

Measuring the Effectiveness of Therapy Sessions Conducted by Process Work Practitioners

A Pilot Study

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ABSTRACT

Process Work is a practical and theoretical system with a variety of applications in individual, group and community work (Diamond & Jones, 2004). Since 1970, when Process Work emerged, there have been many qualitative studies investigating applications of Process Work methodology (e.g., Akerman, 1994; Schwarz 1996; Heizer 1992; Maclaurin, 2005; Vasiliou, 2005). However there is little research which investigates the effectiveness of Process Work applications using quantitative research strategies (Morin, 2002; Hauser, 2004; Kobayashi, 2009).

This pilot study explores methods and strategies for evaluating outcomes from individual therapy sessions within the Process Work approach. The study also presents data from the psychotherapy outcome research field with trends for the future in this area (Hubble, Duncan & Miller, 1999; Snyder et al., 1999; Wampold, 2001; Miller & Duncan, 2004; Hubble, Duncan, & Miller, 1999).

The empirical part of the study aimed to test an ad hoc hypothesis that a client's sense of well-being increases after participation in Process Work therapy sessions. A quasi-experiment design was used to test the hypothesis and Self-Report scales: Outcome Rating Scale and Session Rating Scale (ORS, SRS) were used to gather quantitative data (Miller & Duncan, 2004). The data collected from the study was insufficient to test the hypothesis and make an interpretation. Despite that, we could still see change in the outcomes and as a result read some trends. The outcomes show that Process Work therapists received high ratings for their relationship skills and ability to incorporate feedback from clients which, according to the research on what works in psychotherapy, has significant effects on improvement in process of therapy (Wampold, 2001).

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Chapter I: INTRODUCTION

PSYCHOTHERAPY AS A HELPING PROFESSION AND ITS STANDARDS

The profession of psychotherapy has been developed intensely for the last hundred years. During that time many changes have appeared, giving birth to new therapies and making research more sophisticated. Presently there are hundreds of therapeutic modalities in the field. In the United States, the American Psychological Association (APA) represents standards of care and guidelines in psychotherapy. One of the approaches to implementing standards in the field is the Evidence-Based Practice Psychology (EBPP) movement. Evidence-Based Practice was originally derived from evidence-based medicine, which advocated for improved patient outcomes by informing clinical practice with relevant research (American Psychological Association, 2006). Evidence-Based Practice in Psychology (EBPP) promotes “effective psychological practice and enhances public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention” (p. 271). EBPP is defined as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 284). Based on that policy and definition of EBPP, APA has created guidelines for practitioners in the psychotherapy branch. The Treatment Guidelines indicate that:

The evidence base for any psychological intervention should be evaluated in terms of two separate dimensions: *efficacy* and *clinical utility*. The dimension of efficacy lays out criteria for the evaluation of the strength of evidence pertaining to establishing causal relationships between interventions and disorders under treatment. The clinical

utility dimension includes a consideration of available research evidence and clinical consensus regarding the generalizability, feasibility (including patient acceptability), and costs and benefits of interventions (p. 272).

Additionally, the Guidelines refer to the field of research as well. Psychological research needs to balance internal and external validity and psychologists must recognize the strengths and limitations of evidence obtained from different types of research (American Psychological Association; 2006). Based on APA guidelines, the highest quality of research refers to scientific results obtained with a variety of evidence demonstrating effective psychological practice, such as: efficacy, effectiveness, cost-effectiveness, cost–benefit, epidemiological and treatment utilization. Accordingly, APA supports the following types of research designs (p. 274):

- Clinical observation (including individual case studies) as a valuable source of innovations and hypotheses in the context of scientific discovery
- Qualitative research as used to describe the subjective, lived experiences of people, including participants in psychotherapy
- Systematic case studies are useful when aggregated - as in the form of practice research networks - for comparing individual patients with others with similar characteristics
- Single-case experimental designs are useful for establishing causal relationships in the context of an individual
- Public health and ethnographic research are especially useful for tracking the availability, utilization, and acceptance of mental health treatments as well as

suggesting ways of altering these treatments to maximize their utility in a given social context

- Process–outcome studies are especially valuable for identifying mechanisms of change
- Studies of interventions as they are delivered in naturalistic settings (effectiveness research) are well suited for assessing the ecological validity of treatments
- Efficacy research is the standard for drawing causal inferences about the effects of interventions (context of scientific verification)
- Meta-analysis is a systematic means to synthesize results from multiple studies, test hypotheses, and quantitatively estimate the size of effects

For the future of research programs, EBPP suggests highlighting the following as priorities in the research field (American Psychological Association, p. 275):

- Psychological treatments of established efficacy in combination with—and as an alternative to—pharmacological treatments
- The generalizability and transportability of interventions shown to be efficacious in controlled research settings
- The efficacy and effectiveness of psychological practice with underrepresented groups, such as those characterized by gender, gender identity, ethnicity, race, social class, disability status, and sexual orientation
- The efficacy and effectiveness of psychological treatments with children and youths at different developmental stages
- The efficacy and effectiveness of psychological treatments with older adults

- Distinguishing common and specific factors as mechanisms of change
- Characteristics and actions of the psychologist and the therapeutic relationship that contribute to positive outcomes
- The effectiveness of widely practiced treatments - based on various theoretical orientations and integrative blends - that have not yet been subjected to controlled research
- The development of models of treatment based on identification and observation of the practices of clinicians in the community which empirically obtains the most positive outcomes
- Criteria for discontinuing treatment
- Accessibility and utilization of psychological services
- The cost-effectiveness and costs - benefits of psychological interventions
- Development and testing of practice research networks
- The effects of feedback regarding treatment progress to the psychologist or patient
- Development of profession - wide consensus, rooted in the best available research evidence, on psychological treatments that are considered discredited
- Research on prevention of psychological disorders and risk behaviors

PURPOSE OF THE STUDY

This thesis is designed to collect and present contemporary trends in psychotherapy research and to perform a pilot study aimed at testing an ad hoc hypothesis concerned with the benefits of Process Work individual therapy sessions. This study is one of the first steps in the area of outcome research within the Process Work approach.

Information gathered during this research process will hopefully be used in the future for conducting further studies in evaluating outcomes from Process Work therapy. Based on the data presented in the previous section, if Process Work wants to be closer to mainstream psychotherapy it is necessary for Process Work to refer to outside standards while evaluating outcomes from therapy. One way of doing this is by testing if Process Work therapy actually *works*. Because Process Work lives in a world where quantitative data is dominant, Process Work research methodologies need to also speak the same language, or at least some of them.

OVERVIEW OF THE CHAPTERS

In this section, I present an overview of the chapters from the study. In the Literature Review, the reader can find information about psychotherapy development in general. Next, different approaches to outcome research are explained, and I show the distinction between the medical model and the contextual model of psychotherapy. Before I present research in psychotherapy outcomes, I differentiate between the terms ‘efficacy’ and ‘effectiveness’. Later on, I present evidence that psychotherapy works and what research outcomes say about the benefits of different therapeutic modalities. From emphasizing the variety of ways to investigate the effects of psychotherapy among different

modalities, my focus shifts to the Common Factors view and its benefits.

In the next subchapter, I present a basic summary of the Process Work approach.

Subsequently, in the methodology chapter, I describe the goal of the study, research hypothesis, design of the research, tools used in the process of testing the hypothesis, and organization of the research. Further on, I present findings from the pilot experiment.

In the discussion chapter I write about findings and implications for future studies in Process Work. In the final part of the thesis I review the study, discuss its limitations and contributions, as well as give suggestions for the Process Work research field.

PROCESS WORK AND ITS FIELD OF RESEARCH

Process Work is a multidisciplinary awareness approach for working with individuals, groups, and communities, which has been developing since the early 70s. The central aspect of Process Work is the Taoist principle of ‘following the Tao’, ‘process’, or ‘change’ (Mindell, 1985). Awareness is an essential tool in tracking the process, whether working with oneself, individual clients, couples or groups.

Though there are many studies in Process Work, most of them focus on the application of methods for working on different aspects of life and with clients presenting a variety of problems, e.g. working with relationships, conflict resolution, addiction work, extreme and altered states, coma, body work, physical illness, panic attacks, creativity, family issues, and adolescents. However, there is only one quantitative research study evaluating outcomes from Process Work therapy sessions (see Chapter on Effectiveness of Process Work). This study grew out of the need for more quantitative research.

Chapter II: LITERATURE REVIEW

From one to many... - A SHORT HISTORY OF PSYCHOTHERAPY AND ITS PROFESSIONALIZATION

Donald K. Freedheim (2002) mentioned in the preface to the *History of Psychotherapy: A century of change* that somebody might ask if it is appropriate to write the history of a field in which there is so much diversity in defining what we mean by the term *psychotherapy*. Today the most common definition says that:

psychotherapy is a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client's disorder, problem, or complaint; and it is adapted or individualized for the particular client and his or her disorder, problem, or complaint (Wampold, 2001, p.3).

The diversity within the methods and approaches has been extending more and more. These phenomena lower the ability to know what and when to measure, and has revealed a conflict between different schools in the race of "who is better" (Goldfried, 1980). That competition process is not free from the influence of economics and politics. Nevertheless the trend of diversity helps in establishing professional standards and ethics in that special matter we call psychotherapy. This chapter presents the development of psychotherapy in Western society up to present time.

The roots of the word 'psychotherapy' were derived from the ancient Greek words *psychē* – meaning spirit, soul or breath - and *therapeia* – meaning close attendance or

caring for something (Jackson, 1999; Walter, 1988). As etymology points out, psychotherapy is the activity of healing the spirit. People have used different forms of relief in distress, life changes and challenges for thousands of years. Most often that service was provided by shamans (Eliade, 2004). In western society our current understanding of psychotherapy is rooted in the latter part of the 19th century when psychoanalysis was formed. The word *psychotherapy* itself was used in 1891 in the work by Hippolyte Bernheim- *Hypnotisme, suggestion, psychotherapie*. However it had been used even earlier by two Dutch physicians, Frederick van Eeden (1860-1932) and Albert Willem van Renterghem (1845-1939) (Jackson, 1999). Due to the developments of modern medicine and scientific psychology of the time, research based on observation became more sophisticated and was the first sign of specialization in the field of psychotherapy and mental health.

The emergence of psychotherapy as a profession was strongly influenced by changes in socioeconomic structures which started as far back as the Renaissance (Cushman, 2002). Changes of the self were put into play when the restrictiveness of the feudal system loosened, mercantile capitalism grew, and people were more able to freely move about geographically in the 16th century. Individuals were in danger of being separated from their communities and traditions that were sources of stability, predictability, and vision to people`s lives. With increased mobility and an economically more fluid market, the power of religious authority decreased. In that scene, industrialization, urbanization and secularization had their triumph. People were more interested in the physical world, rationality, science and humanities. The flourishing of the self also brought new problems for emerging modern individuals. While it was also a time of expanding monarchy, Cushman (2002) reports that after Foucault:

Configuration of the self changed from a self under the absolute control of the monarchy to a self that was isolated, less communal and more individual, a self more confused about right and wrong, the ethical and unethical. This new self was a self that needed guidance; tradition and its moral guidelines were just not as available as before. A sense of certainty and truth was lost (p.26).

In that world, a new kind of expert emerged: the modern philosopher became social scientist with a bag of new tools to observe, predict and control the behavior of a new, more independent self. In that modern age period of the 18th century, Jeremy Bentham, English philosopher and social theorist, developed an idea for a new prison where prisoners were observed constantly instead of being burned in the public like in 'old regime' times.¹

Foucault (Cushman, 2002) suggested that design of the prison was supposed to increase the prisoners' tolerance for being observed, as well as their willingness and capacity for self-observation, which was thought to lead to behavioral change. It is interesting that the self-observation proposal later became a main concept in psychotherapy and is a well known aspect nowadays.

Around 50 years after Bentham's conception, the Victorian Era² came in the United Kingdom. In the 19th century, together with increased belief in rationality and science, the unknown moved from the external physical world to the space inside of the self.

Sigmund Freud named that space the *unconscious* (Cushman, 2002). In Victorian Europe,

¹ Old regime - refers primarily to the aristocratic, social, and political system established in France under the Valois and Bourbon dynasties (14th century to 18th century). The term is French for "Former Regime," but rendered in English as "Old Rule," "Old Order," or simply "Old (or Ancient) Regime" (Wikipedia, 2009).

² The Victorian era of the United Kingdom was the period of Queen Victoria's reign from June 1837 to January 1901 (Wikipedia, 2009).

the main recognized illnesses were hysteria, neurasthenia, sexual perversion and criminal violence. At that time, the treatment to cure an individual was medicine and state institutionalization. Across the ocean in America, the main characteristics of illness were described by the medical profession as hysteria and neurasthenia. As we can see in the age of science and rationality, healing tools for psychological symptoms were strongly occupied by medical treatment.

In 1844 the Association of Medical Superintendents of American Institutions for the Insane (AMSAAI) was created. In 1892 they changed their name to The American Medico-Psychological Association and finally, in 1921, became The American Psychiatric Association. Parallel, in 1892, the American Psychological Association was formed.

