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## Chapter 13

# Research on Humanistic-Experiential Psychotherapies

***Robert Elliott, Leslie S. Greenberg, Jeanne Watson, Ladislav Timulak, and Elizabeth Freire***

We acknowledge the contributions of the many colleagues who sent us information on their research; we ask them to continue sending omitted or new studies. The outcome meta-analysis was supported in part by a grant to RE and EF from the British Association for the Person-Centred Approach.

This review covers approaches to psychotherapy generally referred to as *humanistic* or *experiential*. These therapies are part of the main tradition of humanistic psychology (see Cain & Seeman, 2002), with major subapproaches being person-centered therapy (PCT; e.g., Rogers, 1961), gestalt (e.g., Perls, Hefferline & Goodman, 1951), emotion-focused (EFT, also known as process-experiential; Greenberg, Rice, & Elliott, 1993), existential (e.g., Yalom, 1980), psychodrama (J. Moreno & Moreno, 1959), focusing-oriented (Gendlin, 1996), expressive (Daldrup, Beutler, Engle, & Greenberg, 1988), and body-oriented (Kepner, 1993). In addition, humanistic-experiential psychotherapies (HEPs) are often used as generic relationship control conditions by researchers from other theoretical orientations under store-brand labels such as *supportive* or *nondirective*.

Although these approaches have varied somewhat in technique and conception over the course of their historical development, in their contemporary expressions they nevertheless share several distinctive theoretical assumptions. Most important among these is the centrality of a genuinely empathic and prizing *therapeutic relationship*. In the HEPs, the therapeutic relationship is seen as potentially curative. Each person's subjective experience is of central importance, and, in an effort to grasp this experience, the therapist attempts to enter empathically into the client's world in a way that goes beyond usual relationships or the subject-object dichotomy. Being allowed to share another person's world is viewed as a privilege, and all HEPs reject the idea that the relationship between

the client and the therapist can be reduced to an unconscious repetition of previous attachments. Rather, they generally share the view that an authentic but bounded relationship with the therapist provides the client with a new, emotionally validating experience.

HEPs also share a focus on promoting in-therapy client *experiencing*, defined as the holistic process of immediate, ongoing awareness that includes perceiving, sensing, feeling, thinking, and wanting/intending. Thus, methods that deepen or stimulate client emotional experiencing are used within the context of an empathic facilitative relationship. Commitment to a phenomenological approach flows directly from this central interest in experiencing. People are viewed as meaning-creating, symbolizing agents, whose subjective experience is an essential aspect of their humanity. In addition, the experiential-humanistic view of functioning emphasizes the operation of an integrative, formative tendency, oriented toward survival, growth, and the creation of meaning. Moreover, all HEPs are united by the general principle that people are wiser than their intellect alone. Internal tacit experiencing is seen as an important guide to conscious experience, fundamentally adaptive, and potentially available to awareness when the person turns attention internally within the context of a supportive interpersonal relationship. Interpersonal safety and support are thus viewed as key elements in enhancing the amount of attention available for self-awareness and exploration. HEPs are also consistently *person-centered*. This involves genuine concern and respect for each person. The person is viewed holistically, neither as a symptom-driven case nor as a diagnosis.

Recent developments in the HEPs include a revival of research on person-centered therapy (PCT) and continued study of focusing-oriented (Gendlin, 1996) and emotion-focused approaches (Greenberg et al., 1993). Like gestalt therapy, these newer approaches use experiments in directed awareness to help focus and concentrate attention on unformed experience and to intensify its vividness. For example, focusing-oriented therapy emphasizes the creation of new meaning by focusing awareness on bodily feelings, while EFT integrates person-centered and gestalt therapy traditions, emphasizing both the relationship and the process of reflection on aroused emotions to create new meaning. In practice, these and other *process-guiding* contemporary approaches strive to maintain a creative tension between the person-centered emphasis on creating a genuinely empathic and prized therapeutic relationship, and a more active, task-focused process-facilitating style of engagement that promotes deeper experiencing and consequent meaning creation. Although coming from a different tradition, “third generation” cognitive-behavioral therapy (CBT), such as mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2001), acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999), and compassion-focused therapy (Gilbert, 2009) have expanded to have much in common with HEPs.

A continuing key point of contention within the humanistic-experiential psychotherapies, however, is the degree to which therapists should act as process-experts by offering ways clients can work more productively on particular types of problems (“process guiding”). All HEPs are process-guiding to a certain extent, but EFT and gestalt are more so, while PCT and so-called supportive or nondirective therapies attempt to minimize process guiding.

In this chapter we focus on research published since our previous reviews (Elliott, Greenberg, & Lietaer, 2004; Greenberg, Elliott, & Lietaer, 1994), which covered research published between 1978 and 2001, plus additional earlier research on HEP outcome that we have been able to track down. A key element of the chapter is a meta-analysis of nearly 200 HEP outcome studies (through 2008) and a survey of the use of the approach with different client groups. In addition, we offer a meta-synthesis of qualitative research on these therapies (cf. Timulak, 2007), and provide a narrative review of recent quantitative research on change processes in HEPs. Finally, we once again apply the criteria for designating psychotherapies as empirically supported, originally proposed by the Society of Clinical Psychology (Division 12, American Psychological Association; see Task Force on Promotion and Dissemination of Psychological Procedures, 1995) and subsequently modified by Chambless and Hollon (1998). We realize that these criteria are controversial (e.g., Elliott, 1998), but use them here because they are the clearest such guidelines available and are widely recognized.

Because of space limitations and the increasing amount and range of research this survey is not exhaustive. In particular, we have not reviewed research on the therapeutic alliance, child psychotherapy, and on measure development (but see Cooper, Watson, & Hölldampf, 2010, for reviews of these topics). In addition, we have chosen not to review research on the growing number of related integrative approaches, such as emotion-focused psychodynamic approaches (e.g., Fosha, 2000), motivational interviewing (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010), and “third wave” CBT (e.g., Gilbert, 2009; Hayes et al., 1999; Segal et al., 2001).

As noted in our previous review (Elliott et al., 2004), although clear progress has taken place in the past 20 years, including increasing numbers of studies on specific client populations, additional programmatic empirical research on humanistic-experiential therapies is still needed.

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# Are Humanistic-Experiential Therapies Effective?: A Meta-Analysis

In North America and Europe, economic pressures on mental health services and scientific-political trends toward treatment standardization have led to the development of guidelines calling for certain psychological treatments to be officially recognized as effective, reimbursed by insurance, and actively promoted in training courses, at the expense of other treatments (e.g., Task Force on Promotion and Dissemination of Psychological Procedures, 1995; Meyer, Richter, Grawe, von Schulenburg & Schulte, 1991; National Collaborating Centre for Mental Health, 2009). To date, these guidelines have not been kind to the HEPs, and have in effect enshrined widely shared preconceptions about the perceived ineffectiveness of these approaches as supposed scientific fact and health care policy. Although research on HEPs has rapidly expanded over the past 20 years (see previous reviews in Cain & Seeman, 2002; Cooper et al., 2010; Elliott et al., 2004), they continue to be overlooked or dismissed, as in the NICE Guidelines for Depression and Schizophrenia (National Collaborating Centre for Mental Health, 2009, 2010).

Understandably, humanistic-experiential therapists (e.g., Bohart, O'Hara, & Leitner, 1998; Schneider, 1998) have responded to these challenges with alarm. Although philosophical assumptions and methods of the evidence-based practice movement have been and continue to be challenged, our strategy here is to look instead at the existing research evidence, which has sometimes been neglected in the controversy. In fact, as we show, a substantial and rapidly growing body of research data supports the effectiveness of HEPs.

We report here the latest of a continuing series of meta-analytic reviews of HEP quantitative outcome research, substantially updating earlier reports (Elliott, 1996, 2002; Elliott et al., 2004; Greenberg et al., 1994). The present analysis includes more than 5 times the number of studies analyzed in Greenberg et al.'s (1994) original review, from 35 to 195, including 77 studies not included in our most recent review (Elliott et al., 2004). Eleven of these studies were published prior to 1970; 25 came from the 1970s; 36 from the 1980s; 63 from the 1990s; and 60 from the first decade of the 2000s. These studies offer evidence for a revival of outcome research on HEPs. We have included all the studies we could locate and analyze through 2008 (unfortunately, the accelerating pace of the research has currently outstripped our ability to keep up with it beyond that date).

At this point, the analysis includes pre-post effect size data from 199 different samples of clients seen in some form of HEP, drawing from 186 studies (involving a total of 14,206 clients). In terms of controlled studies with wait-list or no-treatment conditions, there are 62 comparisons, from 59 studies (involving 2,149 therapy clients and 1,988 controls); 31 of these were randomized control trials (RCTs). As for comparative studies, in which HEPs were compared to other treatments, there are 135 comparisons, derived from 108 samples of clients in HEP in 100 different studies, 82 of these RCTs ( $n = 6,271$  HEP clients, 7,214 clients in non-HEP therapies). Finally, there are 9 comparisons between more versus less process-guiding HEPs (7 studies, 264 clients).

The pre-post therapy samples were categorized into six clusters: (1) 74 involved person-centered therapy (PCT) in a relatively pure form; (2) 33 focused on generic versions of HEP most commonly referred to as *supportive* or *nondirective*; (3) 34 studies examined task-focused, integrative emotion-focused therapies (EFT, also known as *process-experiential*), including emotionally focused therapy for couples (EFT-C); (4) new in this review, we analyzed 10 studies of existentially oriented supportive-expressive group therapy for medical populations (e.g., cancer); (5) finally, 43 samples of clients received other HEPs (gestalt therapy, psychodrama, focusing-oriented, encounter, or integrative); and (6) five got treatments that mixed HEP with some other kind of treatment such as medication or advice. The average length of therapy was 20 sessions (sd: 21, range 2–124); the average number of clients studied was 70 (sd: 240; range 5–2,742). For the pre-post effects sample, *researcher* theoretical allegiances were most commonly pro-HEP (65%), while for comparative studies this figure was only 31%.

For each study, characteristics of the treatments, clients, therapists or the studies were rated to estimate the contribution of these features to effect size. For example, internal validity was coded, with one group pre-post uncontrolled open clinical trials rated as “0”; one group wait list own control designs as “1”; two group nonrandomized designs as “2”; and two group randomized controlled trials (RCTs), given a “3” rating.

Standardized pre-post differences ( $d$ ) were used for effect size (ES) calculations using standard estimation procedures (e.g., Smith, Glass, & Miller, 1980) and D/STAT (Johnson, 1989). ESs were calculated for each subscale of each outcome measure used, then averaged across subscales within measures for each of three assessment periods: posttherapy, early follow-up (less than a year), and late follow-up (a year or longer). For *pre-post effect sizes*, measure effects were first averaged, then across the three assessment periods to yield an overall value for each treatment in each study. In addition, standard corrections for small sample bias and inverse error (based on sample-size) weighting formulas (Hunter & Schmidt, 1990) were applied to these ESs in order to obtain more precise estimates of overall effect. Analyses of *controlled and comparative effect sizes*

compared mean overall pre-post effects between control or comparative treatment conditions, with positive values assigned where the HEP treatment showed a larger amount of change. In addition, random-effects significance testing (Wilson & Lipsey, 2001), using the *Comprehensive Meta Analysis* software package was combined with equivalence analyses (Rogers, Howard, & Vessey, 1993) for key comparisons, using .4 sd, as previously proposed by Elliott, Stiles, and Shapiro (1993), as a demarcation between a small and a medium effect size. This is useful for defining the minimum clinically interesting difference, relevant to individual clinical practitioners, who see small numbers of clients at one time. Next, we analyzed for heterogeneity of effects using Cochran's Q, which tests for whether the overall effect estimate is compromised by significant between-study variability. Finally, we estimated the proportion of the between study variation due to true variability as opposed to random error by using the  $I^2$  statistic (Higgins, Thompson, Deeks, & Altman, 2003). (Higgins et al. [2003] recommend interpreting  $I^2$  values of 25%, 50%, and 75% respectively as small, medium, and large.)

In addition, when examining particular client populations (e.g., depression), we applied the Chambless and Hollon (1998) revised criteria for designating level of empirical support. According to their formulation, studies are generally expected to meet certain quality criteria: (a) reasonable sample size ( $n > 25$  per group); (b) use of treatment manual or adherence checks; (c) a specific client population defined by reliable, valid inclusion criteria; (d) use of reliable, valid outcome measures, including measurement of targeted client difficulties; (e) appropriate data analysis (e.g., direct comparisons, evaluation of all outcome measures). The three levels of efficacy are defined as:

1. *Possibly efficacious*: One controlled study in absence of conflicting evidence.
2. *Efficacious*: In at least two independent research settings, the treatment is either (a) superior to no treatment or another treatment, or (b) equivalent to an established treatment using studies of reasonable size ( $n > 25$  per group). With conflicting evidence, the preponderance of the well-controlled studies supports the treatment.
3. *Efficacious and specific*: In at least two independent research settings, the treatment must have been shown to be statistically significant and superior either (a) to a non-bona fide treatment (e.g., a "placebo") or (b) to an alternative bona fide treatment. With conflicting evidence, the preponderance of the well-controlled studies supports the treatment.

## Total Pre-post Change in Humanistic-Experiential Therapies

Table 13.1 summarizes pre-post effects for all studies for which these could be calculated. The unweighted average pre-post effect ( $d$ ), across the 199 treatment samples and assessment periods, was .96. This exceeds the .8 standard cited by Cohen (1988) as a large effect size. The data clearly indicate that clients maintained or perhaps even increased their immediate posttreatment gains ( $d = .95$ ) over the posttherapy period, with slightly larger effects obtained at early (1–11 months; 1.05) and late (12+ months; 1.11) follow-ups. Weighting effects by inverse error (a function of sample size) produced a virtually identical overall mean ES of .93 (95% confidence interval: .86 to 1.00).

**Table 13.1 Summary of Overall Pre-Post Change, Controlled and Comparative Effect Sizes**

	<i>n</i>	<i>m</i>	<i>sd</i>
<b><i>Prepost Change ES</i></b> (mean <i>g</i> )			
By assessment point:			
Post	181	.95	.61
Early follow-up (1–11 mos.)	77	1.05	.65
Late follow-up (12+ mos)	52	1.11	.68
<b><i>Overall</i></b> (mES):			
Unweighted	199	.96	.61
Weighted ( $d_w$ )	199	.93	.04 <sup>a</sup>
<b><i>Controlled ES</i></b> (vs. untreated clients) <sup>b</sup>			
Unweighted mean difference	62	.81	.62
<i>Unweighted m diff, RCTs only</i>	31	.81	.68
Experiential mean pre-post ES	59	1.01	.68
Control mean pre-post ES	53	.19	.32
Weighted	62	.76	.06
<i>Weighted m diff, RCTs only</i>	31	.76	.10 <sup>a</sup>
<b><i>Comparative ES</i></b> (vs. other treatments) <sup>b</sup>			
Unweighted mean difference	135	–.02	.53
<i>Unweighted m diff, RCTs only</i>	113	–.02	.53
Experiential mean pre-post ES	124	.98	.62
Comparative treatment mean pre-post ES	124	1.02	.69
Weighted mean difference	135	.01	.03 <sup>a</sup>
<i>Weighted m diff, RCTs only</i>	113	–.01	.04 <sup>a</sup>



**Comparative ES (more vs. less process-guiding experiential)<sup>b</sup>**

Unweighted	9	.33	.51
Weighted by <i>n</i>	9	.14	.18 <sup>a</sup>

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*Note.* Hedge's *g* used (corrects for small sample bias). Weighted effects used inverse variance based on *n* of clients in humanistic-experiential therapy conditions.

