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The Client Is the Most Important Common Factor: Clients' Self-Healing Capacities and Psychotherapy

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I first briefly review the "dodo bird verdict" and suggest that we should be responding to it by looking for a new way to conceptualize how therapy works. Then I describe the dominant "medical" or "treatment" model of psychotherapy and how it puts the client in the position of a "dependent variable" who is operated on by supposedly potent therapeutic techniques. Next I argue that the data do not fit with this model. An alternative model is that the client is the most important common factor and that it is clients' self-healing capacities which make therapy work. I then argue that therapy has two phases—the involvement phase and the learning phase—and that the involvement phase is the most important. I next review the five learning opportunities provided by therapy. Finally, I argue that a relational model of therapy focused on consultation, collaboration, and dialogue is better than a treatment model.

KEY WORDS: self-healing; medical model; common factors; therapy as learning.

INTRODUCTION: THE DODO BIRD

One of the most controversial conclusions possibly ever in the history of psychology is the "dodo bird verdict" that all therapies work about equally well. The results of general meta-analyses (Smith, Glass, & Miller, 1980; Wampold *et al.,* 1997), meta-analyses focusing on particular therapies or disorders (e.g., Elliott, in press; Robinson, Berman, & Neimeyer, 1990), specific comparison studies (e.g., Elkin, 1994; Project MATCH Research

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Group, 1997; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975), consumer surveys (Seligman, 1995), and studies of managed care (Brown, Dreis, & Nace, 1999) have all supported this conclusion. There is little evidence that specific techniques or procedures have specific effects in most cases. Asay and Lambert (1999) observed that "For those convinced of the singular abilities of their models and related interventions, the results have been disappointing" (p. 39) and "Typically, there is little or no difference between therapies and techniques" (p. 40).

Yet the enthusiasm for specific interventions persists. Recently, Suinn (1999) expressed the hope that in the future "For each patient session, psychologists [will write] a detailed treatment plan with targeted goals and a concrete intervention plan," implying that the primary healing force in therapy rests on targeting specific interventions to produce specific effects. Fishman (1999), citing Beutler (1986), notes that despite the fact that research shows that specific techniques and approaches do not contribute that significantly to outcome, over 80% of research is devoted to specific techniques and procedures. Why is this? As Asay and Lambert (1999) observe, "Curiously, the findings of no difference between treatments go largely unheeded. The debate continues over whether one technique is significantly different from and more effective than another" (p. 40). They conclude that "The enthusiasm for researching the effects of specific schools or interventions exists because of clinicians' allegiance to school-based approaches" (p. 39). Similarly, Bergin and Garfield (1994) wrote:

> With some exceptions . . . there is massive evidence that psychotherapeutic techniques do not have specific effects; yet there is tremendous resistance to accepting this finding as a legitimate one. Numerous interpretations of the data have been given in order to preserve the idea that technical factors have substantial, unique, and specific effects. The reasons for this are not difficult to surmise. Such pronouncements essentially appear to be rationalizations that attempt to preserve the role of special theories, the status of leaders of such approaches, the technical training programs for therapists, the professional legitimacy of psychotherapy, and the rewards that come to those having supposedly curative powers (p. 822).

This allegience to techniques is ironic given that so many psychotherapy researchers identify themselves as scientists with the claim that what we do should be "data-driven." Fishman (1999) has noted: "These figures [that most research still focuses on specific techniques] suggest the paradoxical power of paradigms over data in scientific research psychology, even though the positivist paradigm is purportedly 'data driven!'" (p. 233).

Many rationales for why the dodo bird verdict cannot—must not—be true have been offered. I will not review the controversy here (see Bohart & Tallman, 1999). However, my perspective is similar to those of Asay and Lambert (1999), Bergin and Garfield (1994), and Fishman (1999): There is so much data for this conclusion that if it were not so threatening to

special theories it would long ago have been accepted as one of psychology's major findings. Then it would have been built upon and explored instead of continually being debated. The data call for a change in how we view therapy, but the field continues to stick to the old technique-focused paradigm.

In this regard Ogles, Anderson, and Lunnen (1999) wrote, "Models are essential to the advancement of psychotherapy research and practice. Importantly, however, *these models need not necessarily include techniques*. . . . Rather, such a model might emphasize the development of a warm and compassionate client–therapist relationship" (p. 218, italics in the original). A model could be evidence-based, and yet not rely on the paradigm of "what works for what," which is currently the thrust of technique-focused models (e.g., Task Force, 1995). One example of such a model is that of Duncan and his colleagues (Duncan, Hubble, & Miller, 1997; Hubble, Duncan, & Miller, 1999; S. D. Miller, Duncan, & Hubble, 1997). In this paper I will try to suggest a general metatheoretical perspective for such alternative models.

