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Research on Experiential Psychotherapies

Robert Elliott, Leslie S. Greenberg & Germain Lietaer

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This review covers approaches to psychotherapy generally referred to as "experiential." Experiential therapies are part of the tradition of humanistic psychology (see Cain & Seeman, 2002; Schneider, Bugental & Fraser, 2001), with the major subapproaches being the Client-centered (or Person-Centered; e.g., Rogers, 1961), Gestalt (e.g., Perls, Hefferline & Goodman, 1951), and Existential (e.g., Yalom, 1980). Other influential experiential approaches have been psychodrama (Moreno & Moreno, 1959), a cluster of emotion-focused expressive approaches (Mahrer, 1983; Pierce, Nichols & DuBrin, 1983; Daldrup, Beutler, Engle & Greenberg, 1988), body-oriented therapies (Kepner, 1993), and experiential-interpersonal views of such authors as van Kessel & Lietaer (1998), Yalom (1995), and Schmid (1995). Originally designated as "humanistic" or "third force" therapies, these therapies have recently begun to be grouped together under the "experiential" umbrella (Greenberg, Elliott, & Lietaer, 1994; Greenberg, Watson, & Lietaer, 1998).

The Process-Experiential (PE) approach is one current expression of the contemporary humanistic-experiential tradition in psychotherapy that has attracted a substantial research base. It integrates Client-Centered and Gestalt therapy traditions into an emotion-focused approach that emphasizes both the relationship and the process of reflection on aroused emotions to create new meaning (Greenberg, Rice & Elliott, 1993). Other current expressions include Gendlin's (1996) Focusing-oriented approach, emphasizing the creation of new meaning by focusing on bodily felt referents; dialogical gestalt therapy (Yontef, 1993; Hycner & Jacobs, 1995); and integrative forms of person-centered/experiential psychotherapy (Finke, 1994; Mearns & Thorne, 2000; Lietaer & Van Kalmthout, 1995). In practice, these contemporary approaches strive to maintain a creative tension between the client-centered emphasis on creating a genuinely empathic and prizing therapeutic relationship (Rogers, 1961; Biermann-Ratjen, Eckert & Schwartz, 1995; Barrett-Lennard, 1998), and a more active, task-focused process-directive style of engagement that promotes deeper experiencing (Perls et al., 1951; Gendlin, 1996).

Although these approaches vary somewhat in technique and conception, they nevertheless share a number of distinctive theoretical assumptions. Most important among these assumptions is that they view human nature as inherently trustworthy, growth-oriented, and guided by choice. Human beings are viewed as oriented toward growth and full development of their potentialities.

The first and most central characteristic of experiential psychotherapy is its focus on promoting in-therapy experiencing. Methods that stimulate emotional experience 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 humanness. 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 experientially-oriented theorists are united by the general principle that people are wiser than their intellect alone. In an experiencing organism, consciousness is seen as being at the peak of a pyramid of nonconscious organismic functioning.

In addition, experiments in directed awareness help focus and concentrate attention on unformed experience and intensify its vividness. Of central importance is the idea that tacit experiencing is an important guide to conscious experience, fundamentally adaptive, and potentially available to awareness.

Because of their view of tacit experiencing, experiential therapists agree that it is disrespectful and disempowering for therapists to act as experts on the content of their clients' inner experience ("content directiveness"). Continuing key points of contention within experiential camps, however, are (a) whether minor content directive interventions can be used, as long as they are tentative and respectful, and also (b) the degree to which therapists should act as process-experts by suggesting ways clients can work more productively on particular types of problems ("process directiveness"). All experiential therapies are process-directive to a certain extent, but PE, gestalt, and emotional-focused therapy for couples are more process-directive, while client-centered (CC) and so-called "supportive" or "nondirective" therapies are less process directive.

In addition, almost all experiential therapies view the therapeutic relationship as potentially curative. Internal tacit experiencing is most readily available to awareness when the person turns his or her 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. Experiential approaches also are consistently person-centered. This involves genuine concern and respect for each person. The person is viewed holistically, not as a symptom-driven case nor as best characterized by a diagnosis. Each person's subjective experience is of central importance to the humanist, and, in an effort to grasp this experience, the therapist attempts to empathically enter into the other person's world in a special way that goes beyond the subject-object dichotomy. Being allowed to share another person's world is viewed as a special privilege requiring a special kind of relationship. All experiential approaches dispute the psychoanalytic claim 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 a real relationship with the therapist provides the client with a new, emotionally validating experience.

In this chapter we review research published since our previous review (Greenberg et al., 1994), which covered research published between 1978 and 1992, plus earlier research on experiential therapy outcome that has become available. A key element of the chapter is a meta-analysis of over 125 experiential therapy outcome studies. In addition, we carry previous reviews of this literature further by applying criteria promulgated by the Society of Clinical Psychology (Division 12, American Psychological Association) for designating psychotherapies as empirically supported (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). We realize that these criteria are controversial (e.g., Elliott, 1998; Bohart, O'Hara & Leitner, 1998, Wampold, 1997), even in their most recent and polished version (Chambless & Hollon, 1998). Nevertheless, we will use the Chambless-Hollon criteria here, because they 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 bond, helping and hindering processes, child psychotherapy, and on measurement construction of research (but

see Cain & Seeman, 2002, for reviews of many of these topics). In addition, we have chosen not to review research on the growing number of integrative approaches, such as empathic-psychodynamic approaches (the conversational-interpersonal model investigated by Shapiro and colleagues (e.g., Shapiro et al., 1994), motivational interviewing (Project MATCH Research Group, 1997), and Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 1999).

As Greenberg et al. (1998) note, additional programmatic empirical research on experiential therapy is still needed, but clear progress has taken place in the last ten years, including research on specific populations. Especially noteworthy are three recently-published major handbooks of humanistic and experiential psychotherapy that cover research done in the experiential tradition, including research methods for getting at subjective experience (Greenberg et al., 1998; Cain & Seeman, 2002; Schneider et al., 2001). Additional information, including research bibliographies and research protocols is available on the internet at www.experiential-researchers.org.

Are Experiential Therapies Effective?: A Meta-Analysis

In both North America and Europe, economic pressure on mental health services and scientific-political trends toward treatment standardization have led to calls for certain therapies to be officially recognized as effective, reimbursed by insurance, and actively promoted in training programs at the expense of other therapies (Task Force on Promotion and Dissemination of Psychological Procedures (1995; Meyer, Richter, Grawe, von Schulenburg & Schulte, 1991). These reports were not kind to experiential therapies, and attempted to enshrine preconceptions about the supposed ineffectiveness of experiential therapies as both scientific fact and health care policy.

Understandably, experiential-humanistic therapists (e.g., Bohart, O'Hara & Leitner, 1998; Schneider, 1998) responded to these challenges with some alarm. They challenged the assumptions and methods used in the current research literature and in current attempts to institute criteria for designating certain therapies as effective. Strangely, the argument from research evidence has been relatively neglected in this controversy. In fact, a substantial body of research data supports the effectiveness of experiential therapies. Furthermore, this body of research is continuing to grow rapidly.

We report here the latest of a continuing series of meta-analytic reviews of research on the effectiveness of experiential therapies, substantially updating earlier reports (Greenberg et al., 1994; Elliott, 1996, 2002). The present analysis triples the number of studies analyzed in Greenberg et al.'s (1994) original review, from 35 to 111; the added studies are summarized in Table 1. In attempting to be as complete as possible, we have added a substantial number of German studies, as well as many older and more recent studies as we could obtain. At this point, the analysis includes pre-post effect size data from 127 experiential therapy samples in 112 studies (involving a total of 6569 clients). In terms of controlled studies, there are 42 comparisons (from 37 studies, involving 1149 clients) with wait-list or no-treatment conditions; 74 comparisons (55 studies, 1375 clients) between experiential and nonexperiential therapies; and 5 comparisons between different experiential therapies (5 studies, 164 clients).

Of the pre-post therapy samples reviewed, 52 investigated Client-Centered (CC) Therapy in a relatively pure form, while 11 studied "nondirective" therapy with minor directive

(e.g., relaxation training or education) elements. Eighteen studies examined task-focused, integrative Process-Experiential (PE) therapies; 10 studies evaluated the closely related Emotionally-Focused Therapy (EFT) for couples; 10 dealt with Gestalt therapy, 11 with encounter/sensitivity groups (generally in marathon formats) and another 15 looked at the outcome of various other experiential/humanistic therapies (e.g., focusing-oriented, psychodrama or integrative). Ten of the studies reviewed were published prior to 1970; 19 came from the 1970's and 31 from the 1980's; however, more than half (67) have appeared since 1990. These studies offer evidence for a revival of outcome research on experiential therapies. The average treatment length was 22 sessions (sd: 22.5, range 2-124); the average number of clients studied was 51.7 (sd: 142.5; range 6 - 1426). Across the whole sample, researcher theoretical allegiances were most commonly pro-experiential (71%), although this breakdown varies across analyses.

For each study, characteristics of the treatments, clients, therapists or the studies were rated, in order to estimate the contribution of these features to effect size. For example, a "process-directiveness" variable was coded, with PE, gestalt, emotion-focused and "other" experiential therapies coded as more process directive ("1"), and CC and supportive-nondirective therapies coded as less process directive("2").

Standardized pre-post differences (d) were used for effect size (ES) calculations using standard estimation procedures (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: post-therapy, early follow-up (less than a year), and late follow-up (a year or longer). For pre-post effect sizes, measure effects were averaged for each treatment condition, 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 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 experiential treatment showed a larger amount of change. Finally, equivalence analyses (Rogers, Howard & Vessey, 1993) were carried out for key comparisons, using .4 sd as the minimum clinically interesting difference, as previously proposed by Elliott, Stiles & Shapiro (1993).

Total Pre-Post Change in Experiential Therapies

Table 1 summarizes pre-post effects for all studies for which such data could be calculated. Overall unweighted results are given in Table 2. The average pre-post effect, across the 127 treatment groups and assessment periods, was .99 sd. This exceeds the .8 sd standard cited by Cohen (1988) as a large effect size. The data clearly indicate that clients maintained or perhaps even increased their posttreatment gains over the posttherapy period, with largest effects obtained at early follow-up. Weighting effects by sample size produced a somewhat smaller ES of .86 sd. This smaller weighted effect primarily reflects the contribution of large German studies with relatively small ESs, in particular two reported by Tscheulin (1995, 1996), with samples of 1426 and 632 respectively.

Controlled Research on the Effectiveness of Experiential Therapies

Pre-post effects do not tell us, of course, whether clients in experiential therapies fared better than untreated clients, and thus make it difficult to infer that therapy was responsible for

changes made by clients. They also generally produce larger effects than control group comparisons (Lipsey & Wilson, 1993). Therefore, we examined control-referenced effect sizes (differences between pre-post ESs) in the 42 treated groups in which experiential treatments were compared to wait-list or no treatment controls (see Table 3). The unweighted mean controlled effect size for these studies (Table 2) was also large, .89, a value quite comparable to the mean pre-post effect of .99. In fact, the average pre-post effect in the 39 untreated conditions was .11, indicating that there was little or no improvement in the untreated clients in these studies; and clients in 5 of the 42 untreated groups showed a clinically significant level of average deterioration (negative effect sizes of -.40 or larger). The fact that the controlled effects corroborated the pre-post effects also supports the validity of using pre-post effects, making it possible to draw on a much larger sample of studies. Finally, as with pre-post effects, weighting by sample size produced a comparable, though slightly smaller, mean effect of .78.

Comparative Outcome Research on Experiential vs. Nonexperiential Therapies

While impressive, the pre-post and controlled effect-size analyses reported so far do not address the issue of comparative treatment effectiveness, which is central to the current controversy about the effectiveness of experiential therapies. For this, we analyzed 74 comparisons between experiential and nonexperiential therapies, summarized in Table 4. Five studies compared different experiential therapies (e.g., Greenberg & Watson, 1998), and were therefore not included in these analyses. The average unweighted difference in pre-post effects between experiential and nonexperiential therapies (Table 2) was +.04, indicating no overall difference. Once again, weighting by sample size produced comparable results. In 45 (60%) of the comparisons, clients in experiential and nonexperiential therapies were within ±.4 sd of each other. However, there is also heterogeneity in comparative effect sizes, as evidenced by 13 comparisons in which clients in the nonexperiential treatments did substantially better (comparative effect size < -.4 sd) than clients in experiential therapies, while experientially-treated clients did substantially better (> .4 sd) in the remaining 16 comparisons.

Applying equivalence analysis to this and other treatment comparisons makes it possible to “prove the null hypothesis” of equivalence between experiential and nonexperiential therapies. These analyses are summarized in Table 5, with equivalence analyses given in the "t(0)", "t(.4)", and "Result" columns. In the case of the overall comparison between experiential and nonexperiential therapies, the obtained zero-order difference is significantly less than ±.4 sd, the predetermined minimum substantive difference criterion (t [.4] = 5.5; n= 74; $p < .001$). In other words, on the basis of this sample, it can be concluded that experiential and nonexperiential treatments are, in general, equivalent in their effectiveness.

Cognitive-behavioral (CB) vs. experiential therapies. A significant center of controversy involves assumptions shared by many academic or CB-oriented psychologists that experiential therapies are inferior to cognitive-behavioral treatments. The comparative studies analyzed here did not exclusively use CB treatments (only 46 out of 74 comparisons). Therefore, it can be argued that the effects of the CB treatments were watered down by the inclusion of comparisons involving other types of therapy (i.e., psychodynamic, psychoeducational, and “treatment as usual”).

In order to clarify this issue, we undertook a series of subsidiary equivalence analyses (see Table 5). These analyses indicated that, for the subsample of 28 studies analyzed here,

experiential therapies showed larger pre-post effects than nonCB therapies. On the other hand, the 46 studies comparing experiential to CB therapies revealed a mean difference of -.11, which was clinically equivalent (i.e., statistically significantly less than the ±.4 minimum difference but not significantly different from zero). Thus, these data support the claim that experiential therapies in general are equivalent to CB therapies in effectiveness.

Nevertheless, in light of recent controversies in Germany over government recognition of Gesprächspsychotherapie (the German version of CC therapy) as a valid treatment, more precise analyses are required. Specifically, it is important to address claims by Grawe, Donati, and Bernauer (1994) that client-centered therapy is less effective than cognitive-behavior therapy, based on their meta-analysis of ten comparative treatment studies. In fact, when the focus is further narrowed to the 32 studies comparing CC or nondirective/supportive therapies to CB treatments, a "trivial" statistical superiority for CB appeared (comparative ES: -.25); this effect is both significantly greater than zero and significantly less than the .4 sd criterion difference. The same result occurred for the subsample of 20 comparisons between pure CC and CB treatments (mean comparative ES: -.19).

On the other hand, when "process directive" experiential therapies (i.e., Process-Experiential, Emotionally-Focused Therapy for couples, Gestalt and Focusing) are lumped together, the mean difference between them and CB favors the experiential therapies (+.20), but the difference is equivocal (neither significantly different nor equivalent). In fact, in the 5 studies (Greenberg, Goldman & Angus, 2001; Greenberg & Watson, 1998; James, 1991; Watson, Gordon, Stermac, Kalogerakos & Steckley, 2001; Tyson & Range, 1987) in which more vs. less process-directive experiential therapies were compared directly, the mean comparative effect size significantly favored the process-directive therapies (+.47; $t(0) = 4.07$; $p < .05$).

In spite of the clinically trivial superiority of CB treatments to the less process-directive experiential therapies, it appears likely that the significant differences found may reflect method factors, in particular, researcher allegiance effects (Luborsky et al., 1999). 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 5, bottom), all of the treatment comparisons were zero-order and statistically-equivalent: The allegiance-corrected mean comparative effect sizes were significantly less than the .4 criterion, and not significantly greater than zero.

