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**Person-Centered/Experiential Psychotherapy for Anxiety Difficulties:
Theory, Research and Practice**

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Abstract

Anxiety difficulties are an increasingly important focus for person-centeredexperiential (PCE) psychotherapies. I begin by reviewing person-centered, focusing-oriented, and emotion-focused therapy (EFT) theories of anxiety. Next, I summarize a meta-analysis of 19 outcome studies of PCE therapies for adults with anxiety, most commonly supportive or person-centered therapies (PCT) carried out by cognitive behavior therapy (CBT) researchers. The results indicate large pre-post change but a clear inferiority to CBT. I then summarize promising early results from an ongoing study of PCT and EFT for social anxiety, which show large amounts of pre-post change for both forms of PCE therapy but substantially more change for clients in the EFT condition. I conclude with a discussion of the implications for PCE therapy practice, including the value of process differentiation and the possibility of developing more effective PCE approaches for anxiety.

Person-Centered/Experiential Perspectives on Anxiety Difficulties: Theory, Research and Practice

Over the past 20 years, most of the attention of PCE therapists has been on work with depression, where evidence for PCE therapies is becoming increasingly strong (Elliott, Greenberg & Lietaer, 2004; Elliott, Watson, Greenberg, Timulak & Freire, in press). Further, the evidence for the use of PCE therapies for clients with interpersonal or relational difficulties and abuse (but not PTSD) now appears to be overwhelmingly (Elliott et al., in press). Why should we not continue to build on our strengths, instead of pushing into new areas such as anxiety where we know far less and where the research evidence of much less encouraging?

In this article, I try to make the case for the development of PCE theory, research and practice with different kinds of anxiety difficulty, including generalized anxiety, social anxiety, panic, PTSD, and obsessive-compulsive processes. Although there has been some research on complex trauma (eg, Paivio, Jarry, Chagigiorgis, Hall & Ralston, 2010), phobias and panic have been largely ignored by PCE therapists and researchers, and few if any studies have been carried out by researchers with a humanistic or experiential therapy orientation.

This relative neglect of anxiety ignores a common but debilitating set of psychological difficulties, which affect quality of life, social adjustment, and work functioning, and which are also a risk factor for depression and substance misuse (Ruscio et al., 2008), indicating that improving therapies for anxiety could lead to wider social benefits such as greater social inclusion, and decreased health care costs.

At the same time, several things point to the PCE therapies being effective with anxiety: First, depression and anxiety overlap to a large degree, with high correlations between the two and typically large amounts of so-called “co-morbidity” whereby clients frequently fit diagnostic criteria for both depression and anxiety (Dobson, 1985). Second, PCE therapies have been shown to work generally and with mixed populations of clients that would naturally be expected to include substantial numbers of anxious clients. Third, as I will explain later, key theoretical formulations for PCE therapies are really theories of anxiety.

Anxiety is a state of mind characterized by persistent fear or worry about perceived danger. In general, however, when the danger is present or specific (eg, a poisonous snake we see front of us) we are more likely to talk about fear, whereas when the danger is in the future or is undefined (eg, failure or embarrassment) we are more likely to call it anxiety. In terms of etymology, the word “anxiety” comes from the Latin physical action verb *angere*, meaning “to cause torment or distress by choking or squeezing” (Oxford English Dictionary, 1971), indicating how important bodily experiences of constriction or tightening, mostly in throat or chest, are in the phenomenology of anxiety. On the other hand, at manageable, mild to moderate levels, anxiety can also be useful, because it helps us be on the alert for possible dangers and prepares us for taking effective action.

Although humanistic-experiential psychotherapists going back to Rogers (1957) generally distrust psychiatric diagnosis as conceptually flawed, unnecessarily biological, and politically oppressive, the diagnostic literature (eg, American Psychiatric Association, 1993) does contain useful descriptive information about the conditions under which people are likely to experience their anxiety as problematic:

- When the anxiety reaches a level that the person experiences as unwanted or unreasonable;

- When the anxiety is inflexibly consistent over time and situations of a particular type;
- When the person either endures feared situations with intense distress or emotional pain, or else avoids them altogether; and
- When the anxiety interferes significantly with the person's functioning or wellbeing.

Furthermore, the diagnostic manuals recognize different distinct kinds of anxiety difficulty, including

- Excessive fears, referred to as *phobias*, of which social anxiety is the most common (Stravinsky, 2007).
- Episodes of overwhelming fear, or *panic*.
- Excessive worry, referred to as *generalized anxiety*.
- Post-trauma (stress) difficulties, commonly abbreviated as *PTSD* (officially: post-traumatic stress disorder).
- Persistent anxiety-provoking unwanted thoughts (*obsessions*), typically accompanied by feeling driven to do things in order to feel less anxious (*compulsions*).