The first forty years in 20th century were characterized by establishing new approaches in therapy. The first school of psychotherapy was founded in early 1900 by Sigmund Freud and others. Psychoanalysis was interested in the psychological process and individual unconsciousness, and described “individual” as a self conflicted by different impulses. Just after the blooming of psychoanalysis other approaches showed up, such as behaviorism, with theoretical goals to predict and control behavior. Soon after, and built upon Freud's fundamental ideas, different psychodynamic systems started to develop, such as Jungian analysis, the Adlerian school, Sullivan’s interpersonal theory and Klein’s object relation theory. Later on, the 40-50s was a time when experimental therapies were born with a main focus of working with a client’s awareness (Greenberg, Elliott, & Lietaer, 2003). Carl Rogers emphasized the uniqueness of the client-therapist relationship as an important factor in the process of psychotherapy. Rogers brought person-centered psychotherapy to the mainstream focus. That was also the time of rising existentialism in therapy. Fritz Perls, Laura Perls and Paul Goodman co-founded gestalt therapy which

focuses on an individual's experience in the moment and on the relationship between the client and the therapist. During the same time, the founding of the American Association of Marriage Counselors (AAMFT) in 1942 helped to formalize the development of family therapy. During the 50s Albert Ellis originated Rational Emotive Behavior Therapy (REBT). A few years later, psychiatrist Aaron T. Beck developed a form of psychotherapy known as Cognitive Therapy. In the 70s cognitive and behavioral therapy approaches were combined and grouped under the term Cognitive Behavioral Therapy (CBT). Also in the early 70s, Arnold Mindell started to develop Process Oriented Psychology, today called Process Work (see Chapter on Process Work Therapy).

In general, in today's modern psychotherapeutic scene, we can differentiate three main approaches to therapy: psychoanalysis and psychoanalytically influenced therapies, behavioral therapies, and then humanistic (experiential) therapies (Jackson, 1999). To relay a sense of how many modalities arose in the last one hundred years, I have given only a brief description of the development of main approaches in the 20th century. Progress was and is influenced by changes in the outside environment, growth of science, and knowledge about human beings. There are hundreds of psychotherapeutic models nowadays. By 1980 we had more than 250 (Henrik, 1980), in the late 90s more than 450 (MacLennan, 1996), and there are still new developments.

MEDICAL MODEL VERSUS CONTEXTUAL MODEL OF PSYCHOTHERAPY

The medical model and contextual model (Wampold, 2001) are meta-theories which refer to a level of abstraction and related research questions in psychotherapy. We can differentiate four levels of abstraction: techniques, strategies, theoretical approach, and meta-theory (see Table 1 for more details). It is a helpful theoretical distinction to see level partitions, however we should keep in mind that research questions and theoretical explanations can fit into more than one level.

In Western culture the origins of psychotherapy lie in the medical model (Wampold, 2001), meaning there are recognized specific steps in the process of therapy: a diagnosis of disorder; scientifically based explanation of dysfunction; mechanism of change; and specific therapeutic actions. In his first years of developing psychoanalysis, Sigmund Freud used components of the medical model in his practice. He defined a disorder (e.g. hysteria), described a scientifically based explanation of the disorder (repressed traumatic events), a mechanism of change (insight into unconscious), and particular therapeutic actions (free association).

The medical model explains reasons for specific disorders and application of therapeutic actions in treatment, and suggests that the psychotherapeutic effects come from the specific ingredients of a theoretical approach. According to the medical model approach, if those specific ingredients were to be removed from treatment, then the therapy would be significantly less effective.

Table 1 Levels of Abstraction of Psychotherapy and Related Research Questions

Level of Abstraction	Examples of Units of Investigation	Research Questions	Research Design
Techniques (i.e., specific ingredients)	Interpretations Disputing maladaptive thoughts In vivo exposure	Is a given techniques or set of techniques necessary for therapeutic efficacy? What are the characteristics of a skillfully administered technique?	Component designs Parametric designs Clinical trials with placebo controls Passive designs that examine the relationship between technique and outcome (within the corresponding treatment)
Strategies	Corrective experiences Feedback	Are strategies common to all psychotherapies? Are the strategies necessary and sufficient for change?	Passive designs that examine the relationship between technique and outcome (across various treatments)
Theoretical Approach	Cognitive-behavioral Interpersonal approaches Psychodynamic	Is a particular treatment effective? Is a particular treatment more effective than another treatment?	Clinical Trials with no treatment controls Comparative clinical trials (TxA vs.TxB)
Meta-Theory	Medical model Contextual model	Which meta-theory best accounts for the corpus of research results?	Research Synthesis

From *The Great Psychotherapy Debate. Models, Methods, and Findings* by B.E.Wampold,2001, p.9

Wampold (2001) argues that interpersonal psychotherapy, known as an empirically supported treatment, is rooted in Sullivan`s neo-Freudian interpersonal psychoanalysis; which would put that approach in the medical model as well. He applies this same argument to behaviorism as well. Even though the two paradigms - classical behaviorism and psychoanalysis - differ radically, similarities exist on the meta-level. For example, a

specific disorder (e.g. anxiety) is based on the explanation for that dysfunction (classical conditioning), which applies a mechanism of change (desensitization) and postulates specific therapeutic action (systematic desensitization). So we can see how these theoretical approaches use one system of deduction that makes them belong to the same category.

The contextual model is a meta-theory with roots in the Common Factors view of psychotherapy (see chapter Common Factors). The Common Factors view developed together with two other approaches to therapy: theoretical integration and technical eclecticism (Arkowitz, 2002). These three factions showed up as an effect of discontent within a group of practitioners with only “single-school approaches” (p.262) in the late 1970s. This group of practitioners wanted to learn from many different approaches to psychotherapy and different views on change. Theoretical integration brings together two or more concepts into one view. Technical eclecticism pays attention to techniques used within specific circumstances, meaning that it operates in the first level of abstraction (see Table 1) and aims to find the best treatment for an individual who has specific problems. The Common Factors view sees common elements of therapies as responsible for benefits from psychotherapy.

The Contextual model accentuates a holistic common factors view in psychotherapy. Describing the contextual model, Jerome Frank explains, “The aim of psychotherapy is to help people feel and function better by encouraging appropriate modifications in their assumptive worlds, thereby transforming the meanings of experiences to more favorable ones “ (as cited in Wampold, 2001, p. 24). Frank and Frank (as cited in Snyder, Michael, & Cheavens, 1999) describes the components shared by all approaches in the psychotherapy field as follows:

- An emotionally charged relationship with therapist
- A therapeutic setting (context of the relationship between client and professional helper is a healing setting)
- A therapeutic myth (or rationale) which gives reliable explanation for a client`s experiencing presenting symptoms and gives procedure for resolving them
- A therapeutic ritual (the actual procedures used by the therapists which are based on the rationale)

Frank (1991) points out that specific ingredients of therapeutic approaches are important in this model, however it is necessary to assemble a consistent treatment in which the therapist believes in the tools being used and gives the client credible rationale. Furthermore, the success of using specific tools depends on the client`s sense of alliance with the therapist. Also, the therapist should accommodate the type of therapy which best fits each client`s individuality and his/her view of the problem. In other words, the contextual model “states that the treatment procedures used are beneficial to the client because of the meaning attributed to those procedures rather than because of their specific psychological effects” (Wampold, 2001, p.27). Consequently, the model argues that removing one or more specific ingredients from the treatment will not decrease efficacy of the treatment, nor will adding theoretically essential ingredients increase the benefits of the treatment. It actually was found that removing or adding a specific ingredient has no effect on outcomes. In the contextual model the therapist affects the outcome of therapy with her skills. In this view, therapist effect is one of the common factors in psychotherapy. As mentioned earlier, the medical model argues that, specific ingredients (techniques) are significant to the outcome of therapy.

It is also important to identify distinctions between the Contextual Model and the Common Factor view, out of which the contextual model is rooted. The contextual model emphasizes a holistic common factors approach; however, it is something more than that. Wampold (2001) says that common factor model “contains a set of common factors, each of which makes an independent contribution to outcome” (p. 26) while the contextual model “discusses components common to all therapies” and “the healing context and meaning attributed to them by participants (therapist and client) are critical in contextual phenomena” (p. 26). As a result of this distinction we can say that in “a contextual conceptualization of common factors” there are “specific therapeutic actions which may be common across therapies” but “cannot be isolated and studied independently” (p. 26).

The evidence collected through different studies demonstrates that the medical model does not sufficiently explain the benefits of psychotherapy. Rather, the evidence supports the contextual model and its psychotherapeutic benefits based on common factors.

EFFICACY VERSUS EFFECTIVENESS

Since the goal for this thesis is to study the effectiveness of Process Work, it is useful to differentiate two terms used in the field of psychotherapy research: efficacy and effectiveness.

Efficacy (Wampold, 2001) is used to describe outcomes of psychotherapy resulting from comparisons of a treatment group and usually a control group in a well-controlled clinical trial setting with the use of manuals. If treatment is found greater in the treatment group than in the control group (usually the waiting list), then the treatment is called efficacious. Effectiveness, on the other hand, is used to describe the benefits of psychotherapy in a practice setting, referring to how that treatment is beneficial to a client and how that particular client does in the real world. To test the treatment, methodological strength in design should be indicated. For that reason the study should be clinically representative, meaning that the following 11 criteria must be met: clinically representative problem, clinically representative setting, clinically representative referrals, clinically representative therapists, clinically representative structure, clinically representative monitoring, demographic heterogeneity, problem heterogeneity, pre-therapy training of therapist, therapy freedom, and flexible number of sessions; Interestingly, it was shown that treatments administered in clinically representative contexts are not poorer than treatments delivered in strictly controlled clinical trials (Wampold, 2001).

For the purpose of this study I use the term *effectiveness* for measuring the benefits of Process Work therapy sessions because the proposed design (see Chapter on Methodology) meets elements of the ‘effectiveness model’.

MEASUREMENT IN PSYCHOTHERAPY

Today it is widely accepted that psychotherapy is beneficial and there are quantitative findings which support this statement. In this chapter I present a draft of the historical development of psychotherapy research including outcomes from comparative studies and meta-analysis strategies.

The debate about benefits from psychotherapy has been alive for more than 70 years now (Hubble, Duncan, & Miller, 1999). Modern manifestation of the professional base in the psychotherapy research field is: the multidisciplinary international Society for Psychotherapy Research (SPR), founded in 1970; the international scientific journal *Psychotherapy Research*; National Institute of Mental Health (NIMH), which evaluates grant applications in the territory of psychological treatments; and the publication of the *Handbook of Psychotherapy and Behavioral Change: An Empirical Analysis* (Howard & Strupp, 1992).

Historically, the first scientific investigations in psychotherapy started between 1920-1940. The modern phase of outcome research dates from 1952 with Eysenck's criticism of all psychotherapy (Garfield, 1992). Eysenck conducted research in which he examined the effects of psychotherapy by evaluating 24 studies in psychodynamic and eclectic psychotherapy. It is worth mentioning that as a researcher he was a proponent of behavior therapy. In that study a control group was not used and participants were not randomly assigned. The data showed that psychotherapy was not effective: he claimed that approximately two thirds of all clients with diagnosis of neurosis improved within 2 years; and that an equal proportion of clients had spontaneous remission and improved within the same time without therapy. Needless to say, Eysenck's report was

controversial because he argued that the outcome of psychotherapy was no better than the outcome of spontaneous remission.

The method chosen by Eysenck shows *relative efficacy* (see chapter on Relative Efficacy), meaning that efficacy was subtracted from comparison outcomes of different treatments. Eysenck's study found critics as well as advocates. Ten years later, he published two additional studies where he pointed out further insufficiency of psychodynamic and eclectic psychotherapy. As a reaction from the other side, in the 1970s Bergin, Luborsky, Meltzoff and Kornreich – critics of Eysenck's study – presented different conclusions in their own review.

In 1977 M.L. Smith and Glass, and three years later M.L. Smith et al. (Wampold, 2001), endeavored to prove the efficacy of psychotherapy using a meta-analysis strategy. Meta-analysis is a quantitative method (statistical analysis) used to bring together similar studies in order to test hypotheses. A hypothesis in that kind of study is created to test some relationship in the population: for example, 'Psychotherapy is more effective than no treatment'. The goal for Smith and Glass's study was to combine the results from studies that were based on comparison of psychotherapy and counseling with a control group to estimate quantitatively the size of the psychotherapy effect (more about effects sizes reader can find in the *Great Psychotherapy Debate: Models, Methods, Findings* by Bruce Wampold, 2001). Smith and Glass found 375 published and unpublished studies to conduct research. In those studies, the researchers included all controlled studies, despite the quality, to see if the quality was related to the outcomes. The findings showed beneficial effects of psychotherapy and counseling. In 1980 Smith et al. published new studies based on a bigger sample. All 475 studies gave 1766 effect sizes. The main finding was that the arithmetic average of the effect size was .85, which was larger than

in the previous study. That large effect size means that the average client receiving psychotherapy was better than 80% of clients without treatment; and that the success rate would change from 30% in the control group to 70% in the treatment group.