Method, Client and Treatment Moderators of Study Outcome

Outcome effect sizes can potentially be affected by a variety of factors, including research method (type of measure, size of sample, regional origin of the research, year of study, and researcher theoretical allegiance), client problem, and treatment characteristics (modality, setting, length, therapist experience). These factors are also likely to be confounded with differences between various forms of experiential therapy. As Table 6 indicates, most of these potential moderators show little or no relation to effect size.

Method factors. In terms of research design features, researcher theoretical allegiance showed no association with pre-post effect size, but turned out to be a very strong predictor of comparative ES ($r = -.59$; $p < .01$). In other words, proponents of experiential treatments typically produced substantial, positive comparative effects, while advocates of nonexperiential approaches typically found experiential treatments to be less effective than other approaches and

researchers whose allegiance was neutral, mixed, or indeterminate typically obtained no difference results. As noted earlier, when researcher allegiance was controlled for, differences between experiential and other therapies disappeared. (These allegiance effects are likely to include differential effort by trainers, supervisors and therapists.) In addition, researcher theoretical allegiance may also play a role in studies using no-treatment or waitlist controls (r = -.30). We also found experiential therapies show significantly larger effects when compared to waitlist as opposed to no-treatment controls (r = .39), possible because wait-listed clients refrained from seeking treatment while they were waiting for therapy to begin. Finally, as in previous measure-level meta-analyses, we found large differences among different types of outcome measure (n = 480 effects; 11 categories; *eta* = .53; $F = 18.2$; $p < .001$), with individualized and clinician-rated measures showing the largest effects, and measures of personality/coping style, cost, and health status the smallest.

Client factors. Regarding client factors, we expected that clients with less severe or emotion-focused problems (e.g., depression) would show greater change in experiential therapies than clients with more severe or cognitive/behavior-based problems (e.g., schizophrenia, habit disorders). We found that client problem made a difference for pre-post and controlled effects, but not comparative effects (see Table 6). As in our previous reviews, the largest effects were obtained for specific relationship problems, while the smallest effects were generally obtained for habit disorders, severe disorders, and physical problems (e.g., cancer).

Treatment factors. Degree of process-directiveness proved to be the most consistent predictor of effect size across all three types of studies. As implied in the equivalence analyses described earlier, process-directive therapies such as PE and EFT had larger effects than CC or nondirective-supportive therapies, at least in pre-post and comparative treatment analyses. Similarly, treatment modality also predicted pre-post and controlled effect sizes, reflecting the consistently strong results with Greenberg and Johnson's (1988) EFT for couples.

Another recent meta-analysis of 30 controlled outcome studies of experiential-humanistic therapies was carried out by Anderson and Levitt (2000). They reported preliminary results somewhat lower than those reported here (mean weighted, controlled effect size of .50 vs. .79). Because of multiple methods differences between their analysis and ours, and because they did not report pre-post and comparative effect sizes, it is difficult to interpret the discrepancy in results. Nevertheless, the body of available evidence analyzed here strongly supports the effectiveness of experiential-humanistic therapies.

Outcome for Different Client Problems: Differential Treatment Effects

Investigation of treatments for specific client presenting problems or disorders has blossomed during the period since our last review. In particular, experiential treatments have been found to be effective with depression, anxiety and trauma, as well as to have possible physical health benefits and applicability to clients with severe problems, including schizophrenia. In this section, we summarize recent studies, relate them to our meta-analysis and evaluate the status of experiential therapies as empirically supported treatments for specific client problems.

Anxiety

Recent studies. Teusch and colleagues have investigated the effect of CC therapy on anxiety (Teusch, Böhme & Gastpar, 1997; see also Teusch Finke & Böhme, 1999). In this study, clients were randomly assigned to pure CC therapy or to CC plus additional behavioral exposure. In the first study (Teusch et al., 1997), 40 clients with severe panic and agoraphobia were admitted to an inpatient anxiety treatment program. Most of the clients had been treated by pharmacological means unsuccessfully. CC and behavioral agoraphobia manuals were used. The clients were examined for panic, anxiety, agoraphobia, and depressive symptoms on admission, at discharge and at 3, 6, and 12 month follow-up. Both CC treatment and a combination with exposure treatment reduced panic, avoidance and depressive symptoms significantly. At post-treatment, the combined treatment was superior in clients' coping actively with anxiety and improving agoraphobic symptoms. However, at 1 year follow-up, the difference between treatments was no longer statistically significant in the reduction of anxiety and depressive symptoms.

In another study of clients with panic disorder, Shear, Pilkonis, Cloitre, and Leon (1994) compared what they referred to as "nonprescriptive" therapy (information about panic, plus reflective listening) to CB therapy, using a variety of measures. Although the researchers had intended the experiential therapy treatment as a relationship control, overall pre-post change was slightly larger for clients in nonprescriptive therapy (comparative ES: +.24; not statistically significant). (Similar no-difference results were also earlier reported by Grawe, 1976.).

Johnson and Smith (1997) randomly assigned twenty-three snake-phobic participants to one of three groups: gestalt empty-chair dialogue, systematic desensitization, and no therapy control. Following treatment, measures were taken of clients' avoidance behavior and their subjective experience. Both empty-chair dialogue clients and those treated with desensitization were significantly less phobic than those given no therapy. No other group differences were found. The authors concluded that this provided evidence for the efficacy of the Gestalt empty-chair dialogue in the treatment of simple phobia.

On the other hand, two studies by cognitive therapy researchers showed substantial superiority for CB treatments over experiential treatments in clients with anxiety disorders. First, Beck, Sokol, Clark, Berchick, and Wright (1992) used a brief (8 half-hour sessions) individual CC treatment as a relationship control in a study of cognitive therapy of panic. Although the 15 clients in CC therapy showed substantial pre-post change on the symptom measures used (overall ES: 1.32), clients in cognitive therapy showed significantly more change (comparative ES: -.77). Second, Borkovec & Costello (1993) compared 12-session nondirective, applied relaxation, and CB treatments in 55 clients with generalized anxiety, using a variety of symptom measures. Once again, there was substantial pre-post change (overall ES: 1.47), but clients in the two other treatments showed significantly greater change (comparative ES: -.99 for applied relaxation and -.36 for CB therapy). (A very recent study, Barrowclough et al., 2001, reports similar results for elderly adults treated with CB therapy vs. person-centered counseling.)

Meta-analysis and analysis of extent of empirical support. The meta-analysis data set contains eight studies of anxiety disorders, primarily panic and generalized anxiety, treated with CC or nondirective-supportive therapies (Beck et al., 1992; Borkovec & Costello, 1993; Borkovec & Mathews. 1988; Borkovec et al., 1987; Johnson & Smith, 1997; Teusch & Böhme, 1991; Teusch et al., 1997; Shear et al., 1994). The mean pre-post effect size for the experiential

therapies in these studies was 1.30 (sd: .52), a large effect. On the other hand, for the nine treatment comparisons between experiential and nonexperiential treatments, the mean comparative effect size was -.38 (sd: .44). This is moderately and statistically significantly ($t = -2.6$; $p < .05$) in favor of the nonexperiential treatments, all some form of CB therapy, all but two conducted by CB adherents.

Applying the Chambless and Hollon (1998) criteria, we find 4 of the 8 comparative effects favoring the nonexperiential treatments (Beck et al., 1992; Borkovec & Costello, 1993; Borkovec & Mathews. 1988; Borkovec et al., 1987). However, only one of these studies deals with panic (Beck et al., 1992), while the three on generalized anxiety disorder all emanate from Borkovec and colleagues. In other words, the requirement for replication across independent research settings is not satisfied for particular kinds of anxiety disorder. On the other hand, if more relaxed criteria for empirical support are met, such as have been proposed by Elliott (2000), the very strong pre-post effects can be used to provide evidence of effectiveness.

A useful integration of these two kinds of data might run as follows: the large pre-post effects (> .90) obtained in almost all of the studies analyzed suggest that experiential treatments are possibly efficacious (Chambless & Hollon, 1998) in treating anxiety, while also suggesting that CB therapies may be somewhat more specific and efficacious. This apparent moderate CB advantage has two possible explanations: On the one hand, it is likely to be due to researcher allegiance effects; when researcher allegiance is controlled for, the difference is no longer statistically significant (ES: -.18). On the other hand, it is also possible that anxiety disorders may respond somewhat better to CB therapies. In our clinical experience, clients with significant anxiety often appear desperate for expert guidance, a situation which experiential therapists may need to address more directly, either by exploring the issue with clients or by adding content directive elements to their therapy, such as providing information about the role of trauma or emotional processes in panic attacks (e.g., Wolfe & Sigl, 1998).

Trauma and Abuse

Recent studies. Gestalt and psychodramatic treatments have been employed to treat the sequelae of trauma in several studies. Paivio and Greenberg (1995) studied a 12-session PE therapy emphasizing empty chair work for clients with unfinished business with significant others, contrasting it with a psychoeducational comparison treatment.

In a study of childhood attachment injury based on this model, Paivio and Greenberg (1995) randomly assigned 34 clients with unresolved feelings related to a significant other to either experiential therapy using a Gestalt empty-chair dialogue intervention or a psycho-education group (Paivio & Greenberg, 1995). Treatment outcomes were evaluated before and after the treatment period in each condition and at 4 months and 1 year after the experiential therapy. Outcome instruments targeted general symptoms, interpersonal distress, target complaints, unfinished business resolution, and perceptions of self and other in the unfinished relationship. Results indicated that experiential therapy achieved clinically meaningful, stable gains for most clients and significantly greater improvement than the psychoeducational group on all outcome measures (mean comparative effect size: +1.24).

Subsequently, Paivio and Nieuwenhuis (2001) compared a 20-session Emotion-focused therapy (EFT) of adults with unresolved issues of childhood abuse with a wait-list control. EFT clients showed significantly greater improvements than wait-listed clients in multiple domains of

disturbance, including general and PTSD symptoms, global interpersonal problems, self-affiliation, target complaints, and resolution of issues with abusive others. Overall pre-post controlled effect sizes were substantial (+1.43). Clinically significant change on at least one dimension occurred for 100% of clients in treatment, as compared with 36% of waitlist clients.

Ragsdale, Cox, Finn and Eisler (1996) tested 24 participants of a psychodrama-based inpatient posttraumatic stress disorder (PTSD) treatment program both immediately before and following completion of treatment. Responses were compared to a treatment/wait list comparison group composed of 24 clients awaiting entry into the program. All treatment and waitlist comparison group participants received weekly PTSD outpatient group therapy. Significant improvements were found in the inpatient treatment group in areas of hopelessness, feelings of guilt and shame, loneliness, and emotional expressiveness. Other indices of psychological functioning, including interpersonal skills, gender role stress, anxiety, anger, and PTSD symptoms did not change significantly in response to treatment. No positive changes in any area of psychological function occurred in the treatment/waitlist comparison group.

Two recent small-scale studies also provided support for the effectiveness of experiential treatments of trauma: First, Clarke (1993) carried out a pilot study comparing an experiential treatment to a cognitive treatment with sexual abuse survivors. The eight-session experiential therapy combined Meaning Creation with Empty Chair work, depending on the client's initial level of arousal (if high, then Meaning Creation; if blocked, the Empty Chair work). Although the sample consisted of only nine clients in each treatment condition, clients in the experiential treatment did much better than clients in the CB treatment (mean comparative ES: +.76). Second, Elliott, Davis and Slatick (1998) reported pilot outcome data on six clients with crime-related PTSD seen for 16 sessions of PE therapy. These clients evidenced substantial pre-post improvement on both general and PTSD symptoms.

Meta-analysis and analysis of extent of empirical support. The meta-analysis data set contains six studies of trauma and abuse (Clarke, 1993; Elliott et al., 1998; Paivio & Greenberg, 1995; Paivio & Nieuwenhuis, 2001; Ragsdale et al., 1996; Souliere, 1995), all involving process-directive experiential therapies. The mean pre-post effect size for these therapies was 1.15 (sd: .46), a large effect. Two of these studies (Paivio & Niewenhuis, 2001; Ragsdale et al., 1996) used wait-list control groups (mean controlled ES: +.99; sd: .58), while three (Clarke, 1993; Paivio & Greenberg, 1995; Souliere, 1995) used active treatment comparison conditions (mean comparative ES: +.69; sd: .56). The three controlled or comparative studies whose effects favored PE therapy by a statistically significant degree involved two independent research settings (Clarke; Paivio/Greenberg), thus fulfilling the Chambless and Hollon's (1998) criteria for an efficacious and specific treatment.

Depression

Recent Studies. In the York I Depression study, Greenberg and Watson (1998) compared the effectiveness of PE therapy with one of its components, CC therapy, in the treatment of 34 adults suffering from major depression. The CC treatment emphasized the establishment and maintenance of the Rogerian relationship conditions and empathic responding. The experiential treatment consisted of the CC conditions, plus the use of specific process-directive gestalt and experiential interventions at client markers indicating particular cognitive-affective problems. Treatments showed no difference in reducing depressive symptoms at termination and six month

follow-up. The experiential treatment, however, had superior effects at mid-treatment on depression and at termination on the total level of symptoms, self-esteem, and reduction of interpersonal problems (mean overall comparative effect size for PE vs. CC: +.33). The addition of specific active interventions at appropriate points in the treatment of depression appeared to hasten and enhance improvement.

Watson & Greenberg (1996) identified a pathway from in-session process and task resolution, to post-session change and final outcome in the treatment of depression. Clients' degree of problem resolution correlated significantly with depth of client experiencing, and sustained resolution over treatment resulted in better outcome. Clients' task-specific post-session change scores correlated significantly with change in depression post-therapy and 6 months later, indicating that post-session change is related to reduction in symptoms. The two treatments also were compared on client process and outcome. The PE group showed significantly higher levels of experiencing, vocal quality and expressive stance, and greater problem resolution than the CC group in two of three PE interventions studied.

Weerasekera, Linder, Greenberg, and Watson (2001) examined the development of the working alliance in experiential therapy of depression. Results revealed that the alliance-outcome relation varied with alliance dimension (goal, task, or bond), outcome measure (symptom improvement vs. self esteem, relational problems), and when in-treatment alliance was measured. Analyses revealed that early alliance scores predicted outcome independently of early mood changes. Although no treatment group differences were found for bond and goal alliance, the PE group displayed higher task alliance scores in the mid-phase of therapy. The level of pre-treatment depression did not affect alliance formation.

In the York II depression study, Greenberg, Goldman, and Angus (2001) replicated the York I study by comparing the effects of CC and PE on 38 clients with major depressive disorder; they obtained a comparative effect size of +.71 in favor of PE therapy. They then combined the York I and II samples to increase power of detecting differences between treatment groups. Statistically significant differences among treatments were found on all indices of change for the combined sample. This provided evidence that the addition of PE interventions to the basic CC relationship conditions improves outcome.

In another recent study, Watson, Gordon, Stermac, Kalogerakos and Steckley (2001) carried out a randomized clinical trial study comparing PE and CB therapies in the treatment of major depression. Sixty-six clients participated in 16 sessions of psychotherapy once a week. Results indicated that there were no significant differences between groups (comparative ES: +.11). Both treatments were effective in improving clients' level of depression, self-esteem, general symptom distress and dysfunctional attitudes. However, there were significant differences between groups with respect to 2 subscales of the Inventory of Interpersonal Problems: Clients in PE therapy were significantly more self-assertive and less overly accommodating at the end of treatment than clients in CB therapy. At the end of treatment, clients in both groups developed significantly more emotional reflection for solving distressing problems.

In a large, complex study involving three different substudies, King et al. (2000) compared CB and CC therapies to treatment as usual (primarily medication) for depressed clients seen in naturalistic primary care situations in the UK. One substudy (n= 62) was a 3-way randomized

clinical trial (RCT) comparing all three conditions; another substudy (n=107) was a 2-way RCT comparing CB to CC therapies; while the third substudy (n=52) was a 2-way preference trial in which clients were allowed to choose either CB or CC therapy. Measures included self-reports of symptoms and social adjustment measures, as well as estimates of cost, administered pretherapy and 2 and 10 months later. CC clients received an average of 7 sessions. For CC therapy, overall pre-post effects varied from .88 (3-way RCT) to 1.17 (2-way RCT). Treatment comparisons found few if any differences between the three treatments: comparative ES for CC therapy vs. treatment as usual: +.10); comparative ESs for CB therapy: -.08 to -.19.