In addition to the emotions of fear and anxiety, what all these difficulties have in common is that they lead people to avoid fear-related situations and experiences; this avoidance in turn constricts their lives and leads to a sense of stuckness and misery.

In the remainder of this article I will summarize the main PCE theories of anxiety, the evidence base for PCE therapies for adults with anxiety, preliminary results from a study of PCE therapy for social anxiety, and recommendations for working more effectively with anxiety difficulties, exemplified by social anxiety. (For a summary of PCE outcome research on children and young people, see Hölldampf, this issue.)

Person-Centered-Experiential Theories of Anxiety Difficulty

In this section, for simplicity and reasons of space I summarize current theories of anxiety associated with three main brand names in PCE therapy: person-centered, focusing-oriented, and emotion-focused therapy. (There are other humanistic approaches to anxiety, including Yalom's 1980 theory of anxiety as stemming from avoidance of the existential issues of death, freedom, isolation and meaninglessness; Wolfe & Sigl's 1998 integrative theory pointing to the role of early trauma and experiential avoidance; and Carrick & Joseph's in press neo-person-centered account of the role of trauma in generating incongruence as well as the possibilities for post-traumatic growth.)

Person-Centered Theory of Anxiety Difficulties

Person-centered therapy (PCT) and other PCE psychotherapies have from their beginning opposed psychiatric classification and diagnosis, and by association general formulations of particular client populations. In spite of this, there has been a long-standing, even foundational interest in anxiety processes. Rogers (1957, p.96) proposed that the second condition for psychological change is that: "The first [person], whom we shall term the client, is in a state of incongruence, being vulnerable or anxious". In other words, Rogers' formulation was that incongruence is either (a) the same thing as anxiety, or (b) directly causes anxiety.

If incongruence is the central formulation of psychological dysfunction and distress, then anxiety is key to Rogers' understanding of human function, dysfunction and change. Rogers' (1957; 1959) key formulations of PCT personality theory clearly

indicate that it is a self-discrepancy theory of psychological dysfunction. Self-discrepancy theories have a long history in psychology, going back at least to Freud's (1923/1961) doctrines of id, ego and superego, and more recently self-discrepancy theory (Higgins, 1987). In all of these formulations, psychological distress in general and anxiety in particular derives from discrepancies between different aspects of self, variously referred to as "actual/organismic," "perceived," and "ideal" or "ought" selves. For example, Higgins (1987) theorized that a discrepancy between the actual and ought selves gives rise to anxiety.

According to Rogers (1959), incongruence derives from the conditional positive and negative judgments offered by important others, especially parents or other caregivers. Caregiver conditionality is internalized by the person and becomes conditional self-regard, constituting a discrepancy or incongruence between the way the person perceives themselves and how they feel they should be. Conversely, Rogers' (1959) theory of the process of therapeutic change holds that the therapist's unconditional positive regard for the client directly counters the client's negative self-regard, while empathy and genuineness contribute to this process by making it deeper and more credible. It is as if the client feels, "If you truly understand me, then I may begin to believe your positive regard is genuine and not an act or based on ignorance. And if that is the case, then I can begin to think and feel better about myself." In this way, the client comes to internalise the therapist's unconditional positive regard.

Focusing Theory of Anxiety Difficulties

In his work on focusing and focusing-oriented therapy, Gendlin (1964, 1996) reformulated Rogers' incongruence/self-discrepancy theory of anxiety in process terms, redefining incongruence as *structure-bound functioning*, in which new information is skipped over and not allowed access to the current process of experiencing. In other words, old ways of perceiving and acting are applied to the current situation, but unfortunately do not provide a basis for adaptive action, thus creating more anxiety and in turn leading to yet more structure-bound ways of functioning.

Gendlin (1981) later also added an emotion regulation element to his theory: the concept of *working distance*, holding that over-identification or too little working distance from difficult or powerful experiences results in the experience of being overwhelmed, disorganized, and anxious. In addition, he also described how too much working distance in the sense of avoiding experience is also problematic. Horowitz (2011), a psychodynamic therapist specializing in trauma, describes how people faced with overwhelming experiences cycle between being under- and over-distanced, coping with under-distanced anxiety by over-distancing (experiential avoidance); this in turn cannot be maintained and results in further outbreaks of under-distanced anxiety, and so on: another vicious circle.

The opposite of structure is fluidity, and so Gendlin (1964; 1996) proposed that the way to help people move out of structure-boundness is to help them learn how to access their bodily-based current experience of anxiety, using it clarify their implicit experiencing in order to obtain an accurate reading of their current situation and the adaptive actions that would help them address the sources of the anxiety. To do this requires a good working distance, which involves learning how to be in presence with difficult experiences (Cornell, 2005), promoting adaptive emotion regulation.