<sup>a</sup>Standard error of the mean given for weighted effects.

<sup>b</sup>Mean difference in change ESs for conditions compared, except where these are unavailable; positive values indicate pro-HEP or pro-process guiding results.

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## Controlled Studies on the Effectiveness of Humanistic-Experiential Therapies

Pre-post effects do not tell us whether clients in HEPs fared better than untreated clients, and thus make it difficult to infer that therapy was responsible for changes made by clients. They have also been reported to produce generally larger effects than control group comparisons (Lipsey & Wilson, 1993). Therefore, we examined control-referenced effect sizes (differences between pre-post ESs) in the 62 treated groups in which HEPs were compared to wait-list or no-treatment controls. The unweighted mean controlled effect size for these studies (Table 13.1) was also large, .81, a value only slightly less than the mean pre-post effect of .96. In contrast, the average pre-post effect for the 53 untreated conditions (the number for which data were available) was .19, only a fifth the size of the effect for clients in HEPs. The weighted effect ( $d_w$ ) was .76 (CI: .64 to .88) and moderately heterogeneous ( $Q = 162.8$ ;  $p < .001$ ;  $I^2 = 62\%$ ). The same unweighted and weighted results held when only the 31 randomized studies were analyzed. From this pattern of results, three conclusions can be drawn: (1) there is a strong causal relationship between HEP and client change; (2) the controlled effects are highly consistent with the pre-post effects, and suggest that about 80% of the pre-post gains reported for clients in HEPs can be attributed to the therapy (including both client and therapist within-therapy factors), as opposed to external or nontherapy factors; (3) these results hold, regardless of whether RCT designs are used or not, thus supporting the internal validity of the nonrandomized controlled studies, as well as the much larger body of one-group pre-post studies.

## **Comparative Outcome Research on Humanistic-Experiential Versus Other Therapies**

While impressive, the pre-post and controlled effect-size analyses reported do not address the issue of comparative treatment effectiveness, which is central to continuing discussions about mental health policy, the effectiveness of HEPs and the sources of their effects. For this, we analyzed 135 comparisons between HEPs and other therapies. The average unweighted difference in pre-post effects was  $-.02$ , indicating no overall difference (see Table 13.1). Weighting by inverse error produced comparable but moderately heterogeneous results ( $d_w = .01$ ; CI:  $-.05$  to  $.07$ ;  $Q = 305.1$ ,  $p < .001$ ;  $I^2 = 56\%$ ). Once again, analyzing only the 113 randomized effects produced nearly identical results (see Table 13.1). In 81 (60%) of the comparisons, pre-post change in clients in HEPs vs. non-HEP *non-HEPs* were within .4 standard deviation of each other, a value proposed as the minimum clinically interesting difference in effects (Elliott et al., 1993). The heterogeneity in comparative effect sizes was evidenced by the fact that in 28 comparisons (21%) clients in the non-HEP treatment did substantially better (comparative effect size  $< -.4$  sd) than clients in HEP, while HEP clients did substantially better ( $> .4$  sd) in the remaining 26 (19%) comparisons.

Particularly noteworthy recent mixed sample outcome studies are the two studies by Stiles and colleagues (2006, 2008) comparing person-centered, CBT, and psychodynamic therapies in primary care settings, with very large naturalistic U.K. samples (Stiles, Barkham, Mellor-Clark & Connell, 2008; Stiles, Barkham, Twigg, Mellor-Clark & Cooper, 2006). In both studies, the studies approximated RCTs in spite of the lack of randomization, because clients in all three treatments were statistically identical at pre- and posttest yet showed large amounts of pre-post change.

### **Equivalence Analysis**

Applying random effects model significance testing (Wilson & Lipsey, 2001) and equivalence analysis to this and other treatment comparisons made it possible to demonstrate statistical equivalence between HEPs and non-HEPs. These analyses are summarized in Table 13.2, with equivalence analyses given in the “95% Confidence Interval,” “Different from 0,” and “Different from  $|.4|$ ” columns. If the “Different from 0” column is “No” and the “Different from  $|.4|$ ” column is “Yes,” it means that the confidence interval includes zero but neither  $+.4$  or  $-.4$ , indicating that the mean comparative effect demonstrated statistical equivalence. In addition, because of the large sample sizes for most of the equivalence analyses, we adopted the following conventions for interpreting the practical or clinical implications of these and later results: “Equivalent”: within .1

sd of zero (greater than  $-.1$  and less than  $.1$ ); “Trivially Different”: between  $.1$  and  $.2$  sd from zero; “Equivocal”: between  $.2$  and  $.4$  sd from zero; “Clinically Better/Worse”: at least  $.4$  sd from zero.

**Table 13.2 Overall Comparisons Between HEPs and non-HEPs**

	<i>n</i>	<i>d<sub>w</sub></i>	SE	95% CI	Diff: 0	Diff: < .4	Result <sup>a</sup>
<b>Whole Data set</b>							
HEP vs. non-HEP	135	.01	.03	-.05 to .07	No	Yes	Equivalent
HEP vs. CBT	76	-.13 <i>(-.03)<sup>b</sup></i>	.04	-.21 to -.06 <i>(-.11 to .05)</i>	Yes <i>(No)</i>	Yes	Trivially worse <i>(Equivalent)</i>
HEP vs. non-CBT other therapies	59	.17 <i>(.06)</i>	.05	.08 to .27 <i>(-.04 to .16)</i>	Yes <i>(No)</i>	Yes	Trivially better <i>(Equivalent)</i>
<b>RCTs only</b>							
HEP vs. non-HEP	113	-.01	.04	-.09 to .07	No	Yes	Equivalent
HEP vs. CBT	65	-.14 <i>(-.02)</i>	.05	-.24 to -.05 <i>(-.11 to .08)</i>	Yes <i>(No)</i>	Yes	Trivially worse <i>(Equivalent)</i>
HEP vs. non-CBT other therapies	48	.15 <i>(.04)</i>	.06	.04 to .27 <i>(-.08 to .17)</i>	Yes <i>(No)</i>	Yes	Trivially better <i>(Equivalent)</i>

**Note.** *d<sub>w</sub>*: weighted comparative effect size (difference between therapies weighted by inverse variance); SE: standard error for the comparative effect sizes, random effects model; 95%CI: 95% confidential interval; Diff: 0 : mES statistically significantly different from zero; Diff: <|.4| : mES statistically significantly smaller than minimum clinical practical value of  $.4$  sd. HEP: humanistic-experiential psychotherapy; CBT: cognitive-behavioral therapy.

<sup>a</sup>“Result” refers to the practice implications of obtained value of mES: “Equivalent”: within  $.1$  sd of zero (greater than  $-.1$  and less than  $.1$ ); “Trivially (worse/better)”: between  $.1$  and  $.2$  sd from zero; “Equivocally (worse/better)”: between  $.2$  and  $.4$  sd from zero; “Clinically worse/better”: at least  $.4$  sd from zero.

<sup>b</sup>Values in parenthesized italics are results of analyses controlling for researcher allegiance, performed when uncontrolled differences had been obtained.

In the case of the overall comparison between HEPs and non-HEPs, not only was the obtained  $.01$  value within the specified “equivalent” range, but this practical equivalence was also supported statistically by its confidence interval including zero but not  $-.4$  or  $.4$  sd. In other words, on the basis of this sample, it can be concluded that HEPs are in general, equivalent to other treatments in their effectiveness. This result has been a consistent result of our earlier meta-analyses (e.g., Elliott et al., 2004) and appears to be quite stable at this point. Nevertheless, this consistent near-zero figure conceals statistically significant variability in effects, as indicated by a Cochrane’s *Q* of 305.15 ( $p < 0.001$ ); in addition, the estimated proportion of true between study variability ( $I^2$ ) was 56%, considered to

be a medium-size value. This means that examination of possible moderators of comparative outcome effects is called for (Lipsey & Wilson, 2001).

## HEPs Versus Cognitive-Behavioral Therapies (CBTs)

A significant center of controversy involves widely held assumptions to the effect that HEPs are inferior to cognitive-behavioral treatments. The comparative studies analyzed above did not exclusively use CBT (76 out of 135 comparisons). Therefore, it can be argued that the effects of the CBT were watered down by the inclusion of comparisons involving other types of therapy (most often “treatment as usual,” psychodynamic, or integrative).

To clarify this issue, we undertook a series of further equivalence analyses (see Table 13.2). These analyses indicated that, for the subsample of 59 comparisons analyzed here, HEPs showed slightly larger pre-post effects than non-CBT treatments, an advantage of .17 sd, statistically significant but trivial for clinical purposes: it would take at least 10 clients receiving HEP rather than a non-CBT therapy for one additional client to benefit (cf. Furukawa, 1999). By the same token, 76 studies comparing HEPs to CBT revealed a comparable but opposite mean difference of  $-.13$ , in favor of CBT. This effect was statistically significant but also too trivial to serve as a guide for individual practitioners, although when considered from an epidemiological point of view it could be seen as meaningful. Next, we examined the 113 randomized comparisons separately in order to see if these findings held up when only RCTs were analyzed (see Table 13.2): The results were virtually identical.

Of considerable importance to practitioners and policy makers is the fact that statistically controlling for researcher allegiance or bias diminishes the small differences that have been reported. There was, in fact, a relatively high rate of negative researcher allegiance (44%) in these studies, and also a large negative correlation ( $r = -.49$ ;  $n = 135$ ;  $p < .001$ ) between researcher allegiance and comparative effect size. Therefore, we ran additional analyses statistically controlling for researcher allegiance, by removing variance in comparative ESs due to this variable. When this was done (see Table 13.2, values in italics), these statistically significant but trivially small treatment differences disappeared. Thus, these data support the claim that HEPs have been found to be practically and statistically equivalent to CBT in effectiveness. Researcher allegiance in comparative outcome studies continues to confound the interpretation of differences found between treatments generally (e.g., Luborsky et al., 1999).

## CBT Versus HEP Subtypes

In this meta-analysis, our larger sample enabled us to examine our data more closely than in previous meta-analyses, in order to see if we could

understand better the statistically significant but trivially small advantage of CBT over HEPs. In order to do this, we looked at the four types of PCE therapy for which there were at least two comparative studies: PCT, supportive treatments, EFT, and other HEPs. The results of these analyses are given in Table 13.3, which reveal:

1. *Supportive therapies* appeared to be equivocally less effective than CBT (total sample:  $n = 37$ ;  $d_w = -.27$ ; CI:  $-.4$  to  $-.13$ ; RCTs:  $n = 35$ ;  $d_w = -.25$ ; CI:  $-.4$  to  $-.11$ ). As Table 13.3 indicates, the confidence intervals for these differences fall below zero (it is statistically significantly worse than CBT) and at the minimum clinically interesting value of  $-.4$ . Furthermore, these values are moderately inconsistent, with statistically significant  $Q$  values and  $I^2$  of around 40%, indicating further within group differences needing to be explored. Further investigation of the supportive therapies revealed them to be watered down, typically non-bona fide versions of PCE therapies, commonly used by CBT researchers, especially in the United States; in fact, when researcher allegiance was controlled for, the weighted effect dropped to  $-.01$  (CI:  $-.16$  to  $.13$ ). We have included these here as part of our inclusive search strategy, because they meet our inclusion criteria and because they have been widely researched.
2. The supportive subgroup of HEPs appeared to be responsible for the small (“trivial”) advantage of CBT over the remaining HEPs. When the supportive treatments were removed, the result was a relatively consistent equivalence finding for the total sample ( $n = 39$ ;  $mES = -.06$ ;  $Q = 48.1$ ,  $p > .1$ ;  $I^2 = 21\%$ ) and for RCTs ( $n = 30$ ;  $mES = -.03$ ;  $Q = 39.6$ ,  $p > .05$ ;  $I^2 = 27\%$ ).
3. *PCT* appeared to be consistently, statistically and practically equivalent in effectiveness to CBT (22 studies, including 17 RCTs, with effect sizes of  $-.06$  and  $-.1$  respectively and  $Q$ 's with  $p > .5$ ), even without controlling for researcher allegiance.
4. Although based on only six studies (5 RCTs), *EFT* for individuals or couples appeared to be statistically and clinically more effective than CBT, with an effect size of  $.53$  ( $.51$  for the RCTs). However, controlling for researcher allegiance lowered the weighted effect to an equivocal, nonsignificant  $.21$  (CI:  $-.19$  to  $.61$ .)
5. *Other HEPs* were trivially worse than CBT overall (10 studies;  $ES = -.17$ ;  $Q = 6$ ,  $p > .5$ ) but equivalent for the RCT subset (7 studies,  $ES = -.06$ ). (This was a consistent finding with  $Q$ 's having  $p > .5$ , and remained even after controlling for researcher allegiance.)

**Table 13.3 Equivalence Analysis: Comparisons Between CBT and Type of HEP**

	<i>n</i>	<i>d<sub>w</sub></i>	SE	95% CI	Diff: 0	Diff: < .4	Result <sup>a</sup>
PCT vs. CBT	22 (17)	-.06 (-.10)	.02 (.06)	-.11 to -.01 (-.23 to -.02)	Yes	Yes	Equivalent (Trivially worse)
Supportive vs. CBT	37 (35)	-.27 (-.25)	.07	-.41 to -.13 (-.40 to -.11)	Yes	No	Equivocally worse
EFT vs. CBT	6 (5)	.53 (.51)	.2 (.23)	.13 to .93 (.06 to .97)	Yes	No	Clinically better
Other HEP vs. CBT	10 (7)	-.17 (.06)	.10 (.12)	-.37 to .03 (-.30 to .18)	No	Yes	Trivially worse (Equivalent)
Low process-guiding vs. CBT	59 (52)	-.16 (-.19)	.04 (.05)	-.23 to -.08 (-.29 to -.09)	Yes	Yes	Trivially worse
High process-guiding vs. CBT	17 (13)	.04 (.12)	.12 (.13)	-.2 to .27 (-.15 to .38)	No	Yes	Equivalent (Trivially better)
More vs. less Process-guiding	9 (8)	.14 (.08)	.18 (.19)	-.21 to .5 (-.30 to .44)	No	No	Trivially better (Equivalent)

**Note.** For table column abbreviations, see notes for Table 13.2. HEP: humanistic-experiential; CBT: cognitive-behavioral therapy; PCT: person-centered therapy; EFT: emotion-focused therapy. Low process-guiding: PCT + Supportive; high process-guiding: EFT + other experiential + supportive-expressive group.

<sup>a</sup>“Equivalent”: within .1 sd of zero (greater than  $-.1$  and less than  $.1$ ); “Trivially (worse/better)”: between  $.1$  and  $.2$  sd from zero; “Equivocally (worse/better)”: between  $.2$  and  $.4$  sd from zero; “Clinically worse/better”: at least  $.4$  sd from zero.

<sup>b</sup>Values in parenthesized italics are results of analyses of randomized studies.

