Reprinted from **The International Journal of Action Methods**,
published by HELDREF PUBLICATIONS, 1319 18th Street, NW,
Washington, DC 20036-1802. (202)296-6267 (202)293-6130 FAX

The Effectiveness of a Multimodal Brief Group Experiential Psychotherapy Approach

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ABSTRACT. To ensure experiential psychotherapy's survival in the age of managed care, psychotherapists need to demonstrate its therapeutic effectiveness. Because of the vast number of therapeutic modalities that are experiential in nature, the authors maintain that it is essential that researchers operationalize the particular model of experiential psychotherapy that they are studying. After a review of some of the relevant outcome literature, the authors present an empirical study of the effectiveness of a multimodal brief group experiential psychotherapy approach. The authors assessed the treatment outcomes in 41 volunteer participants who completed an 8-day, residential, group-therapy treatment program based on this model. They discuss the results of the study and suggest future directions for research in that area.

Key words: effectiveness of therapy, experiential psychotherapy, multimodal brief therapy

THE CHANGING ZEITGEIST HAS MADE IT PROBABLE that psychotherapists need to demonstrate empirically the effectiveness of their methods to health-care delivery companies (Cummings, 1995). Many therapists have already experienced pressure from managed-care companies to provide evidence of positive therapeutic outcomes. Private practitioners and treatment centers are being challenged to demonstrate cost efficiency and therapeutic effectiveness. Some are also being encouraged to use only those therapeutic techniques for which effectiveness has already been empirically demonstrated. Some schools of psychotherapeutic thought, such as the cog-

nitive therapies and cognitive–behavioral therapies, have provided much empirical evidence of their effectiveness in certain areas (Hollon & Beck, 1994).

When compared with the amount of research on cognitive–behavioral therapies, research on the psychotherapeutic effectiveness of experiential therapies is relatively small (Greenberg, Elliot, & Lietaer, 1994). Unfortunately, adherents of cognitive–behavioral therapies tend to dismiss experiential therapies with the argument that "lack of data should be taken as evidence for their ineffectiveness" (Greenberg, Elliot, & Lietaer, 1994, p. 510). As healthcare companies become increasingly concerned with receiving effective and cost efficient psychotherapy services, they may elect to pay only for treatments having demonstrated effectiveness. Outcome research on experiential therapies not only helps to ensure their survival but also has the potential to provide valuable information that can be used to help modify techniques to serve clients better.

What is true with the experiential approaches as a whole is also true for psychodrama, for which few empirical studies have been reported (Kellermann, 1987; Kipper, 1978). Kellermann (1987, p. 469) asserted: "Practitioners of psychodrama traditionally rely more on clinical experience than on experimental research data when advocating the effectiveness of this method. As a consequence, psychodrama literature mostly includes descriptive rather than empirical studies." Specifically, proponents of psychodrama typically support its effectiveness through the use of reports on therapeutic strategies and case illustrations rather than reports on empirically designed research studies (Kipper, 1978). That is perhaps related to the observations by D'Amato and Dean (1988) that therapists who use psychodrama often consider personal experience to be adequate research. Through the use of case illustrations, proponents have argued for psychodrama's effectiveness when its techniques are integrated with communication models of family therapy, structural family therapy, and more general systems approaches (Flomenhaft & DiCori, 1992; Mann, 1982; Perrott, 1986).

Although little empirical data exist, some empirical studies provide evidence for the effectiveness of psychodrama with a variety of presenting problems in a range of settings (Arn, Theorell, Uvnas-Moberg, & Jonsson, 1989; Carpenter & Sandberg, 1985; Kellermann, 1987; Kipper & Giladi, 1978; Ragsdale, Cox, Finn, & Eisler, 1996; Rezaeian, Sen, & Mazumdar, 1997; Stallone, 1993). Therapeutic approaches using psychodrama have been shown to be effective in reducing the symptoms of test anxiety, in decreasing adolescents' delinquency potential, and in enhancing one's ego strength. Therapists have used psychodrama to decrease symptoms associated with irritable bowel syndrome; reduce unacceptable behaviors of prison inmates; and treat posttraumatic stress disorder, adjustment disorders, antisocial disorders, and depression.