Brent et al. (1997) and Kolko, Brent, Baugher, Bridge, and Birmaher (2000) carried out a comparison between a nondirective-supportive therapy and two different CB treatments (individual and behavioral-systemic family therapy) with depressed adolescents, intending the nondirective therapy as a relational control condition. Using a wide variety of measures, they found a moderate degree of change over the course of therapy and follow-ups (overall ES: .72) in the experiential therapy. The first report of this study (Brent et al., 1997) proclaimed the superiority of individual CB therapy on symptom measures; however, subsequent reports (e.g., Kolko et al., 2000), using 24-month follow-up data and a broader range of measures, including measures of cognitive and family functioning, produced overall no-difference findings (comparative ES: -.13).

Mestel and Votsmeier-Röhr (2000) reported on the results of a 6-week integrative process-experiential inpatient program, involving a large, naturalistic German sample of 412 moderately to severely depressed patients. Using measures of symptoms, interpersonal problems, and quality of self-relationship administered at pre-treatment, at discharge, and at 22-month follow-up, they obtained an overall pre-post effect of 1.05.

Rezaeian, Mazumdar, and Sen (1997) examined the effectiveness of psychodrama in changing the attitudes of 54 depressed male Iranian clients. Participants were divided into 3 treatment groups of 18 clients each: a psychodrama group, a conventional psychiatric treatment group, and a combination therapy. Measures of depression and personal attitudes towards family, sexual matters, and so on were administered before and 24 weeks after treatment. The psychodrama group therapy was more effective than the conventional psychiatric treatment in changing the attitudes of the participants. The combination of both psychodrama group therapy and conventional psychiatric treatment, however, turned out to be the best treatment. However, the results from the combination of both psychodrama group therapy and conventional psychiatric therapy did not differ significantly from the psychodrama group therapy alone.

Meta-analysis and analysis of extent of empirical support. The meta-analysis data set contains 24 study samples of depressed clients, most commonly CC (9 samples) or PE (6 samples). The mean pre-post effect size across these 23 samples is large (1.18; sd: .55). In contrast to the rest of the data set, the four controlled comparisons with no treatment or waitlist controls indicate only a weak effect for therapy (mean controlled ES: .12; sd: .39), including the only negative controlled effect (Tyson & Range, 1987) in the data set, apparently an outlier. The 16 comparisons with nonexperiential therapies support an equivalence conclusion (mean comparative ES: -.02; sd: .69; $t(.4)= 2.23$, $p < .05$). In fact, substantial positive and negative comparative results are perfectly balanced (positive: 3; negative: 4; neutral: 9). Four of the comparisons between more and less process directive experiential treatments involved depressed

clients (mean comparative ES: +.41; sd: 25). It is worth noting, however, that in comparisons with nonexperiential therapies for depression, more process-directive therapies (ES: +.16; sd: .74) did not produce significantly better results than less process-directive therapies (ES: -.15; sd: .66; t = -.89; n.s.).

Given the balanced nature of the comparative effects, Chambless and Hollon's (1998) equivalence criterion is most relevant. In fact, both of the studies with large enough samples (> 25 per group; King et al., 2000; Watson et al., 2001) reported no-difference results for clients seen in experiential therapies as compared to CB therapy. In addition, when Greenberg, Goldman, and Angus (2001) combined data from the two York depression studies, they found that clients seen in PE therapy had a significantly better outcome than clients in another active treatment (CC therapy), thus adding support from a third study. Finally, the four comparisons between different experiential therapies (3 significant differences involving two independent research settings) provides support for process directive experiential therapies as specific and efficacious (Chambless & Hollon, 1998).

Treatment of Anger and Aggression

Wolfus & Bierman (1996) evaluated an integrative, PE treatment program, "Relating without Violence" (RWV), designed to ameliorate psychological and emotional factors believed to contribute to domestic violence and to strengthen conflict resolution skills in perpetrators of domestic violence. Participants were 57 perpetrators who participated in RWV, 20 perpetrators who did not, and 24 offenders with no history of any violence. The group of offenders who participated in RWV showed statistically significant changes over and above the changes exhibited by the two comparison groups, demonstrating that RWV was effective in achieving its main objectives: it changed the way offenders who had committed domestic violence dealt with violence within the confines of the institution and it resulted in the modification of personality traits associated with aggressive behavior. RWV led to a decrease in the use of destructive responses to conflict, both physical and psychological; reduced irritability and readiness for anger; and reduced defensiveness. The reduction in defensiveness, in particular, meant that program participants became less suspicious that other people meant them harm and became less likely to hold themselves in a constant state of readiness to counter-attack in response to any perceived threats of emotional pain. The overall pre-post effect appears to .96, with a comparative effect of +.33. However, the authors appear to have reported only scales on which there were significant differences; such selective reporting makes these values somewhat questionable.

A subsequent study (Goldman, Bierman & Wolfus, 1996) examined changes in expressing anger for 48 RWV participants in groups. Results showed that before RWV the participants frequently experienced intense angry feelings which they expressed with little provocation in aggressive behavior directed toward others. The men's anger was initially higher than 90% of men in general. After participating in RWV, the men's experience and expression of anger declined significantly and they were within the normal range for men (overall pre-post effect: 1.6, again based on selective reporting of data).

Serok & Levi (1993) assessed the efficacy of Gestalt therapy for a group of 9 hard-core criminals as compared with 9 hard-core criminals who met together but were not given Gestalt therapy. Participants were tested in prison before and after intervention using an instrument to

measure internal locus of control and the degree of assumption of personal responsibility. Findings in these areas, in addition to the observations of the prison's social worker, confirmed the effectiveness of the Gestalt therapy.

Although somewhat weak, these data involve a client population which in the past has not been considered appropriate for experiential therapy. The fact that some positive evidence has emerged suggests the need for further research on experiential approaches to working with clients with anger and aggression problems.

Schizophrenia and Severe, Chronic Dysfunction

Surprisingly, more than 30 years after the early disappointment of the Wisconsin Study (Rogers, Gendlin, Kiesler & Truax, 1967) on the impact of CC therapy with clients diagnosed with schizophrenia, recent research in Europe has begun to provide support for the effectiveness of CC and other experiential therapies with clients suffering from severe, chronic difficulties, including schizophrenia and borderline personality processes.

Naturalistic effectiveness studies. Most of these studies are uncontrolled, naturalistic studies, some with large samples of clients treated in inpatient settings for 75 to 100 days (Teusch, 1990; Teusch et al., 1999; Tscheulin, 1995), and others in outpatient or day treatment settings (Snijders, Huijsman, de Groot, Maas & de Greef, 2002; Tschuschke & Anbeh, 2000). Teusch and Tscheulin and their colleagues have, for example, provided reports that cover many hundreds of patients treated in inpatient settings in programs based on CC principles, often with adjunctive art, movement or occupational therapy as well as 12-step programs and occasional medication. These studies are classic effectiveness studies that document the value of inpatient CC treatment program in real-world settings. For example, Tscheulin (1995) reported results for 4 mixed inpatient samples of clients, two followed to discharge (n = 1426 and 632) and two followed over 18 months postdischarge (n = 92 and 156). Overall pre-post effect sizes varied from .53 to .78. Teusch and colleagues (1999) reported extensive test results for 248 clients with chronic, severe problems (overall pre-post ES: .88). Given the severity and chronicity of these clients difficulties, these effect sizes appear to be quite impressive, although the use of nonspecific client groups makes them hard to interpret.

Schizophrenia. Three studies involve treatment of clients diagnosed with schizophrenia (Eckert & Wuchner, 1996; Tarrier et al., 1998, 2000; Teusch, 1990). Eckert and Wuchner (1996) followed the treatment of 13 schizophrenia patients in a 100-day inpatient program based on CC principles (pre-post ES: .59), while Teusch evaluated 73 high-functioning schizophrenia patients in a similar 12 week inpatient program (ES: 1.54). In the only RCT in this area, Tarrier and colleagues (1998, 2000) used an additive design to study the incremental effects of CC supportive counseling and CB training on top of treatment as usual. CC treatment was intended as a relational control condition. Initial reports (Tarrier et al., 1998) on posttreatment outcome favored the cognitive therapy; however, this situation was completely reversed at 24 month follow-up at which time, the CC therapy was substantially better than CB (Tarrier et al., 2000) (overall comparative ES: +.08 vs. CB; +.31 vs. routine care) . The mean pre-post ES for these three studies is .80.

Severe personality disorders. There are also two recent studies involving treatment of borderline and other severe personality disorders: In addition to samples of clients with schizophrenia and severe depression, Eckert and Wuchner (1996) also reported large effects for a

CC inpatient program used to treat clients with Borderline personality disorder diagnoses (overall pre-post effect: 1.9). In addition, Snijders and others (2002) used an integrative experiential day treatment program to treat 72 clients with severe personality disorders (overall pre-post ES: .76)

Meta-analysis and analysis of extent of empirical support. The meta-analysis data set contains 15 studies of therapy with severely dysfunctional clients seen in inpatient or day treatment/aftercare settings, including the domestic violence offenders described in the previous section. The mean pre-post effect size is .85 (sd: .50), a large effect. In addition, there are 10 comparative studies (mean comparative ES: .02; sd: .42). Given the combination of large pre-post effects with zero-order comparative effects, there appears to be enough evidence to indicate that experiential therapies are possibly efficacious (Chambless & Hollon, 1998) and deserving of further investigation in the treatment of severe, chronic problems, including schizophrenia and borderline personality disorder.

Health-Related Problems

Cancer. Three studies have examined the effects of experiential-existential group therapies for people living with cancer. Spiegel, Bloom and Yalom (1981; see also Spiegel, Bloom, Kraemer & Gottheil, 1989) compared a supportive-existential group for women with metastatic breast cancer to treatment as usual. They showed that women in the supportive-existential group showed better improvement on psychological distress measures and substantially longer survival times (means of 31 vs. 11 months). van der Pompe, Duivenvoorden, Antoni and Visser (1997) randomly assigned patients who had been treated for early stage breast cancer and were diagnosed with either positive axillary lymph nodes or distant metastases to either a 13-week experiential existential group psychotherapy (EEGP) program or a waiting list control (WLC) condition. Endocrine and immune measures were obtained before and after the intervention period. After the 13 weeks of treatment, clients in the EEGP group showed improvements on many measures (e.g., lower levels of plasma cortisol, percentages of natural killer cells). Importantly, this was only found in those breast cancer patients presenting relatively high endocrine and immune baseline levels, suggesting that the patients' profile with regard to endocrine and immune function at the start of a program can have an important effect. If replicated on a larger scale, these results might be relevant for the treatment of physical symptoms related to breast cancer.

However, in another study with patients with cancer, de Vries, Schilder, Mulder, Vrancken, Remie and Garssen (1997) examined the effect of experiential therapy on tumor progression in 35 patients in advanced stages of cancer, who were no longer amenable to regular medical treatment. Patients were offered 12 sessions of individual experiential-existential counseling, each session lasting 1.5-2 hrs. In addition, every two weeks, patients participated in supportive group therapy sessions. Results show that in 5 out of 35 patients, tumor growth became stationary during or immediately following therapy. In 4 patients, this stationary period lasted 3-9 months, and in 1 patient the period lasted 2 yrs. Natural killer cell activity, self-reported loneliness, depression, purpose in life, and locus of control showed no change from pre- to post intervention (overall mean effect: .13).

Finally, Edelman, Bell, and Kidman (1999) also recently compared a 12-session supportive therapy group with a CB therapy group for patients with recently diagnosed breast cancer. Clients changed relatively little in either treatment (overall pre-post ES: .19; comparative ES: -.12).

HIV. Mulder, Emmelkamp, Antoni, Mulder, and associates (1994) examined the effectiveness of a CB group therapy and an experiential group psychotherapy program for 39 asymptomatic HIV-infected homosexual men. Both therapies consisted of 17 sessions over a 15-week period. Both psychosocial interventions decreased distress significantly, as compared with a waiting-list control group. The authors reported no significant changes in the intervention groups as compared with the control group in coping styles, social support, and emotional expression. CB and experiential therapies did not differ from each other in their effects on psychological distress or on the other psychosocial variables. In another analysis of the same sample, Mulder, Antoni, Emmelkamp, Veugelers, and associates (1995) examined the effects of CB group therapy and experiential group therapy on decline of immune functioning from preintervention to 24 month posttest with 26 HIV-infected homosexual men. No differences in the rate of decline of CD4 cells or T cell responses between the CB and experiential condition were found. T cell functioning increased in the combined treatment sample and did so to a greater extent than in control patients; however, there were no significant changes in CD4 cell count from pre- to postintervention. Patients who showed larger decreases in psychological distress, however, showed a smaller decline in CD4 cell counts. Thus, this study provided some initial, tentative indication that experiential therapy groups may be helpful for persons living with HIV.

Other medical problems. Jacobi (1995) evaluated the effectiveness of Guided Imagery and Music (GIM) as a music-centered experiential therapy for persons with rheumatoid arthritis. It was hypothesized that therapeutically induced arousal of affect would facilitate the resolution of conflicting emotions and reduce reported pain and psychological distress. Twenty seven patients receiving treatment in an out-patient clinic of a teaching hospital received individual sessions in GIM. Data were collected at entry, at the 6th GIM treatment session and at 2- and 8-week follow-up sessions. There were significant improvements in the level of psychological distress (e.g., SCL-90-R) and behavioral functioning (e.g., 50-foot walking speed).

Sachse (1995) applied Goal-oriented CC therapy (similar to PE) to 29 clients with psychosomatic problems using a variety of measures. He found that clients with psychosomatic problems had difficulty exploring their emotions and other internal experiences, which necessitated longer treatment (mean 33 sessions), the first half which had to be devoted to helping clients learn how to access and describe their experiences. Once this was accomplished, however, these clients were quite able to benefit from experiential therapy. Pre-post effects were large (ES: 1.52).

Meta-analysis and analysis of extent of empirical support. The meta-analysis data set contains seven studies of clients with health-related problems seen in experiential therapies. The mean pre-post effect size is .59 (sd: .50), a medium effect, which is consistent with the generally smaller effects found with measures of physical functioning. In addition, there are five comparative studies (mean comparative ES: +.01; sd: .28) and five controlled studies (mean controlled ES: .70; sd: .57). Given the existence of these studies, there appears to be enough evidence to indicate that experiential therapies are possibly efficacious (Chambless & Hollon, 1998) and therefore deserving of further investigation as adjunctive treatments with physical problems such as cancer (see also Dircks, Grimm, Tausch & Wittern, 1982; Katonah, 1991), HIV, psychosomatic problems (see also Meyer, 1981); and eating disorders (see also Holstein, 1990).

Research on Generic Therapeutic Processes

The central task in experiential therapy is the deepening of experience. An associated but not identical general task is increasing access to emotions and emotional arousal. These two overlapping but distinct generic client processes have received a fair amount of attention over this review period. As will become clear from the review below it appears that it is helpful to promote deeper experiencing and emotional processing (general tasks) in experiential therapy. Deeper emotional processing involves both higher emotional arousal and reflection on the aroused experience (Greenberg, Korman & Paivio, 2001). In addition to these generic processes specific therapeutic tasks and the micro processes involved in resolving these tasks have been studied. The specific tasks, although engaging clients in specific micro-level processes of change unique to each task, all seem to involve deeper emotional experience and processing. Research has also continued on two other general therapist processes, empathy and response modes (types of therapist speech act). Bolth empathy and more specific process directive forms of intervention have been found to be useful in promoting the general client processes of experiencing and emotional processing. Research on the generic client and therapist processes will be reviewed first followed by research on specific tasks.