## **High Versus Low Process-Guiding Humanistic-Experiential Therapies**

As noted earlier, HEPs such as gestalt, EFT, and focusing encourage the therapist to act as a process expert or guide by offering the client different ways of working in the session at different times. This stand has sometimes proven to be controversial (eg., Brodley, 1990), so it is useful to examine what our meta-analytic data have to say about this issue. As shown in Table 13.3, in general, HEPs low on process-guiding (i.e., PCT and supportive therapies) were trivially worse than CBT for the whole sample ( $n = 59$ ;  $mES = -.16$ ) and for RCTs ( $n = 52$ ,  $mES = -.19$ ), while high process-guiding therapies (EFT, other HEP) were equivalent to CBT for the total sample ( $n = 17$ ;  $mES = .04$ ) and trivially better for RCTs ( $n = 13$ ,  $mES = .12$ ). On the other hand, in the nine comparisons (eight randomized) where more process guiding therapies (e.g., EFT, gestalt) were compared directly to less process guiding therapies (most commonly PCT), the

comparative effect sizes for the more process-guiding approaches was only trivially better (and equivalent for RCTs) and not particularly consistent (total sample:  $mES = .14$ ; CI:  $-.21$  to  $.5$ ;  $Q = 16.9$ ,  $p < .05$ ;  $I^2 = 53\%$ ; RCTs:  $mES = .08$ ; CI:  $-.3$  to  $.44$ ;  $Q = 14.3$ ,  $p < .05$ ;  $I^2 = 51\%$ ). It is worth noting that process-guiding exists along a continuum, so that different studies have compared pairs of HEPs at different points on the spectrum, making it difficult to integrate the results. Researcher allegiance effects also likely play a role here. Clearly, more research is needed to explore this key issue.

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## Outcome for Different Client Problems: Differential Treatment Effects

Investigation of HEPs for specific client presenting problems or disorders has blossomed over the past 20 years. The three lines of evidence (pre-post, controlled, and comparative studies) are summarized in Table 13.4 for six commonly studied relatively coherent types of client problem, evaluated both relative to zero and for bench-marking purposes to the whole sample. In brief, the largest amount of evidence and the strongest support for HEPs have been found for depression, relationship problems, coping with chronic medical problems (e.g., HIV, cancer), habitual self-damaging behaviors (substance misuse, eating disorders), and psychosis. There is also considerable, but more mixed, evidence supporting the application of these approaches with anxiety. In this section, we provide meta-analytic evidence, summarize key recent studies, and evaluate the status of HEPs as empirically supported treatments for these six particular client problems.

**Table 13.4 Effect Size by Selected Client Problems/Disorders**

Problem/Disorder	Prepost ES		Controlled ES		Comparative ES	
	<i>n</i>	$d_w \pm 95\%CI$	<i>n</i>	$d_w \pm 95\%CI$	<i>n</i>	$d_w \pm 95\%CI$
Depression	34	1.23 ± .23*(+)	8	.42 ± .36*(=)	37	-.02 ± .15(=)
Relationship/interpersonal/trauma	23	1.27 ± .21*(+)	11	1.39 ± .4*(+)	15	.34 ± .27*(+)
Anxiety	20	.94 ± .22*(=)	4	.50 ± .34*(=)	19	-.39 ± .16*(-)
Medical/physical	25	.57 ± .27*(-)	6	.52 ± .34*(=)	24	-.00 ± .11(=)
Psychosis	6	1.08 ± .17*(=)	--	--	6	.39 ± .29*(+)
Habit/substance misuse	13	.65 ± .26*(-)	2	.55 ± .39*(=)	10	.07 ± .23(=)
Total sample (used for benchmarking)	201	.93 ± .08*	62	.76 ± .12*	135	.01 ± .06

Note. \* $p < .05$  in null hypothesis test against  $ES = 0$ ; *ns* refer to number of client samples (pre-post ESs) or comparisons with other conditions (controlled and comparative ESs). Benchmarking results vs. total sample: (=): confidence interval includes benchmark value; (+): confidence interval is above bench-mark value; (-): confidence interval is below benchmark.

## Depression

There are more studies of depression in our data set than any other client presenting problem, with the strongest evidence provided by pre-post and comparative treatment studies. We found 34 samples of clients (from 27 studies;  $n = 1,287$  clients) for whom pre-post effects could be calculated, most commonly PCT (10 samples), supportive (9 samples), or EFT (8 samples). The weighted mean pre-post effect size across these 34 samples was large ( $d_w = 1.23$ , CI: 1.0 to 1.45).

On the other hand, the eight controlled comparisons with no treatment or waitlist controls provided a somewhat weaker but still statistically significant weighted effect in the small to medium range (weighted controlled ES: .42; 95% confidence interval: .06 to .78), including two outliers (Maynard et al., 1993; Tyson & Range, 1987), the only two negative controlled effects in the data set as a whole, both small sample studies using non-bona fide group interventions.

The 37 HEP versus non-HEP comparisons (from 23 studies,  $n = 755$  and 1,261 respectively; most commonly CBT) support an equivalence conclusion (mean comparative  $d_w$ : -.02; CI: -.16 to .13). In fact, substantial ( $> |.4|$ ) positive and negative comparative results were evenly balanced (positive: 8; negative: 10; neutral: 19).



Four of the comparisons between more and less process guiding HEPs involved depressed clients. These studies showed a consistent, reliable and clinically significant advantage for more process guiding approaches like EFT (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998) or gestalt therapy (Beutler et al., 1991; Tyson & Range, 1987), with a weighted comparative ES of .44 (confidence interval: .10 to .78).

Two clusters of evidence on depression are worth noting: First, there are three well-designed RCTs testing EFT for depression (Goldman et al., 2006; Greenberg & Watson, 1998; Watson, Gordon, Stermac, Kalogerakos & Steckley, 2001) comparing EFT to other therapies in the treatment of major depressive disorder, using medium-size samples and conducted by two different research teams. In particular, Goldman et al. (2006) found that EFT had significantly better outcomes (including very low relapse rates) when compared to PCT. Watson et al. (2003) found equivalent, and on some measures better, results than CBT. Second, there are four well-designed RCTs of PCT for perinatal depression with medium to large sample sizes that either show superiority to treatment as usual (Holden, Sagovsky, & Cox, 1989; Morrell et al., 2009; Wickberg & Hwang, 1996), or no difference in comparison to CBT (Cooper, Murray, Wilson & Romaniuk, 2003) or short-term psychodynamic therapy (Cooper et al., 2003; Morrell et al., 2009). Both of these clusters of well-controlled studies meet Chambless and Hollon's (1998) criteria for *efficacious and specific* treatments.

Key new studies since our last review include the Cooper et al (2003) and Morrell et al. (2009) studies with perinatal depression, mentioned above, and two studies by Mohr and colleagues on depression in a medical population (Mohr, et al, 2005; Mohr, Boudewyn, Goodkin, Bostrom, & Epstein 2001), to be discussed later. The other substantial study is Stice, Burton, Bearman, and Rohde (2006; Stice, Rohde, Gau, & Wade, 2010), in which adolescents with mild to moderate depression were randomized to one of four conditions: supportive group therapy versus CBT group therapy versus CBT bibliotherapy versus controls. Participants seen in supportive therapy showed benefits comparable to those in CBT out to 2-year follow-ups and did much better than control group clients.

## **Relationship and Interpersonal Difficulties**

Of all client presenting problems, HEPs appear to be most consistently effective for clients presenting with either specific unresolved relationship issues or more general interpersonal difficulties. The largest number of the 24 studies included in our meta-analysis addressed specific relationship problems, generally within the context of couples therapy (10 studies, e.g., Denton, Burleson, Clark, Rodriguez & Hobbs, 2000). However, there were also smaller clusters of studies on general interpersonal difficulties, generally treated individually (six studies, e.g., Grawe, Caspar, & Ambühl, 1990); and specific emotional injuries, treated

either individually or in couples (five studies, e.g., Greenberg, Warwar, & Malcolm, 2010; Makinen & Johnson, 2006). Finally, we found three studies that focused on posttrauma difficulties or formally diagnosed PTSD, with some (e.g., Szapocznik et al., 2004) including substantial portions of clients with this diagnosis. The strongest evidence was for EFT-C (emotion- or emotionally focused therapy for couples), developed by Greenberg and Johnson (1988). We found 23 samples of clients (from 21 studies;  $n = 467$  clients) for whom pre-post effects could be calculated, most commonly EFT-C (10 samples), EFT for individuals (6 samples), PCT (3 samples), and other HEP (4 samples). The weighted mean pre-post effect size across these 23 samples was large but quite variable ( $d_w = 1.27$ , CI: .96 to 1.58;  $Q = 96.9$ ,  $p < .001$ ;  $I^2 = 77\%$ ). Effects were somewhat (but not significantly) larger for therapies delivered in couple or family format ( $n = 13$ ;  $d_w = 1.50$ , CI: 1.11 to 1.90) versus being carried out individually ( $n = 10$ ;  $d_w = .97$ , CI: .53 to 1.41).

The 11 controlled comparisons (7 of them RCTs, 7 studies on EFT-C) with no treatment or waitlist controls provided a very large weighted effect ( $d_w = 1.39$ ; CI: .99 to 1.79), with all controlled effects being substantial and positive.

There were 15 controlled comparisons (from 13 studies) of clients seen in HEPs ( $n = 250$ ) versus non-HEPs ( $n = 327$ ), most commonly CBT or psychoeducational interventions. The overall weighted effect was moderately heterogeneous but points to the superiority of HEPs over non-HEPs for relational difficulties (comparative  $d_w = .34$ ; CI: .07 to .62;  $Q = 39.1$ ,  $p < .001$ ;  $I^2 = 64\%$ ). Seven of the 15 comparative effects were substantial ( $> |.4|$ ) and positive, with no substantial effects favoring the alternative treatment. For the eight comparisons involving EFT (both couples and individual), the weighted effect ( $d_w = .69$ ; CI: .32 to 1.06) was significantly larger than for the five comparisons involving PCT ( $d_w = -.08$ ; CI:  $-.30$  to .13). Both forms of EFT appeared to be highly effective: EFT for couples for addressing relational injuries (3 studies;  $d_w = .88$ ; CI:  $-.16$  to 1.92), and EFT for individuals with unresolved interpersonal issues or abuse suffered by individuals (5 studies;  $d_w = .62$ ; CI: .26 to .97). In addition, whether the non-HEP was CBT or psychoeducation made relatively little difference: versus CBT the weighted effect was .34 (6 studies; CI:  $-.15$  to .83); the value for comparisons with psychoeducation was .51 ( $n = 4$ ; CI:  $-.10$  to 1.13).

EFT for couples has long been included in lists of empirically supported treatments for marital distress (e.g., Baucom, Mueser, Shoham, & Daiuto, 1998); however, our meta-analytic data indicate that EFT for individuals is *efficacious and specific* for unresolved relationship issues, including emotional injuries (Greenberg, Warwar, & Malcolm, 2008; Souliere, 1995) such as unresolved abuse survivor issues (Paivio et al., 2001; Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010).

Four recent studies not in our meta-analysis support and extend the results reported here. Two of these underscore and develop the results already reported: Greenberg, Warwar, and Malcolm (2010) offered promising results for an EFT couples approach specific to emotional injury and forgiveness. Paivio and associates (2010) extended earlier results with EFT for individuals who had experienced childhood abuse (62% met criteria for PTSD), finding that EFT with empty chair work produced better outcomes but more dropouts than EFT without chair work. Two other recent pilot studies opened up new areas for working with relational difficulties but were at the same time consistent with the overall findings for this client population: In an initial uncontrolled study, McLean and colleagues (2008) provided promising evidence that EFT-C can help couples improve their relationship and reduce psychological distress in the face of advanced breast cancer. Also, in a newly located study, Miller (1999) found that a PCT group was as effective as a social learning theory-based CBT group for reducing dating violence in at-risk young people with histories of observing domestic violence or committing dating violence themselves. (See anxiety section below for discussion of the evidence on PTSD.)

## **Anxiety**

Research on HEPs for anxiety, most commonly the application of supportive therapies with panic/agoraphobia or generalized anxiety disorder, is much more mixed than is the case for depression, but is strongest for pre-post and controlled studies. We found 20 samples of clients ( $n = 19$  studies, 305 clients) for whom pre-post effects could be calculated, mostly supportive (8 samples of clients), PCT (6 samples), and other HEP (5 samples), carried out in studies where there was a negative researcher allegiance (14 samples). Anxiety disorders studied included panic/agoraphobia (6 samples), generalized anxiety disorder (6 samples), phobias (usually chronic or complex; 6 samples), and mixed anxiety (2 samples). The weighted mean pre-post effect size for the 20 sets of anxious clients was .94 (CI: .73 to 1.16), quite near the bench-mark for the entire sample of pre-post effects (see Table 13.4). Although the confidence intervals all overlapped, pre-post effects varied significantly across type of HEP ( $Q = 8.17; p < .05$ ), with effects for supportive treatments somewhat smaller ( $d_w = .66$ ; CI: .40 to .92) than for PCT ( $d_w = 1.0$ ; CI: .71 to 1.28) or other HEP ( $d_w = 1.41$ ; CI: .84 to 1.97).

There were only four controlled studies, all with relatively small samples (< 25); these showed a controlled effect size of .5 (CI: .17 to .83) a medium effect size slightly but not statistically significantly less than the bench-mark value of .76 for the entire sample.

Of the six client population clusters we are reviewing for comparative effects in this chapter, HEPs fared most poorly with anxiety problems, with a mean comparative effect size of  $-.39$  (CI:  $-.55$  to  $-.23$ ) across 19 comparisons

with non-HEP. This is consistently, moderately and significantly in favor of the non-HEPs, almost all some form of CBT. Nine of the 18 comparative effects with CBT substantially favored CBT ( $< -0.4$ ), with none favoring an HEP. In comparisons with CBT, there was very little variation ( $d_w = -0.42$  to  $-0.36$ ) across type of HEP (supportive, PCT, other).

Applying the Chambless and Hollon (1998) criteria to specific types of anxiety disorder, the picture is clearest for *generalized anxiety disorder*, where six of nine comparisons substantially favored CBT, including studies by two independent research teams (Bond, Wingrove, Curran, & Lader, 2002; Borkovec et al., 1987; Borkovec & Costello, 1993; Borkovec & Mathews, 1988); the other three comparisons showed equivocal results (Blowers, Cobb, & Mathews, 1987; Borkovec & Mathews, 1988; Stanley, Beck, & Glassco, 1996). Here, the preponderance of the evidence, both in terms of overall effect size ( $d_w = -0.44$ ) and numbers of studies and independent research teams, clearly favors CBT. The picture for *panic/agoraphobia* was somewhat more complicated: Two of the 6 comparisons favored CBT over HEP (from independent research teams: Beck, Sokol, Clark, Berchick, & Wright, 1992; Shear, Houck, Grenno, & Masters, 2001), with one comparison favoring medication over HEP (Shear et al., 2001), and three having equivocal results (Craske, Maidenberg, & Bystritsky, 1995; Shear, Pilkonis, Cloitre, & Leon, 1994; Teusch, Böhme, & Gastpar, 1997). Nevertheless, the weighted effect for panic/agoraphobia was  $-0.39$  (CI:  $-0.75$  to  $-0.04$ ). Thus, it can be said that for panic that the preponderance of the evidence somewhat favors CBT over HEP. Finally, for the three comparative studies of phobia, either complex or chronic phobia (Grawe, 1976; Johnson, 1977) or social phobia (Cottraux et al., 2000) all reported equivocal comparative effects ( $d_w = -0.15$ ).