THE CLIENT AS COMMON FACTOR

This paper is based on the common factors approach to psychotherapy integration and argues that the most important common factor is the client. The client as a common factor has previously received little attention. In most models of therapy the hero is the therapist. Clients are often portrayed as so pathological and dysfunctional (Duncan & Miller, 2000; Wile, 1981) that if it were not for the heroic efforts of the therapist the client would never leave his or her defensive, self-deluded, dysfunctionally thinking, and malconditioned state. A perusal of books on therapy turns up virtually no references to clients as productive thinkers. Instead, the only thinking clients do, according to such books, is dysfunctional thinking. Grencavage and Norcross (1990) reviewed different models of common factors. They found that the vast majority of common factors identified had to do with the therapist and therapy process. The only client factors mentioned were the client's positive hope and expectancies for treatment, the client's being distressed or in a state of incongruence, and the client's actively seeking help. Therefore, writers on therapy only see clients contributing by (a) hoping therapy will help, (b) being distressed, and (c) coming to seek help.

Yet, paradoxically, most therapists acknowledge that the client is the single most important variable (e.g., Norcross, 1986). An old joke asks how many psychologists it takes to screw in a light bulb. The answer is: one, but the light bulb must be willing. This joke captures the paradoxical nature

of our view of the client: the client must be willing to change, but it is the therapist who does the screwing (of the light bulb, that is). In this paper I offer an alternative view: It is the client who does the screwing. Clients are the active self-healing agents in therapy, aided and abetted by the therapist, who supplies the chair. Techniques are tools or prostheses clients use in their self-healing efforts, and therapy is ultimately the provision of support and structure for naturally occurring client self-healing processes. Since many different therapeutic structures can be helpful, it is not surprising that few differences are found among them.

OF METAPHORS AND MODELS: THE MEDICAL METAPHOR

Thought and theorizing ultimately rely on the use of metaphors (Lakoff, 1987), and scientific thinking in particular is based on metaphors (Leary, 1990). The dominent metaphor underlying thinking and research on psychotherapy has been the medical, or treatment metaphor (Orlinsky, 1989). Psychotherapy is a *treatment* for a pathological *condition* or *disorder,* in a manner analogous to medicine. Treatments, or therapeutic techniques and procedures, are metaphorically like drugs (Stiles & Shapiro, 1989). The expert therapist, analogous to a physician, diagnoses the cause of the client's dysfunctional behavior and then applies appropriate treatment. Treatment consists of procedures or input designed to alter these dysfunctional conditions. The power of treatment will be maximized by carefully tailoring selected treatment procedures to different disorders.

Analogous to medical thinking, ''real'' treatment lies in ''potent interventions'' instead of putative ''nonspecific factors'' such as the relationship or hope. If it were to be the case that relationship or hope turned out to be more powerful than treatment, then this might even invalidate psychotherapy as a powerful science.[2] The psychiatrist S. Alan Savitz has expressed the medical model distrust of relationship and other nonspecific factors: ''Before the advent of antibiotics, doctors could do very little to actually heal people. They just sat by patients' beds, holding their hand and trying to make them feel a little better. Now, they can really do something for people, patients don't just feel better because of the human touch, they *are* better'' (quoted in Wylie, 1994, p. 32). Savitz goes on to argue that psychotherapy, too, must come up with specific interventions if it is to be anything more than mere hand-holding.

The treatment metaphor dovetails with and is reinforced by the dominent research metaphor—that of the randomized controlled clinical trial. In this model the ''independent variable'' (the treatment) is applied to the

[2]An article I recently reviewed for a professional journal asserted just this.

''dependent variable'' (the client) and effects are measured. If the effects of the independent variable are stronger than comparison variable (placebos, controls, other treatments), then it can be said that the independent variable uniquely ''caused'' the treatment outcome. This model implies a mechanistic, linear causal relationship such that ''treatment'' operates on the condition in the patient to cause outcome. It can be modeled thus:

Treatment → operates on patient → to produce effects

If therapy is analogous to medical treatment, then the following implications should be true. First, the power of healing should primarily come from the treatment or intervention. Relationship at best should be an ''anesthetic'' designed to prepare the client to accept and comply with treatment (to use Goldfried's, 1997, colorful description of the cognitive-behavioral stance). Second, it should be the case that there will be differentially powerful treatments for different disorders. Third, the expertise/experience of the therapist should be crucial, as it is in medicine. Fourth, the expertise of the therapist in applying treatments should be crucial, making therapist-provided treatment far more effective than self-help procedures.

