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Research on Existential–Humanistic Psychotherapy

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This chapter surveys both qualitative and quantitative research published since 2010 to supplement and follow up on extant reviews of research on existential–humanistic (EH) and allied therapies (Angus et al., 2015; Cain et al., 2016; Cooper et al., 2010b; Di Malta et al., 2024; Elliott et al., 2021; Hoffman, 2019b; Hoffman, Vallejos, et al., 2015; Schneider & Krug, 2017, 2020; Scholl et al., 2014; Vos, 2019). It heeds Vos's (2019) call for epistemological and methodological pluralism to provide support for EH therapy. Moreover, it serves to further dispel the false narrative that no evidence exists for EH therapy's effectiveness (Cooper et al., 2010c), especially in a zeitgeist characterized by precarious movement in the direction of therapeutic monoculture (Cooper et al., 2010c; Leichsenring et al., 2018).

The chapter begins with a brief overview of EH therapy, as well as the closely related humanistic–experiential (HE) therapies. Next, qualitative and quantitative research on the effectiveness of the general relational principles of EH therapy is reviewed, along with that of HE therapies—which Hoffman, Vallejos, and colleagues (2015) and Schneider and Krug (2017, 2020) identified as principal empirical support for EH therapy. This is further expanded upon in many of the subsequent chapters in this volume. Included here is a summary of common factors research as well as investigations of specific factors that are central in EH therapy. Then, given the numerous theoretical, philosophical, and practical similarities between EH and HE therapies—person-centered therapy (PCT),

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process–experiential and emotion-focused therapies (PE/EFTs), and gestalt therapy—research pertaining to the utility and therapeutic outcomes of those therapies with specific populations and presenting concerns is outlined in order to provide further empirical support for EH by proxy. Thereafter, a similar approach is employed with existential–phenomenological (EP) therapy. Finally, recommendations for future research are proposed.

When available, meta-analysis and -synthesis articles have been selected and reviewed first. Those are followed by additional empirical studies that were not included in the aforementioned literature reviews or extant meta-analyses and -syntheses. Also, note that (a) case studies based on fictitious or composite clients have been omitted in order to preserve the chapter's empirical focus and (b) occasionally, qualitative studies are briefly mentioned at the conclusion of some sections pertaining more specifically to quantitative research in order to maintain the thematic flow of the text.

OVERVIEW OF EH THERAPY

EH therapy is a "deeply relational" (Scholl et al., 2014, p. 219), collaborative (i.e., "acting with clients, not on them" [Scholl et al., 2014, p. 221]), phenomenologically oriented approach intended to "set people free" by addressing their problems as the "outward signs of unused inner possibilities" (May, 1981, pp. 19–20; see also Schneider, 2019a).[1] That is, EH therapists employ the therapeutic relationship as a platform for helping clients see and act upon their ability to make choices within the natural, cultural, and self-imposed limits of living and to accept life's paradoxes without engaging in denial of either their freedom or constraints (Schneider, 2008). Predicated on therapeutic and conceptual principles articulated by Bugental (1978, 1987), Krug (2019a, 2019b; Schneider & Krug, 2017, 2020), May (1983; Schneider & May, 1995), Schneider (2008, 2019b; Schneider & Krug, 2017, 2020), and Yalom (1980), EH therapy promotes increased self-reflection and "individuals' ability to venture into unfamiliar territory and respond more spontaneously and adaptively in the face of challenges" (Scholl et al., 2014, p. 228).

To facilitate this exploration, first, EH therapists place a premium on the "potentially curative" (Elliott et al., 2021, p. 1) value of *healing through meeting* (Friedman, as cited in Schneider & Krug, 2020) by way of "authentic but boundaried" therapeutic relationships (Elliott et al., 2021, p. 1). Second, with the therapist as a "process expert" (Scholl et al., 2014, p. 222), EH therapy aims to help clients (a) become more present to themselves and others, (b) experience the ways they both mobilize and block themselves from fuller presence, (c) take responsibility for how they have constructed their current lives, and

[1]Portions of this section have been adapted from "The Humanistic Perspective," by A. M. Bland and E. M. DeRobertis, in V. Zeigler-Hill and T. K. Shackelford (Eds.), *Encyclopedia of Personality and Individual Differences* (pp. 2061–2079), 2020, Springer (https://doi.org/10.1007/978-3-319-28099-8_1484-2). Copyright 2020 by Springer Nature Switzerland AG. Adapted with permission.

(d) choose or actualize ways of being based on facing (vs. avoiding) *existential givens* and *boundary situations* (Greening, 1992; Jaspers, 1970; Yalom, 1980; see also Cooper, 2017; Hoffman, 2019b) as well as cultivating meaning and awe (Hoffman, 2019b; Schneider & Krug, 2017). Third, EH conceptualization is holistic and nonreductive (i.e., "[opening] up possibilities instead of restricting ways [clients] can be understood" [Hoffman, 2019b, p. 9]), and EH therapy serves to promote integration both within clients and with their lived world and the cosmos (Schneider & Krug, 2020).

Further, clients are understood to be experts on both their own experience and potentials within themselves in relation to multiple intersecting ecological and cultural contexts (Bland & DeRobertis, 2020; Jackson, 2019; Vallejos & Johnson, 2019; see also Schneider & Krug, 2020). EH therapists value both the content and the process of client experiencing and create relational conditions for clients to forge their identities and senses of control, responsibility, and teleological purpose out of their contextually situated lived experience (Cooper, 2017; Schneider & Krug, 2020). Thus, clients are granted an active and autonomous role in the therapy process, with therapists respecting clients' freedom and potential to make choices, set goals, and even fail (Rogers, as cited in Scholl et al., 2014) as they use the therapeutic experience to both construe and construct meaning in their lives.

Needs have been identified for the individualistic aspects of EH theorizing to be augmented by and situated amongst other ways of knowing (Hoffman, Cleare-Hoffman, et al., 2019; Jackson, 2019; Vallejos & Johnson, 2019), and for EH principles like freedom (Hoffman, Cleare-Hoffman, et al., 2015) and empathy (Hoffman, 2019a) to be broadened insofar as they are conceptualized differently internationally and in cultural contexts different from those in which EH therapy was originally developed (Hoffman, Jackson, et al., 2019). This has contributed to adaptations of EH theorizing through multicultural lenses that acknowledge parallel constructs and principles while preserving and respecting the integrity of the variations (Hoffman, Cleare-Hoffman, & Jackson, 2015; Hoffman, Cleare-Hoffman, et al., 2019; Hoffman, Yang, Kaklauskas, et al., 2019; Hoffman, Yang, Mansilla, et al., 2019; van Deurzen et al., 2019). Meanwhile, Hannush (2007) conceptualizes culture as the form by which existential givens are collectively negotiated as a means of guiding its members. DeRobertis and Bland (2020) provide phenomenological evidence using an international sample that supports EH theorizing on the trajectory by which people approach others who are different: first as a threat and then from a place of empathy and openness to the other. According to this perspective, this transformation occurs through a process of cross-cultural learning by which new meanings emerge from the interpersonal exchange and compartmentalized, intellectualized understandings of the other become outmoded.