At the same time, we found substantial pre-post effects for the great majority of anxiety studies, indicating that HEPs for anxiety meet Chambless and Hollon's (1998) criteria as *possibly efficacious*, while also suggesting that CBT may be somewhat more *specific and efficacious*. This apparent moderate CBT advantage is likely due to two possible factors. To begin with, it is likely to be due in part to researcher allegiance effects: When allegiance-controlled effects were analyzed, the difference, though still statistically significant, shrank to  $-0.21$  (CI:  $-0.38$  to  $-0.05$ ). In addition, it now seems likely to us that anxiety disorders may respond somewhat better to more structured treatments that include a psychoeducation component, such as CBT, as opposed to the predominantly nondirective forms of HEPs that have so far been studied. Interestingly, two recent studies of GAD point to potential benefits from adding forms of HEP to CBT: Newman et al. (2011) combined either supportive-nondirective therapy or interpersonal emotion processing therapy to CBT on a session-by-session basis; they reported no significant differences at post or follow-up but large pre-post effects for the two treatments combined ( $d = 1.86$ ). In addition, Westra and Dozois

(2006) found that adding three sessions of motivational interviewing (adapted for anxiety) prepared clients better for subsequent CBT and was associated with better treatment response and posttherapy maintenance of gains.

In our clinical experience, clients with significant anxiety difficulties frequently have a problem with the lack of structure of typical of nondirective therapies, often asking directly for expert guidance. For this reason, several of the authors of this chapter are currently conducting studies on the effectiveness of EFT with generalized anxiety (Watson, Timulak) or social anxiety (Elliott); Elliott and colleagues (2010) have reported promising initial results from their study in progress comparing PCT and EFT to each other and to published CBT outcome benchmarks. For now, our advice for humanistic-experiential therapists is to discuss the issue with clients, to consider adding process guiding elements to their therapy, or to provide information about the role of trauma or emotional processes in panic attacks (e.g., Wolfe & Sigl, 1998).

Finally, it is worth noting that although there is good evidence that HEPs, especially EFT, are effective with relational/interpersonal difficulties and even the long term sequelae of childhood trauma reviewed in the previous section, there is little research on PTSD per se. Further, the results reviewed here for other anxiety disorders are not encouraging as a basis for extrapolating to PTSD. It is particularly difficult to generalize from these various studies examined here to full blown or nonrelationally focused PTSD, especially PTSD due to combat (e.g., Ragsdale, Cox, Finn, & Eisler, 1996). Further research on HEPs for PTSD is urgently needed.

## **Coping With Chronic Medical Conditions**

The use of HEPs to help clients coping with chronic or life-threatening medical illnesses has burgeoned in the past 20 years, with studies more than tripling since our 2004 review. Our 2008 meta-analysis sample turned up 29 studies ( $n = 1145$  clients). The most common form of HEP studied was supportive-expressive group therapy, an existential-experiential treatment developed by Spiegel, Bloom, and Yalom (1981), which was the subject of 12 studies in our meta-analysis. Person-centered and supportive therapies were each examined in seven studies. Coping with a broad range of medical conditions has now been investigated, the most common being cancer, both early stage/remitted (7 studies) and late stage/metastatic (7 studies); however, autoimmune disorders such as lupus, MS, and rheumatoid arthritis are now being investigated (5 studies), and the meta-analysis also includes two studies each for gastrointestinal problems (IBS, colitis, Crohn's), HIV-positive status, and pain (back- and head-ache) as well as four studies of other conditions (kidney, vitiligo, cardiac rehabilitation, sleep problems). Of the studies, 17 (59%) were carried out by researchers with a favorable researcher allegiance, and 17 were in a group format (see also the review

by Burlingame et al., examining group psychotherapy, this volume). The overall weighted mean pre-post effect size across the 25 samples for which pre-post effects could be calculated was medium in size but highly inconsistent ( $d_w = .57$ , CI: .3 to .84;  $Q = 195.1$ ,  $p < .001$ ;  $I^2 = 88\%$ ). Statistically significant pre-post effects ( $d_w$ ) were found for autoimmune conditions (.68; CI: .08 to 1.29), early stage cancer (.55; CI: .28 to .83), early/late cancer combined (.62; CI: .18 to 1.05), and other medical conditions (.42; CI: .09 to .75).

There were six controlled studies versus no treatment/wait list, on diverse client populations (early stage cancer, cardiac, kidney, vitiligo); overall, these showed a fairly consistent medium effect size of .52 (CI: .19 to .86;  $Q = 7.5$ , NA;  $I^2 = 33\%$ ), although the effects for the three older studies of early/remitted cancer were smaller and not statistically significant ( $d_w = .36$ ; Dircks, Grimm, Tausch, & Wittern, 1982; Katonah, 1991; van der Pompe, Duivenvoorden, Antoni, Visser, & Heijnen, 1997).

There were 19 comparative studies, including 24 comparisons to non-HEPs. All but three comparisons were randomized (88%) and all but two used bona fide treatments (92%). The most common HEPs were PCT (9 comparisons), supportive (7 studies) and supportive-expressive groups (7 studies); HEPs were most often applied to helping clients cope with autoimmune disorders (7 studies), cancer early/remitted or late/metastatic (4 studies each), HIV positive status (3 studies). The most common non-HEPs were CBT (11 studies) and treatment as usual (8 studies). Researcher allegiances were roughly evenly divided (pro: 42%; con: 46%; neutral 13%).

The overall comparative effect was a clear and highly consistent equivalence finding ( $d_w = -.00$ ; CI:  $-.11$  to  $.10$ ;  $Q = 27.7$ , NS;  $I^2 = 17\%$ ). Only three comparisons substantially ( $> .4$ ) favored non-HEPs therapies, two of these from the same study (Machado, Azevedo, Capanema, Neto & Cerceau, 2007; Mohr et al., 2001). Twenty effects were within .4 of each other, while one effect favored an HEP (Spiegel et al., 1981). Furthermore, there were no differences in comparative effects between PCT, supportive, and supportive-expressive group therapies (between groups  $Q = 1.85$ , NS). However, there was a trend for comparisons with CBT ( $d_w = -.13$ ; CI:  $-.29$  to  $.02$ ) to be slightly larger than comparisons with other non-HEP treatments ( $d_w = .07$ ; CI:  $-.07$  to  $.21$ ; between groups  $Q = 3.47$ ;  $p = .06$ ). Furthermore, there were clear differences between different medical conditions ( $Q = 15.4$ ,  $p < .01$ ), with the strongest comparative effects for coping with advanced cancer ( $d_w = .28$ ; CI:  $.10$  to  $.47$ ). HEPs appeared to do less well with autoimmune conditions when compared to non-HEPs ( $d_w = -.22$ ; CI:  $-.44$  to  $.01$ ,  $p = .06$ ), as illustrated particularly in the two studies of Mohr and colleagues (2001, 2005) on clients with MS and depression.

Given the diversity of medical conditions and treatments studies, it is difficult to apply the Chambless and Hollon (1998) criteria to this set of studies.

Nevertheless, from these data, it appears that HEPs are *efficacious* treatments for helping clients cope with a variety of medical conditions, based on (a) their superiority to no treatment control conditions; and (b) their general equivalence to an established treatment (CBT).

However, a word of caution is in order: A recent search turned up at least 20 more studies on HEPs on this topic, about half of them on cancer, with the rest on a variety of other medical conditions, especially cancer, HIV, chronic pain, rheumatoid arthritis, and so on. This is certainly an indicator of the vitality of this area of research on HEPs; but there is a strong possibility that these additional studies will modify the conclusions that can be made about HEP for medically ill populations. This is particularly true for supportive-expressive group therapy for cancer, which has been the subject of intense scientific scrutiny over the past 10 years, including a recent failure to replicate by the originator of the approach (Spiegel et al., 2007) and a large Canadian multicenter trial on the use of supportive-expressive group therapy to improve quality of life for women with metastatic breast cancer, which failed to show a benefit over a no treatment/usual care control (Bordeleau et al., 2003). This led a recent Cochrane review (Edwards, Hulbert-Williams, & Neal, 2008) to conclude, “There is insufficient evidence to advocate that group psychological therapies (either cognitive behavioural or supportive-expressive) should be made available to all women diagnosed with metastatic breast cancer.”

The reviewers did, however, note that there was some positive evidence on psychological (as opposed to medical) outcome variables, especially in the short term. For now, the search continues for promising client subpopulations (e.g., estrogen-negative breast cancer; Spiegel et al., 2007) and target variables (e.g., fear of disease progression, relationship variables, treatment decision making). It is also worth noting that the new comparative outcome data appear to support our main conclusion of outcome equivalence between HEP and CBT for coping with breast cancer. However, the main issue here appears to be whether *any* psychosocial treatment—CBT or supportive-expressive group therapy included—can improve survival rates and psychological adjustment with breast cancer, either early stage or metastatic. We hope that further research now in progress will clarify this important issue.

## **Psychosis**

The use of HEPs for clients diagnosed with psychosis, including schizophrenia, has become controversial, particularly in the United Kingdom, where the latest version of the Department of Health’s treatment guidelines (National Collaborating Centre for Mental Health [NICE], 2010) effectively banned the practice via the following negative recommendation: “Do not routinely offer counselling and supportive psychotherapy (as specific interventions) to

people with schizophrenia” (p. 290). This proclamation has had the effect of wiping out a United Kingdom tradition of offering person-centered counseling to individuals living with psychotic processes, documented by Traynor, Elliott, and Cooper (2011), and marked by the recent advances, including the addition of special methods for making psychological contact with clients when they are in psychotic states (Dekeyser, Prouty, & Elliott, 2008).

The full NICE 2010 guideline includes extensive documentation from the evidence survey on which the recommendation was supposedly based. Thus, it was not difficult for us to carry out a quick, rough analysis of the evidence from the nine studies comparing the supportive treatments (defined in the document as person-centered in orientation) to CBT in the NICE 2010 evidence survey (see Appendix 16D): Contrary to the strongly negative guideline, the data reported in the evidence survey instead point to a trivially small superiority for CBT over supportive counseling: mean  $d = -.19$ ; mean relative risk ratio = 1.08. In addition, these overall mean effects were characterized by large standard deviations (.59, .32 respectively), indicating substantial heterogeneity. In fact, there are many instances in the NICE data summary where supportive treatments actually did substantially better than CBT (e.g., Tarrier et al., 2000, at 19-month follow-up). Two possible interpretations of these data appear to fit the evidence better than that drawn by the NICE committee: First, supportive treatments are almost as effective as CBT, even without the benefit of recent focused treatment development efforts and even when carried out by researchers with an anti-HEP theoretical allegiance. Second, more conservatively, the data are too inconsistent to warrant any overall conclusions at the present moment.

Although the committee defined supportive counseling as person-centered, the NICE 2010 evidence base is a mixture of different approaches, not all of them HEPs. Nevertheless, our meta-analysis data set does contain six studies (mostly RCTs) of patients with schizophrenic or psychotic diagnoses for which pre-post effect sizes could be calculated (Coons & Peacock, 1970; Dekeyser et al., 2008; Eckert & Wuchner, 1996; Serok & Zemet, 1983; Tarrier et al., 1998; Teusch, 1990), involving a total of 209 clients seen in treatments explicitly labeled as nondirective, gestalt, or PCT, including a promising recent form of PCT called pre-therapy. Clients were seen in both inpatient and outpatient settings and in a mixture of individual and group formats and evaluated on a range of measures, including symptom and life functioning ratings. The weighted pre-post effect size for these six studies was 1.08 (CI: .51 to 1.65). Although uncontrolled, these effects nevertheless demonstrate very large pre-post effect sizes with this chronic and severely distressed clinical population.

Second, although there were no studies comparing an HEP to a no-treatment or wait-list control condition, we did locate five comparative treatment RCTs (Coons, 1970; Dekeyser, 2008; Serok, 1983, 1984; Tarrier 1998), providing six comparisons to non-HEPs and a total of 170 patients (75 in HEP). The HEPs



were explicitly labeled as nondirective, gestalt, or pre-therapy; the non-HEPs were most commonly labeled as *treatment as usual*, but one study each involved CBT or exercise. The mean comparative effect size across the six comparisons was .39, in favor of HEP (CI: .10 to .67). This is a moderately large, fairly consistent controlled effect size that supports the effectiveness of HEP versus standard care for clients with schizophrenia or other psychotic diagnoses, and contrasts strongly with results of the studies reviewed by the NICE review committee.

Probably the safest conclusion here is that, based on existing evidence, HEPs appear to be, in Chambless and Hollon's (1998) terms, *possibly efficacious*. In other words, they are promising but require further development and outcome research, especially in light of developments in both the HEP approaches (e.g., new pre-therapy and process-guiding treatments, see Traynor et al., 2011) and in CBT (the advent of new person- or acceptance-based forms of CBT for schizophrenia, e.g., Chadwick, 2006).

## **Habitual Self-Damaging Activities**

Recurrent self-damaging activities such as substance misuse and eating disorders are the subject of an emerging body of evidence using a wide variety of HEPs, including 13 studies already in our meta-analysis, with 15 samples (total  $n = 413$ ) of clients focusing on recurrent, self-damaging habit difficulties, predominantly substance misuse (11 samples of clients) and eating difficulties (3 samples). (There was also one study on Tourette's syndrome; Wilhelm et al., 2003.) The weighted pre-post effect was .65 (CI: .39 to .90). Effects were comparable for substance misuse ( $d_w = .68$ ; CI: .36 to .99) and eating difficulties ( $d_w = .62$ ; CI: .12 to 1.11).

There were two controlled studies of substance misuse (Sellman, Sullivan, Dore, Adamson, & MacEwan, 2001; Washington, 2001) versus no treatment or wait-list controls, with a weighted effect of .55 (CI: .17 to .93). Nine studies (7 RCTs, 10 comparisons of clients) compared a range of HEPs (supportive and other HEP were most common) to other treatments, most often CBT (6 studies). The weighted comparative effect was .07 (CI: -.15 to .30), indicating that HEPs and non-HEPs for habit difficulties were equivalent in effectiveness. For the six comparisons with CBT, the value was -.03 (CI: -.41 to .35), an equivalence finding in terms of effect size but including the  $|\cdot 4|$  boundary. Six of the comparisons involved treatments for substance misuse; the weighted effect for these comparisons was .16 (CI: -.05 to .38). Finally, there were three comparisons between HEPs and CBT for substance misuse ( $d_w = .16$ ; CI: -.27 to .60). Seven of the 10 comparative effects were relatively small ( $<|\cdot 4|$ ). However, two studies—both on alcohol problems—produced effects that substantially ( $> \cdot 4$ ) favored HEPs (Jacobs & Bangert, 2005; Wetzel et al., 2004). The one study on Tourette's

(Wilhelm et al., 2003) yielded a very strongly negative comparative effect ( $< -0.8$ ) for a comparison between supportive therapy and CBT.