ABSOLUTE EFFICACY NOWADAYS

Absolute efficacy shows the effect of treatment deducted from the comparison of treatment group with no-treatment control group. Over the years, findings from different meta-analyses show that effect size related to absolute efficacy ranges from .75 to .85 (Wampold, 2001). Such a large effect in social sciences can be interpreted as: the average client receiving psychotherapy would be better than 79% of clients without treatment, and success rate would be 31% in control group and 69% in treatment group. These numbers illustrate that psychotherapy is very efficacious.

In 1993 Lipsey and Wilson (Wampold, 2001) performed a survey of all meta-analyses related to psychological, educational and behavioral treatments and their efficacy. The mean effect size of the 13 meta-analyses was .81 which is interpretable as significant in social sciences and shows that treatment is efficacious. One year later, Lambert and Bergin reviewed over 25 meta-analyses and found an average effect size of .82 for psychotherapy compared with no-treatment groups. In 1996, Grissom examined 68 meta-analyses which combined outcomes from studies comparing psychotherapy with no-treatment control groups. He computed an average effect size of .75 for the efficacy of psychotherapy.

A series of meta-analyses of humanistic-experiential therapies (Greenberg, Elliott, & Lietaer, 2003) show that the average effect size over time for clients who participate in

that type of therapy is large (1.06) and that post-therapy gains are stable (maintained over 12 month follow-ups). Comparison to randomized clinical trials against wait-list and no-treatment control group for clients in humanistic-experiential therapies show more change than untreated clients, with effect size 0.99.

Studies of psychoanalytic and psychodynamic approaches support efficacy of those treatments. In 2000 in Sweden, Sandell and his colleagues (McWilliams & Weinberger, 2003) collected data from 450 clients. The data from the clients and therapists were gathered using an interview and questionnaire. Findings show that clients improved in treatment; duration and frequency of treatment were important variables for the outcomes. Studies in that approach also demonstrate that deeply embedded problems are acquiescent to that treatment.

RELATIVE EFFICACY (Comparative studies)

The primary design for showing relative efficacy is the comparative outcome strategy (Kazdin, 1994). Relative efficacy shows effect of treatment deducted from comparison of the outcomes of two treatments: A and B. Comparative design is usually performed with a control group to determine if each of the treatments is superior to no-treatment group.

In general, present findings show that different treatments appeared to be equally efficacious and different therapies can gain similar goals (Lambert & Bergin, 1992). However there is proof that behavior therapy, cognitive therapy, and an eclectic mixture of these are sometimes more beneficial for specific disorders; such as cognitive-behavior treatment for phobic disorders, but this is not a general rule. In 1989 Snyder and Wills

(Wampold, 2001) compared the efficacy of behavioral marital therapy and insight-oriented marital therapy. It was found that both treatments were superior to no-treatment control groups and both of the treatments were equivalent to each other. Four years after termination of the treatment an important difference was found: 38% of behavioral marital therapy couples were divorced when only 3% of insight-oriented marital therapy was divorced. As Wampold points out, the statistically significant difference between the outcomes of the two treatments might be the result of statistical error (Type I error). Statistical theory predicts that comparisons of treatments will generate statistically significant difference in outcomes while there is really no difference. That effect creates difficulty with interpreting a single study. To avoid that error, researchers focus on a variety of meta-analytic strategies in designating relative efficacy. In 1996 Grissom (Wampold, 2001) performed meta-meta-analysis of 32 meta-analyses in which he compared different psychotherapies. The effect size found in that study was 0.23. In 1997 Wampold, Mondin, Moody, Stich, et al. (Wampold, 2001) provided evidence through meta-analyses of relative efficacy as well. The approximate effect size in their study was found as 0.20, which is considered a small size within social sciences and without significant statistical difference. That effect size means that: 42% of the clients in treatment A (worse) are better than the average person in the treatment B (improved); only 1% of the variance³ in outcomes is owed to the treatment; 45% of clients in “worse” treatment would gain success in treatment while only 55% of clients from “improved” treatment would gain success. As we can see, the result shows that there is little empirical evidence for the superiority of one treatment over another.

³ Variance - In probability theory and statistics, the variance of a random variable, probability distribution, or sample is a measure of statistical dispersion, averaging the squares of the deviations of its possible values from its expected value (mean).

Table 2 below presents an example of the summary of meta-analyses for relative efficacy of psychological treatments of anxiety.

Table 2 Summary of Meta-Analyses of Relative Efficacy of Psychological Treatments of Anxiety

Author	Year	Direct comparisons	Effect Size Type	Disorder	Treatments Compared	Results
Mattick, Andrews, Hadsi-Pavlovick, & Christensen	1990	No	Post vs. pre	Agoraphobia Panic	Various behavioral CT	Panic: EXP > no EXP Phobia: EXP > anxiety management + EXP No differences on anxiety or depression
Chambless & Gilliss	1993	No	Post vs. pre or Tx vs. control (when control existed)	GAD Social phobia Agoraphobia Panic	CBT Behavioral	CBT = Behavioral (including EXP) in most instances
Clum, Clum, & Surls	1993	Some	Tx vs. control	Panic	Flooding Psychological coping Exposure Combination	No differences
Van Balkom et al.	1994	No	Post vs. pre	OCD	CT Behavioral	No differences among various behavioral approaches Differences between CBT and behavioral not tested
Taylor	1996	No	Post vs. pre	Social Phobia	EXP CT CT+EXP Social skills training	No differences

Abramowitz	1996	No	Post vs. pre	OCD	Various ERP	Some differences were found: therapist-controlled exposure was superior to self-controlled exposure (Author suggests that provides evidence for general effects-meaning therapist presence is a factor)
Abramowitz	1997	Yes	Tx A vs. Tx B	OCD	ERP CT Components of ERP	No differences
Sherman	1998	No	Tx vs. control	PTSD	CBT CT EMDR Psychodynamic Hypnotherapy The Koach program Anger management Adventure based activities Psychodrama Coatsville PTSD program	Treatment produce homogeneous outcomes (no differences)

Tx – Treatment; TxA -Treatment A; TxB –Treatment B; CBT –Cognitive behavioral treatment; EXP –Exposure; CT –Cognitive therapy; ERP –Exposure and response prevention; EMDR –Eye movement desensitization and reprocessing; GAD –Generalized anxiety disorder; OCD –Obsessive-compulsive disorder; PTSD –Posttraumatic stress disorder.

From “Relative efficacy: The Dodo Bird was smarter than we have been led to believe” by B. E Wampold, 2001, The great psychotherapy debate, pp.110-111.

COMMON FACTORS IN PSYCHOTHERAPY

The previous sections establish that there is no significant difference in psychotherapeutic outcomes between different theoretical approaches. In addition, despite differences in theoretical approaches, there are some common factors which are correlated with outcomes from treatment.

In 1936 Rosenzweig (Hubble et al., 1999) argued that common elements of psychotherapy were responsible for positive effects from treatment; which also implied that all psychotherapies are equal in terms of their benefits. That was the first time an idea of active common therapeutic ingredients for different therapies was mentioned. Since that time, the field has produced many studies of measuring effects of psychotherapy in terms of absolute efficacy, relative efficacy and the common factors approach. This chapter focuses on the common factors of psychotherapy.

Common therapeutic factors are distributed into four sections: client variables and extratherapeutic change, therapeutic relationship, expectancy and placebo effects, and technique/model factor (Assay & Lambert, 1999); See below for a breakdown of each of these factors.

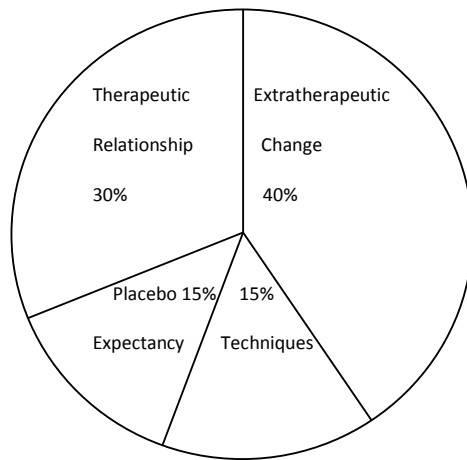


Figure 1. *Percentage of improvement in Psychotherapy Patients as a Function of Therapeutic Factors by M. J. Lambert. From The Heart and Soul of Change. p.31, 1999.*

CLIENT VARIABLES AND EXTRATHERAPEUTIC CHANGE

Client factor refers to everything the client brings to therapy and what influences his/her life outside of the therapy room. As Hubble et al. (1999) point out, it can be “persistence, faith, a supportive grandmother, membership in a religious community, sense of personal responsibility, a new job, a good day at the tracks, a crisis successfully managed” (p.9) as well as “severity of disturbance, motivation, capacity to relate, ego strength, psychological mindedness, and ability to identify a focal problem” (Assay & Lambert, 1999, p. 31). Also, clients who do better in psychotherapy keep treatment goals alive and believe that changes made in therapy are mainly a result of their own efforts.

Included within the client factor is the spontaneous remission phenomenon, which also refers to what clients bring to the therapy room. Spontaneous remission reflects the reality that people improve without psychological intervention, due to supportive and therapeutic aspects of their own environment. Indeed, a study by Howard et al. (Assay &

Lambert, 1999) found that about 15% of clients experience some progress even before starting therapy.

Moreover, Strupp found that clients who benefit from therapy appear to be more willing and able to have a meaningful relationship with the therapist (Assay & Lambert, 1999). Clients who did not improve through the treatment did not relate well to the therapist and kept shallow contact.

Estimated at 40% of outcome variance, the extratherapeutic factor accounts for a large part of psychotherapy results.

THERAPEUTIC RELATIONSHIP FACTOR

Much of the research on therapeutic relationship started within the client-centered approach to therapy. Findings (Bachelor & Horvath, 1999) suggest that the therapist-client relationship is critical in the process of therapy. A number of studies investigating the correlation between outcomes and therapeutic alliance suggest that early alliance – third to fifth session – is a significant predictor of outcome for the treatment.

One aspect of the therapeutic relationship factor refers to the effectiveness of the therapist, as indicated by the following elements: warmth, understanding, affirmation, caring, empathy, acceptance, encouragement and mastery (Hubble et al., 1999). These elements are independent from the therapist's theoretical background. In a study by Najavits and Strupp (Asay & Lambert, 1999), 16 therapists using a dynamic approach were identified as 'more effective' or 'less effective'. Findings showed that more effective therapists presented more positive behaviors and fewer negative behaviors than

less effective therapists. Positive behaviors were described as: warmth, understanding, affirmation. Negative behaviors were described as: belittling, blaming, ignoring, negating, attacking, rejecting. The results illustrate that therapists were differentiated by nonspecific factors (referring to relationship level) - and not to specific ingredients of a particular approach (techniques factors).

The therapist, with his personality and skills, has a significant effect on outcome of therapy. Wampold (2001) says that “the essence of therapy is embodied in the therapist” and “the person of the therapist is a critical factor in the success of therapy” (p. 202). Therapist effect is estimated at 0.50 to 0.60, which indicates the significance of its effect.

Another important aspect of the therapist-client relationship factor is therapeutic alliance, which was described for the first time by Freud (Asay & Lambert, 1999). In a more recent study, Gaston (Asay & Lambert, 1999) suggests components of therapeutic alliance: the client`s affective relationship to the therapist, the client`s capacity to work purposefully in therapy, the therapist`s emphatic understanding and involvement, and the client-therapist agreement on the goals and tasks of therapy; Bordin (1979) classifies three elements of the therapeutic alliance: tasks, bonds, and goals. Tasks form the actual work through therapy. It is essential for strong therapeutic alliance that the therapist as well as the client sees tasks as important and appropriate. Goals refer to the agreed upon objectives of therapy by both sides. Bonds reflect on positive interpersonal attachments between therapists and clients and their effect on mutual trust, confidence and acceptance.

The relationship factor was estimated for 30% of client improvement.

EXPECTANCY AND PLACEBO EFFECTS

The first studies investigating client expectancies and their relationship to outcome were performed by Jerome Frank (1973). Frank stated that since the therapy itself includes strong expectations of being healed, those expectations influence the outcome; meaning that clients will be helped in therapy due to positive expectancy. The degree of improvement in the treatment correlates positively and significantly with such expectancies (Snyder et al., 1999). Research has shown also that a notable portion of client improvement happens within the first 3 – 4 weeks of treatment. Even more, 40% to 66% of clients reported positive changes even before their first session. Snyder says that early stage improvement cannot be the result of specific treatment effects but belongs to the role of hope carried by the client.

One of the common factors that exists across therapies refers to the therapist attitudes toward the therapy he or she performs. This phenomenon is called *therapist allegiance* (Wampold, 2001). If the therapist believes that the delivering treatment is efficacious, it has positive impact on the outcomes as well.

Findings by Lambert, Weber, and Sykes (Asay & Lambert, 1999) show the effect of placebo on psychotherapy outcomes. In their study they compared the effect sizes of psychotherapy, placebo, and no-treatment controls. The effect size of psychotherapy was estimated to be .82, the effect size of minimal treatment (placebo) was estimated to be .42, and effect size in control group was 0. It is important to mention that the placebo effect seems to be weaker for clients with more severe disorders and in studies where more experienced therapists have been used.