Contemporary EH therapy has two vectors: a more experiential approach and an existential analytic approach (Cooper, 2017). Despite some subtle nuances, these vectors share much in common with other allied therapies that will be explored in this chapter: (a) for the experiential vector, HE therapies including Rogerian PCT (a forerunner to EH therapy) as well as contemporary

"neo-humanistic" (Elliott & Greenberg, 2007, p. 1) PE/EFT[2] and (b) for the analytic vector, EP therapy (see Vos, 2019). The existential–integrative (EI) approach (see Schneider, 2008) also has been developed as a "bona fide offspring" of EH therapy (Schneider, 2019a, p. 231) and also is represented in this chapter. As described by Angus and colleagues (2015; see also Elliott et al., 2021; Hoffman, 2019b; Scholl et al., 2014), all of these models emphasize several evidence-based principles of therapeutic practice:

- By entering empathetically into clients' subjective experience—deemed an essential aspect of their humanity—therapists offer clients a new, emotionally validating interpersonal experience (a *corrective experience*; see Bland, 2014; see also Chapter 6 of this volume on working with emotions).
- Tacit experiencing is an important guide to the conscious adaptive experience. An attuned, supportive therapeutic relationship serves to help clients develop comfort looking inward and, therefore, to render emotional pain more bearable.
- Therapists' responses and interventions are intended to stimulate and deepen the process of clients' immediate experiencing and ongoing awareness throughout the course of therapy. This includes clients' perceiving, sensing, feeling, thinking, and striving.
- Emphasis is given to clients' integrative, formative tendencies toward not only survival but also growth, agency, and the creation of meaning through symbolization. The collaborative nature of the therapeutic relationship is key to the unfolding process of therapy and to clients disclosing narratives or personal stories that further develop and maintain a shared understanding and trust.
- Clients are seen as unique individuals with complex arrays of emotions, behaviors, stories, and capacities that can, at times, be viewed as representative of a particular clinical diagnostic category but never reduced to one. As an alternative to viewing clients through the lens of pathology or deficits, their concerns are approached from the stance of thwarted potential and truncated development. In addition, therapists emphasize and affirm how clients' strengths can be employed to address challenges.

The chapters in this volume further delineate evidence-based aspects of EH practice.

Rather than focus solely on *first-order change* (i.e., symptom reduction and adjustment) that offers temporary relief to clients but runs the risk of leaving

[2]It is important to note that HE therapies mainly parallel the aspects of EH therapy that are centered around potential (as noted in the May quotation in the Overview of EH Therapy section), as well as experiencing, self-determination, growth, authenticity, and presence (as discussed further in the Research on Specific HE Therapeutic Outcomes section). More broadly, EH therapy also focuses on freedom within limitations that is experienced and responded to along a constrictive–expansive continuum (Schneider, 2008, 2019a), as well as on existential givens that are assumed to be universal but also are nonprescriptive (Hoffman, Serlin, et al., 2019).

underlying problems relatively unaddressed and prone to eventual return (May, as cited in Schneider et al., 2009), EH therapists emphasize transformative *second-order change* processes, also known as *existential liberation* (Schneider & Krug, 2017). Second-order change involves a deep restructuring of self that results in long-term, core-level shifts in and expansions of clients' perspectives of their presenting concerns, their world, and themselves (for a review of theoretical and empirical literature on this topic, see Bland, 2013). EH therapists rely less on prescriptive techniques that uphold their role as expert and, instead, employ their presence and reflexive capacities as instruments for understanding and reflecting the client's unique patterns of lived experience.

EH therapists attend to clients' narratives, metaphors, nonverbal behaviors, responses to feedback, and other interaction patterns to help clients explore how these may point toward formative histories that contribute to defensive interpersonal or behavior patterns in an effort to uphold a false sense of self. Therapists' presence serves to "reflect back aspects that are evident but unnoticed" and, "in effect, hold a mirror up to the client" (Schneider & Krug, 2017, pp. 4, 44; see also Chapter 5 of this volume) to guide understanding of how the client is both presently living and willing to live (Schneider, 2019a). Accordingly, clients' resistance to growth becomes exposed and challenged to promote *disidentification*—that is, surrendering the need to defend their current position, having confused it for their greater self-identity. Rather than cling to past knowledge and expectations of themselves, others, and situations, clients become better able to realize and act on a sense of presence and capacity for meaning making in all their experience and appreciation of their situatedness in time. The therapeutic relationship offers a safe space in which clients may consider their underactualized potential and limitations in a way that stimulates neural plasticity and therefore new learning. When the process goes well, clients "reclaim and re-own their lives" (Schneider & Krug, 2017, p. 3), developing a worldview and behavior that authentically and responsibly expresses their core values.

The therapeutic encounter presents clients with the choice between (a) becoming consumed by suffering to the point that they attempt to evade it (i.e., engaging in *experiential avoidance*) and thereby generate even more suffering for themselves or others and (b) accepting the aspects of their lives over which they have no control and committing their attention and energy to those which they do (i.e., resiliently suffering well). This sense of *intentionality* (May, 1969; Schneider & Krug, 2017, 2020) enables a person to set goals and self-determinedly move forward instead of become mired in the face of adversity as they deal with the daimonic using self-awareness, integrity, and creativity (Hoffman, 2019b). Accordingly, EH (and especially EI) therapists may also incorporate, amongst other strategies, role play, rehearsal, visualization, problem solving, and mindfulness-based techniques to help clients try out new experiences and behaviors in the interest of incorporating and maintaining them outside the therapy relationship (Cooper, 2017; Schneider, 2019a; Schneider & Krug, 2017; Scholl et al., 2014; see also Part III of this volume). EH therapy has been successfully integrated with cognitive behavior therapy (CBT) and family systems therapy (Shumaker, 2017) as well as narrative therapy (Richert, 2010).

Under- and Misrepresentation of EH Therapy in Textbooks

In a content analysis of 21 introductory psychology textbooks, Henry (2017) notes that EH and HE therapies were represented almost entirely by PCT. Rogers's (1957, 1959) facilitative conditions for change were found to be misconstrued as abilities instead of attitudes. Worse, Rogers's nondirective qualities were characterized as "highly passive," as exemplified by one textbook author who rhetorically inquired what therapists actually do during sessions (Henry, 2017, p. 286).[3] Moreover, although gestalt therapy was also mentioned in over a third of the textbooks, it was exclusively Perls's version without consideration of its contemporary iterations (e.g., Lac, 2016, 2017 as well as PE/EFT). In the meantime, 80% of the books omitted existential therapies altogether, and only one book discussed human science (i.e., qualitative) research methods—a principal means of providing empirical support for existential therapies (Vos, 2019)—and did so in a dismissive manner at that.