A major limitation in the experiential therapy literature is the absence of detailed use of the approaches being studied. One challenge is that there are many types of approaches to therapy that fall within what is commonly referred to as experiential therapy. To varying degrees, they all are linked to a humanistic–existential theory of humanity and use direct experience as the major avenue to psychotherapeutic change (Mahrer, 1983). Besides psychodrama, psychotherapies belonging to the experiential family include feeling-expressive therapy, Gestalt therapy, intense feeling therapy, encounter therapy, cathartic therapy, emotional flooding therapy, psycho-imagination therapy, Mahrer's experiential psychotherapy, process-experiential therapy, process group therapy, aromatherapy, symbolic-experiential family therapy, and metaphoric therapies (Dayton, 1994; Elliot & Greenberg, 1995; Kaye, Dichter, & Keith, 1986; Mahrer, 1983, 1996; Yalom, 1995). When clinicians categorize themselves as experiential therapists, it is not certain exactly what they mean. With the plethora of forms of experiential therapy in existence and the need to demonstrate therapeutic effectiveness, it is important that researchers delineate the model of experiential therapy being examined. Similarly, because there has been no clear definition of what is required of a treatment approach for it to be considered psychodrama (Kipper, 1978), it is essential that research involving psychodrama offer an operational definition of the treatment approach being studied (D'Amato & Dean, 1988).

Researchers in the areas of experiential therapy and psychodrama argue for the usefulness and effectiveness of the therapies in a variety of settings with diverse populations on the basis of personal experience but often to the exclusion of empirical data to support their assertions. Although some empirical research exists, much of the literature focuses on therapeutic strategies and case study reports. Many of the existing studies are limited by inconsistent and poorly applied definitions of what constitutes psychodrama treatment. The studies are limited in sample size and by lack of follow-up data addressing the stability of treatment gains and the effects of individual differences on outcomes. The findings of the studies lack generalizability to real-world clinical settings. Clearly, more empirical research is needed.

The Present Study

In this article, we describe a study conducted to assess the effectiveness of a brief, multimodal experiential therapy approach. The approach is based on the theory and techniques of psychodrama and primarily uses role-playing techniques. Other key components include art therapy, music therapy, family sculpting, and Gestalt techniques, which were combined into an approach with philosophical and theoretical underpinnings in existential-humanistic psychology, developmental theory, and models of family therapy (Klontz,

1999). The approach has a strong emotional component and offers clients the opportunity to increase awareness of their feelings and sensations. An important purpose is to "enact or reenact the emotional climate of the family of origin and/or other past and present significant relationships in a person's life. In re-experiencing these events and relationships, one is able to release the emotions that may have been blocked and repressed" (Wegscheider-Cruse et al., 1990, p. 69). A major goal of the approach is the resolution of unfinished business, mainly the working through of unexpressed emotions surrounding past relationships and events so that one is better able to live fully in the present (Wegschieder-Cruse, et al.). Although this form of multimodal experiential therapy has been used for over 30 years, an extensive literature review showed that not a single empirical study has been published that addresses its effectiveness (Klontz, 1999).

The purpose of the present investigation was to provide empirical data about the therapeutic effectiveness of the multimodal approach and to address some of the deficits in the existing experiential therapy research. To help meet these goals, we included a repeated-measures design and the 6-month follow-up data. The following research hypotheses are a summary of the fundamental questions of the study:

1. Participants will experience significant reductions in their levels of psychological symptoms from pretreatment to posttreatment.
2. Participants will experience significant elevations in areas associated with psychological well-being from pretreatment to posttreatment.
3. Participants' changes in psychological symptoms and areas associated with psychological well-being are maintained at 6-month follow-up.

Method

Treatment Program

We assessed the outcomes at an 8-day, residential group-experiential therapy treatment program in the southwestern United States. The treatment component involved 30 hr of intensive group experiential therapy, primarily using psychodrama. Each psychodramatic vignette used a classic psychodrama approach, including warm-up, action, and sharing phases. Within that structure, treatment focused on addressing the etiology and maintenance of each participant's presenting complaint and diagnostic symptomology. Experiential techniques, such as art therapy, music therapy, sculpting, and Gestalt techniques, were used as warm-up exercises. Those techniques were also used to accentuate themes or deepen emotions that emerged during the action phase. For 6 hr outside the group-therapy room, metaphoric experiential teaching

tools involving horses, a climbing wall, or challenge course initiatives as additional warm-up and focusing tools were used. Participants also attended 15 hr of psychoeducational seminars in which a variety of topics based on therapeutic issues related to this approach were addressed.