Expectancy of the client and placebo effects were estimated overall for 15% of client improvement.

TECHNIQUES AND MODEL FACTOR

As it was mentioned earlier (see Chapter Relative efficacy) there is little evidence to suggest superiority of a particular therapeutic approach or technique over another. However, some exceptions exist which account for approximately 15 % of the client`s improvement in treatment.

Comparative studies show that treatment of phobic disorders with behavioral techniques (exposure) has been significantly effective. However exposure techniques when applied to social phobias, generalized anxiety disorders, or combinations of those disorders were found less effective. Also no difference in effectiveness has been found between cognitive-behavioral therapy and interpersonal psychotherapy with depressed clients (Asay & Lambert, 1999).

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To summarize the discussion on benefits of psychotherapy, Table 3 presents various aspects of psychotherapy and their effects:

Table 3 Effects for Various Psychotherapeutic Aspects

Source	Descriptor or Phenomenon	Design	Effect size	Proportion of variance	Notes
Effects of psychotherapy	Absolute efficacy	Tx vs. Control	0.80	13%	Well-established point estimate of psychotherapeutic effects
Treatments	Relative efficacy	Tx A vs. Tx B	0.00 to 0.20	0% to 1%	Best estimate for effect size is 0.00; 0.20 is upper bound under most liberal assumptions and inflated by not considering therapist effects
Specific ingredients	Specific effects	Component, mediating and moderating	0.00	0%	Little evidence found for specific effects from these designs
Common factor	Placebo effects	Placebo vs. control	0.40	4%	Lower bound for estimate of proportion of variance due to common factors in that placebo treatments contain some, but not all, common factors specified in contextual model
Common factor	Working alliance	Correlation of alliance and outcome	0.45	5%	A single common factor accounts for about 5% of the variance in outcomes
Common factor	Allegiance	Correlation of allegiance and outcome or difference between treatments	Up to 0.65	Up to 10%	Allegiance of therapist has consistently been found to be related to outcome; estimates of effects from various meta-analyses range up to 0.65
Therapist effects	Competence	Nested or crossed	0.50 to 0.60	6% to 9%	Estimates for aggregate of outcome variables; proportion of variability due to therapists for individual variables up to 70%

Tx – treatment

From *The Great Psychotherapy Debate. Models, Methods, and Findings* by B.E.Wampold, 2001, p. 205

PROCESS WORK THERAPY

In this chapter the reader is introduced to the paradigm of Process Work (Process Oriented Psychology), its main methods and techniques for working with clients in therapeutic settings.

Process Work (PW) is an interdisciplinary approach for working with people which began in the early 1970s and developed out of Arnold Mindell's research on body experiences and Jungian dreamwork (Diamond & Jones, 2004). Arnold Mindell, physicist from the Massachusetts Institute of Technology and Jungian analyst, found out that dreams are happening in every moment, so we do not have to work with night dreams in order to discover messages from the numinous (referred to as the unconscious in Jungian psychology). The dreaming process, as Mindell named that phenomenon, might appear through dreams as well as through body symptoms, relationship disturbances, altered states or world events (i.e. synchronicities). Through the years Arnold Mindell developed methods and techniques to work with a variety of human experiences. He hypothesized that our night dreams, body symptoms, relationship disturbances, and other things which happen to us, carry coded messages. If we unfold that which is coded, we will find meaning and discover solutions to life's difficulties, as well as direction for our next step. Today Process Work is viewed as:

A multicultural, multileveled awareness practice including people and their natural environment. Process work is an evolving, transdisciplinary approach supporting individuals, relationships and organizations to discover themselves. PW uses awareness to track "real" and "imaginary" psychological and physical processes that illuminate and possibly resolve inner, relationship, team, and world issues. (Mindell & Mindell, 2009)

Contemporary applications of PW are wide and include: individual therapy (for example: body symptoms, creativity, anxiety, depression, addiction work, co-dependence, abuse work, power, rank, coma work, altered and extreme states of consciousness), relationship work, family work, community and group work, conflict resolution, and working with organizations.

In Process Work paradigm, the term *process* refers to “the flow of the experience” (Mindell, 2006, p. 52). ‘The flow of the experience’ is the stream of information differentiated as pieces closer to our awareness (primary process) and pieces further from our awareness (secondary process). Both of the processes (primary and secondary) are separated by the *edge*. The edge is “the borders or barriers that exist to the eternal and continual flow of inner processes” (Mindell, 2000, p. 57). This is the line between what is known and familiar to us and the unknown world. For example, “In speaking, when we can no longer say something, we reached a communication edge” (p. 57); possibly that reaction appears because the material we wanted to say is new or from unknown territory. When people cross the edge, they get into the direct experience of the secondary process. In that moment, their inner individual psychology changes a little. As Mindell explains:

Just as logs or rocks in a river give form to the river [edges] give form to your inner processes. Edges are neither good nor bad they simply divide us into different worlds. We know this because at one point or another we feel we cannot go more deeply into an experience, insight, thought, or feeling; we have reached an edge (p.57).

The stream of information manifests as primary and secondary processes, which show up through *signals*. From communication theory, a ‘signal’ is a piece of intended or

unintended information (Watzlawick, Beavin, & Jackson (1967). According to Process Work theory, intended signals are sent by primary process while unintended signals are sent by secondary process. When two signals - one belonging to primary process, and one belonging to secondary process - exist at once they are called *double-signals*. All signals appear in different modalities, named channels. Mindell differentiates four simple channels and two complex channels (Mindell, 1985; Diamond & Jones, 2004):

* Proprioceptive channel – carries the experience of body sensations, such as tension, weight, temperature. Those physical sensations are usually present when a person closes her eyes and speaks slower. It is characterized by specific qualities like: light, heavy, sharp, dull, pressed, spreading or pulsating.

* Visual channel – carries the experiences of seeing and being seen. It might reveal itself as images, fantasies or picture. In language the visual channel “is indicated by the use of active or passive forms of verbs such as ‘see’, ‘look’, ‘notice, or ‘observe’ “(Diamond & Jones, 2004, p. 65). It can be expressed in movement as an upward look, quick blinking of eyelids or looking in distant in space.

* Auditory channel – carries the experiences of internal and external sounds. It might reveal as inner dialogue, hearing music, outside noises, hearing voices. In language the auditory channel will be indicated by statements like ‘he said that in that specific way....’, ‘it sounds like...’

* Movement channel – carries kinesthetic experience and expression of the body. It can also be recognized when a person uses a specific word which refers to action like: go, jump, run, bite, etc.

* Relationship channel – carries the experiences which are communicated through relationship with somebody. It might show up as conflict with somebody or when a

person describes others' behaviors, qualities in words.

*World channel – carries “the experiences that are related to collective, global, social, or political events or institutions” (Diamond & Jones, 2004, p. 67). If person says that some world event has impact on him, it indicates world channel.

While working with a client, it is essential to know the skills for mapping the structure of the process, meaning identifying which signals belong to the primary process and which signals belong to the secondary process, also referred to as the dreaming reality. For that task we need to gather sensory grounded information which is “the phenomenological description of dreaming experience” (Diamond & Jones, 2004, p. 45). Sensory grounded information appears in channels (see above) unoccupied by our awareness. In gathering sensory grounded information there are four steps to follow:

- listening to what the client says
- looking at what the client is doing
- sensing the therapist's own experience and the field of synchronicities
- linking all these steps together

Sensory grounded information appears through signals referring to things that happen to us, which at first are expressed as ‘not me’ and portrayed as “other people, figures, events, or symptoms” (p. 48). Following that information takes the therapist to further steps of *unfolding* the process where we *amplify* secondary signals.

Amplification is one of the main methods of unfolding in the Process Work approach. It means “increasing the strength of signal” (Mindell, 1982, p. 180), “expanding the signal so that all its details – its full message and expression – can emerge” (Mindell, 2006, p.135). Amplification of a signal needs to be done in the channel in which it

appeared; such that on the next step of work, the experience might be expanded and brought into other channels. When a signal is amplified long enough, out of that single piece of information emerges a *dreamfigure* or “into an interaction between two or more dreamfigures” (Diamond & Jones, 2004, p. 87). The dreamfigure, role, part, or ghost is “a personification of dreaming tendencies which coalesce momentarily into a role or character”(p. 86).

The main technique of working in this phase is *shapeshifting* and *role-playing*. When a client imagines oneself as a particular dreamfigure, she shapeshifts into or ‘becomes’ that figure for a moment during the work; meaning that person can see, feel, speak, and move like the dreamfigure. Shapeshifting brings a quality and meaning somehow needed in the client’s life. Role-playing is “a vehicle for amplifying experience” by acting out “inner and outer conflict, different parts and figures to gain a deeper understanding of an experience” (Diamond & Jones, 2004, p. 101). This interaction between the parts “becomes a vehicle for the conscious integration of previously marginalized parts”(p. 90).

While working with the client the most important guide-post for direction in therapeutic work is following feedback from the client. This main idea is rooted in the “belief in inherent wisdom of nature (process). In this paradigm where the practitioner is viewed as an awareness facilitator who follows the patterns and movements of nature (the flow of experience), feedback is viewed as the navigational compass” (Vasiliou, 2006, p. 123). In Process Work there are differentiated types of feedback: positive feedback, negative feedback, and edge feedback. Positive feedback means that secondary signals “self-amplify in response to facilitative input, and so the process continues to go in the direction in which it is already headed” (Diamond & Jones, 2004, p. 74). Negative

feedback means that signal does not change, reduces in strength, or comes as a verbal 'no' response. Edge feedback appears when "there is a lot of energy and mixture of positive and negative signals; the person is saying 'yes' and 'no' simultaneously" (Mindell, 2006, p. 137).

Process Work is based on the idea of respecting the whole process with all its parts. This implies bringing awareness to all the parts; ones we know more and feel closer to our identity, and the ones we tend to marginalize. This is why Process Oriented Psychology applies moment to moment awareness while working with clients and with ourselves.

Presented here are the basic features and summary of the Process Work theory and practice. Readers who are interested in further information about the Process Work paradigm and methods of working with clients are welcome to see Arnold Mindell's *River's Way*, *Working With the Dreaming Body*, *Working on Yourself Alone*, *The Dreambody in Relationships*, Amy and Arnold Mindell's *Riding the Horse Backwards*, Amy Mindell's *Alternative to Therapy. A Creative Lecture Series on Process Work*, Joe Goodbread's *The Dreambody Toolkit*, and Julie Diamond and Lee Spark Jones' *A Path Made by Walking: Process Work in Practice*.

EFFECTIVENESS OF PROCESS WORK

Since the early 1970s, when Arnold Mindell originated theory of the Dreambody, Process Work has been developed into a multidimensional awareness approach with applications for individual therapy work, family work, small and large group work, conflict resolution, and organizational development. Studies of Process Work and its

applications have produced many different research projects (for details see Manuscripts by Process Work Faculty & Students: <http://www.processwork.org/manuscripts.htm>).

However, only one quantitative study has been conducted with the goals of measuring the effectiveness of Process Work in a clinical setting and as a comparative study. This thesis is the first step toward furthering this direction.

Other studies in the field of Process Work which are similar to the subject of this current research include:

- *Rank and Salutogenesis: A Quantitative and Empirical Study of Self-Rated Health and Perceived Social Status* by Pierre Morin (2002). This is a quantitative survey in which the researcher investigates relationships between self-rated health, subjective rank, Antonovsky's sense of coherence, and objective measures of social status. The study sample consists of 133 U.S. and 59 Swiss participants of Lava Rock Seminars (Seminar concentrates on psychological and physical needs related to chronic illness). Findings showed that subjective rank was significantly related to self-rated health among both groups. The study gives evidence that:

A low perceived rank is linked to greater stress by either increasing stress directly or in increasing the vulnerability to the effect of stress. These results demonstrate that rank has a considerable impact on subjective health. This study positions Mindell's concepts of rank within a larger academic discourse of power and privilege. Further, by integrating newer concepts based on Antonovsky's 'Salutogenesis' and Mindell's ideas on rank, this study contributes to a change of our attitude toward illness and deviance (Morin, 2009, Research and Publications).

- *Heroin Addiction and Altered States. Can a Single Process-oriented Intervention Help?*

by Reini Hauser (2004). This is the pilot study that investigates the effectiveness of a single process work intervention within two sessions for 13 opiate-dependent persons. This is a quantitative study in which the researcher compared a verbal-exploratory session and process work intervention session. The effects showed highly significant improvements toward health on the health/illness continuum after the sessions where Process Work interventions were applied, stronger involvement in the therapeutic process, and significant increase in self-awareness level.

- *Beyond Compare: A Personal Reflection on Process Oriented Approaches with Emotionally Disturbed Children* by Lesli Heizer (1992). This thesis is focused on the application of Process Work in psychiatric treatments for adolescents. The study uses heuristic and Process Work methodology.

- *Discovering Meaning in Panic: A Process-oriented Approach to Panic Attacks* by Lily Vasiliou (2006). This work presents application of Process Work therapy with panic attacks through case studies; however, it is not a quantitative study and it does not measure the effect of its application.

