

**Emotion-Focused and Person-Centered Therapies for Social Anxiety:**

**A Pilot Comparative Outcome Study**

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## Highlights

- Person-centered and emotion focused therapies can be used to treat social anxiety.
- Socially anxious clients showed large pre-post gains in each treatment.
- Gains were comparable to benchmarked research on CBT and medication.
- Clients in emotion focused therapy had better outcomes but used more sessions.

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**Abstract**

We present quantitative results of a pilot outcome study comparing two forms of humanistic-experiential psychotherapy for clients with social anxiety (SA), Person-Centered Therapy (PCT) and Emotion-Focused Therapy (EFT). Using a mixed randomized and non-randomised two group pre-post design, we assessed client outcome on the Social Phobia Inventory (SPIN), CORE-OM, Personal Questionnaire, and three other measures. Fifty-three clients were seen within a 20-session protocol, in either Person-Centered or Emotion-Focused Therapy. Outcome was analysed using analyses for all clients who engaged in at least 3 sessions of therapy. Overall, clients in both conditions showed large, statistically-significant pre-post gains, comparable or better than benchmarked previous research on CBT and medication on the SPIN. Clients in EFT chose to receive more sessions and showed significantly better outcomes on two of the five outcome measures and overall. Consistent with their respective treatment models, adherence analyses indicated that therapists in both treatments were seen by clients as successfully offering a person-centered relationship, with PCT therapists seen as more nondirective and EFT therapists providing a stronger working alliance. Despite the limitation of being only partially randomized, this is one of the first comparative studies of *bona fide* humanistic therapies for social anxiety, and provides a basis for further research.

**Keywords:** Social anxiety, humanistic psychotherapy, psychotherapeutic outcomes, person centered therapy, emotion focused therapy, benchmarking

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## **1. Introduction**

Social Anxiety (SA; also known as Social Phobia) is a common, debilitating anxiety disorder characterized by persistent fear of social interactions or situations in which one might be scrutinized or judged by others (Heckleman & Schneier, 1995). People with SA are typically not only highly fearful of public speaking but of talking or just being seen in a range of social situations (Stravinsky, 2007). It is the third most prevalent psychological difficulty, after depression and substance abuse, affecting up to 10% of the population during their lifetime (Keller, 2003). SA is often comorbid with other psychiatric diagnoses, such as Major Depression, Generalized Anxiety Disorder, Agoraphobia and Panic Disorder. It is also associated with impaired ability to form and maintain good interpersonal relationships, leading to loneliness and isolation (Alden & Taylor, 2004). Higher risk of suicidal ideation and suicide attempts are also associated with SA (Cox, Dorenfeld, Swinson & Norton, 1994).

At present, Cognitive-Behavioural Therapy (CBT) has the strongest evidence base as an intervention for Social Anxiety, with treatment focusing on identifying the unhelpful cognitions and safety behaviors that underlie anxiety responses, and working to challenge and alter these (Schneier, 2006). In the UK, the National Institute for Health and Clinical Excellence (NICE; National Collaborating Centre for Mental Health, 2013) guidelines recommend two forms of CBT as front line evidence-based treatments for SA: the Clark and Wells (Clark et al., 2006) and Heimberg (Hope, Heimberg & Turk, 2010) models. While these approaches have been shown to be effective, between a third and a half of SA sufferers do not show clinically significant decreases in symptoms in the majority of trials (Davidson et al, 2004).

A recent development is the emergence of promising alternative treatments for social anxiety, including interpersonal therapy (Alden & Taylor, 2004) and brief dynamic therapy (e.g., Leuchingsring et al., 2013); these have begun to be recognized as second line approaches in treatment guidelines (National Collaborating Centre for Mental Health, 2013). However, there is little current evidence for the use of humanistic-experiential psychotherapies, which are one of the principal psychotherapeutic modalities. To address this, the current study investigated the efficacy of Person-Centered Therapy (PCT) and Emotion-Focused Therapy (EFT) in the treatment of social anxiety. Though similar, these approaches that vary primarily in terms of degree of therapist guiding of the process (structuring and active task intervention), as described below.

Person-centered therapy has a long-standing interest in anxiety processes. Aspects of the experience and expression of social anxiety can be understood from the perspective of each of four major models of mental ill health have developed within contemporary person-centered theory: incongruence, psychological contact difficulties, styles of processing and issues of power (Wilkins, 2017). Rogers (1957) proposed that the second condition for psychological change is that the client, is “in a state of incongruence, being vulnerable or anxious” (p.96). Schmid (2017) has described Rogers’ (1959) theory of psychological development as a critical theory of socialisation in which the person is striving towards authenticity within a joint process of self-development and relationship development. Mearns (2002) also emphasised the dialogical nature of the “actualization process” (p.22) involving the interplay between growth (the actualizing tendency) and the restraint of social mediation. According to Mearns, disorder occurs when the person becomes stuck within this process. Of these models. Rogers’ (1959) theory of the process of therapeutic change holds that therapist’s unconditional positive regard for the client – “the primary change agent” (Bozarth, 2001, p.77) - can directly counter client negative self-regard, while empathy and genuineness

contribute to this process by making it deeper and more credible, enabling the client eventually to internalise the therapist's unconditional positive regard, which then translates into increased self-acceptance and reduced fear of others.