Experiencing and Levels of Processing

The Experiencing Scales (Klein, Mathieu, Gendlin, & Kiesler, 1969; Klein, Mathieu-Coughlan, & Kiesler, 1986) measure the degree to which clients or therapists are fully engaged in their experience. Scores range from a score of 1, in which individuals narrate their experience in a detached manner and do not represent themselves as agents in their own narratives, to a 3, representing a simple, reactive emotional response to a specific situation, through a score of 4 in which a person focuses on feelings. At levels 6, readily accessible feelings and meanings are synthesized to solve problems, and at level 7, clients are fully engaged in their momentary experience in a free-flowing, open, focused, manner. Research on depth of experiencing in therapy has found a consistent relationship between depth of experiencing and outcome, especially in CC therapy (Bohart et al., 1996; Hendricks, 2002; Klein et al., 1986).

Greenberg, Watson and Goldman (1998) argued that increases in depth of experiencing in successful brief treatments produce emotional problem-solving specific to core issues, rather than overall change in level of functioning, as initially formulated by Rogers (1961). They further argued that previous failures to find a clear linear increase in experiencing over time in successful treatments (e.g.. Rogers et al., 1967) may have been due to the failure of these previous studies to rate experiencing on meaningful therapeutic episodes. Taking a perspective that change occurs in key events, they contended that taking experiencing measurements from random samples across therapy is not meaningful because random sampling misses important events. They proposed that resolution of key emotional issues is best measured by an increase in depth of experiencing on core themes and should relate to outcome.

Goldman and Greenberg (2001), therefore, identified segments in which clients were addressing core therapeutic themes, and found that increases across treatment in experiencing on these core themes predicted outcome on a range of measures). They found that increase in on-theme depth of experiencing, from early to late in therapy, was superior to the working alliance in

predicting outcome. Higher EXP while narrating traumatic events has also been correlated with better immune response (Lutgendorf et al. 1994).

In a recent study of therapist experiencing, Greenberg and Adams (2000), building on Goldman's study described above, found that the level of client experiencing to which therapist interventions referred predicted subsequent client level of psychotherapeutic experiencing and outcome. Therapists' interventions oriented toward internal client experience were found to exert an immediate influence in shifting clients from external to internal experience. Significant correlations between proportion of therapist-initiated client shifts from external to internal process and residual gain scores on the outcome measures were also found. Thus, within the context of experiential psychotherapy for depression, the level of client experience at which therapists aim their interventions can exert an immediate influence on client depth of experiencing and is related to reduced symptoms and increased self-esteem.

Level of client processing. Level of client cognitive-affective processing is a process closely related to client experiencing. In programs of research by Toukmanian (e.g., 1986, 1992), Sachse (see Sachse & Elliott, 2001) and Takens (2001), levels of client perceptual processing (LCPP) and clients processing modes (PM) in therapy were studied. The LCPP scale consists of 7 categories, each measuring a particular pattern of cognitive-affective processing (Toukmanian, 1986). The seven categories code client statements, from shallow to deep levels, as follows: undifferentiated statements, elaborations, differentiation with external focus, differentiation with analytic focus, differentiation with internal focus, reevaluation, and, finally, integration. The PM scale similarly measures levels of linguistic processing related to explication of meaning. Clients who gain more from treatment have been shown to be more likely to engage in more complex mental operations such as internally differentiating and integrating, and re-evaluating (Toukmanian, 1992, Toukmanian & Grech, 1991; Stinckens, 2001), while clients with the greatest in-therapy gains in perceptual-processing tended to have greater pre-treatment to post-treatment gains on the measures of self-concept and perceptual congruence (Day, 1994).

Emotional Arousal, Expression, and Processing

Empirical evidence for the key role of emotion in therapy is growing. Recent process research has consistently demonstrated a relationship between in-session emotional activation and outcome in various therapies (Beutler, Clarkin & Bongar 2000; Iwakabe, Rogan & Stalikas, 2000; Jones & Pulos, 1993). For example, Korman (1998) has shown that emotion-focused, PE therapy of depression, when successful, led to significant changes in clients' emotional states. This research used the Emotion Episode (EE) method (Greenberg & Korman, 1993; Korman, 1998) to identify in-session episodes in which clients talk about their emotions. Clients with better outcomes showed significantly more changes in their emotions from early to late sessions than did clients with poorer outcomes.

Another source of evidence on the role of affective experience in psychotherapy comes from research on the expression of emotion. Mahrer and colleagues have shown that certain types of "good moments" in therapy (Mahrer, Dessaulles, Nadler et al., 1987) are characterized by emotional expression. Fitzpatrick, Peternelli, Stalikas and Iwakabe (1999) studied two sessions conducted by Rogers (and six by Ellis) and found that good moments of therapy had significantly higher emotional involvement than a control sample of therapy segments, as measured by the Experiencing Scale and the Strength of Feeling Scale – Revised.

In terms of the measurement of emotional arousal, Burgoon, Le-Poire, Beutler, Engle and colleagues (1993) found that both general and specific aspects of emotional arousal can be reliably rated from nonverbal behaviors. Vocal tension, nervous vocalizations and laughter, random body movement, and vocal expressiveness were all associated with higher global arousal. (Machado, Beutler, and Greenberg, 1999, also found that training in emotionally focused methods increases therapists' affect sensitivity to these sorts of emotion cues.)

Emotion has also been found to be important in resolving interpersonal problems. Research on the relationship between emotional arousal and the resolution of unfinished business with a significant other has shown that emotional arousal is significantly related to outcome (Greenberg & Foerster, 1996; Paivio & Greenberg, 1995; Hirscheimer, 1996; Greenberg & Malcolm, 2002). In addition, Raphael, Middleton, Martinek, and Misso (1993) concluded from reviews of the bereavement outcome literature that controlled studies offer general support for the beneficial effects of treatments that promote emotional expression in bereavement. Some studies, however, failed to demonstrate superior outcome for treatment over controls.

Furthermore couples who showed higher levels of emotional experiencing accompanying a softening in the blaming partners' stance in therapy were found to interact more affiliatively, and ended therapy more satisfied, than couples who showed lower emotional experiencing (Greenberg, Ford, Alden & Johnson, 1992). A similar effect of the expression of underlying emotion has been found in resolving family conflict in structural family therapy (Diamond & Liddle, 1996).

Although research suggests that the expression and arousal of emotion can contribute to change, this may be true only for some people with some types of concerns (cf. Pierce, Nichols & DuBrin, 1983). For example, Rosner, Beutler, Daldrup (2000) compared the role of emotional arousal and vicarious emotional experience in cognitive group therapy (CGT) and focused expressive psychotherapy (FEP; a manualized form of Gestalt therapy), two treatments with opposite process assumptions about the desirability of expressing emotions. While the types of emotions generally experienced by CGT clients and FEP clients did not differ significantly overall, differences in arousal were found in group members who were either active or primarily observed during sessions, i.e., that actively participating clients in the FEP group expressed more emotion than those in the CGT group, while this was not true for the observing group members.

In spite of these promising indications of the importance of emotional involvement in therapy, the actual relationships between emotion, cognition, and somatic processes remain unclear. Arousal and expression of emotion alone may be inadequate in promoting change. For example, venting has not been found to be effective in reducing distress (Bushman, Baumeister & Stach, 1999; Kennedy-Moore & Watson, 1999). Several theorists have concluded that discharge works best when combined with some form of cognitive processing, suggesting that therapeutic change is a function of a dual cognitive-affective process (Bohart, 1980; Greenberg & Safran, 1987; Mecheril & Kemmler, 1994). For example, expressing anger reduces hostile feelings only if it leads to coping with the stimulus; that is, only if it leads to changing the environment or one's perception of it. This points to the need for processing aroused emotion in order to make sense of it by symbolizing it in awareness, and by clarifying its sources. Making sense of emotion in new ways also helps to break cycles of maladaptive automatic emotions.

Pos (1999) found that increase in depth of experiencing on Emotion Episodes across therapy predicted outcome in the treatment of depression, while Warwar and Greenberg (2000) showed that good outcome clients showed both higher emotional arousal and deeper levels the Experiencing scale, during Emotion Episodes. This indicated that emotional arousal, plus making sense of this arousal to solve problems (level six on the Experiencing scale) distinguished good and poor outcomes. Mergenthaler (1996) also found that emotional tone plus the use of more abstract words distinguished good and poor cases of dynamic and experiential therapy, again demonstrating that it is both emotion *and* reflection on emotion that is important to the change process. He demonstrated that an in-session emotion cycle (relaxation, increase in arousal, arousal plus reflection, more abstract reflection alone, and back to relaxation) is associated with good outcome. Stalikas and Fitzpatrick (1995) showed that in-session change was related to both higher levels of reflection and strength of feeling. These studies indicate, that to be transformed, and transformative, emotion needs to be both aroused and reflected on.

Thus, the empirical literature on emotion in experiential psychotherapy suggests that therapies successfully targeting clients' emotional experience are associated with changes over treatment in clients' in-session emotional experiences. The type of emotional expression investigated, however, affects the outcomes found. Emotional arousal and expression in specific circumstances, and with certain types of individuals and problems, is related to constructive change in physical and mental health. The evidence also indicates that certain types of therapeutically facilitated emotional awareness and arousal, when expressed in supportive relational contexts and in conjunction with some sort of conscious cognitive processing of the emotional experience, is important for therapeutic change, for many clients and problems.

Therapist Empathy

Empathy and outcome. Empathy has long been considered to be central the change process in experiential-humanistic therapies (e.g., Rogers, 1975; Barrett-Lennard, 1981). In a recent meta-analysis of the general association between therapist empathy and client outcome, Bohart, Elliott, Greenberg and Watson (2002) found a medium effect size (weighted, corrected r) of .30. This effect size is on the same order of magnitude as previous analyses of the relationship between therapeutic alliance and outcome (e.g., Horvath & Symmonds, 1991). Interestingly, only six of the existing studies involve experiential therapies, and the average association of empathy to outcome in these studies was .25, a value in the same range as the overall sample value. Clearly empathy does not appear to be differentially effective in experiential therapies (and there was even a suggestion that it might be *more* important in cognitive-behavioral therapies).

Further evidence for the effects of empathy on outcome comes from research on the outcome of CC therapy, analyzed in our meta-analysis (see also Elliott, 2002; Greenberg & Watson, 1998). While the therapist in CC therapy intends to provide unconditional positive regard and congruence as well as empathy, the only obvious "technique" in classical client-centered therapy is therapist empathy; successful CC treatment therefore provides indirect evidence of the effects of empathy. Nevertheless, empathy is probably better conceived of as a "climate" variable created by both therapist and client together, rather than as a variable unilaterally "provided" by the therapist.

Empathy: Experience and Behavior. Greenberg and Rosenberg (2000) qualitatively analyzed therapist reports of their experience of empathy based on tape assisted process recall. Although the therapists reported occasionally feeling a little of what the client was feeling, this was not the predominant experience of being empathic. Rather, understanding, imagining, sensing and thinking were the predominant processes involved in the therapist's experience of empathy. Taylor (1996) also explored psychotherapists' experiences of empathy with their clients in order to understand the characteristics and the meanings of such experiences. Phenomenological analysis of interview texts of retrospective accounts of empathy in this study resulted in four major interrelated themes: Letting Go (of expectations), Connecting (with the client's experience), Being Responsible and Responsive (to the client), and Danger (of misunderstanding).

Vanaerschot (1999), in an intensive study of the characteristics of client and therapist-perceived change events, found that 82% of these events, taken from three long-term psychotherapies (2 client-centered/experiential, 1 psychodynamic), contained high to medium (referred to as "varying") degrees of empathic attunement, while only18% of the events had minimal empathic attunement. Client perception of empathy in these events was also found not to be dependent on the therapist response mode of reflection of feelings. Furthermore, the client-perceived helping processes that distinguished the high attunement events were insight into oneself, having the opportunity to and risking talking about personal issues, and searching together (Vanaerschot, 1997b).

Brodley (1994, 2001) recently provided some clues about what makes empathic responses effective. She selected therapist responses from her own and Rogers' tapes based on strong confirming responses by the client (e.g. "That's exactly it"). In her own sessions, she found that words for emotional components (like "tense", "hurt", "furious") were used only in 31% of the therapist speech units, whereas words or phrases that refer to complex meanings (e.g. "feeling ignored") were used in 59% of the speech units. In the case material of Rogers, the proportion of both types of targets was lower, but the proportion between the two was similar. Furthermore, for both therapists, 55 - 66% of speech units contained brief and relatively common figures of speech (e.g. "part of you has been torn away"), which make the reflections more lively and personal, while 80 - 84% of their responses reflected the client's agency, either in relation to the outside world (two-thirds) or in relation to self (one-third).

Therapist Response Modes

An archive of 140 therapy session transcripts of Carl Rogers (Lietaer & Brodley, 1998) has been a rich basis for studies on his response modes (e.g. Farber, Brink & Raskin, 1996), and has proved useful for questioning assumptions about client-centered practice, especially its supposed nondirectiveness. A number of investigators have found that responses stemming from the therapist's frame of reference - feedback, confrontation, interpretation and personal self-disclosure - are much more pronounced in Rogers' later demonstration sessions. There were 2 to 4% of responses from the therapist's frame of reference in the Chicago therapies, versus an average of about 10% in the later demonstration sessions (Brodley, 1994; Gundrum, Lietaer & Van Hees-Matthyssen, 1999; Merry, 1996). These data show that the older Rogers became more free in "the use of self" and that his "content directivity" became a bit more pronounced. Gazzola and Stalikas (1997) also investigated qualitative differences between interpretations leading to different in-session client change events in six sessions conducted by Carl Rogers.

Results indicated that significant in-session therapeutic phenomena were preceded by interpretations and that qualitative differences exist between interpretations that precede change events and those that do not. This investigation indicated that not only are interpretations used in CC therapy, but they are also efficient in producing in-session client change.

Stinckens (2001) compared the response profile of Rogers with the profile of a sample of neo-client-centered/experiential therapists and a sample of PE therapists, all working with the internal critic. The two comparison groups, in contrast to Rogers, used many more open exploratory questions (18% versus 1%) and much less reflection of *expressed* feelings (25% versus 63%). The rate of process directives (e.g., proposing that the client turn attention inside or speak to the empty chair) was quite high in the PE sessions in which chair dialogue was being used (23%), low but visible in the neo-client-centered/experiential sessions (5%) and almost non-existent in Rogers' sessions. Similar differences are found when Rogers was compared to Perls in their interviews with Gloria (Missiaen, Wollants, Lietaer, & Gundrum, 2000). Leijssen et al. (2000) compared 4 therapists when they were doing client-centered therapy versus when they were doing focusing training: While process directives where much higher in the focusing training sessions (16% versus 2%), content-directive responses (interpretation, feedback, confrontation) were much lower (3% versus 17%). Some studies have also shown that a variety of response modes such as exploratory reflections, open exploratory questions and interpersonal responses (feedback, confrontation and here-and-now disclosure of the therapist), are used in client centered and experiential therapy (Davis, 1995; Lietaer & Dierick, 1996). All these findings show that a variety of response profiles occur within the experiential family of therapies; even within a same therapist, large variations in style are often found.

Finally, a few studies have shown differences between Experiential and other approaches. Vanaerschot (1997a) found a higher rate of reflection of expressed feelings and narrative aspects in Experiential therapy than in psychodynamic therapy, while Vansteenwegen (1997) reported a greater focus on feelings of the individual partners in experiential couples therapy than in treatment with a communication therapist, who focused on the here-and-now interaction of the couple. Using a post-session therapist intervention style questionnaire, Lietaer & Dierick (1999) compared three samples of experiential group therapists (client-centered, Gestalt and psychodrama) with a sample of behavior group therapists and a sample of psychoanalytic group therapists. While the three experiential suborientations were highly similar on the dimensions "Facilitating experiential exploration," "Meaning attribution," and "Personal presence," large differences were found on "Executive function," with psychodramatists and Gestalt therapists being more structuring and using more procedures. The psychoanalytic group was lowest on all dimensions except for "Meaning attribution" and highest on the subscale "Psychodynamic interpretation." Behavior therapists were lowest on the subscale "Psychodynamic interpretation" and highest on the subscale "Direction, advice, procedures."