Although the program is considered outpatient, the participants stayed on the treatment facilities grounds. To enhance treatment effects, they discontinued the use of mood-altering substances throughout the duration of the program. All participants complied with both requirements throughout the treatment program. The acting medical director strictly monitored the use of medication. Participants also received detailed behavioral guidelines, designed to lessen potential social influences (i.e., treatment romances, contact with outer world through phone calls, etc.), chemical influences (i.e., sugar, caffeine, nicotine, alcohol, etc.), and habitual influences (i.e., excessive exercise, television viewing, etc.) that could possibly detract from the effects of treatment. For more specific information about this treatment approach, we refer readers to the treatment manual that was developed for the program (Wegscheider-Cruse et al., 1990). Adherence to the treatment manual helped ensure continuity of care.

Participants

All participants attending four separate 8-day treatment programs provided in a retreat-type setting in southwestern United States were encouraged to consider participating in the study. A total of 116 individuals participated in the four programs. Eighty-six people agreed to participate and to provide pretreatment and posttreatment data. Of the original sample, 41 participants (26 women and 15 men) provided follow-up data, on average, 6 months following the completion of treatment (M = 183.76 days, SD = 32.45 days, range = 132 to 232 days). Given the nature and restrictions inherent in the repeated measures design, only those 41 participants were included in the data analysis. The average age of the 41 volunteers was 42.5 years (range, 18 to 67). The participants came from a total of 22 different U.S. states, and 98% were Caucasian. Twenty-nine percent identified themselves as single, 46% as married, and 25% as divorced. They had an average of 15.2 years of formal education. Twelve percent had participated in a previous program at the treatment center, and 87% had received some form of prior mental health treatment in their lifetimes (on average, 2.6 years of therapy). After reviewing scores from the Millon Clinical Multiaxial Inventory-III, data from the referral source, data from the group leaders, and a clinical interview, a licensed clinical psychologist using *DSM-IV* criteria diagnosed the participants. Fifty-nine percent presented with an-anxiety disorder, including 51% with generalized anxiety disorder, and 8% with posttraumatic stress disorder.

Twenty-two percent presented with a mood disorder, including 12% with dysthymic disorder and 10% with major depressive disorder, recurrent, severe without psychotic features. The remaining 19% presented with an adjustment disorder, including 10% with adjustment disorder with anxiety, 8% with adjustment disorder with mixed anxiety and depressed moods, and 1% with adjustment disorder with depressed mood.

Psychotherapists

The therapists in this study were selected from a pool of approximately 60 therapists trained in this multimodal experiential therapy approach. All of the therapists had demonstrated proficiency in using that approach by successfully completing a training program. On average, each therapist led a group of 10 participants. The therapists followed a careful regimen of daily administrative and therapeutic tasks for which they were monitored by three supervisory meetings a day. Six therapists (two masters-level psychologists and four masters-level counselors) participated in the outcome study and led the 12 groups in the four programs from which participants involved in this study received treatment. The average age of the therapists was 46.2 years (range, 35 to 54 years), with an average of 17.5 years of clinical experience (range, 10 to 31 years). The therapists had an average of 8.2 years experience using the multimodal experiential approach (range, 1 to 12 years) and had been consultants for the treatment facility for an average of 6.2 years (range, 1 to 10 years).

Instruments

Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 1994). As a diagnostic measure, participants were given the MCMI-III, a 175-item self-report instrument designed to reflect patterns of current psychological symptoms. The instrument is scored on 11 clinical personality patterns, 3 severe personality pathologies, 7 clinical syndromes, 3 severe syndromes, and 4 modifying indices. Millon reported internal consistency coefficients ranging from .6 to .95 and test–retest stability coefficients between .82 and .95.

Beck Depression Inventory (BDI; Beck & Steer, 1987). The overall severity of depression was assessed by the BDI, one of the most frequently used self-report measures for assessing therapeutic outcome (Lambert & Hill, 1994). It is a 21-item self-report measure designed to assess the severity of depression in adults and adolescents. Beck reported internal consistency coefficients ranging from .80 to .90 and test–retest stability from .48 to .86 for psychiatric patients and .60 to .90 for nonpsychiatric patients.

Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1994). The SCL-90-R is one of the most widely used multiple-symptom measures in psychotherapy outcome research (Lambert, Christensen, & DeJulio, 1983). It is a 90-item self-report instrument designed to reflect patterns of current psychological symptoms. The instrument is scored on nine primary symptom dimensions and three global indices of distress. Derogatis reported internal consistency coefficients ranging from .77 to .90 and test–retest stability from .68 to .90. Outpatient psychiatric norms were used because they best fit the characteristic of the treatment sample (Derogatis, 1994).

Personal Orientation Inventory (POI; Shostrom, 1974). The POI is another popular self-report personality instrument used for assessing change (Lambert, Christensen, & DeJulio, 1983). It is a 150-item self-report instrument designed to measure constructs related to self-actualization. The instrument is scored on 2 basic scales of personal orientation and 10 complementary subscales measuring elements of self-actualization. Shostrom reported test–retest stability coefficients ranging from .52 to .82. Although there has been some debate about whether the POI is a valid measure of the construct of self-actualization, there is some agreement that it measures constructs related to self-actualization, and its scales were developed to reflect concepts that form Self-Actualization theory (Burnswick & Knapp, 1991; Fogarty, 1994; Hattie, 1986; Ray, 1984, 1986; Weiss, 1991). As such, the content of the subscales of the POI makes it an ideal measure for assessing the effectiveness of experiential therapy and psychodrama because it was designed to reflect changes on dimensions important to humanistic theories of growth.

Procedures

Several weeks before their arrival at the program site, the participants received by mail a brief description of the study and a request that they consider becoming volunteer participants. When they arrived at the program site, they were again asked to consider participating. Those who volunteered to participate completed a battery of questionnaires at pretreatment and immediately following therapy. Between 4 and 6 months following treatment, the participants were mailed the follow-up test battery, which included the same measures, and were asked to return the completed test through the mail. The batteries were completed on average 6.1 months following the treatment program. Because of the brief nature of the treatment program and our desire to measure differential symptoms levels at two time points within the same week, the directions for completing the SCL-90-R were altered, as recommended by the manual, to reflect an individual's feelings in the last few days, rather than in the past 7 days (Derogatis, 1994).

Five participants returned follow-up test batteries with incomplete BDIs (they did not complete the back half of the BDI form). No pattern emerged with regard to demographic variables or any other systematic variables that distinguished that group of individuals from the other participants.

Results

We used a conservative overall strategy for data analysis in this study. All initial analyses were multivariate analyses of variance (MANOVAs), and univariate contrasts were used only as follow-up tests after multivariate results proved to be significant. When possible, analyses focused on global scales before an examination of subscales. The data analysis included 2 MANOVAs, 1 one-way analysis of variance (ANOVA), and 52 univariate contrast tests: 55 tests in all. We adopted an experiment-wide p value of .05 for the study, which required the use of a Bonferroni corrected p value of .001 (.05/55) for individual tests, rounded up to .001 for ease of data display. Effect sizes (Cohen's d) were calculated, using the pooled standard deviation (Cohen, 1988).

SCL-90-R

To determine whether global symptom complaints diminished significantly, we conducted a repeated measures MANOVA comparing mean scores on the Global Severity Index (GSI) of the SCL-90-R from pretreatment, posttreatment, and follow-up. The means and standard deviations associated with that analysis are displayed in Table 1. In that initial analysis, we found a significant effect for the time of measurement, Wilk's $\lambda = .37$, $F(2, 39) = 33.32$, $p < .001$. A follow-up univariate contrast indicated that mean scores at posttreatment and follow-up were significantly lower than pretreatment scores ($t = 8.22$, $p < .001$). The effect size (d) associated with this contrast was 1.42. A contrast also indicated that there was no significant difference between GSI scores immediately following treatment and those obtained at 6-month follow-up; in fact, mean scores on the GSI were slightly lower at follow-up ($t = -1.71$; $p > .001$).