Emotion-focused therapy (previously referred to as process-experiential psychotherapy; Elliott, Watson, Goldman & Greenberg, 2004; Greenberg, 2010) regards emotion as central to psychological function, dysfunction and change. In EFT terms, SA is seen as a function of maladaptive emotion schemes developed as a result of a person being chronically or traumatically criticised or shamed due to their appearance, social presentation, or person. These experiences lead to the development of fear- and shame-based emotion schemes in which interpersonal interactions are seen as dangerous situations where the person will be seen as socially defective in some way, thus cuing first shame (a primary maladaptive emotion) and then fear of the shame and situations that elicit it (a secondary reactive emotion; Shahar, 2014.) The EFT approach to SA (Elliott & Shahar, 2017) is built, first of all, on a strong and genuinely caring and empathic therapeutic relationship. This relational foundation makes it possible for client and therapist to begin to collaboratively address the client's deeply entrenched pattern of dysfunction. The therapist then helps the client to explore the presenting anxiety process by which they make themselves anxious. They then move on to the primary maladaptive shame, the underlying self-critical process, and its developmental origins. Over time, the therapist helps the client begin to access a series of primary adaptive emotions, beginning with curiosity about their fear of people, sadness at loss of connection with others, anger at previous mistreatment, and finally self-compassion and self-affirmation. These new, emerging emotions are hypothesised to form the basis of new, more useful self-organisations, leading to behavior change and more fulfilling interactions with others. In comparison to PCT, EFT has been described as "process guiding" (Elliott et al., 2004) and emphasises active collaboration with clients on identification and pursuit of shared goals and

tasks of therapy as well as therapist responses aimed at helping clients explore their experiences and at setting up in-session therapeutic work (referred to as “tasks”).

Empirical evidence supports the general effectiveness of both PCT and EFT as treatments for depression (Elliott, Watson, Greenberg, Timulak & Freire, 2013), with EFT now designated as an evidence-based treatment for depression in the US (Strunk, 2016). However, the extent to which either may prove effective as a treatment specifically for SA remains unknown. Given that Major Depressive Disorder is commonly comorbid with SA it could be argued that this evidence points to these approaches as potentially effective for SA. On the other hand, a recent meta-analysis of outcome research on humanistic treatments of a range of anxiety disorders indicated that these therapies were generally less effective than CBT (Elliott et al., 2013). Nevertheless, as far as we can tell, only two group design studies of SA with a humanistic psychotherapy have so far been reported: First, Cottraux and colleagues (2000) compared CBT to what they referred to as ‘Supportive Therapy’ (with a focus on empathic engagement, reformulation and clarification) and concluded that CBT was more effective than Supportive Therapy. However, their CBT consisted of 20 hours of treatment (consisting of a mixture of individual sessions and group social skills training, delivered over 12 weeks), while clients in Supportive Therapy received only 6 half-hour sessions, pointing to a researcher allegiance effect. Second, Shahar, Bar-Kalifa and Alon (2017) recently reported the results of a multiple baseline design for EFT with 12 clients offered up to 28 sessions; they randomized clients to wait four, eight or 12 weeks between intake and beginning therapy. Of the 11 completers, seven no longer met criteria for SA at the end of treatment. Clients did not show improvement in social anxiety during baseline, but experienced large and statistically significant improvements during treatment and remained improved during follow-up.

In addition to the above, a recent series of systematic single case studies with clients diagnosed with SA have explored the effectiveness of PCT (MacLeod & Elliott, 2014; Stephen, Elliott & MacLeod, 2011) and EFT (MacLeod, Elliott & Rodgers, 2012; MacLeod & Elliott, 2012; Shahar, 2014), including clients with varying outcomes. This body of single case evidence provides a basis for larger scale outcome research comparing the efficacy of PCT and EFT.

Our research questions were as follows: (a) Will socially anxious clients seen in PCT or EFT show substantial *change* over the course of therapy (as a group and individually)? (b) Will there be statistically significant *differences* in outcome between clients seen in EFT vs. PCT? (c) Using a SA target measure (the Social Phobia Inventory; SPIN), will EFT and PCT show pre-post effect sizes *comparable (i.e., within .2 sd) to benchmarks* based on available studies of CBT and medication in the literature? (d) Using relevant process measures assessing therapeutic relationship and therapist interventions, will PCT and EFT show expected patterns of *similarity* across treatments (in terms of client or therapist-reported person-centered therapist-offered relational conditions, aims and response modes) as well as *differences* (in terms of client-perceived working alliance and therapist directivity, and therapist reported process-guiding therapist aims and response modes).

## **2. Method**

The current pilot study began with a nonrandomized treatment development phase with two arms and then moved into a randomized phase comparing PCT and EFT. In the first phase PCT and EFT were adapted as treatments for SA, within a two-group pre-post non-equivalent comparative treatment design. During this phase, clients were assigned unsystematically to therapists purely on the basis of therapist availability. During this phase there were more PCT therapists, so more clients were assigned to the PCT condition. In the



second phase clients were randomly assigned to the two treatments, making it a small pre-post randomized comparative treatment design. Successive pairs of participants were assigned randomly by the principal investigator to the two treatments using the 2 digit random sequence generator found at random.org.

The research team included strong advocates for both PCT and EFT, with the Principal Investigator a founder of the EFT approach. The pilot nature of the study led us to focus on description of treatment effects rather than rigorous testing of differences between treatments; for this reason engager rather than intent-to-treat analyses will be reported.

## **2.1. Participants**

### **2.1.1. Clients**

Clients were primarily recruited through notices posted in the local community (supermarket notice boards, libraries etc.) or referred by local mental health agencies. Clients were recruited for two studies, one offering up to 20 sessions of free humanistic psychotherapy for social anxiety, the other a 40-session general outpatient psychotherapy research protocol. All clients (n = 327) received brief telephone screenings to determine which research protocol to refer them to; 108 were referred to the SA protocol. Following that, they entered the intake process (n = 77), where they took part in four hours of intake assessment including diagnostic screening, pre-testing, and informed consent.

Sixty-five clients met inclusion criteria: (a) saw self as having social anxiety difficulties; (b) met criteria for DSM–IV diagnosis of social anxiety disorder, assessed by a trained researcher using the research version of the SCID (First, Spitzer, Gibbon & Williams, 2007), judged as their main presenting problem; (c) were willing to take part in research procedures (interviews, questionnaires, video/audio recording); (d) were age 18 or older; (e) were mentally competent to give consent; and (f) had basic competence in written and spoken

English. Clients were excluded if they were currently in psychotherapy or counselling elsewhere; were currently in a domestic violence situation; or were currently experiencing severe substance abuse, a psychotic condition, or other current clinically predominant disorder/problem requiring primary focus of clinical attention. Ethics approval was obtained through both university and local National Health Service ethics committees.