Overall, the preponderance of the current evidence, including both controlled and comparative treatment lines of evidence, indicates that HEPs meet the Chambless–Hollon standards as an *efficacious* treatments for substance misuse (i.e., problems with alcohol and cocaine): Consistent with our meta-analysis, they have been shown to be superior to no treatment controls (two good-size, independent RCTs: Sellman et al., 2001; Washington, 2001); at the same time, the comparative treatment evidence (2 independent  $n > 25$  studies) indicates that they are either equivalent or superior to an already established treatment, CBT (Washington, 2001; Wetzel et al., 2004). The evidence on the use of HEPs for eating difficulties, however, remains equivocal at this point: there are only two small studies of overeating (Holstein, 1990; Kenardy, Mensch, Bowen, Green, & Walton, 2002), with equivocal, no difference results. As for Tourette’s syndrome, supportive therapy might be inferior to CBT (specifically, habit reversal), but so far there is only a single, negative researcher allegiance, small  $n$  study (Wilhelm et al., 2003).

Our meta-analysis missed at least one noteworthy recent study of an HEP for eating difficulties, a good-size German-language RCT by Schutzmann, Schutzmann & Eckert (2010), in which person-centered therapy had better results than guided self-help for bulimia. In addition, an EFT group treatment on a sample of 12 bulimic clients was associated with statistically significant decreases in the frequency of binge episodes, improvements in eating disorder related psychopathology, depression, alexithymia, emotion regulation, self-esteem, general psychiatric distress, and self-efficacy (Wnuk, 2009).

A more significant omission is that we have not to date included research on motivational interviewing (also known as motivational enhancement therapy, Miller & Rollnick, 2002), described as a directive form of client-centered therapy, adapted for clients who engage in patterns of self-damaging activity such as excessive drinking. This approach is often quite brief ( $< 3$  sessions) and mixes PCT with significant information and feedback, making it difficult to categorize in spite of its clear roots in HEP and its large evidence base. Fortunately, a recent meta-analysis by Lundahl et al. (2010) provides up-to-date, comprehensive coverage of 119 controlled and comparative studies of motivational interviewing for a variety of habitual self-damaging activities (about 80% substance misuse), including 35 wait-list controlled studies, with an overall mean effect of .32 (CI: .22 to .42); 42 comparisons with nonspecific treatment as usual ( $d_w = .24$ ; CI: .17 to .31); and 39 comparisons with specific evidence-based alternative treatments (primarily 12-step or CBT;  $d_w = .09$ ; CI:  $-.01$  to .18). These results are roughly comparable to ours, especially for the comparative studies.

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# Qualitative Outcomes in Humanistic-Experiential Psychotherapies

The increased use of qualitative methods in the field of psychology generally, and for psychotherapy research specifically (see McLeod, this volume) has produced enough findings examining outcome to allow for a “meta-analytic” style of review (see Timulak, 2009). Timulak and Creaner (2010) recently conducted a qualitative meta-synthesis of qualitative studies on HEPs, covering outcome descriptions from 106 clients participating in a variety of HEPs (such as EFT and PCT). The data collection method most typically used was a posttherapy (follow-up) interview, such as the client change interview (Elliott, Slatick, & Urman, 2001).

Timulak and Creaner (2010) reported 11 categories that offered a comprehensive conceptualization of the outcomes reported by clients in individual HEPs (see Table 13.5). They found that many of the qualitative outcomes in the original studies corresponded with humanistic-experiential theories of therapy outcome. For instance, healthier emotional experiencing, empowerment, resilience, and increased self-awareness are traditionally emphasized as potential outcomes of HEPs (cf. Greenberg, 2010). It is interesting to note that the clients in these therapies also reported outcomes that are likely to be shared with other approaches to therapy such as mastery of symptoms (CBT) or improved interpersonal functioning and insight (psychodynamic approaches).

Two findings are, however, of particular interest. One of them is increased self-compassion. Though it resonates with the traditional concept of self-acceptance (cf. Rogers, 1961), it also captures the uniquely, warm, emotional quality of this type of self-relating. The other interesting finding is that of appreciating vulnerability as an outcome of therapy. This finding stands in quite the opposite position to the mainstream focus on symptom relief. Though unexpected, it is fully compatible with HEP theories, which place an emphasis on authentic being. Authentic being is not necessarily free of suffering and pain. However, clients apparently still appreciate that overcoming the avoidance cutting them off from fulfilling their needs in life is worth the risk of pain and suffering. The finding that some clients prefer settling for no change rather than risking pain, however, illustrates that this process may not be that straightforward or always pursued by clients in therapy (cf. Lipkin, 1954). What is interesting is that only two of the reviewed studies included negative outcomes of therapy. These included nonresolution of the problem(s) that led clients to seek therapy, feeling overwhelmed, feeling harmed by the therapist, disappointment over not being understood by the therapist, and, interestingly, fear of changing and a consequent increase in emotional restriction thereby preventing change.

Timulak and Creaner's (2010) qualitative meta-synthesis of outcomes in HEPs is one of the first of its kind, so it may be too early to draw firm conclusions from it. However, an independently conducted qualitative meta-synthesis by Elliott and colleagues (Elliott, 2002b) that also included unpublished studies, as well as recent case studies that also included qualitative assessment of outcome (e.g., Stephen, Elliott, & Macleod, 2011) draw very similar conclusions.

**Table 13.5 Qualitative Outcomes/Effects Reported in Timulak and Creaner (2010) Qualitative Meta-Synthesis**

<b>Main Meta-Category</b>	<b>Meta-Categories</b>	<b>Primary Studies Findings</b>
A. Appreciating experiences of self	1. Smoother and healthier emotional experiencing	Hopefulness (Klein & Elliott, 2006), peace and stability (Klein & Elliott, 2006), emotional well-being, greater sense of energy (Klein & Elliott, 2006); calmer, at peace (Elliott, 2002a; Lipkin, 1954); improved mood, optimism (Elliott et al., 1990); general openness to own feelings (Elliott et al., 1990); ability to express and contain feelings (Dale, Allen, & Measor, 1998); feeling more free and easy, more light and lively (Lipkin, 1954) (4/8; i.e., 4 out of 8 studies on individual therapy)
	2. Appreciating vulnerability	Permission to feel the pain (Rodgers, 2002); transparency (dropping barriers and defenses) (Rodgers, 2002); honest with self (Elliott, 2002a; Rodgers, 2002); open to change (Elliott, 2002); awareness of being old, process of grieving, grieving is undoing problematic anger/anxiety (Elliott, 2002); self-acceptance of existential isolation (Dale et al., 1998) more tolerant of difficulties and setbacks (Elliott et al., 2009) (4/8)
	3. Experience of self-compassion	Self-esteem, self-care (Klein & Elliott, 2006), improved self-esteem (Elliott et al., 1990); engagement with self (experiencing support from within) (Rodgers, 2002); valuing self (Dale et al., 1998) (4/8)
	4. Experience of resilience	restructuring (recycling the bad things) (Rodgers, 2002); insight first painful then feeling better (Lipkin, 1954) (2/8)
	5. Feeling empowered	Self-confident, strength within (Rodgers, 2002; Klein & Elliott, 2006; Lipkin, 1954); General sense of well-being: health, energy, activities (Klein & Elliott, 2006), newfound or improved abilities to act (Klein & Elliott, 2006); improved general day-to-day coping (Dale et al., 1998); giving self credit for

		accomplishments, try new things, reading (Elliott, 2002); improved ability to cope (Elliott et al., 1990); preparing to take action to deal with problems (Elliott et al., 1990); specific wishes/attitudes strengthened (Elliott et al., 1990); being able to make decision, gaining control over life (Lipkin, 1954; Rodgers, 2002; Timulak, Belicova & Miler., 2010); able to stand up for self, more initiative instead of fear of doing things (Lipkin, 1954) (7/8)
	6. Mastering symptoms	Can cross bridges, can fly (Elliott et al., 2009); symptoms went one by one, sudden relief (Lipkin, 1954) (2/8)
	7. Enjoying change in circumstances	Improved nonrelationship aspects of life independent of therapy (Elliott et al., 1990; Elliott, 2002a) (2/8)
B. Appreciating experience of self in relationship with others	1. Feeling supported	Feeling respected by children, seeking support group (Klein & Elliott, 2006). Note: Reported changes in others' view of self (Elliott et al., 1990); people tell me I am a nicer person (Elliott et al., 2009). In many studies attributions to therapy/therapist as providers of support (3/8)
	2. Enjoying interpersonal encounters	Better interpersonal functioning (all, romantic, family) (Klein & Elliott, 2006); reordering relationships (Dale et al., 1998); being able to cope with reactions of others (Timulak et al., 2009); increased independence/assertion (Elliott et al., 1990); increased positive openness (Elliott et al., 1990); improved relationships (Elliott et al., 1990); better relationship with my spouse, more tolerant (Elliott et al., 2009) (5/8)
C. Changed view of self/others	1. Self-insight and self-awareness	Development of meaning and understanding of abuse, learning from therapy (Dale et al., 1998; Lipkin, 1954); more aware and true to myself (Klein & Elliott, 2006); realizations about self (Elliott et al., 1990); enlightened (problem fitting in like a glove), better understanding self (I am not in the dark, I can do something about it), seeing patterns (Lipkin, 1954) (4/8)
	2. Changed view of others	See other viewpoints (Klein & Elliott, 2006); being more interested in others (Timulak et al., 2009); changes in client views and attitudes toward others (Elliott et al., 1990); accepting parent faults (Timulak et al., 2009) (3/8)

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*Note.* From. (2010). “Qualitative meta-analysis of outcomes of person-centred/experiential therapies,” by L. Timulak & M. Creaner, 2010, in M. Cooper, J. C. Watson, & D. Hölldampf (Eds.), *Person-centred and experiential psychotherapies work*, Ross-on-Wye, United Kingdom: PCCS Books, pp 75-76. Copyright Ladislav Timulak and Mary Creaner, 2010, Adapted with permission.

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# Qualitative Process Research on Humanistic-Experiential Psychotherapies

For this review we looked for qualitative research on HEPs and included all process studies identified by searching PsychInfo using combination of the key words “humanistic/experiential/client-centered/emotion-focused therapy” with “qualitative process research” (we also included some studies referenced in the selected studies). We located 22 studies on HEPs that included a relevant qualitative research element. (We did not include studies that focused solely on the therapists’ opinions about or experiences of therapy, e.g., Geller & Greenberg, 2002, studies that used traditional content analysis, e.g., Lietaer, 1992,-or studies that used exclusively nominal scales with preset categories, e.g., Nicolo et al., 2008.)

## Client General In-Session Experiences of Therapy

Qualitative studies of psychotherapy often focus on client experiences of therapy, either in general or in particular aspects (client-identified significant events studies are discussed separately). A landmark in research on client experiences was the work of Rennie (1990, 1992, 1994a, 1994b), who interviewed 14 clients of predominantly humanistic (person-centered and Gestalt) therapists about one of their recent therapy sessions. The interview (Interpersonal Process Recall, IPR; Elliott, 1986) was assisted by a recording of the session and clients were encouraged to stop the tape at any point where they remembered something meaningful happening; they were asked to describe the recalled experience. Clients’ accounts were then analyzed using a version of grounded theory analysis (Rennie, Phillips, & Quartaro, 1994). Rennie documented many interesting phenomena, including showing how clients in the therapy session were engaged in a twofold process of pursuing personal meaning for themselves while also

monitoring the therapist. Clients evaluated therapist interventions in terms of their compatibility with client plans or strategies for the session. The clients were also deferential toward the therapists (they did not confront them with criticism) and preferred to tolerate therapist shortcomings rather than challenge them. Most of the findings reported by Rennie have since been replicated by others, for example, Moerman and McLeod (2006), who used the IPR method with six clients who took part in person-centered counseling for alcohol-related problems.

A variation of Rennie's method was used by Watson and Rennie (1994), who investigated client experiences during evocative unfolding, an EFT intervention. Using IPR, eight clients with interpersonal problems were interviewed about their experiences during unfolding interventions. The authors reported that during this intervention clients were involved in creating a symbolic representation of their experiencing of the puzzling situation, reflectively examining their own experience and achieving new realizations that led to revision of self-concepts and understandings. These processes were either helpful and flowing, with the interaction between the client and the therapist being collaborative, or else they were hindering, in which case the flow was interrupted and the client felt confused by the therapist. The authors also noted that the intervention led to more new realizations and revisions of the self-concept when accompanied by client emotional experiencing along with curiosity and interest in recalling and re-examining disturbing material.

## **Client Retrospective Experiences of Helpful and Hindering Aspects of Therapy**

Several recent studies of HEPs used client interviews given at the end of therapy to study helpful aspects of therapy (Knox, 2008; Lillie, 2002; Meyers, 2000; Rodgers, 2002; Schnellbacher & Leijssen, 2009). Overall, research on client experiences of helpful aspects of HEPs studies underscores the central importance of the relational qualities offered by the therapist, not only for client perceived safety in the relationship but also for the client perceived personal change. These studies show that therapist empathic skills may play a central role in fostering the development of insight and a new self-understanding in clients, and that clients appreciate having a space devoted to tracking their own experiencing and expression of feelings. Additionally, clients appear to be reflective and to intentionally follow their own agenda, an observation still not adequately stressed in the theoretical literature. These studies also show that therapist misattunement (either from active misunderstanding or superficial interaction) may threaten the therapeutic work, and that this misattunement may not be pointed out to the therapist (cf. Rhodes, Hill, Thompson, & Elliott, 1994), although it can be tolerated by at least some clients.

## Research on Helpful and Hindering Events

Helpful and hindering significant events studies represent a unique genre of research often using mixed methods. Significant events research focuses on the most helpful or hindering client-identified events in therapy sessions, which are subsequently studied in-depth by using the client descriptions to locate the event on the session recording. The recording of the event is then played back for the client and therapist in order to learn about their experience of the event (Elliott, 1985; Timulak, 2007, 2010). Given that the events are chosen by the client (as opposed to the researcher or the therapist), this type of research fits well with the humanistic-experiential paradigm, which gives voice to the client's felt experience.

Studies of helpful and hindering events (Grafanaki & McLeod, 1999, 2002; Timulak & Elliott, 2003; Timulak & Lietaer, 2001; Timulak et al., 2010), like those on client perceived outcomes and retrospective experiences just reviewed, show the importance of both fostering client safety in therapy and also its potential fragility. They also show that therapist skills at facilitating relational, empathic, and experiential processing can help the client to bear emotional pain, bring new awareness and insight, and help bring about a new sense of empowerment. These in-session events may thus be memorable experiences that can lead to a lasting impact. In these studies clients typically experienced the quality of relationship as a mutual encounter that had an enduring impact. For some it improved the therapeutic relationship and for others it was a moment of personal change. In general, the therapist's skillful clarification, guidance, compassionate presence, interpersonal affirmation, and awareness-promoting communication of empathic understanding contributed to helpful impacts, but sometimes private inner work by the client played an important role as well. In hindering events client vulnerability and occasionally therapist anxieties played role.