Research Findings Contradicting the Medical Model

However, research findings contradict this model. First, the dodo bird verdict contradicts the idea that different treatments are differentially powerful, or that different treatments are needed for different disorders, in most cases. Second, the majority of outcome variance does not appear to be due to treatments. To use Lambert's (1992) estimate: about 40% of the variance in outcome is due to the client and to factors in the client's life; 30% is due to common factors, particularly the relationship; 15% is due to placebo effects; and 15% is due to treatment effects. Others have also concluded that treatment effects are not that important in therapy outcome (Asay & Lambert, 1999; Ogles, Anderson, & Lunnen, 1999; Snyder, Michael, & Cheavens, 1999). Instead, the therapeutic relationship generally seems to be the best predictor of outcome (Bachelor & Horvath, 1999) and hope and placebo may be even more important than once thought (R. P. Greenberg; 1999, Scovern, 1999), particularly when the concept of active placebo is included.

Third, reviews have concluded that therapist expertise and training are either not important (Christensen & Jacobson, 1994) or make only a modest difference in outcome (Stein & Lambert, 1995). As Christensen (1992) has noted, the differences between trained and untrained brain

surgeons or even electricians are large and striking compared to differences between trained and untrained therapists.

Fourth, a number of studies have found that clients using self-help books do as well as clients who see therapists for a variety of disorders (Gould & Clum, 1993; Scogin, Bynum, Stephens, & Calhoon, 1990. Arkowitz (1997) notes that the research on self-help finds a variant of the dodo bird verdict: There is little evidence that different self-help books are differentially effective, or that different ways of providing self-help procedures make any difference in outcome. Computer-provided therapy also has been found to be as effective as professionally provided therapy (Jacobs, 1995; Selmi, Klein, Greist, Sorrell, & Erdman, 1990). In one study conducted by Marion Jacobs and Andrew Christensen of UCLA at a major Southern California HMO, clients who came in for psychotherapy were either randomly assigned to see a therapist or to work with a computer program. For those in the computer condition, the only contact they had with a professional was a brief weekly contact to monitor the need for crisis intervention. Other than that, the client worked with a computer program designed by Gould (1989). This program was not even a typical highly structured cognitive-behavioral one. Instead, it prompted clients to think about their goals, examine obstacles to achieving the goals, and to rehearse ways of achieving their goals. Yet these clients did as well as clients who saw professional therapists (Jacobs, 1995).

In sum, the evidence that it is therapists and their powerful interventions which make therapy work is sparse. A much more plausible explanation is that the healing force in therapy primarily comes from the ''dependent variable'' side of the equation—the client.

THE CLIENT AS ACTIVE SELF-HEALER

We have contended (Bohart & Tallman, 1996, 1999; Tallman & Bohart, 1999) that much of the mystery in the research findings melts away if one considers therapy from a different vantage point. In contrast to the idea that healing power primarily comes from therapists and their interventions, it is clients who are the healers. Clients are intelligent, thinking beings who are not merely operated on by supposedly ''potent'' interventions and treatments which change them. Rather, clients are active agents who operate on therapist input and modify it and use it to achieve their own ends. There is no simple linear mechanistic relationship between a ''treatment'' and ''output.'' Therapist inputs join with complex active intelligent systems. The mystery of the dodo bird verdict can be solved if one considers the possibility that clients are capable of using many different therapy ap-

proaches to resolve their problems. If we think of different approaches as different "tools" or "prostheses," clients may use many different tools from different therapy approaches. However, they need *some* assistance: They have come to therapy because they have not solved problems with the resources available in their life spaces.

Clients' capacities to use the different possibilities for problem resolution provided by different approaches in most cases overwhelm whatever supposed unique advantages different approaches and procedures are supposed to have. From this point of view, therapy is modeled as follows:

Client → operates on treatments and procedures → to produce effects.

This simple and obvious alternative vision of therapy has been obscured because (a) the medical model places the emphasis on the therapist's role, and (b) most of our models of pathology portray clients as slow, dull-witted "dinosaurs" (Duncan & Miller, this issue) or receptacles of pathology (Wile, 1981).

Evidence Compatible with the Idea of the Client As Active Self-Healer

There is evidence compatible with our thesis from a variety of sources.

Explaining the Dodo Bird and Related Findings

Our perspective can be used to explain the previously reviewed research findings. First, if healing power primarily comes from the client, then the dodo bird verdict is no surprise: different therapies each provide some useful structure or tools for solving personal problems. Second, the therapist's technical expertise will matter comparatively less, which may be one reason why there is only weak evidence that the therapist's professional training and experience make any difference. Third, it is also no surprise that clients can self-heal with a wide variety of modalities, including self-help books and computer programs, particularly a computer program that stimulates them to think, but provides no specific guidelines for what to change or how to change it (Jacobs, 1995).