- *No Small Change: Process-Oriented Play Therapy for Children of Separating Parents* by Silvia Camastral (2008). This work presents the contribution of the Process Work approach to child therapy; however, it is not a quantitative study.

- *An Assessment of Effects of the Group Process Method of Process Work on the Development of Individuals' Intercultural Sensitivity: A Quantitative and Qualitative Analysis* by Akira Kobayashi (2009). In this doctoral dissertation, the author performs quantitative and qualitative strategies to measure changes within individuals' 'intercultural sensitivity' after participation in a World Work Seminar where Process

Work methods for working with groups were applied. The change of individual intercultural sensitivity was measured by the Intercultural Development Inventory (IDI). The results showed significant differences between pre & post test scores. The study investigated as well, who among participants responded favorably to the Process Work methods for working with groups, who not, and why.

- *Riding the Sentient Wave. A discourse on the challenges and benefits of intuition in therapeutic work and everyday life* by Gerald Maclaurin (2005). This is a heuristic survey of psychotherapists of their use of inner work and helping others.

- *Shifting the Assemblage Point: Transformation in Therapy and Everyday Life* Salome Schwarz (1996). This work presents applications of the Process Work methodology throughout case studies to describe change of person`s identity and sense of reality in the therapy process.

Chapter III: METHODOLOGY

GOAL OF THE STUDY

The goal for this pilot study is to obtain data to design, in the future, quantitative research for studying outcomes of Process Work psychotherapy. This study serves as one of the first steps toward gathering quantitative information which will represent the effectiveness of psychotherapy conducted by therapists using the Process Work psychology paradigm and methodology. Quantitative research on the practice of Process Work is necessary in order to bring together Process-Oriented Psychology with other psychotherapeutic approaches and address the dispute in the field concerning research outcomes and professional practice, as well as search for new paths of effective therapy for clients.

RESEARCH PROBLEM – INQUIRY AND HYPOTHESIS

In *Methodology of Psychological Research*, Jerzy Brzeziński (1996) explains that:

A scientific research initiates from formulate research problem which refers to relation that exists between variables. It refers to dependent variable Y (or their set) and independent variables X_1, \dots, X_n , which are treated by the researcher in cause-effect relationship with variable Y. Researcher will be interested not only: if particular variable X_j has influence on Y (X_j as cause of Y) but also how particular variable X_j cause on Y (define relation between Y with X_j) (p. 216).

We can differentiate multiple types of research problems depending on what the inquiry refers to. According to Stefan Nowak`s (1985) classification, there are research

problems which refer to variables' values and there are research problems which refer to dependence between variables. For the purpose of this study, I am interested in inquiries about variables' values; the question is about the dynamic characteristics of objects or processes these objects are subject to.

Formulating inquiries and hypotheses which are part of our research requires having some presumptions. When we build research inquiry it is necessary to assume some answers as right and others as wrong. Right answers might be true or false. When initiating research, we should make the assumption that at least one of the possible answers is false. This is called negative presumption of inquiry.

We need to keep in mind that research inquiry should be rather unequivocal. This condition is important to let us perform decisions. However it does not guarantee empirical conclusions. The inquiry satisfies this requirement if we know what facts, phenomenon and processes should be observed to give right answers for research inquiry. For the purpose of this study, the inquiry is formulated as: *“Does a client’s sense of well-being increase after participation in Process Work therapy sessions?”*

Let`s look now at the process of formulating a hypothesis. Hypotheses must be formulated precisely in order to be testable and must be stated in such a way that leaves them open to falsifiability. A hypothesis is of little use unless it has potential to be found false (Popper, 1959). A hypothesis must also be adequate and allow the simplest answer for the research problem so empirical conclusion can be performed. This means that we know what observations are needed to gain specific answers for the inquiry. If that answer was formulated already in research inquiry as a hypothesis, then it is a *verifiable* hypothesis. If we just know what outcomes from what observations are needed to dismiss

the hypothesis – then that hypothesis is *falsifiable*. Because the inquiry formulated for this study contains a hypothesis it is a verifiable hypothesis. The hypothesis of this study states: *A client's sense of well-being increases after participation in Process Work therapy sessions.*

Additionally, the hypothesis used here is an *ad hoc* hypothesis. Latin phrase *ad hoc* means 'for this purpose' and indicates that an *ad hoc* hypothesis is designed for a specific problem or task, and cannot be adapted to other purposes.

VARIABLES AND THEIR INTERDEPENDENCE

Jerzy Brzeziński (1996) defines a variable as a feature that has some values. If we can say that some feature has different values (at least two), then this is a variable.

There are different classifications of variables (Brzeziński, 1996). One classification differentiates variables as: dichotomic variables (two value variable), trichotomic variables (three value variable), or polytomic variables (many values variable); the other classification differentiates continuous variables (where set values of the variable show as a continuum, such that a third value can be found in between two variable from discrete variables (if there is no middle value between two variables). Within this study variables are *continuous*. The next classification divides four kinds of variables: nominal, ordinal, interval, ratio (Stevens, 1946). And finally there are variables differentiated as dependent and independent. Dependent variables (Y) are the objects of our research; we want to investigate the relation of Y with other variables. Independent variables (X) might be controlled or selected by the researcher to determine their relationship to an observed phenomenon (Y). The researcher wants to find the evidence that the independent variable

affects the dependent variable. The ones with strong influence we call *main independent variables* and the ones with weak influence we call *side independent variables*. We should consider that through the process of testing hypothesis there exist also *disturbing independent variables* which can be correlated with the act of empirical research, or not.

In this study's hypothesis – *A client's sense of well-being increases after participation in Process Work therapy sessions* – the dependent variable is *well-being* and independent variable is *process work therapy*.

The term *well-being* refers to the level of satisfaction in a client's life. In the study, satisfaction and improvement in therapy will be measured by changes in four ratios which are used to determine the increase of *well-being*. The four ratios are:

- individual level (which refers to personal well-being),
- interpersonal level (which refers to family, close relationships),
- social (which refers to work, school, friendship),
- overall (refers to general sense of well-being).

Rise of value of ratios on each level will mean an increase in client's sense of well-being.

(More about the research tool in the chapter on Research Tools: Self-rating Scales.)

The object of interest in the study is to record a change in level of life satisfaction (sense of well-being) for clients from the general population after individual therapy sessions with therapists using Process-Oriented Psychology model.

If outcomes show a statistically significant increase or decrease of the dependent variable, then it will mean high interdependence between variables. If we register an

increase of the dependent variable after therapy sessions conducted by Process Work therapists, we can conclude that Process Work therapy sessions are effective.

RESEARCH DESIGN

The study uses a **quasi-experimental model** to test the hypothesis. Within quantitative research design, we can differentiate two types (Barker, Pistrang, & Elliott, 1994):

- non-experimental designs: descriptive designs with the goal to describe phenomena and correlational designs with the goal to explore the relationship between two or more variables
- experimental designs and quasi-experimental designs

The difference between experimental model and quasi-experimental depends on the fulfillment of four fundamental conditions necessary to perform the experiment. Let's start first with the definition of experimental model proposed by Jerzy Brzeziński (1996): "experimental method relies on manipulation by researcher variability of one or more independent variables and measure variability of dependent variable or variables" (p. 285). In other words, experimental model verifies relationships between variable Y and variable X.

Additionally experimental procedures must meet the following assumptions (Barker et al., 1994):

- Manipulation of at least one main independent variable which means random allocation of different values (at least two) for people participating in the experiment (in experimental and control group)

- Monitoring side independent variables
- Minimizing influence of disturbing independent variables on dependent variable
- Performing measurement variability of dependent variable caused by main independent variables

If the procedure does not meet at least one of those conditions, then we call that model *quasi-experimental*. Measurement applied in this study is a one group design, without a control group, with beginning and ending measurement. Because there is no control group, we cannot perform randomized group design. Since we cannot meet that condition, the model is quasi-experimental. Though the advantage of that model is simplicity and ease of application, many researchers underline that there is no-control on the impact of the pre-test on the experimental stimulus and this disturbs inner validity. Inner validity is found if the main independent variable affects the dependent variable and its impact crosses the edge of disturbances that come from side variables (Brzeziński, 1996).

In order to verify a hypothesis within a quasi-experimental design, the ending measurement of the dependent variable must be higher than the beginning measurement.

Yb _____ X _____ Ye

Ye > Yb b –the beginning measurement of dependent variable

e – the ending measurement of dependent variable

The research includes three phases:

1. Perform beginning measurement of dependent variable
2. Introduce independent variable X to the sample group
3. Perform ending measurement of dependent variable

RESEARCH TOOLS: Self-Report Scales

In the study I used the following self-report tools: Outcome Rating Scale and Session Rating Scale (Miller & Duncan, 2004). These two scales were developed by the team at the Institute for the Study of Therapeutic Change (ISTIC). The idea for the scales was to measure clients' progress over the time of treatment, as well as their satisfaction from the session itself, which reflects how strong or weak the therapeutic alliance is. The scales are simple and quick to fill out. Each scale includes four items which refer to different dimensions of the client's measured experience. The client marks a hash on the line in the place which best describes his/her experiences. ORS is administered at the beginning of each session and SRS at the end of the session.

ORS

ORS is a self-report scale which measures change in specific areas of client functioning. ORS was designed as a new tool in comparison to the Outcome Questionnaire 45 (OQ45) developed by Lambert and others. It has four levels: *individual* (personal well-being), *interpersonal* (family, close relationships), *social* (work, friends, school, friendships), and *overall* (general sense of well-being); study of the reliability of the ORS was conducted by an independent institution (Center for Clinical Informatics) with results of coefficient alpha of .97 and test-retest reliability of .53. Research

conducted in 2003 by Miller, Duncan, Brown et al. (Miller & Duncan, 2004) showed that the scale is sensitive to change for those receiving psychotherapy, and stable for non-clinical group. More information about reliability and validity of the tool reader can find in *The Outcome and Session Rating Scales, Administration and Scoring Manual* (Miller & Duncan, 2004). The clinical cut off for outcome from ORS was determined at score of 25 based on sample n=34790. Clinical cut off indicates the line between normal and clinical distress, as well as severity of distress. If scores from ORS increased through time, we can say that treatment is effective.

SRS

SRS is a self-report scale which measures client satisfaction from the session itself. This scale contains four levels as well: *relationship* (refers to client`s experience of being heard, understood and respected by the therapist), *goals and topics* (refers to client`s sense of working and talking about what she/he wanted to work on and talk about), *approach or method* (refers to client`s satisfaction of therapist approach to work), and *overall* (refers to client`s satisfaction from today session);

Reliability and validity of the SRS was tested by comparison with the well-known measure of therapeutic alliance found in the *Revised Helping Alliance Questionnaire* (HAQ-II) by Duncan, Miller, Reynolds et al. (2003). The reliability for the SRS with evaluation of coefficient alpha was positive with the HAQ-II, .88 versus .90. The reliability of test-retest for the SRS compared to the HAQ-II was .74 versus .69. There was also an independent study conducted by Center for Clinical Informatics, which sampled approximately 15,000 administrations, with results coefficient alpha .96 and test-retest .50.

Evidence of validity was found for the SRS. Pearson product moment correlation between the SRS and HAQ averaged .48, meaning that the two scales have similar ranges. It was found that scores at intake are not a strong predictor of ORS change, but it was found also that increase of the scores in SRS over the time of treatment is associated with positive change in ORS outcomes. However the high SRS scores are not interpretable. There was found evidence that the act of monitoring the SRS brings positive impact on client outcomes. Those clients who were asked to fill out SRS at intake were three times more likely to have additional sessions and experienced more change by the end of the treatment than those who did not have a chance to give feedback through SRS.

Clinical cut off for SRS was determined at a score of 36 in independent analysis conducted by the Center for Clinical Informatics. Scores under clinical cut off show that client is at risk for dropping out or is experiencing no benefits from therapy, or even negative outcome (Miller & Duncan, 2004).

ORGANIZATION OF THE RESEARCH

The research was performed from November 2008 to July 2009 with Process Work Diplomates at The Process Work Institute in Portland, Oregon. The first step was introducing the idea of the research to the Process Work practitioners who hold the Diploma of Process Work and practice with clients in Portland. From that group, Process Work therapists were selected who work with clients from the general population, as opposed to Process Work students. The next step in design involved each Diplomate asking five clients to complete both scales (ORS and SRS) over five sessions: A total of ten diplomats, fifty clients, and 250 sessions. While the design aimed to have ten Process

Work Diplomates participate in the study, only eight Diplomats met the above criteria.

A system of response that guarantees participant anonymity was used in the study.

Chapter IV: FINDINGS

The plan for statistical analysis of the research included using a t-test to measure change over the time of treatment for ORS and SRS outcomes between the initial session and 5th session of the treatment. However, gathered data was not sufficient for statistical analysis nor for testing the hypothesis based on the outcomes. In spite of not being able to make statistical conclusion, we still can see some trends of change in the outcomes. All outcomes show some changes in clients' life functioning and their perception of satisfaction from the sessions. To highlight the trend in the changes, profiles of each client over the time of treatment are presented below.

