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Why are some therapists generally helpful and some are not? Journals and books are full of plausible explanations, ranging from the frequency of using certain interventions to the presence of particular interpersonal factors. And yet, while theoreticians, researchers, and practitioners argue among themselves about what exactly makes a difference — which elements, variables, qualities, processes, concepts, behaviors, and attitudes — clients are remarkably clear about what they want and need in their helpers. Generally, they prefer someone who is warm and approachable, someone who listens to and understands them. They want a professional who is competent and confident, who gives them a sense of hope. They want an active collaborator in the process. They want someone who they perceive to be like themselves, but not too similar. They favor a helper who is also emotionally healthy. And they prefer an expert who is perceived as having power, status, and prestige. In short, clients have definite ideas about what they want in their helpers, even if they do not know what they want in their lives.

A Client Looks at Three Therapists

During the writing of this book I experienced what I believe was a mid-life transition. I began to feel restless with my life, confused as to what I

wanted to do next, and somewhat unhappy with the progress I was making on my own. I was feeling anxious, and then once I began exploring options, I started feeling depressed by what I perceived were limited possibilities. What I was living through had all the hallmarks of what I recognized as a developmental crisis.

I became indecisive. I found it difficult to concentrate. And yet, I suppose like most prospective consumers of therapy, I made up a bunch of excuses for why I could handle this on my own. I am a therapist, after all. . . and a pretty good one. I should be able to help myself through this, just as I have lived through it with so many clients. Finally, I rationalized to myself that this would make good research for the book I was writing. (What is the use of being a therapist if it does not help us to invent good rationalizations?) All in the interest of science, I could visit several different therapists and see what makes them effective, actually *experience* the effects of what they do. Hey, maybe I would even find it personally helpful.

I scheduled appointments with three different therapists in the same week, unwilling to trust just one. I figured I could see what each of them was like and decide who was the best for me. My first awareness after taking this initial step was already how much better I felt. Clients, of course, have said this to me all the time, but I had not realized just what they meant. (It has been many years since my last therapy experience as a client.) I noticed

myself doing a lot of rehearsing of how I would present myself and what I would say. It was hard to sit back, relax, wait, and trust the process I purport to believe in and teach to others. It was a test of faith.

Dr. Genghis. The first therapist was a small man in a cavernous office. Trained originally as a psychiatrist and analyst, Dr. Genghis's office had many of the trappings I would expect in such a setting — big desk, swoon couch, separate entrances. Very formal. Yet I did not for a moment expect I would be seeing a conventional analyst . . . and I was not disappointed.

Before I even got my bearings and settled in my chair, he was on me like a predator. He asked me some questions but did not like my answers. It took him about five minutes to size me up and give me his assessment. And it was brutal. I reeled from the accusation that I was essentially irresponsible. I tried to process what he was saying, but by then he had leveled several more rounds. My back was drenched with sweat. I was smiling like an idiot, stammering out my protests of disagreement.

"It's simple," he says. "You don't want to grow up."

"Well, that *could* be true, but . . .

"See, even now you intellectualize. You talk around things.

You don't say what you mean."

Gosh, he *was* right about that. Maybe the other stuff is true, too. And if so, then everything I thought about myself is false. I am not who I am, but someone else I do not know.

I could see where he was taking me and I did not like it one bit. If I stayed in treatment with him I would become more responsible, more like him, and what *he* views is appropriate conduct for a man my age. Shame on me for wanting to change aspects of my life that were not broken — all to placate some silly dream I will never reach.

"Kottler, when are you going to stop this nonsense, stop running away, and start facing yourself?"

I was devastated. My knees felt like rubber; I could barely walk. I sat in my car for an hour trying to recover from the onslaught. In some ways he really had me pegged. But could it *all* be true?

Clearly, I was genuinely moved by this experience. I cannot recall, ever, spending a more frightening hour in my life. I felt beat up, bruised, and yet it was a "good" ache. I was even telling myself: "Boy, that was fun!" like a kid who screamed in terror all the way through a roller coaster ride, stumbles off in tears, and then says, "Let's do that again!"

The question was, should I go back? A part of me was so intrigued by his bluntness and assaults on what I thought was my reality. And another part of me thought he was a lunatic. He was everything I have always wanted *not* to be as a therapist. He was neither warm nor accepting; in fact he was extremely critical and judgmental. He did not deal with my feelings nor did he work with me in areas that I preferred. He ignored my desires. He ridiculed my defenses. He called me names. He was quite simply the meanest bastard I had ever met. So, how could I even dream of going back for more? What did he do that was so effective?

