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The Client's Theory of Change: Consulting the Client in the Integrative Process

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This article casts a critical eye upon the integration literature and asserts that, as in psychotherapy in general, the client has been woefully left out of the therapeutic process. An alternative that privileges the client's voice as the source of wisdom and solution is presented. It is proposed that conducting therapy within the context of the client's own theory of change offers ways of integrating multiple therapy perspectives. An argument is made for not only recasting the client as the star of the drama of therapy, but also giving the heroic client directorial control of the action as it unfolds.

KEY WORDS: client's theory; theory of change; integration; common factors; client directed.

> We feel that it would be fruitful to explain patient's own ideas about psychotherapy and what they expect from it.
>
> Hoch (1955)

Many therapists have made the disappointing discovery that any given model that purports to ameliorate human suffering is limited. One size does not fit all. The field's response has been rival schools, brand names, and high fashion in the therapy boutique of techniques. Thus, therapists have not suffered a dearth of models from which to choose; indeed, there are now more choices than Baskin and Robbins and Howard Johnson's combined.

The up side, of course, is that under certain circumstances a given flavor may really hit the spot. The lure of increasing the efficiency of therapy

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through the selective application of disparate models has fueled interest in integrative strategies for practice. Eclectic theorists have sought to find relevant client characteristics beyond diagnosis to guide the selection process (e.g., the groundbreaking work of Beutler & Clarkin, 1990). Recent efforts have added an emphasis on matching relational methods (e.g., Blatt, 1992; Lazarus, 1993; Norcross & Beutler, 1997) looking for "relationships of choice" (Norcross & Beutler, 1997, p. 44).

While the eclectic movement has not suffered from the "dogma eat dogma" (Saltzman & Norcross, 1990) mentality of warring factions of therapy, it is beginning to resemble the field as a whole with its immense heterogeneity. Norcross (1997) summarizes:

> We have the prescriptive eclectics, pragmatically blending methods; we have the theoretical integrationists, actively smushing theories; we have the common factorists, relentlessly searching for underlying commonalities; and we have the system complementarists, astutely sequencing psychotherapy systems to maximize their domains of expertise. . . (p. 87).

Despite significant advances, Norcross (1997) suggests that the integration field invites confusion and irrelevancy unless the immense differences are defined, and the "me and not me" are established (p. 87). In the spirit of addressing this concern, this article casts a critical eye upon the integration literature and asserts that, as in psychotherapy in general, the client has been woefully left out of the therapeutic process. An alternative that privileges the client's voice as the source of wisdom, solution, and model selection is presented.

A TALE OF TWO DINOSAURS

While the intellectual appeal of theoretical integration is compelling, the search for a unified metatheory is reminiscent of the rapid-fire development of models in search of the Holy Grail. The field has "been there, done that." Given that model and technique only account for 15% of outcome variance (Assay & Lambert, 1999; Lambert, 1992; Miller, Duncan, & Hubble, 1997), theoretical integration efforts focus on the weakest link in the chain of factors accounting for change.

The love affair with models blinds therapists to the roles clients play in bringing about change (Duncan, Sparks, & Miller, 2000). As models proliferate, so do their specialized languages, systems of categories, and arsenal of techniques. All such articulations take place outside the awareness of those most affected. When models, whether integrative or not, crowd the thinking of therapists, there is little room left for *clients' models*—their ideas about their predicaments and what it might take to fix them—to take shape. Client's ideas, are, at best, patronized for the sake of friendliness

or compliance; at worst, part and parcel of the problem, those very elements needing to be eradicated or transformed (Duncan, *et al.,* 2000).

A technical eclecticism based on empirically validated techniques (EVT) suffers the same problems that EVTs bring to noneclectic therapists. Efficacy over placebo or customary treatment is not differential efficacy over other approaches (Duncan & Miller, 2000). Where differences do occur over other models, they are often trivial and explainable by chance alone (Wampold, 1997). Further, efficacy speaks more to the approach's privilege of being researched (Hubble, Duncan, & Miller, 1999) rather than how such research should be privileged. Finally, efficacy in randomized clinical trials does not equate to effectiveness in clinical settings; internal validity does not ensure external validity (Goldfried & Wolfe, 1998). More importantly, any technique, EVT or the plain variety of everyday practice, gains its power to change from its ability to enlist client's resources, court the alliance, and fit the client's view of what is helpful (Duncan, Hubble, & Miller, 1997).