Sixty-one clients gave consent and began therapy; of these, 53 received at least 3 sessions and will be reported on here (see Table 1 for CONSORT information about client flow). In addition to social anxiety, other common diagnoses (assessed by the SCID; First et al., 2007) were generalized anxiety (51%), depression (34%), panic (28%), and other specific phobia (24%). Avoidant personality traits (assessed by the Personality Disorders Questionnaire – IV; Hyler, 2007) were the most common Axis II pattern (76% of participants). Fifty-two percent were female; almost all (93%) clients were of European origin. The average age was 35.2 (sd: 10.7). Thirty-three percent listed a current medication for a psychological condition. Thirty-five percent of clients were living alone. Thirty-one percent were in paid employment; 21% were students; and 17% were unemployed. Clients typically rated their presenting problems (predominantly social anxiety-related) as having been present for six to ten years.

### **2.1.1. Therapists**

Fifteen therapists were involved in the study, 11 female and four male. Ten were postgraduate diploma level or MSc level counselors; the rest were PhD level in counselling (2), counseling psychology (2) or clinical psychology (1). Therapists saw between 1 and 9 clients (mean: 3.5; sd: 2.1). All therapists had trained in PCT and had at least 2 years post-qualification experience. There was, however, wide variation in amount of experience carrying out EFT: several EFT therapists had only recently completed EFT training, while

one EFT therapist was one of the developers of EFT with over 30 years' experience in that approach.

## 2.2. Measures

### 2.2.1. Outcome Measures.

We had two primary outcome measures: The first was the *Social Phobia Inventory* (SPIN; Connor et al., 2000), a 17-item problem-specific measure of social anxiety symptoms supported by evidence for good reliability and validity (internal alpha for this sample: .93). The second primary outcome measure was the *Personal Questionnaire* (PQ; Elliott et al., 2016), an individualized outcome measure, consisting of a list of about 10 problems (mean number of items: 9.9, sd: 2.9) identified by the client during the intake process as issues they wanted to work on in their treatment. Elliott et al. have reported strong reliability and validity findings for this sample (pre-therapy inter-item alpha: .76; pre-therapy test-retest reliability: .57; between-client convergent validity with other outcome measures: .47 to .73). In the present sample, items identified by clients predominantly focused on aspects of their social anxiety, making this primarily an individualized social anxiety measure. Clients completed the PQ at the beginning of each therapy session as well as at all other assessment points, allowing us to maximize the number of clients represented. For individual change analyses, we used a clinical cut-off of 3.25 and a minimum reliable change index value of 1.5 (Elliott et al.).

Three other outcome measures were also used: (a) The *CORE-OM* (Evans et al., 2002) is a well-established, 34-item general clinical distress measure scored in the direction of greater distress (internal alpha for this sample: .95). (b) The 26-item version of the *Inventory of Interpersonal Problems* (IIP; Maling, Gurtman & Howard, 1995) is an interpersonal problem distress measure also scored in the direction of greater distress (internal consistency

for this sample: .90). (c) The *Strathclyde Inventory* (SI; Freire, Elliott & Cooper, 2007) is an experimental person-centered outcome measure assessing a single 31-item dimension of congruence/fluidity vs incongruence/structure-boundness (internal alpha: .93), scored in the direction of higher client functioning. Measures were completed at screening, session 1, mid-therapy (after session 8), post-therapy, and at 6- and 18-month follow-ups.

### **2.2.2. Process measures/Adherence analyses**

In order to test hypotheses about similarities and differences between the two treatments, we used the following measures: (a) The *Working Alliance Inventory-12-R* (WAI; Horvath & Greenberg, 1989; Hatcher & Gillaspay, 2006) is a client self-report measure that assesses the therapeutic relationship in terms of Bordin's (1979) model of therapeutic bond, and agreement on goals and tasks; it consists of 12 items rated on a 5-point scale. Research on the WAI is extensive and supports its reliability and validity (Horvath, Del Re, Flückiger & Symonds, 2011). As the WAI was developed in part to be sensitive to relational processes that are found in EFT, we predicted that scores would be generally good ( $> 3$ , "fairly often") but slightly higher in EFT than in PCT ( $smd > .3$ ). (b) The *Therapeutic Relationship Scale* (TRS; Carrick & Elliott, 2013; Sanders & Freire, 2008) was developed as a targeted client and therapist self-report measure assessing to two key PCT concepts: quality of offered therapeutic relationship (Rogers, 1957) and therapist nondirectiveness (Brodley, 2006); the version we used consisted of 27 items each rated on a 5-point scale (0: "never"; 1: "seldom"; 2: "sometimes"; 3: "frequently"; 5: "always"). Carrick & Elliott (2013) reported reliability and validity data on the TRS supporting its psychometric status, using a data set that included the present study. We predicted relatively high ( $> 2.5$ ) and comparable ( $smd < .3$ ) scores on quality of offered therapeutic relationship but more therapist directiveness for EFT ( $smd > .5$ ). (c) Parallel *therapist postsession questionnaires* for PCT and EFT were developed for this

study based on an earlier EFT therapist post-session forms (Elliott, 2006). Both instruments assessed PCT treatment principles (e.g., empathic attunement;  $\alpha = .90$ ), PCT therapist response modes (e.g., empathic reflections;  $\alpha = .87$ ), EFT treatment principles (e.g., progress on tasks;  $\alpha = .88$ ), EFT therapist response modes (e.g., process suggestions;  $\alpha = .72$ ); and content directive therapist response modes (e.g., giving advice;  $\alpha = .67$ ); in addition, the EFT form used multiple items to assess specific EFT therapeutic tasks (e.g., Two Chair work for conflict splits;  $\alpha .90 - .94$ ). We expected EFT and PCT to be high and comparable ( $smd < .3$ ) on the PCT variables, and low and comparable on content directive response modes ( $smd < .3$ ); we also expected EFT to be higher than PCT on the EFT variables ( $smd > .5$ ). Finally, we expected EFT therapists to report at least a moderate level of active EFT tasks ( $> 25\%$  of sessions reporting process-guiding tasks under each of three groupings: focusing, narrative work, chair work).

