short-term relief and the stabilization of the patient by enhancing coping skills to help make symptoms more manageable. The second and third phases (confrontation and integration) entail working through the traumatic experiences and integrating the traumatic event. Before entering into the second phase of treatment, it must be ensured that the patient's life circumstances are safe and secure. The risk of re-traumatization must be excluded, which for example in the case of sexual abuse requires that the patient is not living in the same household as the offender. If these requirements for confrontation are not met, treatment phase 2 cannot be initiated. The third and last treatment phase includes furthering the integration process as well as self and relational development. Different protocols for trauma treatment exist. Many of these include cognitive methods which for example are applied to the treatment of disturbed concepts of the self and others.

2. Monitoring and Feedback System at the Outpatient Clinic of Trier University

Unfortunately, psychologists are not immune to the so-called better-than-average (BTA) effect. Like in many other professions, therapists regularly overestimate the

probability of positive therapy outcomes. On average, therapists rate their own skills on the 80% level and no one rates their own skills below the 50% level in comparison to all other therapists (cf. Walfish, McAlister, O'Donnell and Lambert; Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa and Sutton). Although one can argue that the better-than-average effect is good for the therapist's conviction of being helpful to the patient, which is certainly beneficial for the therapeutic process, it also shows that our perception as therapists is selective and indications of deterioration or treatment failure can quickly be overlooked.

Additionally, practitioners are often faced with the question, whether an intervention, which has proved to be effective on average, also works for the individual patient. This essential question has fostered a paradigm shift from treatment- to patient-focused research (PFR) (see Lutz and Rubel). PFR evaluates whether generally successful treatments also show positive effects for an individual patient and analyzes how this treatment can be adapted to improve individual treatment outcome. To achieve this goal, information from the treatment process is used to optimize clinical decision-making at the beginning, during, and at the end of treatments. In doing so, differential adaptations of the treatment process can be provided to avoid treatment failure and to guarantee the best possible treatment outcome for an individual patient (see Lambert, Hansen and Finch; Lutz and Böhnke). Patient-focused psychotherapy research attempts to broaden nomothetic research results by integrating idiographic elements and thereby adding to the research field's practice orientation. Statistical developments, which allow the combination of nomothetic and idiographic elements when analyzing treatment data (e.g. hierarchical linear models), open up new possibilities in this area of research.

Patient-focused psychotherapy research requires close monitoring of the developments an individual patient undergoes during different phases of the treatment process and the feedback of this information to the therapist (cf. Lambert 2007; Lutz 2002). Feedback tools can be based on empirical data or rational decision strategies. These tools allow practitioners to track individual progress and adapt ongoing treatment, especially for patients with an early negative development. PFR therefore establishes a constant exchange between research and practice. Furthermore, data generated in settings following a patient-focused research paradigm can be used for supervision or, on a systems level, as part of an evaluation or quality management system (see Lutz, de Jong and Rubel). The monitoring process involves repeated assessments – usually during every therapy session – and allows the investigation of typical change patterns over the entire treatment period. These typical change patterns are essential to therapists as a reference point for the decision, whether the change observed for an individual patient corresponds to expected change trajectories, or whether it deviates from the expected course. Feedback studies have provided clear evidence of the fact that treatments show enhanced effects when therapists are provided with feedback of their patients' progress (cf. for example