Cornell and McGavin's *inner relationship focusing* (IRF) updated the focusing theory of anxiety (Cornell & McGavin, 2008; McGavin & Cornell, 2008; but see also

Gendlin, 1997). They redefined incongruence as *stopped process*, a painful lack of presence dominated by *partial-selves*, that is, repetitive, habitual, over-identified-with aspects of self. When a person's situation does not allow them to be in presence with their experiencing, so that they try to shut it out or attack it, the result is stopped process. Stopped process leads to a sense of something incomplete or missing. The person attempts to supply what is missing without being in presence, a solution that makes the problem worse. McGavin and Cornell (2008) describe the resulting partial selves that are most relevant to understanding anxiety difficulties: A *compromised partial self* anxiously lives its sense of something missing and sees itself as defective. For example, in our research on social anxiety, a client whom I will refer to as "Carol" saw herself as ugly and clumsy. A *controlling partial self* is afraid of the compromised self and, in order to protect the person, reacts by becoming self-critical and controlling. This creates more stopped process, and intensifies the compromised self, and so on. For Carol, this took the form of an aspect of her that constantly criticized her so that she avoided social situations like weddings or parties, which in turn made her feel lonely and like a social pariah.

In focusing-oriented therapy (FOT), the therapist offers, models and teaches presence, also known as *radical acceptance* of the client (Cornell, 2005). This enables the client to begin to develop *self-in-presence* in relation to the two partial selves. As they do so, the controlling self-aspect begins to access its implicit fear of the compromised partial self, while the compromised partial self allows itself to gently access its longing for what was missed, that is, its unmet organismic needs. Over time, this process of emotional deepening undoes the stopped process, and anxiety decreases. For example, when Carol used focusing her critical aspect withdrew, she felt less anxious in the moment, and she was left with a sense of sadness that pointed to a desire to connect with others.

Emotion-Focused Therapy Theory of Anxiety Difficulties

EFT (Elliott et al, 1998; see also Paivio & Pascual-Leone, 2010) conceptualizes anxiety difficulties first in terms of *anxiety splits*, internal conflicts in which the person makes themselves anxious, a process involving critical and experiencing self-aspects very similar to McGavin and Cornell's (2008) controlling and compromised partial-selves. The controlling aspect takes the form of an internal *critic* or *coach*, while the compromised aspect is a collapsed *experiencer*, who gives in to the anxiety and retreats from situations and experiences, while still longing to have its needs met. Furthermore, the presenting anxiety split overlays a deeper anxiety split in which the coach/critic aspect fears what will happen if the experiencing aspect makes itself vulnerable by pursuing its unmet needs for self-assertion or closeness. For example, Carol's critical aspect feared her experiencing aspect's deep hunger for social connection and therefore tried get her avoid weddings and parties by telling her that people would reject her once they saw she really was: "old and grumpy".

In EFT these self-aspects are seen as organized around *emotion schemes*, consisting of networks of key stuck emotions, the perceptions and memories that the emotions refer to, associated bodily experiences and expressions, verbal-symbolic representations of the emotional state, and finally the wishes/needs and action tendencies motivated by the emotion. Different forms of anxiety difficulty are organized around specific types of core emotion scheme:

- Vulnerability-related fear (phobias, PTSD, panic, generalized anxiety)
- Guilt/shame (Obsessive-compulsive, social anxiety)

- Worried hyper-responsibility (generalized anxiety)
- Overwhelming loss of control (panic)

These are either *secondary reactive* or *primary maladaptive* emotion responses, that is, either reactions to other more primary emotion response, or else automatic, overgeneralized and no longer useful emotion responses (Elliott et al., 2004). Such emotion responses are typically grounded in early attachment injuries, including abuse, rejection/bullying, or neglect/abandonment by primary caregivers, siblings or peers. These early injuries are internalized as anxiety splits between a vulnerable self experiencer and a harsh internal critic/coach self-aspect. The latter is the introject of early rejection, abuse, or neglect, but continues to prime the person to monitor for dangers in order to protect them from various kinds of harm. For example, Carol's social anxiety emotion scheme consisted of a secondary reactive emotion deriving from a deep, highly general sense of primary maladaptive shame; this emotion scheme stemmed from multiple forms of early abuse by her mother and brother, was symbolized by words like "ugly" and "clumsy," and made her want to hide her face and retreat to her bed.