### **2.3. Procedure**

Clients were offered up to 20 weekly 50-min sessions of either person-centered therapy (PCT) or emotion-focused therapy (EFT) for social anxiety; clients could finish earlier if they wished. We used an engager sample; that is, clients were included in outcome analyses if they received at least 3 sessions. Clients in PCT received an average of 14.7 sessions ( $sd: 5.7$ , range 3 – 20), while clients in EFT received an average of 17.9 ( $sd: 5.5$ , range: 4 - 22), three more sessions than in PCT ( $t = 2.35$ ;  $p < .05$ ;  $SMD = .67$ ).

As Table 1 indicates 32 clients were seen for at least three sessions in the nonrandomized, treatment development phase of the study, and assigned on the basis of therapist availability (19 clients in PCT and 13 clients in EFT; see Table 1). Twenty-one clients were seen in the treatment testing phase and were randomly assigned to either PCT ( $n = 12$ ) or EFT ( $n = 9$ ) (the odd number was due to an error in the randomization process).

Overall, five clients dropped out before session 1 and eight clients attended only one or two sessions; of the latter, five clients dropped out of EFT and three out of PCT.

*Person-Centered Therapy* is based on the work of Carl Rogers (1951, 1957, 1959). Merry (2002) outlined the central principles of PCT as: the actualising tendency is understood to be the sole motivation for human behaviour, growth, change and development; the causal agent in promoting change is seen as a therapeutic relationship in which the six necessary and sufficient conditions for psychological growth (Tudor, 2011) are present, among them, unconditional positive regard, empathy, and genuineness. In this approach the therapist's nondirective attitude and behavior are seen as communicating deep trust in the client's internal processes and capacity for personal change. In the present study, the PCT condition included therapists within both strict nondirective (e.g., Brodley, 2006) and broader (eg, Mearns, Thorne & McLeod, 2013) versions of PCT.

*Emotion-Focused Therapy*. As applied to social anxiety, EFT consists of the following elements (Elliott, 2013): (a) a strong, genuinely accepting and empathic relationship; (b) exploratory work for accessing, deepening, and symbolising emotional experiences related to social anxiety; (c) narrative work for unfolding particular episodes of SA and developing a coherent account of the social anxiety in the person's life; (d) within-session enactments (chair work) of internal self-critical and social anxiety processes, plus unresolved painful relationships connected with social anxiety, and (e) within-session enactments of self-soothing processes (self-compassion).

#### **2.4. Benchmarking Meta-analysis**

In order to compare our results to those obtained by other researchers, we conducted a meta-analysis of all available social anxiety treatment outcome studies (including both psychological treatments and medication) using our primary outcome measure, the SPIN.

Table 3 provides the PRISMA information summarizing the identification of the sample of studies, beginning with a cited-source search of the PsycInfo and Medline databases (28 November 2016), which identified 397 studies that cited Connor et al (2000), the study that introduced the SPIN. These were winnowed down to 21 studies, including 37 samples of clients (total  $n = 2438$  clients; see Table 3 for inclusion/exclusion criteria). These studies included 19 samples of clients (from 15 studies;  $n = 1019$ ) seen in cognitive-behavioral therapy (CBT), primarily group CBT following the Heimberg model (Hope et al., 2010) but also a few internet-based treatments. Eight samples of clients (from 6 studies;  $n = 808$ ) received medication (primarily SSRI/SNRIs) as the primary intervention. There were also eight samples of clients (from 8 studies;  $n = 529$ ) who were assigned to control groups (either pill placebo or a usual care/waitlist condition). In addition, two samples of clients (from 2 studies;  $n = 82$ ) received a new mindfulness/acceptance-based intervention (Kocovski et al. 2009, 2013). Finally, two studies (Barnett et al., 2002; Huang et al., 2013) produced results that were clear outliers and were dropped. The samples of clients came from a mix of completer ( $n = 17$ ), intent-to-treat ( $n = 15$ ), and engager (11) studies.

The SPIN benchmarking meta-analysis was intended to establish pre- and post-treatment normative data; therefore, SPIN means and standard deviations were analysed rather than effect sizes. However, because of different reporting standards in the psychopharmacology literature, a high proportion of the medication (63%) and control (38%) studies failed to provide standard deviations, making the results for these treatment conditions potentially uninterpretable. Therefore, we used multiple data imputation (van Buuren, 2012) to estimate the missing standard deviations, using the following predictor variables: mean and sample size for pre- and post-SPIN scores, treatment condition category, and treatment completion rate estimate. Eight pre-treatment and eleven (of 37) post-treatment SPIN study

standard deviations were estimated by pooling 10 sets of imputations and used in the benchmarking analysis.

### **3.0 Results**

#### **3.1. Preliminary Analyses**

##### **3.1.1. Therapist Effects**

In order to test for therapist effects on client outcome, we ran ANCOVAs (within the SPSS 22 MIXED procedure, REML model) on client post-therapy score, using pre-therapy score as covariate. Only the value for the SI was statistically significant (partial eta-squared = .55;  $p < .05$ ); the mean of the other five Eta-squared values was .29 varying between .19 for the IIP to .41 for the SPIN. Thus, therapist effects appeared to account overall for about one third of variance in client outcome; however, the large number of therapists in the study ( $n = 15$ ) meant that statistical power (estimated at a mean of 47% across of analyses) was low. In our main analyses we included therapists as a subject factor only for the SI.