Human Resilience and Self-Healing Outside of Therapy

If clients are capable of self-healing, then there ought to be evidence that humans can self-heal outside of therapy. Masten, Best, and Garmazy

(1990) have concluded that "studies of psychosocial resilience support the view that human psychological development is highly buffered and self-righting" (p. 438). There is evidence that many alcoholics recover without treatment (W. R. Miller & Rollnick, 1991), and many individuals who engage in antisocial behavior outgrow it with time (Pulkinnen, in press). Tedeschi, Park, & Calhoun (1998) conclude that 40–60% of people who experience traumas either recover on their own or even grow from the trauma. A Gallup poll (Gurin, 1990) found that 90% of a random sample of 1000 individuals reported that they had overcome a significant health, emotional, addiction, or lifestyle problem in the last year.

The studies of Prochaska and his colleagues (Prochaska, Norcross, & Di Clemente, 1994) have found that many individuals are able to overcome problems such as smoking on their own. They also find that *clients use the same healing processes that therapists use.* This suggests, compatible with our thesis, that the kinds of assistance therapists provide consist of naturally occurring human self-healing processes, perhaps in a more refined and systematic form. Efran and Blumberg (1994) also noted this, observing, for instance, that the popular behavioral procedure of exposure is part of common folk wisdom.

Finally, studies on journaling by Pennebaker and his colleagues (Pennebaker, 1990) have shown that individuals can self-heal through the use of activities that involve no professional input at all. Journaling can help individuals overcome trauma (see also Segal & Murray, 1994). A related procedure, talking into a tape recorder, can also be beneficial (Segal & Murray, 1994; Schwitzgebel, 1961).

In sum, there is considerable evidence of a human capacity for self-healing. If so many individuals are capable of using naturally occurring self-healing processes on their own, it is no surprise that they are able to enter therapy and use widely different therapy approaches and procedures to self-heal, particularly since these approaches are themselves based on these same self-healing processes.

Studies Supporting Clients' Activity

Phillips (1984) found that clients in a variety of therapy approaches reported that the most healing thing therapy offered was a time and place for them to devote to working on their problems. Rennie (2000) in a series of qualitative studies has shown that clients are highly active, not merely receiving corrective therapist input, but covertly thinking about it, agreeing or disagreeing, drawing their own inferences, and subtly arranging and manipulating the session to get what they want. Elliott (1984) found that

clients are active in selecting out what they want from therapists' interpretative statements and discarding what they do not want. Gold (1994) found that some clients are capable of generating their own ways of integrating different approaches to therapy together.

Client Involvement

Orlinsky, Grawe, and Parks (1994) state that "patients who are cooperative and open . . . are more willing to participate, can more readily absorb the experiences generated by effective therapeutic operations, [and are] thus . . . more likely to benefit from therapy" (p. 363). They also note that "The quality of the patient's participation in therapy stands out as the most important determinant of outcome" (p. 361). It was also found in the *Consumer Reports* study (Seligman, 1995) that clients who reported being actively involved benefitted most. Bergin and Garfield (1994), in their summary overview to their last volume on psychotherapy research, conclude as follows:

> Another important observation regarding the client variable is that it is the client more than the therapist who implements the change process. If the client does not absorb, utilize, and follow through on the facilitative efforts of the therapist, then nothing happens. Rather than argue over whether or not 'therapy works,' we could address ourselves to the question of whether or not 'the client works'! In this regard, there needs to be a reform in our thinking about the efficacy of psychotherapy. Clients are not inert objects upon whom techniques are administered. They are not dependent variables upon whom independent variables operate . . . It is important to rethink the terminology that assumes that 'effects' are like Aristotelian impetus causality. As therapists have depended more upon the client's resources, more change seems to occur (pp. 825–826).

Studies of psychiatric institutions find similar results (Dazoid, Gerin, Seulin, Duclos, & Amar, 1997; Gerin, Dazoid, Guisti, Sali, & Marie-Cardine, 1992). Looking at clients with diagnoses of neurotic disorders, personality disorders, and schizophrenia, it was found that therapeutic approach was not predictive of outcome, but strength of client commitment to the framework of the therapeutic mileu was.

Placebo

A strong source of evidence for client self-healing powers comes from research on placebos in both therapy and medicine (R. P. Greenberg, 1999; Scovern, 1999). Placebo healing comes from clients experiencing hope and expectations that they will improve. There is reason to believe that anywhere from 70% to 100% of the healing power of antidepressants is a

placebo effect (Kirsch and Lynn, 1999). Roberts, Kewman, Mercier, and Hovell (1993) found a 70% placebo rate for medical treatments when both physician and patient were optimistic.