Anxiety splits are driven by a deeper *protective split* in Critic: When cued, primary maladaptive emotion schemes highlight the vulnerability of the Experiencer aspect (eg, Carol's shame at being defective, but also her fear of abandonment and her emotional pain from deprivation), which frightened the critical/coaching self-aspect, so that the latter attacked the experiencer aspect (ie, *secondary reactive anger*), thus creating the surface anxiety split. Over time, anxiety splits lead to chronic psychological pain and avoidance of both feared situations and painful emotions (experiential avoidance). Current loss, rejection, threat, or interpersonal conflicts re-activate these core emotion schemes and split processes, exacerbating the anxiety difficulties, interfering with important life projects, and leading to a sense of stuckness and depression. For Carol, this involved a traumatic job loss several years earlier and more recent threat of a loss of her disability benefits.

EFT's general theory of the change process with anxiety difficulties (Elliott et al, 1998; Elliott et al., 2004; Paivio & Pascual-Leone, 2010) proposes that therapeutic change begins with a genuinely empathic and caring therapeutic relationship. The therapist first offers the client genuine, caring empathy for their current life situation, interrupted life projects, and life story; this is soothing in itself and contributes directly to reducing the client's anxieties about starting therapy, while also creating safety for the client to work on their inner experiences and difficult emotions. Client and therapist then work through at least two layers of anxiety splits beginning with the presenting anxiety split, then proceeding to the underlying protective split in critic/coach self-aspect. This is a critical step; EFT therapists hold that the surface anxiety split will not resolve without accessing the underlying fear that drives the critic. As they proceed, client and therapist track the core maladaptive emotion schemes back to vulnerabilities that originated in the person's unresolved relationships with developmentally significant others (most often parents or siblings). After helping the client to resolve this *unfinished business*, client and therapist return to the experiencer's need for self-assertion or contact in their current life.

Although this formulation sounds rather prescriptive, EFT therapists find that the specifics vary substantially first across the different types of anxiety difficulty and second across different clients with the same presenting anxiety difficulty. Although there are many common elements, every client has a unique configuration of emotion schemes, conflict splits, unresolved relationships, and change processes.

Research on the Effectiveness of PCE Therapies for Anxiety Difficulties

In this section I review evidence up to 2008 on the outcomes of PCE therapies for anxiety and summarize preliminary results from research in progress on PCE for social anxiety being carried out at the University of Strathclyde.

Research on the Outcome of PCE Therapy for Anxiety Difficulties: A Meta-analysis

Elliott and colleagues (in press) report a meta-analysis of research on almost 200 studies (published up to 2008) of the effectiveness of PCE therapies with adults or young people. The data include evidence on six distinct client populations: depression, psychosis, habitual self-damaging activities, relational/interpersonal problems (including relational trauma), coping with medical conditions, and anxiety.

The research evidence on PCE therapies for anxiety, most commonly the application of supportive or person-centered therapies, is much more mixed than is the case for depression or interpersonal problems, but is strongest for pre-post 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 PCE therapies (5 samples, eg, gestalt), generally carried out in studies where there was a negative researcher allegiance (14 samples, almost always cognitive-behavioral). Anxiety difficulties studied included panic/agoraphobia (6 samples), generalized anxiety disorder (6 samples), phobias (usually chronic or complex; 6 samples), and mixed anxiety (2 samples). (We did not find any studies entirely focused on PTSD.)

Pre-post effects. Table 1 summarizes the overall results of the analysis of these 19 studies, including 19 pre-post studies, four controlled studies and 19 comparisons between PCE and some other kind of therapy. The weighted mean pre-post effect size for the 19 sets of anxious clients was .88, quite near the overall pre-post figure of .93 for the entire sample. Table 2 displays the pre-post effects by type of PCE therapy: Although the confidence intervals all overlapped, pre-post effects varied significantly across type of PCE therapy ($Q = 8.17$; $p < .05$), with weighted effects for supportive treatments somewhat smaller (.66) than for PCT (1.0) or other PCE therapies (1.41).

Controlled effects. There were only four controlled studies (total $n = 70$ clients), all with relatively small samples (<25); these showed a controlled effect size of .5, a medium effect size significantly greater than zero but a bit less than the overall sample value of .76. The sample was too small for meaningful comparison between types of PCE therapy.

Comparative effects. Of the six client population clusters reviewed by Elliott and colleagues (in press) for comparative effects, PCE therapies fared most poorly with anxiety difficulties, with a mean comparative effect size of -.39 (see Table 1) across 19 comparisons with other therapies. This is consistently, moderately and significantly in favor of the other therapies, all but one some form of CBT. Nine of the 18 comparative effects with CBT substantially favored CBT ($<-.4$), with none favoring a PCE therapy. Furthermore, in comparisons with other therapies, there was very little variation between type of PCE (see Table 2); effects varied from -.49 to -.36, all of them statistically significantly worse than the other therapy (almost always CBT). In fact, although the number of comparisons of CBT with PCT and other PCE therapies was small, there was a consistent, moderate advantage for CBT regardless of type of PCE therapy. In further analyses I broke the comparative effects down by type of anxiety difficulty: Although differences between types of anxiety are not

significant, the strongest advantage for CBT can be seen for panic/agoraphobia and generalized anxiety (ES: -.44 and -.39 respectively, both significantly less than zero), while it appears to be slightly less for phobias (ES: -.15, not significantly less than zero).