It certainly was not his sweet disposition and kindness. He did not exactly inspire me to trust him. Everything I confided in him he turned against me. He was, at times, cruel and impatient, going for the jugular when I was already disoriented and vulnerable. I did not feel heard or understood.

So what *did* he do that helped me? And I truly felt helped, although at the time I could not exactly say how. Obviously, he was a master at shaking me up, helping me to feel uncomfortable with myself and thereby prodding me. I absolutely loved his stunning honesty and I appreciated his directness. I also got a kick out of his eccentric style — he had me enthralled by the force and power of his personality. Heck, I did not agree with much of what he had to say, but I liked the show he put on.

I just knew I would get my money's worth with Dr. Genghis. I liked the way he knew how to get to me so quickly. His intuition about some things was remarkable. At one point he asked me what my earliest memory was. I described, at age three, carrying my brother home from the hospital after he was born. He asked me how I *felt* in the memory, and I replied: terrified. He asked me what I was so afraid of. "Why, of the responsibility. What if I dropped him?"

Dr. Genghis looked at me with those vulturous, beady eyes and said, "Of course! Can't you hear yourself? Since age three you have been terrified of responsibility."

Well, whether this interpretation was accurate or not, it sure got my attention. It got me thinking in new ways. He touched me in a way that I still cannot forget.

Dr. Glinda. I must say that I was feeling somewhat leery about showing up for my scheduled appointment with the next therapist the following day. As so many clients say to themselves: maybe I do not need therapy after all. I found myself making up the same feeble excuses I hear every day — that it is too costly, too time consuming, that I am too old to change my ways or too seasoned to fall for the tricks of the trade. This last remark was especially revealing of my underlying skepticism and mistrust of the process that I have

devoted my life to believing in . . . for others.

In spite of my apprehensions, by this time I *really* needed professional help just to recover from the first experience. Dr. Glinda was as different from Dr. Genghis as two therapists could be. Everything he was not, she was. And vice versa. She was warm, approachable, quite loving and caring. I felt unnerved by her look. It was as if she knew some deep, dark secrets about me too, but unlike Dr. Genghis, she was not going to share them yet.

We spent most of the session talking about the meaning of the previous session with Genghis. She asked me how I felt about changing my basic nature: "How does it feel to have an expert tell you that you don't know what's good for yourself?"

Dr. Glinda did everything I would have done for myself if I had walked into my office as a client. She listened closely. She supported me. She reinforced the idea that I *did* know what was best. Well, this was just what I wanted to hear. Maybe I would not have to grow up after all!

I found Dr. Glinda to be effective in most senses of what I would expect from a therapist. She heard me and understood what I wanted from her at that moment (although she may have been colluding with my resistance). It certainly was not nearly as frightening to work with her. I felt safe in her presence. She seemed to genuinely care about me. She would go at *my* pace

rather than hers. I decided this was also someone who could help me, but in a way profoundly different from Dr. Genghis.

Dr. Wright. The first thing that struck me about the third therapist I consulted was his smile — he seemed so natural and inviting. Dr. Wright appeared to be the perfect compromise between someone who is caring yet confrontational, low key but direct. He gave me hope but made no promises. I knew after five minutes that I had found an excellent match.

Once I had decided in my own mind that this was the professional I could trust and who I believed could help me, I tried to figure out what about him seemed most significant. I liked his calmness. He listened very closely, and proved it by describing things I said in a way I had never considered before. He asked me difficult questions that I could not answer. I liked that.

I think, above all else, I had an image in my mind of who could help me — and Dr. Wright fit the profile I was looking for. I enjoyed the messages I heard from him — that he would let me do whatever I wanted and be whoever I am. I realized also that it was not only important to be heard, but to be responded to.

It was frustrating to me that I could not put my finger on exactly what made this therapist right for me. He was not using any interventions or techniques that were not part of the repertoire of others. His approach also

seemed to be somewhat similar to what I experienced before — an insight-oriented style that was part psychodynamic, part existential, and yet somewhat pragmatic. Yet, as hard as I could try, I could not (and cannot) put into words what Dr. Wright *did* that I found so helpful. Perhaps that was because it did not matter what he *did* as much as how he *was* with me. He seemed self-assured but quite modest and low key. He was intense but also relaxed. He was obviously quite bright but did not feel the need to prove anything. In short, Dr. Wright was what I wanted to be.

What was apparent to me was that he was a desirable model for me — in fact, he was the "me" I show to clients, although I rarely get a chance to observe that person. He was intriguing to me as a human being, someone I looked forward to spending time with. Yet as good as it felt to be with Dr. Wright, I still walked out of his office confused. For whichever therapist I stayed with, I felt that I would miss out on what the others could offer me — whether it was Dr. Genghis's bone-jarring confrontations or Dr. Glinda's soothing nurturance. Each of the three touched a part of me that was responsive to what they were doing and being. And yet I felt comforted with the realization that I really could not make a mistake: any of the three could help me grow; it was just a question of which road I wished to take.