I particularly want to mention the concept of the *active placebo* and make the radical suggestion that much of the healing power of all the techniques therapists use may come from their active placebo properties. An active placebo in medicine is a chemical which is not inert like a sugar pill, but rather has discernible effects on the body. These discernible effects are not actually healing, but promote a sense of hope and expectation. There is some evidence that the more clients experience side effects from antidepressant medication, the more likely they are to report that it helps (R. P. Greenberg, 1999; Kirsch & Lynn, 1999). Applying this to therapy, the more a therapy procedure has a specific plausible rationale tying specific procedures to the client's problem, the more this rationale fits clients' implicit models of how problems are solved in this culture, and the more the procedure includes active engagement in a task which challenges them, the more likely they may be to mobilize client hope and optimism. This may especially apply to procedures such as those used in cognitive-behavioral and experiential therapies.

Following upon Frank's (1974) work, I speculate that one way placebos may operate is that by mobilizing hope and optimism, one is more likely to reengage in life, be more patient in accepting temporary setbacks (believing that one is on the path to cure), begin again actively to search life for positive outcomes, begin to look again for possibility rather than focus on negativity and what cannot change, take risks, not be devastated if something goes wrong, try out new ideas based on what they have concluded therapy is teaching them, and so on.

The Relationship

The finding that the relationship is the single most important thing therapists provide is also compatible with our view. Various "therapist-as-hero" explanations have been offered for the importance of the relationship, typically revolving around the idea that the therapist provides a corrective experience. This may be true. However, we believe a key component is that a good relationship encourages client involvement. Clients who feel related to in a warm and empathic manner will be more likely to experience therapy as a safe space in which to take risks and learn. Feeling accurately perceived, they will also be more likely to invest themselves in the process. The fact that the early relationship in therapy has been found to be the best predictor of outcome (Bachelor & Horvath, 1999) is compatible with

the idea that it is the engagement qualities of the relationship which are most important. Evidence that the therapist's personal qualities matter more than training or experience (Bachelor & Horvath, 1999; Brown *et al.,* 1999; Luborsky, McClellan, Woody, O'Brien, & Auerbach, 1985) also is compatible. These all suggest that the therapist's capacity to engage clients and offer them hope is more important than professional expertise. This may even be true for psychiatric prescription. For instance, with physicians prescribing chlorpromazine, Feldman (1956) found that enthusiastic physicians had a 77% success rate, while unenthusiastic physicians had a 10% success rate.

Conclusion

There is considerable evidence consistent with the idea that therapy is a process primarily in which human beings, with active self-healing capacities, use the therapy relationship to solve their problems. Clients who are involved are more likely to benefit. A key component of why the therapy relationship is important has to do with its capacity for fostering client involvement. The placebo effect also demonstrates the power of client self-healing.

IMPLICATIONS FOR THERAPY PRACTICE

The idea that the client as active self-healer is the primary agent responsible for success in therapy leads to a revisioning of the therapy process. No longer are specific treatments for specific disorders seen as crucial in most cases. Instead of the therapist mechanistically choosing a treatment from a list and applying it to the client based on the client's diagnosis, a more collaborative model is indicated. Far more important is that the therapist be able to engage the client in the therapy process, help him or her mobilize active efforts to cope, encourage him or her to try to master problems, encourage a possibility-focus, and so on. The therapist should be able to encourage a good learning attitude. If the client is not already motivated, then the relationship will become crucial. Otherwise what is crucial is that whatever learning activities therapist and client engage in they sustain client motivation, provide a sense of hope, and provide some kind of structure that allows the client productively to think about, explore, experiment with, and master his or her problems.

Therapy therefore consists of an *involvement phase* and a *learning phase.* These phases may occur sequentially or simultaneously, and they

may feed into one another. From the standpoint of the client, the therapeutic experience provides *a set of learning opportunities*[3] which the client utilizes to understand, restructure, and resolve problems.

The Involvement Phase of Therapy

Involvement comes first—if clients are not involved, they will not learn. If they are involved, then many different methods may help. This parallels learning in school, where Murphy (1999) has noted that ''the success of teaching rests largely on the student's involvement in the learning process.'' D. Stipek (as cited in Ratner, 1990) also found that the most important factor in student learning in elementary school is the teacher's capacity to positively motivate students. In regards to the involvement phase in therapy, Saul Raw (as quoted by Fensterheim, 1999) notes that ''Therapy is not so much in the techniques as it is in getting clients to use the techniques.'' Involvement and learning interact in that therapists who provide plausible rationales for what they are doing, or who match their learning strategies to the client's theory of change (Duncan *et al.,* 1997) will have a better chance of involving the client.

Involvement consists of (a) a *willingness* to become involved and (b) an *ability* to be productively involved. Willingness does not equate to motivation. Research on client motivation has generally found that it does correlate with outcome, but results are inconsistent (Bohart & Tallman, 1999; Garfield, 1994). Part of the problem is the construct of motivation. One can be motivated to change without being motivated to engage in the tasks of therapy. Sheldon and Elliot (1999) noted that ''not all personal goals are personal.'' They break motives down into four groups: externally driven motives (in therapy because of a court order), introjected motives (shoulds and guilt), identified motives (motives arising from one's personal and identified goals), and intrinsic motives (motives arising from what one intrinsically wants). Sheldon and Elliot demonstrate that external and introjected motives do not sustain effort very well, while identified and intrinsic motives do. A plausible hypothesis from this is that clients who enter therapy because of identified goals or intrinsic goals will benefit more than clients who enter therapy driven by external factors or by shoulds. In the case of the latter, one of the first goals of the therapist would be to help the client access intrinsic or identified motives for changing.