The problem that plagues integrative efforts is the same problem that has all but reduced psychotherapy to medical diagnoses and the prescription of empirically validated treatments—the key figure, the client, has been left out of the loop. Most, if not all integrative efforts focus exclusively on the therapist's frame of reference, the therapist's overarching framework for integration, the therapist's synthesis of the myriad models that exist, and the therapist's acumen at differential therapeutics, be it selecting technique or relational style.

The client figures into the equation as an object of assessment and intervention. The therapist either knows *a priori* what method is best, or through expert interviewing and testing, assesses the matching characteristics to determine the proper treatment or style. The therapist remains the star, the Herr Doctor, and the client is an extra, the patient. The import of clients is diminished and their viewpoints excluded.

Asking the client directly about their expectancies provides a notable exception. Lazarus (1992) and Norcross and Beutler (1997) both solicit client expectations. Both, however, also add a caveat that it would be naive to assume that clients necessarily know what they want or what is best for them. With all due respect, it is precisely this attitude that permeates the field of psychotherapy. And what is this attitude? The attitude that clients are pathological monsters or dimwitted plodders.

Godzilla Meets *Deinonychus*

The mental health field, including integration, has tenaciously held on to the notion of the client as a pathological monster of epic proportions

(e.g., *Borderlines*). Imagine you are attending a workshop and the presenter announces that you are about to see a videotaped case that illustrates a new diagnostic category. Then, instead, you recognize the excerpt from the classic movie, *Godzilla.*

As huge guns are raised, tanks hurried into place, and technicians worriedly look after mysterious instruments, a very young Raymond Burr looks out over Tokyo Bay giving an eye witness account of the horror. ''A prehistoric monster, that the Japanese call Godzilla, has just stepped out of Tokyo Bay. It is as tall as a thirty story building and it is making its way to Tokyo's main line of defense, a 300,000 volt barrier, a barrier against Godzilla.'' Godzilla reaches the power lines and the technicians anxiously throw the switch, pouring everything the city has into stopping the monster's progress. Godzilla thrashes about and makes loud screeching noises that sound like feedback at a heavy metal concert—but to no avail. All it accomplishes is to enrage Godzilla—it unleashes a powerful white ray, setting Tokyo on fire.

The new diagnostic category, Godzilla Personality Disorder, has the following characteristics:

- Larger than life hideous monster (at least that's what it feels like)
- Makes loud screeching noises (especially between sessions)
- Destroys everything in its path, really irritable when shot or electrocuted (no approach is safe, no intervention works regardless of demonstrated efficacy)
- Emits deadly white ray from mouth (dissatisfied with service, spews litigious words)

Recall the countless number of clinical descriptions you have heard and read that portray clients as larger than life, dangerous adversaries who crush therapists between their toes. An equally detrimental view of clients, albeit more subtle, is the take on clients as hapless bozos, dimwitted plodders who barely stumble their way from one situation to another. Another dinosaur story illustrates:

In the summer of 1964, John Ostrom and Grant Meyer, Yale paleontologists, were walking along the slope of an eroded mound in South Central Montana. They came across the fossil remains of a creature that Ostrom would later call *Deinonychus* (Terrible Claw). This discovery shook the very foundation of paleontological thought and fueled the flames of a major revolution in the way dinosaurs were viewed.

Whereas before dinosaurs were seen as ponderous, cold-blooded, shuffling monsters, *Deinonychus,* by its skeletal anatomy, pointed to the undeniable existence of an agile, aggressive, larger brained, and perhaps even warm-blooded hunter that was anything but slow and stupid. As a result

of the chance encounter with *Deinonychus,* the earlier orthodoxy, solidly in place in paleontology, was doomed, soon to be as extinct as the animals it presumed to explain (Wilford, 1986).

Psychotherapy has unfortunately misunderstood the client as much as paleontologists did the dinosaur. Clients, like *Deinonychus,* are not dullwitted, passive plodders (or pathological monsters), but rather are resourceful, motivated hunters of more satisfying lives. The integration literature has paid little attention to not only the clients' inherent abilities, but also their own preferences for treatment, their own integration efforts.