Understanding Our Common Language

In their research on how experienced therapists select their own helpers, Norcross, Strausser, and Faltus (1988) found that decisions were made primarily on the basis of professional competence, experience, and reputation, as well as personal qualities such as warmth, flexibility, and caring. Indeed, like the 500 therapists in their study, I did not particularly care about which theoretical orientation my therapist followed, as long as he or she was an expert at applying it and had the capacity to treat me with kindness, compassion, and respect.

Also evident in my experiences in search of a therapist are the major themes explored in this book: (1) there are many different ways to be helpful to people, (2) there are some things that all effective therapists do, and (3) it is possible to identify common therapeutic principles and integrate them into a personally evolved style of practice.

What makes this task of searching for common denominators among diverse theoretical systems so difficult is the existence of so many distinct languages that are spoken among tribal groups: "If the phenomenologist uses terms like 'the phenomenal sense of self,' the psychoanalyst, 'projection of mental representations onto others,' and the behaviorist, 'conditioned stimuli and responses,' how are we to understand each other and develop a common framework?" (Messer, 1986, p. 385).

We have trouble communicating with one another when we speak different languages and come from different professions, training programs, philosophical positions, theoretical orientations, and work settings. And we have little tolerance for colleagues who operate differently than we do. What is truly amazing is that therapists who operate as differently as the three I consulted could all be effective with their clients. The inescapable conclusion is that we must have more in common with one another than we are willing to admit, including the definition of what constitutes a successful resolution of the client's presenting complaints.

Definitions of Effectiveness

What does it mean for a therapist to be effective? Certainly it is more than "having an effect," as the word implies, since effectiveness is judged principally on the basis of meeting stated goals. In the case of psychotherapy, we are also concerned with the kind of effect we initiate, since our influence can be for better or worse. Ineffective therapists may, in fact, produce more of an effect than those who are most helpful.

If positive outcomes are the criteria by which effectiveness is judged, then who determines whether the results are *positive,* and how is this decision made? If it is the therapist, as expert, who makes this determination when he or she has performed well, then the evaluation is subject to all of the

biases and perceptual distortions that are part of any subjective assessment: "The client seems better to me, so I guess I've done good work."

Of course, we are actually a lot more obtuse than that. We will state essentially the same thing in progress notes, but cloaked in pseudoscientific jargon to lend credibility to our optimistic opinions: "There is a significant reduction in the frequency of depressive symptomology." This evaluation is usually based on two considerations: first, the observations of the client during interviews, which may or may not reflect actual functioning in the outside world; and second, the client's self-report about how much he or she has improved.

Ultimately, then, by direct or indirect means, the client decides the degree to which he or she has been helped. This is true for most other professions as well — it is the physician's patient, the attorney's client, the salesperson's customer who determines the degree to which the professional has been effective in getting the job done. The effective therapist, therefore, is a professional who produces a high number of "satisfied customers."

But this cannot be the whole picture. There are practitioners who, because of the way they work, are successful in their clients' eyes, but not necessarily in meeting initial treatment goals. They may be effective, essentially, in fostering dependencies in their therapeutic relationships, or

creating distortions or denial of unresolved issues. One common way this takes place is in the assertion that: "You *are* better, you just don't know it yet."

Just as multiple measures of therapy outcomes (client self-report, observer ratings, changes in dependent variables) are used simultaneously in research settings, the clinician relies on several criteria to measure progress. While the most important is the client's assessment of "feeling better," we also collect data from family members, clinical observations, and a "felt sense" that things have improved. The compleat therapist is skilled not only in producing consistent positive outcomes, but in assessing all changes accurately and honestly.

Statistically Insignificant but Clinically Meaningful

Research efforts during the past three decades have been devoted to figuring out the complex puzzle of which core conditions of helping seem to be related to positive outcomes. Depending on which dependent variable is measured (client perception or observer ratings or frequency of behaviors), it can be found that variables such as empathy, warmth, and genuineness are important, are not important, or are sometimes important (Orlinsky and Howard, 1986). Based on empirical research, perhaps all we can conclude is that empathy may or may not help, but it does not seem to hurt.