Outcomes from the research include: completed scales from nine clients and three different therapists (therapist is indicated here as A, B, C):

- I. 5 ORS and 5 SRS x 1 client (over 5 sessions of treatment) A 1
- II. 4 ORS and 4 SRS x 1 client (over 4 sessions of treatment) A 2
- III. 3 ORS and 3 SRS x 1 client (over 3 sessions of treatment) A 3
- IV. 5 ORS and 2 SRS x 1 client (over 5 sessions of treatment) [initial session of treatment, ORS from 1st, 2nd, 3rd, 4th, 5th session of treatment, SRS from 1st, 3rd session] B 1
- V. 3 ORS and 5 SRS x 1 client (over 5 sessions of treatment) C 1

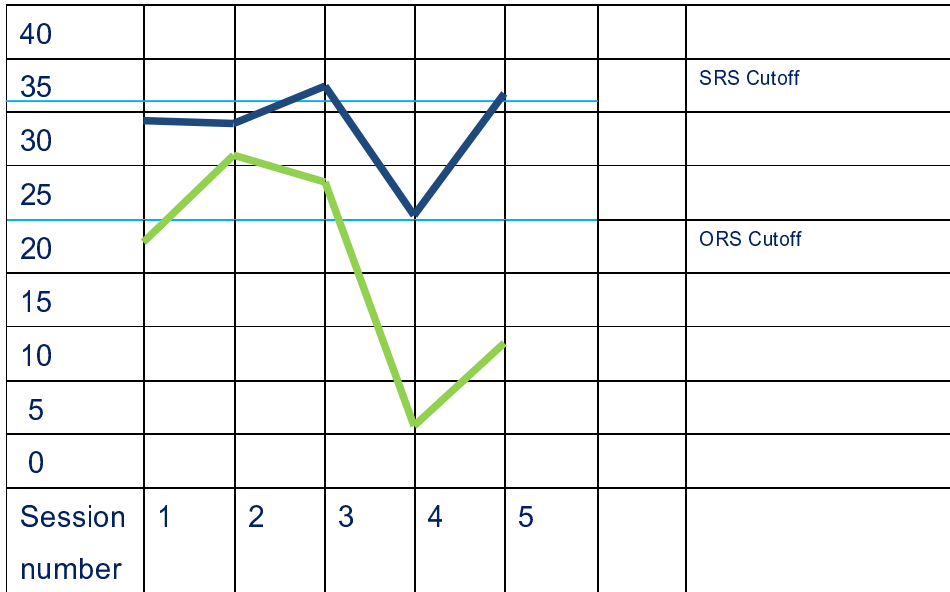
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- VI. 1 ORS and 1 SRS x 1 client (initial session of treatment) A
- VII. 1 ORS x 1 client (initial session of treatment) B
- VIII. 1 ORS x 1 client (initial session of treatment) B
- IX. 2 ORS and 1 SRS x 1 client (initial and 2nd session ORS,
second sessions SRS) B

Below reader can see charts with drawn profiles that show changes through the time of the treatment from five clients who completed both scales more than once.

PROFILE OF CLIENT 1

Chart A 1 – client 1



ORS outcome - Green line, SRS outcomes - Blue line

ORS cutoff - light blue line, at 25 score. SRS cutoff - light blue line, at 36 score.

Chart A1 shows 5 ORS and 5 SRS outcomes from 1 client over 5 sessions of treatment. Captured by chart, treatment was performed through 1.5 months with approximately one session in a week. Because the time variable is short, it is difficult to see consistent change over time. At intake ORS score is a 23.5, then goes to 30.8 at second session, 28.7 at third session, goes down at fourth session to 5.1, and finishes higher at fifth session with score 13.1. We can see that between the 1st and 3rd session there was visible positive change in rating on ORS, between 3rd and 4th session score goes down radically and then at 5th session score rises up. One of the explanations for why scores go down after 3rd

session might be that scores which are above the clinical cutoff (or very close to it) tend to deteriorate in the future (Miller & Duncan, 2004). Here we see an initial session very close to clinical cutoff. The next two sessions are above clinical cutoff so we may expect deterioration in outcomes. However, the score may drop so low due to external situations which can have a strong influence on outcomes (Hubble et al., 1999). The SRS line over three sessions mirrors ORS outcomes. Scores at intake are 34.8, second session 34.6, third session 37.3, fourth session 25, and fifth session 36.3. If initial scores from SRS are below clinical cutoff, it indicates stronger relationship with outcomes from ORS (Miller & Duncan, 2004). SRS scores below clinical cutoff indicate that client may drop out and have poor treatment outcome (Miller & Duncan, 2002). This fact refers to the importance of relationship factor in therapeutic process.

Tables 4 & 5 present SRS and ORS outcome scores for Client 1 (A1 Chart):

SRS	Session 1	Session 2	Session 3	Session 4	Session 5
Relationship	8.8	8.4	9.4	9.2	9.1
Goals and topics	8.6	8.7	9.4	4.5	9.0
Approach/ method	8.6	8.7	9.6	4.3	9.4
Overall	8.8	8.8	8.9	7	8.8
Total:	34.8	34.6	37.3	25	36.3

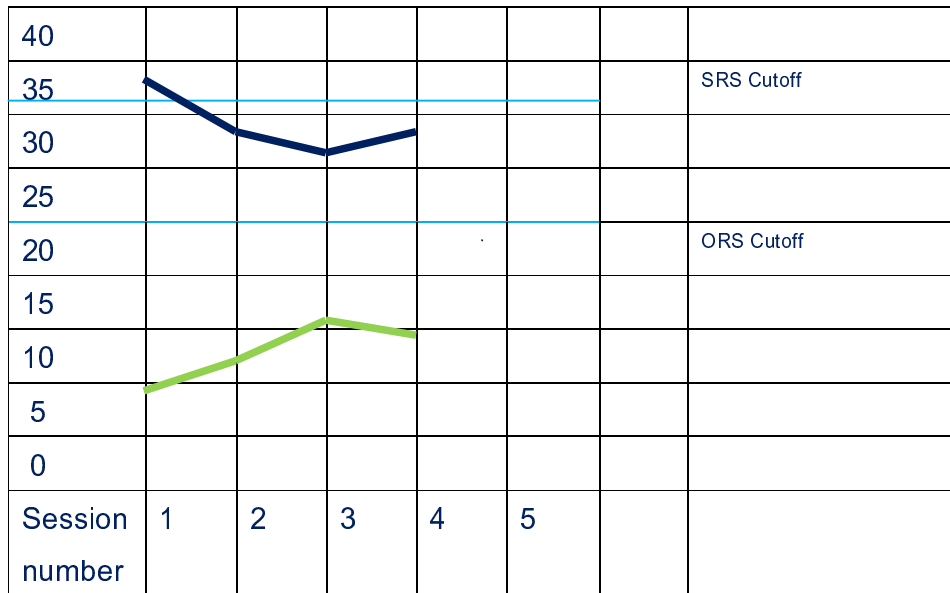
Table 4. SRS outcome for client 1.

ORS	Session1	Session 2	Session 3	Session 4	Session 5
Individually (personal well-being)	3.2	7.4	6.6	2.1	5.2
Interpersonally (family, close relationships)	6.6	7.7	7.7	0	0
Socially(work, school, friendships)	6.7	7.8	7.8	2.4	2.7
Overall (general sense of well-being)	7	7.9	6.6	0.6	5.2
Total:	23.5	30.8	28.7	5.1	13.1

Table 5. ORS outcome for client 1.

PROFILE OF CLIENT 2

Chart A 2 – client 2



ORS outcome - Green line, SRS outcomes - Blue line

ORS cutoff - light blue line, at 25 score. SRS cutoff - light blue line, at 36 score.

Chart A2 shows 4 ORS and 4 SRS outcomes from one client over four sessions of treatment. Captured treatment was performed over a 2-month period with one-month break in between 1st and 2nd session, and approximately 2-3 week break between 2nd, 3rd, 4th. ORS score at intake is 9.3, second session 12.2, third session 15.3, and fourth session 14.3. SRS score at intake is 38, second session 34.2, third session 31.5, and fourth session 34.5.

Here we can observe increase in scores on ORS between the 1st and 4th session, which is a good predictor for overall change. Also scores from ORS are significantly below clinical cutoff, which means that client will probably improve over time (Miller & Duncan, 2004). Outcomes from SRS at intake are above clinical cutoff, which is good; however, outcomes dropped below cutoff over the next sessions. This means there might

be a need to discuss feedback with client due to performed sessions. It would be interesting to see what happens during further stages of therapy.

Tables 6 & 7 present SRS and ORS outcome scores for Client 2 (A2 Chart):

SRS	Session 1	Session 2	Session 3	Session 4
Relationship	9.4	8.1	7.9	8.6
Goals and topics	9.6	8.5	7.8	8.5
Approach/method	9.5	9.0	7.9	8.7
Overall	9.5	8.6	7.9	8.7
Total:	38.0	34.2	31.5	34.5

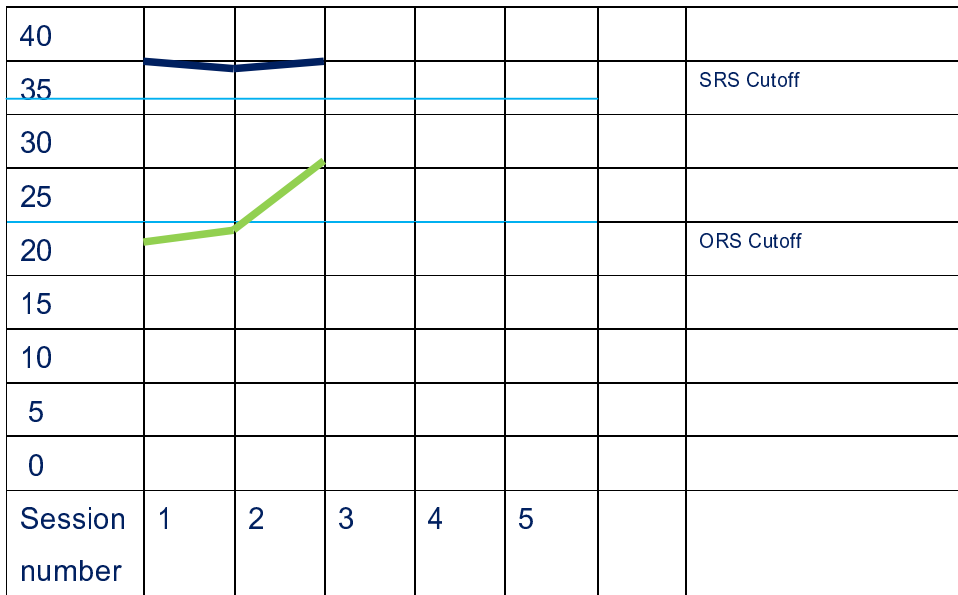
Table 6. SRS outcome for client 2.

ORS	Session1	Session 2	Session 3	Session 4
Individually (personal well-being)	2.1	3.6	3.8	4.2
Interpersonally (family, close relationships)	3.2	4.0	6.6	4.0
Socially (work, school, friendships)	1.6	1.2	1.2	1.7
Overall (general sense of well-being)	2.4	3.4	3.7	4.4
Total:	9.3	12.2	15.3	14.3

Table 7. ORS outcome for client 2.

PROFILE OF CLIENT 3

Chart A 3 – client 3



ORS outcome - Green line, SRS outcomes - Blue line

ORS cutoff - light blue line, at 25 score. SRS cutoff - light blue line, at 36 score.

Chart A3 shows 3 ORS and 3 SRS outcome from one client over three sessions of treatment. Captured treatment was performed over 2 months with approximately 3 weeks in between 1st and 2nd session, and one month and a half break between 2nd and 3rd session. ORS score at intake is 23.4, second session 24.6, third session 30.5. SRS score at intake is 40, second session 39, third session 40.

There is observable change in ORS outcomes in the first sessions, which are a good predictor for overall change (Miller & Duncan, 2004). SRS scores show good alliance between client and therapist, which also supports findings that positive therapeutic relationship is one of the main factors in reaching good outcomes (Asay & Lambert, 1999; Wampold, 2001). However, Miller and Duncan (2004) found that high scores on

the SRS are not interpretable. Appearance of positive relationship here is not correlated with outcomes.