In a refreshing article that challenges conventional practices, Gold (1994) presents several compelling examples of clients' own integrations of different therapies. He makes a strong case for emphasizing client's idiosyncratic syntheses of ideas even though it may make therapists uncomfortable to have the client in the driver's seat. Gold (1994) concludes, "Without theories that embrace patient-initiated integrations and include a first-person point of view, we may be stuck in taking third person dominated models too seriously, and thereby blind ourselves to what our patients have to teach us about psychotherapy integration" (p. 156).

Just as the finding of *Deinonychus* dramatically changed how dinosaurs were viewed, the inclusion of "a first-person point of view" into psychotherapy integration challenges medicalized practices that discount client competencies and exclude their perceptions and ideas. It is time to recast the drama of psychotherapy, to retire the star therapist and place the heroic client in the leading role.

The Heroic Client

Research makes clear that the client is actually the single, most potent contributor to outcome in psychotherapy—the resources clients bring into the therapy room and what influence their lives outside it (Assay & Lambert, 1999; Miller *et al.,* 1997). These factors might include persistence, openness, faith, optimism, a supportive grandmother, or membership in a religious community: all factors operative in a client's life before he or she enters therapy. They also include serendipitous interactions between such inner strengths and happenstance, such as a new job or a crisis successfully negotiated. Lambert (1992) ascribes 40% of improvement during therapy to these factors. Highlighting the client's contributions to change, Tallman and Bohart (1999) argue that the infamous "dodo bird verdict" (Luborsky, Singer, & Luborsky, 1975) can be explained by the client's regenerative abilities. Therapies work equally well, they assert, because the client's propensities toward change transcend any differences between models.

Just as clients have traditionally been miscast as villains or town idiots in therapy, clients' perspectives regarding therapy frequently wind up on the cutting room floor. This is curious given that client perceptions of relationship quality account for 30% of successful outcome (Asay & Lambert, 1999). The client's view of the relationship is the "trump card" in therapy outcome, second only to the winning hand of the client's strengths. For example, Blatt, Zuroff, Quinlan, and Pilkonis (1996) analyzed client perceptions of the relationship in the Treatment of Depression Collaborative Research Project (TDCRP). Like hundreds of other studies, improvement was minimally related to the type of treatment received, but substantially determined by the client-rated quality of the relationship. Further, the alliance has repeatedly been shown to be one of the best predictors of outcome (Batchelor & Horvath, 1999). For example, Krupnick *et al.* (1996) analyzed data from the TDCRP and found that the alliance was predictive of success for all conditions.

In fact, client perceptions rule when it comes to outcome. The client, like *New York Times* film critics, should be taken very seriously if any desire exists for box office outcome success. Research detailing the client's contributions to change lead to the inevitable conclusion that the field must transcend the bonfire of the vanities found in flashy models, sexy techniques, charismatic gurus, and snake oil peddlers.

THE CLIENT'S THEORY OF CHANGE

> The patient, as I finally grasped, insisted—and had a right to insist—that I learn to see things exclusively in his way, and not at all in my way.
>
> Kohut (1984)

Because all approaches are equivalent with respect to outcome, and technique pales in comparison to client and relationship factors, we propose that the clients' map of the therapeutic territory be unfolded and followed as the "theory" for therapy (Duncan *et al.,* 1997). The notion that client perceptions of problem formation and resolution—the client's theory of change—have important implications for therapy has a rich, although somewhat ignored theoretical heritage.

As early as 1955, Hoch stated that "There are some patients who would like to submit to a psychotherapeutic procedure whose theoretical foundations are in agreement with their own ideas about psychic functioning" (p. 322). At about the same time, Kelly (1955) posited that each individual has a "personal construct theory," a scientific theory "worth taking into account" in the process of therapy (p. 228). Kelly saw treatment

as formulating hypotheses on this theory, planning field trials, and evaluating outcomes, allowing the client to actively test his or her theory.

Later, Torrey (1972) asserted that sharing similar beliefs with clients about both the causes and treatment of mental disorders was a prerequisite to success. Wile (1977), too, believed that clients enter therapy with their own theories about their problems, how they developed, and how they are to be solved. Wile (1977) stated that ''many of the classic disputes which arise between clients and therapists can be attributed to differences in their theories of [etiology and] cure''(p. 437). Similarly, Brickman *et al.* (1982) hypothesized that ''many of the problems. . .arise from the fact that the two parties are applying models that are out of phase with one another'' (p. 375).