These studies on response modes show that besides some similarities, some striking differences between orientations are observed. An empathic moment-by-moment focus on the experiencing self of the client seems always to be more salient in experiential forms of therapy than in other approaches.

Research on Specific Therapeutic Tasks

In addition to the general therapeutic processes reviewed in the previous section, research has continued on several key experiential tasks, each characterized by a particular client sign of readiness (marker), a sequence of therapist actions and client in-session microprocesses, and definition of successful resolution (Greenberg et al., 1994).

Focusing on an Unclear or Painful Felt Sense

Focusing is a method devised to deepen client experiencing. In focusing (Gendlin, 1996), the therapist encourages the client to imagine an internal psychological "space" in which he/she feels things, then helps the client explore and symbolize experiences which are either unclear or painful. The full focusing procedure consists of six steps, each with its own markers or indicators, but the most common marker is the immediate presence of an unclear internal feeling ("felt sense"). Focusing is also sometimes used when the client is experiencing immediate painful feelings or is having trouble finding an internal focus. Recent studies have been done in Japan, North America and Europe, on factors which enhance the effectiveness of focusing. For example, Morikaya (1997) factor analyzed questionnaires from focusing sessions, finding that “clearing a space,” “finding a right distance,” and having a listener refer to their experiencing each helped clients focus, Iberg (1996) found that clients reported increased impact of session in which therapists used focusing-type questions.

In the most extensive research program to date on focusing, Leijssen (1996) investigated whether focusing enhanced client-centered therapy. In an initial study she took sessions with explicitly positive and negative evaluations by client or therapist and found that seventy-five percent of positive sessions contained focusing steps, and only 33% of negative sessions contained focusing. In a second study (Leijssen, 1996-1997), eight clients who successfully terminated therapy in less than 20 sessions were studied: Prominent use of focusing occurred in all eight cases; almost every session acquired an intense experience-oriented character in which the client discovered aspects of the problem which had remained hitherto out of reach. It is believed that all of these clients achieved contact with their bodily felt experience without being flooded by it. Leijssen (1996) also investigated whether long-term clients deemed to be stagnating in their therapy could be taught to focus and to increase experiencing level. Of the four clients studied, she found that the two clients who returned to their previous levels of experiencing after Focusing training both expressed unhappiness with their regular therapists and wished to continue with the Focusing trainer. For clients with low levels of experiencing, it appears that clients don’t easily learn the skill; thus, for focusing to take place and be sustained, continued process direction is required (Leijssen, Lietaer, Stevens & Wells, 2000).

Two Chair Dialogue for Conflict Splits

This therapeutic task is most clearly manifested when clients present verbal statements of "splits," indicating an experienced conflict between the two aspects of self and resolution has been found to involve microprocesses such as deeper experiencing of feelings and needs and softening of an internal critical voice Greenberg (1979, 1983). Recent research on this task has continued to provide support for and elaboration of models of resolution, while also placing more focus on understanding self-critical processes. Mackay (1996) provided some empirical support for Greenberg ‘s (1983) three-stage model of successful two chairwork, consisting of Opposition (conflict), Merging (softening and mutual understanding), and Integration (negotiation of mutually satisfying compromises). Moderate support was found for the model, but adding a Pre-

opposition stage (for people who experienced a substantial interruption of contact) was also suggested. McKee (1995) found that clients engaged in Two-Chair dialogue tended to use significantly more Focused (inwardly exploring) and Emotional (distorted by overflow of emotion) vocal qualities than clients receiving Empathic Reflection. Furthermore, these clients also used significantly less Externalizing (lecturing) and Limited (emotionally restricted) voical qualities.

Turning to self-criticism processes, Sicoli and Halberg (1998) investigated novice client performance using the Gestalt two-chair technique. The presence of "wants and needs" was found to be significantly greater overall for sessions in which the critic softened, compared to sessions with no softening. Similarly, Whelton and Greenberg (2000) found that high contempt and low resilience in response to the critic related to depression proneness.

In the most extensive study on conflict splits to date, Stinckens (2001) analyzed 75 episodes in which an inner critic was clearly present. She found that therapists use five strategies in working with the inner critic: (a) identifying it; (b) putting it at a distance; (c) empathically attuning to it; (d) shifting attention to organismic experiencing; and (e) integrating different parts of the Self. In general, identifying the inner critic and shifting attention to organismic experiencing were most frequently used. Rogers typically made extensive use of the strategy of identifying the critic but avoided empathizing with it. In contrast to Rogers, contemporary client-centered/experiential psychotherapists were more likely to empathize with the critic (18% versus 2%). Process-experiential therapists working with the two-chair technique, more frequently used the strategy of integrating parts of self, and avoided putting the critic at a distance. In addition, Stinckens (2001) also carried out more intensive analyses of a smaller number of critic episodes, finding that a variety of strategies were used flexibly in relation to the specific type of inner critic (e.g. rigid versus mild) in order to facilitate constructive change.

Empty Chair Dialogue for Unfinished Business

This task, drawn from Gestalt therapy, addresses a class of processing difficulties in which schematic emotion memories of significant others continue to trigger the re-experiencing of unresolved emotional reactions. Thus, when one thinks of the other person, bad feelings ensue. This task involves re-experiencing the unresolved feelings in the safety of the therapeutic environment. The purpose of the intervention is to allow the person to express feelings fully to the imagined significant other (such as an alcoholic parent) in an empty chair. This helps remobilize the client's suppressed needs and the sense of entitlement to those needs, thereby empowering the client to separate appropriately from the other person. This occurs by either achieving a better understanding of the other or holding the other accountable for wronging done to the self (Greenberg & Foerster, 1996). Outcome research on the use of empathy and chair work for unfinished relationships (Paivio & Greenberg, 1995) were reviewed earlier in the section on trauma and abuse.

Process research. O'Leary & Nieuwstraten (1999) explored the identification and exploration of "unfinished business" in gestalt reminiscence therapy with 7 older adults (all over 65 yrs old). Results showed that the initial expression of unfinished business by older adults is often in nonpersonal language and that the task of the therapist is to assist them in both personalizing the issue and exploring and finishing it.

A refined model of the microprocesses involved in change (developed by a task-analytic research program) was validated by comparing successful and unsuccessful resolution of unfinished business (Greenberg & Foerster, 1996). Four performance components – intense expression of feeling, expression of need, shift in representation of other, and self-validation or understanding of the other – were found to discriminate between resolution and nonresolution performances. McMain (1996) related changes in self-other schemas to psychotherapy outcome in the treatment of unfinished business. Measures of self-other schemas were based on ratings of clients' performances while engaged in an imaginary dialogue with a targeted significant other. The results indicated that successful outcome was predicted by change in the representation of the self. Specifically, an increase in self-autonomy, self-affiliation, and positive responses of self in relation to the significant other were each predictive of treatment outcome at posttherapy and four-month follow-up. Change in the representation of the other failed to predict treatment outcome. Using the same sample, Paivio and Bahr (1998) found that interpersonal problems at the beginning of treatment predicted alliance.

Greenberg and Malcolm (2002) demonstrated that clients who resolved their unfinished business with a significant other in a manner consistent with the model enjoyed significantly greater improvement in symptom distress, interpersonal problems, affiliation toward self, degree of unfinished business, and change in target complaints. This suggests that the components of resolution capture a clinically important process that relates to outcome. More specifically, a significantly greater number of clients in the resolved group were found to express intense emotions. In addition, almost all clients in the resolution group experienced the mobilization of an interpersonal need and a shift in their view of the other, while no clients in the unresolved group experienced a shift in their view of the other. These results provide evidence of the importance of emotional arousal in this task and that those clients who identified and expressed previously unmet interpersonal needs, and experienced a shift in their view of the other, changed more than those who did not engage in these processes. Finally, in a study of childhood maltreatment, Paivio, Hall, Tran and Jellis (2001) found that high and low engagers in imaginal confrontations in empty chair dialogue, differed significantly in their outcomes. High engagers achieved significantly greater resolution of issues with abusive and neglectful others, and reduced discomfort on current abuse-related target complaints.

The preceding studies, in combination, provide substantial evidence that degree of client engagement in expression of emotions and unmet needs during empty chairwork predicts successful resolution of unfinished issues with significant others.

Evocative Unfolding of Problematic Reactions

This task, identified in the context of CC therapy (Rice, 1974; Rice & Saperia, 1984), addresses a class of schematic processing difficulties that control interactions with other people and situations. The problematic reaction point (PRP) marker for this event consists of three identifiable features: a particular incident; a reaction on the part of the client; and an indication that the client views his/her own reaction as puzzling, inappropriate, or otherwise problematic. Watson and Rennie (1994) used tape-assisted process recall to obtain clients' reports of their subjective experiences during the exploration of problematic reactions, and found that clients alternated between two primary activities: symbolic representation of their experience and reflexive self-examination.

In addition, Watson (1996) found that resolution sessions, in contrast to nonresolution sessions, were characterized by high levels of referential activity (Bucci, 1985), which occurred when clients described problematic situations and then immediately differentiated an emotional reaction; in these sessions, clients also reported a change in mood immediately following vivid descriptions of the problematic situation. These two studies highlight both the role that vivid description can play in promoting clients' emotional arousal during sessions and the role of self-reflection in the change process. These findings validate proposition that vividly re-evoking the situation, and clients' subsequent differentiation of their subjective experience, are both necessary but different aspects of productive therapy process, and in particular are important steps in resolving problematic reactions (Greenberg et al., 1993; Rice & Saperia, 1984).

Creation of Meaning in Emotional Crises

Consistent with the interests of existential therapists, meaning creation events occur when a client seeks to understand the meaning of an emotional experience or crisis (Clarke, 1989, 1991). This task involves the linguistic symbolization of emotional experience when high emotional arousal is present. Clarke (1996) conducted a study to determine which client performance components distinguish successful from unsuccessful creation of meaning episodes. The test of the performance model revealed that it contained four steps that distinguished between successful and unsuccessful creation of meaning. These steps involved symbolization of the challenge to a cherished belief, the emotional reaction to that challenge, an hypothesis as to the origin of the belief, and an evaluation of the present tenability of the belief. The change processes involved in successful creation of meaning were demonstrated to include a cognitive and emotional dimension. The end result of creation of meaning – the change in a particular belief or the emotion attached to that belief – is similar to the result sought by cognitive interventions.

Body Work

Body work involves awareness and modification of breathing patterns (and sometimes therapeutic massage); it is a little-researched task in experiential therapy. Holmes, Morris, Clance, and Putney (1996) investigated the relationship between the use of Breath work and therapeutic changes in levels of distress associated with self-identified problems, death anxiety, self-esteem, and sense of affiliation with others. Two treatments were compared with 24 adult clients, with one group participating in a combination of experientially-oriented psychotherapy plus six monthly sessions of Breath work; the second group participated only in experientially-oriented psychotherapy. The psychotherapy plus Breath work condition showed significant reductions in death anxiety and increase in self-esteem compared to the therapy alone condition.

Hershbell (1998) interviewed eleven adults in an advanced Gestalt therapy training program hours about their experience of Gestalt body-oriented interventions. The interventions included attention to breathing, therapist observation and mirroring of gestures and posture, directed awareness of a client's embodied sensations, and working with "I statements" which verbally expressed the observed bodily phenomena. Clients indicated that the methods heightened self-knowledge and contributed to the emergence of a new perspective for the future. The methods were experienced on several dimensions, most often as physical sensations, emotions and cognitions, and less frequently, spiritually, intuitively, or as an energy phenomenon. These studies offer some support for the benefits of body-oriented methods in psychotherapy.

Intensive Process Research

Experiential-humanistic therapies have a long tradition of intensive process research. In this section, we review a few of the studies from the review period.

Client agency. Rennie (2000) analysed the opening moments of dialogue between a client and her therapist making use of the client's commentary given during a tape-assisted process recall interview of the interaction. Even in this brief space of time, the client was found to have exerted conscious control over the therapy process. Such control is understood to be an expression of clients' reflexivity, defined as both as self-awareness and as agency within that self-awareness. This expression of agency complements Rennie's (1994) earlier finding of the prevalence of client deference in therapy. Bolger's (1999) qualitative analysis of the experience of emotional pain revealed that the experience of brokeness lies at the heart of emotional pain and that allowing the brokenness and staying with it with an increased sense of agency led to transformation of the sense of self (Greenberg & Bolger, 2001).

Narrative processes. Research on the construction of meaning in experiential therapy has been developed by investigators of narrative processes in therapy. Grafanaki and McLeod (1999) analyzed narrative processes in the construction of helpful and hindering events in experiential psychotherapy. Three main categories emerged from analysis of this material: therapist as audience, negotiation of a new story line, and co-constructing the story of therapy. A comparison of narrative processes occurring during helpful and hindering events revealed that helpful events were characterized by the experience of a sense of "flow" between participants, which facilitated the storytelling process. Results suggest that existing narrative approaches to therapy have not given enough attention to the role of the client-therapist relationship in enabling the client to construct a life narrative.

Levitt, Korman and Angus (2000) found that in a good outcome dyad in the therapy of depression, metaphors of "being burdened" were transformed into metaphors of "unloading the burden" over the course of the therapy, while there was no transformation evident in the poor-outcome dyad. The good outcome therapy tended to have a higher level of experiencing when discussing burden-metaphors, in comparison with the poor-outcome therapy. Furthermore, in the exploration of metaphoric expressions, the successful dyad had more narrative sequences involving internal experiences.

Angus and colleagues studies of narrative sequences have revealed interesting patterns associated with good outcomes in Experiential therapies (Angus, Levitt, and Hardtke, 1999; Lewin, 2000). Using log-linear narrative-sequence analyses, Angus et al. (1999) found that Perceptual Process CC (Toukmanian, 1992), PE and Psychodynamic therapy dyads differed significantly from one another in terms of both the number of identified narrative sequences and the type of narrative sequences (External, Internal, Reflexive). More specifically, in the psychodynamic therapy sessions a pattern of Reflexive (40%) and External (54%) narrative sequences predominated, with therapist and client engaged in a process of meaning construction (Reflexive) linked to the client's descriptions of past and current episodic memories (External). In contrast, the PE therapy dyad evidenced a pattern of Internal (29%) and Reflexive (46%) narrative sequences, in which the client and therapist engaged in a process of identifying and differentiating emotional experiences (Internal) and then generating new understandings of those

experiences (Reflexive) during the therapy hour. As compared to the other two dyads, the proportion of Internal narrative sequences were three times higher in PE therapy sessions than in the Perceptual Processing CC sessions and five times higher than in the Psychodynamic sessions. The primary goal of PE psychotherapy is to assist clients in developing more differentiated and functional emotion schemes, and the evidence from these analyses indicates that this goal is achieved by an alternating focus on client exploration of experiential states (Internal narrative modes/sequences), followed by meaning-making inquiries (Reflexive narrative modes/sequences) in which new feelings, beliefs, and attitudes are contextualized and understood.

For its part, the Perceptual Processing CC therapy dyad revealed a pattern of consecutive reflexive narrative sequences (54%) occurring across topic segments in which clients and therapist engaged in extended reflexive analyses of both life events (External, 36%), and to a lesser extent emotional experiences (Internal, 19%). The chaining of the Reflective narrative sequences appeared to facilitate an extended client inquiry into core self-related issues in which automatic processing patterns were identified and challenged.

The Narrative Processes Coding System (NPCS; Angus et al., 1999) has also been used to identify shifts in reflexive/meaning-making, internal/emotion-focused and external/event descriptions in therapy sessions (Lewin, 2000). Using this method, good outcome experiential therapists were found to be twice as likely to shift clients to emotion-focused and reflexive narrative modes than poor outcome experiential therapists. Additionally, good outcome depressed clients initiated more shifts to emotion-focused and reflexive discourse than poor outcome clients. Depressed clients, who achieved good outcomes in brief experiential therapy, were found to spend significantly more time engaged in reflexive and emotion-focused discourse than were poor outcome clients. These findings provide empirical support for the importance of emotion and reflexive processes in the treatment of depression.