Tables 8 & 9 present SRS and ORS outcome scores for Client 3 (A3 Chart):

SRS	Session 1	Session 2	Session 3
Relationship	10.0	9.0	10.0
Goals and topics	10.0	10.0	10.0
Approach/method	10.0	10.0	10.0
Overall	10.0	10.0	10.0
Total:	40.0	39.0	40.0

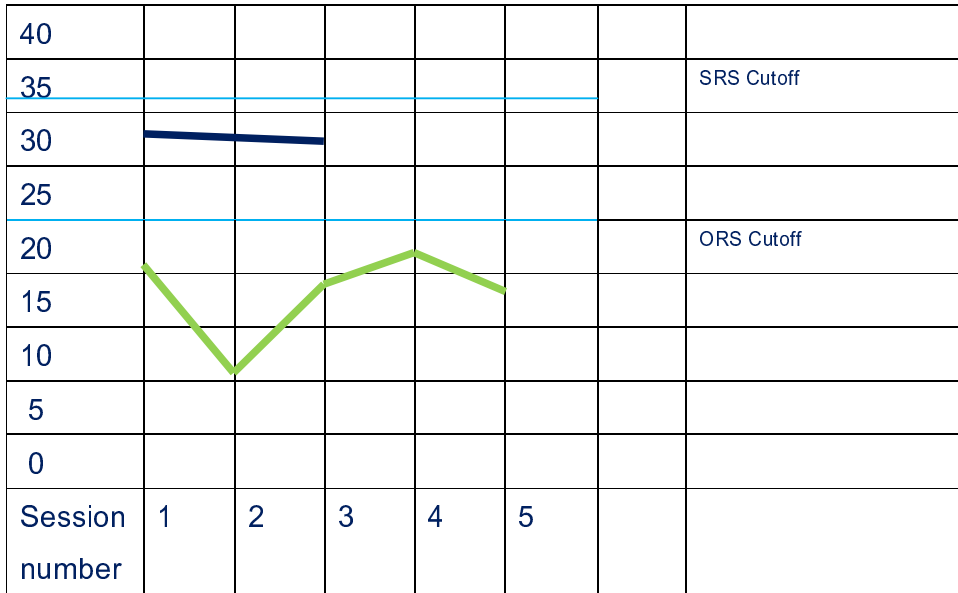
Table 8. SRS outcome for client 3.

ORS	Session1	Session 2	Session 3
Individually (personal well-being)	7.0	6.1	7.3
Interpersonally (family, close relationships)	3.7	4.9	7.6
Socially (work, school, friendships)	6.2	6.7	7.8
Overall (general sense of well-being)	6.5	6.9	7.8
Total:	23.4	24.6	30.5

Table 9. ORS outcome for client 3.

PROFILE OF CLIENT 4

Chart B 1 – client 4



ORS outcome - Green line, SRS outcomes - Blue line

ORS cutoff - light blue line, at 25 score. SRS cutoff - light blue line, at 36 score.

Chart B1 shows 5 ORS and 2 SRS outcome from one client over five sessions of treatment. Captured treatment was performed over 2 months, with approximately one session every two weeks. ORS score at intake is 20.7, second session 10.3, third session 19, fourth session 22.8, fifth session 17.2. SRS score at intake is 33.1 and third session 32.9. ORS at intake is below cutoff and remains under for five sessions. On the second session score goes down; however, next scores improve. SRS scores are below clinical cutoff and show first and third session. I think that outcomes are not interpretable. However we can say that SRS shows pretty good alliance; the scores are below clinical cutoff but still high.

Tables 10 & 11 present SRS and ORS outcome scores for Client 4 (B1 Chart):

SRS	Session 1	Session 3
Relationship	8.6	7.8
Goals and topics	9.1	9.4
Approach/method	7.7	8.0
Overall	7.7	7.7
Total:	33.1	32.9

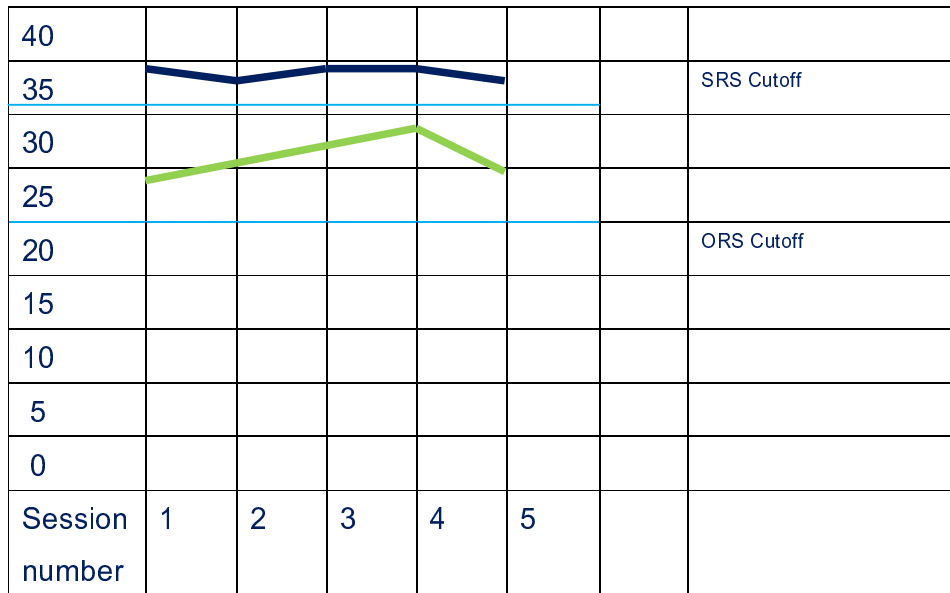
Table 10. SRS outcome for client 4.

ORS	Session1	Session 2	Session 3	Session 4	Session 5
Individually (personal well-being)	5.4	1.3	4.7	5.2	3.6
Interpersonally (family, close relationships)	1.6	1.2	4.7	3.7	3.7
Socially(work, school, friendships)	7.9	5.0	4.8	7.2	5.8
Overall (general sense of well-being)	5.8	2.8	4.8	6.7	4.1
Total:	20.7	10.3	19	22.8	17.2

Table 11. ORS outcome for client 4.

PROFILE OF CLIENT 5

Chart C 1 – client 5



ORS outcome - Green line, SRS outcomes - Blue line

ORS cutoff - light blue line, at 25 score. SRS cutoff - light blue line, at 36 score.

Chart C1 shows 3 ORS and 5 SRS outcomes from one client over five sessions of treatment. Captured treatment was performed over 5 months with approximately one month in between sessions 1-4, and two months break in between 4th and 5th session. ORS score at intake is 29.5, fourth session 34.1 and fifth session 29.9. SRS score at intake is 39.2, second session 37.1, third session 39.7, fourth session 39.2, fifth session 38.7. As we can see, ORS scores go up after first session and end up lower at fifth session. However, scores are still higher than at intake and all ORS profiles show outcomes above clinical cutoff. That means that client is doing pretty well in the outside world and is generally satisfied with life. SRS outcomes show good alliance between client and therapist.

Tables 12 & 13 present SRS and ORS outcome scores for Client 5 (C1 Chart):

SRS	Session 1	Session 2	Session 3	Session 4	Session 5
Relationship	9.7	9.7	9.9	9.7	9.4
Goals and topics	9.7	8.2	10.0	9.5	9.5
Approach/ method	9.9	9.6	9.8	10.0	10.0
Overall	9.9	9.6	10.0	10.0	9.8
Total:	39.2	37.1	39.7	39.2	38.7

Table 12. SRS outcome for client 5.

ORS	Session 1	Session 4	Session 5
Individually (personal well-being)	8.1	8.6	7.7
Interpersonally (family, close relationships)	6.9	7.8	7.3
Socially (work, school, friendships)	6.6	8.8	7.2
Overall (general sense of well-being)	7.9	8.9	7.7
Total:	29.5	34.1	29.9

Table 13. ORS outcome for client 5.

Horizontal profile from SRS

In the above section, vertical ORS and SRS outcomes are presented for each client after each session. Table 14 below shows horizontal profiles for all clients with arithmetic means from each SRS level (relationship, goals & topics, approach or method, overall). If we compare outcomes from SRS for those different levels, it will show which areas have the highest scores.

SRS	Client 1(A1)	Client 2 (A2)	Client 3 (A3)	Client 4 (B1)	Client 5 (C1)	arithmetic mean
relationship	8.98	8.50	9.66	8.2	9.68	9.004
goals and topics	8.04	8.60	10	9.25	9.38	9.054
approach or method	8.12	8.77	10	7.85	9.86	8.92
overall	8.46	8.67	10	7.7	9.86	8.93

* ratings min-max from 0-10

Table 14.

We can see that the highest scores (9.004, 9.054) are for behaviors referring to relationship skills in the therapeutic process and incorporating feedback from clients about which direction they wanted to go in the session. Here it means that the client felt heard, understood and respected, and worked with the therapist on and talked about what she/he wanted to. These factors – active ingredients of therapeutic relationship – are powerful for overall outcome in the process of treatment. Those factors are also common

factors which exist across all therapeutic modalities. These outcomes (relationship = 9.004, goals & topics = 9.054), according to the Common Factor view on what works in psychotherapy, give evidence that Process Work therapists were evaluated high in the Common Factor area of therapeutic relationship.

Chapter V: DISCUSSION

REFLECTIONS ON FINDINGS

Although the gathered data was insufficient to perform statistical analysis, we can still see trends and make some interpretations based on the outcomes. Generally, we can say that outcomes from the treatment are positive because change in successful therapy occurs earlier rather than later (Miller & Duncan, 2004), and outcomes from 4 out of 5 clients on ORS profiles show improvement in client well-being between the first and third session. However, it is important to be careful with that interpretation because this effect might refer to one of the common factors in psychotherapy: client expectancies, client variables, and placebo effects (Assay & Lambert, 1999). Additionally, people tend to improve at the beginning of therapy even while therapists have not applied specific interventions and therapeutic alliance is just starting to emerge. This phenomenon was described by Joe Goodbread (1997) as the ‘therapeutic honeymoon’. Like all relationships, therapeutic relationship goes through this phase too.

The outcomes from SRS scales for 5 clients show: an improvement in satisfaction from sessions for one client; constant scores in satisfaction for three clients; and a deterioration in satisfaction for one client (scores at intake 38.0 to 34.5 at fourth session). However, even those deteriorating scores are still high.

The horizontal table (Table 14, see Findings chapter) presents outcomes from SRS scales for each dimension (relationship, goals & topics, approach/method, overall) for all clients. Comparison by arithmetic mean shows that relationship, goals and topics dimensions had the highest scores (respectively 9.004, 9.054). That indicates that Process Work therapists are well trained on relationship skills and incorporate client

feedback into their work in order to determine what the client wants to do on the session in terms of goals and discussed issues. As we know from previous chapters (see Chapter on Common Factors in Psychotherapy), the relationship between client and therapist, skills of the therapist and the person of the therapist are some of the common factors which strongly account for outcomes in therapy. Discussing feedback with clients is also an important factor for improvement in therapy (Brown, 2009). Similar results were found in Miller and Duncan's (2004) study of ORS and SRS, in which clients who were asked to complete SRS at the end of the session at intake were three times more likely to have additional sessions and experienced more change by the end of the treatment than those whose did not have a chance to give feedback through SRS.

In this final section, I discuss the difficult elements I encountered throughout different stages of the research process. The first element relates to data collection for the study. It was not easy to find participants for the study. I originally aimed to include ten Process Work Diplomates who work individually with clients who are not process work students. Each of those ten Diplomates would ask five clients to complete both scales (ORS and SRS) over five sessions: A total of ten diplomats, fifty clients, and 250 sessions. However, only eight Diplomates met the above criteria and were willing to participate in the study at the initial stage of introducing the idea to the public. During the last stage of gathering participants, there were only three therapists who were able to participate in the study.

The second factor belongs to the process of analyzing the data. I found it difficult to compare outcomes from different clients and make interpretations out of the data due to interferable variables, such as:

- The length of the time between first and last evaluated session was different
 - Client 1 evaluated treatment and change in his/her life over 1.5 months
 - Client 2 evaluated treatment over 2 months
 - Client 3 evaluated treatment over 2 months
 - Client 4 evaluated treatment over 2 months
 - Client 5 evaluated treatment over 5 months

- The length of time between each session for each client was different. Client 1 had weekly sessions, Client 2 had approximately one month between 1st and 2nd session and 2-3 weeks between 2nd, 3rd, and 4th session, Client 3 varied between 2-3 weeks per session, Client 4 had approximately 2-3 weeks between sessions, Client 5 had one month between 1st and 4th session and two months between 4th and 5th sessions

- Very few clients participated in the research
 - Gathered outcomes came from only 9 clients
 - Only 5 clients completed both scales (ORS, SRS) more than once
 - Only 1 client filled out scales (ORS and SRS) over the 5 sessions of treatment as was proposed for the study. Furthermore, that outcome only shows change over 1.5 months, which is insufficient time to see consistent change.

Despite the challenges described above, the current study still may be regarded as successful, especially considering the long and difficult process of gathering the data. I

believe this study serves as an invitation and provides a platform for further research in the field of Process-Oriented Psychology.

IMPLICATIONS FOR FURTHER STUDIES

In this section I present some ideas for further research in studying the effects of Process Work therapy, based on my own experience as a researcher as well as information in the field of psychotherapy research about what works and what is worth studying.

Through the process of research I realized something important: conducting quantitative research (plus inquiry about effectiveness) in the Process Work paradigm, which is so much based on heuristic methodology, and experience-based techniques, is like applying the medical model to study the contextual model of psychotherapy. While perhaps not an impossible task, such as endeavor works on the area where two different paradigms meet; so we know it will not be easy. As a result of this these realizations, I would like to offer some suggestions for the future of this field of research:

1. As a first step in conducting the study, the researchers may do a group process⁴ with potential participants (Process Work Diplomates) on the following topics: what is effectiveness in psychotherapy, what is or might be the effectiveness in the process work approach, how to measure outcomes, do people want to measure the outcomes, who needs that, who does not; identify the roles that appear in the group process and facilitate discussion.