A willingness to be involved in the tasks of therapy also depends on the client's stage of change (Prochaska *et al.,* 1994). A stage of change is

[3]I take learning here in the broadest possible sense to include creative discovery and solution-finding, as well as corrective learning and learning of skills.

a combination of how clients perceive problems, with a readiness to take action. Clients' willingness to engage in different kinds of learning activities will be different depending upon the stage of change they are in.

Willingness to be involved is also associated with how hopeful/optimistic or hopeless the client feels. Clients who enter therapy feeling demoralized and hopeless may not involve themselves for several reasons. First, they may feel so hopeless they think nothing will help. Second, they may feel personally helpless and so sit passively and wait for the therapist to fix them. Third, helplessness and low self-efficacy can engender defensiveness and self-protection (Tallman, 1996; Bandura, 1997). Clients may become more focused on protecting themselves than on learning.

In general, client defensiveness will interfere with involvement. There are many different reasons for defensiveness. Some clients feel helpless and hopeless, as just noted. Others may feel vulnerable and perceive therapy as a threat to their personal integrity or lifestyle. Still others are in therapy involuntarily. Some may be afraid of legitimate authority and not trust therapists. Finally, the way the therapist approaches the problem may be so discrepant with the clients values, goals, and view of the world as to engender resistance.

One of the major insights of the psychoanalytic approach is that resistance and defensiveness get in the way of learning. The therapeutic learning of importance in psychoanalysis has to do with uncovering reasons for defensiveness. Many of the procedures of modern psychotherapy were devised by psychoanalysts to help overcome defensiveness: suspending judgment, lack of moralizing, and listening. In psychoanalysis, once resistances are overcome, the rest of the therapy process is up to the client—clients' ability to think rationally and intelligently is freed up and they begin to find answers to life problems on their own.

Given a willingness to be involved, clients still need to be involved *productively.* Productive involvement means being able to maintain a focus on the tasks at hand, persist in the face of temporary failure, and maintain an open learning-oriented stance so that they can confront painful material, explore, and learn from failure (Bohart & Tallman, 1999; Tallman, 1996). However, many clients enter therapy focusing on their shortcomings, what others think of them, what they "should" be doing, catastrophizing about all the dangers in their lives, being defensive, or focusing too much on the distal future ("I'll never be happy"). These distract them from focusing on the learning/exploring aspects of therapy.

Factors that influence keeping a task focus include self-efficacy beliefs (Bandura, 1997) and beliefs about one's ability to change (Dweck & Leggett, 1988; Tallman, 1999), as well as feeling hopeful or optimistic (Seligman, 1990). Clients often come to therapy when they feel low in self-efficacy

to make changes in their lives, or when they view it as hopeless (i.e., unchangeable). This may occur either as a function of preexisting personal dispositions or as a function of overwhelming situational stressors and personal problems.

It could be that the most important thing therapy provides is helping clients maintain a learning-oriented task focus. Tallman (Bohart & Tallman, 1999; Tallman, 1996) has argued that many of the tasks and procedures of therapy operate to induce a task focus. These include the therapist's providing a supportive context to reduce stress, adopting a nonjudgmental attitude, using empathic reflections, and challenging dysfunctional beliefs. Therapists also encourage a task focus by modeling an exploratory trial-and-error approach, and by themselves remaining optimistic in the face of temporary client failure. Both Bandura (1997) and Goldfried (1995) have argued that procedures such as exposure work by promoting a sense of self-efficacy.

Therapy As Provision of Personal Learning Opportunities

Once clients are able to be productively involved, therapy presents an opportunity for clients to learn how to master their problems. Most therapists would agree that therapy is ultimately the provision of a learning opportunity. However, this gets obscured by the language of the medical model. Consider the difference between saying that the client has come to "*be treated for* an anxiety disorder" versus saying that the client has come to "*learn how to deal with or reduce his anxiety.*" The treatment language obscures the nature of therapy as learning, and further, disempowers the client.