Erickson (1980) railed against imposing therapist's theories on clients. He instead advocated what he called utilization: ''Exploring a patient's individuality to ascertain what life learnings, experiences, and mental skills are available to deal with the problem. . . [and] then utilizing these uniquely personal internal responses to achieve therapeutic goals'' (Erickson & Rossi, 1979, p. 1). Building on Erickson's tradition of utilization, the Mental Research Institute (MRI; Watzlawick, Weakland, & Fisch, 1974) developed the concept of position, or the client's beliefs that specifically influence the presenting problem and the client's participation in therapy (Fisch, Weakland, & Segal, 1982). The MRI recommended rapid assessment of the client's position so that the therapist could tailor all intervention accordingly. Similarly, Frank and Frank (1991) suggested that ''ideally therapists should select for each patient the therapy that accords, or can be brought to accord, with the patient's personal characteristics and view of the problem'' (p. xv).

Held (1991) defines the client's informal theory as the specific ideas held by clients about the causes of their complaints. Held suggests that strategies may be selected from any model based on congruence with this informal theory. Duncan, Solovey, and Rusk (1992) demonstrate such a selection process in their ''client-directed'' approach.

Duncan and Moynihan (1994) assert that utilizing the client's theory of change facilitates a favorable relationship, increases client participation, and therefore enhances positive outcome. Duncan *et al.* (1997) view the client's theory of change as holding the keys to success regardless of the model used by the therapist, and especially with cases of multiple treatment failures. Similarly, Frank (1995) concludes, ''I'm inclined to entertain the notion that the relative efficacy of most psychotherapeutic methods depends almost exclusively on how successfully the therapist is able to make the methods fit the patient's expectations'' (p. 91).

Many scholars from a wide variety of clinical orientations tend to agree

that clients' perceptions about problem etiology and resolution are likely to impact the process and outcome of therapy. Do these hypothesized impacts have empirical support?

Attribution Research

Psychologists have increasingly investigated the role causal attributions play in therapy. Martin (1988) proposed the following question to identify the relationship between the theories of therapists and clients: ''Does the degree of similarity in client and counselor theories predict success in counseling?'' (p. 263). A growing number of studies address this question.

Claiborn, Ward, and Strong, (1981), for instance, placed clients in conditions that were discrepant and congruent with the therapist's beliefs about problem causality. Clients in the congruent condition showed greater expectations for change, achieved more change, and rated higher levels of satisfaction than those in the discrepant condition. Tracey (1988) investigated attributional congruence about responsibility for the cause of the problem, and found that agreement between the therapist and client was significantly related to client satisfaction and client change and inversely related to premature termination.

Two studies (Atkinson, Worthington, Dana, & Good, 1991; Worthington & Atkinson, 1996) found that clients' perceptions about the similarity of causal beliefs with their therapists were related to ratings of therapist credibility, how well they felt understood by the therapist, and their satisfaction with therapy. Worthington and Atkinson (1996) conclude that therapists who clients perceive to hold similar attributions of etiology are judged to be more credible and approachable. Similarly, Hayes and Wall (1998) found that treatment success depends on congruence between clients' and therapists' attributions about client responsibility for their problems. They suggest that attending carefully to clients' attributions and tailoring interventions accordingly enhances effectiveness.

These studies support the argument that therapist–client attributional similarity is beneficial to outcome.

Expectancy and Acceptability

Client expectancies about the credibility of therapeutic procedures are also important in predicting who will benefit from therapy (Frank & Frank, 1991; Lambert, 1992). For example, Safran, Heimberg, and Juster (1997) examined the expectancies of socially phobic clients regarding their pros-

pects for improving in cognitive-behavioral group treatment. They found that initial expectancy ratings accounted for a modest, but significant portion of the variance in post treatment severity of social phobia. Safran *et al.* (1997) suggest that early detection of low expectancies for treatment outcome should be a priority, even when that treatment has established efficacy in other cases.

Hester, Miller, Delaney, and Meyers (1990) compared the effectiveness of traditional alcohol treatment with a learning-based approach. Clients who believed that alcohol problems were caused by a disease were much more likely to be sober at 6 months if they had received the traditional alcoholic treatment. In contrast, clients who believed that alcohol problems were a bad habit were more likely to be successful if they had participated in the learning-based therapy. It was the match between client beliefs, expectations, and therapeutic approach that proved crucial.

