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Research on Humanistic-Experiential Psychotherapies: Updated Review

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Abstract

We review recent research on humanistic-experiential psychotherapies (HEPs), which include person-centered therapy (PCT), emotion-focused therapy (EFT), gestalt, and psychodrama approaches, along with generic relationship control conditions characterized as supportive or nondirective. A key part of this review is a meta-analysis of 91 studies of the effectiveness/efficacy of HEPs, published between 2009 and 2018, which produced the following results: (1) HEPs were associated with large pre-post client change (d = .86). (2) In controlled studies, clients in HEPs generally showed large gains relative to clients who received no therapy (.88). (3) In comparative outcome studies, HEPs in general were statistically and clinically equivalent in effectiveness to other therapies (-.08). (4) Overall, CBT appeared to have an equivocal advantage over HEPs (-.26). However, these studies were overwhelmingly delivered by CBT researchers in largely non-bona fide versions of HEPs as comparison conditions. Overall, the strongest results were found for EFT, followed by PCT; generic supportive-nondirective approaches were least effective, especially when compared to CBT. HEPs appeared to be most effective with relationship/interpersonal difficulties, self-damaging activities, coping with chronic medical conditions, and psychosis. Findings were more mixed for depression and anxiety. In addition, we offer an updated meta-synthesis of the qualitative outcomes of these therapies, which fell into three main categories: appreciating experiences of self; appreciating experience of self in relationship to others; and changed view of self/others. We also provide narrative reviews of recent qualitative research on helpful and unhelpful factors in HEPs, along with quantitative process-outcome research on HEPs including process-outcome research and work on mediating processes. In an integrative summary we identify a core set of interwoven client change processes involving emotional expression, deepening and transformation, the emergence of new client narratives, and the assimilation of problematic experiences. We conclude with a set of recommendations for research, practice and mental health guideline development.

Content Outline

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This review covers approaches to psychotherapy generally referred to as *humanistic* or *experiential*. These therapies are part of the main tradition of humanistic psychology (see Cain et al., 2016), with major subapproaches being person-centered therapy (PCT; e.g., Rogers, 1961), gestalt (e.g., Perls et al., 1951), emotion-focused (EFT, previously referred to as process-experiential; Greenberg et al., 1993), motivational interviewing (Miller & Rollnick, 2012), psychodrama (Moreno & Moreno, 1959), focusing-oriented (Gendlin, 1996), expressive (Daldrup et al., 1988), and body-oriented (Kepner, 1993), and, in some cases, existential (e.g., Schneider & Krug, 2017; Yalom, 1980). In addition, humanistic-experiential psychotherapies (HEPs) are often used as generic relationship control conditions by researchers from other theoretical orientations under store-brand labels such as *supportive* or *nondirective* (See Table 14.1 for an overview).

Although these approaches have varied somewhat in technique and conception over the course of their historical development, in their contemporary expressions they nevertheless share several distinctive theoretical assumptions. Most important among these is the centrality of a genuinely empathic and prizing *therapeutic relationship*. In the HEPs, the therapeutic relationship is seen as potentially curative. Each person's subjective experience is of central importance, and, in an effort to grasp this experience, the therapist attempts to enter empathically into the client's world in a way that goes beyond usual relationships. Being allowed to share another person's world is viewed as a privilege, and all HEPs reject the idea that the relationship between the client and the therapist can be reduced to either a technically-oriented service encounter or an unconscious repetition of previous attachments. Rather, they generally share the view of an authentic but boundaried relationship with the therapist providing the client with a new, corrective and validating emotional experience (Greenberg & Elliott, 2012).

HEPs also share a focus on promoting in-therapy client *experiencing*, defined as the holistic process of immediate, ongoing awareness that includes perceiving, sensing, feeling, thinking, and wanting/intending. Thus, methods that deepen or stimulate client emotional experiencing are used within the context of an empathic facilitative relationship. Commitment to a phenomenological approach flows directly from this central interest in experiencing. People are viewed as meaning-creating, symbolizing agents, whose subjective experience is an essential aspect of their humanity. In addition, the experiential-humanistic view of functioning emphasizes the operation of an integrative, formative or actualizing tendency, oriented toward survival, growth, and the creation of meaning. Moreover, all HEPs are united by the general principle that people are wiser than their intellect alone. Internal tacit experiencing is seen as an important guide to conscious experience, fundamentally adaptive, and potentially available to awareness when the person turns attention internally within the context of a supportive interpersonal relationship. Interpersonal safety and support are thus viewed as key elements in enhancing the amount of attention available for self-awareness and exploration. HEPs are also consistently *person-centered*. This involves genuine concern and respect for each person. The person is viewed holistically, neither as a symptom-driven case nor as a diagnosis (Pos et al., 2008).

Recent developments in the HEPs include the continuing revival of research on person-centered therapy (PCT) and expanding study of process-guiding forms of HEP, including emotion-focused therapy (EFT; Elliott et al., 2004; Greenberg & Johnson, 1988) and motivational interviewing (Miller & Rollnick, 2012). A continuing key point of contention

within the humanistic-experiential psychotherapies, however, is the degree to which therapists should act as process-experts by offering ways clients can work more productively on particular types of problems ("process guiding"). All HEPs are process-guiding to a certain extent, but EFT, gestalt, psychodrama and MI are more so, while PCT and so-called supportive or nondirective therapies attempt to minimize process guiding. On the other hand, recently-developed existential therapies such as meaning-centered psychotherapy (Breitbart & Poppito, 2014) take a more explicit content directive approach, putting them outside the purview of this review, along with compassion-focused therapy (Gilbert, 2009) and schema therapy (Young et al., 2003), which, though typically associated with CBT, have borrowed heavily from HEPs.

In this chapter we focus on research published since our previous reviews (Elliott et al., 2004; Elliott et al., 2013; Greenberg et al., 1994), which covered research published prior to 2009. A key element of the chapter is a meta-analysis of 91 studies of the effectiveness/efficacy of HEPs, published between 2009 and 2018, together with a survey of the use of the approach with different client groups. We also offer an updated meta-synthesis of qualitative research on these therapies (cf. Timulak & Creaner, 2010). Finally, we provide narrative reviews of recent quantitative process research on HEPs, including process-outcome research and work on mediating processes.

Because of space limitations and the increasing amount and range of research this survey is not exhaustive. In particular, we have not reviewed the rather sparse literature on predictors/moderators of client outcome in HEPs. Similarly, we do not review therapeutic alliance, child psychotherapy, and on measure development (but see Cooper, Watson, & Hölldampf, 2010, for reviews of these topics). In addition, we have chosen not to review research on the growing number of related integrative approaches, such as emotion-focused psychodynamic approaches (e.g., Fosha, 2000), and "emotion-friendly" forms of CBT (e.g., Gilbert, 2009; Young et al., 2003). Limitations of resources and the availability of other systematic reviews have also led us to limit coverage of motivational interviewing.

Are Humanistic-Experiential Therapies Effective? 2009-2018 Meta-Analysis Update

In North America and Europe, economic pressures on mental health services and scientific-political trends toward treatment standardization have led to the continued development of guidelines calling for certain psychological treatments to be officially recognized as effective, reimbursed by insurance, and actively promoted in training courses, at the expense of other treatments (e.g., American Psychological Association, 2019; National Collaborating Centre for Mental Health, 2009). To date, the evidence supporting the efficacy of HEPs has not found its way into mainstream guidelines, which and have in effect enshrined as supposed scientific fact and health care policy widely shared preconceptions about the perceived ineffectiveness of these approaches. Although research on HEPs has rapidly expanded over the past 20 years (see previous reviews in Elliott et al., 2004; Elliott et al., 2013), they continue to be overlooked or dismissed, as in the NICE Guidelines for Depression and Schizophrenia (National Collaborating Centre for Mental Health, 2009, 2014).

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

We report here the latest in a continuing series of meta-analytic reviews of HEP quantitative outcome research, substantially updating earlier reports (Elliott, 1996, 2001; Elliott et al., 2004; Elliott et al., 2013; Greenberg et al., 1994). The present update includes 91 studies published between 2009 and 2018, and follows PRISMA guidelines for systematic reviews. These studies offer further evidence for a revival of outcome research on HEPs.

Our most recent HEP outcome meta-analysis (Elliott et al., 2013) included pre-post effectiveness effect size data from 199 different samples of clients seen in some form of HEP, drawing from 186 studies (involving a total of 14,206 clients). In terms of efficacy research, we reported on 59 controlled studies with wait-list or no-treatment conditions (62 comparisons, involving 2,149 therapy clients and 1,988 controls); 31 of these were randomized control trials (RCTs). In addition, we also analyzed results from 100 comparative studies, in which HEPs were compared to other treatments: There were 135 comparisons, involving 108 samples of clients in HEPs; 82 of the studies were RCTs (n = 6,271 HEP clients, 7,214 clients in non-HEP therapies).

Meta-analytic Approach

Because of its history and the philosophy behind this line of meta-analyses, we have followed (and continue to follow) a set of analytic strategies at variance with the practice of much of the burgeoning field of meta-analysis. Our fundamental principle continues to be to use all available data, including pre-post effectiveness data (as opposed to post-only contrasts) and associated open clinical trial designs; studies focused on general or mixed (rather than specific) client populations; and studies of widely varying methodological quality. We have also compared analyses using all available outcome measures to those looking only at primary outcomes. In our experience, the more selective reviewers are about the studies they take into a review, the more opportunities there are for reviewer bias to creep in. Instead, we have followed Smith et al.'s (1980) strategy of taking studies of widely varying quality in order to determine which methodological factors make a difference. In our experience, the results of following these meta-analytic practices have often been surprising and at odds with widely-shared conventional wisdom.

Nevertheless, the previous versions of this meta-analysis have had a couple of key limitations, which we have attempted to address in this update. First, our previous versions ignored primary outcomes and intent-to-treat (ITT) designs, making it difficult to compare our results to other meta-analyses (e.g., Cuipers et al., 2012). Second, owing to the cumulative collection of the large number of studies over time, we were unable to construct a PRISMA diagram tracing our handling of studies, now a necessity for meta-analyses.

For this update, we decided to focus on the 10 years since our previous review (2009-2018). The inclusion criteria were: treatment labeled as Client/Person-centred, (Process-) Experiential, Focusing, Gestalt, Motivational Interviewing; or described as using empathy as a key element of therapy or being centered on client experience; psychotherapy or mental health counselling carried out by mental health professional or professional-in-training; treatment of three or more sessions; sample size of 10 or more; therapy outcome study; clients aged 13 or old; effect size (standardised mean difference) could be calculated. Figure 1 summarizes the results of this search process and the subsequent screening of possible studies. The final sample consisted of 91 separate studies, many represented by several publications (which were combined in our analyses). (See Supplemental Material Table 14S-1 for more detail on the screening of sources; and Table 14S-2 for a summary of the characteristics of the sample.)

Diversity Issues

For our update, we were able to locate studies from a broader range of cultures and client populations than ever before. Eleven studies came from middle-east (especially Iran and Turkey); six were from east or south Asia (including China and India); there was one study from South Africa (Edwards & Edwards, 2009). Two studies included a majority of black clients (Foa et al., 2013; Magidson et al., 2011). Seven studies involved elderly clients; three addressed the application of HEPs for people with disabilities (head injury or autism; Moss-Morris et al., 2013; Murphy et al., 2017; Ward & Hogan, 2009).

Effectiveness Research on Humanistic-Experiential Therapies: Total Pre-Post Change

How much do clients seen in HEPs change over the course of therapy? In our previous meta-analysis (see Table 14.2, lines designated as "2013"), Hedge's g for PP-All (per protocol analyses of all outcome measures) was .93 (k = 199 study samples; 95% CI [.88, 1.04]). For the current sample, the comparable value was statistically significantly smaller but still a large effect: .73 (k = 97; 95% CI [.62, .83]). In contrast, the intent-to-treat primary outcome (ITT-PO) value for the current sample was comparable to our previous value but had a larger confidence interval: 95% CI [.73, 1.16]). The increased variability can be attributed to a substantially smaller sample size (k = 35), which in turn raises issues of representativeness and possible bias in ITT-PO values. In this case, we found the per protocol primary outcome (PP-PO) value of .94 (k = 94; 95% CI [.74, .97]) to be a reasonable compromise, both more representative of the existing research and less variable, with a larger sample and smaller confidence interval, while at the same time correlating essentially perfectly with ITT-PO scores (r = .99) and strongly with PP-All scores (r = .90). Thus, we conclude that our best estimate of client pre-post change in HEPs is likely to be provided by PP-PO scores, pointing to an effect of about .86 sd, a large effect only slightly smaller than the .93 value we reported in 2013. For these reasons, we will focus on PP-PO scores for the remainder of this meta-analysis. On the other hand, this effect size figure is characterized by large estimates of heterogenenity (Cochrane's Q of 559.5; $p < .01$; Higgins' I^2 = 88%).

Next, we looked at how much change clients showed at different times following the end of therapy. In our 2013 analysis, we found that clients maintained or perhaps even increased their immediate posttreatment gains (d = .95) over the posttherapy period, with slightly larger effects obtained at early (1–11 months; 1.05) and late (12+ months; 1.11) follow-ups. With our current data set, at immediate post-therapy, we found weighted mean effects ranging from .73 (PP-All; k = 91), to .86 (PP-PO; k = 91), to .94 (ITT-PO; k = 33), all virtually identical to the overall effect. In addition, similar to the previous meta-analysis, clients generally maintained their post-therapy gains during the year following therapy (ES_w = .88; k = 41; 95% CI [.67, 1.1]) and beyond (ES_w = .92; k = 15; 95% CI [.52, 1.31]).

Controlled Efficacy Studies on Humanistic-Experiential Therapies

Pre-post effects do not tell us whether clients in HEPs fared better than untreated clients, and thus make it difficult to infer that therapy was responsible for changes made by clients. They have also been reported to produce generally larger effects than control group comparisons (Lipsey & Wilson, 1993). Therefore, we examined control-referenced effect sizes (differences between pre-post ESs) in the 21 studies/treated groups in which HEPs were compared to wait-list or no-treatment controls. The weighted mean-controlled effect size (ES_w) for these studies (Table 2) was .88 (95% CI [.55, 1.20]), quite similar to the overall pre-post effect reported earlier and

slightly larger than the .76 controlled PP-All ES reported by Elliott et al. (2013). Breaking down the current controlled ES, we found that the average pre-post effect for clients seen in HEPs was virtually identical (k = 20; ES_{wc} = .95; 95% CI [.65, 1.26]), while participants seen in untreated control groups showed little or no change (ES_{wc} = .09; 95% CI [-.03, .21]). When only the randomized studies were considered (k = 15), the controlled effect was slightly but not significantly larger (ES_{wc} = .98; 95% CI [.51, 1.44]). From the pattern of results in this section, three conclusions can be drawn: (1) There is likely to be a strong causal relationship between the HEPs delivered in these studies and client change. (2) The controlled effects are roughly equivalent to the pre-post effects, which would be consistent with the idea that almost all of the pre-post gains reported for clients in HEPs can be attributed to the therapy (including both client and therapist within-therapy factors), as opposed to external or nontherapy factors. (3) These results suggest that if anything treatment effects might be stronger for RCTs than for nonrandomized controlled studies. As in our earlier meta-analyses, randomization appeared to make little difference in the effects obtained, thus supporting the internal validity of the nonrandomized controlled studies, as well as the larger body of one-group pre-post studies. One caution: Although this body of evidence supports the internal validity efficacy of HEPs, it does not tell us what aspects of the HEPs studied might be responsible for client pre-post change.

Comparative Outcome Research on Humanistic-Experiential Versus Other Therapies

While impressive, the pre-post and controlled effect-size analyses reported do not address the issue of comparative treatment effectiveness, which is central to continuing discussions about mental health policy, the effectiveness of HEPs and the sources of their effects. For this, we first examined the whole set of 63 comparisons between HEPs and other therapies (including 56 RCTs). Applying random effects model significance testing (Lipsey & Wilson, 2001) and equivalence analysis to this and other treatment comparisons made it possible to examine the statistical equivalence between HEPs and non-HEPs. These analyses are summarized in Tables 14.2 and 14.3, with equivalence analyses given in the "95% Confidence Interval," "Different from 0," and "Different from |.4|" columns. If the "Different from 0" column is "No" and the "Different from |.4|" column is "Yes," it means that the confidence interval includes zero but neither +.4 or –.4, indicating that the mean comparative effect demonstrated statistical equivalence. In addition, when these first two criteria didn't apply (i.e., because of small numbers of comparisons and large confidence intervals) we adopted the following conventions for interpreting the practical or clinical implications of these ambiguous results: "Equivalent": within .1 sd of zero (greater than –.1 and less than .1); "Trivially Different": between .1 and .2 sd from zero; "Equivocal": between .2 and .4 sd from zero; "Clinically Better/Worse": at least .4 sd from zero.

The overall mean weighted comparative effect (ES_w) was –.08 (k = 63; 95% CI [-.21, .04]); analyzing only the 56 RCTs produced nearly identical results (ES_{wc} = -.07; 95% CI [-.21, .07]). As indicated in Table 3, these results suggest that in general HEPs and other treatments (including CBT) are equivalent in effectiveness. In keeping with this conclusion, we found that for 43 (68%) of the comparisons, pre-post change for clients in HEPs vs. non-HEPs was within .4 standard deviations of each other, a value proposed as the minimum clinically interesting difference in effects (Elliott et al., 1993). This general result has been a consistent result of our earlier meta-analyses (e.g., Elliott et al., 2004; Elliott at al., 2013) and appears to be quite stable at this point. Nevertheless, this consistent statistical equivalence conceals significant variability in effects, as indicated by a Cochrane's Q of 245.8 ($p < 0.01$); the proportion of true between-

study variability (I^2) was estimated at 91%, extremely high. Examination of possible moderators of comparative outcome effects is clearly called for (Lipsey & Wilson, 2001).