At the level of graduate training, Prochaska and Norcross's (2018) *Systems of Psychotherapy* textbook does include chapters on existential, PCT, and experiential therapies. However, they are presented in separate chapters with EH and EI therapy (a) mentioned only briefly and (b) "interchangeably" merged with EP therapy (p. 93) without acknowledging their subtle differences (see Cooper, 2017; van Deurzen et al., 2019). More importantly, though the research cited to support experiential therapy is generally more favorable, much of the research selected by the authors to represent existential therapy and PCT tends to include older studies or those involving variant models that employ only isolated fragments of EH theorizing. Not surprisingly, these studies fail to offer support for those therapies. This overlooks evidence to the contrary from studies that are newer and that maintain a greater degree of fidelity to the original models. As Elliott and Freire (2010) observe, if EH and HE therapists "let others define our reality by studying watered-down versions of what we do, we are going to be in trouble" (p. 12).

Existing Reviews of EH and Related Therapies

As an antidote to this predicament, during the 2010s, critical reviews of empirical research supporting EH and allied therapies have been published (Angus et al., 2015; Cain et al., 2016; Cooper et al., 2010b; Elliott et al., 2021; Hoffman, 2019b; Hoffman, Vallejos, et al., 2015; Scholl et al., 2014; Schneider & Krug, 2017, 2020; Vos, 2019). In particular, these authors have focused on 21st-century research in

[3]This problematically conflates PCT—and, with that, EH therapy—with supportive/nondirective therapy that will be discussed later in this chapter and which researchers have found to be ineffective. In contrast, with its emphases on promoting openness to immediate emotional and cognitive experiencing, a "shift from incongruence to congruence," and a "change in [one's] manner of relating" as well as in their "relationship to [their] problems" (Rogers, 1961/1995, p. 157, emphasis added), PCT qualifies as a legitimate psychotherapy, described by Wampold (2007) as entailing "understanding the [client's] explanation (i.e., [their] folk psychology) and modifying it to be more adaptive" (p. 863).

an effort to render it "inappropriate for academicians and policymakers to consider these treatments ineffective or inferior" (Lambert et al., 2016, p. 59). Moreover, Elkins (2016) summarized classic research findings on relational healing (including Rogers's seminal research on PCT; Rogers, 1961/1995) as well as contemporary research on attachment and relational neuroscience to make the case that the human element is the most potent determinant of psychotherapy effectiveness because it draws on humans' evolutionarily derived ability to heal emotionally via social means. This chapter surveys research published since 2010 to supplement and follow up on these extant reviews—which primarily, though not exclusively, cover studies from before 2010 and up to 2015.

REVIEW OF QUALITATIVE RESEARCH ON EH THERAPY

Qualitative methodologies have long been favored by EH psychologists for their phenomenological, holistic, narratively based, and tentative (e.g., hypothesis-generating as an alternative to hypothesis-testing; Charon & Marcus, 2017) stance (Timulak & Creaner, 2010; see also Bland & DeRobertis, 2020). Qualitative methodologies are particularly conducive to (a) understanding clients' internal experiencing from their frame of reference and (b) identifying contextual factors to inform therapists' decision making and enhance their responsiveness and intentionality (Levitt, 2016). Taken together, these contributions lend themselves to better understandings of "the experience of change [that] consists of a qualitative shift into a whole new way of seeing the world" (Rousmaniere et al., 2020, p. 569).

Case Studies

Case studies produced by EH psychologists have been valuable not only for establishing effectiveness but also for theory building (Elliott et al., 2021). Adding to EH therapy's "enduring lineage" (Schneider & Krug, 2020, p. 282) of "some of the most eloquent case studies in the professional literature" (Schneider & Krug, 2017, p. 101), Krug and colleagues (2019), Schneider and Krug (2017, 2020), and Shumaker (2017) provide case histories and vignettes to illustrate EH therapists' responsiveness to clients' feelings, experiences, and protective patterns via a process orientation, as well as successful integration of EH principles with psychodynamic and CBT approaches.

Gordon and colleagues (2021) demonstrate how EH therapy illuminates therapists' ability to help clients with preexisting medical conditions reflect on the unanticipated changes and anxieties ignited by the COVID-19 pandemic while simultaneously reinforcing the potential to live with greater purpose and intention. Case illustrations depict the practical import of EH therapy as being its ability to help clients reevaluate their values and priorities, engage in life review and cultivate presence, integrate mindfulness and meaning in life, redefine meaning in life and priorities, and enhance their strengths and find resilience.

Further, Himelstein (2011) provides case illustrations to demonstrate the effectiveness of EH therapy for incarcerated adolescents. The EH emphases on self-awareness (vs. change as a necessity), authentic human encounters, exploration of resistance, and exploration of the client's relationship with death were found to resonate with that population. Next, Thompson (2012) discusses how an addiction treatment center's shift from a behavioral model to a meaning-centered EI approach was conducive to a more positive environment that resulted in a drop in attrition as well as elimination of behavioral problems. Moreover, Lac (2017) explores the effectiveness of EI equine-assisted therapy for helping an adolescent girl with anorexia develop a sense of safety and increased presence that alleviated her constricted way of being in the world and enabled her to feel a greater sense of significance.

Finally, Ribeiro studies therapeutic collaboration during the emergence of *reconceptualization innovative moments* (i.e., exceptions to and/or contrasts with problematic self-narratives in session; Ribeiro et al., 2018) as well as the effectiveness of PCT (Ribeiro et al., 2014), narrative therapy (Ribeiro, Braga, et al., 2016), and PE/EFT (Ribeiro, Cunha, et al., 2016) for depression. Taken together, Ribeiro's findings suggest the importance of (a) therapists' sensitivity to clients' Vygotskian zones of proximal development and responsiveness to clients' moment-to-moment experiencing and growth within the bounds of their readiness for change and (b) therapists balancing supportive and challenging interventions as clients move into areas of unfamiliarity and healthy risk taking.