At length, Crane, Griffin, and Hill (1986) found that how well treatment seemed to "fit" clients' views of their problems accounted for 35% of outcome variance. They concluded that the therapist's ability to present therapy as consistent and congruent with client expectations was critical.

A construct related to expectancy, arising from the school and behavioral consultation literature, is acceptability. Kazdin (1980) asserted that although a treatment may have demonstrated its efficacy, it may still be viewed as inappropriate, unfair, unreasonable, or too intrusive to the client. Acceptability to the client of a particular procedure is a major determinant of its use and ultimate success (Elliot, Witt, Galvin, & Peterson, 1984; Reimers, Wacker, Cooper, & De Raad, 1992; Witt & Elliot, 1985). For example, two studies (Conoley, Ivey, Conoley, Scheel, & Bishop, 1992; Scheel, Conoley, & Ivey, 1998) compared matched and unmatched intervention rationales with teachers and couples, respectively. Both studies found a greater acceptance of and compliance with treatment when rationales were congruent with clients' perceptions about themselves, the target problem, and their theory of change.

The expectancy and acceptability research points to a similar conclusion reached from the attribution literature. The credibility of a given procedure, and therefore the positive expectancy effects, is enhanced when complementary to clients' preexisting beliefs about their problem(s) and the change process.

The Alliance

Gaston (1990) partitions the alliance into four components: (1) the client's affective relationship with the therapist, (2) the client's capacity to

work in therapy purposely, (3) the therapist's empathic understanding and involvement, and (4) client–therapist agreement in the goals and tasks of therapy. While components 1 and 3 capture the relationship, Gaston suggests that items 2 and 4 refer to the congruence between the client's and the therapist's beliefs about how people change in therapy.

Accommodating the client's theory, therefore, builds a strong alliance. The therapist attends to what the client considers important, addresses what the client indicates is relevant, and tailors both in- and out-of-session intervention to accomplish goals specified by the client. The therapist and client work to construct interventions that fit with the client's experience and interpretation of the problem.

CONVERSATION, CONTENT, AND CHANGE

The word "conversation" provides a better description of exchanges with clients than the word "interview" (Goolishian & Anderson, 1987). Interviewing implies something done to clients rather than with them, and connotes an expert gathering information for evaluative purposes (e.g., diagnostic or mental status interview, matching characteristics). Consequently, interviewing provides an inaccurate description if therapy intends to be nonjudgmental, collaborative and to encourage maximum client participation (Duncan *et al.,* 1997).

Conversation, on the other hand, is the oral exchange of sentiments, observations, opinions, or ideas (*Webster's Collegiate Dictionary,* 1993). Conversation enlists clients in the exploration and discovery of possibility, defining therapy as an intimately interpersonal event committed to the client's goals. One way of looking at the conversation is to examine the content of the topics discussed.

Held (1991) defines the content of the therapeutic conversation on either formal or informal theoretical levels. Formal theory consists of either general notions regarding the cause of problems or specific explanations which must be addressed to solve problems. Clients' complaints are recast into these preconceived contents, compelling therapy down well-trodden paths flowing from the formal theory. The formal theory of the therapist enjoys a privileged position over the client's views and structures problem definition as well as outcome criteria.

Recall that informal theory involves the specific notions held by clients about the causes of their particular situations, and is necessarily highly personal (Held, 1991). Rather than recasting the client's unique views into the therapist's formal theory, we accommodate any applicable theories to the client's personal beliefs, thereby privileging the client's perceptions to

select therapeutic choices. Each client, therefore, presents the therapist with a new theory to discover and a different path to cut.

Therapist allegiance to any particular theoretical content involves a tradeoff that simultaneously enables and restricts options. Theoretical loyalty provides direction, but is inherently limited; theoretical anarchy enables flexibility, but also inserts uncertainty. All therapists have their preferences, but there are no fixed and correct ideas or methods that run across situations that clients bring to therapy, and therefore no inherently right ways to conduct therapy. As mind-boggling as it sounds and as frightening as it feels, such a view opens unlimited possibilities for change.