HEPs Versus Cognitive-Behavioral Therapies (CBTs) and Other Therapies

A significant center of continuing controversy involves widely held assumptions that HEPs are inferior to cognitive-behavioral treatments (CBT). The comparative studies analyzed above did not exclusively use CBT (36 out of 63 comparisons). Therefore, it can be argued that the effects of CBT were diluted by the inclusion of comparisons involving other types of therapy, often a mixture of ill-defined treatment as usual or integrative approaches.

To clarify this issue, we undertook a series of further equivalence analyses (see Table 14.3). For the 36 studies comparing HEPs to CBT, ES_w was -.26 (95% CI [-.37, -.15]), which is an equivocal result in favor of CBT (significantly different from both zero and |.4| and larger than .2). Results for RCTs were identical, and also best characterized as equivocally in favor of CBT (see Tables 14.2 & 14.3).

We also compared HEPs to other psychotherapies that weren't CBT in 27 studies involving a wide range of treatments, including treatment at usual. The ES_w was .19 for the whole sample (k= 27) and .24 (k = 24) for RCTs (see Table 14.3), suggesting trivially or equivocally better outcomes for HEPs.

Of considerable importance to practitioners and policy makers is the possibility that differences between active treatments may be due to researcher allegiance effects (e.g., Luborsky et al., 1999), which therefore need to be statistically controlled, as we did in previous versions of this meta-analysis. For the current sample of comparative studies, we found both: (a) a high rate of negative researcher allegiance: overall 59% but even higher in the HEP vs CBT studies (78%); and (b) a very large negative correlation between researcher allegiance and comparative effect size (meta-regression r = –.56; n = 63; p < .01), higher than reported by Elliott et al. (2013). Therefore, we ran additional analyses attempting to statistically control for researcher allegiance by removing variance in comparative ESs due to this variable. Table 14.3, where these analyses are indicated in italics and parentheses, shows mixed results, attenuating to zero (i.e., equivalence) the advantage for CBT for RCTs, but not when nonrandomized studies were included. We were able to trace this discrepancy to the presence of outliers (especially Marriott et al., 2009). Along the same line, in comparisons between HEPs and Non-CBT other therapies, controlling for researcher allegiance reduced the effect to near zero, resulting in equivalence.

Thus, our data present a less clear picture than Elliott et al (2013) were able to provide, at least when it comes to the issue of the whether CBT is more effective or equivalent to HEPs. In our view, the researcher allegiance problem has gotten worse since our previous review, reaching a level that in some cases made it difficult to control for statistically.

CBT Versus HEP Subtypes

Moderator analyses for HEPs vs CBT indicated a significant effect for type of HEP (Q_m = 19.07; p < .01). We were able to examine the two types of HEP for which there were at least 10 comparative studies: supportive-nondirective and person-centered. The results of these analyses are given in the lower part of Table 14.3. Supportive-directive therapies in this dataset were equivocally less effective than CBT. The comparative effect for CBT vs supportive-nondirective therapies was -.29 (k = 22, all RCTs; 95% CI [-.42, -.16]), a result that might be due in part to the use of non-bona fide versions of the therapy which were either very generic (Kiosses et al. 2015) or in which something had been done to render the treatment less effective (e.g., "supportive emotion-focused" therapists working with traumatized clients were told not to help clients elaborate trauma memories; Ehlers et al., 2014). Further investigation of the supportive therapies

revealed that in addition to being subjected to negative researcher allegiance, 59% were diluted, non–bona fide versions of person-centered therapy. Removing supportive treatments rated as non-bona fide (but not correcting for researcher allegiance) resulted in a slightly less negative effect (ES = -.15; k = 9; 95% CI [-.27, .03]), but still in the trivially worse range. We have included these here as part of our inclusive search strategy, because they meet our inclusion criteria and because they have been widely researched; however, we question their ecological validity and representativeness in clinical practice.

In contrast to our previous review, person-centered therapy (PCT) in this dataset was not equivalent in effectiveness to CBT, but instead, like supportive-nondirective therapy, was equivocally worse than CBT (all studies: -.30; k = 10; 95% CI [-.55, -.05]), although the effect was less negative for clients in RCTs (-.20; k = 8; 95% CI [-.45, .04]). The source of this difference from our previous review is not entirely clear to us: On the one hand, it is likely to be due at least in part to high levels of negative research allegiance; on the other, it is possible that in more recent research PCT has been pitted against more challenging, complex client populations outside its natural range of effectiveness, such as young people with mixed complex sexual abuse trauma and substance misuse problems (e.g., Foa et al., 2013).

Comparisons among Types of Humanistic-Experiential Therapies

As noted at the beginning of this chapter, HEPs can be divided into different groupings, sometimes referred to as "tribes". In the current sample of studies these fall naturally into five categories (see Table 14.2): As in previous versions of this meta-analysis, person-centered therapy (PCT) was the best represented of these, with EFT close behind; gestalt therapy and psychodrama use similar methods and for convenience have been grouped here. Supportive-nondirective therapy continued to be the most common form of HEP studied, even though it appeared to be an intervention of questionable ecological validity largely constructed by CBT researchers to contrast with their approach. Finally, there was an assortment of other HEPs. In Table 14.2, we summarize the pre-post data for these five groupings. Moderator variable analysis (using R) examined the relation between type of HEP and pre-post mean ES, resulting in a statistically significant main effect (Q_m [df = 7] = 19.9, $p < .01$). Unsurprisingly, given issues of negative researcher allegiance and non-bona fide treatments, supportive-nondirective therapies showed the smallest pre-post effects (.68; k = 31; 95% CI [.47, .89]). In contrast, clients in EFT had the largest pre-post effects (ES = 1.31, k = 18 95% CI [1.05, 1.58]), with clients in EFT showing statistically significantly more pre-post change than clients in supportive-nondirective therapies.

None of these comparisons, however, were direct, and only six studies in our dataset involved direct comparisons between different HEPs. It was possible to code the six pairs of treatment conditions in these studies into more (i.e., EFT) vs. less (e.g., PCT) intensiveness or process-guiding, so that we could test the hypothesis that more intensive/process-guiding HEPs would produce larger pre-post effects. However, as was the case in previous versions of this meta-analysis, the difference was equivocal and only trivially in favor of more process-guiding HEPs: neither large/statistically different from zero, nor equivalent (ES = .18; 95% CI [.12, .48]). Unfortunately, the sample is too small and diverse to provide adequate statistical power or even to be considered particularly reliable. Clearly, more research is needed to explore this key issue.

Outcome for Different Client Problems: Differential Treatment Effects

Investigation of HEPs for specific client presenting problems or disorders has blossomed over the past 30 years, since this series of meta-analyses began. The three lines of evidence (pre-post, controlled, and comparative studies) are summarized in Table 14.4 for six commonly studied relatively coherent types of client problem plus other populations, evaluated both relative to zero (no change/difference) and for bench-marking purposes to the whole sample. In brief, the largest amount of evidence and the strongest support for HEPs have been found for depression, relationship problems, coping with chronic medical problems (e.g., HIV, cancer), habitual self-damaging behaviors (substance misuse, eating disorders), and psychosis. There is also considerable, but more mixed, evidence supporting the application of these approaches with anxiety. In this section, we provide meta-analytic evidence, summarize key recent studies, and evaluate the status of HEPs as empirically supported treatments for these six particular client problems plus other client populations.

Depression

Pre-post Effects

There were more studies of depression in our data set than any other client presenting problem, with results generally consistent but somewhat smaller than in our previous review. Within the larger dataset we included studies in which either a majority of clients had been assessed as depressed using standard diagnostic instruments, or where the mean pre-treatment score on a standard measure of depression (e.g., BDI) was in the clinical range. We identified 30 samples of clients (from 27 studies; n = 5053 clients) for whom pre-post effects could be calculated, most commonly supportive-nondirective (14 samples), EFT (7 samples), PCT (5 samples), or other HEPs/Gestalt/Psychodrama (6 samples).

The weighted mean pre-post effect size across these 30 samples was substantial but highly heterogeneous (ES = .96, 95% CI [.80, .1.12]; Q = 190.8, p < .01; I^2 = 85%). Most of these samples involved mild to moderately depressed clients (26 out of 30). Clients were generally seen in individual psychotherapy (23 samples) rated as a bona fide HEP (23 samples). Severity of depression appeared to make little difference (ES_w = .95 for mild/moderate vs. 1.00 for severe). The main effect for HEP type was significant (Q_m = 200.0; df = 5; p < .001); however, the confidence intervals for all four sets of studies all overlapped with each other and fell within the confidence interval for depression studies as a whole. The pre-post effects varied from .52 (95% CI [.20, .83]; k = 5) for PCT to 1.33 (95% CI [.85, 1.81]; k = 7) for EFT.

Controlled Effects

We found only three reasonably-sized controlled studies (Cho & Chen, 2011; Grassi et al., 2009; Stice et al., 2008), in which depressed clients (total n = 157) were compared to untreated participants (total n = 204). The mean-controlled effect was relatively and consistently of medium-size across these three studies: ES_w = .51 (95% CI [.21, .81]; Q = 3.1; ns; I^2 = 35%). This effect reflects a reasonably-sized and highly consistent HEP pre-post effect (ES_w = .81; 95% CI [.58, 1.04]; Q = .4; ns; I^2 = 0%) equivalent to that reported for the whole sample. However, the effect for the untreated control group was unexpectedly large and consistent (.31; 95% CI [.12, .51]; Q = 1.9; ns; I^2 = 0%), in contrast to the mean-controlled effect of .09 for the whole sample. As the controlled effect for depression is virtually identical with what we found in our previous meta-analysis, we are inclined to hypothesize that this is a generalizable finding, possibly consistent with the idea of depression as episodic and subject to spontaneous recovery, as least on a short-term basis (Whiteford et al., 2013).

Comparative Effects

The 25 HEP versus non-HEP comparisons included 19 samples of clients, from 18 studies, n = 4679 and 8717 respectively. Most commonly CBT (18 comparisons) was compared to supportive-nondirective therapy (13 comparisons), with clients with mild to moderate depression (20 comparisons). There were also studies using person-centered therapy (9 comparisons), other HEPs or EFT (1 each). Half of the studies used modern, more rigorously designed RCTs (with ITT analyses or specified randomization methods; 12 comparisons) but researcher allegiance was overwhelmingly negative (17 comparisons). Using meta-regression, we found a clear negative research allegiance effect of r = -.42.

The overall comparative effect was -.19 (k = 25; 95% CI [-.30, -.07]), with high heterogeneity (Q = 129.8; p < .01; I^2 = 82%). Following our equivalence analysis strategy, this effect would be designated trivially worse, in contrast to the -.02 equivalence finding reported by Elliott et al. (2013). At the individual comparison level, seventeen of the effects were neutral (between -.4 and .4), but seven were substantial and negative, with very large negative effects for studies by Kiosses et al. (2010) and Koszycki et al. (2012), and one strongly positive comparative effect for McLean et al. (2013).

Breaking down the overall comparative effect, we looked first at type of HEP, the main effect for which was significant (Q_m = 12.5; df = 4; p < 05). The effect for supportive-nondirective treatments was equivocally worse (-.30; k = 14; 95% CI [-.49, -.10]); for person-centered therapy the negative effect was smaller but still in the equivocally worse range (-.20; k = 9; 95% CI [-.39, -.01]).

Next, we calculated the mean comparative effect for comparisons between HEPs and CBT: -.26 (k = 18; 95% CI [-.37, -.15]), finding that in general HEPs were equivocally less effective than CBT. However, a large majority of CBT studies were characterized by negative researcher allegiance (13 out of 18 samples); this effect was somewhat attenuated when only studies with pro-HEP or neutral researcher allegiance were analyzed separately (ES_w = -.19; k = 5; 95% CI [-.37, -.01]). On the other hand, when HEPs were compared to non-CBT therapies, the effect was in the equivalent range (ES_w =.06; k = 7; 95% CI [-.31, .44]).

One very large recent study in this data set used an HEP approach that fell into the other HEP category (because of minor directive elements) and is worth mentioning here due to the fact that it comprised 55% of the total sample for this meta-analysis. Barkham and Saxon (2018) compared 3000 clients seen in generic humanistic counselling ("Counselling for Depression", now referred to as "person-centred experiential counselling" or "person-centred experiential therapy") to almost 6000 clients who received CBT, all in primary mental health services in the UK, in a reanalysis of an earlier UK practice-based study by Pybis et al (2017) using data from a national audit of Improving Access to Psychological Therapies (IAPT) services. In our analysis we favored the Barkham and Saxon report over Pybis et al. because the latter had included clients who had also received low intensity CBT prior to their high intensity CBT or supportive counselling, thus confounding their results. In their re-analysis Barkham and Saxon looked only at clients whose treatment was limited to either high intensity CBT or supportive counselling (coded here as other HEP rather than person-centered because of the presence of minor directive elements). Outcome was assessed using the Personal Health Questionnaire (PHQ-9), a measure of depression, on which the client pre-treatment mean was in the clinical range. Clients were not assigned randomly; however, the authors reported equivalent outcome for supportive counselling and CBT with a comparative effect of -.06 (95% CI [-.11, -.01]; HEP n = 3003; CBT n = 5975). As an interesting side note, they reported that in treatments that lasted up to 11 sessions clients

did better in supportive counselling than in CBT; in contrast, CBT did better in treatments of 12 sessions or more. They also reported that the HEP was equivalent to CBT in effectiveness with more severely depressed clients, concluding that: "Such a finding challenges the current NICE guideline for the management of severe depression." (p. 5)

In addition to the evidence discussed here, the PRaCTICED Trial (not included in this meta-analysis because it fell outside our review period and was not available when we carried out our analyses) is a large, balanced allegiance study, designed to test the clinical efficacy and cost-effectiveness of contemporary PCE therapy in comparison to CBT in a real-world clinical practice setting (Barkham et al., 2020; Saxon et al., 2017). A sample of 298 clients completed at least 4 sessions (PCE: 154; CBT: 144) and provided data on the primary outcome measure, the PHQ-9 (Patient Health Questionnaire-9) at the primary outcome point, six months after randomization. The pre-post effects for PCE therapy were much closer to EFT than PCT pre-post effects for our meta-analysis: ES = 1.22. Moreover, at 6 months PCT was found to be equivalent (i.e., noninferior) in outcome to CBT, using both intent-to-treatment and per protocol analyses. When we applied our meta-analysis methods to this study, we calculated a comparative effect size of .0 sd. However, CBT had better outcomes than PCE therapy 12 months post-randomization, with a negative effect size of -.48 on the primary outcome measure. In addition, more severely depressed clients did better with CBT, especially at 12 months. Pooling these two effects produces an overall result quite comparable to that found in this meta-analysis (comparative ES: -.20). Looking further into the data, we found that clients in PCE therapy retained their post-therapy gains, while clients who had been seen in CBT continued to improve during the post-therapy period. Although the form of PCE therapy used in this trial contained some process-guiding elements of EFT, we note that it did not include chair work. Left for future research is the question of whether EFT chair work might have led to delayed post therapy benefits comparable to those found in CBT.

Conclusions

In comparison to our previous review of research on the application of HEPs to depression, we again found large pre-post effects (current: .96 vs. 2013: 1.23) and medium-sized controlled effects (.51 vs. .42). On the other hand, comparative effects were slightly worse here (-.2 vs. -.02), reflecting either stronger negative researcher allegiance effects or more focused, effective forms of CBT in the past 10 years. Two clusters of promising studies featured in our previous review, EFT for depression (e.g., Watson et al., 2003) and person-centered therapy for perinatal depression (e.g., Cooper et al., 2003). Two key studies on these topics fell within our review period here: McLean et al. (2013) applied EFT for couples to anxious-depressed couples with a partner with metastatic cancer, with strongly positive pre-post and comparative effects relative to treatment as usual; and a major study (Morrell et al., 2009b) with a large sample size that showed superiority to treatment as usual and no difference in comparison to CBT. In addition, two large-sample studies in naturalistic health care settings produced results consistent with the rest of the sample, while suggesting that there is room for improvement in the outcomes of HEPs with clinically depressed clients. Pooling evidence from this review and the previous one, it appears to us that the evidence continues to meet Chambless and Hollon's (1998) criteria for *efficacious and specific* treatments.

Relationship and Interpersonal Difficulties

Pre-post Effects

In our previous reviews, HEPs came out as consistently and strongly effective for clients presenting with either specific unresolved relationship issues or more general interpersonal difficulties. In this review, the largest number of the 23 studies (including 28 samples of clients, total $n = 769$) addressed specific current relationship problems (10 samples, e.g., Burgess-Moser et al., 2016) or general interpersonal difficulties, such as social anxiety (Elliott et al., 2018) or high functioning autism (9 samples, e.g., Murphy et al., 2017). However, there were also smaller clusters of studies on single incident trauma or specific emotional injuries (4 samples, e.g., Nixon, 2012), and childhood abuse/complex trauma (4 studies, e.g., Foa et al., 2013). In contrast to our previous review, most clients in these studies were seen individually (15 samples, e.g., Marriott et al., 2009) or in groups (10 samples, e.g., Cho & Chen, 2011); only three studies involved couples or family therapy (e.g., Diamond et al., 2016). EFT was the most common studied therapy in the pre-post sample, with 10 studies involving 13 samples of clients: six on individual therapy (e.g., Paivio et al., 2010), three on group therapy (e.g., Hagl et al., 2015), two on couples therapy (e.g., McLean et al., 2013) and one on family therapy (Diamond et al., 2016). Person-centered therapy (e.g., Yousefi & Kiani, 2014) and gestalt/psychodrama (e.g., Karatas, 2011) each featured in six studies. Two studies used supportive-nondirective therapy (e.g., Hagl et al., 2015).