Allen Bergin, coeditor of the classic research volume *Handbook of*

Psychotherapy and Behavior Change (1986), laments his own frustration with trying to reconcile hundreds of discrepant studies and somehow integrate them into clinical practice. In an earlier work on the synthesis of therapeutic theory and research, Bergin (1980, p. 85) advises us to trust our intuition and personal judgment as well as the findings of empirical research: "The field of psychotherapy is made up of many different kinds of views and findings. With some we may have a fair degree of confidence, with some we may feel the data point us in one direction, but just slightly, and in others we may have to conclude that in the absence of data we are proceeding on what appear to be reasonable or warranted hypotheses or assumptions. Final answers are simply not available, and we must proceed on what appears to be the soundest path possible. In some instances, we can have confidence that our procedures are based on reasonably sound empirical results. In others, we must trust our own judgment and intelligence, recognizing fully what we are doing and the bases for our decisions."

We are left with the realization that research to date has not always supported those variables that most of us believe constitute effective therapy. There are more than a dozen different studies that show that even the clinician's level of experience is not necessarily a predictor of effectiveness. But, of course, we *know* it is, if it is the kind of practice that truly qualifies as "experience" — that is, further exposure to new knowledge, situations, opportunities that are processed in a way that fosters growth. The other kind

of “experience” measured in these studies is the kind in which the longer a therapist practices, the more cynical, lazy, and rigid he or she becomes.

This lack of consistent, empirical support that can be replicated in a variety of situations over time is what makes the debates over what works best in our profession so intense. There are studies available to substantiate or refute almost any claim one would like to make. The behaviorists have convincing evidence that psychoanalytic treatment is nothing but the haphazard application of such principles of reinforcement and extinction. The analysts can demonstrate that the behaviorists are only dealing with surface symptoms and not getting at the root of problems. The cognitive therapists can show dozens of studies substantiating their claims that all other clinicians are missing the key to change, as can almost any other school of thought.

It All Looks the Same to Me

A stranger to our culture would be quite puzzled by what all the fuss is about — this bickering about which therapeutic approach works best, the conflicts and arguments about what makes therapy most effective. After all, to even the most astute observer, things would seem very much the same in offices across the land. Look in on a therapist, *any* therapist, and we are likely to see two people sitting comfortably opposite one another. Basically, the room would be furnished just like any other of its kind — framed pieces of

paper and colorful images on the wall, bookshelves, a desk, a few chairs and a couch, a file cabinet, and a phone. Usually a Kleenex box.

Perhaps this alien visitor would be a little surprised to discover that in a certain percentage of these offices that also cater to little people of our culture, there would also be some toys on the shelves. But, basically, the office of any therapist would look pretty much the same. And so would the procedures.

Our stranger would probably assume that all practitioners of this profession do the same things. He or she would notice, for instance, that the two participants appear to like one another, since they seem at ease, take turns talking, and show caring and respect for what the other has to say. In fact, the alien would be surprised to find that this is the one place he or she has visited where people seem to truly listen to one another. This is obvious because there are no interruptions or distractions. Everything is quite private and discreet. They even repeat what the other says occasionally, just to show they are paying attention. Further, each member of the partnership seems to be more important than the other in different ways. At first, the visitor would assume it is the one who owns the office who is most important — after all, she occupies the most comfortable chair and seems to be directing things, even when she is silent. But then, the observer would notice that the other one — the one who sometimes cries or displays intense emotional reactions

— seems to be the more important of the two. He is the one who chooses what they talk about. It is almost as if the other one works for him, the way she communicates an attitude of "whatever *you* want." And strangely, she does this without appearing subservient or sacrificing her own power.

From these visits to therapists, the alien would have to conclude that, while there are some subtle differences in what they do — some talk a bit more or less, some seem more or less permissive — there are few substantial deviations (although at one strange place the alien saw the therapist molding members of the same family into frozen positions where they looked like statues pointing or leaning on one another). The one person, who seems to need help, walks in, introduces himself, and tells his story. The other one, offering such help, listens very closely, asks questions, and supports the person to do what he most wants. Sometimes she offers more direct interventions, explains things, reminds him of previous things that were said, even challenges him to consider other alternatives. But to this innocent alien, not concerned with detail or trained to detect subtlety, it all looks the same. A person feels lousy. He goes to talk to this professional about what is bothering him. And he leaves feeling better.

It is the premise of this book that not only could an innocent observer be unable to discern significant differences among most therapists who are effective, but trained experts have their difficulties as well. When we filter out

the jargon and the superficial concepts, what we have left is a consensus of effective practice. If we do not get so caught up in which approach works best and concentrate instead on what universal and specific aspects of each approach work best, what we will have is the essence of effective therapy.

What's the Difference?