It is this indeterminacy that gives therapy its texture and infuses it with the excitement of discovery. Given this indeterminacy, a purpose of the conversation is to make explicit the client's perspectives specifically related to change. Spotlighting the client's ideas requires a focused effort to follow the client's lead regarding the content of the conversation.

Therapy begins by inviting clients to tell their stories: "What brings you here today?." In the course of telling their stories, clients unfold their experiences, their philosophies of life, their reasons for living—or not wanting to. The heroes, heroines, villains, and plot lines are revealed as clients tell the comedies, tragedies, and triumphs of their lives. This adventure story sets the content parameters of the therapist's questions. The therapist learns and converses in the client's language because the words the client uses represent an edited commentary of the client's view of life. Clients are novelists who carefully choose words to convey their story in a specific light.

Therapist questions stay within the client's content frame and add to it as it unfolds over time. Questions impose minimal therapist content and allow maximum space for the client to find new connections, distinctions, and meanings. Questions are not designed to influence particular meanings or other theory-based realities, but rather to invite the client's verbal and nonverbal reactions to and descriptions of the concerns that initiated therapy. A candid exchange between the therapist and client evolves, resulting in a collaborative formulation of what will be addressed, criteria for successful resolution, and how therapy will proceed.

The client's judgment regarding experiences that are relevant for discussion and revision is respected. The therapist is an active participant and draws upon possibly relevant ideas to interject into the conversation. This input grows into meaningful dialogue or fades away depending upon the client's response. Studious attention to client reactions to therapist-generated content provides guidance to what the client finds important. Client enthusiasm about particular ideas informs the choice of what is next in the conversation. Therapists' moment to moment experiences of what enlivens clients and brightens their participation mediates the next step and so on.

When introducing ideas to the conversation, we keep three things in mind. While we all have our personal favorites, those preferences are discarded like yesterday's news if the idea does not enlist clients' strengths or rally their energies to address their concerns. Second, any idea must explicitly accept what the client wants and provide an option that addresses the client's desires. If an idea does not pass that acid test, then it is discarded as quickly as sour milk. Finally, and reiterating, we rely on the client's hearty reception to therapist ideas. If the client does not enthusiastically endorse the idea, it is abandoned like a blind date with a "born to lose" tattoo. Reliance on a warm reception not only continues the client's intimate involvement, it immerses the client into a collaborative pool of possibilities from which the client can emerge with ownership of the ideas.

Checking-out questions, or questions verifying that therapy is on the right track and addressing key issues, are liberally sprinkled in the conversational recipe to insure clients find dialogue delicious and whet their appetites for change. Process and outcome measures contribute to the conversation. All scoring and interpretation of the instruments is done *with* the clients, giving clients a new way to look at and comment on their own progress in therapy. Assessment, therefore, does not precede and dictate intervention, but is a pivotal component to the therapeutic relationship and change itself.

Therapy, then, uniquely intertwines the client's perceptions with ideas arising in therapy, forming a theory of change that explains and predicts the client's specific circumstance. The ultimate client matching variable, from this perspective, is this evolved theory of change. Clients are, in essence, in "charge" of the content and their lives, while therapists are in "charge" of unfolding that content and channeling it toward change. The matching decision is based entirely on the content-rich description of change possibilities that unfolds from the therapist–client conversation.

Learning the Client's Theory: Practical Guidelines

Within the client is a uniquely personal theory of change waiting for discovery, a framework for intervention to be unfolded and utilized for a successful outcome. To learn clients' theories, we must adopt their views in their terms with a very strong bias in their favor. We seek a pristine understanding of a close encounter with the client's unique interpretations and cultural experiences.

We begin by listening closely to the client's language and recommend taking notes so that the exact words that clients choose to describe problems and their desires for treatment can be recorded. Taking notes, when done unobtrusively, conveys therapist interest in, as well as the importance of,

the client's input. Clients are shown the notes or can make copies if they desire. Using clients' language privileges their idiosyncratic understandings, and conveys to clients the importance of their ideas and participation. It represents one more way for therapists to keep clients center stage, respect their contribution to change, and build on what clients already know (Miller *et al.,* 1997).