The weighted mean pre-post effect size was large but moderately variable (ES = 1.12, 95% CI [.92, 1.33]; $Q = 88.4$, $p < .01$; $I^2 = 69\%$). Effects did not vary between individual, group or couple/family formats, ranging between 1.08 and 1.16 sd. Similarly, there was little variability in pre-post change between general interpersonal difficulties (ES = 1.09; $k = 9$; 95% CI [.7, 1.49]) and specific relational difficulties or conflicts (ES = 1.17; $k = 10$; 95% CI [.8, 1.54]). However, unexpectedly, effects for childhood abuse/complex trauma (ES = 1.31; $k = 4$; 95% CI [.72, 1.9]) were about .5 *SD* higher (but not significantly so) than for single episode trauma (ES = .8; $k = 4$; 95% CI [.38, 1.22]). Finally, effects for EFT (ES = 1.36; $k = 13$; 95% CI [1.09, 1.64]) were somewhat larger than those for person-centered therapy (ES = .98; $k = 6$; 95% CI [.65, 1.3]) and gestalt therapy/psychodrama (ES = .98; $k = 76$; 95% CI [.54, 1.43]). However, none of these differences were statistically significant.

Controlled Effects

There were ten controlled comparisons (6 of them RCTs) in which clients seen in HEPs ($n = 212$) were compared to participants assigned to no treatment or waitlist control conditions ($n = 320$). These comparisons provided a large and highly heterogeneous weighted controlled effect (ES = 1.13; 95% CI [.45, 1.82]; $Q = 58.1$, $p < .01$; $I^2 = 85\%$), with all controlled effects being substantial and positive. The controlled effect was almost identical to the uncontrolled pre-post effect, pointing to the absence of natural self-healing processes in this broad client population. (In our previous review we even found evidence of client deterioration in this population.) In spite of the heterogeneity, overall controlled effects were large for both clients seen individually (ES = 1.33; $k = 3$; 95% CI [.84, 1.82]; e.g., Cornish & Wade, 2015) and in group format (ES = 1.65; $k = 4$; 95% CI [.65, 2.65]; Singal, 2009). This broad between-group consistency was also the case for clients seen in EFT (ES = 1.13; $k = 6$; 95% CI [.45, 1.82]; e.g., Shahar et al., 2017) and in gestalt therapy/psychodrama (ES = 1.4; $k = 3$; 95% CI [.01, 2.8]; e.g., Cho & Chen, 2011). In terms of kind of interpersonal difficulty, clients with general interpersonal difficulties (ES = 1.72; $k = 3$; 95% CI [.35, 3.1]; e.g., Karataş & Gökçakan, 2009) did better than clients with specific relational difficulties (ES = 1.01; $k = 7$; 95% CI [.46, 1.56]; e.g., Greenberg et al., 2010). We are not sure why more generalized interpersonal difficulties might respond better than specific relational difficulties; perhaps this is a sample difference in

that the current crop of studies didn't include much in the way of couples therapy, where the two parties to a relational conflict are able to face each other and work through the difficulty. In the absence of a partner, clients are encouraged to work at a more general level on their own side of a difficulty, which could be easier to do in individual or group therapy.

Comparative Effects

There were 12 comparisons (from 10 studies) of clients seen in HEPs (n = 273) versus non-HEPs (n = 338), most commonly CBT (8 comparisons; e.g., Ford, Chang, Levine & Zhang, 2013) but also one study with two samples of clients seen in cognitive analytic therapy (CAT; Marriott et al., 2009). The overall weighted effect was highly heterogeneous and trivially worse than non-HEPs for interpersonal difficulties (comparative ES_w = -.10; 95% CI [-.49, .27]; Q = 66.8, $p < .01$; I^2 = 84%). Four (involving 3 studies) of the 12 comparative effects were substantial (> |.4|) and negative, favoring the alternative treatment (Foa et al., 2013; Marriott et al., 2009; Nixon, 2012); two effects were substantial and positive (Karatas et al, 2011; McLean et al., 2013). There was a large negative correlation between researcher allegiance and comparative effect size for these 12 comparisons (r = -.48, $p < .01$, weighted meta-regression), with only 2 positive researcher allegiance studies included. The effect size for the negative allegiance studies was -.37 (k = 6; 95% CI [-.69, -.14]); the effect for pro and neutral allegiance studies combined was .21 (k = 6; 96% CI [-.6, 1.01]).

The typical comparative study in this dataset involved CBT (ES = -.46; k = 8; 95% CI [-.75, -.16]) compared to individual (ES_w = -.40; k = 9; 95% CI [-.68, -.11]) person-centered therapy (ES_w = -.41; k = 7; 95% CI [-.78, -.04]) for clients with general interpersonal difficulties (ES = -.16; k = 6; 95% CI [-.61, .28]). (Marriott et al., 2013, is an example of such as study.) HEPs fared most poorly when applied to clients with simple or complex trauma (ES = -.50; k = 4; 95% CI [-.95, -.06]; Foa et al., 2013). The exception to this pattern was the three comparisons using either EFT or gestalt therapy/psychodrama (ES = .8; k = 3; 95% CI [-.59, 2.18]; e.g., Karatas et al., 2011).

Conclusions

Overall, in the present review the effects of HEPs for interpersonal difficulties are lower than those we found in our previous meta-analysis, across all three lines of evidence: For pre-post and controlled studies the drop was minimal: .15 and .19 *SD*s respectively. However, for the comparative studies the drop was substantial and clinically important: .45 *SD*, from .34 (equivocally more effective than nonHEPs) to -.11 (trivially less effective than nonHEPs). The drop in comparative effectiveness for pre-post and controlled effects is consistent with the overall drop in effectiveness for the entire current dataset (-.09 *SD*), but the large drop in the comparative effects greatly exceeds that (-.45 *SD*).

What is the reason for the apparent drop in effectiveness over the intervening years? There are at least five explanations for which there is evidence in our data: First, by broadening the inclusion criteria for the client population with interpersonal difficulties, we may have diluted the evidence. In particular, in this round we have added client presentations involving social anxiety, autism, and PTSD, much of which we had included only under anxiety in our 2013 review (in this review most of these studies are included in both interpersonal and anxiety subsets). Second, it also appears likely that since our previous review there have been shifts in the client subpopulations that are the focus of research. For example, within this client population over the past ten years there has been a decreased interest in couples therapy, especially in comparative studies; more studies of young people (e.g., Foa et al., 2013) and the first outcome study examining HEP (person-centered therapy) for autism (Murphy, 2017).

Third, HEPs may have become less effective (either generally or because less effective versions are being studied). As noted, we have documented a slight drop in HEP pre-post effectiveness in our data, but more importantly we have noted a decrease in the amount of research on EFT for couples, especially comparative studies. While these had strongly bolstered the results of our previous analysis, here they have been replaced by individual person-centered therapy. Fourth, nonHEPs (especially CBT) may have become more effective with the advent of treatments such as Resnick's cognitive processing therapy for PTSD (cf. Foa et al., 2013, here). On the other hand, NonHEP pre-post effects also have dropped from our previous review (1.02 *SD*) to the present one (.8 *SD*). Fifth, researcher allegiance effects may have become more pronounced over time. This was certainly our impression in reading and analyzing the studies included here, an impression that is borne out by an increase in negative researcher allegiance in comparative outcome studies from 44% in our 2013 review to 58% in this review. All these explanations appear to have played some role in the results we obtained here.

We close this section on a more positive note by recalling some of our conclusions from our previous review: To begin with, we want to remind readers that in spite of its relative dearth in the present review, EFT for couples has long been included in lists of empirically supported treatments for marital distress (e.g., Baucom et al., 1998); and our previous meta-analytic review found that EFT for individuals was *efficacious and specific* for unresolved relationship issues, including emotional injuries (e.g., Greenberg et al., 2010) and unresolved abuse survivor issues (Paivio et al., 2001; Paivio et al., 2010). While it would be encouraging to see more recent studies on this well-established treatment, we see no reason to revise these earlier conclusions.

Anxiety

Research on HEPs for anxiety, most commonly the application of supportive therapies with PTSD, is strongest for pre-post and controlled studies and weakest for comparative studies.

Pre-post Effects

We found 27 samples of clients from 23 studies (n = 1045 clients) for which pre-post effects could be calculated, covering a range of HEPs, mostly commonly supportive-nondirective (9 samples of clients), EFT (8 samples), followed by PCT and gestalt/psychodrama (4 samples each). There was a mix of researcher allegiance (15 pro vs. 11 con). Types of anxiety difficulties studied were also quite varied and included PTSD (10 samples; many more than in our previous review), mixed anxiety (8 samples), social anxiety (4 samples), medical/disease progression/ recurrence (3 samples), and generalized anxiety (2 samples). The weighted mean pre-post effect size for the 27 sets of anxious clients was .92 (95% CI [.73, 1.12]), quite near the bench-mark for the entire sample of pre-post effects (see Table 14.4) and almost identical to the pre-post effect reported by Elliott et al. (2013). Although the confidence intervals mostly overlapped, pre-post effects varied significantly across type of HEP (Q_m = 15.8; p < .001), with the effect for EFT significantly larger (k = 8; ES = 1.49; 95% CI [1.17, 1.81]) than for supportive treatments (k = 9; ES = .62; 95% CI [.37, .88]). There was also a large effect for other HEPs (ES = 1.25; k = 5; 95% CI [.74, 1.76]), while gestalt/psychodrama (ES = .78; k = 4; 95% CI [.46, 1.10]) and PCT (k = 4; ES = .82; 95% CI [.26, 1.39]) fell in between. In terms of client anxiety subpopulations, the most promising applications for HEPs appear to be PTSD (ES = 1.04; k =10; 95% CI [.75, 1.34]), social anxiety (ES = 1.20; k = 4; 95% CI [.54, 1.87]), and GAD (ES = 1.48; k = 2; 95% CI [.2, 2.77]). We found substantially smaller effects for mixed anxiety populations (ES = .62; k = 7; 95% CI [.36, .88]) and medically-related anxiety (ES = .38; k = 3; 95% CI [.09, .66]).

Controlled Effects

There were only three controlled studies in our dataset (n = 112 clients in HEPs; 113 participants in no treatment conditions) drawn from a range of HEPs and client anxiety subpopulations. The mean-controlled effect was large: .93 (95% CI [.21, 1.66]), the same as the uncontrolled pre-post effect and substantially larger than the controlled effect of .5 reported by Elliott et al. (2013).

Comparative Effects

Comparative studies with anxious client populations were carried out in 13 studies (n = 566 clients in HEPs vs. 607 clients in nonHEPs). Six of these studies addressed PTSD. All had high internal validity and used modern RCT designs. The great majority of these were of supportive-nondirective therapy vs. CBT (11 out of 13 studies) with a negative researcher allegiance (10 out of 13 studies). Thus, it is not surprising that the overall mean comparative effect was negative and fairly homogeneous (ES = -.36; 95% CI [-.59, -.13]; $Q = 10.2$, $p < .01$). Five of the 13 comparative effects favored CBT by more than .4 sd, the cut-off we are using defining superior effectiveness in clinical settings. Of the six specific client population clusters we are reviewing for comparative effects in this chapter, HEPs fared most poorly with anxiety problems (this was also case in our 2013 review). The confounding of CBT with negative researcher allegiance made it impossible to run allegiance-corrected analyses. Digging into the data, it appears that the source of this negative effect is studies on *post-traumatic stress difficulties*, which we included here in spite of recent changes in DSM-5 because of the prominent place of anxiety in its presentation. In fact, the effect for CBT vs supportive-nondirective therapy for PTSD is quite large: -.68 ($k = 6$; 95% CI [-1.05, -.31]). In complete contrast are the results for medically-related anxiety, the second most common client anxiety presentation in our dataset, where we found equivalence (ES = -.03; $k = 4$; 95% CI [-.19, .14]; $Q = 1.9$, NS) in a set of four studies, all on supportive-nondirective HEP vs either CBT or treatment as usual (two studies each). Based on this, we provisionally conclude that clients seen in supportive-nondirective approaches to PTSD would probably be better served by CBT.

However, this conclusion says nothing about promising HEPs for post trauma difficulties, including EFT for complex trauma (Paivio et al., 2010) and a closely related form of gestalt therapy referred to as dialogical exposure therapy (Butollo et al., 2016). To date, there have been no studies directly comparing CBT to these more recent process-guiding HEPs. The best we could do here is to compare pre-post effect sizes for the six CBT/PTSD studies in our dataset (ES = 1.81; 95% CI [1.26, 2.37]) to the pre-post effects for the ten HEP/PTSD studies included here (ES = 1.04; $k = 10$; 95% CI .75 to 1.34]). Clearly research directly comparing these two promising approaches to PTSD and other anxiety difficulties is urgently needed.

Conclusions

Applying the adaption of the Chambless and Hollon (1998) criteria used in our previous review to specific types of anxiety difficulty, we found very large pre-post effects across multiple studies of HEPs for generalized anxiety (Brenes et al., 2015; Timulak et al., 2017), social anxiety (Elliott et al., 2018; Shahar et al., 2017), and PTSD (Butollo et al., 2016; Ehlers et al., 2014; Foa et al., 2013; Paivio et al., 2010). Thus, we conclude that the application of HEPs for these kinds of anxiety difficulties, especially EFT and newer process-guiding HEPs such as dialogical exposure therapy (e.g., Butollo et al) meet Chambless and Hollon's (1998) criteria as *possibly efficacious*, while also suggesting that CBT may be more *specific and efficacious* for PTSD when compared to supportive-nondirective therapy. As we concluded in our previous review, the apparent CBT advantage with PTSD is likely due to two possible factors: First, researcher allegiance effects were operating, and so pervasive that we were unable to control for

them statistically here. In addition, it now seems likely that anxiety difficulties may respond somewhat better to more structured, process guiding approaches including in session psychoeducation and structured therapeutic tasks such as empty chair work that share something in common with exposure work in CBT, as opposed to the predominantly nondirective forms of HEPs that have so far been studied.

A surprising result to have emerged from this set of anxiety studies came out of the studies of medically-related anxiety, such as fear of disease progression or recurrence. We were surprised to find reliable statistical equivalence between supportive-nondirective HEPs and CBT or treatment as usual, in spite of negative researcher allegiance and minimal treatment development. In our view, this is a particularly promising area for further HEP treatment development and research, especially with the application of a broader range of HEPs such as EFT. (For an example, see Elliott et al., 2014.)

In our clinical experience, clients with significant anxiety difficulties frequently have a problem with the lack of structure in purely nondirective therapies, often asking directly for expert guidance. For the past ten years the authors of this chapter have been involved in research on the effectiveness of EFT with generalized anxiety (Watson, Timulak) and social anxiety (Elliott, Shahar). For now, our advice for humanistic-experiential therapists is to discuss the issue with clients, to consider adding process guiding elements to their therapy, and to provide information about the role of trauma or emotional processes in anxiety difficulties (e.g., Wolfe & Sigl, 1998).

Coping with Chronic Medical Conditions

Pre-post Effects

The use of HEPs to help clients coping with chronic or life-threatening medical illnesses has continued to burgeon, with the total number of studies having doubled since our 2013 review. Our current sample turned up 28 new studies over the past 10 years (n = 1210 clients); in 2013 we reported on 29 studies (n = 1145 clients). Intervention with a broad range of medical conditions has now been investigated, the most common being cancer, both early stage/remitted (8 studies; e.g., Carlson et al., 2017) and late stage/metastatic (4 studies. e.g., Breitbart et al., 2015). Others include autoimmune disorders such as MS and rheumatoid arthritis (3 studies; e.g., Herschbach et al., 2010) and early dementia (i.e., executive dysfunction, cognitive impairment; 3 studies: e.g., Kiosses et al., 2015); the meta-analysis also includes two studies each for gastrointestinal problems (IBS, obesity; e.g., Compare et al., 2013b), pain, including ME (myalgic encephalopathy; e.g., Ward & Hogan, 2009), surgery patients (heart and hip fracture; e.g., Gambatesa et al., 2013), and infertility (e.g., Terzioğlu & Özkan, 2018). Of the studies, 15 (53%) involved group formats (e.g., Manne et al., 2016). Fifteen were also carried out by researchers with a negative researcher allegiance, and ten (36%) utilized treatments rated as non bona fide.

During the same period the nature of the HEPs being studied has shifted. Ten years ago, the most common form of HEP studied was supportive-expressive group therapy, an existential-experiential treatment developed by Spiegel et al., (1981) and the subject of 12 studies. In the current review, this approach was the subject of five studies, usually as a foil for a newer treatment, such as meaning-centered group therapy, a directive form of existential therapy. In its place we found that more than half of the identified studies used supportive-nondirective therapy (16 studies). In addition, person-centered therapy was examined in three studies, and EFT in two studies.

The overall weighted mean pre-post effect size across the 28 samples for which pre-post effects could be calculated was medium in size but highly inconsistent (ES = .70, 95% CI [.47, .92]; Q = 177.5, p < .01; I^2 = 85%). Statistically significant pre-post effects (ES), in descending order of size, were found for six kinds of medical condition: gastro-intestinal problems/obesity (1.53; k = 2; 95% CI [1.03, 2.03]), early dementia (1.37; k = 2; 95% CI [1.13, 1.60]), infertility (1.27; k = 2; 95% CI [.7, 1.84]), pain/ME (.60; k = 2; 95% CI [13, 1.07]), early stage cancer (.37; k = 8; 95% CI [.20, .55]), and autoimmune conditions/HIV (.26; k = 3; 95% CI [.03, .50]), Three other conditions were also represented by two or more studies, but were not significantly greater than zero: patients preparing for or recovering from surgery (1.06; k = 2; 95% CI [-.18, 2.36]), metastatic/late stage cancer (.78; k = 4; 95% CI [-.07, 1.62), and diabetes (.12; k = 2; 95% CI [-.87, 1.11]).