Therapy provides five different kinds of learning opportunities. These five, along with the approaches most associated with them, are (a) provision of an empathic workspace (client-centered therapy), (b) provision of interpersonal learning experiences [modern psychoanalysis, existential-humanistic therapies, recent radical-behavioral approaches (e.g., Kohlenberg & Tsai, 1987)], (c) coconstructive dialogue, which includes opportunities to gain insight and new perspectives and question one's beliefs (psychoanalysis, existential approaches, narrative and constructivistic approaches, cognitive approaches), (d) provision of structured exercises that channel or stimulate client generated creativity and self-discovery (Gestalt, process-experiential therapy, strategic and solution-focused approaches), and (e) skills training and specific guided learning opportunities such as exposure (cognitive-behavioral approaches).

I shall briefly consider each of these in turn.

Provision of an Empathic Workspace

One way people can learn is through their own self-generated exploration and activity. At times what people need is a safe space in which to spread out their problem, explore it, and find their own solutions. The analogy is to having a workspace in one's garage. For some clients this is all that is needed (Phillips, 1984). In the empathic workspace, the primary ''driver'' of therapy is the client. The therapist helps by providing emotional support and by carefully listening and understanding.

Provision of an Opportunity for Interpersonal Learning

If children are lucky they grow up in homes where the interactions support, model, and reward effective interpersonal behavior and self-regulation. A second kind of learning opportunity provided by therapy is equivalent to this: a relationship in which the therapist relates to the client in a ''healthy'' manner. Clients can extract from their interactions with the therapist new learnings such as that (a) not all people are dangerous, fragile, or oppressive, or (b) some people cannot be manipulated and will not manipulate you. They may also learn that (a) they are valuable and have something of worth to contribute, (b) they can learn more effective ways of asking for what they need, and (c) their emotions are not scary or too overwhelming and can be managed. These learnings can occur through patient and persistent efforts by the therapist to be supportive while setting clear but not punitive boundaries, conveying immediate feedback on harmful interpersonal behavior (Kohlenberg & Tsai, 1987), being appropriately honest and genuine within the bounds and purposes of the relationship, and not getting maneuvered into playing complementary dysfunctional roles.

Provision of an Opportunity for Learning Through Coconstructive Dialogue

In this kind of learning opportunity the therapist actively gives the client input in the form of dialogue designed to make it a setting for discovery. The therapist may give interpretations (e.g., as in psychoanalysis, Gold, 2000) like a good teacher who provides a new perspective on something students are studying, or may ask stimulating questions designed to get clients to think (e.g., as in cognitive therapy).

Other forms of coconstructive dialogue include therapist and client brainstorming on a problem, engaging in historical exploration, or narrative

reconstruction. In these cases the therapist may function like a dissertation mentor. Finally, the therapist may help by providing informational feedback.

In all cases nothing will be true for the student unless it makes sense from the "student's" point of view. The "Laura Schlessinger" model of therapy is rejected, not because people are not capable of occasionally using confrontive feedback (they are), but because such a manner of confrontation is as likely to alienate as it is to promote learning (W. R. Miller and Rollnick, 1991).

Provision of the Opportunity for Structured Exploration and Self-Generated Creativity

In the fourth kind of learning opportunity therapists provide specific structured activities to promote client discovery and creativity. The school analogy is to classes where students have to write their own short stories or practice improvisation in an acting class. There are two types. The first is the kind of structure provided by the guided exploration activities of experiential therapy (L. S. Greenberg, Rice, & Elliott, 1993; Mahrer, 1996), particularly role-playing activities, which are also used in cognitive therapy (Beck, Rush, Shaw, & Emery, 1979). The other kind of activity is that provided in strategic and solution-focused therapy (e.g., Berg & Miller, 1992; De Shazer, 1985). Another approach which falls into this category is Eye Movement Desensitization and Reprocessing (Zabukovec, Lazrove, & Shapiro, 2000).

Provision of Skills Training and Other Structured Learning Exercises

Finally, therapists can be like a teacher teaching algebra, ballroom dance, or some physical skill. The teacher has a particular "curriculum" for the student to learn. Cognitive-behaviorists primarily are the members of this category, with their emphasis on skills training. Curricula can also include learning through activities like exposure.

Implications of Therapy as Learning

Two implications follow from using a learning metaphor to portray therapy. First, different clients may take to different kinds of learning opportunities. Some clients may prefer more self-directed and self-guided

learning, such as through talking to an empathic listener, or using self-help material (e.g., Beutler *et al.,* 1991). Other ''students'' may prefer to be taught a ''curriculum.''

Second, in the course of a therapy experience with a given client, different learning opportunities may be useful at different times, sometimes within the same session. Thus, the therapist might use EMDR to explore a trauma. After this, therapist and client may ''rehash'' what was learned and engage in coconstructive dialogue. This may lead to the usefulness of teaching a specific skill, or using a role-play technique for further exploration. In contrast to the mechanistic format of empirically validated treatments, the therapist's choices at given point would be dictated by (a) what the client wants to do and (b) what kind of learning opportunity seems most appropriate at that point. Along these lines, the ''marker'' idea of L. S. Greenberg *et al.* (1993) seems one good start at identifying when certain kinds of learning opportunities are more likely to be useful than others.