## Qualitative Change Process Case Studies

Several qualitative studies examined processes perceived by clients to bring about change in HEPs. The most typical strategy for this kind of research was the intensive case study (for instance, Elliott's, 2002a, Hermeneutic Single Case Efficacy Design), which collects a mixture of quantitative and qualitative process and outcome data from several sources while also offering a qualitative analysis of causal links between the therapy outcome and therapeutic processes. By means of this analysis Stephen, Elliott, and Macleod (2011) captured the connections between an improvement of a client with social phobia and her participation in PCT, while Elliott (2002a) reported on the change processes in EFT for a client diagnosed with bipolar disorder. The studies identified, for instance, the importance of client experience of connection on a human level, increase in



awareness of their own needs, support offered, and credit attributed to the therapist for bringing the client to experiences that the client would normally have avoided.

Several studies have analyzed HEP cases using the Assimilation of Problematic Experiences protocol (Stiles, 2002). Assimilation analysis tracks clients on a 7-stage stage model, in which the main foci of therapy are analyzed on a continuum ranging from being *warded-off*, through *insight into their nature* until they are *mastered*. The method uses the Assimilation of Problematic Experiences Scale (APES) as a qualitative framework for understanding the change process in therapy. APES was applied to three cases of EFT for depression (Brinegar, Salvi, & Stiles, 2008; Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999) and one case of PCT for depression (Osatuke, Glick, Stiles, Shapiro, & Barkham, 2005). The studies highlighted several interesting findings. For instance, a comparison of a successful versus an unsuccessful case (Honos-Webb et al., 1998) not only revealed more advanced assimilation of problematic issues in the successful case, but also showed that the successful case sustained a clear focus of therapy, while the unsuccessful one did not. The same successful case was re-analyzed by a somewhat different team (Brinegar et al., 2008) who found that the change (assimilation of problematic experiences) could be conceptualized as assimilation of two important empowering voices.

Another assimilation analysis of successful EFT (Honos-Webb et al., 1999) and PCT (Osatuke et al., 2005) cases showed a major change process to be the clients' gradual recognition of their own needs and the empowerment they experienced from standing up for self. Although assimilation analysis focuses on client change processes, careful reading of these cases along with the comments of the researchers (e.g., Osatuke et al., 2005) indicates that therapist affirmation of the client's previously disowned needs often played a crucial role in the change process.

Interestingly, one of the successful EFT cases analyzed using an APES framework (Brinegar et al., 2008; Honos-Webb et al., 1998) was also analyzed using the innovative moments coding system framework (Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010). This analysis, though using a different conceptual framework, converged with the assimilation analysis, reporting that the client's protest moments, in which she reclaimed her needs, allowed her to create a distance from significant others by whom she felt let down.

It is obvious that various theoretical frameworks such as assimilation of problematic experiences or similar theory-laden studies (e.g., Stinckens, Lietaer, & Leijssen's [2002] study on resolution of inner criticism) can be used to illustrate changes clients undergo in therapy. These changes might, however, just be accompanying epiphenomena that correspond with progress in therapy, but may not necessarily capture the core causal processes in change. Indeed, the more

open-ended Hermeneutic Single Case Efficacy Design studies had greater difficulty in identifying clear, unambiguous links. Regardless of this, it seems that all of the reported case studies and the change processes tracked in them suggest that change comes via (a) the therapist responding to the client's core hurt/pain; (b) mobilization of the client's previously obscured unmet needs (typically to be respected, close, or secure); (c) the therapist offering compassion and affirmation to those unmet needs, as well as the client's self-compassion or protective anger/determination. These observations, reported by a variety of teams, are in line with recent work on change processes using a task analytic approach (e.g., Pascual-Leone & Greenberg, 2007).

## **Limitations of Qualitative Research on Humanistic-Experiential Therapies**

Qualitative research on HEPs gives voice to client (and therapist) experiences of therapy and also provides a flexible framework that can facilitate studying the complexity of therapeutic change processes. Nevertheless, it is useful to be aware that these studies were conducted with clients with unrelated presenting issues, such as mood and anxiety disorders, and alcohol misuse, and may thus represent different underlying change processes. Also, there seems to be a lack of qualitative studies that use HEP theoretical frameworks for interpreting change processes and client experiences. For instance, the richness of APES studies (which use a rather trans-theoretical framework) illustrates how theoretically informed investigations of HEPs might look. As qualitative research is still a relatively recent development, the quality of studies reviewed here varied widely. Further attention needs to be devoted to raising standards in this area of research (cf. Elliott, Fischer, & Rennie, 1999; Chapter 3, this volume).

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## **Quantitative Process Research on Humanistic-Experiential Psychotherapy**

Research on the process of change is foundational to HEP approaches, as research clinicians within this approach have tried to specify the therapist and client processes that contribute to successful outcomes. Historically the focus of this research agenda has been on general therapeutic relationship conditions or attitudes as delineated by Rogers (1959) and on client experiencing (Gendlin, 1981). This has changed over time to a more differentiated focus on therapist

interventions and techniques and client processes that are related to change in psychotherapy.

## **Process-Outcome Research on the Therapeutic Relationship**

Since Rogers (1957) first articulated his hypothesis about the necessary and sufficient conditions of therapeutic change, much evidence has accumulated. Recent comprehensive reviews collected in Norcross (2011) *Psychotherapy Relationships that Work* provide an up-to-date summary of the broad base of evidence supporting these therapist relational conditions, including Elliott, Bohart, Watson, and Greenberg (2011) on empathy; Farber and Doolin (2011) on positive regard and affirmation; Kolden, Klein, Wang, and Austin (2011) on congruence/genuineness, and Horvath, Del Re, Flückiger, and Symonds (2011) on the therapeutic alliance generally. Subsequently, the task force on the therapeutic relationship designated therapist empathy as “demonstrably effective”; positive regard as “probably effective”; and congruence/genuineness as “promising but insufficient research to judge” (Norcross & Wampold, p. 424).

The research collected and meta-analyzed in the Norcross (2011) review volume comes from a broad range of therapies, mostly not from the HEP tradition. For example, only 8 out of 59 (14%) of the studies reviewed by Elliott et al.’s (2011) empathy-outcome meta-analysis focused on HEPs. The mean weighted correlation for these eight studies was .26, statistically significant, highly consistent ( $I^2 = 9\%$ ) and in line with the overall value of .30 for the entire sample of 59 studies. HEPs are grouped under “other treatments” in the Farber and Doolin (2011) and Kolden et al. (2011) reviews of positive regard and genuineness respectively, but appear to comprise only a tiny proportion the studies reviewed.

Moreover, several methodological weaknesses have been identified in this body of quantitative process-outcome research on the impact of the relationship conditions on outcome. In an earlier, unsystematic review, Sachse and Elliott (2002) noted that the facilitative conditions did not yield consistent results for all clients and client problems, as some clients seem to benefit and others not. Other methodological problems are failure to assess clients for incongruence (as originally proposed by Rogers, 1957); poor sampling methods; small sample sizes; different rating perspectives; inadequate levels of the therapeutic conditions; restricted range of measurement of the relationship conditions; possible nonlinear effects; low measurement reliability; and inconsistencies in the experience levels of the therapists (Watson, Greenberg, & Lietaer, 2010). Notwithstanding these methodological problems, the accumulated evidence to date points to a moderately strong relationship between the therapeutic conditions and outcome, although the relationship may be somewhat more complex than initially thought.

Among others, Lambert and Barley (2002) attributed the decline of research on the relationship conditions to the ascendancy of the therapeutic alliance construct. Nevertheless, the links between outcome, therapist empathy, and the working alliance are some of the most highly evidence-based findings in the psychotherapy research literature (Elliott et al., 2011; Horvath et al., 2011; Lambert, 2005). In an attempt to distinguish the two constructs Watson and Geller (2006) examined relationships among clients' ratings of the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962), psychotherapy outcome, and the working alliance in CBT and EFT. Overall, client reports of therapist positive regard, unconditionality, empathy, and congruence on the BLRI correlated .72 with clients' self-reports of the working alliance, pointing to the possibility of conceptual overlap. Nevertheless, client ratings of the four relationship conditions were predictive of treatment outcome on a wide range of outcome measures. The impact of the relationship conditions on outcome appeared to be mediated by therapeutic alliance for three out of four outcome measures, consistent with a model of the relationship conditions as instrumental in facilitating formation of a therapeutic bond and agreement on goals and tasks. There were no significant differences on client ratings between CBT and EFT therapists on therapist empathy, unconditionality, and congruence, but clients in EFT reported feeling more highly regarded by their therapists than clients in CBT.

Subsequently, McMullen and Watson (2005) examined differences between therapist and client behaviors in high and low alliance sessions in EFT and CBT. They found that in contrast to EFT therapists, CBT therapists taught more and asked more directive questions, while EFT therapists offered more support. However, therapists in both CBT and EFT provided more support during low-alliance than high alliance sessions. Interestingly, clients in EFT were rated as expressing more disagreement with therapist responses, and showing greater "resistance" in low-alliance sessions than clients in CBT.

However, process-outcome research supporting the role of therapist-offered relational conditions does not tell us what mediates the relation between therapist relational conditions and outcome. In order to address this question, Watson and her team have been investigating the role of the facilitative conditions and specifically empathy in the change process. Building on Barrett-Lennard's (1997) suggestion that therapist empathy leads to increased self-empathy, Steckley and Watson (Steckley, 2006; Steckley & Watson, 2000) examined this hypothesis in clients who were treated for major depression with either CBT or EFT. They found that client ratings of therapist empathy predicted improvements in client posttherapy attachment styles, as clients became less insecure and more self-accepting and protective of themselves. These changes were also associated with positive outcomes, accounting for moderate to large amounts of variance (42% to 70%). A subsequent study showed that empathy was an active ingredient of change. Watson and Prosser (2007) examined the complex relationship between

empathy, affect regulation, and outcome using path analysis, reporting that the effect of therapist empathy on outcome was mediated by changes in clients' affect regulation. These more recent studies continue to provide additional evidence and support for the role of the clients' experience of the therapeutic relationship in promoting positive outcomes in psychotherapy.

## **Research on Specific Therapeutic Tasks**

Research on specific therapeutic tasks continues to be a fruitful line of inquiry for understanding the relationship between tasks and client processing during sessions, and also for deepening our understanding of the steps necessary for facilitating client change in therapy.

### **Two-Chair Dialogue for Conflict Splits**

Intensive analyses of the client change processes in the two-chair dialogue task in EFT and Gestalt therapies, originally led to the development of a model of the essential components of resolution of splits (Greenberg, 1979, 1983) that subsequently received empirical validation (Greenberg & Webster, 1982; Sicoli & Halberg, 1998; Whelton & Greenberg; 2000). More recently, Shahar and colleagues (2011) examined the efficacy of two-chair dialogue task at times of stress with nine clients who were judged to be self-critical. The intervention was associated with clients becoming significantly more compassionate and reassuring toward themselves, and to significant reductions in self-criticism and symptoms of depression and anxiety. Effect sizes were medium to large, with most clients exhibiting only low and nonclinical levels of symptoms at the end of therapy, and maintaining these gains over a 6-month follow-up period.

### **Empty Chair Dialogue for Unfinished Business**

The empty chair task has been found to be more effective in resolving unfinished business than empathy using measures of both in-session process and session outcome (Greenberg & Foerster, 1996). Clients rated by observers as resolving their unfinished business reported significantly greater improvement in symptom distress, interpersonal problems, target complaints, affiliation toward self, and degree of unfinished business (Greenberg & Malcolm, 2002). More recently in a study of the resolution of interpersonal, emotional injuries, EFT was found to be more emotionally arousing than a psychoeducational treatment. However, the reported in-session emotional arousal did not relate directly to outcome in either group. The authors suggested that this finding probably reflects the fact that emotional arousal may signal different processes at different times (Greenberg et al., 2008). For example, emotional arousal at one point in therapy

may be a sign of distress and at another point a sign that the client is actively working through distress (Greenberg & Watson, 2006; Kennedy-Moore & Watson, 1999).

Paivio et al.'s (2010) recent study comparing two forms of EFT for trauma is also relevant here: In one condition ("imaginal confrontation"), clients were required to use empty chair work, that is, to speak directly to the perpetrator of their abuse or important nonprotective others in the empty chair. In the other condition ("empathic exploration"), clients instead spoke to the therapist *about* the perpetrator/nonprotective other. Clients in both forms of EFT showed substantial pre-post gains. Clients using empty chair, showed more pre-post change; however, they also dropped out at a higher rate (20% versus 7%), suggesting that it may not be a good idea to require all clients to use this highly evocative therapeutic task.

## Interpersonal Forgiveness

Research on specific therapeutic tasks has occurred within the context of couples therapy as well as individual therapy. Meneses and Greenberg (2011) explored how forgiveness unfolds in EFT for couples (EFT-C), using eight cases where women felt their partners had betrayed them. Forgiveness was defined as a process involving the reduction in negative feelings and the giving out of undeserved compassion. A task analysis was performed to rigorously track the steps leading to forgiveness using videotapes of therapy sessions. A comparison of those who forgave to those who did not yielded a model of the process of forgiveness in EFT for couples, from which a process rating system was developed. Five essential components of the model were found to distinguish between those who forgave and those who did not: (a) first, the injurer offered nondefensive acceptance of responsibility for the emotional injury; they then (b) expressed shame or empathic distress and (c) offered a heartfelt apology; (d) this was followed by the injured partner showing a shift in their view of the other; and (e) the injurer expressing acceptance of forgiveness, and relief or contrition.

In a further study, Woldarsky (2011) related the in-session process during the interpersonal forgiveness task to outcome, based on data from 33 couples who received emotion-focused couples therapy for an emotional injury (a betrayal) (Greenberg et al., 2010). The results showed that expressed shame accounted for 33% of the outcome variance in posttherapy forgiveness; the addition of acceptance explained an additional 9%, while in-session forgiveness explained another 8%, with the final regression model accounting for 50% of the outcome variance. These findings lend support to the couples' forgiveness model (Meneses & Greenberg, 2011). In addition, the therapeutic process was found to be more relevant to whether the injured partners forgave their partners than the degree of distress a couple was experiencing at the start of treatment.

## Modeling Client Emotional Processing

Emotional processing of global distress is a generic task in EFT, in that clients often enter therapy with strong or partially blocked but undifferentiated feelings (i.e., feeling “upset” or “bad”). For this reason, Pascual-Leone and Greenberg (2007) carried out a task analysis on the emotional processing steps involved in clients’ resolution of global distress, defined as an unprocessed emotion with high arousal and low meaningfulness, beginning with a rational-empirical model. The model hypothesized that in processing their emotions clients would move from a state of global distress through fear, shame, and aggressive anger to the articulation of needs and negative self-evaluations; then they would move on to assertive anger, self-soothing, hurt, and grief as states indicating more advanced processing (Pascual-Leone & Greenberg, 2007). The model was tested using a sample of 34 clients. Results showed that the model of emotional processing predicted in-session outcomes and that distinct emotions emerged moment-by-moment in predicted sequential patterns.

Intermediate components in the form of personal evaluation and reevaluation predicted in-session outcomes. Experiences of fear/shame and statements of negative evaluation about the self (i.e., feeling worthless, frail, or unlovable) were present in both good and poor outcome cases and could not be predicted by in-session outcome. However, a heartfelt statement expressing an existential need to feel valuable, lovable, safe, or alive did predict and often preceded good within-session outcome (as measured by the Client Experiencing Scale).