In terms of type of HEP, we found the largest pre-post effects for active, process guiding approaches including EFT (couples and individual) or psychodrama (ES = 1.78; k = 3; 95% CI [1.45, 2.11]; Q = .35, ns). Although the three studies (Compare et al., 2013; McLean et al., 2013; Terzioğlu & Özkan, 2018) in this subset involved different modes of delivery (structured treatment program, couples' sessions, group work) and diverse client populations (obesity with binge eating disorder, metastatic cancer, and infertility), the effect sizes were quite consistent. Quite substantial effects were also found for person-centered therapy (ES = .90; k = 3; 95% CI [.12, 1.67]); while smaller effects were found for supportive-nondirective therapy (ES = .60; k = 16; 95% CI [.30, .89]) and supportive-expressive group therapy (ES = .4; k = 5; 95% CI [.11, .65]; Q = 8.6, ns; I^2 = 53%).

Group formats were used frequently with medically-related presentations, but produced slightly (but not statistically significant) smaller effects (ES = .52; k = 15; 95% CI [.28, .77]) than individual treatment (ES = .86; k = 11; 95% CI [.47, 1.25]).

Controlled Effects

There were five controlled studies (e.g. van der Spek et al., 2017) versus no treatment/wait list, on diverse client populations of primarily older adults (early stage or remitted cancer, heart surgery patients, HIV, ME). There were 179 clients in HEP conditions and 213 participants in no treatment or waitlist control groups. Overall, these studies showed a highly consistent medium effect size of .48 (95% CI [.27, .69]; Q = 3.8, ns; I^2 = 0%), a value very similar to that reported by Elliott et al (2013): .53 *SD*. Three of the studies used some form of supportive-nondirective therapy.

Comparative Effects

There were 21 comparative studies, including 26 comparisons to non-HEPs. All but two comparisons were randomized (88%) and there was a mixture of bona fide (54%) and non bona fide (46%) HEPs. The most common HEPs were supportive-nondirective treatments (16 comparisons; e.g., Szigethy et al., 2014), PCT (9 comparisons), and supportive-expressive groups (5 comparisons; e.g., Ho et al., 2016). Also represented were EFT (3 comparisons; e.g., Compare et al., 2013) and person-centered therapy (2 studies; Manne et al., 2016). HEPs were most often applied to helping clients cope with cancer early/remitted (9 comparisons, e.g. Carlson et al., 2013); also represented by three comparisons each were advanced/metastatic cancer (McLean et al., 2013), autoimmune diseases (e.g., Moss-Morris et al., 2013), gastro-intestinal conditions/obesity (e.g., Szigethy et al., 2014), and early dementia (e.g., Arean et al., 2010). The most common non-HEP comparison treatments were CBT (12 studies; e.g., Wei et al., 2018) and treatment as usual (6 studies, e.g., Herschbach et al., 2010a). Researcher allegiances substantially favored nonHEPS, mostly CBT (con: 62%).

The overall comparative effect was a highly heterogeneous equivalence finding (ES_w = -.08; 95% CI [-.27, .10]; Q = 139.7, p < .01; I^2 = 82%). (In the previous meta-analysis, the comparative effect was also an equivalence result: -.01 but was much more consistent.) Five comparisons substantially (> .4) favored non-HEPs therapies, two of these from the same study (Breitbart et al, 2010; Kiosses et al., 2010; Koszycki et al., 2012; Rief et al., 2017); two comparisons substantially (>1.80) favored HEPs (Gambatesa et al., 2013; McLean et al., 2013). Nineteen effects were within .4 of each other.

Supportive-nondirective treatment, the most common HEP condition studied, was also the least effective when compared to other treatments (ES = -33; k = 16; 95% CI [-.52, -.15]). The combination of all the other HEPs (person-centered, EFT and supportive-expressive group therapy) was significantly more effective when compared to other treatments (ES = .38; k = 10; 95% CI [.04, .71]). HEPs did best when compared to mental health treatment as usual conditions (often psychoeducation, e.g., Carlson et al., 2013): ES = .66 (k = 6; 95% CI [.06, 1.25]). They did significantly less well when compared to CBT (e.g., Kiosses et al., 2010), where we found a comparative effect of -.22 (k = 12; 95% CI [-.4, -.03]), or when compared to other psychological treatments (most often meaning-centered group therapy, e.g., van der Spek et al., 2017; ES = -.31; k = 8; 95% CI [-.61, -.00]). Finally, we compared CBT to supportive-nondirective therapy, and found that CBT was equivocally more effective (ES = -.30; k = 10; 95% CI [-.49, -.11]; Q = 21.7, p < .01; I^2 = 58%).

In contrast to Elliott et al. (2013), we did not find clear differences between different medical conditions. However, the strongest comparative effects were coping with cancer (either early or late stage, e.g., Carlson et al., 2017), where ES was .05 (k = 12; 95% CI [-.17, .27]), an equivalence finding. Grouping all the rest of the disparate medical conditions together, we obtained an overall equivocally worse comparative effect of –.21 (k = 14; 95% CI [-.50, .08]).

Researcher allegiance proved to be a very strong predictor of comparative effect size; the meta-regression r was .59 (p < .01). Positive researcher allegiance was associated strongly with positive comparative effects (ES = .54; k = 8; 95% CI [12, .96]) while negative researcher allegiance was associated with moderately negative comparative effects (ES = -.34; k = 16; 95% CI [-.51, -.16]).

Conclusions

Given the diversity of medical conditions and treatments studies, it is difficult to apply the Chambless and Hollon (1998) criteria to this set of studies. Nevertheless, from these data, we can conclude that in working with clients coping with a range of medical problems: (1) CBT appears to be equivocally more effective than supportive-nondirective therapy; and (2) mainstream HEPs such as person-centered, EFT and supportive-expressive group therapy appear to be *efficacious* treatments for helping this population of clients, based on (a) their substantial pre-post effects, (b) their superiority to no treatment control conditions; and (c) their greater effectiveness than nonHEP treatments. These optimistic recommendations need to be tempered by several cautions: First, strong researcher allegiance effects (on both sides) continue to compromise findings, along with the use of non bona fide versions of HEPs. Second, there are still very few head-to-head comparisons between CBT and bona fide, standard HEPs (we counted two in our sample of studies), which makes it difficult to draw clear conclusions. Third, except for cancer, there are only a few studies for each kind of medical condition that has been studied. As we concluded in our previous review, this continues to be a highly promising area of the development of theory and practice for HEPs. However, much more research is needed.

Psychosis

> In our 2013 review, we wrote:
>
> The use of HEPs for clients diagnosed with psychosis, including schizophrenia, has become controversial, particularly in the United Kingdom, where the latest version of the Department of Health's treatment guidelines (National Collaborating Centre for Mental Health [NICE], 2010) effectively banned the practice via the following negative recommendation: "Do not routinely offer counselling and supportive psychotherapy (as specific interventions) to people with schizophrenia". (Elliott et al., 2013, p. 508)

This proclamation is still on the NICE website (see guideline 1.4.4.6 at https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations#care-across-all-phases). When first implemented in 2009, the prohibition on the use of counselling and supportive psychotherapy had a severely damaging effect on the provision of mental health care to individuals living with psychotic processes, wiping out a long-standing tradition of offering person-centered counseling to this client population (documented by Traynor et al., 2011), and cutting off development of promising newer practices such as pre-therapy contact work for restoring psychological contact with clients in psychotic states (see Dekeyser et al., 2008, for a review).

In our previous review, we also reported our re-analysis of the evidence NICE had used to ban supportive therapy for psychosis:

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

We then went on to report the results of our own small meta-analysis of six studies (including 5 RCTs): Large pre-post effects (ES = 1.08; 95% CI [.51, 1.65]) and greater change in HEPs than nonHEPs (ES_w = .39; 95% CI [.10, .69).

Pre-post Effects

Given the controversy and tantalizing nature of our previous results, we were naturally curious (and more than a little apprehensive) to see the results of another ten years of research on the use of HEPs with clients with psychotic processes. Our current meta-analysis dataset does contain pre-post effects for five studies (all RCTs), including a total of 200 clients. These clients were either diagnosed with schizophrenia (2 studies; e.g., Martin et al., 2016) or showed early signs of psychosis (3 studies; e.g., Stain et al., 2016). The HEPs they were seen in consisted of either supportive-nondirective therapy (3 studies; e.g. Shi et al. 2017) or bodily-expressive movement therapy (2 studies, e.g., Priebe et al., 2016); the most common comparison nonHEP used in these studies was CBT (two studies, e.g., Addington et al., 2011); clients were seen in

either individual (3 studies; Shi et al., 2017) or group (2 studies; e.g., Martin et al., 2016) modalities.

The weighted pre-post effect size for these five studies was .72 (95% CI [.21, 1.23]; Q = 16.3, $p < .01$; $I^2 = 75\%$). Although uncontrolled and highly heterogenous, these effects nevertheless demonstrate moderate to large pre-post effect sizes with this chronic and severely distressed clinical population. Consistent with effects throughout the current meta-analysis, this result is .36 *SD* smaller than the value of 1.08 we reported in 2013; however, this value is only a little less than the review-wide pre-post bench mark of .86 *SD* (see bottom row in Table 14.4), not surprising for what is considered to be a challenging client population. There were two subclusters of rather different studies, the contrast between which tells us a lot about the politics and practicalities of contemporary psychotherapy outcome research: On the one hand, two studies by pro-HEP researchers (Martin et al., 2016; Priebe et al., 2016) tested a new, bona fide group-based body-movement expressive therapy with populations of clients with long-standing psychotic conditions (diagnosed with schizophrenia); this new body-oriented HEP was compared to medication (Martin et al, 2016) and to a pilates exercise control condition (Priebe et al., 2016). The weighted mean pre-post effect for the HEP body therapy was small but highly consistent: .34 (k = 2; 95% CI [.11, .56]; Q = .2, ns: $I^2 = 0$). On the other hand, there were three studies carried out with populations judged to be at high risk for developing psychosis because of the emergence of mild psychotic symptoms. In all three studies, clients in the HEP condition received individual supportive-nondirective therapy as a control condition for new individual treatment being advocated by the researchers: new forms of CBT in two instances (Addington et al., 2011; Stain et al., 2016) and a new systemic treatment in the other study (Shi et al., 2017). In two of these studies (Shi et al., 2017; Stain et al., 2016), the HEP was judged by two raters to have failed Wampold et al.'s (1997) test for bona fideness. Nevertheless, for these three studies, the pre-post HEP effect size was very large: 1.05 (95% CI [.13, 1.98]; Q = 8.4, $p < .05$; I^2 = 76%).

Comparative Effects

Although there were no studies comparing an HEP to a no-treatment or wait-list control condition, we did locate six comparative treatment RCTs; 265 clients were seen in HEPs and 253 in nonHEPs, bringing the total number of clients to 518, more than three times the size the total sample reviewed by Elliott et al. (2013). To the five pre-post studies reviewed above, we were able to add a sixth (Bechdolf et al., 2012), another negative researcher allegiance study comparing a non bona fide supportive-nondirective treatment to a new form of mostly individual cognitive remediation-based CBT aimed at preventing individuals with prodromal mild psychotic symptoms from transitioning into full psychosis. (Because this study used only survival analyses we were unable to calculate a valid pre-post effect, but were able to compare post-therapy rates of transition to psychosis.)

The mean weighted, highly heterogenous comparative effect size across the six studies was .15 (95% CI [-.25, .55]; Q = 19.6, $p < .01$; $I^2 = 74\%$), which can be interpreted as indicating that HEPs are trivially but equivocally more effective that nonHEPs in psychological intervention with clients on the psychotic spectrum. The six comparative effects included one that favored CBT over supportive-nondirective (Bechdolf et al., 2012) and two that favored an HEP (body movement therapy: Martin et al., 2016; or nondirective listening: Stain et al., 2016) over standard treatments (medication or CBT respectively); the other three effects were in the neutral zone (between -.4 and +.4). We ran the same subgroup analyses of comparative effects as we had for pre-post effects. The CBT-vs.-supportive-nondirective-for-high-risk-prodromal-

psychosis cluster of studies produced a moderately heterogenous mean weighted comparative effect of -.02 (k = 4; 95% CI [-.5, .47]; Q = 7.5, ns; I^2 = 60%). This result is probably best described as "equivocally equivalent": the value is near zero but the confidence interval wide enough to encompass all three critical values (-.4, 0, and +.4). The comparative effect size for the expressive-body-movement-therapy-vs-medication/exercise cluster was .45 (k = 2; 95% CI [-.52, 1.41]; Q = 8.8, p < .01; I^2 = 89%), a result than can be described as "equivocally better" because of extremely high heterogeneity and a very wide confidence interval.

Conclusions

Probably the safest thing to say about these results is that more research is needed, except that our results here replicate the results we found in our previous meta-analysis. Thus, we conclude that for psychosis, treatment guidelines (such the NICE guidelines in the UK) that unquestioningly recommend CBT over HEPs are out of date and are hampering care for an important and vulnerable client population. We have now shown consistent results from two separate small meta-analyses that indicate the following: (1) When clients with a range of psychotic processes are seen in HEPs (whether these be nondirective or process-guiding), they generally show large pre-post improvement. (2) Those improvements are at a minimum on par with improvements seen in clients offered CBT (and possibly other nonHEPs), and in some cases have been found to be superior to nonHEPS, even under adverse conditions of negative researcher allegiance and when non bona fide versions of supportive nondirective therapy are used.

Finally, we conclude that, based on existing evidence, HEPs appear to be, in Chambless and Hollon's (1998) terms, *efficacious and specific,* having been shown to be at equivalent to and in some case superior to another established treatment (CBT). In other words, they are supported by enough evidence to make them front-line treatments. In a way, this conclusion is confirmed by recent moves in CBT toward more person- or mindfulness-based forms of CBT for schizophrenia (e.g., Chadwick, 2019).

Habitual Self-Damaging Activities

Recurrent self-damaging activities such as substance misuse and eating difficulties are the subject of an emerging body of evidence using a wide variety of HEPs. Most of these studies are on motivational interviewing (MI), which was developed by Miller in the 1980s as a person-centered humanistic alternative to behavioral approaches to alcohol abuse (Miller & Moyers, 2017). MI has been the subject of hundreds of RCTs, and in our initial search we found 183 possible MI outcome studies published between 2008 and 2018. Given the limits of our available resources and time as well as the existence of a large number of systematic reviews and meta-analyses (PubMed listed 184 as of 15 April 2020, 164 of which were published during our review period), we have decided to omit this HEP from our meta-analysis. The most recent general quantitative meta-analysis of MI for the wide range of self-damaging activities is Lundahl et al.'s (2010) review (k = 119), which reported small-sized but consistent comparative effects against waitlist or treatment as usual control groups (Hedges' g = .28; k = 88) and no difference (i.e., equivalence) results against specific, active treatments such as CBT or 12-step programs (g = .09; k = 39).

In contrast, the past ten years has seen systematic reviews and meta-analyses of many specific applications of MI. One collection of such reviews can be found in Arkowitz et al.'s (2015) survey of applications of MI to a wide range of psychological problems, which range across all of the different client populations reviewed here. In an attempt to integrate these

disparate literatures, DeClemente et al., (2017) carried out a qualitative systematic review of reviews of the application of MI to substance misuse and gambling, identifying 34 review articles. They concluded that the strongest evidence was for MI for alcohol, tobacco and marijuana use problems, with some evidence supporting its use with gambling problems, and insufficient evidence for methamphetamine and opiate use difficulties. It is worth noting that the robustness of MI effects is all the more impressive given that it is a brief intervention typically of two to four sessions.

Pre-post Effects

In our current review, we identified 8 non-MI studies (total $n = 248$) of clients focusing on recurrent, self-damaging activities, most commonly eating difficulties (4 studies; e.g., Compare et al., 2013) but also four studies on a range of other self-damaging activities such as substance misuse (2 studies; e.g., Kay-Lambkin et al., 2011), self-injury (Cottraux et al., 2009) and oppositional/defiant behavior (Singal, 2009). A wide range of HEPs feature in these studies, with 2 each on person-centered (e.g. Schützmann et al., 2010), supportive-nondirective (e.g., Magidson et al., 2011), EFT (e.g., Wnuk et al., 2015), and psychodrama/expressive therapy (e.g., Boerhout et al., 2016). Half of the studies studied individual therapy, the other half group therapy. All HEPs in these studies were rated as bona fide and all except Compare et al. (2013) were RCTs.

The weighted pre-post effect was large and highly heterogenous: .99 ($k = 8$; 95% CI [.41, 1.58]; $Q = 59.8$, $p < .01$; $I^2 = 88\%$), but substantially larger than the .65 effect obtained in our 2013 review. Effects were much larger for eating difficulties (ES = 1.49; $k = 4$; 95% CI [.82, 2.16]) than for the collection of other self-damaging activities (ES = .41; $k = 4$; 95% CI [.14, .69]), a difference that was statistically significant. In terms of type of HEP, the largest effects were for person-centered (ES = 1.23; $k = 2$; 95% CI [-.79, 3.25]) and EFT (ES = 1.23; $k = 2$; 95% CI [.00, 2.46]), both with very large confidence intervals. Pre-post effects about .5 *SD* smaller were obtained for supportive-nondirective therapy (ES = .72; $k = 2$; 95% CI [.27, 1.18]) and psychodrama/expressive (ES = .79; $k = 2$; 95% CI [.20, 1.37]). We found little or no difference in pre-post effect sizes for individual vs. group formats.