Empirical Support for General Relational Principles

As noted, research on the fundamental relational principles that undergird HE therapies also provides empirical support for the effectiveness of EH therapy by proxy. Timulak and Creaner (2010) conduct a metasynthesis of qualitative investigations into outcomes of PCT and PE/EFT. The metasynthesis is based on eight studies—all from 1990 to 2009, as well as one 1950s study—involving a total of 108 clients (including two couples). Elliott and colleagues (2021) follow with an updated metasynthesis of an additional nine studies with 71 more clients that yields largely consistent findings. They maintain the general thematic structure from the 2010 metasynthesis but also consolidate some subthemes and fine-tune the wording to emphasize newly understood nuances of experiences involving the self and interpersonal changes. Taken together, these findings reflect EH's focus on promoting clients' ability to be present to—and stand in awe of—life's paradoxes (Schneider & Krug, 2020). First, in the domain of appreciating experiences of self, EH therapy's focus rests upon clients'

- smoother and healthier emotional experiencing (e.g., becoming more hopeful or optimistic and energetic while also more stable, calmer, and at peace; enhancing emotional openness as well as expression and regulation);
- self-acceptance of vulnerability: (a) appreciating vulnerability (e.g., experiencing openness to and transparently showing a greater range of emotion)

and (b) strengthening self-compassion and self-acceptance, and valuing self (e.g., improving self-esteem, practicing self-care, engaging internal support);

- mastery and resilience of problematic experiences: (a) cultivating resilience (e.g., restructuring and transcending pain); (b) feeling empowered (e.g., improving confidence, coping, decisiveness, ability to take action, assertiveness); and (c) mastering symptoms; and
- enjoyment of changes in life circumstances.

Second, in the domain of appreciating one's experience of self in relation to others, EH therapy prioritizes clients'

- feeling supported (e.g., deepening interpersonal relations, building a greater support network) and
- being different or healthier in interpersonal encounters (e.g., increasing openness or tolerance, establishing relational priorities).

Third, in the domain of changed view of self and others, EH therapy promotes clients'

- self-insight and self-awareness (e.g., developing meaning, authenticity, self-understanding) and
- changed view of others (e.g., perspective taking in interpersonal encounters, accepting imperfections).

In addition, Elliott and colleagues' (2021) metasynthesis examines clients' perspectives on the helpful aspects of HE therapies. Themes include (a) clients feeling understood, listened to, and validated by the therapist; (b) clients and therapists coconstructing new awareness and meaning regarding clients' experience; (c) clients attending to their own needs in session and thereby feeling free and empowered; (d) clients expressing vulnerability, processing painful emotional experiences, and accessing adaptive ones; and (e) clients arriving at a new awareness and recognition of their own agency in experiences such as self-criticism. Unhelpful aspects reported by some clients include experiencing continuing symptoms, finding experiential work overwhelming, and encountering misunderstandings in the therapeutic relationship.[4]

[4]This finding seems attributable in part to EH therapy's eudaimonic or chaironic instead of hedonic focus (Bland & DeRobertis, 2020; Hoffman, 2019) as well as to its likelihood to increase emotional arousal (Pos et al., 2017). Indeed, Brintzinger and colleagues (2021) find that only clients with an underregulated style of emotional processing benefited from mindfulness—a core ingredient of EH psychology and psychotherapy since its beginning (Bland & DeRobertis, 2020)—to reduce depressive symptoms, whereas therapeutic success actually was hindered for clients with an over- or well-regulated style of emotional processing. As Schneider and Krug (2017) acknowledge, EH therapy is not for everyone: "Clients who seek short-term, symptom-reducing therapy probably will not appreciate" its depth-oriented approach (p. 104). This implies the need for EH therapists to be competent in multiple therapeutic modalities reflecting a breadth of theoretical orientations in order to honor and suit clients' preferences.

Further, Elliott and colleagues identify how the studies in their metasynthesis have begot more precision in descriptions of (a) productive therapy processes (e.g., self-reflection on broader meanings spurred by shifts from descriptions of external events to internal experiences), (b) spiraling movement between action and reflection in the development of new narratives, (c) assimilation of problematic or painful client experiences, (d) favorable outcomes from client emotional expression grounded in autobiographical memories and accompanied by deeper levels of experiencing, and (e) the need to provide clients opportunities for growth via the healthy tension between therapist responses that are supportive and following (e.g., providing safety and openness) and those that are challenging and process guiding. Taken together, these findings support the position that successful therapy involves movement "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" (Elliott et al., 2021, p. 29).

REVIEW OF QUANTITATIVE RESEARCH ON EH THERAPY

During the last decade, researchers have heeded Cooper and colleagues' (2010a) call for outcome studies involving HE—and with that, EH—therapies that employ symptom-based measures, a focus on specific presenting conditions, more clearly defined practices of seasoned therapists, and follow-up data. In addition, researchers have furnished both randomized controlled trial (RCT) studies that can be included in meta-analyses in order "to fully impact on policy" (p. 244), as well as process–outcome research to identify specific factors that make the therapies unique and to study specific means of conveying relational conditions that serve as a vehicle for meaningful change.

Common Factors

Since the 1990s, researchers including Wampold (see Duncan, 2015; Elkins, 2019; Wampold & Imel, 2015) and Norcross (see Norcross & Lambert, 2019) have conducted meta-analyses of therapy research studies to identify therapeutic factors to which effective therapy can be attributed, irrespective of theoretical orientation. Their findings have shown that common factors—including goal consensus/collaboration, empathy, alliance, positive regard/affirmation, therapist variables, congruence/genuineness, cultural adaptation of evidence-based treatments, and expectations—have been shown to be the most salient agents of change. Notably, these researchers had not set out to bolster EH therapy. However, their findings are "a major vindication of [EH therapy's] emphasis on the importance of the human and relational elements of psychotherapy" (Elkins, 2019, p. 5). In particular, the common factors findings lend support to Rogers's (1957, 1959) three facilitative conditions for meaningful change (i.e.,

unconditional positive regard, accurate empathetic understanding of the client's internal frame of reference, and congruence/genuineness). Indeed, employment of Rogers's facilitative conditions has been shown to beget small and small to moderate effects in therapy outcome (empathy: $r = 0.28$ [Elliott et al., 2018]; positive regard: $g = 0.28$ [Farber et al., 2018]; congruence/genuineness: $r = 0.23$ [Kolden et al., 2018]). Moreover, Bayliss-Conway and colleagues (2021) note that therapeutic relationships incrementally increase clients' authenticity over the course of 10 sessions. Also, therapists' long-term (12 months post-therapy) effectiveness has been found to be at least partially an artifact of their facilitative interpersonal skills (Anderson et al., 2016).