Assimilation of Problematic Experiences. The assimilation model is a recent attempt at developing a stage model of how change occurs in successful therapy, one which lends itself to intensive, narrative case study research. According to this model, therapeutic progress consists of the successive assimilation of problematic experiences into the client's schemata. The Assimilation of Problematic Experiences Scale (APES; see Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999) is a 0 to 7, fully anchored rating scale of the degree of assimilation of a particular problematic experience, from Level 0, Warded Off, through Level 7, Mastery.

Honos-Webb, Stiles, Greenberg, and Goldman (1998) applied the assimilation model to two cases of process-experiential psychotherapy, one with good outcome and one with relatively poor outcome. Qualitative analysis of the successful client's transcripts suggested that assimilation occurred over time in at least three problematic experiences. Analysis of three themes in the less successful therapy suggested that the client made progress but that assimilation was blocked at two levels of the assimilation sequence. In a further qualitative assimilation analysis of the successful case, the researchers excerpted 43 relevant passages tracking two major themes, and rated each passage on the APES (Honos-Webb, Surko, Stiles & Greenberg, 1999). Ratings by independent raters who used a marker-based APES manual were highly correlated with the investigators' consensus ratings. APES ratings tended to increase across sessions, as expected in successful therapy. In this study, the client's dominant

"superwoman" voice was shown to assimilate a voice of need and weakness while her dominant "good-girl" voice assimilated a voice of rebellion and assertiveness, yielding a more complex and flexible community of voices within the self. This was interpreted as supporting an emerging formulation of the self as a "community of voices," leading to a reformulation of the goal of therapy as facilitating diversity and tolerance among the different self-aspects or voices.

Conclusions

Experiential therapies as empirically supported treatments. In contrast to our previous review (Greenberg et al., 1994), we have emphasized outcome research in this summary. This is not because we favor outcome research over process research, but rather because the political nature of the current historical moment requires the collection, integration, and dissemination of information about the large body of accumulated evidence, in the face of numerous challenges to experiential-humanistic therapies in several countries, including the USA, UK, Germany, and the Netherlands (to mention only those with which we are most familiar).

At the same time, there is much more solid evidence for the efficacy and effectiveness of these therapies than at our last review. The data on experiential therapy outcome research has grown rapidly, with half of the existing studies appearing in the past 10 years. This has allowed us to pursue more sophisticated strategies than in our previous reviews, including equivalence analyses, weighting of effect sizes, controls for researcher allegiance and analysis of bodies of evidence on specific client problems. We believe that these analyses go a long way toward meeting the demands implicit in the criteria put forward by the APA Division 12 Task Force and others (e.g., Chambless & Hollon, 1998; Nathan, 1996; Meyer, Richter, Grawe, von Schulenburg & Schulte, 1991; Roth & Fonagy, 1996).

In fact, we have argued that for some classes of client problems, the existing research is now more than sufficient to warrant a positive valuation of experiential therapy conclusion in four important areas: depression, anxiety disorders, trauma, and marital problems, even using the strict version put forward by Chambless and Hollon (1998; the successor to the APA Division 12 Criteria). First, for depression, experiential therapies have been extensively researched, to the point where the claim of empirical support as "efficacious" (based on equivalence to established treatments or superiority to another active treatment in two or more independent research settings) can be supported for experiential therapies in general and for PE therapy in particular (see Greenberg et al., 2001; King et al., 2000; Watson et al., 2001). In addition, the PE therapy suborientation warrants the claim of empirical support as "specific and efficacious" (based on superiority to another treatment or equivalence to an established treatment in two or more research settings; see Greenberg et al., 2000; Watson et al., 2001).

Second, for anxiety disorders, the existing evidence is mixed, but sufficient to warrant a verdict of "possibly efficacious" (at least one study shows "equivalence" to an established treatment; see: Borkovec & Mathews, 1988; Shear et al., 1994). However, the available evidence on treatment of panic and generalized anxiety also suggests that experiential therapies may be less efficacious than CB therapies. Although this may reflect researcher allegiance effects, the possibility may also be cause for concern among experiential therapists treating these disorders.

Third, for helping clients deal with the sequelae of traumatic and abusive events, the evidence we reviewed points to a conclusion that PE therapies are "specific and efficacious" treatments (see Clarke, 1993; Paivio & Greenberg, 1995; Paivio & Nieuwenhuis, 2001; Souliere,

1995). The existing data do not speak directly to the efficacy of CC therapy with these problems, and so it is not yet known the extent to which the active, process-directive elements of PE therapy are important elements of work with trauma and abuse survivors.

Fourth, while individual therapy is emphasized here, Emotionally-focused therapy (EFT) for couples (e.g., Greenberg & Johnson, 1988; Johnson & Greenberg, 1985) continues to gain research support as an experiential treatment for marital distress. Now, with ten pre-post studies (mean ES: 1.40), six controlled studies (mean ES: 1.93) and five comparative outcome studies (mean ES: +.89), EFT has the best track record of any experiential therapy, and was moved from "probably efficacious" to "efficacious and possibly specific" in a recent review (Baucom, Mueser, Shoham & Daiuto, 1998) using the Chambless-Hollon criteria.

Continuing differentiation of key experiential processes. The review period also saw continuing work on such central therapeutic processes as experiencing, emotional arousal and expression, and empathy. In particular, recent research supports the idea that although deeper emotional experiencing and emotional arousal are important in therapy, researchers need to focus on these not in general but rather during key therapeutic episodes and in relation to important client content themes. As for emotional arousal, we see the evidence as suggesting that it is not sheer emotional experiencing and expression by itself that is therapeutic; rather, *what is critical is emotional expression in conjunction with reflective processing*. Thus, the therapist works with the client to construct or reconstruct a meaning perspective on the emotional experience. We have also noted the re-emergence of the previously moribund area of therapist empathy in the form of a book (Bohart & Greenberg, 1997) and a meta-analysis of the general psychotherapy literature (Bohart et al., 2002), as well as interesting new work on the nature of empathy. The meta-analysis suggested that empathy is an "empirically supported relational element" of psychotherapy in general. As to therapist response modes, recent research has shown that empathic reflection is no longer the only key therapist response, but that a variety of more process-directive therapist responses have come to be used in a flexible way within a broadly conceived empathic-experiential therapy process. At the same time, process research has continued on important therapeutic tasks, including empty chair work, two chair work, evocative unfolding, meaning creation, and focusing. This research is building on previous research-informed task models, providing confirmation in some cases, and clarification and differentation in others. Clearer links between process and outcome have been identified.

Promising emerging areas. Beyond the client problems which have now been shown to be "efficacious" or "efficacious and specific," and the key therapeutic processes which are gathering empirical support and clarification, we uncovered several promising areas worthy of further study. But even at this time, using the Chambless and Hollon (1998) criteria, there is enough evidence to designate most of these promising new approaches as "possibly efficacious." Part of what is so interesting about these areas is that none of them falls within the axis of depression-anxiety-trauma-interpersonal difficulties that have traditionally been seem as the purview of experiential-humanistic therapies. First, based on a small number of naturalistic studies, experiential treatments for problems related to anger and aggression (especially domestic violence) have gained some support (e.g., Wolfus & Bierman, 1996). Second, experiential therapies have emerged as viable alternatives for problems of severe client dysfunction including schizophrenia (see Tarrier et al, 1998; Teusch, 1990) and severe personality disorders (see Eckert

& Wuchner, 1996; Tscheulin, 1996; Snijders et al., 2002). Third, multiple studies -- mostly naturalistic -- now exist on various health-related problems, including cancer (e.g., Edelman et al., 1999), HIV (e.g., Mulder et al., 1994), and psychosomatic problems (e.g., Sachse, 1995). In other words, experiential therapies show promise as possibly efficacious treatments for a variety of problems of pressing societal significance, touching on areas of criminal justice, severe and persistant mental illness and the health care system.

The process-directiveness issue. As we have shown in the meta-analysis, process-directive experiential therapies such as PE, gestalt, and emotion-focused therapy for couples appear to have somewhat larger effect sizes and to do better when pitted against CB and nondirective (CC and supportive-nondirective) therapies. While we tend to take these results as indicating a slight superiority for process directive over nondirective experiential therapies, we are aware that it is also possible that researcher allegiance effects are once again operating, since much of the current pro-experiential therapy research has been carried out by PE and Emotionally Focused Therapy researchers, while much of the research on less directive therapies such as CC therapy has been conducted by CB-oriented researchers looking for "relational controls."

In spite of our own theoretical "reviewer allegiance" in favor of the process-directive therapies, we continue to find ourselves impressed by the robustness of the client-centered (or person-centered, as it is commonly called today) approach to therapy. Time and time again, nonexperiential therapy researchers have been surprised by the long-term effectiveness of CC and nondirective-supportive therapies, even when these were intended as control groups (two recent examples: Tarrier et al., 2000; Kolko et al., 2000). After more than 50 years, it appears unwise to dismiss Rogers' original vision of the optimal therapeutic relationship and its healing power.

Recommendations for research. While the field of experiential therapy research has made signal progress during the past 10 years, more research is needed. It is essential to clarify the parameters of client response in well-researched areas such as depression, for example, by studying depressed adolescents (e.g., Brent et al., 1997), or by trying to optimize treatments (e.g., comparing more vs. less process-directive therapies). Experiential therapy research has achieved momentum. It is essential that this momentum be maintained! Experiential therapists and others looking for resources to help them begin doing research may find it useful to check out the following website for measures, research bibliographies, protocols, and criteria: www.experiential-researchers.org.

Second, we have outlined some promising client problem areas which warrant development as substantial areas of research, including severe client problems, anger and aggression, and health-related problems.

Third, research on health outcomes and costs is needed. The initial evidence suggests that health consequences are a neglected but important topic for outcome research. Furthermore, if experiential therapists continue to seek funding and training support from government and private insurance, cost research is needed to justify the investment of "other people's money." The recent study of King and colleagues (2000), documenting the cost of CC vs. cognitive-behavior therapy for treating depression in primary care settings, is a good start in this direction, but much more and more sophisticated research is needed.

Fourth, elaboration of emotion theory (e.g., Greenberg, Korman & Paivio, 2001) and others has led to greater appreciation of how emotion is expressed in the human brain, as part of a dynamic, three-way interaction between brain processes, behavior and experience. Such a systemic view is nonreductionist and entirely consistent with humanistic principles. Following from this, over the next 10 years, we hope to see brain scanning methods applied to studying change in clients in experiential therapies.

Fifth, in order to stay in the research arena, experiential therapists need not simply attack previous attempts to develop criteria for designating experiential therapies as "empirically supported," but need to develop alternative criteria which are more appropriate to the assumptions and goals of experiential therapies (Bohart et al., 1998; Elliott, 2000; McLeod, 2001) and to the well-being of their clients.

Practical training implications. We conclude with the proposition that the neglect of experiential therapies in many training programs is no longer warranted. Experiential therapies should generally be offered in graduate programs and internships, especially as treatments for depression and trauma, relationship problems, and possibly for other client problems as well. In training programs that have emphasized CB therapy to the exclusion of other approaches, the evidence is now strong enough to for us to recommend that experiential-humanistic therapies should be considered empirically-supported treatments. In fact, students' education as psychologists is incomplete without a greater emphasis on such training.

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Table 1:

Outcome Research on Humanistic-Experiential Therapies: Pre-post Effect Sizes

Study	Treatment[a] (length)	Population (n of completers)	Type of Measure[b]	Mean Change E.S.[c]
1. Client-Centered: (n: 52; mES: .91; 1994: 13 samples; mES: 1.15)				
Baehr (1954)	CC Inpatient Program (variable)	Hospitalized (66)	SSy	Post: .64
Barrett-Lennard (1962)	CC Individual (33)	Mixed outpatient (36)	SSy, Adj	Post: .77
Beck et al. (1992)	CC Individual (8)	Panic (15)	SSy, CSy	Post: 1.32
Boeck-Singelmann et al. (1992)	CC Individual w/ 2 therapists (13)	Mixed outpatient (immediate + delayed = 53)	Imp, Scm	Immed. Post: .59 Delay Post: .99
Borkovec & Costello (1993)	Nondirective (12)	Generalized Anxiety(18)	CSy, SSy, Exp	Post: 1.18 FU6mo: 1.72 FU12mo: 1.50
Braaten (1989)	CC Group (14)	Volunteer Professionals (25)	SSy, Exp (25)	Post:.36 FU10mo: .20
DiLoreto (1971)	CC (10)	Minor (20)	Ssy, Csy, PC	Post: .36 FU: .57
Dircks et al. (1982)	CC Group (11)	Cancer (30)	Imp	Post: .91
Eckert & Biermann-Ratjen, (1990)	CC Group in Inpatient Setting (50)	Mixed Severe (non-psychotic) (117)	PC, Scm, Adj	Post: .18+
Eckert & Wuchner (1996)	CC Inpatient Program (100 days)	1. Borderline (14) 2. Schizophrenia (13) 3. Depression (16)	CSy	1. Post: 1.71 FU: 2.08 2. FU: .59 3. FU: 1.00
Engels-Sittenfeld et al. (1980)	CC (15)	Chronic sleep problems (6)	Csy, Phy	Post: 0.14 FU6mo: 0.22
Eymael (1987)	CC (16)	Neurotic,Psychosomatic(14)	Imp	FU7mo: 2.20
Fife (1978)	Individual CC (8)	Parents of children with leukemia (8)	Rel	Post: .26
Fleming & Thornton (1980)	Group CC (16)	Depression (9)	SSy, Adj, Scm	Post: 2.26 FU: 2.72

Gallagher (1953)	CC (mdn: 5.5)	Mixed Students (41)	SSy, PC	Post: .29
Grawe, et al. (1990)	CC (m:32)	Interpersonal problems (15)	Adj, CSy,Exp, PC, Scm, SSy, TC	Post: .79 FU6mo: .83 FU12mo:.96
Greenberg & Watson (1998) "York I"	CC (16)	Depression (17)	Ssy, Scm, Adj, TC	Post: 1.85 FU6mo: 1.85
Greenberg et al. (2001) "York II"	CC (18)	Depression (19)	SSy, Adj, Scm	Post: 1.09
Haimovitz & Haimowitz (1952)	Invidual or group CC (max: 38)	Mixed outpatient (56)	PC	Post: .56 FU1yr: .84
Holden et al. (1989)	Rogerian (9)	Post-partum depression (60)	CSy, SSy	Post(2): .76
King et al. (2000)	CC (7)	Depression in Primary Care (1. 3-way RCT: 62; 2. 2-way RCT: 107; 3. Pref trial: 52)	SSy, Adj, Cost	1. FU2mo: .85 FU10mo: .91 2. FU2mo: 1.13 FU10: 1.21 3. FU2mo: 1.00 FU10mo: .95
Lietaer (1989)	CC(50)	Neurotic (33)	Imp	Post: 1.92
Meyer (1981)	CC (19)	Psychosomat.(Immediate + Delayed: 33)	CSy, PC, Scm	Post(3): .59 FU3mo(3): .66 FU9mo(3): .84 FU12yr(1):1.22
Muench (1947)	Nondirective (various)	Mixed outpatient (12)	Adj, Exp, PC	Post: .97
Raskin (1949, 1952)	CC (6)	Mixed outpatient (10)	Exp, Adj, Scm	Post: 1.27
Rudolph et al. (1980)	CC (m:11)	Neurotic (149)	Imp	Post: 1.15
Schmidtchen et al. (1993)	CC Play therapy (30)	Children	CSy	Post: 2.08 FU6mo: 2.55
Schwab (1995)	Intensive + weekly group CC (1. Immed.: 34 hrs.; 2. Delayed: 22)	Lonely (1. 40; 2. 21)	Adj	1. Post: .53 FU4mo: .61 2. Post: .61 FU4mo: .68
Shaw (1977)	Group Nondirective (8)	Depression (8)	CSy, SSy	Post: .93
Shlien et al. (1962)	CC (1. Time unlimited: 37; 2. Time limited: 18)	Mixed outpatient (1. 30; 2. 20)	Scm	1. Post: 50 FU: .50 2. Post: .64 FU: .64
Speierer (1979)	CC (26)	Neurotic (87)	PC, Imp	Post: 1.67 FU16mo: 2.48
Speierer (2000)	CC w/ inpatient rehabilitation	Alcoholics (37)	Scm	Post: .29