Controlled and Comparative Effects

The only controlled study was Singal's (2009) study on psychodrama for adolescents with oppositional defiant difficulties, which found no difference between the HEP and a waitlist control group.

In terms of comparative studies, we found six studies (8 comparisons of clients; HEPs: $n = 221$; nonHEPs: $n = 365$), which involved a range of HEPs (supportive and other HEP were most common) compared to other treatments, most often CBT (6 studies). The weighted comparative effect was .07 (95% CI [-.24, .38]; $Q = 27.2$, $p < .01$; $I^2 = 74\%$), identical to what we found in out 2013 review, and a statistically-significant equivalence result, indicating that HEPs and non-HEPs for habitual self-damaging difficulties were equivalent in effectiveness, although with high heterogeneity. One study favored the nonHEP by more than .4: Cottraux et al. (2009) compared supportive-nondirective therapy to CBT for self-harm in clients with borderline diagnoses (referred to as "fragile process" by HEP therapists). Two studies favored HEPs by more than .4: Boerhout et al. (2018) compared a brief 6-session psychomotor therapy (an expressive, body-oriented treatment) to supportive contact (a treatment as usual) for clients with a range of eating difficulties; and Schützmann et al., (2010) compared person-centered therapy to guided behavioral self-help for clients diagnosed with bulimia. The other five studies fell into the neutral zone.

The comparisons/studies again fell into two clusters, with distinctly different results: The first cluster consisted of four comparisons from three studies (Boerhout et al., 2016; Compare et al., 2013; Schützmann et al., 2010) focused on eating difficulties, used a process guiding HEP (i.e., EFT, psychomotor therapy, and a more structured person-centered therapy), generally compared the HEP to a non-CBT intervention (except in one case), and were carried out by researchers with a pro-HEP researcher allegiance. For these studies, the weighted mean comparative effect was .44 (95% CI [-.06, .94]; $Q = 10.7$, $p < .05$; $I^2 = 72\%$), a strong effect favoring HEPs but highly heterogenous and not significantly different from zero. The second cluster consisted of the other four comparisons from three studies with negative researcher allegiance (Cottraux et al., 2009; Kay-Lambkin et al., 2011; Magidson et al., 2011). This cluster addressed the application of CBT to forms of self-harm (substance misuse, self-injury), and used a non-process-guiding HEP (supportive-nondirective or person-centered therapy) as a control condition. The comparative effect was in the equivocally negative range with low heterogeneity ($ES_w = -.25$; 95% CI [-.50, .00]; $Q = 4.7$, ns; $I^2 = 36\%$).

Unsurprisingly, we found a very strong researcher allegiance operating in these studies, with a weighted meta-regression correlation of -.84 between researcher allegiance and comparative effect size. Comparisons with a pro-HEP researcher allegiance returned a weighted mean comparative effect of .63 ($k = 3$; 95% CI [.21, 1.04]); while for comparisons with an anti-HEP researcher allegiance the effect was -.23 (k = 5; 95% CI [-.42, -.03]).

Conclusions

Overall, the preponderance of the evidence reviewed here, including both pre-post and comparative treatment lines of evidence, indicates that process-guiding HEPs are *possibly efficacious* treatments for eating difficulties. They have been shown to be either equivalent to another treatment (Boerhout et al., 2016; Schützmann et al., 2010) or equivalent to an already established treatment, CBT (Compare et al., 2013). This is a turn-around from our previous meta-analysis, when the evidence for the application of HEPs to eating difficulties was weak and just emerging, and represents the recent development of robust HEP approaches for this challenging client population. On the other hand, substance misuse difficulties fared less well in this review than in the previous one (Elliott et al., 2013).

It is our continuing view that HEPs are likely to be useful and effective approaches for use with a range of self-damaging activities, including in particular substance misuse and eating difficulties, and we note the relative neglect of these difficulties by HEP practitioners and researchers. Actually, this statement is not completely accurate, indicating a common prejudice among HEP researchers, theoreticians and practitioners that motivational interviewing is not really an HEP, probably because, for political reasons it has been widely portrayed as a form of CBT. It is our view that MI, when properly practiced within "the spirit of MI" (Miller & Rollnick 2012) is just another one of the many tribes or suborientations within the broader HEP approach. HEP practitioners do themselves, the MI community, and their clients a disservice by continuing to ignore the many contributions of MI.

Other Client Populations

The six client populations that we have reviewed above accounted for about 85% of the HEP outcome studies we identified. However, 21 studies (including 22 separate samples of clients; $n = 3971$) did not fit readily into any one of these six client populations. These studies fell into several groups, the largest of which were studies of general or mixed client populations, roughly corresponding to what used to be referred to as "neurosis" (11 studies, 12 samples of

clients; Barkham & Saxon, 2018, being the largest). Other groupings included: (a) nonclinical populations with only minor levels of distress (3 studies; i.e., masters students, nurses, psychological helpers; e.g., Fillion et al., 2009); (b) prisoners and other individuals with violent or antisocial processes (2 studies; e.g., Ford et al., 2013); and (c) various other client populations (5 studies: borderline personality disorder, parents, divorced individuals, people with autism). Nine of these studies had secondary foci such as depression or anxiety (e.g., Barkham & Saxon, 2018), which also led us to include them in those client populations, but thirteen were included nowhere else. Although the heterogeneity of these populations meant it would be unlikely that we would be able to come to general conclusions, we include them here for the sake of completeness, and will primarily focus on the separate subgroups.

Pre-post Effects

Overall, the weighted mean pre-post effect for this group of studies was .87 (k = 22; 95% CI [.68, 1.07]; Q = 123.2. p < .01; I^2 = 83%), with high heterogeneity, but very similar to the whole sample benchmark of .87 sd. The effect size for the thirteen studies not included elsewhere was somewhat higher, at 1.06 (95% CI [.55, 1.21]). All of this subgroup of studies used bona fide HEPs; ten were RCTs.

For the largest group of these studies, which used general or mixed client populations (approximating the old "neurotic" category), the mean pre-post effect was 1.03 (k = 12; 95% CI [.78, 1.28]), slightly above the overall benchmark confidence interval for the whole sample (.74 to .98). Clients from nonclinical populations showed relatively small amounts of pre-post change (ES = .41; k = 3; 95% CI [.08, .75]), as did clients in the various other populations grouping (ES = .58; k =5; 95% CI [.22, .94]).

Controlled Effects

Controlled studies, in which HEPs for other client populations were compared to no treatment or waitlist conditions, produced nine comparisons (HEP n = 307; control n = 424), with an overall mean ES of 1.02 (95% CI [.41, 1.36]; Q = 105.0; p < .01; I^2 = 92%), a large but highly heterogenous effect. (For the 5 studies only in this subsample, controlled ES = .95; 95% CI [-.10, 2.0)]. All comparisons used bona fide HEPs and had a pro-HEP researcher allegiance. All but two (Leung & Khor, 2017; Pascual-Leone et al., 2011) were RCTs (ES = 1.25; 95% CI [.37, 2.13]). There was small cluster of studies worth noting here: Three UK-based studies examined school-based humanistic counselling for young people, generally positioned as broadly person-centered (Cooper et al., 2010; McArthur et al., 2013; Pybis et al., 2015), comparing them to a waitlist control group. For these studies the controlled effect was medium-sized: .6 (95% CI [.09, 1.12]). Another apparent cluster of two studies both used process-guiding HEPs for aggression but involved such different populations and research designs and produced such divergent results that in our view no sound conclusion can be drawn (e.g., Karataş & Gokçakan, 2009; Pascual-Leone et al., 2011).

Comparative Effects

There were eight comparative studies in which HEPs were compared to other treatments, producing 11 comparisons (HEP n = 3187; nonHEP n = 6228). The overall mean weighted effect was -.19 (95% CI [-.39, .02]; Q = 24.2, p < .01; I^2 = 59%), which fell into the trivially worse range, but also met the criteria for statistical equivalence (see Table 14.3). In three comparisons (from 2 studies) CBT did better than HEP by more than the .4 standard (Cottraux et al., 2009; Marriott et al., 2009); the other eight comparisons fell into the neutral zone; there were no studies in which HEP did better than the nonHEP by at least .4 sd. A medium-sized researcher allegiance effect was operating in this data set (meta-regression r = -.36). All HEPs

were judged to be bona fide and six were RCTs. HEPs did slightly better in RCTs (ES = -.05; *k* = 6; 95% CI [-.33, .24]) than in nonrandomized studies (ES = -.31; *k* = 5; 95% CI [-.65, .03]), although the difference was not statistically significant. In nine of the eleven comparisons the HEP was either person-centered or supportive-nondirective. There were six general/mixed ("neurotic") population comparisons (4 from Marriott et al., 2009), with a comparative effect of -.22 (95% CI [-.61, .25), equivocally worse in comparison to a nonHEP, generally (in all but one case) either CBT or cognitive analytic therapy.

Qualitative Research on Humanistic-Experiential Psychotherapies

Because of its philosophical compatibility, researchers within the HEP tradition continue to favor qualitative research, including most importantly outcome studies (to complement the quantitative meta-analysis presented in the initial sections of this review), research change processes, and qualitative case study research.

Update on Qualitative Outcomes in Humanistic-Experiential Psychotherapies

The previous edition of this chapter reported on the qualitative meta-analysis conducted by Timulak and Creaner (2010) who analyzed qualitative descriptions by a total of 106 clients participating in a variety of HEPs. The results of that qualitative meta-analysis were summarized in eleven meta-categories of qualitative outcomes (e.g., healthier emotional processing, feeling empowered). For this chapter we carried out a cumulative review, updating Timulak and Creaner and finding a further nine studies reporting the views of another 71 clients on outcomes of HEPs (See Supplemental materials for more detail about the search and screening process.)

The findings of those studies were generally consistent with and helped elaborate the category system offered by Timulak and Creaner (2010; for more detail see Supplemental Table 14S-3). We found three main categories: *appreciating experiences of self*; *appreciating experience of self in relationship to others*; and *changed view of self/others*. In terms of second-level meta-categories, our analysis (in addition to fine-tuning the wording of original meta-categories), further stresses nuances of experiences regarding the self and interpersonal changes. There were four second-level meta-categories under the first main category (appreciating experiences of self): *smoother and healthier emotional experiencing*; *self-acceptance of vulnerability* (which included *appreciating vulnerability* and *experiencing self-compassion/self-acceptance/valuing self*); *mastery/resilience of problematic experiences* (which included *experience of resilience, feeling empowered*, and *mastering symptoms*); and *enjoying change in circumstances*. The second main category (*appreciating experience of self in relationship to others*) contained two meta-categories: *feeling supported* and *being different/healthier in interpersonal encounters*. The third main category (*changed view of self/others*) had two meta-categories under it: *self-insight and self-awareness*, and *changed view of others*.

Furthermore, two studies (McElvaney & Timulak, 2013 and Steinmann et al., 2017) offered interesting comparisons. McElvaney and Timulak's study looked at qualitative outcomes reported by primary care clients who quantitatively (as measured by pre-post CORE-OM) achieved successful vs. unsuccessful outcomes. Interestingly, there was a minimal difference in what these two groups reported as changes due to therapy. The only observable difference concerned increased awareness, which was more likely to be reported by clients with quantitatively poor outcomes. Although they reported increased awareness, it seemed to be an awareness of their problematic functioning. Steinmann et al.'s study looked at client reported outcomes in individual EFT vs. attachment-based family therapy for anger directed at a parent.

Although, clients in the two therapies reported roughly comparable outcomes, there were suggestions of some differences. In general, these differences were as might perhaps be expected with clients in individual EFT reporting more emotional processing and agency/individuation, and clients in attachment-based family therapy more likely to report changes for the better in their relationship with the parent.

In the previous edition of this chapter we noted the lack of studies on negative outcomes of HEPs. Although we identified a few more in this follow-up study, there was at times an overlap between negative outcomes and unhelpful/hindering experiences of therapy process, which will be reported on later in this chapter. Steinmann at al. (2017) reported the following negative outcomes: therapy increased levels of anger; therapy made the relationship with the target parent worse; and positive changes did not last. The issue of changes not lasting was also reported in Perren et al. (2009). These add to the other negative outcomes reported in the previous edition of this chapter, such as non-resolution of the presenting issues and increase in emotional restriction/avoidance.

Qualitative Process and Case Study Research on HEPs

Our search for qualitative HEP research also yielded several new studies focusing on helpful/unhelpful aspects of therapy, significant events studies, studies focusing on clients' in-session presentations, and case studies, some of which studied a particular theoretical conceptualization coming from the HEP tradition. While the picture of what clients find helpful in HEPs was quite clear in the previous edition of this chapter, we could now identify more studies that spoke to difficulties clients may experience in HEPs.

Helpful and Difficult Aspects of HEPs

Firstly, to summarize, many recent qualitative studies on HEPs documented the importance of clients feeling understood, listened to, supported, and validated by the therapist, (e.g., MacLeod & Elliott, 2014; MacLeod et al., 2012; McElvaney & Timulak, 2013; Smith et al., 2014; Sousa, 2018; Timulak et al., 2017). These findings also extend to a group format (Vassilopoulos & Brouzos, 2012). Studies also reported the client's agency, motivation to work and particular personal attributes as contributing critically to the success of therapy (e.g., Perren et al., 2009; Timulak et al., 2017). Similarly, important and already mentioned in the previous edition of this chapter was client-therapist co-construction of new awareness and meaning regarding their experience (e.g., Balmforth & Elliott, 2012; MacLeod & Elliott, 2014; McElvaney & Timulak, 2013; Smith et al., 2014; Sousa, 2018; Stephen et al., 2011; Watson et al., 2012). In the case of group therapy, this could also include learning from co-participants (Vassilopoulos & Brouzos, 2012).

Particularly relevant were in-session emotional experiences of attending to own needs, feeling free, or having a sense of empowerment (e.g., MacLeod et al., 2012; Stephen et al., 2011; Vassilopoulos & Brouzos, 2012; Watson et al., 2012), but also expressions of vulnerability (e.g., Steinmann et al., 2017). Again, in the group format this type of experience includes shared poignant experiences with other group members (Vassilopoulos & Brouzos, 2012). Some studies captured the importance of clients opening up to the therapist in therapy (e.g., Balmforth & Elliott, 2012; Stephen et al., 2011; Timulak et al., 2017) and/or co-participants (Vassilopoulos & Brouzos, 2012). This could be also a difficult experience for clients, but beneficial in the long run.

The processing of painful emotional experiences also appeared very important (e.g., MacLeod et al., 2012; Steinmann et al., 2017; Timulak et al., 2017). Clients in experientially

active therapies such as EFT reported that experiential work such as the use of empty chair dialogues played a major and meaningful role in therapy (e.g., MacLeod et al., 2012; Steinmann et al., 2017; Stiegler et al., 2018; Timulak et al., 2017). Clients could access particularly powerful adaptive emotional experiences such as the feeling of being cared for and loved by the self or other (even God – see MacLeod et al., 2012). This process was also reported as being particularly difficult but helpful in the long run (e.g., Stiegler et al., 2018; Timulak et al., 2017). Chair work could be demanding as enactments pushed clients outside their comfort zone (Stiegler et al. 2018), but also because they tended to bring up chronically painful emotions (Timulak et al., 2017). Experiential work also stimulated new awareness and recognition of the client's own agency (Steinmann et al., 2017; Stiegler et al., 2018) in certain experiences such as self-criticism (Stiegler et al. 2018).

Unhelpful Aspects of HEPs

In a small minority of cases, the experience could be difficult to the extent that clients did not see the benefit in it (Stiegler et al., 2018; Timulak et al., 2017). All of this points to the central role of evocative experiential exercises as used in process-guiding HEPs (e.g., EFT). While they are seen by clients as central to the main therapeutic work, they are also difficult to engage in and occasionally are not well tolerated (this may be in some respects similar to exposure in cognitive-behavioral therapy). The therapist's facilitative style and awareness of the client's potential fragility thus has to remain central when engaging in these powerful tasks.

Nevertheless, unhelpful aspects of therapy were sometimes reported as a part of negative or problematic outcomes of therapy. In the previous edition of this chapter, we mentioned a number of unhelpful aspects of therapy, for instance, non-resolution of presenting issue, feeling overwhelmed, disappointment over not being understood by the therapist, and fear of changing/increase in emotional restriction. Some of these also presented in our current search, including continuing symptoms (Timulak et al., 2017), finding experiential work overwhelming and being too exposing (Steinmann et al., 2017; Stiegler et al., 2018; Timulak et al., 2017), and misunderstandings in the therapeutic relationship (MacLeod et al. 2012). The current studies also reported as problematic shortness of therapy (MacLeod et al., 2012; Steinmann et al., 2017; Timulak et al., 2017), and the client not putting in enough work or holding back (MacLeod et al., 2012; Timulak et al., 2017).

Other Qualitative Studies

Apart from qualitative outcome studies and qualitative process studies focusing on helpful, difficult and unhelpful aspects of therapy, we located a number of other qualitative studies on HEPs. Some looked at therapists' experiences of therapy (e.g., Carrick, 2014). There were also studies using mixed methods approaches, such as task analysis, which has a long tradition particularly in EFT research (Greenberg, 2007). This method uses strategies that rely on an interpretive framework embedded in an HEP theory. For instance, Murphy et al. (2017) applied task analysis to explicate the therapist and client processes in worry dialogues as used in EFT for generalized anxiety.

In a theory-guided qualitative study, O'Brien et al. (2019) examined in-session presentations of clients with generalized anxiety disorder. They used EFT theory to illustrate that although clients were pre-occupied with apparently indiscriminate anxieties about what could happen in various situations, these anxieties were related to the underlying painful feelings of loneliness/loss, shame, and terror that those worried-about situations could bring. Narratively, the feared painful feelings were related to idiosyncratic client stories in which they had experienced those painful feelings in an unbearable manner.