It is important to note that this should not be construed as saying that EH therapy holds a monopoly on effective therapy. Rather, "the common factors perspective transcends the 'battle of the brands'" (Elkins, 2019, p. 4; see also Goldman, 2019; Norcross & Lambert, 2019). Indeed, CBT, psychodynamic therapy, and PCT have been shown to yield comparable pre–post outcomes (Stiles et al., 2008). Similarly, as discussed further later, Stephenson and Hale (2020) find that CBT and EP therapy yield comparable effectiveness. Moreover, Flückiger and colleagues' (2018) meta-analysis of 295 studies involving over 30,000 clients suggests a small to moderate effect of therapeutic alliance upon outcome across theoretical orientations in both face-to-face ($r = 0.278$) and teletherapy ($r = 0.275$) formats. Likewise, Leibert and Dunne-Bryant (2015) find that the therapeutic alliance ($\beta = 0.35$) plus an additional common factor, client expectancy, most significantly predicts therapy outcome. Interestingly, client expectations about outcome tend to hinder therapeutic success ($\beta = -0.28$); this seems to reflect EH and HE therapies' focus on promoting openness to experience as an alternative to symptom reduction alone. Further, Bartholomew and colleagues (2021) note that, after controlling for client level of distress as well as for number of sessions, when clients' perceptions of the working alliance with their therapist increased, their positive affect also increased ($\beta = 0.20$).

Per the report of the Third Interdivisional American Psychological Association Task Force on Evidence-Based Relationships and Responsiveness, therapeutic relationships account for client improvement (or lack thereof) as much as, and probably more than, the particular treatment method (Norcross & Lambert, 2019). In light of these findings, the task force concludes their review of multiple meta-analyses by proposing that psychotherapy relationships (a) should be promoted by therapist qualities and behaviors that are explicitly addressed in practice and treatment guidelines (otherwise, evidence-based treatments may be "seriously incomplete and potentially misleading" [p. 631]); (b) enhance treatment effectiveness when they are adapted to specific client characteristics, including transdiagnostic ones, in addition to diagnosis; and (c) act in concert with treatment methods, client characteristics, and helper qualities to determine and form a comprehensive understanding of effectiveness.

Additional characteristics of EH therapy that were discussed in the introduction to this chapter, such as corrective experiences and second-order

change, also have been treated as common factors by Castonguay and Hill (2012) and Fraser and Solovey (2007), respectively. Further, Bland (2013, 2014, 2019) satisfies Cooper and colleagues' (2010a) and Elliott and colleagues' (2021) recommendations for more case studies to shed additional light on these processes.

Specific Factors

Fulfilling Cooper and colleagues' (2010a) and Raffagnino's (2019) calls for research into more specific factors associated with EH and HE therapies, both quantitative and qualitative investigations have been conducted on additional EH and HE therapies constructs and principles beyond Rogers' facilitative conditions. These include presence (Geller & Greenberg, 2022; see also Bland, 2013, and Chapter 5 of this volume); self-disclosure (Hill et al., 2018; Pinto-Coelho et al., 2018; see also Chapter 13 of this volume); immediacy (closely related to the EH strategy of invoking the actual; Hill et al., 2018, 2020); human flourishing (Fosha & Thoma, 2020); relational savoring (i.e., helping clients recognize and benefit from moments of positive connection; Borelli et al., 2020); the real relationship (i.e., authenticity between therapist and client; Gelso et al., 2018; Gelso & Silberberg, 2016; see also Chapter 12 of this volume); mutuality (Cornelius-White et al., 2018); therapists' hope for their clients (Bartholomew et al., 2019); and confronting existential givens (Bland, 2021; Frediani et al., 2023). In addition, Fisher and colleagues (2020) find that clients' capacity to negotiate between conflicted self-states and the ability to experience and process emotions work synergistically to predict symptomatic improvement. Also, meta-analyses have shown that symptom improvement can be predicted by client experiencing in session ($r = -0.19$; Pascual-Leone & Yeryomenko, 2017) as well as by therapists' ($d = 0.56$) and clients' ($d = 0.85$) emotional expression (Peluso & Freund, 2018). Using Cohen's (1988) guidelines, these are moderate and large effects, respectively.

Finally, providing support for the meaning making component of EH therapy (Schneider & Krug, 2020; see also Chapter 10 of this volume), Vos's (2016a) meta-analyses show that meaning-centered therapies spur improvements in clients' existential, psychological, physical, and general well-being when compared not only to baseline measurement but also to other modalities (such as acceptance and commitment therapy) that do not include a meaning component. Moreover, incorporating a meaning-centered perspective in CBT for chronic pain has been found to significantly lower pain-related disability compared with traditional CBT alone, especially for clientele with a spiritual orientation (Gebler & Maercker, 2014). Further, chronically ill patients can use meaning to deal with and transcend the limitations of their disease, with "the goal of helping patients to live a meaningful life despite their disease at its center" (Vos, 2016b, p. 183). Likewise, existential interventions have been found to improve existential well-being, quality of life, hope, and self-efficacy in cancer patients that can serve as a protective factor against depression, demoraliza-

tion, and desire for death (Bauereiß et al., 2018). Similarly, meaning-centered group therapy has been found to promote long-term positive effects on positive interpersonal relations and sense of personal growth in cancer survivors (Holtmaat et al., 2020); increase psychological and physical well-being; improve satisfaction with life and retirement; and also reduce depressive symptoms, hopelessness, loneliness, and suicidal ideation in men confronting existential givens as they transition into late adulthood (Heisel et al., 2019).

RESEARCH ON SPECIFIC HE THERAPEUTIC OUTCOMES

As noted, EH therapy shares much in common with HE therapies, particularly PE/EFT (which are treated as synonymous in this chapter insofar as EFT evolved out of PE therapy; Goldman, 2019). Both EH and PE/EFT have mutual roots in the therapeutic approaches of PCT, gestalt therapy, Gendlinian focusing, and existential therapy (Elliott & Greenberg, 2007; Goldman, 2019). They share foundational values and assumptions that experience is central, people are greater than the sum of their parts and are capable of self-determination, a growth tendency exists, and therapists need to be authentic and present with their clients (Elliott & Greenberg, 2007; see also Greenberg et al., 1996).

Moreover, like EH, the PE/EFT therapist is an "expert on process" (Greenberg et al., 1996, p. 23) who strives to foster clients' immediate experiencing, presence/authenticity, agency, wholeness (which arises out of dialectic creative tension), pluralism/diversity (i.e., equality and empowerment), and growth (i.e., increasing differentiation and adaptive flexibility). This is done via (a) empathetic attunement (e.g., entering and tracking clients' immediate and evolving experiencing), (b) therapeutic bond (e.g., communicating empathy, caring, and presence to the client), (c) task collaboration (e.g., mutual goal setting, engaging the client as an active participant in therapy), (d) experiential processing (e.g., helping clients work in different ways at different times), (e) task completion (e.g., resolving key therapeutic foci over time), and (f) self-development (e.g., fostering client responsibility and empowerment; Elliott & Greenberg, 2007; see also Greenberg et al., 1996). Importantly, a key point of divergence from EH therapy is PE/EFT's being comparably more directive in guiding the client toward engaging in particular affective information-processing and meaning-making strategies (see Greenberg et al., 1996). On the other hand, both aim to promote clients' ownership of emotions and other denied aspects of self, changes outside of therapy, and interpersonal impacts (Greenberg et al., 1996; Scholl et al., 2014).