##### **3.1.2. Pre-treatment Differences**

Pre- and post-treatment descriptive statistics for PCT and EFT conditions (sample sizes, means, standard deviations) are reported in Table 2. Because the design was only partially randomized, we first tested for pretreatment differences between PCT and EFT. We found small, statistically nonsignificant ( $smd < |.3|$ ) differences for all five outcome measures, of varying signs such that they cancelled each other out, resulting in a mean  $smd$  of  $-.03$ , consistent with overall pre-therapy equivalence. This indicated that direct comparisons between treatments would be valid; nonetheless, we erred on the side of caution by controlling for pre-therapy status, which was a consistent and strong predictor of post-therapy scores (mean  $r = .51$ ).



## **3.2. Change over Time: Combined Treatment Results**

### **3.2.1. Overall Pre-post Change**

In order to answer our first research question, about whether socially anxious clients seen in PCT or EFT would show substantial change over the course of therapy, we analyzed outcomes for all clients in both conditions with at least 3 sessions. The top section of Table 2 provides the pre and post descriptive statistics and effect sizes (standardized mean differences; SMDs) for the combined sample. These results showed large, statistically significant pre-post gains in group mean scores, particularly for our two primary outcome measures, the Social Phobia Inventory (SPIN) and the Personal Questionnaire (PQ), as well as the Strathclyde Inventory (SI). Somewhat smaller amounts of change were obtained on the two more generic measures, the CORE-OM and the Inventory of Interpersonal Problems. The mean pre-post smd across the five measures was 1.13.

### **3.2.2. Randomized vs Nonrandomized Cohorts**

Effect sizes for the randomized cohort were slightly but consistently larger than those for the nonrandomized cohort, with mean pre-post SMDs of 1.40 and 1.02 respectively (see bottom two sections of Table 2). Comparative SMDs were +.6 for the PQ and +.29 for the SPIN; overall, the mean comparative SMD across the five outcome measures was +.38. For most of the outcome variables we carried out standard ANCOVAs comparing randomized with nonrandomized cohorts; however, for the SI we also included therapists as a subject factor. Only on the SI did the randomized cohort show significantly larger effects ( $F = 7.49$ , d.f., 2, 35.35;  $p < .01$ ; smd: .28). In addition, there were no significant interactions between treatment and randomization. Therefore, for subsequent analyses randomized and nonrandomized cohorts were combined in order to increase statistical power and to estimate effect sizes more precisely.

### **3.2.3. Reliable Change**

We also looked at reliable and clinically significant client change on our two primary outcome measures, using the Jacobson-Truax (1991) criteria. In contrast to the group outcome results, on the SPIN, only 35% of clients showed reliable improvement, with 68% still in clinical range. On the PQ, only 29 out of 53 clients (55%) showed reliable change ( $p < .05$ ) at the end of therapy (a mean score drop of at least 1.5 points); with 66% still in the clinical range ( $> 3.25$ ; slightly more than “little”) on the PQ. Two different clients (about 4% of the sample) showed evidence of reliable deterioration on any measure: one on the PQ and the other on the CORE-OM; there was no reliable deterioration on the other three measures, including the SPIN.

### **3.3. Comparative Outcome: PCT vs EFT**

#### **3.3.1. Pre-post change in PCT and EFT conditions**

Table 2 (sections 2 and 3) provides the pre-post SMD values for PCT and EFT respectively: Clients in PCT showed large and fairly consistent amounts of pre-post change, with an SMD of 1.05 on both the SPIN and the PQ, our two primary outcome measures. The mean pre-post SMD for the PCT group across the five outcome measures was .91. Clients in EFT also showed even larger amounts of pre-post change, with SMDs of 2.19 on PQ and 1.55 on the SPIN. The mean SMD across the five outcome measures was 1.44. All pre-post differences within PCT and EFT treatment groups were statistically significant (paired t-tests,  $df = 15 - 30$ ;  $p < .01$ ).

#### **3.3.2. PCT vs. EFT Comparison**

Comparative EFT vs PCT effects were quite variable but somewhat favored EFT: The largest difference was on the PQ, where the comparative SMD was 1.14 in favor of EFT over PCT, while on the SPIN it was .50. The smallest differences were on the CORE-OM (.10) and the IIP (.08). The mean comparative pre-post effect across the five outcome measures was .53 in

favor of EFT (.33 and 1.02 for nonrandomized and randomized cohorts). To test the statistical significance of these comparative differences we used the MIXED procedure in SPSS 22 to analyse posttherapy scores with pretherapy scores as covariates. As with the tests for the effects of randomization, we used standard ANCOVAs for all measures except the SI, where we used multi-level analyses controlling for therapist effects. For the PQ, one of our two primary outcome measures, the ANCOVA was statistically significant ( $F = 8.35$ ;  $df: 1, 50$ ;  $p < .01$ ). PCT and EFT did not differ significantly on outcome on the other main outcome measure, the SPIN ( $F = 1.19$ ;  $df: 1, 37$ ). Of the other three outcome measures, only the SI produced significant differences, with clients in EFT showing more improvement in covariate analyses including therapist effects ( $F = 10.45$ ,  $df: 2, 12.33$ ,  $p < .01$ ).

### **3.4. Benchmarking Meta-analysis on SPIN Scores**

Overall, across the 21 studies in the benchmarking sample, socially anxious clients' pre-treatment average total SPIN scores were 44.82 (see Table 4; 95% confidence interval: 42.34 – 43.30). In the present study, the combined PCT/EFT sample pre-treatment mean SPIN score was slightly lower (41.99) and outside the benchmark sample pre-treatment range. Similarly, at post-treatment, the benchmark SPIN score across all treatment conditions was 29.62 (95% CI: 29.10 – 30.14). In the present study, socially anxious clients in humanistic-experiential psychotherapy averaged 27.03 at post-treatment, well below the benchmark; and the SMD was 1.27 (vs 1.04 for the benchmark).