Although not explicitly a theory-guided study, but nonetheless clearly embedded in EFT theory, Brennan et al. (2015) examined the perspectives of participants in an EFT group for patients with eating disorders. Perspectives were expressed in feedback forms and in clients' letters to their critic and eating disorder. The findings show how clients struggle with not being defined by their critic, how they recognize the destructive impact of the critic, but how they can also recognize its protective function. Clients also became aware of their needs in the face of such self-criticism and reported on the importance of self-assertion on behalf of those needs, all of this in the context of a group that offered an opportunity for learning from others' struggles with their own self-criticism. Another study (Toolan et al., 2019), embedded in EFT theory, examined the relationship between the worry process (in worry dialogues in EFT for generalized anxiety) and the self-critic process. Examination of recordings of worry dialogues showed that worries focus on potential situations that could trigger emotional vulnerabilities in the person, thus setting off a self-critical process.

Qualitative Case Studies

Empirical case study research has a rich tradition in the humanistic-experiential paradigm (see Elliott, 2002a; McLeod, 2010; Stiles, 2007). The previous edition of this chapter reviewed case studies establishing efficacy of a HEP therapy as well as theory-building case studies. The period since the last edition of this handbook again saw original contributions in this area. Several hermeneutic single case studies examined the efficacy of person-centered as well as EFT for conditions such as health anxiety (Smith et al., 2014) and social anxiety (MacLeod & Elliott, 2014; MacLeod et al., 2012; Stephen et al., 2011). These studies showed that these therapies can be effective with those conditions and that processing of painful emotions as well as relational validation provided by the therapist plays an important role in therapy.

Theory-building case studies looked also at extending the work of person-centered/experiential therapists to presentations or client populations not typically associated with these types of therapies. For example, Gunst and Vanhooren (2018) illustrated a powerful longing for connection in a client with an offender history. Such case studies also demonstrated their ability to shed light on theoretical aspects of humanistic therapies such as the reciprocal/mutual interaction between the relational conditions that both clients and therapists offer each other (Tickle & Murphy, 2014). As in the previous edition, we could also find at least one instance of an assimilation of problematic experiences case study, here used to examine therapeutic collaboration (Ribeiro et al., 2016).

Several studies (Dillon et al., 2018; McNally et al., 2014; Pascual-Leone et al., 2019) examined a theory of sequential emotional processing (Pascual-Leone & Greenberg, 2007; Pascual-Leone, 2018) that is becoming a central pillar of understanding the process of change in EFT and a range of other therapies. Some of those studies examined aspects of this theory, while others elaborated and built on the original formulation. The studies illustrated that in successful cases of EFT, clients move from an undifferentiated, global, symptomatic distress; through underlying core painful feelings of shame, fear and/or loneliness; to unmet needs; and eventually to a response to those unmet needs in the form of self-compassion and/or boundary setting healthy anger. This theoretical conceptualization has not only been developed within a humanistic tradition, but is very powerfully informing the therapeutic practice of EFT (Timulak & Pascual-Leone, 2015).

Qualitative Research on HEPs: Conclusions

Systematic qualitative research on HEPs has a long tradition. It is clearly a success story as perhaps none of the other therapeutic approaches have been influenced to such an extent by qualitative studies. Its contribution is well established in informing the development of these therapies (cf. Timulak et al., 2018). Nevertheless, it is also worth noting the lack of cultural (or even clinical) diversity in the current body of qualitative research on HEPs. It appears that future research of this type should further focus on more diverse client populations, as well as adverse experiences of clients in HEPs and how to overcome them. We see potential also in theoretically informed qualitative studies as these can further and deepen our understanding of therapeutic process and further inform development and training in HEPs.

Quantitative Process Research on Humanistic-Experiential Psychotherapy

Research on the process of change is foundational to HEP approaches, as research clinicians within this approach have tried to specify the therapist and client processes that contribute to successful outcomes. Historically the focus of this research agenda has been on general therapeutic relationship conditions or attitudes as delineated by Rogers (1957) and on client experiencing (Gendlin, 1981). This has evolved over time to a more differentiated focus on therapist interventions and techniques and client processes that are related to change in psychotherapy.

Process-Outcome Research on the Therapeutic Relationship

Since Rogers (1957) first articulated his hypothesis about the necessary and sufficient conditions of therapeutic change, much evidence has accumulated. Norcross and Lambert (2019) updated the reviews for the most recent edition of *Psychotherapy Relationships that Work.* They have provided up-to-date summaries of the broad base of evidence supporting the therapist relational conditions specified by Rogers, including chapters by Elliott et al. (2019) on empathy; Farber et al. (2019) on positive regard and affirmation; Kolden et al. (2019) on congruence/genuineness, and Flückiger et al. (2019) on the therapeutic alliance in adult psychotherapy generally. The Elliott et al. meta-analysis of the relation between therapist empathy and client outcome found a weighted mean r of .28 (equivalent to d = .58), only slightly lower than their 2011 analysis (r = .31; to d = .65). As for positive regard, Farber et al. found a mean r of .18 (d = .36), clearly lower than they reported in Farber et al (2011; r = .27; d = .56). Nevertheless, both have been shown to be robust, medium-sized predictors of client outcome. Finally, Kolden et al. (2019) reported the r for congruence/genuineness as .23 (d = .46). Thus, the effect for empathy has been more consistent and slightly larger than the effect for positive regard and congruence.

The research collected and meta-analyzed in the Norcross & Lambert (2019) review volume came from a broad range of therapies, mostly not from the HEP tradition. For example, only 14 out of 82 (17%) of the studies reviewed in Elliott et al.'s (2019) empathy-outcome meta-analysis focused on HEPs. The mean weighted correlation for these eight studies was .24, statistically significant, highly consistent (I^2 = 15%) and in line with the overall value of .28 for the entire sample of 82 studies. HEPs were grouped under "other treatments" in the Farber et al. (2019) and Kolden et al. (2019) reviews of positive regard and genuineness respectively, but appear to comprise only a tiny proportion the studies reviewed.

In any case, the links between outcome, therapist empathy, and the working alliance are some of the most strongly evidenced findings in the psychotherapy research literature (Elliott et al., 2019; Norcross & Lambert, 2019). This has been found across different therapeutic

approaches (Watson & Geller, 2005). As originally formulated, Rogers specified that therapists needed to convey the relational attitudes of acceptance, empathy, congruence and prizing, and these attitudes needed to be received by clients. In a recent study investigating the role of the therapeutic relationships on outcome, Murphy and Cramer (2014) found that client progress was better if both clients and therapists rated the relationship as improving over the course of therapy. Nevertheless, as we noted in earlier versions of this review, several methodological weaknesses have been identified in this body of quantitative process-outcome research on the impact of the relationship conditions on outcome. In an earlier, unsystematic review, Sachse and Elliott (2002) noted that the facilitative conditions did not yield consistent results for all clients and client problems, as some clients seem to benefit and others not. Other methodological problems include a failure to assess clients for incongruence (as originally proposed by Rogers, 1957); poor sampling methods; small sample sizes; different rating perspectives; inadequate levels of the therapeutic conditions; restricted range of measurement of the relationship conditions; possible nonlinear effects; low measurement reliability; third variable or reverse causation; and inconsistencies in the experience levels of the therapists (Elliott et al., 2019; Watson et al., 2010). Notwithstanding these methodological problems, the accumulated evidence to date points to a moderately strong relationship between the therapeutic conditions and outcome, although the relationship may be substantially more complex than initially thought. Chief among these complexities is the large degree of conceptual overlap between empathy, positive regard and genuineness; indeed, Elliott et al. (2019) recently concluded that these relationship variables are so deeply interwoven that it is a mistake to treat them as distinct and to study them independently of one another.

Relationship Variable Mediator and Moderator Research

Key among the failings of traditional process-outcome research therapist-offered relational conditions is the fact that they do not tell us what mediates the relation between therapist relational conditions and outcome (Elliott et al, 2019). To address this gap in the literature, Watson and colleagues have investigated the role of different mediating variables, including attachment insecurity and negative treatment of self, e.g. criticism, neglect, and self-silencing behaviors, on the empathy-outcome relationship (Watson et al., 2014). Watson et al investigated whether clients' self-reported experience of therapists' empathy contributed to changes in their attachment styles and treatment of self, after 16 weeks of psychotherapy for depression. There was a significant direct relationship between therapists' empathy and outcome and a significant indirect effect, showing that clients' perceptions of therapists' empathy was associated with significant improvement in attachment insecurity and significant decreases in negative self-treatment, including self-criticism and self-silencing, at the end of therapy as well as reductions on BDI, IIP, DAS and SCL-90-R, GSI, and increases on RSE. The findings suggest that clients' perception of their therapists as empathic is an important mechanism of change in psychotherapy that warrants ongoing investigation. These more recent studies continue to provide additional, more nuanced evidence and support for the role of the clients' experience of the therapeutic relationship in promoting positive outcomes in psychotherapy. In a later study, Malin & Pos (2015) continued to explore the impact of therapist empathy, the working alliance, and client emotional processing on client outcome. Using an observer measure of therapist expressed empathy in the first session, they found that therapists' empathy predicted outcome indirectly and was mediated by clients working alliance scores after the first session and the level of clients' emotional processing in the mid-phase of therapy.

Wong & Pos (2014) examined the relationships among client pre-treatment characteristics, clients' and therapists' interpersonal process in the first session and the working alliance after the first session in low and high alliance groups. Both clients' pre-therapy interpersonal problems as measured by the IIP and clients' in-session process as measured by SASB predicted clients' first session alliance scores. Clients who were more socially inhibited had significantly lower alliances scores after the first session, while greater self-disclosure predicted higher alliance scores after session 1. Moreover, clients in the low alliance group disclosed less during the second and third phase of the first session than those in the high alliance group. There were significantly more asserting and separating behaviors in the low alliance group than the high alliance one. Client disclosure significantly and uniquely predicted the bond sub-scale of the alliance, while social inhibition and client disclosure significantly predicted the goal sub-scale, although in opposite directions. Notably therapists' loving and approaching behaviors were higher in the high alliance group than the low alliance group. This study highlights the impact of client pre-treatment characteristics and mode of engagement from the point of initial contact on the formation of the alliance and therapist behaviors. We recommend more research like the studies we've reviewed in this section, to clarify on the role of moderator and mediator variables in the relationship between key HEP relationship variables and client outcome. (see also chapter 8 in this volume)

Research on Specific Therapeutic Tasks

As we noted in previous versions of this review, research on specific therapeutic tasks has been an important and useful line in HEP research for deepening our understanding of the steps necessary for facilitating client change in therapy.

Two-Chair Dialogue for Conflict Splits

There is a long tradition of research on the client change processes in the two-chair dialogue task in EFT and Gestalt therapies (e.g., Greenberg, 1979; Whelton & Greenberg; 2000). Shahar and colleagues (2012) examined the efficacy of two-chair dialogue task with nine clients who were judged to be self-critical. The intervention was associated with clients becoming significantly more compassionate and reassuring toward themselves, with significant reductions in self-criticism and symptoms of depression and anxiety, which were maintained over a 6-month follow-up period. More recently, Stiegler et al. (2018) used a multiple-baseline additive design to compare person-centered therapy (=baseline) to EFT chair work for depressed-anxious clients with self-critical processes; they found that two chair work was associated with greater reductions in client anxiety and depression.

Empty Chair Work for Unfinished Business

Earlier studies found the empty chair task to be more effective in resolving unfinished business than empathy using measures of both in-session process and session outcome (Greenberg & Foerster, 1996) and clients who resolved their unfinished business reported significantly greater improvement in symptom distress, interpersonal problems, target complaints, affiliation toward self, and degree of unfinished business (Greenberg & Malcolm, 2002). Following up on this line of research, Paivio et al.'s (2010) study compared two forms of EFT for trauma. In one condition ("imaginal confrontation"), clients were required to use empty chair work, that is, to speak directly to the perpetrator of their abuse or important nonprotective others in the empty chair. In the other condition ("empathic exploration"), clients instead spoke to the therapist *about* the perpetrator/nonprotective other. Clients in both forms of EFT showed substantial pre-post gains, with those in the empty chair work condition showing more pre-post

change; however, they also had a higher drop-out rate (20% versus 7%), suggesting that not all clients will respond positively to this highly evocative therapeutic task, and should not be forced to use it.

Interpersonal Forgiveness in Couples

Research on specific therapeutic tasks has occurred within the context of couples' therapy as well as individual therapy. Parallel task analytic studies have explored how forgiveness unfolds in EFT for couples (EFT-C), using cases where one member of the couple felt abandoned or betrayed by their partner (Johnson et al., 2001; Makinen & Johnson, 2006; Woldarsky Meneses, 2006; Woldarsky Meneses & Greenberg, 2011). The task analyses tracked the steps leading from markers of injury to forgiveness using videotapes of therapy sessions.

The earliest presentations of the resolution models from the two research teams had some notable differences. The early versions of Johnson et al. (2001; Makinen & Johnson, 2006) included the injured party requesting and receiving comfort and care from the injurer as central to the change process. In contrast, Woldarsky Meneses's model (2006; Woldarsky Meneses & Greenberg, 2011) described the injurer's expressions of shame about the injury and their apology as pulling for forgiveness from the injured party, without necessarily requiring comfort and care. Subsequent refinements of the Johnson et al. model have deemphasized the role of comfort and care for the injured (e.g., Zuccarini et al., 2013), bringing the two models into closer alignment about the central elements required for resolution: (a) First, the injured party expresses their hurt and the impact of the injury; (b) then the injurer offers non-defensive acceptance of responsibility for the emotional injury; (c) they express shame, remorse or empathic distress about the injury; (d) before offering a heartfelt apology. This is then followed by (e) the injured partner showing a shift in their view of the other and expresses forgiveness; and (f) after which the injurer expresses acceptance of the forgiveness, along with relief or contrition.

Woldarsky Meneses & Greenberg (2014) further related the in-session process during the interpersonal forgiveness task to outcome, based on data from 33 couples who received emotion-focused couples' therapy for an emotional injury (a betrayal; Greenberg et al., 2010). The results showed that expressed shame accounted for 33% of the outcome variance in posttherapy forgiveness; the addition of acceptance explained an additional 9%, while in-session forgiveness explained another 8%, with the final regression model accounting for 50% of the outcome variance. These findings lend support to the couples' forgiveness model (Meneses & Greenberg, 2011).

Research on Client Processes

In HEP theories of personality change (Gendlin, 1970; Greenberg, 2019; Rogers, 1959), depth of experiential self-exploration is seen as one of the pillars of psychotherapy process and client change. During the past 50 years much research has been carried out on the relationship between experiential depth and outcome. Within this context several instruments have been constructed to measure levels of clients' involvement in an experiential process of self-exploration, the most common being the Client Experiencing Scale (Klein et al., 1986).

Depth of Experiencing and Emotion Processing

Client Experiencing. Ratings of clients' depth of experiencing have been related to good outcome consistently in HEPs, consistently showing a positive relationship: the higher the experiencing level, the better the therapy outcome (Elliott et al., 2004; Hendricks, 2002**;** Pascual-Leone & Yeryomenko, 2017). In particular, Pascual-Leone and Yeryomenko (2017) reported a meta-analysis of 406 clients from 10 studies that found that client experiencing was a small to

medium size predictor of outcome, with *r* =.19 for self-report measures of outcome. This increased to *r* =*.25* with observational measures of clients' process and outcome. Thus, although the association between client experiencing level and outcome is consistent, it is not large, suggesting that other factors play a role in fruitful therapy process. In addition, it is simplistic to hold a linear view of the stages of the experiencing scale (i.e., "the higher the score, the better the process quality of the exploration process"). Two lines of investigation of psychotherapy change process (e.g., Angus et al., 1999; Watson et al., 2007) emphasize that *all* narrative modalities, representing the full range of the client experiencing scale, are important and serve useful functions for clients in exploring their problems.

Rogers' process view (1961), however, also predicted that there would be an *increase* of experiencing level throughout the course of successful therapy. Unfortunately, this has not been confirmed in most studies, possibly due to methodological issues such as sampling problems. Most importantly, researchers typically measure experiencing levels at the beginning, middle, and end phases of therapy, but randomly select segments within and across sessions. On the other hand, several studies have revealed significant differences in the manner in which good and poor outcome clients refer to their emotional experience during the session, across different therapeutic approaches (Pos et al., 2003; Watson & Bedard, 2006). These findings suggest that processing one's bodily felt experience and deepening this in therapy may well be a core ingredient of change in psychotherapy regardless of approach**.** However, an alternative interpretation is that clients who enter therapy with these skills do better in short term therapy than those who do not enter with these skills. Thus, these skills may be an indicator of clients' readiness or capacity to engage in short term therapy (Watson et al, 2007).

Depth of Experiencing, Emotional Expression and Outcome. EFT researchers have examined the relationship between client levels of emotional arousal and outcome. These studies found that higher emotional arousal at mid-treatment, coupled with reflection on the aroused emotion and deeper emotional processing late in therapy, and predicted good treatment outcomes (Pos et al, 2003; Warwar, 2003). EFT thus appears to work by enhancing a particular type of emotional processing: first helping the client experience, then accept, and finally make sense of their emotions. Pos et al. (2010) examined the role of the alliance and emotional processing across different phases of therapy and how they relate to outcome. After controlling for both the alliance and client emotional processing at the beginning of therapy, client level of experiencing during the working phase predicted reductions in depressive and general symptoms, as well as gains in self-esteem.