Elliott and Freire (2010) summarize and critically review six meta-analyses of HE therapies, particularly PCT and PE/EFT, that were conducted between 1980 and 2008. Their overall conclusions are outlined here and are supplemented with statistics from Elliott and colleagues' (2021) replication meta-analysis of 91 additional studies from 2009 to 2018 on the effectiveness of HE therapies—including EH/EI therapy—for a broader range of clinical populations

and cultural backgrounds. The results were found to be generally consistent with the previous research:

- HE therapies produce large effects (g = 0.73) when comparing clients' reported frequency, duration, and intensity of symptoms pre- and post-therapy.
- Clients reported that these therapeutic benefits were maintained during follow-up assessment both within a year (ES_w = 0.88) and over a year (ES_w = 0.92) after termination.
- Clients who received HE therapies showed large gains relative to clients who received no therapy (ES_w = 0.88).
- HE therapies are clinically and statistically equivalent to other therapies (ES_w = −0.08).
- Broadly, HE therapies may be trivially less effective than CBT (ES_w = −0.26). However, when supportive–nondirective therapies ("diluted, non–bona fide versions of PCT" [Elliott et al., 2021, p. 9]) were removed, the effect size raised to −0.15. Elliott and colleagues attributed these findings to negative researcher allegiance (to CBT) as well as to studies involving particularly complex client issues for which HE therapies may not be as well-suited.
- HE therapies have been found to be as or more effective than other therapies (like CBT) for addressing relationship and interpersonal problems, chronic health problems, eating difficulties, and psychotic conditions. For anxiety and depression, evidence was mixed—but again, the scales may have been tipped in favor of CBT due to allegiance effects.

Further, Marren and colleagues' (2022) metasynthesis of 11 qualitative studies on clients' experience of the helpful versus unhelpful aspects of PE/EFT showed comparable outcomes as those identified by Elliott and colleagues (2021), as summarized earlier.

Effectiveness Research on PCT, PE/EFT, and Gestalt Therapy

During the last decade, researchers have satisfied Elliott and Freire's (2010) recommendation for effectiveness research to be conducted on PCT for depression (Watson & Pos, 2017) and chronic health problems (Epstein et al., 2018; Lynass & Gillon, 2017); PCT and PE/EFT therapies for generalized anxiety (Elliott, 2013; Timulak, 2018; Timulak et al., 2022; Watson et al., 2017) and social anxiety (Elliott & Shahar, 2017; MacLeod & Elliott, 2014); PE/EFT for eating disorders (Compare & Tasca, 2016; Hibbs et al., 2020; Wnuk et al., 2015); and psychological contact for psychosis (García-Mieres et al., 2019) and dementia (Chenoweth et al., 2019; Kim & Park, 2017). Additional areas researched during the last decade include

- PCT for addressing intrapersonal differentiation (i.e., fragmentation) in psychosis (García-Mieres et al., 2019);

- PE/EFT for facilitating identity integration and resolution of grief in third culture kids (Davis et al., 2015), addressing fear of cancer reoccurrence (Almeida et al., 2022), and working with autism (Robinson, 2020; Robinson & Elliott, 2017);
- humanistic–integrative therapy (van Rijn & Wild, 2013) and PE/EFT (Pos et al., 2017), including couples therapy (Wittenborn et al., 2019), for depression;
- HE therapies for child anxiety (Nuding, 2013), trauma (Khayyat-Abuaita et al., 2019; see also Serlin et al., 2019), depression (Petrei & Gemescu, 2020), and incarcerated offenders of intimate partner violence (Pascual-Leone et al., 2011);
- humanistic school-based counseling (Cooper et al., 2010; Pearce et al., 2017); and
- HE-oriented, social–emotional and mindfulness-based interventions for promoting self-awareness, improved emotional reactivity, and present centeredness in early childhood educators (Palacios & Lemberger-Truelove, 2019).

Further, Di Malta and colleagues (2024) summarize research findings related to the effectiveness of PCT (including person-centered arts therapies) for working with a variety of populations including children and adolescents, couples and families, and older adults as well as concerns involving grief, trauma, and addiction. Qualitative studies have brought increased attention to the role of developmental processes and narrative expression for enhanced emotion regulation in PE/EFT (Angus et al., 2015). Also, Timulak and Keogh (2022) published a clinical guide (which includes interview transcriptions) that demonstrates the integration of PE/EFT with a transdiagnostic framework to guide clients' transformation of emotional pain.

Traditional gestalt experiential interventions also have been investigated. Raffagnino's (2019) systematic review of 11 studies on gestalt therapy conducted since the mid-2000s suggested its effectiveness for promoting clients' reflection on their life narrative, confidence in interpersonal participation, and ability to overcome experiential avoidance and enhance presence and self-compassion. Illustrations of the effectiveness of chairwork for promoting emotional experiencing, expression, and enactment in session have been provided by Kellogg and Garcia Torres (2021). Also, Lac (2016) showcased the effectiveness of gestalt-oriented equine therapy for providing a supportive developmental environment that fosters children's self-direction of their own growth and learning through a phenomenological and embodied experience of playing. Finally, gestalt-oriented pastoral care in both individual and especially group formats has been found to decrease anxiety, depression, and trauma symptoms and spiritual distress (Thomas et al., 2022).

RESEARCH ON EXISTENTIAL–PHENOMENOLOGICAL THERAPY

Steeped in the tradition of Heidegger, Husserl, Buber, Boss, Binswanger, and Laing (see Cooper, 2017), EP therapy (see Spinelli, 2015; van Deurzen, 2019;

van Deurzen & Adams, 2016), also known as the British school, emphasizes "a descriptive, non-diagnostic exploration of clients' lives and experiences" that promotes *unknowing*—"an openness and receptivity to what which emerges in the therapeutic encounter in all its novelty, mystery, and otherness" (Cooper, 2017, pp. 135, 156). EP therapy shares in common with EH therapy (a) a client-centered focus on the therapeutic relationship (Stephenson & Hale, 2020; Vos, 2019) and close alignment with the common factors (Alegria et al., 2016) and (b) a focus on clients' "attempts to evade [existential] reality" that are "the primary fount of [their] psychological difficulties" via sedimentations in worldview (Cooper, 2017, p. 141). The therapist's role is to help clients develop a deeper understanding of the physical, social, personal/psychological, and spiritual dimensions across or along which they are pulled to "identify their core values: [what] they think [is] worth living or dying for" (p. 147).