In 1980, Herink published an encyclopedia of psychotherapy approaches that contained more than 250 entries. If we consider that in the decade since this publication the trend toward the proliferation of different therapeutic modalities has continued, and if we consider that the editor missed many other theories that are out there, I am certain that the actual number of conceptual frameworks would run into the thousands. Perhaps it could even be said that for each practitioner of therapy there is a unique implicit theory of operation that is being applied, one that reflects the individual personality, values, interests, goals, training, and experience of each clinician.

Yet all these diverse approaches produce similar results: satisfied clients. Luborsky, Singer, and Luborsky (1975) conducted a comparative study of all major forms of therapy then in existence. They calculated "box scores" from each outcome study and tallied the results, concluding that all forms of therapy studied have demonstrated effectiveness, and no approach

to therapy works better than any other. In an update of this study completed a decade later, Luborsky and others (1986) concluded that whatever differences do exist in various types of treatment, they have little to do with the theory that is applied and everything to do with who the individual therapist is.

If we assume that all of the hundreds of therapeutic methodologies now in existence continue to flourish because they are helpful with some people some of the time, we are left with the conclusion that: (1) it does not make much difference what approach is used, or (2) all of the approaches are doing essentially the same things.

Even though therapists may be doing different things in their sessions — interpreting dreams, role playing, reflecting feelings, disputing irrational beliefs, analyzing themes, reinforcing fully functioning behaviors, among thousands of other possible techniques — it is apparent that most seem to be getting the job done. What, then, do effective therapists have in common if not a shared theoretical base or body of interventions? If we assume the differences are more illusion than reality, or that they are tangential rather than truly substantive, then perhaps we are all doing essentially the same things with our clients.

Similarities and Differences

While the premise of this book is that effective therapists have more in common than would seem apparent from their espoused differences, it should also be mentioned that there are several factors that clearly differentiate helping styles. In a survey of attempts to measure differences in theoretical orientations, Sundland (1977) described several variables according to which therapists differ — for example, in terms of their activity levels (passive versus active), directiveness (guiding versus challenging), structure (spontaneous versus planned), control (permissive versus limit-setting), temporal focus (past versus present), nature of alliance (authoritarian versus egalitarian), dogma (rigid versus flexible), and content (cognition versus affect).

Therapists can vary in each of these dimensions and still be effective. They can work in a highly structured way or a style that is more intuitive and spontaneous. They can talk a little or a lot. However, in spite of these variances, most effective therapists have a lot in common. Consider, for example, the behavior of some of the leaders in our field.

In the second volume in this series (Kottler and Blau, 1989), several of the profession's most prominent therapists described their experiences with failure, and by so doing, also articulated what they believe does play the most significant role in therapy. The following commonalities of what works in therapy can be constructed from what does *not* work in the therapy of Arnold

Lazarus, Albert Ellis, Clark Moustakas, Richard Fisch, James Bugental, and Gerald Corey:

1. understanding, accurately and fully, the nature of the client's presenting complaints

2. establishing a productive therapeutic alliance

3. exhibiting confidence in the methods employed

4. demonstrating flexibility when and where it is needed to alter plans to fit specific client needs

5. being aware of one's own limitations and countertransference reactions that may be impeding progress

6. employing specific interventions with a defensible rationale that can be articulated

This last area of prescribing specific strategies with different clients and presenting complaints has been seen by many, such as John Norcross and Arnold Lazarus, as the hallmark of effective practice. In an invited address at an American Psychological Association convention, Lazarus (1989) called many of the conclusions of meta-analysts — and of other writers who believe that generalized effects of therapy are what make the greatest difference — utter nonsense! Lazarus explains: "There are those who have said it's all in the relationship. If you've got a good, warm, empathic, loving relationship, the

rest takes care of itself. And if that's the case, why the hell bother to collect doctorates, study, take courses, if being a nice human being is all that matters?"

Lazarus emphatically states that there are indeed very specific treatments of choice for specific problems — lithium carbonate for bipolar disorders, response prevention for compulsive disorders, sensate focus exercises for sexual dysfunctions, limit-setting for borderline personalities. He believes that all therapists, regardless of training and professional and theoretical affiliations, should be able to agree on the most optimal strategies to employ with problems such as these.

In spite of a possible reconciliation of viewpoints regarding situation specific treatment methodologies, there is one bone of contention between many theoreticians and clinicians: whether the client or therapist should assume primary responsibility for therapeutic gains. Whereas some practitioners believe that the client is the one who directs progress and movement in sessions, other therapists feel just as strongly that the therapist is the one in charge. What is so interesting is that both strategies seem to work.