In a subsequent study (Pascual-Leone, 2009) univariate and bootstrapping statistical methods were used to examine how dynamic emotional shifts accumulate moment-by-moment to produce in-session gains in emotional processing. It was found that effective emotional processing was simultaneously associated with steady improvement and increased emotional range. Good events were shown to occur in a “two-steps-forward, one-step-backward” fashion, and it was found that there were increasingly shorter emotional collapses in helpful in-session events, as compared to unhelpful in-session events where the opposite was true.

## Research on Client Processes

In HEP theories of personality change (Gendlin, 1970; Greenberg & Van Balen, 1998; Rogers, 1959), depth of experiential self-exploration is seen as one of the pillars of psychotherapy process and change. During the past 50 years much research has been done on the relationship between experiential depth and outcome. Within this context several instruments have been constructed to

measure levels of experiential depth, the first ones being Rogers' *Process Scale* (Rogers, Walker, & Rablen, 1960) and Truax's *Tentative scale for the measurement of depth of intrapersonal exploration* (1962; Truax & Carkhuff, 1967). Subsequently, the *Client Experiencing Scale* (Klein, Mathieu, Gendlin, & Kiesler, 1969/1983; Klein, Mathieu-Coughlan, & Kiesler, 1986) was developed, followed by Toukmanian's *Levels of client perceptual processing scale* (1986, 1992; Toukmanian & Gordon, 2004) and Sachse's *Processing Mode Scale* (1992a; Sachse & Maus, 1991). Although there are some differences between these scales, they all describe and measure the level of clients' involvement in an experiential process of self-exploration.

## Depth of Experiencing and Outcome

Ratings of client depth of experiencing have been related to good outcome consistently in HEPs (Elliott et al., 2004; Hendricks, 2002). Moreover, clients' emotional processing in the session has been found to be beneficial across a range of other therapeutic approaches, including CBT and psychodynamic (Giyaur, Sharf, & Hilsenroth, 2005; Godfrey, Chalder, Risdale, Seed & Ogden, 2007; Leahy, 2002). Research on depth of experiencing in therapy has found a consistent relationship between client experiencing during therapy and outcome: the higher the experiencing level, the better the therapy outcome (Elliott et al., 2004; Purton, 2004). Although the association between experiencing level and outcome is clear and consistent, it is not perfect, suggesting that other factors play a role in fruitful therapy process. In addition, it is simplistic to hold a linear view of the stages of the experiencing scale (i.e., "the higher the score, the better the process quality of the exploration process"). Recent investigations of psychotherapy change process (Angus & McLeod, 2004; Watson, Goldman, & Greenberg, 2007) emphasize that *all* narrative modalities, representing the full range of the client experiencing scale, are important and serve useful functions for clients in exploring their problems.

Rogers' process view (1961), however, also predicted that there would be an *increase* of experiencing level throughout the course of successful therapy. Unfortunately, this has not been confirmed in most studies, possibly due to methodological issues such as sampling problems. Researchers typically measure experiencing levels at the beginning, middle, and end phases of therapy, but randomly select segments within and across sessions. Noting this practice, Rice and Greenberg (1984) originally suggested that as a result key events of the psychotherapy process were not being investigated. As an alternative sampling method they selected segments that were linked to clients' problematic issues. Subsequently, Goldman, Greenberg, and Pos (2005) found that an increase in client levels of experiencing from early to late in therapy was a stronger predictor of outcome than the working alliance.



Like the early observations of Rogers (1959) and Gendlin (1970), several studies have revealed significant differences in the manner in which good and poor outcome clients refer to their emotional experience during the session, across different therapeutic approaches (Pos, Greenberg, Goldman, & Korman, 2003; Watson & Bedard, 2006). Watson and Bedard (2006) found that good outcome clients in both EFT and CBT for depression, began, continued, and ended therapy at higher modal and peak experiencing levels during the session than did clients with poor outcome. Good outcome clients engaged in deeper exploration, referred to their emotions more frequently, were more internally focused, and examined and reflected upon their experience to create new meaning and resolve their problems in personally meaningful ways. In contrast, clients with poorer outcomes were not as engaged in processing their emotional experience, nor did they reflect on or pose questions about their experience during the session, to examine it and try to understand the origins and implications of their experience more fully. As a result, poor outcome clients did not report important shifts in perspective or feeling during the session. These findings suggest that processing one's bodily felt experience and deepening this in therapy may well be a core ingredient of change in psychotherapy regardless of approach. However, an alternative interpretation is that clients who enter therapy with these skills do better in short term therapy than those who do not enter with these skills. Thus these skills may be an indicator of clients' readiness or capacity to engage in short term therapy.

## **Depth of Experiencing, Emotional Expression and Processing, and Outcome**

Therapy researchers have begun to examine the relationship between clients' levels of emotional arousal and outcome. Process-outcome research on EFT for depression has shown that both higher emotional arousal at mid-treatment, coupled with reflection on the aroused emotion (Warwar & Greenberg, 2000) and deeper emotional processing late in therapy (Pos et al., 2003), predicted good treatment outcomes. High emotional arousal plus high reflection on aroused emotion distinguished good and poor outcome cases, indicating the importance of combining arousal and meaning construction (Missirlian, Toukmanian, Warwar, & Greenberg, 2005; Warwar, 2003). EFT thus appears to work by enhancing a particular type of emotional processing: first helping the client experience, then accept, and finally make sense of their emotions.

Warwar (2003) examined mid-therapy emotional arousal as well as experiencing in early, middle, and late phases of therapy. In this study clients who had higher emotional arousal at mid-therapy were found to have changed more at the end of therapy. Furthermore, client ability to use internal experience to make meaning as measured by the Client Experiencing Scale, particularly in the late phase of treatment, added to the outcome variance over and above middle phase

emotional arousal. Thus, this study showed that the combination of emotional arousal and experiencing was a better predictor of outcome than either index alone.

It is important to note this study measured *expressed* as opposed to *experienced* emotion. In a study examining in-session client reports of *experienced* emotional intensity, Warwar, Greenberg, and Perepeluk (2003) found that client reports of in-session experienced emotion were not related to positive therapeutic change. A discrepancy was observed between clients' reports of in-session *experienced* emotions and the emotions that were actually *expressed* based on arousal ratings of videotaped therapy segments. For example, one client reported that she had experienced intense emotional pain in a session; however, her level of expressed emotional arousal was judged to be very low based on observer ratings of emotional arousal from videotaped therapy segments.

Pos et al. (2003) suggested that emotional processing late in therapy mediates between early emotional processing and outcome. Here emotional processing was defined as depth of experiencing during emotion episodes. Emotion episodes (Greenberg & Korman, 1993) are in-session segments in which clients express or talk about having experienced an emotion in relation to a real or imagined situation. The Client Experiencing Scale was used to rate only those in-session episodes that were emotionally laden. They found that client early capacity for emotional processing did not guarantee good outcome, nor did entering therapy without this capacity guarantee poor outcome. Thus, early emotional processing skill did not appear as critical as the ability to acquire or increase depth of emotional processing throughout therapy. In this study late emotional processing independently added 21% to the explained variance in reduction in symptoms, over and above early alliance and emotional processing.

Pos, Greenberg, and Warwar (2010) measured emotional processing and the alliance across three phases of therapy (beginning, working, and termination) for 74 clients who each received EFT for depression. Using path analysis, a model of the role of the alliance and emotional processing across different phases of therapy and how they relate to and predict improvement in depression and other symptoms, self-esteem, and interpersonal problems at the end of treatment, was proposed and tested. Both therapeutic alliance and emotional processing significantly increased across phases of therapy. After controlling for both the alliance and client emotional processing at the beginning of therapy, client level of experiencing during the working phase was found to directly and best predict reductions in depressive and general symptoms, as well as gains in self-esteem. Within working and termination phases of therapy, the alliance significantly contributed to emotional processing and indirectly contributed to outcome. In addition, the alliance, measured after session one, also directly predicted outcome, and client therapy process at the beginning of treatment predicted reductions in interpersonal problems. These findings suggest that although the EFT theory of

change was supported, the quality of client emotional processing at the beginning of therapy may constrain their success in a short-term HEP and in particular resolution of interpersonal problems.

In another study of relations among the alliance, frequency of aroused emotional expression, and outcome, in EFT for depression, Carryer and Greenberg (2010) found that the expression of high versus low emotional arousal correlated with different types of outcome. Moderate frequency of heightened emotional arousal was found to add significantly to outcome variance predicted by the working alliance. The majority of process research studies have focused on a direct linear relationship between process and outcome; however, this study showed that a rate of 25% for moderate-to-high emotional expression predicted best outcomes. Lower rates, indicating lack of emotional involvement, represented an extension of the generally accepted relationship between low levels of expressed emotional arousal and poor outcome, while higher rates, indicating excessive amounts of highly aroused emotion, were related to poor outcome. This suggests that having the client achieve an intense and full level of emotional expression is predictive of good outcome, as long as the client does not maintain this level of emotional expression for too long a time or too often. In addition, frequency of reaching only minimal or marginal level of arousal was found to predict poor outcome. Thus, emotional expression that does not attain a heightened level of emotional arousal, or that reflects an inability to express full arousal and possibly indicates interruption of arousal, appears undesirable, rather than a lesser but still desirable goal. This complex relationship offers a challenge to therapists in managing levels of arousal and possibly selecting clients for EFT.

In an intensive examination of four poor and four good outcome cases, however, Greenberg, Auszra, and Herrmann (2007) did not find a significant relationship between the frequency of higher levels of expressed emotional arousal measured over the whole course of treatment and outcome. They measured both aroused emotional expression and productivity of the expressed emotion, and concluded that productivity of aroused emotional expression was more important to therapeutic outcome than arousal alone.

The measure of productive emotional arousal used in the earlier study was further developed and its predictive validity was tested on a sample of 74 clients from the York depression studies (Auszra, Greenberg, & Herrmann, 2007). Emotional productivity was defined as a state of being in contact with and aware of a presently activated emotion, where contact and awareness were defined as involving the following necessary features: (a) attending to nonverbal aspects of experience; (b) symbolization in words; (c) congruence, matching between content and manner of expression; (d) acceptance, non-negative evaluation; (e) agency, not experiencing self as a victim of emotion but responsible for it; (f) regulation, not being overwhelmed; and (g) differentiation, being in a process of developing more specific meanings. Emotional productivity was found to increase from the

beginning to the working and the termination phases of treatment. Working phase emotional productivity was found to predict 66% of treatment outcome variance, over and above variance accounted for by beginning phase emotional productivity, session four working alliance, and high expressed emotional arousal in the working phase. These results suggest that productive processing of emotion may be the best predictor of outcome of all process variables studied thus far.

In studies of EFT for trauma (Paivio & Pascual Leone, 2010) good client process, early in therapy, has been found to be particularly important because it sets the course for therapy and allows maximum time to explore and process emotion related to traumatic memories (Paivio et al., 2001). One practical implication of this research is the importance of facilitating clients' emotional engagement with painful memories early in therapy. A study of EFT for trauma found that therapist competence in facilitating imaginal confrontation using empty chair work, predicted better client processing. Moreover, when adult survivors of childhood abuse engaged in empty chair work, it contributed to the reduction of interpersonal problems, a contribution independent of therapeutic alliance (Paivio, Holowaty, & Hall, 2004). These important findings are consistent with those found in research on EFT for depression, which showed deeper levels of emotional experiencing had a curative effect over and above the alliance (Pos et al., 2003). Emotional processes have also been studied in the two controlled studies on resolving emotional injuries and interpersonal difficulties. Emotional arousal during imagined contact with a significant other was a process factor that distinguished EFT from a psycho-educational treatment and was related to outcome (Greenberg et al., 2008; Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995).

Extending this line of inquiry, Watson, McMullen, Prosser, and Bedard (2011) recently examined relationships among client affect regulation, in-session emotional processing, working alliance, and outcome in 66 clients who received either CBT or EFT for depression. They found that client initial level of affect regulation predicted their emotional processing during early and working phases of therapy. Moreover, the quality of client emotional processing in the session mediated the relationship between client level of affect regulation at the beginning of therapy and at termination; and client level of affect regulation at the end of therapy mediated the relationship between client level of emotional processing in therapy and final outcome, independently of the working alliance. These studies demonstrate the importance of client emotional processing in the session and suggest important ways that it can be facilitated by specific therapist interventions, for example, by facilitating client symbolization, acceptance, owning, regulation, and differentiation of key emotions.

Finally, recent content analysis studies of client experiences of helpful factors in therapy (Dierick & Lietaer, 2008; Vanaerschot & Lietaer, 2010) have shown that processes referring to depth of experiential self-exploration have a

central place among the therapeutic ingredients mentioned by clients as helpful and that these processes discriminate between “very good” and “rather poor” sessions. In content analysis studies done by Vanaerschot and Lietaer (2007, 2010) 20% to 40% of helpful factor descriptions mentioned by clients could be put under the following three categories: stimulation and deepening of self-exploration; focusing on and exploring more deeply; and intensively living through and experiencing fully.

## Therapist Interventions and Client Experiencing

Several studies have investigated the role of therapist interventions in facilitating client productive engagement in the session. While the Experiencing Scale (Klein et al., 1986) has mainly been used to investigate client process in psychotherapy, Sachse has focused on the *interaction* between therapist and client. To do so he constructed two parallel scales, respectively for “the processing modes” (PM) of the client and the “processing proposals” (PP) of the therapist (Purton, 2004; Sachse, 1990, 1992b; Sachse & Elliott, 2002; Takens, 2008). In a series of empirical studies (Sachse, 1992a; Sachse & Maus, 1991; Sachse & Elliott, 2002; Sachse & Takens, 2004) showed the impact of therapist proposals on the depth of clients’ exploration process. Similar to Rogers’ (1961) and Gendlin’s (1981) early observations about variations in client process, Sachse emphasized that the results of these micro-analytic studies suggest that the manner in which therapists respond to their clients can exert a significant influence on client exploration processes. As some clients may find it quite difficult to clarify, check, and modify their own feelings, needs, goals, and convictions, therapists can offer active assistance to support client processing efforts.

Adams and Greenberg (1996) looked at whether therapist experiencing had an impact on client level of processing. They found that therapist statements that were high in experiencing influenced level of client experiencing and that depth of therapist experiential focus predicted outcome. More specifically, if the client was externally focused and the therapist made an intervention that was targeted toward internal experience, the client was more likely to move to a deeper level of experiencing. This study replicates Sachse’s (1990) earlier research and highlights the importance of the therapist’s role in deepening emotional processes. Given that client experiencing predicts outcome, and that therapist depth of experiential focus influenced client experiencing and predicted outcome, a path to outcome was established that suggests that therapist depth of experiential focus influences client depth of experiencing, which in turn relates to positive outcome.

A series of studies carried out by Toukmanian and co-workers also examined the impact of therapist interventions, including attunement, tentativeness, and meaning exploration, on client level of cognitive and emotional processing in the session. They found that therapist empathy, attunement, and

exploration were each associated with higher levels of client experiencing and client perceptual processing (Gordon & Toukmanian, 2002), and that therapist empathy was best predicted by therapist attunement (Macaulay, Toukmanian, & Gordon, 2007). Moreover, complexity of client manner of processing over the course of therapy predicted reduction in depression at post treatment (Toukmanian, Jadaa, & Armstrong 2010).