Further exploration focused on participants' scores on the Positive Symptom Distress Scale (PSDS) and Positive Symptom Total (PST), which indicate the severity of symptoms and the total number of symptoms endorsed respectively. The means and standard deviations associated with that analysis are also displayed in Table 1. Repeated measures MANOVA indicated a significant effect for the time of measurement, Wilk's $\lambda = .29$, $F(4, 37) = 22.15$, $p < .001$. Follow-up univariate contrasts indicated that symptom severity (PSDS scores) diminished significantly between pretreatment and both posttreatment and follow-up ($t = 7.54$, $p < .001$). The effect size (d) associated with this contrast was 1.69. The total number of symptoms reported (PST) also dropped

TABLE 1
Means and Standard Deviations for the SCL-90-R Scales at Pretreatment, Posttreatment, and Follow-Up ($N = 41$)

Scale	Time		
	Pretreatment	Posttreatment	Follow-up
SCL-90-R			
Global Severity Index			
M	1.307	0.655	0.532
SD	0.620	0.426	0.453
Positive Symptom Distress Scale			
M	2.073	1.453	1.346
SD	0.477	0.307	0.413
Positive Symptom Total			
M	54.049	37.927	32.561
SD	17.073	19.533	17.049
Somatization			
M	0.992	0.758	0.430
SD	0.735	0.674	0.482
Obsessive-Compulsive			
M	1.611	0.747	0.776
SD	0.787	0.547	0.563
Interpersonal Sensitivity			
M	1.604	0.745	0.659
SD	0.893	0.608	0.617
Depression			
M	1.854	0.866	0.750
SD	0.890	0.494	0.742
Anxiety			
M	1.459	0.805	0.505
SD	0.862	0.618	0.537
Hostility			
M	0.765	0.351	0.320
SD	0.568	0.349	0.491
Phobic Anxiety			
M	0.512	0.181	0.108
SD	0.613	0.252	0.239
Paranoid Ideation			
M	1.297	0.488	0.537
SD	0.864	0.502	0.571
Psychoticism			
M	1.003	0.459	0.362
SD	0.704	0.464	0.407

TABLE 2
Means and Standard Deviations for the BDI at Pretreatment, Posttreatment, and Follow-Up (N = 36)

Scale	Time		
	Pretreatment	Posttreatment	Follow-up
BDI			
M	18.083	4.944	7.417
SD	9.886	2.746	7.625

significantly after the treatment (t = -2.03, $p < .001$). The effect size (d) associated with this contrast was 1.05. No significant differences between posttreatment and follow-up were found in either case.

To examine more closely the significant effect for time, we conducted a repeated-measures MANOVA on the nine individual symptom scales of the SCL-90-R across pretreatment, posttreatment, and 6-month follow-up. That analysis uncovered a significant effect of time for this group of variables, Wilk's $\lambda = .134$, $F(18, 23) = 8.27$, $p < .001$. Follow-up univariate contrasts were then conducted on each of the SCL-90-R symptom scales. All nine scales showed pretreatment vs. posttreatment and follow-up reductions in symptomology significant at $p < .001$. The t scores associated with these contrasts ranged from 4.14 to 8.14. The effect sizes (d) associated with these contrasts ranged from .61 for the Phobic Anxiety subscale to 2.28 on the Depression subscale. No significant differences between posttreatment and follow-up emerged for any symptom scales: differences ranged from nonsignificant continued improvement of symptoms to nonsignificant symptom increases not exceeding a t score of .30, $p > .001$.

BDI

To determine whether symptoms of depression diminished significantly, we conducted a repeated measures MANOVA comparing mean scores on the BDI from pretreatment, posttreatment, and follow-up. The means and standard deviations associated with that analysis are displayed in Table 2. This initial analysis found a significant effect for the time of measurement, (Wilk's λ = .33, $F(2, 34) = 34.48$, $p < .001$. Follow-up univariate contrasts indicated that mean scores at posttreatment and follow-up were significantly lower than pretreatment scores ($t = 7.81$, $p < .001$). The effect size (d) associated with this contrast was 1.76. Contrasts also indicated that there was no significant dif-

TABLE 3
Means and Standard Deviations for the POI Scales at Pretreatment, Posttreatment, and Follow-Up ($N = 41$)