However, the overall benchmark includes untreated/placebo control samples (SMD: .79); thus, a better comparison would be clients in CBT (SMD: .99) or medication (SMD: 1.13) conditions. In relation to CBT, clients in the present study fell within the CBT benchmark at pre-treatment but below it (i.e., were less anxious) at post-treatment (PCE: 27.03 vs. CBT: 30.26, 95% CI: 29.45 – 31.07). In contrast, when compared to the medication

benchmark (using imputed data), clients from the combined samples in this study were comparable at pre-treatment but at post-treatment fell above (27.03; i.e., more anxious than) the benchmark range for medication (mean: 25.23; 95% CI: 24.20 – 26.26). Only clients seen in EFT fell within the medication benchmark range at the end of therapy (25.08). Clients seen in PCT had pre-post effects for PCT (SMD: 1.05) that were comparable to those seen in CBT, and slightly better than control clients (.79). Clients in EFT showed pre-post effects substantially better (comparative SMDs > .4) than both bench-marked CBT and medication treatments.

### **3.5. Treatment Adherence Tests**

Finally, in order to assess treatment adherence and differentiation we tested our predictions about similarities and differences between PCT and EFT (see Table 5): (a) As expected clients in EFT reported higher scores on the Working Alliance Inventory than clients in PCT, a medium effect (smd = .60;  $t = 2.23$ ;  $p < .05$ ) reflecting greater attention to goal and task agreement. (b) Clients seen in PCT and EFT reported similarly high levels (> 2.0) on the therapist Relational Quality factor of the Therapeutic Relationship Scale (TRS) (SMD: .21). However, contrary to expectation, EFT therapists rated themselves substantially higher on Relational Quality than PCT therapists rated themselves (SMD: .78;  $t = 2.76$ ;  $p < .01$ ). (c) We expected PCT therapists to be rated at higher levels than EFT therapists on the therapist Nondirectiveness factor of the TRS; this expectation was also supported for client ratings at a medium effect size level (SMD: .61;  $t = 2.17$ ;  $p < .05$ ), but not for therapist ratings (SMD: .07). (d) We expected PCT and EFT therapists to report similar levels of PCT treatment principles and response modes on the PCT and EFT Therapist Postsession Forms; here we found that EFT therapists reported themselves substantially higher on PCT treatment principle quality but not on PCT response mode use. EFT therapists also reported using much higher

levels of EFT treatment principles and response modes. (e) Using the EFT Therapist Postsession Form, EFT therapists reported moderate or extensive use of process-guiding EFT tasks in a high proportion of sessions: Focusing tasks were reported in 32% of sessions; narrative tasks (systematic narrative retelling and unfolding) in 41% of sessions; and chair work (especially two chair work for anxiety or self-critical splits) in 37% of sessions. (f) Finally, PCT and EFT therapists both reported low levels (less than “possibly present”) of content directive responses, with EFT therapists somewhat higher than PCT therapists (most commonly mildly interpretive or reassuring responses or occasional information questions). Thus, PCT and EFT therapists generally performed in ways consistent with their related but distinct treatment models, at least as viewed by their clients, although this sample of EFT therapists rated themselves as higher on person-centred relational qualities and treatment principles.

#### **4. Discussion**

This is the first study comparing the outcome of two humanistic psychotherapies for social anxiety. We have reported evidence for the effectiveness of both PCT and EFT with social anxiety: Clients in the combined sample showed large gains over therapy on all measures and overall did slightly better than clients in the studies reviewed in a recent meta-analysis of humanistic psychotherapies for anxiety (Elliott et al., 2013; SMD: 1.27 vs. .94). In fact, in the benchmarking analyses we have reported here, PCT did slightly better (1.13) and EFT did substantially better (1.5) when compared to CBT (.99). This is consistent with our anecdotal impressions that many clients showed substantial change over therapy on long-standing problems.

Clients who received EFT did reliably better on two of the five outcome measures. The difference was largest on the Personal Questionnaire (an individualized outcome measure

that tilted toward social anxiety difficulties in our sample), where pre-post effects for EFT clients were more than twice as large as for PCT clients, but also showed up on the Strathclyde Inventory, a measure of outcome derived from person-centered theory. The differences were smallest for the most general measures (CORE Outcome Measure, Inventory of Interpersonal Problems). Across the five outcome measures, the mean comparative effect size for EFT vs. PCT was .53, a medium effect size and comparable to previously-reported comparisons between EFT and PCT for depression (Greenberg & Watson, 1998; Goldman, Greenberg & Angus, 2006) and for complex trauma (Paivio, Jarry, Chagigiorgis, Hall & Ralston, 2010). However, this difference may be due in part to the fact that clients in EFT chose to attend 22% more sessions.

Other clues about what might account for the apparent difference in outcome might lie in the differences identified in our adherence analyses. We were able to differentiate between PCT and EFT on standardized measures of the therapeutic relationship, including the Working Alliance Inventory, where clients rated EFT therapists substantially higher than PCT therapists; similarly, clients rated PCT therapists as higher on nondirectiveness, which might be counterproductive for some clients with SA.

This study adds to emerging evidence on the effectiveness of EFT for clients with anxiety difficulties, including complex trauma (Paivio et al., 2010), social anxiety (Shahar et al., 2017) and generalized anxiety (Timulak, McElvaney, Martin, Keogh & Greenberg, 2017). However, in contrast to the existing literature (Elliott 2013), it also identifies substantial benefits for clients in PCT as well. It was clear to us that many clients engaged well and showed clinically significant and reliable change in PCT. For these clients, their therapists' nondirective relational offer seemed to be exactly what they needed to counter the conditions of worth on which their social anxiety was based, according to person-centered theory.