A RELATIONAL METAPHOR FOR PSYCHOTHERAPY

The idea of the client as an active self-healer implies a collaborative model of therapy rather than a treatment metaphor. In the traditional medical model, the relationship is hierarchical. The therapist is the expert who diagnoses the client's problem and applies treatment. In recent formulations (e.g., Task Force, 1995) treatment is manualized to make the relationship even more one-way from therapist to patient, linear, and hierarchical. Some manuals make a point of stressing a collaborative relationship with the client. Yet this collaboration is embedded *within* a highly structured therapist-controlled treatment format.

However, truly relational, nonhierarchical models can be constructed in which the client is more genuinely a coequal partner to the therapist, based on the metaphor of *consultation.* The metaphor is one of giving tools to clients rather than operating on them with techniques. In consultation models consultants offer ideas to their clients, who may or may not use them. All degrees of collaboration might exist. In some cases consultants may offer minimal guidance and support; in others they may more actively take the lead and offer a structured program, depending on what the client wants and needs. An apt metaphor is the community psychology model of the 1960s. The community psychologist was a consultant to the community, but was not the expert who diagnosed the community's problems and then applied a ''treatment'' to fix them. Rather, he or she was a consultant with expertise, whose ideas joined with that of the community in a collaborative dialogue to generate solutions.

In a collaborative model choice of "treatment" is codictated by therapist and client. In this regard, addressing school-based consultation, Murphy (1999) has advocated "An empowerment philosophy [which] shifts the focus of helping from the diagnosis and treatment of problems to the collaborative discovery of existing strengths and resources relevant to the client's goals" (p. 370). Referring to the therapy literature, he notes that "A growing body of research challenges model-driven therapies and suggests that the success of therapy results largely from common factors. . . . Outcomes improve when practitioners instill hope and accommodate therapy to clients instead of requiring clients to conform to the therapist's favorite model or technique. Change is enhanced when practitioners prioritize client beliefs, resources, and preferences throughout therapy" (p. 364).

In the traditional "treatment" model, if it really were interventions that "made the change," they ought to work even if clients do not believe in them, as long as clients comply and "take the drug" (i.e., do the intervention). In a collaborative model, the client's role is much more active than mere compliance. Therapy is not a drug which the client takes and then the drug operates on the client, any more than an algebra lesson is a treatment which operates on students to change their understanding of algebra. In contrast, therapists' "lesson plans" depend crucially not only on "student" involvement in the sense of compliance, but their active investment of their intelligence, their ability to extract the underlying concepts, and then their ability generatively to extrapolate these concepts to new and different situations.

Therefore it is even more crucial in therapy than in medicine that clients actively agree with therapist suggestions. Experts on organizational change know that staff must "buy into" innovations for them to work (Murphy, 1999). For schools, interventions are more likely to be implemented if they are rated as acceptible by parents and teachers (Murphy, 1999).

In a collaborative model, therapists' abilities to entice and engage clients are more important than their interventional expertise. Therapist personality is therefore more important than professional training. Some evidence supports the idea that therapists are differentially effective and that that differential effectiveness overshadows manualization, treatment approaches, and so on (Brown *et al.,* 1999; Luborsky *et al.,* 1985). Bachelor and Horvath (1999) note that "the personality organization of the therapist may be more relevant than therapist skills." (p. 152).

Professional training and models are of some importance. S. D. Miller, *et al.* (1997) suggest that it is important for the therapist to have faith in what he or she is doing because that inspires faith in the client. Having an approach also gives the therapist something to fall back on when things

get rough. However, I would extend Miller *et al.*'s contention and suggest that having a model is important for still another reason: While different models may all work about equally well, clients need the support of *some* learning structure to confront their problems. Different therapies provide different structures or scaffoldings which promote learning. It is the lack of such structure in everyday life which has interfered with persistent, systematic problem-solving efforts. Further, some research has shown that creativity flourishes in situations where some moderate amount of structure is provided (Finke, 1995).

CONCLUSION

Viewing the client as an active self-healer and therapy as the mobilization of naturally occurring self-healing forces provides an alternative to the medical model of therapy. Therapy, as Strupp (cited in Norcross *et al.,* 1993) has noted, is not a treatment. Rather, therapy is the provision of a learning opportunity to an active, self-healing client. It works to the degree that the client accepts the conditions of learning and participates. Therefore our field should be working to develop collaborative, relationship-based models that emphasize mobilizing hope and optimism, active client involvement, helping clients learn how to stay task-focused, and helping clients mobilize their own instrinsic intelligence for solution-finding rather than models that rely on cookbook lists of manualized interventions for specific disorders (e.g., Task Force, 1995).

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