I suppose this really is not so extraordinary when we consider that unique styles of practice are part of any profession. Athletes can perform at

their peak by strategies that either emphasize regimented, disciplined hard work or a relaxed manner. Consider the performance of baseball players. Some especially successful hitters are able to attain their level of skill through endless practice, the scientific study of relevant principles, and other forms of single-minded determination. These "left-brained" professionals are not unlike those therapists who are highly effective in their structured styles. Yet other "right-brained" hitters or therapists are able to be just as effective by relying on intuition, a relaxed manner, and natural and trained reflexes. So what *is* operable is *not* which style is used; rather the common variable is that the practitioner has developed a unique style that feels personally comfortable. And, of course, anyone who invents a unique theory is going to be even more at ease practicing what has been custom designed to his or her own personality, values, and needs.

Yet, another reason why the various forms of therapy are all effective is not only because they do the same things, but because they do different things. Each system relies on distinct learning principles. These could include mechanisms of trial and error, experientially based processes, didactic instruction, modeling demonstrations, reinforcement principles, gestalt insights, classical conditioning, gradual learning curves, response discrimination, intuitive sensings, problem solving, or neurochemical information processing.

Since individuals have distinct preferences in terms of how they learn best, therapies that employ some concepts are going to be more useful to some people than to others. Those clients who work well with structure and concrete goals are going to naturally gravitate toward a therapist who can work well within those parameters. And others who prefer the realm of the intellectual or the experiential will search until they, too, can find a good match. And then, of course, there are those who can adapt quite well to almost any system. But the point is that there are many ways to accomplish the same things.

I am reminded of a furious debate that took place at a hearing of a state Board of Licensure in which a number of rule changes for practice had been proposed. One of these included adding a mandatory residency requirement in doctoral programs that would effectively eliminate many alternative schools that are geared to older students who cannot leave or relocate their families to complete their studies. A representative of one prestigious state university gave an impassioned and quite articulate speech about the necessity of continuous, ongoing supervision and classroom monitoring in the training of a therapist. He believed that such daily contact with peers and instructors is critically important in the development of good work habits. In fact, he could not conceive of training a therapist any other way, and found it absurd that someone could ever be licensed as a professional who had not spent prolonged time in residence at an institution.

A representative from one of the nonresidency programs then presented an equally compelling argument: "I understand that *you* learn best in a formal classroom setting, and perhaps even the students that *you* have worked with do well in lecture halls and seminar rooms. I, however, have much preferred concentrated periods of interaction with my peers and instructors, with time in between these meetings to study, read, and practice independently. So what you are saying is that students who learn differently than you do can't possibly learn to be competent therapists."

There have been endless arguments among the representatives of the various schools of thought as to which approach is the best. Both sides level this claim: "You are patently incorrect, whereas we have the market on truth cornered. If only you would do what we do so well, then your clients would make more real/rapid/lasting changes."

Several things are clear: (1) different therapists do apparently different things, and (2) except for adopting certain behaviors that are known to have deleterious effects, no matter what they do, their clients get better anyway. Whether the clinician is fond of listening or talking, supporting or confronting, reflecting or advising, clients will typically respond favorably if certain basic conditions are met. Empirical research cannot yet account for the paradoxical finding that therapists who do different things get similar results, so that there is something else going on that we cannot altogether

explain.

Shared Themes in the Client's Journey

There is doubt in some circles as to whether anything the therapist does makes much of a difference in producing positive outcomes; rather, it is the client who is effective or ineffective, not the clinician. This nihilistic perspective was expressed by one psychiatrist who claimed to have strong reservations with regard to *any* therapist or therapy as being effective: "In my experience the person 'undergoing' therapy is the one who is doing the 'getting better' and hence *he* is the one being effective. I know that many clients object to accepting the credit for their improvement and they will insist that the therapy has made them better. I cannot blame them. It is expensive stuff. Also, if you refuse responsibility for your improvement you can always blame others or external circumstances if things do not go right in the future."

The perspective revealed by this clinician — that therapists are neither effective nor ineffective, it is their clients who are — is somewhat provocative. Yet, it is a shared theme in all therapies that the client is the one who does the changing based on his or her motivation.

Stiles, Shapiro, and Elliot (1986) contend that "there really are different ingredients in the different psychotherapies, although whether these are

active ingredients or flavors and fillers remains to be established" (p. 166). The authors attempt to resolve the paradox by pointing out methodological problems inherent in comparative studies of outcome. While they mention that indeed common features shared by all therapists (such as warmth and communication of new perspectives) or therapies (such as the therapeutic relationship) might override differences in verbal technique, they also propose that perhaps it is not the therapist's behavior that matters much. Maybe it is the client who makes all the difference. Those who have positive and realistic expectations, who are trusting and disclosing, who have acute problems, no severe personality disturbances, and who are willing to accept responsibility for their growth, are going to do well in practically *any* form of therapy with almost *any* practitioner.