In one final analysis, I looked at the researcher allegiance effects in this sample of comparative effects. Two sets of results here suggest that the negative comparative effects for PCE therapy with anxiety are only partly due to negative researcher allegiance: First, although only about half the size of the negative researcher allegiance effects (-.44, significantly different from zero), the effects for neutral and pro-PCE allegiance studies were still negative (-.24 and -.25 respectively, not significantly different from zero). Second, even when researcher allegiance was controlled for statistically, the negative comparative effect persisted (-.21) and was statistically significant.

In conclusion, the research evidence on application of PCE therapies with anxiety difficulties shows reasonable pre-post effects, somewhat weaker controlled effects, and fairly negative comparative effects. These effects cannot be attributed simply to the use of watered down so-called “supportive” therapies or to negative researcher allegiance, although they may be less negative for phobias and for neutral or positive researcher allegiance studies. Instead, they point to the real possibility that PCE therapies may be somewhat less effective than CBT for anxiety. Furthermore, although it is a limitation of this meta-analysis that it goes only up to 2008, more recent studies (e.g., Marchland et al., 2008) show quite similar results.

There is, however, another possibility: The problem may be that PCE therapies have not been implemented in an effective manner with this client population. For example, it seems to me that few PCE therapists have taken the time to gain experience and to consider the full range of potentially effective PCE methods for this client population. At the time of this review, I found no studies of EFT or Focusing-oriented therapy for anxiety, and only one gestalt study (Johnson, 1977, reported quite promising results for snake phobia). Furthermore, clients with significant anxiety difficulties often have a problem with the lack of structure typical of nondirective therapies, often asking for expert guidance. For this reason, EFT researchers are currently carrying out studies on the effectiveness of EFT with generalized anxiety (Watson, Timulak) or social anxiety (Elliott).

The Strathclyde Social Anxiety Project: Preliminary Results

Method. One of these studies is the Strathclyde Social Anxiety Project, a therapy development study currently nearing completion. This study is comparing standard PCT, including nondirective and broader relational versions (eg, Mearns & Thorne, 2007) with EFT (Elliott et al., 2004), which following Greenberg and Watson (1998) can be understood as PCT plus active tasks, specifically focusing, systematic unfolding, and various forms of chair work. I briefly summarize here results reported by Rodgers and Elliott (2012) on 50 clients who received 3 or more sessions (two clients are still in therapy as of this writing and are thus not reported here). The last 20 clients in the study were randomized. The research team included strong advocates for both PCT and EFT, thus balancing researcher allegiances.

A community sample of socially anxious clients was recruited and screened using the following criteria: (a) considered self to have a problem with social anxiety; (b) met diagnostic criteria for social anxiety following four hours of screening using the Structured Clinical Interview for DSM IV (SCID-IV; First, Spitzer, Gibbon &

Williams, 2007); (c) willingness to be recorded and to complete out research procedures.

Clients were offered up to 20 sessions, but could finish earlier if they wished. We used a modified intent to treat sample; that is, clients were included in outcome analyses if they received at least 3 sessions. (For various reasons, five clients each in PCT and EFT dropped out after one or two sessions and are not included in the analyses.) Clients in PCT received an average of 14.7 sessions (sd: 5.7), while clients in EFT received an average of 17.9 (sd: 5.5), three more sessions than in PCT.

Only pre-post outcome data are presented here. The main outcome measure was the Personal Questionnaire (Wagner & Elliott, 2001), an individualized weekly problem distress measure consisting of about 10 problems identified by each client as something they wanted to work on in therapy. We also used the CORE-Outcome Measure (Barkham, Mellor-Clark, Connell & Cahill, 2006), which assessed general problem distress; the Social Phobia Inventory (Connor et al., 2000); a problem specific measure of social anxiety “symptoms”; the 26-item version of the Inventory of Interpersonal Problems (Maling, Gurtman & Howard, 1995), an interpersonal problem distress measure; and the Strathclyde Inventory (Freire, 2007), a person-centered outcome measure assessing congruence vs incongruence.