***Narrative processes.*** Studies led by Angus on client narrative sequences in EFT have revealed interesting patterns associated with good outcomes (Angus, Levitt, & Hardtke, 1999), with unique processing patterns associated with good treatment outcomes (Angus, et al., 1999; Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004). Lewin (2001) found that therapists in good outcome in EFT cases were twice as likely to help clients shift to internal/emotion-focused and reflexive narrative modes than therapists of clients with poor outcome. Additionally, good outcome depressed clients initiated more shifts to emotion-focused and reflexive discourse than poor outcome clients. Clients with good outcome in brief HEP, spent significantly more time engaged in reflexive and emotion-focused discourse than did poor outcome clients. These findings provide empirical support for the importance of emotion and reflexive processes in the treatment of depression.

Moreover high emotional arousal plus high reflection on aroused emotion distinguished good and poor outcome cases, indicating the importance of combining arousal and meaning construction (Missirlian et al., 2005; Warwar, 2003). More recently, Boritz, Angus, Monette, and Hollis-Walker (2008) and Boritz, Angus, Monette, Hollis-Walker, and Warwar (2010) investigated the relationship of expressed emotional arousal and specific autobiographical memory in the context of early, middle, and late phase sessions drawn from the York I Depression Study (Greenberg & Watson, 1998). Hierarchical Linear Modeling analyses established that there was a significant increase in the specificity of autobiographical memories from early to late phase therapy sessions and that treatment outcome was predicted by a combination of high narrative specificity plus expressed arousal in late phase sessions. However, neither expressed emotional arousal nor narrative specificity alone was associated with complete recovery at treatment termination. Specifically, Boritz et al. (2010) found that recovered clients were significantly more able to emotionally express their feelings in the context of telling specific autobiographical memory narratives than clients who remained depressed at treatment termination.

## **Client Postsession Change and Outcome**

A recent study by Watson, Schein, and McMullen (2010) examined the relationship of client reported postsession change to determine whether it predicted outcome over and above the therapeutic alliance in a study of 66 clients treated with EFT or CBT for depression. An updated measure of client postsession

change was used, the Client Task-Specific Changes-Revised scale. The measure showed high internal consistency. Factor analyses showed that the measure comprised two factors, conceptualized as Behavior Change and Awareness/Understanding. Client postsession scores increased over the course of psychotherapy and predicted change in depression at the end of therapy over and above the therapeutic alliance, explaining an additional 13% of the variance in outcome on the BDI.

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## Conclusions

In this latest review of research on humanistic-experiential psychotherapies, we have once again emphasized outcome research, but have also looked at qualitative studies of client experiences of outcome and helpful factors, as well as quantitative investigations of change processes.

## Humanistic-Experiential Psychotherapies as Evidence-Based Treatments

Current mental health politics urgently require continuing collection, integration, and dissemination of information about the rapidly expanding body of accumulated outcome evidence, to help deal with challenges to HEPs in several countries, including the United States, United Kingdom, Germany, and the Netherlands (to mention only those with which we are most familiar). HEP outcome research has grown rapidly, with half of the existing studies appearing in the past 10 years. This has allowed us to pursue increasingly sophisticated analysis strategies and to break down the evidence by client subpopulation and type of HEP. We believe that these analyses go a long way toward meeting the demands implicit in the criteria put forward by various national guideline development groups (e.g., APA Division 12 Task Force on Empirically Supported Treatments in the United States; National Institute for Clinical Excellence [NICE] in the United Kingdom).

Looking at our entire data set of roughly 200 outcome studies, we see that evidence for the effectiveness of HEPs comes from three separate lines of evidence and supports the following conclusions:

First, overall, HEPs are associated with large *pre-post* client change. These client changes are maintained over early (< 12 months) and late (a year or more) follow-ups.

Second, in *controlled studies*, clients in HEPs generally show large gains relative to clients who receive no therapy, regardless of whether studies are

randomized or not. This allows the causal inference that HEP, in general, causes client change; or rather, speaking from the client's perspective, we can say that clients use HEP to cause themselves to change.

Third, in *comparative outcome* studies, HEPs in general are statistically and clinically equivalent in effectiveness to other therapies, regardless of whether studies are randomized or not.

Fourth, overall, CBT appears to have a trivial advantage over HEPs. However, this effect seems to be due to non-bona fide treatments usually labeled by researchers as *supportive* (or sometimes *nondirective*), which are generally less effective than CBT. These therapies are typically delivered when there is a negative researcher allegiance and in non-bona fide versions, and appear to be the mediator for the substantial researcher allegiance effect that we found. When the supportive treatments are removed from the sample, or when researcher allegiance is controlled for statistically, HEPs appear to be equivalent to CBT in their effectiveness.

Going beyond these general conclusions, we have argued that the existing research is now more than sufficient to warrant varying positive valuations of HEP in six important client populations: depression, relationship/interpersonal problems, anxiety, coping with chronic medical conditions, psychosis, and substance misuse, even using the fairly strict criteria put forward by Chambless and Hollon (1998; the successor to the APA Division 12 Criteria).

For *depression*, HEPs have been extensively researched, to the point where the claim of empirical support as *efficacious and specific* (i.e., superior to a placebo or active treatment) can be supported for them in general (using meta-analytic data), and more specifically for EFT for mild to moderate depression (e.g., Goldman et al., 2006; Watson et al., 2003), and PCT for perinatal depression (e.g., Cooper et al., 2003; Holden et al., 1989).

For *relationship and interpersonal problems* EFT clearly meets criteria as an *efficacious and specific* treatment. These include current relationship problems among couples, where EFT for couples has long been recognized as an empirically supported treatment (e.g., Baucom et al., 1998). In our review here, however, we have also highlighted the use of EFT in both couples and individual formats for emotional injuries, including childhood abuse trauma (e.g., Greenberg et al., 2008; Paivio et al., 2010). It is important to note, however, that these studies do not focus on PTSD.

For helping clients cope psychologically with *chronic medical conditions* in general based on the meta-analytic data, it now appears that HEPs meet criteria as *efficacious* treatments, based either on their superiority to no treatment control conditions or on their equivalence to an established treatment (CBT). Supportive therapy, PCT, and supportive-expressive group therapy have been used with a



wide variety of chronic and disabling medical conditions, including most commonly early and late stage cancer, and autoimmune disorders (e.g., lupus, MS), but also gastrointestinal problems (e.g., IBS), HIV, chronic pain and others. To date, the strongest pre-post and comparative effects have been found for cancer; however, recently reported large studies (e.g., Bordeleau et al., 2003; Spiegel et al., 2007) have shown weaker effects and point to the continuing need for further research.

For habitual self-damaging activities, our analysis indicates that HEPs (primarily supportive and other HEPs) meet the criteria for being *efficacious* treatments for substance misuse. (The sample was too small and the results too equivocal to properly assess the evidence for eating disorders.) These results are comparable for those of a closely related treatment for substance misuse, Motivational Interviewing (Lundahl et al., 2010).

For *anxiety* problems overall, the existing evidence is mixed, but sufficient to warrant a general continuing verdict of *possibly efficacious* (at least one study shows “equivalence” to an established treatment) for panic, generalized anxiety and phobia (see Borkovec & Mathews, 1988; Shear et al., 1994). However, the available evidence on treatment of panic and generalized anxiety (but not phobia) also suggests that HEPs may be *less efficacious* than CBT. Although this is likely to reflect researcher allegiance effects, it is also possible that the supportive, person-centered and other HEPs used so far are less effective than CBT for these client subpopulations, and that a more process-guiding approach is needed, as indicated by evidence now emerging from ongoing research (e.g., Elliott & Rodgers, 2010).

For *psychotic* conditions such as schizophrenia, we continue to recommend a cautious verdict of *possibly efficacious*, in spite of a recent UK guideline contra-indicating humanistic counseling for clients with this condition (National Collaborating Centre for Mental Health, 2010). In fact, the comparative evidence we have reviewed points to the possibility that HEPs may be *more* effective than the other therapies to which they have been compared; however, the number and sample size of the existing studies is relatively small, so we have preferred to err in the direction of caution here rather than going for a stronger conclusion.

## **Key Change Processes in Humanistic-Experiential Psychotherapies**

Our review of quantitative and qualitative change process research on HEPs shows that researchers continue to refine their understanding of the therapist and client processes that bring about change in therapy. This research uses all four of the change process research paradigms defined by Elliott (2010), including quantitative process-outcome, qualitative helpful factors, significant events, and

sequential process approaches, in the context of both group and individual case studies. Over time, the research has moved beyond global therapist facilitative processes such as empathy, positive regard, genuineness and collaboration to more specific within-session change processes.

Qualitative change process research, for example, reveals the complexity of clients' experiences of therapy. Clients have their own agendas, may be ambivalent about change, and may have doubts about the therapist, all of which can significantly affect the outcomes of therapy. In successful therapy, the therapist is seen as reaching out to the client in a way that promotes the client's sense of safety, but that also responds to the client's emotional pain and unmet needs with compassionate and authentic presence. These needs are affirmed by the therapist, thus facilitating the development of self-compassion and self-acceptance as well as self-empowerment grounded in awareness of key emotions and unmet needs. All this interweaves with the collaborative development of a personally meaningful client narrative (Angus & Greenberg, 2011).

Furthermore, the use of task analysis to model sequences of particular client and therapist performances has led to the development of additional models of processes in individual and couples therapy and has broadened the range of therapist behaviors and types of interventions that have been shown to facilitate good outcome. Sequential and process-outcome research on client experiencing has been extended to look at clients' cognitive and emotional processing during the session as well as the quality of their narratives in order to identify productive client processes in HEPs.

The recent quantitative change process research reviewed here has involved continuing work on central therapeutic processes such as client experiencing, emotional expression, and elements of narrative, but has added a new set of important variables, including emotion episodes, emotional productivity and differentiation, affect regulation, innovative moments, and autobiographical memory specificity. These new variables and their associated process measures are providing more fine-grained tools for understanding how client change occurs. These conceptual and research tools are generating new, more precise maps of the change process. Thus, we can see more precise answers emerging to key questions about productive therapy process:

Question 1: When is client emotional expression most likely to lead to good outcome? Answer: When it is grounded in specific autobiographical memories, accompanied by deeper levels of experiencing, and becomes more regulated and differentiated as it is explored (research by Greenberg, Angus, Pascual-Leone, and colleagues).

Question 2: What is the most productive sequence of narrative exploration in therapy? Answer: Description of external events, leading

to initial self-reflection, leading to access to internal experiences, leading to self-reflection on broader meaning (research by Angus and colleagues).

Question 3: How do problematic or painful client experiences get assimilated? Answer: Via an extended sequence over time starting from warded off or painful awareness, then to problem clarification and insight, and finally to working through and mastery (research by Stiles and colleagues).

Question 4: How do new narratives emerge and become established in client's lives? Answer: By a spiraling movement between action and reflection, starting with attempts to change the problem, leading to reflection on the nature of the old problematic narrative, followed by active protest or working against the problem, then to emerging re-conceptualization of self and the process of change, and finally to carrying out the change in one's life (research by Gonçalves and colleagues).

The many ways in which these different lines of theory development and research run parallel to and complement one another are plain to be seen and point to the possibility of a larger synthesis with many useful clinical implications.

## **Recommendations for Research, Practice, and Training**

It is our view that the research reviewed here has important scientific and practical implications.

First, while the field of humanistic-experiential therapy research has made substantial progress during the past 10 years, more research is clearly needed, particularly with client populations where clear recommendations are not yet possible, such as different types of anxiety, psychosis, particular medical conditions, and eating disorders, and others. At the same time, more research on well-studied client problems such as depression are also needed, in order to bolster or upgrade the existing evidence, which runs the risk of becoming obsolete as standards for research evidence shift over time (e.g., requiring larger samples, RCTs, intent-to-treat analyses, and more sophisticated meta-analysis techniques).

Second, from a health care policy point of view, the available outcome data clearly support the proposition that HEPs are empirically supported by multiple lines of scientific evidence, including “gold standard” RCTs and recent large RCT-equivalent practice-based studies in the UK (e.g., Stiles et al., 2006, 2008). This body of research suggests that the lists of empirically supported or evidence-based psychotherapies that have been constructed in various countries—the NICE

Guidelines in the United Kingdom or the list of empirically supported treatments in the United States, for example—need to be updated with the type of evidence we have reviewed. HEPs should be offered to clients in national health service contexts and other mental health settings, and paid for by health insurance, especially for the well-evidenced client populations highlighted.

Third, there is an important lesson to be learned from the negative results we have identified for supportive therapies. For those of us in the HEP tradition, the moral of this story is that we do not need to be afraid of quantitative outcome research, including RCTs. Naturally, there are many problems and limitations with RCTs, just as there are with all research methods. If, however, we insist as a matter of principle on conscientiously objecting to quantitative outcome research in general and RCTs in particular, then we create a situation in which we let others define our reality by constructing watered-down versions of what we do as a representation of our practice. If we continue to let this happen, then we are going to be in worse trouble than we already are. For this reason, it is imperative that as humanistic-experiential therapists we do our own outcome research—including RCTs—on bona fide versions of our therapies. It is also essential for us to train more HEP researchers.

Fourth, as for the specific research implications of our review, it certainly seems to us to illustrate the value of using a wide range of research methods, qualitative and quantitative, group and single case, to address questions of therapeutic change, effectiveness and efficacy. At the same time, it is worth noting that our data indicate that the current emphasis on randomization in controlled and comparative outcome studies is misplaced: In fact, we found that randomization made no difference whatsoever in our meta-analysis. Although randomization is a useful research tool, nonrandomized studies also need to be given significant weight in integrating research findings.

Fifth, it now appears to us that research alone will not suffice; the development of treatment guidelines in various countries has in our experience become increasingly politicized, with powerful interest groups dominating the committees charged with reviewing the evidence. These groups determine what counts as evidence, what evidence is reviewed, and how that evidence is interpreted as a basis for formulating treatment guidelines. This is often portrayed as an objective, neutral process of making straightforward inferences from research evidence to the real world of practice. According to Bayesian statistics (e.g., Lynch, 2010), however, this is an instance of the logical fallacy of the “transposed conditional” (Siegfried, 2010): The famous “null hypothesis” against which we test our results only evaluates the likelihood of hypothetical inference from practice (the “real world”) to our research results, not in the opposite direction, from our results to practice, which is the inference that we want to make. Inference from evidence to practice only becomes possible when we factor in our prior expectations, that is, our researcher and reviewer theoretical

allegiances. This means that it is critically important who reviews the research evidence and what their prior expectations or allegiances are. And that means that the guideline development committees that review research evidence will only produce valid and fair guidelines if they contain a balanced representation of researchers with varied theoretical allegiances. The implication for the HEPs is that they need to put pressure on guideline development bodies for proper representation.

Finally, we conclude as we did in our previous review (Elliott et al., 2004), with training implications: The neglect of HEPs in training programs and treatment guidelines is no longer warranted. Humanistic-experiential therapies should generally be offered in postgraduate programs and internships, especially as treatments for depression, relationship problems, and substance misuse, and also to help people cope with chronic medical problems, and possibly to support clients with psychotic processes, anxiety disorders, and eating difficulties. Like CBT, HEPs are evidence-based for a wide range of client presenting problems. In fact, we argue that the education of psychotherapists is incomplete and unscientific without a greater emphasis on these approaches, to the ultimate detriment of clients.

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\*References marked with an asterisk indicate studies newly added or updated in the meta-analysis.

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