EP therapists employ relational and intersubjective processes and a "genuinely engaged posture" to convey a sense of interest in clients' subjective experiencing to promote analysis of clients' personal existential meaning as emerging in contradictory tensions and paradoxes as well as choice and responsibility for their life path (Alegria et al., 2016, p. 87; see also van Deurzen, 2019). Also, like EH therapy, EP therapy "focuses on challenges in everyday life, breaking down our self-deception . . . that life can be challenge-free, and instead accepting life as it comes and realizing our freedom" (Vos, 2019, p. 599).

Explored in relation to clients' life context, EP therapists tend to understand symptoms as, in some cases, healthy responses (Wharne, 2021), and in other contexts, normal responses to an abnormal situation (Jackson, 2019; Vallejos & Johnson, 2019). They employ the phenomenological methods of bracketing (i.e., setting aside biases and assumptions), description (i.e., exploration, challenge, clarification), and horizontalization (i.e., treating all phenomena as equal). These methods are focused on what emerges in the here-and-now and are grounded in descriptive exploration of what it means to be a human being capable of language and reflection, which provides the capacity for freedom, responsibility, and choice as to how to live one's life (Stephenson & Hale, 2020).

As with PCT and PE/EFT, researchers have noted that EP therapy's effectiveness is contingent upon an active therapist who not only helps clients develop a deeper understanding of their core values and beliefs but also challenges the contradictions in their narratives (Alegria et al., 2016; Bauereiß et al., 2018). This is consistent with Wampold's (2007) suggestion that legitimate therapies involve clients acquiring a "new, more adaptive explanation" (p. 862) in conjunction with empirical findings that "laypersons want things to 'happen' in their therapy" (Cooper et al., 2019, p. 213) and, as aforementioned, supportive/nondirective therapy is ineffectual (Elliott et al., 2021; Vos, Cooper, et al., 2015).

Quantitative Research

Notably, quantitative research on EP therapy has been limited. This is attributable in part to its theoretical incompatibility with the positivistic assumptions of

the medical paradigm that focuses on objective explanations at the expense of understanding individuals' subjective lived experience (Vos, 2019)—and, with that, its aforementioned outcomes not aligning with the typical outcome measures used in conventional effectiveness research. On the other hand, Stephenson and Hale (2020) conducted a quantitative analysis that compared EP therapy with CBT for treating patients in a National Health Service (NHS) secondary care setting in the United Kingdom. They observed that both therapies resulted in a comparable amount of change—from severe to moderate distress and with a quarter of participants having moved from a clinical to a nonclinical population. These findings contribute to the feasibility of EP therapy being included among therapies that further provide empirical support for EH therapy by proxy. Accordingly, they also "open up the possibility of a real choice for NHS patients, in line with NHS directives" (p. 448).

Also, Vos (Vos, Cooper, et al., 2015; Vos, Craig, et al., 2015) performs a systematic literature review and meta-analysis of 15 studies (including RCTs) involving EP therapy for 1,792 clients facing *boundary situations* including health crises. EP therapies were found to spur moderate to large effects ($d = 0.64$) in terms of clients' ability to experience meaning in life, as well as moderate increases in self-efficacy and moderate decreases in psychopathology.

Moreover, Daei Jafari and colleagues (2020) study the effectiveness of EH therapy with Iranian couples. They find that an EP-oriented psychoeducational modality promotes relationships characterized by greater search for meaning (e.g., partners committed to cooperation and responsibility in the face of relational tension) as well as intimacy, respect, mutual understanding, and compatible expectations and common goals between partners.

Case Studies

Rayner and colleagues (2017) demonstrate the effectiveness of EP therapy for helping a depressed, middle-aged, adult female client align her possibilities for a future self (i.e., a realistic view of where she might be in 5 years) with her ideal self in a way that integrates EP principles with NHS standards of practice to "achieve a 'both/and' stance" (p. 66).

Vanhooren and colleagues (2018) study the outcomes of an existential–experiential intervention for promoting posttraumatic growth in an incarcerated female client in her thirties. They note improved self-care and awareness of her finiteness and vulnerability (i.e., the physical dimension), appreciation for individual differences while incarcerated and more authentic relationships after release (i.e., the social dimension), shifts in self-knowledge and self-concept that allows both positive and negative self-experiences (i.e., the physical/psychological dimension), and steps toward a more meaningful life (i.e., the spiritual dimension). Taken together, developing alternatives to existential alienation or isolation and to destructive behavior as a means of meeting the client's needs for intimacy, contact, and meaning "gave her important keys to desist from crime" (p. 161).

Case reports also have explored (a) the themes of waiting and the experience of despair that arose during existential therapy with a midthirties woman who anticipated heart transplantation following a heart attack (Schulz, 2015); (b) the role of existential therapy for helping clients accept death, which resulted in decreased death anxiety and recurring dreams involving death (Akbari, 2019); and (c) the role of EP therapy for helping a gay man in his forties overcome self-condemnation in light of his religious background (van Deurzen & Arnold-Baker, 2019).

Integrative and Brief Therapy Models

The effectiveness of EP therapy also has been supported by quantitative investigations of integrative and brief therapy models that employ existential theorizing and practice assumptions. For example, Cooper and colleagues (2015) find that clients in pluralistic therapy for depression—an integrative approach that employs phenomenological bracketing of therapists' assumptions about therapeutic method and outcome as well as focuses on experienced needs and client preferences (Vos, 2019)—report reduced anxiety and depression and greater attainment of personal goals, as well as having found both the relational and the technical dimensions of therapy helpful. Similarly, VITA (Latin for "life"), an existential, short-term, dynamic group modality, has been found to improve symptom distress and relational problems for clients with treatment-resistant depression—both during the course of treatment and at one year follow-up, when employment was likely to be higher and medication use to be lower (Stålsett et al., 2012). Further, short-term therapy that incorporates existential experimentation (proactive and creative engagement with clients with their personal difficulties) has been shown to reduce depressive and anxiety symptoms, perceived distress, and need for psychological services in primary care settings (Rayner & Vitali, 2016, 2018).