Overall Pre-post Results. Because this is not the final report of this study, I report here only the preliminary effect sizes estimates for this study. These are given in Table 3, which provides the pre-post effect sizes (ES, standardized mean differences) for the combined sample and separately for PCT and EFT, as well as the differences between PCT and EFT ESs. First, these results show clearly that both PCT and EFT are effective with social anxiety: Clients in the combined sample showed large gains over therapy on all measures and overall did somewhat better than clients in the pre-post studies reviewed in the meta-analysis (1.18 vs. .88). Furthermore, the pre-post gains on the Social Phobia Inventory for the combined samples (ES = 1.28) compared quite favorably to a set of studies on CBT and medication for social anxiety used here for bench-marking (Connor et al., 2000: medication ES = 1.28; Antony, Coons, McCabe, Ashbaugh, & Swinson 2006: group CBT ES = .94; Taube-Schiff, Suvak, Antony, Bieling, & McCabe, 2007: group CBT ES = .68).

PCT vs. EFT Comparison. Second, clients who received EFT did reliably better on three of the five outcome measures and overall. The difference was largest on the Personal Questionnaire, where pre-post effects for EFT clients were more than twice as large as for PCT clients. Statistical trends at $p < .1$ were obtained for the Social Phobia Inventory, the Strathclyde Inventory, and overall. The differences were smallest for the most general measures (CORE Outcome Measure, Inventory of Interpersonal Problems). The EFT advantage overall here was a substantial and clinically relevant effect size of .62, a figure comparable to previously-reported comparisons between EFT and PCT for depression (Greenberg & Watson, 1998; Goldman, Greenberg & Angus, 2006) and complex trauma (Paivio et al., 2010). Although this difference in pre-post effect size may have been due in part to EFT clients receiving more sessions, the ratio for EFT to PCE effect sizes ($15.7/.94 = 1.67$) substantially exceeded the ratio for average number of sessions ($17.9/14.7 = 1.21$).

Discussion. Anecdotally, it is clear that many clients showed substantial change over therapy on long-standing problems. Furthermore, although the clients in EFT did better on average, many clients engaged quite well and showed clinically significant and reliable change in PCT. For these clients, their therapists' nondirective relational offer seemed to be exactly what they needed to counter the

conditions of worth on which their social anxiety was based. On the other hand, although most clients were able to use EFT chair work, some clients were too self-conscious to do so, requiring the therapist to abandon this aspect of EFT or to find creative work-around strategies (eg mediating for the client). Possibly because of its greater structure, clients in EFT appeared generally to engage more fully with therapy; for example, they were more likely to make use of the full 20 sessions offered in the study, whereas clients in the PCE condition often stopped before this.

Nevertheless, several cautions are in order: First, the research design was only partially randomized. Second, treatment overlap issues may have reduced the observed differences: As noted, some clients refused EFT Chair work, so that their therapy devolved into a broadly PCT/Experiential therapy featuring structured exploration and focusing.

Interestingly, therapists in both conditions improved in their effectiveness over the course of the study as they learned how to work with this challenging client population. For example, therapists learned that their clients were extremely sensitive to anything that might indicate rejection or judgment by the therapist, and went out of their way to greet their clients with genuine enthusiasm at the beginning of sessions. Over the course of the study, EFT conceptualization and methods of working with social anxiety were evolving, based on emerging experiences with clients. For one thing, the EFT therapists began refining and making more use of a relatively new form of chair work called *compassionate self-soothing*. This therapeutic task involves helping the client to enact a dialogue in which a deeply wounded and vulnerable aspect of the self (the compromised partial-self in McGavin & Cornell's 2008 formulation) is comforted and affirmed by a nurturing and prizing aspect of the self (*self-in-presence*, in Cornell's 2005 terms). In fact, toward the end of the data collection, an integrated EFT protocol for working with social anxiety emerged, which I will discuss in the next section.

Implications for PCE Practice with Anxiety Difficulties

Based on the meta-analysis and the early Strathclyde Social Anxiety Project results summarized here, I think that it is possible to draw a set of important lessons for the practice of PCE therapy with anxiety difficulties.

1. *Process Differentiation is Useful.* The meta-analysis shows that the PCE therapy track record with anxiety difficulties is not as good as it should be. While there are many problems with psychiatric diagnosis and clients with the same diagnosis vary widely from one another, it is also the case that different client presenting problems reveal distinct client phenomenologies. Anxious clients see the world, others and themselves differently from depressed clients, from clients with psychotic processes, from clients with habitual self-damaging activities, from clients coping with chronic medical conditions, and from clients locked in unresolved relational conflicts or trauma. Learning about the worlds that anxious clients live in can help therapists to be more empathic and accepting of their clients, as long as these understandings are held lightly and tentatively.

As Cooper and McLeod (2010) have argued, we should not assume that a given therapeutic approach will work equally well and in the same way for all clients. Instead, I am advocating that PCE therapists approach new client groups with attitude of humility and openness about what they are likely to find helpful or unhelpful. Thus, it may be that the relatively poor track record of PCE therapies with anxiety is due not just to researcher allegiance or even to a mismatch between these therapies

and the needs of clients with anxiety difficulties but more to inadequate preparation and understanding of this client population.