The reasons for the discrepancy between the older literature and recent studies such as the present one are not entirely clear. Interestingly, both conditions improved in their effectiveness between the first and second phases of the study, as they learned how to work with this challenging client population. We speculate that the focus on particular kinds of anxiety difficulty in recent studies has enabled therapists to better understand their anxious clients' experiences and needs more thoroughly and to develop more responsive ways of working with highly anxious clients. Examples of this enhanced responsiveness include the following: First, therapists in both PCT and EFT learned that their clients were extremely sensitive to anything that might indicate rejection or judgment by the therapist; for example, as the study progressed therapists increasingly went out of their way to greet their clients with genuine enthusiasm at the beginning of sessions. Second, both PCT and EFT therapists also learned that many of their socially anxious clients struggled with lack of structure, particularly early in therapy; they thus began to talk more and to ask more questions in early sessions, before tapering off in order to provide these clients with more space and control over sessions. Third, some clients were too self-conscious to use EFT chair work, requiring the therapist to abandon this aspect of EFT or to find creative work-around strategies (eg mediating for the client).

Over the course of the study, EFT conceptualization and methods of working with social anxiety were evolving, based on emerging experiences with clients. For example, the EFT therapists began refining and making more use of a relatively new form of chair work called *compassionate self-soothing* (Sutherland, Peräkylä & Elliott, 2014) This therapeutic task involves helping the client to enact a dialogue in which a deeply 'wounded' and vulnerable aspect of the self is comforted and affirmed by a nurturing and prizing aspect of the self. In fact, toward the end of the data collection, an integrated EFT protocol for working with social anxiety emerged (Elliott & Shahir, 2017).

Despite the overall positive results of the study, a number of cautions are in order: First, the research design was only partially randomized (although somewhat larger effect size differences were found for the randomized part of design). Second, treatment overlap issues may have reduced the observed differences: As noted, some clients refused EFT Chair work, so that their therapy devolved into a broadly PCT/Experiential therapy featuring structured exploration, focusing, and narrative work. Third, although the research team overall was balanced in its theoretical allegiance, the principal investigator is a strong advocate of EFT, which means that researcher allegiance effects could still have been operating.

Crucially, analyses of reliable clinical change indicated that while 55% of clients showed reliable change on the PQ, only 35% showed reliable change on the SPIN. Clearly, as with CBT for social anxiety (Stravinsky, 2007) and in the studies of CBT in our benchmarking study, there is substantial room for improvement in the effectiveness of PCT and EFT for social anxiety.

Recommendations for future research on PCT and EFT for SA include carrying out larger, randomized studies; investigating change processes (e.g., therapeutic alliance) in order to improve effectiveness, and adding observer measures of therapist adherence and competence.

In terms of implications for clinical practice with social anxious clients, we close with the following observations: First, humanistic-experiential psychotherapies can be effective with social anxiety if they are targeted at the presenting social anxiety. Second, learning about the worlds that anxious clients tend to live in can help therapists to be more empathic and accepting of their clients. Third, many socially anxious clients do better with a certain degree of structure, particularly early in therapy. For many clients with SA, an unstructured therapeutic offer too closely resembles the type of social situation that they most fear. Even the EFT therapists offered more structure than usual in early sessions with their socially anxious clients and provided more information about the nature of therapy and common



experiential processes in anxiety, such as anxiety splits and fearful critics. Finally, therapists applying PCT and EFT with SA need to pay particular attention to engaging frightened, interpersonally vigilant clients in therapy.

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**Table 1****Consort Diagram Information**

<b>Stage of Research</b>	<b>N in Study</b>	<b>N out of Study</b>	<b>Notes</b>
1. Contacted Research Clinic	327	0	
2. Referred to Social Anxiety Protocol	107	220	Referred to another protocol
3. Entered diagnostic screening process	78	29	Declined to enter screening
4. Met selection criteria	66	12	Referred back to other protocol
5. Started therapy	61	5	Did not enter therapy
6. Completed at least 3 sessions	53	8	Stopped after 1 or 2 sessions: PCT: 3; EFT: 5
6a. Treatment Development Phase (Nonrandomized): PCT: 19; EFT: 13	32	6	Stopped after 1 or 2 sessions: PCT: 3; EFT: 3
6b. Treatment Testing Phase (Randomized): PCT: 12; EFT: 9	21	2	Stopped after 1 or 2 sessions: PCT: 0; EFT: 2

**Table 2. Overall Outcome for Combined PCT and EFT Treatments for Social Anxiety**

Measure	Pretreatment		Posttreatment		Pre-post SMD	
	n	m	sd	m		sd
<b>1. Combined PCT &amp; EFT</b>						
PQ	53	5.47	.84	3.83	1.37	1.44
CORE-OM	42	1.69	.64	1.20	.66	0.75
SPIN	40	41.99	11.34	27.03	12.21	1.27
IIP	36	1.90	.54	1.40	.53	0.93
SI	41	1.82	.44	2.41	.52	1.22
Mean Combined Pre-Post SMD:					1.13	
<b>2. PCT</b>						
PQ	31	5.42	.90	4.21	1.35	1.05
CORE-OM	23	1.71	.60	1.27	.66	.70
SPIN	22	41.7	11.29	28.61	13.52	1.05
IIP	20	1.80	.46	1.36	.53	.89
SI	23	1.90	.43	2.33	.55	.87
Mean PCT Pre-Post SMD:					.91	
<b>3. EFT</b>						
PQ	22	5.53	.77	3.28	1.23	2.19

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CORE-OM	19	1.67	.71	1.12	.66	.80
SPIN	18	42.26	11.71	25.08	10.42	1.55
IIP	16	2.02	.62	1.46	.53	.97
SI	18	1.71	.44	2.50	.49	1.70
mean EFT Pre-Post SMD:						1.44
mean EFT – PCT Pre-Post SMD:						.53