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

minimal or marginal level of arousal was found to predict poor outcome. Thus, emotional expression that does not attain a heightened level of emotional arousal, or that reflects an inability to express full arousal and possibly indicates interruption of arousal, appears undesirable, rather than a lesser but still desirable goal. This complex relationship offers a challenge to therapists in managing levels of arousal and possibly selecting clients for EFT. For example, Paivio and Pascual Leone (2010) noted that studies of EFT for trauma (e.g., Paivio et al., 2001) have found that good client process early in therapy is important because it sets the course for therapy and allows more time to explore and process emotion related to traumatic memories.

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

Modeling Client Emotional Processing. Emotional processing of global distress is a meta-task in EFT, in that clients often enter therapy with either strong or partially blocked/ undifferentiated feelings (i.e., feeling "upset" or "bad"). Using a model of emotional processing that identifies clients' movement through various emotional states (Pascual-Leone & Greenberg, 2007), Pascual-Leone (2009) used univariate and bootstrapping statistical methods to examine how dynamic emotional shifts accumulate moment-by-moment to produce in-session gains in emotional processing. This study found that effective emotional processing was simultaneously associated with steady improvement and increased emotional range. Good events were shown to occur in a "two-steps-forward, one-step-backward" fashion, and it was found that there were increasingly shorter emotional collapses in helpful in-session events, as compared to unhelpful in-session events where the opposite was true.

Choi et al. (2014) continued the examination of clients' emotional change process in the resolution of self-criticism as measured by changes in self-esteem at the end of therapy in a sample of 9 clients, consisting of 5 who had improved significantly in terms of their self-esteem by the end of therapy and 4 who had not. They found that resolvers (who decreased self-criticism over the course of therapy) also showed drops in expression of secondary emotions and increases in expression of primary adaptive emotions, both within and across phases of therapy. Good resolvers also exhibited more sequences of EEs consistent with transformation of secondary and maladaptive emotions to adaptive emotions.

Recently, Dillon et al. (2018) examined emotional processing in using the model of sequential emotional processing for an intensive case analysis of a good outcome client's emotional processing over 15 sessions. A model of change emerged that highlighted the important role played by accessing clients' adaptive primary emotions and expressing self-compassion and assertive anger in positive outcome in EFT.

Another focus of inquiry in EFT has been the examination of clients' optimal emotional processing in therapy and its relationship with outcome. Using a measure of Client Emotional Productivity (CEP), Auszra et al., (2013) examined whether productive processing of emotion predicted improvement at the end of therapy in clients receiving experiential therapy to treat depression. Hierarchical regression showed that clients' emotional processing during the working or middle phase of therapy predicted improvement over and above that predicted by their emotional processing in the beginning phase, working alliance and clients' emotional arousal during the working phase of therapy. The quality of clients' emotional processing during the working phase of therapy emerged as the sole predictor of improvement in depression. This suggests that improvement in experiential therapy is characterized by the activation of productive primary emotion.

Herrmann et al., (2016 continued the investigation of client in-session emotion processing as a predictor of good outcome. Using a process measure of the four types of emotion response identified in EFT theory (adaptive primary, maladaptive primary, secondary, instrumental), they studied a sample of 30 clients in EFT who were treated for depression. They found that a lower frequency of secondary emotion and a higher frequency of primary adaptive emotion in the working phase predicted outcome. In addition, it was important that clients not be overwhelmed by negative emotion, because moderate levels of primary maladaptive emotion were related to outcome and the frequency with which clients moved from primary maladaptive to primary adaptive in the working phase predicted outcome. Thus, evidence of clients moving through different stages of emotional processing and transforming maladaptive into adaptive emotions is significantly related to successful change in psychotherapy.

Narrative Processes and Assimilation

Narrative processes in humanistic and experiential psychotherapies have been investigated using several different scales, including narrative processing markers (Angus & Greenberg, 2011), as well as innovative moments and narrative shifts (Goncalves et al., 2011). Studies on client narrative sequences in EFT have revealed interesting and unique patterns associated with good outcome (Boritz et al., 2008; Boritz et al., 2011). These authors investigated the relationship of expressed emotional arousal and specific autobiographical memory in the context of early, middle, and late phase sessions drawn from the York I Depression Study (Greenberg & Watson, 1998). Hierarchical Linear Modeling analyses established that there was a significant increase in the specificity of autobiographical memories from early to late phase therapy sessions and that treatment outcome was predicted by a combination of high narrative specificity plus expressed arousal in late phase sessions. Recovered clients emotionally expressed their feelings in the context of telling specific autobiographical memory narratives to a greater degree than clients who remained depressed at treatment termination (Boritz et al, 2010). However, neither expressed emotional arousal nor narrative specificity alone was associated with complete recovery at treatment termination.

Subsequently, Angus and Greenberg (2011) developed a map of narrative indicators that have been tested in different therapeutic approaches. Boritz et al. (2017) examined narrative flexibility, defined by movement among the various indicators, in clients' narratives in CBT and EFT in relation to treatment outcome. Using logistic regression, the authors reported that the probability that client narratives would shift among different narrative markers over the course of therapy was constant for those clients who recovered but declined for those that did not change. This suggests that client narrative flexibility may be an important indicator of good outcome.

Client narrative processes have also been extensively investigated by Gonçalves and colleagues. They developed a coding system that identifies five kinds or stages of innovative moments including action, reflection, protest, reconceptualization and performing change. In a study of innovative moments (IMs) in therapy, Gonçalves and colleagues (2011) showed that clients shift from focusing on habitual problematic narratives about self to new alternative narratives. In an exploratory study with a small sample, Mendes et al. (2011) examined the role of the two most common IMs, reflection and protest, in good and poor outcome cases. Two sub-types were identified for each of the IMs: *Reflection sub-type 1* involved new understandings that created distance from the problem; it decreased across sessions in both poor and good outcome cases. On the other hand, Reflection sub-type 2, which was centered on change (both changes made already and strategies going forward), increased and was highest in good outcome cases. Differences in the Protest IM subtypes were also observed: Sub-type 1 involved statements of problem-oriented positions, and was stable across sessions in both outcome groups. Sub-type 2 involved the emergence of self-empowerment; it was absent in the sessions of the poor outcome group and increased in the middle phase of therapy in the good outcome group.

Cunha et al. (2012) analyzed both client and therapist behaviors using the Innovative Moments scale and the Helping Skills System (HSS-Hill, 2009). A study of therapists' use of exploration, insight, and action skills and IMs in two initial, two middle, and two final sessions of three good outcome and three poor outcome cases treated with EFT for depression found that IMs occurred more often in good outcome cases than poor outcome cases. Furthermore, therapists' use of exploration and insight skills more often preceded client action, reflection, and protest IMs in the initial and middle phases of therapy in the good outcome cases than the poor outcome ones. However, in the final phase of therapy these therapist skills of exploration and insight more often preceded moments identified as reconceptualization and performing change. Therapists' use of action skills was more often associated with client innovative moments identified as action, reflection, and protest across all phases, and especially in the final phase for good outcome clients.

Expanding IM research, Cunha and associates (2017) conducted an exploratory task analysis of the consolidation phase in EFT which shows clients moving from an exploration of a problem to reconstructing a new view of self. The authors identified nine steps in the resolution of the task including recognition of the differences between present and past views of self; development of a meta-perspective on past and present; amplifying the contrast between past and present; expressing a positive appreciation of change; experiencing feelings of empowerment; identifying ongoing difficulties; emphasizing that the problem is no longer central; seeing change as ongoing and gradual; and referring to new projects, plans and experience of change.

In a further examination of changes in clients' narratives, Fernández-Navarro et al. (2018) examined moments when clients reconceptualized their narratives. They identified two sub-types of reconceptualization, one when the client made a positive contrast between a present view of self and a past view and another in which the client described why and how this change occurred. In order to determine whether the global category of reconceptualization of a problem state predicted outcome as much as either single sub-type alone, they analyzed 16 cases of clients treated for depression in EFT. Longitudinal regression models showed that the umbrella category of reconceptualization occurred less frequently than either of the other two did separately. However, reconceptualization was a better predictor of outcome than either of the two sub-types. Changes in clients' narratives were indicative of changes in psychotherapy and the authors

suggested that these types of changes might be encouraged or consolidated by therapists asking clients to identify what has changed and what has facilitated the change.

We recognize that much of this research is exploratory and has focused on developing the Innovative Moments Rating Scale. Much of it has been based on small samples, and in some studies raters were not blind to outcome, being very familiar with the data set; there have also been challenges identifying problematic narratives.

A recent line of research has focused on the relation between narrative processes and Stiles' (2001) assimilation of problematic experiences (APES) model, a stage model of client change. Mendes et al. (2016) examined change in one good and one poor outcome case drawn from an EFT treatment study for depression using the assimilation model (APES; Stiles, 2001). They found that both clients experienced setbacks, that is moments in the session when their ratings on the APES reverted to a lower level. However, the type of setback varied in each case: Setbacks in the poor outcome case typically occurred when the therapist was working ahead of the client's proximal level of development (ZPD), trying to get them to move to a higher level of assimilation before they are ready. On the other hand, setbacks in the good outcome case resulted from the use of either (a) a "balanced strategy" in which the therapist recognized client progress before redirecting the client's attention to less assimilated aspects of a problem or (b) allowed the client to change focus to less assimilated aspects of a problem ("spontaneous switches"). Thus, in the good outcome case setbacks were part of a process of capitalizing on therapeutic progress to broaden or deepen therapeutic work.

Similarly, using the assimilation model, Ribeiro et al. (2016) compared two cases drawn from the EFT arm of the York Depression Project. They observed how two different EFT therapists worked within their clients' ZPDs. Specifically, they found that the therapist of the client who achieved higher levels on APES used a balance of supportive and challenging interventions, in contrast with the therapist of the other client who used primarily supportive interventions. The authors suggested that challenging interventions that foster change may be helpful in a positive relationship in which the client feels safe, as long as the therapist stays within their client's ZPD.

Finally, Barbosa et al. (2018), using data from a good outcome case of EFT for depression, found that lower levels of client assimilation were associated with what they referred to as *immersion.* characterized by a narrow, self-absorbed perspective on difficult experiences, which were more common early in therapy. Higher levels of assimilation, however, occurred later in therapy and involved a *distanced* perspective, in which the client took a distanced, observer perspective on their difficult experiences, pointing to an increase in client capacity to reflect on and make meaning out of emotional experience, an important outcome in EFT.

Conclusions

In this update of research on humanistic-experiential psychotherapies, we have emphasized recent outcome research, but have also updated our reviews of qualitative research on client experiences of therapy and quantitative investigations of change processes. We therefore begin by summing up what we have learned about the outcome of HEPs.

Humanistic-Experiential Psychotherapies as Evidence-Based Treatments

Current mental health politics urgently require continuing collection, integration, and dissemination of information about the rapidly expanding body of outcome evidence, to help deal with challenges to HEPs in many countries. HEP outcome research has grown rapidly, with

a fifty per cent increase in the past 10 years. This has allowed us to pursue increasingly sophisticated analytic strategies and to break down the evidence by client subpopulation and type of HEP. We believe that these analyses go a long way toward meeting the demands of the various national guideline development groups (e.g., APA Division 12 Task Force on Empirically Supported Treatments in the United States; National Institute for Clinical Excellence [NICE] in the United Kingdom).

Looking at our current data set of 91 recent studies, together with our previous collection of nearly 200 outcome studies, we see that evidence for the effectiveness of HEPs comes from five separate lines of evidence and supports the following conclusions:

First, overall, HEPs are associated with large *pre-post* client change. These client changes are maintained over the early posttherapy period (< 12 months), although not enough recent studies have addressed late (a year or more) outcomes.

Second, in *controlled studies*, clients in HEPs generally show large gains relative to clients who receive no therapy, regardless of whether studies are randomized or not. This allows the causal inference that HEP, in general, causes client change; or rather, speaking from the client's perspective, we can say that clients use HEP to cause themselves to change.

Third, in *comparative outcome* studies, HEPs overall are statistically and clinically equivalent in effectiveness to other therapies (especially non-CBT therapies), regardless of whether studies are randomized or not.

Fourth, in the current dataset, CBT appears to have a small advantage over HEPs. However, this effect seems to be due in part to non–bona fide treatments usually labeled by researchers as *supportive* (or sometimes *nondirective*), which are generally less effective than CBT. These therapies are typically delivered when there is a negative researcher allegiance and in non–bona fide versions, and appear to be the mediator for the substantial researcher allegiance effect that we have found repeatedly. In our previous review, when the supportive treatments were removed from the sample, or when researcher allegiance was controlled for statistically, HEPs appeared to be equivalent to CBT in their effectiveness. However, levels of researcher allegiance in the current sample were so high that it proved difficult to control for them statistically, leading to an equivocal finding in favor of CBT over person-centered therapy, in contrast to the clear equivalence finding we reported in our previous review.

Fifth, in terms of type of HEP, EFT continues to fare the best, although the number of recent controlled and comparative studies is too small to warrant a strong conclusion. There are plenty of studies of supportive-nondirective therapy, a weaker form of HEP, and these continue to do most poorly against CBT. However, it is not clear how much this is due to negative researcher allegiance effects and how much is due to this approach being less effective. In terms of effectiveness, Person-centered therapy falls in between supportive-nondirective therapies and EFT, a consistent finding across both our previous and current meta-analyses.

Going beyond these general conclusions, we have argued that there is now enough research to warrant varying positive valuations of HEP in six important client populations: depression, relationship/interpersonal problems, anxiety, coping with chronic medical conditions, psychosis, and self-damaging activities.

For *depression*, HEPs continue to be extensively researched, with large pre-post effects and medium controlled effects; for this dataset we found an equivocally negative comparative effect size, characterized by overwhelmingly negative researcher allegiance. This result is suspect because it contradicts our previous clear equivalence finding that supported the use of HEPs for depression generally, but particularly for EFT for mild to moderate depression (e.g.,

Goldman et al., 2006; Watson et al., 2003), and PCT for perinatal depression (e.g., Cooper et al., 2003; Holden et al., 1989). However, recent large-scale balanced allegiance studies (Barkham & Saxon, 2018; Barkham et al., 2020) suggest that there are some specific situations in which CBT may do better that PCT: for example, with more severely distressed clients seen for more sessions or tracked a year later. This in turn points to the possibility that when applied to depression PCT may need to bolstered with more powerful methods, e.g., EFT chair work.

For *relationship and interpersonal problems* HEPs clearly meet criteria as an *efficacious* treatment, based on pre-post and controlled effects. Our previous review contained a substantial number of studies of couples therapy, with large pre-post, controlled and even comparative effects. However, the current review was dominated by individual therapy and included more studies of social anxiety and PTSD, which resulted in smaller comparative effects in the equivalent or trivially less effective range.

For helping clients cope psychologically with *chronic medical conditions*, we found a large body of studies and replicated our previous finding of reasonably large pre-post effects, clear superiority to no treatment control conditions, and equivalence to other treatments including CBT. This client population continues to be a promising one for further exploration of the value HEPs including supportive-nondirective and PCT.

For *habitual self-damaging activities*, including eating difficulties, our analysis points to the effectiveness of HEPs in general (primarily supportive and other HEPs). Although time and resources precluded including Motivational Interviewing (MI) here, our results are again comparable to those commonly reported for MI (Lundahl et al., 2010).

For *anxiety* difficulties overall, the recent evidence is as in the previous review mixed, but sufficient to warrant a general continuing verdict of possibly efficacious: We found large pre-post and very large controlled effects, but general superiority of CBT to supportive-nondirective treatments in negative researcher allegiance studies. There are at least two major comparative treatment studies (e.g., Timulak et al. 2018) pitting EFT against CBT currently in progress, but none of these have yet reported results.

For *psychotic* conditions such as schizophrenia, we replicated our previous finding of promising pre-post and comparative effects supporting the use of HEPS for this challenging client population. This directly contradicts the UK guideline contraindicating humanistic counseling for clients with this condition (National Collaborating Centre for Mental Health, 2010). In fact, the comparative evidence we have reviewed points to the possibility that HEPs may in some cases be *more* effective than the other therapies to which they have been compared. Clearly, this is an area that warrants further investigation and treatment development.

Key Change Processes in Humanistic-Experiential Psychotherapies

Our review of quantitative and qualitative change process research on HEPs shows that researchers continue to refine their understanding of the therapist and client processes that bring about change in therapy. This research uses all four of the change process research paradigms defined by Elliott (2010), including quantitative process-outcome, qualitative helpful factors, significant events, and sequential process approaches, in the context of both group designs and single case studies. Over time, the research has moved beyond global therapist facilitative processes such empathy, positive regard, genuineness and collaboration to more specific within-session client change processes.

Qualitative change process research, for example, reveals the complexity of clients' experiences of therapy. Clients have their own agendas, may be ambivalent about change, and

may sometimes experience aspects of therapy as difficult or hindering, all of which can significantly affect the outcomes of therapy. In successful therapy, the therapist is seen as reaching out to the client in a way that promotes the client's sense of safety, but that also responds to the client's emotional pain and unmet needs with compassionate and authentic presence. These needs are affirmed by the therapist, thus facilitating the development of self-compassion and self-acceptance as well as self-empowerment grounded in awareness of key emotions and unmet needs.

Furthermore, the use of task analysis to model sequences of particular client and therapist performances has led to the development of additional models of therapeutic change processes and has broadened the range of therapist behaviors and types of interventions that have been shown to facilitate good outcome. Process-outcome research on client experiencing has been extended to productive emotion and narrative processes. Over the past 20 years much quantitative change process research has focused on central client processes such as emotional processing, including expression, deepening, transformation and regulation, the emergence of new client narratives, changes in clients' self-organizations and the assimilation of problematic experiences. These new client variables and their associated process measures are providing more fine-grained tools for understanding how client change occurs. These conceptual and research tools are generating new, more precise maps of the change process. Thus, we can see more precise answers emerging to key questions about productive therapy process:

Question 1: What is the most productive sequence of narrative exploration in therapy? Answer: Description of external events, leading to initial self-reflection, leading to access to internal experiences, leading to self-reflection on broader meaning (research by Angus and colleagues).