CONCLUSION

The literature summarized in this chapter clearly supports the position that EH and allied therapies are "empirically supported by multiple lines of scientific evidence"—which include both "'gold standard' RCTs" and qualitative inquiries (Elliott et al., 2021, p. 42). In addition to symptom reduction, EH therapy's focus on second-order change via healing relationships, working with emotions and experience, and meaning making (Hoffman, Vallejos, et al., 2015) promotes outcomes that involve a more complex identity, greater authenticity/congruence, increased levels of self-directedness, self-compassion, and perspective taking (Scholl et al., 2014). However, despite the consistency of the evidence, EH therapy has not found its way into mainstream treatment guidelines in either the United States or the United Kingdom. Among other factors, this seems attributable to a rise of conservative cultural and political ideologies

(Elkins, 2009), to infiltration of interest groups onto committees that review evidence (Elliott et al., 2021), and to a focus on outcomes at the expense of process as well as the disconnect between research outcomes and clinical outcomes (Scholl et al., 2014). Accordingly, to help promote the effectiveness of EH therapy, both lists of evidence-based treatments (Angus et al., 2015; Elliott & Freire, 2010) and textbooks (see Henry, 2017) should be updated to better account for the research presented in this chapter.

Stamoulos and colleagues (2016) note that although the majority of therapists continue to regard the therapeutic alliance and therapist empathy as salient predictors of successful therapy outcome, on the whole, they view factors such as unconditional positive regard, clients' hope for recovery, and clients' emotional expression more neutrally. This seems attributable to EH and related therapies having become underemphasized, if not dismissed, in clinical training in the face of therapeutic monoculture, as aforementioned. Importantly, therapists' undervaluing of these qualities comes despite the abundance of research evidence supporting their relevance. To illustrate, meta-analyses have shown that positive regard is a "demonstrably effective" element of the therapy relationship (Norcross & Lambert, 2019, p. 632), and clients' emotional expression has been found to have a large effect ($d = 0.85$) upon therapy outcome (Peluso & Freund, 2018). Further, the value of therapeutic presence was implied in Abargil and Tishby's (2021) research, which concluded that "therapists should pay attention to their feelings in the course of treatment" and be cautious about becoming stuck in specific emotions when clients are not progressing (p. 13).

Recommendations

First and foremost, to complement research pertaining to the experiential vector of EH therapy, more quantitative research that directly assesses the effectiveness of EH/EI and EP therapies without relying on common factors or evidence by proxy from other models is recommended to enhance the empirical canon for the analytic vector. Such research could serve as an opportunity to build bridges between EH/EI and EP modalities and other therapies and to strengthen the foundation of existing evidence reviewed in this chapter in order to prevent them from becoming atrophied in the current evidence-based practice era. Equally, given that symptom reduction is not necessarily a principal goal of EH/EI and EP therapies,[5] "it is very important to develop and validate measures that can identify the kind of changes that [EH] therapy would be hypothesized to bring about" (Cooper et al., 2010a, p. 246). Instruments pertaining to EH-oriented therapeutic and outcome constructs (see Freire & Grafanaki,

[5]EH therapists typically view many of the goals of mainstream therapy (e.g., symptom reduction, decreased sadness, increased happiness) as byproducts of a well-lived life. Thus, even though symptom reduction is not a direct goal of therapy, it is often a side effect (Elkins, 2009; see also Bland, 2013).

2010; Kaufman, 2020; Watson & Watson, 2010) also should be reviewed and potentially employed in future studies.[6]

Second, given the "theoretical, practical, and political barriers" faced by those who have attempted to conduct research on EH therapy in conjunction with the increasing legitimization of qualitative inquiry in psychology (Schneider & Krug, 2020, p. 282), as aforementioned, further qualitative studies can better capture EH/EI and EP therapies in their relational as well as philosophical depth. In particular, though quantitative research on symptom reduction has suggested that therapies are equivalent in their effectiveness, qualitative methods may reveal "greater effectiveness of therapies that emphasize client growth and transformation" (Elkins, 2019, p. 7). Accordingly, further research that defines and describes transformative phenomena experienced by clients is recommended to supplement extant literature on clients' experiences of second-order change (e.g., Murray, 2002). This would serve as a relevant antidote to the ubiquity of reductionistic thinking and brief therapy models in health care at the expense of continuity (Mauksch & Fogarty, 2018). Further, EH therapy is well-suited to heed Hammer's (2019) call for both qualitative and quantitative research that examines additional factors like "compassion, hospitality, wisdom, and serenity and the ways these soulful qualities of the therapist enhance and deepen the therapeutic encounter" and, thus, enhance therapy outcome (p. 143).

Third, Elliott and colleagues (2021) call for research to compare more versus less process-guiding HE therapies. Doing so could help clarify and contribute to closing the theory–practice gap regarding the role of directiveness in effective therapy as well as stimulate further theory development in EH/EI therapy and PE/EFT circles. In addition, given the between-study variability in effects between HE therapies and other therapies, Elliott and colleagues also recommend more thorough examination of possible moderators of comparative outcome effects.

Fourth, Tarsha (2016) suggests that compulsive engagement in social media is a contemporary supplement to the maladaptive defenses against existential isolation identified by Yalom (1980). Accordingly, EH therapy has promise to be effective for both preventing and treating social media–induced anxiety (fear of missing out) in adolescents—especially as they have grappled with isolation and loneliness both during the COVID-19 pandemic and in a hypertechnologized era (Twenge, 2017). Research that both reflects and guides the development of therapeutic strategies in this area seems warranted.

Fifth, to help make EH therapy more palatable in a multicultural, global society, additional research on its effectiveness not only with a variety of client

[6]Moreover, with respect to the centrality of the therapeutic relationship in EH/EI and EP therapies, Duncan and colleagues' (2018) *Partners for Change Outcome Management System* offers measurement of (a) holistic second-order change to complement existing measures of symptom reduction, (b) global functioning, and (c) therapy experience. In addition, Levitt's *Client Experiences of Therapy Scale* (Levitt et al., 2019) provides a tool for assessing the quality of in-session therapy based within the experiences of clients and what they value.

populations and presenting concerns but also from a range of cultural–contextual backgrounds is recommended. Researchers continuing to integrate "the cultural and social aspects of the client in a more explicit and direct manner" (Hoffman, Vallejos, et al., 2015, p. 14) should help overcome criticisms of EH therapy as overly individualistic (Prochaska & Norcross, 2018; see also Hoffman, Cleare-Hoffman, et al., 2019; Jackson, 2019; Vallejos & Johnson, 2019). Also, empirical explorations of international variations of EH therapy, like Zhi Mian therapy (see Dueck & Wei, 2019; Hoffman, 2019b; Hoffman, Jackson, et al., 2019; Wang, 2019), are suggested.

Finally, bringing this chapter full circle, given the centrality of therapists' presence in EH therapy, especially as a means of both modeling and nurturing clients' own sense of presence (Schneider & Krug, 2017, 2020), Angus and colleagues (2015) and Geller and Greenberg (2022) identify the development of the helper-as-person as an area ripe for exploration. Bland (2018) offers one such pedagogical/supervision strategy, and further inquiry into multiple facets of the development of the helper-as-person within clinical training is recommended.

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