Even if this were so, effective practitioners are those who can nurture the right qualities in their clients. Even those clients who are poor risks because they have negative, unrealistic expectations, chronic problems, and avoidant styles can be helped to change them. It is just in the way this is done — through pushing, shoving, waiting, or guiding — that methodologies are different.

To return to the baseball metaphor: ninety percent of all professional players can hit a little white ball traveling at 90 miles per hour to a place where nobody else is standing between 25 and 30 percent of the time. To the

untrained eye, they all appear to be doing the same thing: standing there swinging a stick. But to anyone who has studied this activity, there are vast differences in technique that are equally effective. One can hit from the left side, the right side, or both, and yet that makes little difference. People have different stances, grips, rituals, training routines, philosophies, and strategies — and they all work if certain basics are followed (lightning reflexes, upper body strength, adaptability, and so on).

All of these things could be said about compleat therapists. On the surface, it does appear as if we are doing different things. Yet a new student of our discipline would have as much trouble seeing these differences as would a first-time spectator at a baseball game: we all look like we are standing up there with a stick swinging away.

There are those who doubt that it is possible to find a common factor across all therapy. Yet it could be said that the struggle of all human lives comes down to a single story told again and again in our mythology. In his classic work on prevalent themes in folklore, Campbell (1968) traces the common threads found in various cultures since ancient times. These myths are constructed not as a pure art form, or as history or entertainment, but they all tell the same story. He sums up (1968, p. 3) that "whether we listen with aloof amusement to the dream like mumbo jumbo of some red-eyed witch doctor of the Congo, or read with cultivated rapture thin translations

from the sonnets of the mystic Lao-tse; now and again crack the hard nutshell of an argument of Aquinas, or catch suddenly the shining meaning of a bizarre Eskimo fairy tale: it will be always the one, shape-shifting yet marvelously constant story that we find, together with a challengingly persistent suggestion of more remaining to be experienced that will ever be known or told."

No matter whether disguised as Apollo, Buddha, Oedipus, or the Frog King, the legends and myths across time have followed similar rites of passage: the hero stumbles on a magical world that contains great obstacles to be overcome. These struggles lead to the crossing of a threshold and the resolution of life's riddles.

This journey that is so prevalent in the myths and legends of all cultures is also a vivid description of what the client experiences while undertaking almost any therapeutic journey. Campbell identified the following stages:

Call to Adventure. By some surreptitious event or blunder, a chance encounter opens a window to a new, magical, ominous world.

Refusal of the Call. There is balking and reluctance to accept the invitation; fear and apprehension scream out warnings.

Supernatural Aid. For those who venture forward, the first encounter is

with a guiding figure (fairy godmother, angel, helpful crone, Merlin, Hermes) who gives advice and amulets as protection against the forces of evil.

Crossing the Threshold. The hero enters the world of the unknown, the darkness of uncertainty. He or she steps beyond the portals of secure ground onto more precarious footing — one that holds a promise of rewards, but also of danger.

The Trials. For a while things look pretty bleak. The hero is stymied and frustrated by the obstacles that seem insurmountable; however, with perseverance and a tireless will, he or she confronts a series of tests. The hero is supported by a benign power that cannot be seen. He or she survives the ordeals, wiser, stronger, carrying the spoils of victory.

Refusal to Return. With the mission accomplished the hero is reluctant to leave the magic kingdom and the benevolent protector. Yet the hero is commissioned to return to the outside world to give back what he or she has taken or learned.

Rescue from Without. The return is not without dangers of its own. Often assistance is required from someone on the outside — either a loved one who is waiting or the prospect of a new relationship.

Master of Both Worlds. The hero attains the status of Master after being

able to travel between the magical land and the world he or she now resides in — without letting one contaminate the other. “Even as a person casts off worn-out clothes and puts on others that are new, so the embodied Self casts off worn-out bodies and enters into others that are new. Weapons cut It not; fire burns It not; water wets It not; the wind does not wither It. This Self cannot be cut nor burnt nor wetted nor withered. Eternal, all-pervading, unchanging, immovable, the Self is the same forever” *(Bhagavad Gita,* quoted in Campbell, 1968, pp. 22-24).

If this journey sounds suspiciously familiar, it is because, according to Campbell, the usual initiation rites and transitional rituals have been replaced in our culture by the journey of psychotherapy. This is illustrated in the following example. Brenda enters the office after a crisis has precipitated panic attacks — she discovered her husband is having an affair *(Call to Adventure).* At first, she was reluctant to confront the issue; maybe if she left it well enough alone, the relationship would end on its own *(Refusal of the Call).* But her symptoms only became worse, disrupting her sleep, her appetite, and the ways she related to her husband.