Question 2: How do new narratives emerge and become established in client's lives? Answer: By a spiraling movement between action and reflection, starting with attempts to change the problem, leading to reflection on the nature of the old problematic narrative, followed by active protest or working against the problem, then to emerging re-conceptualization of self and the process of change, and finally to carrying out the change in one's life (research by Gonçalves and colleagues).

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

Question 4: When is client emotional expression most likely to lead to good outcome? Answer: When it is grounded in specific autobiographical memories, accompanied by deeper levels of experiencing, and becomes more regulated and differentiated as it is explored (research by Greenberg, Angus, Pascual-Leone, Auszra and Hermann, and others).

Question 5: How do stuck, symptomatic emotions get transformed into more useful, productive emotions? Answer: By helping clients move from an undifferentiated, global or secondary symptomatic distress (e.g., anxiety, depression); through underlying core painful feelings (e.g., shame/guilt, fear, brokenness); to unmet needs (e.g., for validation, safety, protection); and thence to a response to those unmet needs in the form of self-compassion or assertive anger (research by Pascual-Leone, Timulak and colleagues).

The many ways in which these different lines of theory development and research run parallel to and complement one another continue to point to the possibility of a larger synthesis with many useful clinical implications, and leads to a further question:

Question 6: How can therapists most effectively facilitate these client change processes? Answer: After focusing for so long on the evolution of client change processes, more precise research is just beginning on how therapists can best facilitate this evolution. At present, several promising leads are being pursued: (a) Therapist responses within the client's zone of proximal development, that are neither too behind or too far ahead the client's current state of progress are likely to be most effective. (b) A balance is needed between, on the one hand, supportive/ following therapist responses that provide safety and openness and, on the other hand, challenging, process-guiding responses that offer clients opportunities to move forward when they are ready to do so. Clearly, much more research on therapist facilitation of client productive processes is needed.

Recommendations for Research, Practice, and Training

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

First, while the field of humanistic-experiential therapy research has continued to make substantial progress during the past 10 years, more research is clearly needed, particularly with client populations where clear recommendations are not yet possible, such as different types of anxiety, psychosis, particular medical conditions, and eating difficulties, and others. At the same time, more research on well-studied client problems such as depression are also needed, in order to bolster or upgrade the existing evidence, which runs the risk of becoming obsolete as standards for research evidence shift over time (e.g., requiring larger samples, RCTs, intent-to-treat analyses, and more sophisticated meta-analysis techniques). In addition, more research on different types of HEPs is needed, particularly comparing more vs less process-guiding HEPs. In general, however, we are heartened by the continuing flow of HEP studies being produced.

Second, from a health care policy point of view, the available outcome data (almost 300 outcome studies) clearly support the proposition that HEPs are empirically supported by multiple lines of scientific evidence, including "gold standard" RCTs and recent large RCT-equivalent practice-based studies in the UK (e.g., Barkham & Saxon, 2018). This body of research suggests that the lists of empirically supported or evidence-based psychotherapies that have been constructed in various countries—the NICE Guidelines in the United Kingdom or the list of empirically supported treatments in the United States, for example—need to be updated with the type of evidence we have reviewed. HEPs should be offered to clients in national health service contexts and other mental health settings, and paid for by health insurance, especially for the well-evidenced client populations highlighted.

Third, there are two possible lessons to be learned from the negative results we have consistently identified for often non bona fide supportive-nondirective therapies: On the one hand, if these results are due to negative researcher allegiance, the lesson is: Don't do therapies you don't believe in. On the other hand, it is possible that in general such nonspecific, nontargeted, non-process guiding therapies are just not as effective as CBT; in this case, if the choice is between a supportive-nondirective HEP and CBT, then clients should generally receive CBT. In other words, based on the large body of evidence we've reviewed over the past thirty years, we don't recommend supportive-nondirective therapies for use in routine practice situations, especially when these have been modified to make them less effective. Even here, however, the literature is full of exceptions this rule, where supportive-nondirective and CBT failed to differ in outcome.

Fourth, for those of us in the HEP tradition, the moral of this story continues to be that we do not need to be afraid of quantitative outcome research, including RCTs. Naturally, there are many problems and limitations with RCTs, just as there are with all research methods. Nevertheless, it is imperative that as humanistic-experiential therapists we do our own outcome research—including RCTs—on bona fide versions of our therapies and that we train more HEP researchers to carry out such studies. Beyond this, it is also essential that we collaborate with researchers from other therapeutic approaches on balanced-researcher-allegiance comparative RCTs, in order to achieve the level of equipoise in our studies needed to really understand the strengths and limitations of our approach.

Fifth, as for the specific research implications of our review, it certainly seems to us to illustrate the value of using a wide range of research methods, qualitative and quantitative, group and single case, to address questions of therapeutic change processes, effectiveness and efficacy. Furthermore, going forward it will be possible to make good use of this diverse range of research methods to bear on a more diverse range of clients, including those from more different countries, minority populations, LGBTQIA clients, and neuro-atypicals. At the same time, it is worth noting that our data indicate that the current emphasis on randomization in controlled and comparative outcome studies is misplaced: In fact, we once again found that randomization made no difference whatsoever in our meta-analysis. Although randomization is a useful research tool, nonrandomized studies, especially large-scale practice-based research, also need to be given significant weight in integrating research findings.

Sixth, it now appears to us that research alone will not suffice. The development of treatment guidelines in various countries has in our experience become increasingly politicized, with powerful interest groups dominating the committees charged with reviewing the evidence. These groups determine what counts as evidence, what evidence is reviewed, and how that evidence is interpreted as a basis for formulating treatment guidelines. We are particularly disturbed by the recent trend toward using increasingly opaque methods such as network analysis, which are built on questionable assumptions such as the equivalence of client populations, versions of a treatment, and research procedures (cf. Faltinsen et al., 2018). This is often portrayed as an objective, neutral process of making straightforward inferences from research evidence to the real world of practice. According to Bayesian statistics (e.g., Lynch, 2010), however, this is an instance of the logical fallacy of the "transposed conditional" (Siegfried, 2010): The famous "null hypothesis" against which we test our results only evaluates the likelihood of hypothetical inference from practice (the "real world") to our research results, not in the opposite direction, from our results to practice, which is the inference that we (and policymakers in general) want to make. Inference from evidence to practice only becomes possible when we factor in our prior expectations, that is, our researcher and reviewer theoretical allegiances. This means that it is critically important who reviews the research evidence and what their prior expectations or allegiances are. And that means that the guideline development committees that review research evidence will only produce valid and fair guidelines if they contain a balanced representation of researchers with varied theoretical allegiances. The implication for the supporters of HEPs is that they need to put pressure on guideline development bodies for proper representation.

Finally, we conclude as we did in our previous review (Elliott et al., 2013), with training implications. The neglect of HEPs in training programs and treatment guidelines is not warranted. Humanistic-experiential therapies should generally be offered in postgraduate programs and internships as an alternative to CBT, especially as treatments for depression,

interpersonal difficulties, coping with chronic medical conditions and psychosis, and self-damaging activities, and possibly also to support clients with anxiety difficulties. Like CBT, HEPs are evidence-based for a wide range of client presenting problems and therefore need to be included in the education of psychotherapists.

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Table 1
Humanistic-Experiential Psychotherapies: Main Features & Subapproaches

I. Main features:	
Therapeutic relationship	Facilitative: empathy, unconditional positive regard, genuineness
Focus	Experiencing: immediate involving awareness, including perceiving, sensing, feeling, thinking, and wanting/intending
Goals	Self-awareness, growth, meaning creation
Main exclusion feature:	Major content direction: Advisement, interpretation, disagreement
II. Main subapproaches:	
A. Less Process-Guiding:	
Person-Centred/Client-Centred	Developed by Rogers: relatively nondirective; based on therapist empathy, unconditional positive regard, genuineness
Supportive/Nondirective	Not associated with a particular HEP subapproach; therapist empathy and/or client experiencing are central; generally used as a control condition by CBT researchers (often in non bona fide)
B. More Process-Guiding:	
Emotion(ally)-Focused/ Process-Experiential/ Attachment-based	Integrates person-centred and gestalt therapies; focused on client emotions; process-guiding; uses therapeutic tasks
Motivational Interviewing/ Motivational Enhancement Therapy	Helping client explore their ambivalence about change; focusing on desire for change
Gestalt	Developed by Perls: enacting experiments in session; spontaneity, authenticity are central
Psychodrama	Developed by Moreno: enacting experiences in group therapy context
Expressive	Emotional expression is central
Body-Oriented	Awareness of and work with body are central
Humanistic-Existential	Focused on existential themes: responsibility, isolation, meaning, mortality
Focusing-Oriented	Focus on helping clients slow down and turn attention inside to bodily experiencing

Table 2
Summary of Overall Pre-Post Change, Controlled and Comparative Weighted Effect Sizes

	k	*n*	*m*	*se*	*95% CI*	*Q*	I^2
Pre-Post Effects in HEP samples							
Overall (combined time periods):							
ITT Primary Outcomes	35	2430	.95	.11	.73, 1.16	329.6**	90%
Per Protocol Primary Outcomes	94	7558	.86	.06	.74, .97	559.5*	88%
Per Protocol All Outcomes	94	7376	.73	.05	.62, .83	466.7**	85%
2013: Per Protocol All Outcomes	*199*	*14,032*	*.93*	*.04*	*.88, 1.04*	--	
Post (0 – 1 mo post):							
ITT Primary outcomes	33	1474	.94	.11	.73, 1.15	213.4**	86%
Per Protocol Primary Outcomes	91	6842	.86	.06	.75, .98	462.0**	87%
Per Protocol All Outcomes	91	6813	.73	.05	.63, .83	407.6**	83%
2013: Per Protocol All Outcomes	*181*	*13,109*	*.95*	*.05*	*.86, 1.04*	--	--
Early follow-up (2–11 mos.)							
Per Protocol Primary Outcomes	41	2161	.88	.11	.67, 1.10	265.4**	89%
2013: Per Protocol All Outcomes	*77*	*2125*	*1.05*	*.07*	*.90, 1.20*	--	--
Late follow-up (12+ mos.)							
Per Protocol Primary Outcomes	15	599	.92	.20	.52, 1.31	105.5**	90%
2013: Per Protocol All Outcomes	*52*	*2611*	*1.11*	*.09*	*.93, 1.29*	--	==
Type of HEP *(PP-PO effects combined over time periods)*							
Supportive-Nondirective	30	1564	.73	.09	.55, .92	163.3**	82%
Person-Centered	18	1258	.98	.16	.66, 1.29	138. 0**	89%
EFT	18	464	1.31	.13	1.05, 1.58	47.8**	67%
Gestalt/Psychodrama	17	723	.78	.10	.57, .98	54.2**	65%
Other HEPs	11	3521	.53	.10	.32,.73	47.6**	78%
Controlled ES (HEPs vs. untreated participants)							
Controlled studies overall	21	1519	.88	.16	.55, 1.20	119.8**	87%
Controlled RCTs	14	848	.98	.24	.51, 1.44	105.6**	90%
2013 Controlled PP-All	*62*	*4102*	*.76*	*.06*	--	--	
HEP pre-post	20	621	.95	.15	.65, 1.26	103.3**	84%
2013 HEP pre-post ES	*59*	*2144*	*1.01*	--	--	--	
Untreated Control pre-post ES	20	648	.09	.06	-.03, .21	18.1**	15%
2013: Control pre-post ES	*53*	*1958*	*.19*	--	--	--	
Comparative ES (HEPs vs. NonHEP treatments)							
Overall – all studies PP-PO	63	16266	-.08	.06	-.21, .04	245.8**	91%
2013 HEP comparative ES PP-All	*135*	6097[a]	*.01*	*.03*	*-.05, .07*	*305.2***	
RCTs only	56	6931	-.07	.07	-.21, .07	225.6**	88%
2013 RCTs only PP All	*113*	--	*-.01*	*.04*	*-.11, .07*	--	
HEP pre-post PP Primary	62	5876	.76	.07	.62, .88	450.9**	91%
2013 HEP pre-post ES PP All	*124*	*6097*	*.98*	--	--	--	
NonHEP PP Primary	62	10,262	.82	.09	.65, 1.00	693.2**	95%
2013 NonHEP pre-post ES PP All	*124*	--	*1.02*	--	--	--	
HEP vs. CBT							
All Studies	36	13,785	-.26	.06	-.37, -.15	103.2**	78%
RCTs	32	4641	-.26	.05	-.36, -.16	74.8**	58%

2013 Comparative PP-All	*76*	--	*-.13*	*.04*	*-.21, -.06*	--	
HEP vs. non-CBT							
Overall	27	2481	.19	.12	-.04, .43	110.3**	90%
RCTs	24	2290	.24	.14	-.03, .51	107.1**	92%
2013 Comparative PP-All	*59*		*.01*	*.03*	--	--	
More vs less intensive/ process guiding HEPS	6	640	.18	.15	-.12, .48	??	??

Note. Hedge's *g* used (corrects for small sample bias). Weighted effects used inverse variance based on *n* of clients in humanistic-experiential therapy conditions. Positive values indicate pro-HEP or pro-process guiding results. All values are Per Protocol-Primary Outcomes (PP-PO) unless otherwise noted. PP-All: Per Protocol-All Outcomes; ITT-PO: Intent-to-Treat-Primary Outcomes.

Table 3
Equivalence Analyses: Key Comparisons Between HEPs and non-HEPs (Per Protocol Primary Variable Analyses)

	k	ES_w	SE	95% CI	Diff: 0	Diff: <|.4|	Result[a]
All HEPs							
HEP vs. non-HEP: All studies	63	-.08	.06	-.21, .04	No	Yes	Equivalent
RCTs only	56	-.07	.07	-.21, .07	No	Yes	Equivalent
HEP vs. CBT: All studies	36	-.26	.06	-.37, -.15	Yes	Yes	Equivocally worse
(allegiance-controlled)[b]		*(-.26)*	*(.15)*	*(-.56, .04)*	*(No)*	*(No)*	*(same)*
RCTs only	32	-.26	.05	-.36, -.16	Yes	Yes	Equivocally worse
(allegiance-controlled)		*(.00)*	*(.16)*	*(-.31, .32)*	*(No)*	*(Yes)*	*(Equivalent)*
HEP vs. non-CBT All studies	27	.19	.12	-.04, .43	No	No	Trivially better
(allegiance-controlled)		*(.06)*	*(.24)*	*(-.41, .52)*	*(No)*	*(No)*	*(Equivocally better)*
RCTs only	24	.24	.14	-.03, .51	No	No	Equivocally better
(allegiance-controlled)		*(.05)*	*(.26)*	*(-.46,.56)*	*(No)*	*(No)*	*(Equivocally better)*
CBT vs Common Forms of HEP							
PCT vs. CBT: All studies	10	-.30	.13	-.55 to -.05	Yes	No	Equivocally worse
(allegiance-controlled)		*(-.27)*	*(.21)*	*(-.68,.13)*	(No)	(No)	*(same)*
RCTs only	*8*	-.20	.12	-.45, .04	No	No	Equivocally worse
		(.01)	*(.22)*	*(-.42,.44)*	*(No)*	*(No)*	*(same)*
Supportive vs. CBT: (All RCTs)	23	-.28	.06	-.40, -.16	Yes	No	Equivocally worse
Supportive vs. CBT: (Bona fide HEP)	9	-.15	.06	-.27, .-.03	Yes	Yes	Equivocal

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

[a]"Result" refers to the practice implications of obtained value of mES: "Equivalent": within .1 sd of zero (greater than –.1 and less than .1); "Trivially (worse/better)": between .1 and .2 sd from zero; "Equivocally (worse/better)": between .2 and .4 sd from zero; "Clinically worse/better": at least .4 sd from zero.

[b]Values in parenthesized italics are results of analyses controlling for researcher allegiance, performed when uncontrolled differences had been obtained.

Table 4
Effect Size by Selected Client Problems/Disorders

Problem/Disorder	Pre-post ES		Controlled ES		Comparative ES	
	k	ES_w ± 95% CI	*k*	ES_w ± 95% CI	*k*	ES_w ± 95% CI
Depression	30	.96 ± .16*	3	.51 ±. 30*(-)	25	-.20 ± .18* (=)
Relationship/interpersonal/trauma	27	1.13 ± .20*(+)	8	1.26 ± .59*	12	-.10 ±.42
Anxiety	26	.94 ± .20*	3	.93 ± .74*	13	-.34 ± .23*(-)
Medical	28	.69 ± .22*(-)	5	.48 ± .23*(-)	26	-.07 ± .24(=)
Psychosis	5	.72 ± .54*(-)	0	--	6	.15 ± .43(+)
Self-damaging activities	8	1.00 ± .51*(+)	1	.53 ± .80(-)	8	.09 ± .35(+)
Other Populations	21	.89 ± .24*	9	1.00 ± .65*	11	-.17 ± .21(=)
Total sample (used for bench-marking)	94	.86 ± .10*	21	.88 ± .32*	63	-.08 ± .12(=)

Note. *$p < .05$ in null hypothesis test against ES = 0; *k*s refer to number of client samples (pre-post ESs) or comparisons with other conditions (controlled and comparative ESs). 95% CI: 95% confidence intervals; Benchmarking results vs. total sample: (+): value is above bench-mark confidence interval; (-): value is below benchmark confidence interval. (=): meets criteria for statistical equivalence (not significant difference from 0 and also significantly different from |.4|.

Figure 1
HEP Outcome Meta-analysis PRISMA Diagram
(See Supplemental Material, Table 14S-1 for more detail.)