Tarrier et al. (1998, 2000)	Supportive counselling (20)	Chronic schizophrenia (23)	CSy, SSy, Adj, Scm, Imp	Post: .13 FU12mo: .09 FU24mo: .62
Teusch (1990)	CC inpatient program (12 wk)	Schizophrenic (high-functioning) (73)	Imp	Post: 1.54
Teusch & Böhme (1991)	CC inpatient program (12 wk)	Agoraphobia w/ Panic (29)	CSy, PC	FU12mo: 1.32
Teusch (1997)	CC inpatient program (12 wk)	Panic w/ agoraphobia (20)	CSy, PC	Post: .70 FU6mo: .96 FU1yr: 1.04
Teusch, Finke & Böhme (1999); Böhme, Finke & Teusch (1999)	CC inpatient program (12 wk)	Mixed inpatient (385)	CSy, PC	Post: .80 FU1yr: .96
Tscheulin (1995, 1996)	CC inpatient program (~75 days)	Mixed inpatient (1. 1426; 2. 632; 3. 92; 4. 156)	SSy, Scm, PC	1. Post: .63 2. Post: .74 3. Post: .60 FU18mo: .46 4. Post: 74 FU18mo: .82

2. Supportive/Nondirective plus Minor Directive: (n: 11; mES: .84; 1994: 5 samples; mES: 1.15)

Beutler et al. (1991)	Supportive/Self-directed (readings) (20)	Depressed (20)	CSy, SSy	Post: 1.22 FU3mo: 2.22 FU10mo: 1.19
Borkovec et al. (1987)	Nondirective + Relaxation (12)	Generalized Anxiety (14)	CSy, SSy	Post: .92
Borkovec & Mathews (1988)	Nondirective + Relaxation (12)	Gen. Anx. + Panic (10)	CSy, SSy	Post: 1.17 FU6mo: .93 FU12mo: 1.06
Brent et al. (1997); Kolko et al. (2000)	Nondirective Supportive (16)	Depressed adolescents (23)	CSy, SSy, Adj, Scm, Rel	Post: 0.62 FU24mo: 0.82
Edelman et al. (1999)	Supportive therapy group (12)	Recently diagnosed breast cancer (24)	CSy, Adj, Scm	Post: .19 FU4mo: .19
Gruen (1975)	Supportive (m: 17)	Heart Attack inpatients (34)	CSy, SSy, PC	Post: .40 FU4mo: .66
Lerner & Clum (1990)	Supportive (10)	Suicidal students (9)	Adj, Ssy	Post: .68 FU3mo: .67
Propst et al. (1992)	Pastoral Counseling (religious content) (18)	Depressed Religious (10)	Adj, CSy,SSy	Post: 1.35 FU3mo: 1.57 FU24mo: 1.80
Salts & Zonker (1983)	Unstructured Group (8)	Divorced (21)	Scm, Ssy	Post(2): .41

Schefft & Kanfer (1987)	Group CC + readings (9)	Shyness (21)	Ind, SSy, Scm, PC	Post: 93 FU2mo: .93
Shear et al. (1994)	Nonprescriptive (information) (15)	Panic (21)	CSy, SSy,Adj	Post: 91 FU6mo: 1.17

3. Process-Experiential (Marker-guided): (n: 18; mES: 1.26; 1994: 6 samples; mES: 1.39)

Clarke (1993)	Meaning Creation (8)	Childhood sexual abuse (9)	Exp, Sim, Adj	--[d]
Clarke & Greenberg (1986)	Experiential 2-chair (2)	Decisional Conflicts (16)	Adj	Post: 1.14
Elliott et al. (1998)	PE (16)	Crime-related PTSD (6)	SSy, EXP	Post:.82 Post6mo:.93
Gibson (1998)	Feminist PE (12)	Depression (6)	SSy, CSy, Adj	Post: 0.50
Goldman et al. (1996)	Relating without Violence Program (36)	Domestic violence perpetrators (48)	Ssy	Post: 1.6
Greenberg & Watson (1998) "York I"	PE (16)	Depression (17)	SSy, Scm, Adj, TC	Post: 2.49 FU6mo: 1.88
Greenberg et al. (2001) "York II"	PE (18)	Depression (19)	SSy, Adj, Scm	Post: 1.79
Greenberg & Webster (1982)	Experiential 2-chair (6 max)	Decisional conflicts (31)	Adj, SSy	Post: 2.07 FU1mo: 2.16
Jackson & Elliott (1990)	PE (16)	Depression (15)	Adj, CSy, Exp, Scm, SSy, TC	Post: 1.36 FU6mo: 2.05 FU18mo: 1.80
Lowenstein (1985)	CC + Evoc Unfolding (5)	Interpersonal plus anxiety (12)	Scm, SSy, TC	Post: .94
Mestel & Votsmeier-Röhr (2000)	Integrative Experiential Inpatient Program (6 weeks)	Depression (412)	SSy, Adj, Exp	Post: 1.11 FU22mo: .98
Paivio & Greenberg (1995)	Empty Chair (12)	Unresolved relationship issues (15)	SSy, Adj,TC, Rel, Scm	Post: 1.65 FU4mo:1.57
Paivio & Nieuwenhuis (2001)	Individual EFT (20)	Adults abused as children (Immed. + delayed: 32)	Ind, SSy, Adj, Rel, Scm, Imp	Post: 1.53 FU9mo: 1.45
Sachse (1995)	Goal-oriented CC (33)	Psychosomatic(29)	SSy, Adj, Scm, PC	Post: 1.52
Souliere (1995)	Empty Chair (2)	Unresolved relationship	Ind, Exp, Scm, Rel	Post: 1.52

		issues (20)		
Toukmanian & Grech (1991)	Perceptual Processing Experiential (10)	Interpersonal problems (18)	Scm Exp	Post: .70
Watson et al. (2001)	Process Experiential(15)	Depression (33)	SSy, Adj, Scm, PC	Post: .90
Wolfus & Bierman (1996)	Relating Without Violence program (36)	Domestic violence perpetrators (55)	Scm, PC	Post: .96

4. Gestalt Therapy: (n: 10; mES: 1.23; 1994: 3 samples; mES: 1.27)

Beutler et al. (1984)	Gestalt group (3)	Mixed inpatients (39)	Adj, SSy	Post(2): .78 FU13mo(1): 1.09
Beutler et al. (1991)	Gestalt group (20)	Depressed (22)	CSy, SSy	Post: 1.18 FU3mo: 1.89 FU10mo: 1.87
Cross et al. (1982)	Gestalt/TA (12)	Mixed (15)	Adj, Exp, TC	Post: 1.22 FU4mo: 1.23 FU1yr: 1.26
Felton & Davidson (1973)	Gestalt educational program, w/ group counseling (semester)	Under-achieving high school students (61)	Scm	Post: .94
Greenberg et al. (1978)	Gestalt/TA weekend marathon group	Mixed, mostly neurotic (24)	Adj, Scm	Post: .73
Jessee & Guerney (1981)	Gestalt Relationship Enhancement group (12)	Marital distress (18)	Rel	Post: 3.05
Johnson (1977); Johnson & Smith (1997)	Gestalt Two-chair (5)	Snake phobia (8)	CSy, Adj	Post: 2.55
Little (1986)	Gestalt parent group (10)	Parents of "problematic children" (10)	Rel	Post: .87
Serok et al. (1984)	Intensive Gestalt group (48)	Inpatients with schizophrenia (7)	Imp	--[d]
Serok & Zemet (1983)	Gestalt group (10)	Inpatients w/ schizophrenia/(9)	PC	Post: .54
Tyson & Range	Group Gestalt	Mild depression	SSy, PC	Post: .56

(1987)	empty chair dialogues (4)	(11)		FU7wk: .88
Yalom et al. (1977)	Gestalt weekend marathon group	Mixed neurotic (23)	Exp	FU2mo: .23

5. Emotionally-focused Therapy for Couples: (n: 10; mES: 1.40; 1994: 4 samples; mES: 2.21)

Dandeneau & Johnson (1994)	EFT Couples (6)	Normal/mildly distressed (12)	Rel, Ind	Post: .98 FU3mo: 1.77
Dessaulles (1991)	EFT Couples (15)	Depression (6)	Rel	Post: .80
Goldman & Greenberg (1992)	EFT Couples(10)	Marital distress (14)	Rel, Ind	Post: 2.51 FU4mo: 1.52
Gordon-Walker et al. (1998)	EFT Couples (10)	Parents of chronically-ill children (16)	Rel	Post: 1.90 FU3mo: .90
James (1991)	EFT Couples (12)	Moderate marital distress (14)	Rel, Ind	Post: 1.73 FU4mo: 1.26
Johnson & Greenberg (1985a, 1985b)	EFT Couples (8)	Marital distress (1. Immed.:15; 2. Delayed: 14)	Rel, Ind	1. Post: 2.47 FU2mo: 2.96 2. Post: 1.27 Fu2mo: 2.62
Johnson & Talitman (1997)	EFT Couples (12)	Marital distress (34)	Rel	Post: 1.35
Johnson et al. (1998)	Emotionally focused family therapy (10)	Families with bulimic adolescents (9)	Ssy	Post: .67
MacPhee et al. (1995)	EFT Couples (10)	Female inhibited sexual desire (25)	SSy, Adj, Rel	Post: .57 FU: .49

6. Other Experiential (focusing-oriented, emotive, psychodrama, or integrative): (n: 15; mES: .86; 1994: 5 samples; mES: 1.02)

Bierenbaum et al. (1976)	Emotive(9)	Neurotic students (41)	Exp, SSy, Ind	Post: 1.09
Beutler & Mitchell, 1981	Experiential	Mixed outpatient (20)	Imp	--[d]
Dahl & Waal (1983)	Primal Therapy (1 yr)	Chronic neurotic (13)	CSy, Ind	FU2yr: 1.10
de Vries et al. (1997)	Experiential + existential (18)	Cancer (in active progression) (35)	SSy, Scm, Phy	Post: 0.13
Durak et al. (1997)	Supplemental Focusing training (5)	Outpatient clients in various therapies (17)	Exp	Post: .62

Holstein (1990)	Focusing + Cog.-Behav. group (20)	Weight problems (7)	Phy	Post: .38 FU3mo: .66
James (1991)	EFT Couples + Relationship Enhancement (12)	Moderate marital distress (14)	Rel, Ind	Post: 2.63 FU4mo: 1.82
Katonah (1991)	Focusing (6)	Cancer (in remission)(12)	PC, SSy	Post: .50 FU6mo: 1.03
Mulder et al. (1994)	Experiential group therapy	HIV-positive gay men (13)	SSy, Adj, Exp, Rel, Phy	--[d]
Nichols (1974)	Emotive (9)	Neurotic students (21)	Exp, SSy, Ind	Post: 1.28 FU2mo: 1.73
Pierce et al. (1983)	Emotive (>6mo)	Mixed Private Practice (97)	CSy, Scm, Ind, PC	Post: 1.37
Ragsdale et al. (1996)	Adventure/Psychodrama (26 days)	Chronic PTSD	CSy, Adj	Post: .41
Rezaeian et al. (1997)	Intensive Psychodrama (60)	Depressed males (18)	Scm	Post: 1.51
Sherman (1987)	Reminiscence + Focusing Group (10)	Community Elderly (35)	Exp, Scm, PC	FU3mo: .40
Snijders et al. (2002)	Integrative CC day treatment program	Personality disorders (72)	SSy, Adj, PC	Post: .57 FU6mo: .95
Spiegel et al. (1981, 1989)	Supportive-existential group (50)	Women with metastatic breast cancer	Imp, Phy	--[d]
Tschuschke & Anbeh, 2000	Psychodrama (12)	Mixed outpatients (72)	Ind, SSy, Adj	Post(early): .44
Tyson & Range (1987)	Active expression group (4)	Mild depression (11)	SSy, PC	Post: .38 FU7wk: .04
Van der Pompe et al. (1997)	Experiential-existential group (13)	Metastatic breast cancer (11)	Phy	--[d]

7. <u>Encounter/Growth/Marathon Groups:</u> (n: 11; mES: .69)

Bruhn (1978)	CC Marathon Group (2.5 days)	Neurotic (78)	Scm	FU1mo: .26 FU6mo:.50
Foulds (1970)	Experiential-Gestalt growth group (9 4-hr)	Normal college students (19)	Exp	Post: .82
Foulds et al. (1970)	Weekend marathon group	Normal college students (16)	Scm	Post: 1.18

Foulds (1971a)	Experiential-Gestalt growth group (8 x 4.5 hr)	Normal college students (15)	Exp	Post:.59
Foulds (1971b)	Experiential-Gestalt growth group (8 x 4.5 hr)	Normal college students (29)	Exp	Post:.80
Foulds & Guinan (1973)	Gestalt marathon group (2 weekends)	Normal college students (30)	Scm	Post: .98
Foulds et al. (1974a)	Weekend marathon group	Normal college students (15)	Adj	Post: .75
Foulds et al. (1974b)	Experiential-Gestalt weekend marathon group	Normal college students (18)	PC	Post: .24
Monti et al., (1980)	Sensitivity Training Group (20)	Mixed inpatients (23)	PC	Post(3): .02 FU6mo(3): .40
Pomrehn et al. (1986)	CC Group Marathon (2.5 days)	Neurotic (87)	Imp, Scm, Exp	FU1mo:.50 FU12mo:1.22
Westermann et al. (1983)	CC Group Marathon (2.5 days)	Neurotic (164)	Imp, Scm,PC	FU1mo(4): .47 FU6mo(1): 1.32

[a]Individual treatment unless otherwise noted; number of sessions given in parentheses; CC: Client-Centered Therapy; PE: Process-Experiential therapy; EFT: Emotionally-Focused Therapy.
[b]Adj: social adjustment or interpersonal problems measures; CSy: clinician ratings of symptoms; Exp: measures of experiential functioning; Imp: estimates based on improvement ratings or percent recovered; PC: measures of personality and coping style; Rel: measures of relationship quality (e.g., marital); Scm: schematic/self image measures; SSy: self ratings of symptoms; Ind: Target complaint or individualized problem measures; Phy: health, physical status.
[c]ESs for multiple outcome measures were first averaged within instruments (e.g., 8 scales of Freiberg Personality Inventory), then across instruments for each treatment group and each assessment period. FU: Follow-up (followed by time period in months or years; e.g., 3mo=3 months).
[d]Pre-post ES could not be calculated from data provided.

Table 2

Summary of Overall Pre-post Change, Controlled and Comparative Effect Sizes

	n	m	sd
Pre-Post Change ES (mean d)			
By Assessment Point:			
Post	114	.97	.61
Early Follow-up (1-11mos.)	53	1.16	.72
Late Follow-up (_12 mos)	33	1.04	.52
Overall (mES):			
Unweighted	127	.99	.58
Weighted by n	6569[a]	.86	.42
Controlled ES (vs. untreated clients)[b]			
Unweighted mean difference	42	.89	.71
Experiential mean pre-post ES	40	1.02	.63
Control mean pre-post ES	40	.11	.49
Weighted mean difference	1149[a]	.78	.57
Comparative ES (vs. other treatments)[b]			
Unweighted mean difference	74	+.04	.56
Experiential mean pre-post ES	69	1.00	.66
Comparitive treatment mean pre-Post ES	69	1.00	.73
Weighted mean difference	1375[a]	+.01	.44
Comparative ES (more vs. less process-directive experiential)			
Unweighted	5	.48	.26
Weighted by n	164[a]	.45	.25

Note. Hedge's d used. Where indicated, number of clients in humanistic treatment conditions used as weighting variable (corrects for small sample bias).