With considerable help from her therapist *(Supernatural Aid),* Brenda begins to explore not only the dynamics of her marriage, but also the circumstances that permitted her to feel so vulnerable and helpless in other areas of her life *(Crossing the Threshold).* She attempts to confront her

husband, who denies any indiscretion, claiming it is all the result of her overactive imagination. Unwilling to live any longer with a relationship she now realizes has been empty and destructive for quite some time, Brenda decides to move out on her own *(The Trials).* Much to her surprise, although she still feels generally anxious, the original debilitating symptoms of panic have now subsided. She feels resolved to continue her efforts at growing.

Yet Brenda has come to depend on her therapist for support and guidance *(Refusal to Return).* How can she ever manage being really and truly alone? They begin to work on helping her to internalize what she has learned and to wean herself from this transitional dependency. She starts socializing with friends more often and even starts to date cautiously *(Rescue from Without).* She experiments more and more with her sense of power and self-control. This increased confidence is most evident in her behavior in the singles group she has joined: she takes a more active role in helping others beginning the struggles that she is now completing *(Master of Both Worlds).*

The shared themes of mythological tales and the psychotherapy process highlight the universal variables that have been part of adventures in growth for thousands of years. While Compleat therapists (or story tellers) may not *do* the same things the same ways, they certainly deal with similar themes: confusion, frustration, anger, meaninglessness, loneliness and alienation, powerlessness, helplessness, and fear and dread.

Toward a Consensus

In 1985 the first "Evolution of Psychotherapy" conference was held; two dozen of the world's most prominent therapists were invited to present their views and respond to others' ideas. The stated mission of this auspicious event was to build on one another's work and integrate commonalities among the various ideas. These were, after all, the most brilliant minds in our profession; surely they could devote their energies toward finding common ground.

In reviewing a dialogue between object relations theorist James Masterson and family therapist Jay Haley at this conference, we are witness to an event that has become so common in our field: the skewing of one person's ideas in an effort to elevate one's own approach.

Masterson begins with the presentation of his ideas about how the developmental object relations approach evolved. Haley comments that (1) these ideas have died long ago; (2) the phenomena that were discussed do not exist; (3) Masterson's observations are cloudy and ill-formed; (4) his attitude is so rigid and fixed that he cannot see what is *really* going on; and (5) Haley's own ideas make a lot more sense.

Masterson retorts to Haley that (1) he is wrong; (2) he is not reflective and thoughtful; (3) he is so negative, rigid, and fixed that he cannot open his

mind to other possibilities; (4) he misunderstands Masterson and his ideas; (5) his ideas are better than Haley's.

If we were listening to children on a playground, this would sound comical. But we are not. These are two of the brightest minds in the field arguing about who has cornered the truth. Neither will budge from his position. And we have heard the same kinds of conflicting claims in thousands of similar debates over the decades.

Now, I have always found this tremendously puzzling — that is, why do Masterson's clients improve while he is working with their individual dynamics of separation-individuation, and yet Haley's clients also improve when he is realigning their family hierarchies? And if this is not confusing enough, then how do we account for Rogers's effectiveness when he is empathetically resonating with his clients, or Ellis's successes by confronting irrational beliefs? There are, of course, many other variations that are equally effective.

In his analysis of the trends that emerged during an "Evolution of Psychotherapy" conference, Zeig (1986) concluded that once upon a time, all of the therapists in attendance were considered mavericks, considerably out of the mainstream in their thinking. As such, they were forced to limit their focus in attempts to protect their provocative ideas from attack. Now,

however, their theories *are* the mainstream — and their proselytizing seems to reflect rigidity and an extreme commitment to their own perspectives. Zeig sees little chance there will be much convergence among the different therapeutic approaches; he finds the authors of the various theories to be too stubborn, too committed to perpetuating their own ideas, too territorial in their thinking, to be open to greater cross-fertilization.

This, I think, is a tragedy. It is time to stop fighting among ourselves about which theory works best and about which of us really understands the true nature of reality. To gain greater respectability, efficiency, and efficacy, we would be much better off if we took the advice we give our clients: Let go of rigid beliefs that keep us from growing. Stay open to new possibilities. Create an individually designed set of values, but one that fits with what others are doing. Unify our experiences. Synthesize what we know and understand into ideas we can use. Integrate the past with the present and future, the person we are with the person we would like to be. Confront the paradoxes and polarities of life and resolve them by creating a whole being greater than the sum of its parts.

The compleat therapist is, most of all, someone who takes his or her own advice.

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