2. Value of More Differentiated Models of Anxiety. In fact, I do not think that we have gone far enough toward clarifying and differentiating anxiety difficulties. For one thing, it seems to me that traditional PCE models of anxiety, though useful as far as they go, are too simple to capture the complexity of the clients we work with. Single factor theories of psychological distress, such as incongruence theory or structure-bound processing, are not rich enough to support the complexity of our clients' problems. Instead, flexible but more differentiated theories and models of practice may be able to help PCE therapists work more effectively with anxious clients. These more differentiated models include, eg, Cornell and McGavin's (2008) inner relationship focusing and the formulations and tasks of EFT. Furthermore, it would probably be a mistake to generalize too much across different kinds of anxiety difficulty. Thus, phobias, generalized anxiety, panic, post-trauma, and obsessive-compulsive processes all have their own phenomenologies and require hard work and experience to understand and work with effectively. For example, Timulak and McElvaney (2012) recently reported work on a version of EFT for generalized anxiety, with a model emphasizing the role of avoidance of core psychological pain and highly promising early outcome results.

3. With Anxious Clients, Offer More Structure. As an example of process differentiation, in our study, both PCT and EFT therapists learned that many of their socially anxious clients found lack of structure, particularly early in therapy, to be unbearable; for many clients, an unstructured therapeutic offer too closely resembled the type of social situation they most feared. Thus, even the most nondirective PCT therapists learned to be more active and engaging with their socially anxious clients and came to offer them more process guiding, for example asking more questions early in therapy, before tapering off in order to provide these clients with more space and control over sessions. Even the EFT therapists offered more structure than usual in early sessions with these clients and provided more information about the nature of therapy and common experiential processes in anxiety, such as anxiety splits and fearful critics.

4. An Integrated EFT Protocol for Social Anxiety. Gradually, over the course of seeing clients in the EFT arm of the Strathclyde Social Anxiety Project, it became clear that there is a common change process that appears to be quite effective for working with many socially anxious clients. Table 4 outlines this change process, which is facilitated by linking several different EFT tasks together to form a sequence that is built up over the first half of therapy.

In fact, the client used as an example earlier in this article illustrates many aspects of this emerging model: Carol (see also MacLeod, Elliott & Rodgers, 2012) was a single Scottish working class woman in her mid-50's, who had been unemployed for ten years following a psychiatric breakdown. At the beginning of therapy she was very socially isolated and spent most days hiding in bed. She met the diagnostic criteria for severe social anxiety, centering on fears of social situations, especially weddings and parties. She had a history of alcohol misuse but had been sober for at least 15 years, and had had previous unsuccessful CBT. She had a childhood history of emotional and sexual abuse. At the end of therapy she confessed that she had been severely suicidal when she started and had planned to kill herself if the therapy failed.

The most commonly used tasks in Carol's therapy were empathic exploration, focusing, and several kinds of chair work, including two chair (for anxiety and

conflict splits), empty chair (for unfinished business with important others), and compassionate self-soothing. Carol's distress levels started at high levels (Phase I in Table 4) through the first half of the therapy as she began to work with her anxiety splits (Phase II) and then moved into work with the deeper split (Phase III), where her attempts to change led to harsh reprisals from her terrified inner critic and a sense of impasse. Gradually, through repeated use of inner relationship focusing and self-soothing, her experiencing aspect gained power, to the point where it was able to move past the impasse, and the critical aspect diminished in power. She was largely improved by session 16; at that point her recent changes still felt fragile, so the last four sessions took place at monthly intervals (Phase V). Her large post-therapy gains were maintained at 6- and 18-month follow-up assessments.

In retrospect, it now appears to me that the very difficult middle phase of Carol's therapy might have gone better if we had been better able to address her critical aspect's fears of what was going to happen if it stopped making her feel defective in social situations.

As she entered the consolidation phase, Carol was interviewed by her researcher. As that point, she reported:

When I think back from very very early on in working with him, it's been so powerful, experiencing things and in the session going into how I'm feeling. And I've been amazed that I have felt so much.... I'll tell you what I think is the most, the greatest thing that I'm feeling: It's that I'm feeling a sense of belonging ... Just this sense of general belonging.

Conclusions

In this article I have tried to argue that person-centered-experiential psychotherapists and researchers no longer need to neglect of this important client population. There are understandable reasons for the current situation, two of them being antipathy toward diagnosis and CBT's 60-year head start on understanding and developing effective therapies for anxiety. Nevertheless, I have no doubt that PCE therapies have a great deal to contribute to helping clients with anxiety difficulties, particularly if we invest the time and energy needed to carry out research that truly represents what we do and if we collaborate with our clients to enhance the appropriateness and effectiveness of what we have to offer.