After direct inquiries about the client's goals for treatment are made, questions regarding his or her ideas about intervention are asked. What the client wants from treatment and how those goals can be accomplished may be the most important pieces of information that can be obtained. We embrace the strong probability that clients not only have all that is necessary to resolve problems, but also may have a very good idea about how to do it. Questions that elicit the client's hunches and educated guesses encourage participation, emphasize the client's input, and provide direct access to the client's theory of change.

- What ideas do you have about what needs to happen for improvement to occur?
- Many times people have a pretty good hunch about not only what is causing a problem, but also what will resolve it. Do you have a theory of how change is going to happen here?
- In what ways do you see me and this process helpful to attaining your goals?

It is also helpful simply to listen for or inquire about the client's usual method of or experience with change. The credibility of a procedure is enhanced when it is based on, paired with, or elicits a previously successful experience of the client.

- How does change usually happen in the client's life?
- What does the client and others do to initiate change?

Finally, discussion of prior solutions also provides an excellent way for learning the client's preferred modus operandi. Exploring solution attempts enables the therapist to hear the client's frank evaluation of previous attempts and their fit with what the client believes to be helpful.

- What have you tried to help the problem/situation so far? Did it help? How did it help? Why didn't it help?

Given the frequent hyping of the method of the month, there is a temptation to turn an idea like the client's theory of change into one more invariant prescription. Ask what they would like to do (or prescribe a ritual, finger waving, or etc.) and watch the miracles roll out the office door! All cases will not blossom from the first question about the client's theory. The

client's theory of change is an "emergent reality" that unfolds from a conversation structured by the therapist's curiosity about the client's ideas, attitudes, and speculations about change.

Further, centering the client's perspective does not prohibit the therapist from offering ideas or suggestions, or contributing to the construction of the client's theory of change. Exploration for and discovery of the client's theory is a coevolutionary process, a criss-crossing of ideas that generates a seamless connection of socially constructed meanings. The degree and intensity of therapist input varies and is driven by the client's expectations of the therapist's role.

Selecting Content

Since it is an idiosyncratic process that begins with no preconceived notions of theoretical correctness, describing how to integrate different approaches via the client's theory of change is challenging. Trust in the process of therapy and faith in the resources of clients is a necessary prerequisite. While clients may come to therapy at low ebb, demoralized, defeated, and confused, it is not naive to assume that they know what is best for them.

Honoring the client's theory occurs when a given therapeutic procedure fits or complements clients' preexisting beliefs about their problems and the change process. We therefore simply listen and then amplify the stories, experiences, and interpretations that clients offer about their problems as well as their thoughts, feelings, and ideas about how those problems might be best addressed. As the client's theory evolves, we implement the client's identified solutions or seek an approach that both fits the client's theory and provides possibilities for change.

It is not the correct or corrective nature of selected content that is important, but rather the relationship between the content and the client's theory of change that provides change potential. The therapist can respond to the client from a number of content sources: (1) specific problems, (2) specific approaches, and most likely (3) solely from the client's descriptions and experiences. Each of these sources is described below and illustrated by case examples. The cases are not intended to capture the subtleties and complexities of the interpersonal event called therapy, but only to illustrate the three content areas. Consequently the cases do not adequately showcase the clients' contributions or highlight the importance of the alliance.

Specific problems are made up of generic response patterns and particular areas of concern. Generic response patterns (e.g., the grief process, rape trauma, posttraumatic stress, etc.) describe typical phases of response

to developmental transitions or incidental crises. Likewise, content derived from a particular area of concern (e.g., anxiety, AIDS, etc.) may provide an organizing framework for the introduction of ideas to the conversation.

Pat, a 38-year-old homemaker, was referred by her child's principal because Pat had ruffled feathers at the school with her ardent concerns about her 9-year-old daughter's genetically transmitted depression. The school did not agree with Pat's assessment and saw her as the problem. She cited her own history of depression, as well as her own mother's depression history, as evidence of her conclusion. Pat, a loving mother, feared that her daughter would be doomed to the bouts of depression that had terrorized the previous two generations. The client's beliefs about the biological, genetic risk to her daughter and her desire to help served as a framework for the conversation, the theory that directed the process.

The therapist utilized content derived from a biological/genetic depression perspective, and linked it to a diathesis-stress paradigm (Davison & Neale, 1986). The therapist suggested that, given the familial predisposition to depression, environmental factors could be critical in the expression of the predisposition. With this framework in place, the therapist and client problem-solved ways Pat could assist her child in learning how to cope with her depression. She successfully implemented a creative version of the discussion with the therapist and reported that her daughter seemed happier. Pat also added that perhaps her daughter was only mildly predisposed to depression.