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#### 4. Nonrandomized Treatment Development Phase

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PQ	32	5.66	0.85	4.13	1.46	1.29
CORE-OM	26	1.74	0.67	1.25	0.75	0.68
SPIN	25	2.53	0.64	1.68	0.76	1.20
IIP	22	1.95	0.62	1.47	0.61	0.78
SI	25	1.89	0.48	2.48	0.54	1.14
Mean Nonrandomized Pre-Post SMD:						1.02

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#### 5. Randomized Phase

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PQ	21	5.17	0.76	3.37	1.11	1.89
CORE-OM	16	1.60	0.61	1.12	0.48	0.878
SPIN	15	2.37	0.71	1.44	0.64	1.37
IIP	14	1.82	0.38	1.30	0.36	1.41
SI	16	1.70	0.35	2.30	0.48	1.43

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Mean Randomized Pre-Post SMD: 1.40

Mean Randomized – Nonrandomized Pre-Post SMD: .38

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**Note.** SMD: Standardized mean difference (Cohen's d). PQ: Personal Questionnaire; CORE-OM: CORE Outcome Measure; SPIN: Social Phobia Inventory; IIP: Inventory of Interpersonal Problems; SI: Strathclyde Inventory. Sample sizes vary due to missing data. Mean item scores used for all measures except the SPIN, for which total scores were used. All pre-post t-tests significant ( $p < .01$ ), using paired t-tests.

**Table 3: Prisma Diagram for Benchmarking Meta-analysis of Pre- and Post-Treatment Social Phobia Inventory Scores**

Stage	N Studies in	N Studies out	Notes
1. Search Result: Cited Connor et al., 2000	397		Search of PsycInfo and Medline, 28 November 2016
2. First pass abstract screening 1: Outcome studies possibly using SPIN	73	324	Not outcome studies
3. Second pass abstract screening: Study fits current study profile (3+ sessions; social anxiety as major client presentation; SPIN used)	48	26	Study doesn't fit current study profile: <ul style="list-style-type: none"> <li>• &lt; 3 sessions (n = 13)</li> <li>• Social anxiety not a major presentation (n = 6)</li> <li>• SPIN not used (n = 7)</li> </ul>
4. Full text retrieval	38	10	Unable to retrieve full text
5. Used for bench-mark estimation <ul style="list-style-type: none"> <li>• CBT (19 samples)</li> <li>• Medication (8 samples)</li> <li>• Control (8 samples)</li> <li>• Other psychotherapy (2 samples)</li> </ul>	21 (37 samples)	17	Not used in bench-mark calculation: <ul style="list-style-type: none"> <li>• Duplicate/secondary analysis (n = 7)</li> <li>• SPIN not used (n = 3)</li> <li>• Cross-over designs with responders or nonresponders dropped (n = 2)</li> </ul>



			<ul style="list-style-type: none"><li>• Other reasons (could not calculate, &lt; 3 sessions, social anxiety not major presentation; n = 3)</li><li>• Outliers (n =2; Barnett et al., 2002; Huang et al., 2013)</li></ul>
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**Table 4. SPIN Pre- and Post-Treatment Benchmarking Results**

	Pre-treatment		Post-treatment		Effect size
	Weighted Mean (n) <sup>a</sup>	Pooled sd (n)	Weighted Mean (n)	Pooled sd (n)	SMD
Overall (37 samples)	42.82 (2438)	12.03 (1374) <i>12.17</i>	29.62 (2438)	13.12 (1229) <i>13.10</i>	1.05 <i>1.04</i>
CBT (mostly group; 19 samples)	43.42 (1019)	12.28 (1019)	30.26 (1019)	13.24 (1019)	.99
Medication (mostly SSRIs; 8 samples)	42.08 (808)	<i>12.64</i>	25.23 (808)	<i>14.88</i>	<i>1.13</i>
Controls (mostly pill placebo; 8 samples)	42.86 (529)	<i>11.76</i>	34.62 (529)	<i>10.45</i>	<i>.79</i>
Other Treatments (Acceptance- based; 2 samples)	43.32 (82)	13.36 (82)	32.76 (82)	13.58 (82)	.78
Current study (combined PCT & EFT)	41.99 (40)	11.34	27.03 (40)	12.21	1.27
Current study: PCT	41.70 (22)	11.29	28.61 (22)	13.52	1.05

Current study:	42.26	11.71	25.08	10.42	1.55
EFT	(18)		(18)		

<sup>a</sup>Number of clients

*Note.* Sd = standard deviation. Values based in part of multiply-imputed standard deviations are given in italics

**Table 5. Therapy Adherence Analyses**

Adherence Variable	PCT			EFT			EFT vs. PCT SMD
	n	m	sd	n	m	sd	
WAI-12-R – Client ratings	30	3.16	.57	22	3.53	.63	.60*
TRS Relational Quality – Client ratings	30	2.42	.37	22	2.50	.39	.21
TRS Nondirectiveness – Client ratings	30	2.71	.28	22	2.55	.24	-.61*
TRS Relational Quality – Therapist ratings	31	2.22	.31	21	2.48	.37	.78**
TRS Nondirectiveness – Therapist ratings	31	2.18	.46	21	2.21	.34	.07
TPQ PCT treatment principle quality	6	4.31	.38	19	5.14	.71	1.27*
TPQ EFT treatment principle quality	3	3.56	.10	19	5.01	.72	2.12**
TPQ PCT therapist response modes	8	2.61	.58	19	2.76	.59	.26
TPQ EFT therapist response modes	7	1.17	.22	19	2.38	.33	3.95**
TPQ content directive responses	7	1.15	.26	19	1.36	.25	.83+

+ $p < .1$ ; \* $p < .05$ ; \*\* $p < .01$

**Note.** WAI-12-R: Working Alliance Inventory (12-item revised version). TRS:

Therapeutic Relationship Scale. TPQ: Therapist Postsession Questionnaire