[a]Total number of clients in studies combined.

[b]Mean difference in change ESs for conditions compared, except where these are unavailable; positive values indicate pro-humanistic therapy results.

Table 3
Controlled Outcome Research on Experiential Therapies

Study	Experiential Treatment	Control Condition	Mean Difference in Effect Size
1. Client-Centered: (n: 11; m ES: .78)			
Boeck-Singelmann (1992)	CC (1. Immed.; 2. Delayed)	Waitlist	1: +1.51 2: +1.14
Braaten (1989)	CC group	No-treatment	+1.19
DiLoreto et al. (1971)	CC	No treatment + No contact	+.31
Dircks et al. (1980)	CC group	No treatment	+.27
Eymael (1987)	CC	Waitlist	+2.20
Meyer (1981)	CC	Waitlist	+.56
Rudolph et al. (1980)	CC	Waitlist	+.30
Schwab (1995)	CC group (1. Immed.; 2. Delayed)	Waitlist	1: +.42 2: +.51
Shaw (1977)	Nondirective	Waitlist	+.25
2. Supportive/Nondirective plus Minor Directive: (3 samples; m ES: .43)			
Gruen (1975)	Supportive-experiential	No treatment	+53
Propst et al. (1991)	Pastoral Counseling	Waitlist	+.55
Salts & Zonker (1983)	Unstructured Group	Waitlist	+.23
3. Process-Experiential/Emotion-Focused: (n: 3; m ES: .89)			
Clarke & Greenberg (1986)	Experiential 2-chair	Waitlist	+.96
Paivio & Nieuwenhuis (2001)	Individual EFT	Waitlist	+1.43
Wolfus & Bierman (1996)	Relating Without Violence program	No treatment	+.33
4. Gestalt Therapy: (n: 3; m ES: .64)			
Johnson (1977)	Gestalt Two-chair	No treatment	+1.05
Little (1986)	Gestalt parent group	Treatment early terminators	+.84
Tyson & Range (1987)	Group gestalt empty chair dialogues	No treatment	+.10
5. Emotionally-focused Therapy for Couples: (n: 6; m ES: 1.93)			
Dandeneau & Johnson (1994)	EFT couples	Waitlist	+1.51
Goldman & Greenberg (1992)	EFT couples	Waitlist	+2.14

Gordon-Walker, et al. (1996)	EFT Couples	Waitlist	+1.47
James (1991)	EFT Couples	Waitlist	+.85
Johnson & Greenberg (1985a & 1985b)	EFT Couples (1. Immed.; 2. Delay)	Waitlist	1: +3.28 2: +2.51

6. Other Experiential: (n: 7; m ES: .68)

James (1991)	EFT Couples + Relationship Enhancement	Waitlist	+1.58
Katonah (1991)	Focusing	Waitlist	+1.57
Mulder et al. (1994, 1995)	Experiential group therapy w/ HIV	Waitlist/No treatment	+1.04[a]
Ragsdale et al. (1996)	Adventure/Psychodrama	Waitlist	+.59
Sherman (1987)	Focusing	No treatment	+.27
Tyson & Range (1987)	Active expression group	No treatment	-.41
van der Pompe et al. (1997)	Experiential-existential group w/ breast cancer (n=11)	Waitlist	+.17

7. Encounter/Growth/Marathon Groups: (n: 9; m ES: .75)

Foulds (1970)	Experiential-Gestalt growth group	No treatment	+.65
Foulds et al. (1970)	Weekend marathon	No treatment	+1.36
Foulds (1971a)	Experiential-Gestalt growth group	No treatment	+.48
Foulds (1971b)	Experiential-Gestalt growth group	No treatment	+.75
Foulds & Guinan (1973)	Gestalt marathon	No treatment	+1.02
Foulds et al. (1974a)	Weekend marathon	No treatment	+.65
Foulds et al. (1974b)	Experiential-Gestalt weekend marathon	No treatment	+.23
Pomrehn et al. (1986)	CC Group Marathon	Waitlist	+.61
Westermann et al. (1983)	CC Group Marathon	Waitlist	+1.07

Note. Effect size values given are differences in change effect sizes (averaged across measures and assessment periods). Abbreviations: CC: Client-Centered Therapy; PrExp: ND+: Nondirective plus minor directive; EFT: Emotionally-Focused Therapy (for couples).
[a]Based on combined sample of reportedly equivalent experiential and cognitive treatments.

Table 4
Comparative Outcome Research on Experiential Therapies

Study	Experiental Treatment	Comparison Treatment	Mean Difference in Effect Size
1. Client-Centered: (n: 28; m comparative ES: -.04)			
Beck et al. (1992)	CC	Focused Cognitive Therapy	-.95
Borkovec et al. (1993)	Nondirective	Cognitive Therapy	-.36
Borkovec et al. (1993)	Nondirective	Applied Relaxation	-.99
Diloreto et al. (1971)	CC	Systematic desensitization	-.03
Diloreto et al. (1971)	CC	Rational Emotive therapy	+.06
Eckert & Biermann-Ratjen (1990)	CC	Psychodynamic Inpatient Group	.00[a]
Engel-Sittenfeld et al. (1980)	Individual CC	Group Autogenic training	-0.14
Engel-Sittenfeld et al. (1980)	Individual CC	Individual Biofeedback	-0.23
Eymael (1987)	CC	Behavior therapy	-.53
Fife (1978)	CC	Behavior therapy	+.25
Fleming & Thornton (1980)	Nondirective group	Cognitive therapy	+.50
Fleming & Thornton (1980)	Nondirective group	Coping skills training	+.50
Grawe et al. (1990)	CC	Behavior Therapy (Broad-Band & Individualized)	-.08
Grawe et al. (1990)	CC	Group Behavior Therapy	-.22
Greenberg & Watson (1998) "York I"	CC	PrExp	-.33
Greenberg et al. (2001) "York II"	CC	PrExp	-.71
King et al. (2000) (1. 3-way trial; 2. 2-way trial; 3. Preference trial)	CC	CBT	1: -.19 2: -.16 3: -.08
King et al. (2000)	CC	Treatment as Usual (Primary care physician)	+.10
Meyer (1981)	CC	Short-term Dynamic Therapy	+.44
Shaw (1977)	Nondirective	Cognitive therapy	-1.15
Shaw (1977)	Nondirective	Behavioral therapy	.22
Shlien et al.(1962)	CC	Adlerian therapy	.00[a]
Schmidtchen et al. (1993)	CC Play therapy	Pedagogical support group	+1.47
Tarrier et al. (1998, 2000)	Supportive counselling + routine care	Cognitive Behavior therapy + routine care	+.08
Tarrier et al. (1998, 2000)	Supportive counselling + routine care	Routine care	+.31

Teusch et al. (1997)	CC program	CCT plus behavioral exposure	-.37

2. Supportive/Nondirective plus Minor Directive: (n: 13; m ES: -.32)

Beutler et al. (1991)	Supportive/Self-directed (bibliotherapy)	Cognitive Therapy Group	+.06
Beutler et al. (1991)	Supportive/Self-directed (ND+)	Focused Expressive group	+.11
Borkovec et al. (1987)	Nondirective + Relaxation	Cognitive Therapy/Relaxation	-.68
Borkovec & Mathews (1988)	Nondirective + Relaxation	Cognitive Therapy/Relaxation	-.50
Borkovec & Mathews (1988)	Nondirective + Relaxation	Desensitization/Relaxation	+.02
Brent et al. (1997); Kolko et al. (2000)	Nondirective supportive + Information	Cognitive behavior therapy	-.13
Brent et al. (1997); Kolko et al. (2000)	Nondirective supportive + Information	Systemic behavior family therapy	-.08
Edelman et al. (1999)	Supportive therapy group	Cognitive behavior therapy group	-0.12
Lerner & Clum (1990)	Supportive	Behavioral Problem-solving group	-1.42
Propst et al. (1991)	Pastoral Counseling	Cognitive Therapy (non-religious or religious)	+.09
Salts & Zonker (1983)	Unstructured Group	Social Skills Training group	-.31
Schefft & Kanfer (1987)	Group CC + readings	Cognitive Behavioral therapy	-.72
Schefft & Kanfer (1987)	Group CC + readings	Cognitive behavioral plus structured process therapy	-.68
Shear et al. (1994)	Nonprescriptive	Cognitive behavioral therapy	+.25

3. Process-Experiential/Emotion-Focused (individual): (n: 6; m ES: +.55)

Clarke (1993)	Meaning creation + empty chair	Cognitive therapy	+.76
Clarke & Greenberg (1986)	PrExp	Behavioral Problem-solving treatment	+.57
Greenberg & Watson (1998) "York I"	PrExp	CC	+.33
Greenberg et al. (2001) "York II"	PrExp	CC	+.71
Paivio & Greenberg (1995)	PrExp	Psychoeducational group	+1.24
Souliere (1995)	Empty chair dialogue	Cognitive restructuring	+.11
Toukmanian & Grech (1991)	PrExp	Self-help/psycho-educational groups	+.55
Watson et al. (2001)	PrExp	Cognitive behavioral	+.11

4. Gestalt Therapy: (n: 11; m ES: -.07)

Beutler et al. (1984)	Gestalt group	Inpatient treatment as usual (w/out group)	-.41
Beutler et al. (1984)	Gestalt group	Process-supportive (Psychodynamic) group	-.55
Beutler et al. (1984)	Gestalt group	Behavior Therapy Group	-.17
Beutler et al. (1991)	Focused Expressive group	Cognitive Therapy Group	+.17
Beutler et al. (1991)	Focused Expressive group	Supportive/Self-directed (ND+)	-.11
Cross et al. (1982)	Gestalt	Behavior Therapy	-.45
Felton & Davidson (1973)	Gestalt educational program	Standard school program	+1.16
Jessee & Guerney (1981)	Gestalt couples group	Relationship Enhancement	-.36
Johnson & Smith (1997)	Gestalt Two chair	Systematic desensitization	+.10
Serok, Rabin & Spitz (1984)	Intensive gestalt group w/ schizophrenia	Inpatient treatment as usual	+.90
Serok & Zemet (1983)	Additional Gestalt group	Inpatient treatment as usual	+.35
Tyson & Range (1987)	Group gestalt empty chair	Theatre workshop	+.51
Tyson & Range (1987)	Group gestalt empty chair	Active expression group (=Other experiential)	-0.34
Yalom et al. (1977)	Gestalt marathon group	Meditation/Tai Chi	+.06

5. Emotionally-focused Therapy for Couples: n: 5; m E.S: +.89)

Dandeneau & Johnson (1994)	EFT	Cognitive Therapy	+.70
Dessaulles (1991)	EFT	Antidepressant medication	+1.49
Goldman & Greenberg (1992)	EFT	Structural-Systemic Therapy	-.02
James (1991)	EFT	EFT + Relationship enhancement	-.73
Johnson & Greenberg (1985a)	EFT	Marital Problem-Solving Therapy	+1.47

6. Other Experiential: (n: 12; m ES: +.18)

Beutler & Mitchell (1981)	Experiential. Group	Analytic group	+.82
Holstein (1990)	CB group + Focusing	Cognitive-Behavioral Weight-loss Group	+.14
Monti et al. (1980)	Sensitivity Training Group	Social Skills Training group	-.34

Mulder et al. (1994)	Experiential group w/ HIV	Cognitive Behavioral group	0[a]
Nichols (1974)	Cathartic	Dynamic therapy	+1.16
Rezaeian et al. (1997)	Intensive psychodrama	TAU	+.74
Rezaeian et al. (1997)	Intensive psychodrama	TAU + Intensive psychodrama	-.16
Sherman (1987)	Reminiscence + Focusing Group	Traditional Reminiscence group	+.10
Spiegel et al. (1981, 1989)	Existential Support Group + TAU	TAU	+.50
Tschuschke & Anbeh, 2000	Psychodrama	Group analysis	+.00
Tschuschke & Anbeh, 2000	Psychodrama	Eclectic/integrative group	+.04
Tyson & Range (1987)	Active expression group	Theatre workshop	-.85

Note. Multiple treatments for a given study listed separately. Effect sizes are differences in change effect sizes (averaged across measures and assessment periods). Types of experiential treatment correspond to main headings in Table 1. Abbreviations: CC: Client-Centered Therapy; EFT Emotionally-Focused Therapy (for couples); ND+: Nondirective plus minor directive; PrExp: Process-Experiential Therapy; Other: Other or unspecified experiential treatment; TAU: treatment-as-usual.

[a]Based on reported equivalence.

Table 5
Equivalence Analysis: Comparisons between Treatments

	n	mES	sd_{ES}	t(0)	t(|.4|)	Result
Experiential vs. Nonexperiential therapies	74	+.04	.56	+.61	-5.5**	Equivalent
Experiential vs. CB therapies	46	-.11	.51	-1.49	+3.88**	Equivalent
Experiential vs. nonCB therapies	28	+.29	.57	+2.65*	-1.03	Better
CC/Nondirective-supportive vs. CB	32	-.25	.45	-3.11**	+1.96+	Trivially different
Pure CC vs. CB	20	-.19	.44	-1.94+	+2.15*	Trivially different
Process-Directive vs. CB	14	+.20	.51	+1.43	-1.49	Equivocal
More vs. less Process-Directive	5	+.48	.26	+4.07*	-.60	Better
Allegiance-Controlled Comparisons						
Experiential vs. CB	46	-.05	.43	-.74	+5.65**	Equivalent
Experiential vs. nonCB therapies	28	+.08	.50	+.81	-3.45**	Equivalent
CC/ND+ vs. CB	32	-.03	.42	-.37	+4.97**	Equivalent
CC(pure) vs. CB	20	-.03	.43	-.32	+3.89**	Equivalent
Process-Directive vs. CB	14	-.09	.44	-.76	+2.65*	Equivalent
More vs. less Process-Directive	5	+.01	.22	+.08	-3.90*	Equivalent

+ $p < .10$; * $p < .05$; **$p < .01$

Note. mES: mean comparative effect size (difference between therapies); sd_D: standard deviation for the comparative effect sizes; t(0): usual one-group t value against a zero-difference null hypothesis; t(|.4|): equivalence t value against a ±.4 sd difference null hypothesis. "Result" refers to the interpretation of the results of the equivalence testing: "Equivalent": significantly less than ±.4 sd criterion, but not significantly greater than zero; "equivocal: neither significantly different or equivalent); "Worse/Better": humanistic shows poorer or better outcome (significantly different from zero, but not significantly different from ±.4 sd criterion); "Trivially different": both significantly different from zero and significantly less than ±.4 sd criterion.

Table 6
Predictor Analyses: Correlations

	Pre-post ES (n = 127)	Controlled ES (n = 42)	Comparative ES[a] (n = 74)
Year of Publication	.12	.19	-.02
Regional origin (North America: 1; German-speaking: 2)	-.13	-.13	.04
Sample size (n of clients)	-.08	-.14	-.05
Researcher allegiance (pro: 1; neutral: 2; con: 3)	-.08	-.30+	-.59**
Type of control group (no treatment: 1; waitlist: 2)	--	.39*	--
Setting (outpatient: 1; inpatient: 2)	-.18*	-.16	-.05
Client age (adolescent, college: 1; adult: 2; old adults (>50): 3	.07	.16	.10
Client problem/disorder (nonlinear correlation *eta*, 9 categories)	.44**	.58*	.38
Therapist experience level	-.18	-.04	-.04
Therapy length (n of sessions)	-.01	-.19	.16
Therapy modality (nonlinear correlation *eta*, 5 categories)	.44**	.71**	.33+
Process-directiveness vs. client-centered/nondirective (CC, nondirective: 1; PE, gestalt, EFT, other: 2)	.23*	.25	.34**

+p <.1; *p <.05; **p <.01
[a]Comparisons between experiential and nonexperiential therapies.