With some complaints, the efficacy of particular approaches has been established. Attending to the literature and selecting interventions associated with successful outcomes provides options to discuss with clients. Similarly, should the client's presentation appear congruent with a particular theoretical orientation, or the client request a specific approach, the therapist may use that approach to provide input and direction. As we have emphasized, though, regardless of how well the selected content (technique or approach) is supported by research, tradition, and/or clinical literature, client acceptance is the critical variable.

Stacey, a very bright marketing representative in her early 30s described having "episodes" in which she felt panicky and sometimes cried for hours on end. She reported that the episodes capped off a night laden with nightmares. Stacey intimated that she was horribly damaged from something in her past and that her dreams held the key.

Following her vision of change to its logical conclusion, the therapist offered several approaches to interpreting Stacey's nightmares. Stacey chose one that resembled something she had read about in a self-help book. This is the essence of honoring the client's theory of change—to follow the client's preferences, trusting that it will evolve into change possibilities.

And it did. With each dream that was discussed, Stacey remembered more events from her childhood until she concluded that her dad had sexually abused her. Stacey was a sensational young woman bound and determined to find the truth about her troubled past. She took that information, just as she said she would, and channeled it into dealing with her life better. Her nightmares stopped and she reported being no longer intimidated by her father, or other men.

Content, then, is only the vehicle through which the conversation flows and possibilities arise. EVTs and specific approaches are merely lenses to try on that may or may not fit the frame and prescription requirements of the client. In this way, methods and models are neither deified nor demonized, but are useful adjuncts that offer metaphorical accounts of how people can change.

The third and most prevalent source of content is that generated solely by the client. In these cases, possibilities arise without therapist introduction of formal content of any kind. For 10 years, Bill, a courageous 26-year-old truck driver, had become increasing distressed by thoughts of having sex with young boys. Although he had never acted on his thoughts, Bill described himself as a pedophile and shared that he was considering chemical castration. Bill's theory of change was that finding a relationship would eliminate the thoughts. Consequently, the therapist worked with Bill on methods to meet women.

No outside content was introduced. Bill's theory evolved throughout the process as he made new discoveries and practiced new behaviors. As he met women and noticed his attraction, he changed his self-diagnosis from pedophile to fantasizer and learned that he could change his fantasies from children to women. The emergent process of the therapy intertwined with Bill's ideas to produce a theory that was helpful for his unique circumstance. Recent follow-up revealed Bill's continued attraction to, and pursuit of, women.

CONCLUSIONS

This article asserted that the client's map provides the best guide to the therapeutic territory. The therapist is a coadventurer, exploring the landscape and encountering multiple vantagepoints while crossing the terrain of the client's theory of change. When stuck along the way, we join clients in looking for and exploring alternate routes on their own maps. In the process, clients uncover trails we never dreamed existed.

We do not follow this map only to gain rapport, although it most certainly woos the client's participation, or to gain compliance with treat-

ment, although it likely courts a favorable impression. We honor the client's theory of change, and in that process, a modus operandi evolves and possibilities emerge to overcome the client's difficulties.

Historically, mental health discourse has relegated clients to playing nameless, faceless parts in therapeutic change. This is giving way. No longer interchangeable cardboard cutouts, identified only by diagnosis or problem type, clients emerge as the true heroes and heroines of the therapeutic stage. This article proposed that the client's theory of change offers ways of integrating multiple therapy perspectives. Honoring the client's theory of change is a proactive initiative that requires the conduct of therapy within the client's ideas and circumstances. Since model and technique only represent 15% of outcome variance, they are perhaps best viewed as content areas, metaphorical possibilities that may or may not prove useful.

It is time to recast the drama of therapy. All the stories—written, edited, and directed by and for therapists—recanting the tale of the epic heroic therapist high atop a charging white stallion of theoretical purity and technical proficiency rescuing the one-dimensional, dimwitted, but tragically pathological client are, we hope, soon to go out of print. The client's voice, formally utilized in all aspects of therapy, establishes an entirely different drama of change—a drama in which the leading character is given full editorial and directorial control of the action as it unfolds.

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