Scale	Time		
	Pretreatment	Posttreatment	Follow-up
POI			
Time Competent			
M	12.610	17.463	16.878
SD	3.485	2.656	3.385
Inner Directed			
M	69.683	93.854	91.537
SD	15.774	8.762	12.170
Self-Actualizing Value			
M	17.390	20.829	20.659
SD	3.943	2.509	2.762
Existentiality			
M	16.854	23.878	23.024
SD	4.922	2.926	4.162
Feeling Reactivity			
M	12.293	17.463	17.341
SD	3.913	2.599	2.972
Spontaneity			
M	9.268	14.268	13.366
SD	3.413	2.377	3.056
Self-Regard			
M	8.610	13.146	12.463
SD	3.390	2.116	2.675
Self-Acceptance			
M	11.683	17.122	16.756
SD	3.357	2.676	3.961
Nature of *M*an, Constructive			
M	10.732	12.220	11.927
SD	2.037	1.458	1.849
Synergy			
M	6.098	7.146	7.195
SD	1.715	1.085	1.123
Acceptance of Aggression			
M	12.902	17.854	17.317
SD	3.455	3.143	3.150
Capacity for Intimate Contact			
M	14.732	21.829	21.317
SD	5.153	2.616	3.636

ference between BDI scores immediately following treatment and those obtained at 6-month follow-up ($t = 2.03$, $p > .001$).

POI

To determine whether changes in participants' psychological well-being from pretreatment to posttreatment and follow-up were statistically significant, we conducted a repeated measures MANOVA comparing mean scores on the 12 scales of the POI. The means and standard deviations associated with this analysis are displayed in Table 3. This analysis found a significant effect for the time of measurement, Wilks's $\lambda = .10$, $F(26, 15) = 4.96$, $p < .001$. Follow-up univariate contrasts indicated that mean scores at posttreatment and follow-up were significantly lower than pretreatment scores. The t scores associated with those contrasts ranged from –3.85 to –10.67, all p values < .001. The effect sizes (d) associated with these contrasts ranged from .82 for the Synergy scale to 1.59 on the Self-Acceptance scale. No significant differences between posttreatment and follow-up emerged for any POI scales: differences ranged from nonsignificant improvements to nonsignificant declines not exceeding t scores of –1.91, $p > .001$.

Discussion

This study provides empirical support that this multimodal brief group experiential psychotherapy approach was effective in reducing negative psychological symptoms and enhancing psychological well-being in the participants studied. The large effect sizes offer strong support for the clinical relevance of this treatment modality. The study is an important step that can be used to inform future research in this area and to support the continued use of experiential therapy in the age of mental health treatment accountability. Although the present study has important limitations, the participants who underwent the treatment reported statistically significant symptoms improvement and personality change in a positive direction immediately following treatment, with changes remaining stable 6 months following treatment. Furthermore, positive changes were seen across a variety of diagnoses and varying levels of scope and intensity of psychological symptomology.

Significant reductions in psychological symptoms were observed immediately following treatment, as measured by the SCL-90-R and BDI. Participants reported significantly fewer psychological symptoms with significantly less intensity of perceived distress. Specifically, reductions in psychological symptoms occurred in the following areas: (a) less distress arising from perceptions of bodily dysfunction; (b) fewer thoughts, impulses, and actions that were experienced as irresistible and unremitting; (c) fewer feelings of inade-

quacy and inferiority; (d) fewer symptoms of depression; (e) fewer symptoms of anxiety including nervousness, tension, trembling, panic attacks, and feelings of apprehension and dread; (f) fewer thoughts, feelings, or actions characteristic of anger; (g) fewer irrational fear responses; (h) less paranoid behavior; and (i) fewer psychotic symptoms. The changes were stable at the 6-month follow-up.

The areas of psychological well-being that were enhanced included changes in several aspects of personality functioning as measured by the POI. Following treatment, participants were (a) more oriented to the present, (b) more independent and self-supportive, (c) more likely to hold and live by the values of self-actualizing people according to Maslow's conceptualization, (d) more flexible in their application of values, (e) more sensitive to their own needs and feelings, (f) more likely to express feelings behaviorally, (g) more able to like themselves, (h) more accepting of themselves in spite of weaknesses, (i) more able to see people as essentially good and synergic in their understanding of human nature, (j) more able to relate all objects of life meaningfully, (k) more able to accept feelings of anger and aggression, and (l) more able to develop meaningful, warm interpersonal relationships with others. Those changes were stable at the 6-month follow-up.