It is important to notice that roles which appear during this group process might

⁴ Group Process – in Process Work approach the main method working with groups.

be both internally and outside of the researcher throughout the study; especially if the discussion is unresolved. So it is useful to facilitate that process.

Also this discussion will help the researcher to: operationalize the research issue into more specific terms; construct better research inquiry; help to find appropriate tools to verify the hypothesis.

2. Researchers might focus on studying outcomes of psychotherapy in terms of contextual model and Common Factors Model (see Chapter II on Medical Model vs. Contextual Model of Psychotherapy, and on Common Factors in Psychotherapy). Meta-analysis shows that factors which significantly contribute to successful outcomes in therapy are derived from Contextual Model and Common Factors Model (Wampold, 2001).
3. However, if researchers chose to test relative efficacy by performing comparative research strategy, or absolute efficacy by comparison outcomes from treatment group vs. control group, or effectiveness of the approach itself by using self-report tools in practice setting, it might be useful to be focus one area based on client`s presenting problem. For example: design study which would evaluate effectiveness of therapy for clients with panic attacks, physical illness, or anxiety, etc. In that study you need to refer to DSM-IV manual and “client self-report measures of improvement in functioning, symptom severity, emotional well-being, and general quality of life” (Brown et al., 1999).

The findings on relative efficacy already give the evidence that all treatments are equally efficacious and findings on absolute efficacy already give the evidence that psychotherapy is highly effective: the average client receiving therapy is better off than 79% of untreated clients and the success rate changes

approximately from 13% for the control group to 69% for the treatment group (Wampold, 2001). So researchers will be testing if Process Work outcomes are in the range of effect sizes and percentages found for absolute efficacy and relative efficacy for other approaches and for psychotherapy in general.

4. Researchers may conduct a Consumer Report by using Self-rating measurements. The Consumer Report survey complements the efficacy method. It was discussed recently in the field of psychotherapy research that the efficacy studies are inaccurate methods for studying empirical validation of psychotherapy because they skip crucial elements of what is done in the field. Those elements are described in Consumer Report Study published by American Psychological Association (Seligman, 1995):

- Psychotherapy (like other health treatments) cannot be performed in fixed duration of time. It usually keeps going until the patient is markedly improved or until he or she quits. In contrast, the intervention in efficacy studies stops after a limited number of sessions regardless of how well or how poorly the patient is doing.

- Psychotherapy (like other health treatments) is self-correcting, meaning that if one technique is not working, another technique or another modality is usually tried. In contrast, the intervention in efficacy studies is confined to a small number of techniques, all within one modality and manualized to be delivered in a fixed order.

- Psychotherapy clients often get there by entering a kind of treatment they actively sought with a therapist they screened and chose. Clients enter efficacy studies by the passive process of random assignment to treatment and acquiescence with whom and what happens to be offered in the study

-Psychotherapy clients usually have multiple problems; psychotherapy is geared to relieving parallel and interacting difficulties. Patients in efficacy studies are selected to have usually one diagnosis.

- Psychotherapy focuses on improvement in the general functioning of the client, as well as reduction of the symptoms. Efficacy studies usually focus only on specific symptom reduction and whether the disorder ends.

5. Researchers may conduct qualitative research in the area of measuring effectiveness of Process Work. There are already many studies in Process Work about its applications; however they are not focused of the effects of therapy.
6. Despite the choice of method in the study, outcomes from the clients should come from more than five sessions of treatment.

These are some of the ideas which arose in me during the research process. I think it is just the beginning of these types of studies in Process Work field.

Chapter VI: CONCLUSION

In conclusion, this chapter provides an overview of the study, including presentation of a goal of the study, review of related research in the field of psychotherapy as well as Process Work in particular, and looks again at the importance of the issue of measuring outcomes, with recommendations for future study. I also speak about limitations of this study, as well as contributions for Process Work.

REVIEW OF THE STUDY

This project aimed to perform a pilot study measuring the effectiveness of therapy sessions conducted by Process Work practitioners, collect psychotherapy outcome research data, and evaluate the outcomes of the pilot study in order to check its feasibility and improve the design of future studies in this area.

As discussed in the Literature Review, the outcomes from different studies over the years produce evidence that psychotherapy works. Meta-analyses conducted by Lipsey and Wilson, Lambert and Bergin, and Grissom (Wampold, 2001) showed that the efficacy of psychotherapy is estimated to be 0.80 effect size. In other words, the average client receiving psychotherapy is better off than 79% of clients without treatment, and success rate changes from 13% for the control group to 69% for the treatment group. Moreover, as comparative studies show, different approaches in psychotherapy are equally effective. The implication from that discovery is that benefits of psychotherapy should be found not in the medical model but in the contextual model and common factors approaches. The medical model postulates that benefits of psychotherapy are due to specific ingredients, meaning techniques and specific therapies. The contextual model

postulates that benefits of psychotherapy are due to general effects and common factors, such as “transforming the meanings of experiences into more favorable ones” (Frank, 1991, p.30) for the client, therapeutic alliance, therapeutic setting, therapeutic myth, therapeutic ritual, therapist-as-person, therapist’s belief in efficacy of using techniques, client variables, and expectancy (Wampold, 2001).

Based on those findings, it is worthwhile to consider planning a study focused on the contextual model and common factors in psychotherapy. In the field of Process Work research, the focal point has been on different individual and group applications, yet studying the effectiveness of Process Work applications has been an untouched area. The earned learning from this study may assist in designing subsequent quantitative research to test benefits of Process Work therapy sessions.

Because findings from this study were not sufficient for a statistical analysis, I was not able to test hypothesis. The analyzed data came from five clients and three therapists. The outcomes from 4 out of 5 clients show improvement in clients’ well-being between the first and third sessions. Since change in successful therapy occurs earlier rather than later, such evidence supports the interpretation that Process Work therapy was beneficial to the clients and increased clients’ well-being (Miller & Duncan, 2004). However, there is also the well known phenomenon that people tend to improve at the very first stages of treatment; also called the ‘therapeutic honeymoon’ (Goodbread, 1997). Consequently, the outcomes from this study most likely refer to client variables and the extratherapeutic change factor. Due to that short-term effect, future studies in this area should ~~to~~ be performed over periods of time longer than five sessions.

LIMITATIONS OF THE STUDY

There are multiple limitations to this study. The first limitation exists in the methodological approach of the study. The chosen quasi-experimental design lacks a control group; a factor which includes a “pre-limitation,” in that it is not feasible for Process Work therapists in private practice to have a control group.

Another limitation is that the study was bound to process work therapists, and that, the researcher is also a Process Work therapist in training. My own subjective orientation and bias, as a student of Process Work and a client in therapy, is that Process Work is an effective theoretical and practical system for working with people.

The next limitation of the study refers to the small sample size. Having only three therapists as participants might be connected with my personal edge to introduce the study to an audience with high rank yet may also reflect the edge among Process Work therapists to participate in quantitative study. Because the Process Work paradigm is an experiential approach to working with people, the therapist who has already chosen this therapeutic modality might be more interested in the contextual model of therapy than the medical model. In this light, it may have been more preferable if the methods of testing the hypothesis had been derived from experiential strategies rather than quantitative. After all, the contextual healing aspect of Process Work therapy is imprinted into its paradigm.

Another limitation relates to challenge of testing a hypothesis based on therapeutic effectiveness within the Process Work paradigm. Arny Mindell, describing Process Work in one of the courses, said:

Process work does not primarily offer another healing method. It fills the need for an alternative way of thinking. I see process work stepping out of a dualistic way of thinking where being sick opposes being healthy, and a long life means success while a short life is associated with personal failure, or where living is in contrast to dying. A non-dualistic or unifying way of thinking is furthered by the following the actual experience and discovering the ancient Chinese concept of the Tao as the governing principle behind life (Ackermann, 1994, p. 58).

The theoretical framework of Process Work believes in the wisdom of the nature and meaningfulness of the experience itself, such that a reduction of the symptom - the aim of most psychotherapy - is not really the goal. In Process Work, an elimination of the symptom may very well be a welcomed side effect of the treatment but “the key lies in experiencing the reality of the symptom rather than in trying to eliminate them” (Ackermann, 1994, p. 55).

The last limitation refers to the chosen tool for testing the hypothesis. Self-report scales ORS and SRS were not built to test hypotheses due to effectiveness of any therapeutic modality. Primarily they were constructed to be used as a therapeutic tool in the process of therapy (client fills out the scales before, after and/or during the session, and therapist uses them as a feedback from client to incorporate it into the treatment), and to measure the therapeutic alliance between client and therapist. In my mind, a better instrument for this study would be more detailed in describing client functioning.

CONTRIBUTIONS AND FINAL COMMENTS

This study furthers the field of quantitative research in Process Work, particularly by opening the door toward evaluating the outcomes of the therapy process itself.

The data from more than 40 years of outcome research gives little empirical evidence for “the differential effectiveness of competing therapeutic approaches, the superiority of psychopharmacological over psychological intervention, or the utility of psychiatric classifications in either determining the appropriate course of predicting the outcome of treatment” (Hubble et al., 1999, p. 435). However, knowing that it is still important to study outcomes and see the effect of therapy, the field of psychotherapy aims to have practitioners use evidence-based practices so their outcomes can be viewed and compared in order to establish outcome norms (Brown et al., 1999).

Considering all the available information and APA guidelines (see Introduction), Process Work outcomes presents a worthwhile area for further research. Quantitative research on the practice of Process Work is necessary to bring together Process Oriented Psychology with other psychotherapeutic approaches, in order to address the dispute in the field concerning research outcomes and professional practice, as well as search for new paths of effective therapy for the clients.

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APPENDIX A:

Participant Information Sheet and Consent Form

Participant Information Sheet

Research Title: Measuring the Effectiveness of Therapy Sessions Conducted by Process Work Practitioners - A Pilot Study

Researcher: Kamisia Anna Staszewska

Supervisor: Caroline Spark, Pierre Morin

Institution through which research is being conducted: Process Work Institute, Portland, OR

About this research project

The purpose of the study is to investigate the effectiveness of Process Works in individual psychotherapy settings using a quantitative approach to inquiry.

If you agree to take part in this research:

For therapists - you will be asked to give 5 clients simply scales after each of 5 sessions.

For clients – you will be asked to respond to the scales after each of 5 your sessions.

If you would like to discuss any aspect of the research at any stage, please contact me by phone 503 619 7536, email: kamisia.ania@gmail.com or in person.

If you have any inquiries about the conduct of this research, please contact Process Work Institute 503 223 8188

All of the information collected in the course of this study, including Participant Information Sheet and Consent Form, Session Rating Scale and Outcome Rating Scale will be treated with the utmost confidentiality. In written reports of the research, anonymity will be protected by changing names.

If the research is published at a later date, the same care will be taken to respect confidentiality and preserve anonymity.

Your participation in the research is entirely voluntary, and you are free to not answer questions, end your participation, or withdraw from the research at any time. If you do, this will not affect how you are treated in anyway. In any event, your interest and involvement is respected and very much appreciated.

Thank you for your participation

Consent form

Research Title: *Measuring the Effectiveness of Therapy Sessions Conducted by Process Work Practitioners - A Pilot Study*

Name of researcher: Kamisia Anna Staszewska

This research project is being conducted as part of my *Final Project for the Diploma/MA in Process Work* supervised by Caroline Spark and Pierre Morin at the *Process Work Institute*.

The purpose of the study is to investigate the effectiveness of Process Work in individual psychotherapy settings using a quantitative approach to inquiry.

Participation in this research involves

For therapists – to ask 5 clients to respond to the scales after each of 5 sessions.

For clients – to respond to the scales after each of 5 your sessions.

Your participation is entirely voluntary, and you are free to not answer questions, end your participation, or withdraw from the research at any time. Your refusal to participate or withdrawal of consent will not affect how you are treated in any way.

If you would like to discuss this research further, please contact Kamisia Staszewska 503 619 7536 or Caroline Spark 503 223 8188. If you have any inquiries regarding the conduct of this research please contact the Process Work Institute 503 223 8188.

Research Title: *Measuring the Effectiveness of Therapy Sessions Conducted by Process Work Practitioners - A Pilot Study*

I,, consent to participate in the research conducted by Kamisia Anna Staszewska as it has been described to me in the information sheet.

I understand that the data collected will be used for research purposes as outlined in the information sheet, and I consent for the data to be used in that manner.

Signed Date

APPENDIX B

Outcome Rating Scale (ORS)

Name _____ Age (Yrs): _____ Sex: M / F
Session # _____ Date: _____
Who is filling out this form? Please check one: Self _____ Other _____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually

(Personal well-being)

|-----|

Interpersonally

(Family, close relationships)

|-----|

Socially

(Work, school, friendships)

|-----|

Overall

(General sense of well-being)

|-----|

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Session Rating Scale (SRS)

Name _____ Age (Yrs): _____
ID# _____ Sex: M / F
Session # _____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected.

|-----|

I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about.

|-----|

We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me.

|-----|

The therapist's approach is a good fit for me.

Overall

There was something missing in the session today.

|-----|

Overall, today's session was right for me.

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