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Table 1. PCE Therapy for Anxiety Meta-analysis: Overall Results

| Type of Effect | N of samples or comparisons | N of clients | ES (±95%CI) |
|---|-----------------------------|--------------|-------------------------|
| Pre-Post Effects | 19 samples | 305 | .88 (.69 to 1.06)* |
| Controlled Studies (vs. no-treatment or waitlist) | 4 comparisons | 70 | .50 (.17 to .83)* |
| Comparative Studies (PCE vs. non- PCE) | 19 comparisons | 264 | -.39 (-.55 to -.23)* |

* $p < .05$ in null hypothesis test against $ES = 0$.

Note. ES: weighted effect size (d_w); CI: confidence interval.

Table 2. Pre-post Effects by Type of PCE Therapy

| Type of PCE therapy | Pre-Post Effects | | Controlled Effects | | Comparative Effects | |
|---------------------|------------------|------------------------|--------------------|-----------------------|---------------------|-------------------------|
| | N | ES (±95% CI) | N | ES (±95%CI) | N | ES (±95%CI) |
| Supportive | 8 | .66* (.40 to .92) | 1 | .22 (-.36 to .80) | 12 | -.36* (-.58 to -.15) |
| Person-Centered | 6 | 1.00* (.71 to 1.28) | 2 | .57* (.13 to 1.02) | 4 | -.43* (-.80 to -.07) |
| Other PCE | 5 | 1.41* (.84 to 1.97) | 1 | .99 (-.05 to 2.03) | 3 | -.49* (-.96 to -.03) |
| Overall | 19 | .88* (.69 to 1.06) | 4 | .50* (.17 to .83) | 19 | -.39* (-.55 to -.23) |

* $p < .05$ in null hypothesis test against $ES = 0$.

Note. Ns for pre-post effects are number of client samples; Ns for controlled and comparative effects are number of comparisons; ES: weighted effect size (d_w); CI: confidence interval

Table 3. Strathclyde Social Anxiety Project: Pre-Post Effect Sizes

| | Combined Sample (n = 35 – 50) | PCT (n = 19 - 29) | EFT (n = 15 – 21) | EFT-PCT Difference |
|---|--|------------------------------|------------------------------|-------------------------------|
| Personal Questionnaire | 1.45 | 1.05 | 2.22 | 1.17** |
| CORE Outcome Measure | .86 | 0.80 | .95 | .15 |
| Social Phobia Inventory | 1.28 | 1.01 | 1.75 | .74 ⁺ |
| Inventory of Interpersonal Problems | 1.03 | 0.88 | 1.21 | .33 |
| Strathclyde Inventory | 1.29 | 0.98 | 1.71 | .73 ⁺ |
| Mean Effect Size | 1.18 | .94 | 1.57 | .62 ⁺ |

**p < .01 ⁺p < .1

Notes. PCT: Person-Centered Therapy; EFT: Emotion-Focused Therapy. Effect sizes are standardized pre-post differences (Cohen's d).

Table 4. Integrated EFT Protocol for Social Anxiety

Phase I: Beginning: Making Contact (Sessions 1 – 3)

- Alliance Formation
- PCT narrative work/empathy

Phase II: Working with Anxiety Splits (Sessions 4 – 7)*EFT task Sequence:*

- (1) Systematic Unfolding of social anxiety episodes, leads into:
- (2) Two chair work on anxiety splits (secondary reactive anxiety / fear)

Phase III: Deepening: Working with the Deeper Split (Sessions 6 – 9)*EFT task sequence:*

- (1) Systematic Unfolding of social anxiety episodes, leads into:
- (2) Two chair work on anxiety splits (secondary reactive anxiety / fear), leads into:
- (3) Two chair work + Inner Relationship Focusing on deeper split: defective self vs. frightened critic (primary maladaptive shame / fear)

Phase IV: Emotional Change: Five-step integrated EFT task sequence
(Sessions 8 – 15)

- (1) Systematic Unfolding of SA episodes, leads into:
- (2) Two Chair Work for Anxiety Splits, leads into:
- (3) Two Chair Work with Frightened Critic, leads into:
- (4) Empty Chair work with developmentally significant shaming/abusive/ neglectful others, leads into (core pain, unmet needs), leads into:
- (5) Compassionate self-soothing (primary adaptive emotions: connecting sadness, protective anger, exploratory curiosity)
(Repeated as needed within and across sessions)

Phase V: Consolidation and ending (Sessions 15 – 20)

- Tapering off frequency of therapy
 - Helping client carry forward changes in their life
 - Preparing for and processing end of therapy
-