The present study makes a strong argument for the effectiveness of this multimodal experiential approach in a brief group format. Group therapy can be provided in a more cost-effective manner than treatment in individual formats, and the brief nature of the treatment provided in this study is also cost-effective. Such findings have clear implications for today's clinical practice with its emphasis on efficiency, cost-effectiveness, and treatment effectiveness. Evidence suggesting that brief, intensive, group-experiential psychotherapy can promote significant and lasting change is important for clinicians, clients, and third-party payers.

Because of the absence of many of the controlled conditions that are essential to efficacy studies and because of the study's focus on therapy as it is actually practiced in the field, this research falls into the category of a study measuring the effectiveness of the treatment approach. Seligman (1996) argued that "the effectiveness method investigates the outcome of therapy as it is actually delivered in the field" and that unlike efficacy studies, such studies have "no problem with inferential distance because it tests exactly what it wants to generalize to" (p. 1072). He asserted that effectiveness studies should investigate outcomes in therapy as it is actually practiced in the field, that is, without random assignment to treatment conditions and with patients who typically present with multiple problems. Seligman concluded that well-done effectiveness studies better answer many questions of interest to researchers, including whether a certain treatment "as it is actually delivered in the field, works for those who choose it" (p. 1077).

As is often the case with effectiveness studies, it was not possible to use random selection or assignment because all participants who volunteered for the study sought that particular type of treatment. The process of self-selection occurred in much the same way that clinical practice takes place, with clients actively choosing particular therapists and particular therapeutic approaches. The findings of a study of that nature, taking place in the setting in which the treatment naturally occurs, have clear implications for clinical practice, and it is likely that the results can be generalized to other individuals who wish to undergo similar treatment in similar settings. However, because of lack of a control group and the use of a nonrandom sample, it is impossible to be certain whether the results were due to the treatment or such other factors as history or maturation.

Another limitation is that the four therapy groups were combined into one analysis to keep the sample size and statistical power as high as possible. As such, differences in the various therapy groups that may have resulted from therapist and idiosyncratic group process factors were not controlled.

The present study was also limited in that it relied on data obtained from participant self-report. As such, there is no proof that identifiable behavioral changes occurred following treatment. The changes were observed only at the level of verbalization. The self-report data may have been influenced by demand characteristics. Participants may have wanted to appear improved, although they may not have improved following the treatment. Therefore, the validity of self-report data is always subject to question. The study also lacked data about the differences, if any, between those participants who volunteered to be part of the study and those who did not volunteer. Because we adhered strictly to informed consent guidelines, we collected no data on those individuals.

Another limitation of the study involves the participants' drop-out rate between the posttreatment and 6-month follow-up time periods. It is uncertain whether there were any differences between the degrees of stability of changes in the group that responded to the follow-up, compared to those who did not respond. Although the nonreturn rate was acceptable, given the nature of the data collection procedures (the loss of 45 participants out of original 86), more data points would have been ideal.

The use of a control group was not feasible because of practical constraints. Future research in this area would benefit from the inclusion of a control or comparison group. Future research might also benefit from a design that would take into account any differences that might be occurring as a result of specific-therapist and group-process factors. Such a design might offer useful information about such variables as therapist factors that may have differentially influenced change.

From the results of the present study, we can empirically demonstrate that participants reported statistically significant reductions in psychological

symptomology and enhancements in personality functioning after an 8-day treatment program that took place in a natural clinical setting. Unlike many of the studies in the available literature, in this study, we operationalized the experiential treatment procedures s and demonstrated that the effects on participants were stable at a period 6 months following treatment. Despite noting the clear limitations of the study, we believe that it was an important first step in validating the usefulness of this brief form of multimodal experiential group psychotherapy approach. In today's world, psychotherapists must show that they can obtain results in a timely and cost-effective manner. Anecdotal evidence addressing experiential therapy's effectiveness is no longer sufficient. To ensure the proliferation and continued use of experiential therapy, its proponents need to meet the challenge of the future. They must operationalize their approaches to therapy and add to the literature that empirically demonstrates experiential therapy's effectiveness.

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