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CORRECTIVE EXPERIENCES IN PSYCHOTHERAPY: DEFINITIONS, PROCESSES, CONSEQUENCES, AND RESEARCH DIRECTIONS

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After 5 years of conceptualizing, investigating, and writing about corrective experiences (CEs), we (the authors of this chapter) met to talk about what we learned. In this chapter, we summarize our joint understanding of (a) the definition of CEs; (b) the contexts in which CEs occur; (c) client, therapist, and external factors that facilitate CEs; (d) the consequences of CEs; and (e) ideas for future theoretical, clinical, empirical, and training directions. As will become evident, the authors of this chapter, who represent a range of theoretical orientations, reached consensus on some CE-related topics but encountered controversy and lively debate about other topics.

WHAT ARE CORRECTIVE EXPERIENCES?

Although we based our discussions, as well as the chapters in this book, on the definition presented in Chapter 1, additional thoughts emerged from considering and investigating this construct. Currently, we understand CEs in psychotherapy to involve a disconfirmation of a client's conscious or unconscious expectations (see Chapters 3 and 4) as well as an emotional,

interpersonal, cognitive, and/or behavioral shift. In CEs, clients typically reencounter previously unresolved conflicts (see the Alexander & French, 1946, definition) or previously feared situations (whether internal or external) but reach a new outcome in terms of their own responses, the reactions of others, or new ways of interacting with others.

Despite consensus on this broad definition of CEs, we debated the details. Some authors argued that the correction needs to include new behaviors, whereas others argued that the correction may consist solely of new internal experiences. We finally agreed to distinguish two types of CEs. *Type 1 CEs* are new or unexpected thoughts, emotions, sensations, behaviors, or feelings about one's self that result from the client encountering an event that is different from (and thus disconfirming of) his or her frame of reference. In Chapter 10, for example, Heatherington et al. reported that 30% to 40% of clients identified this type of "new experiential awareness" as a salient change event. In such events, it could be that the client behaves as he or she always has but the therapist responds differently than have other influential people in the client's life, which leads the client to experience differently, and perhaps reevaluate, self and/or others. Relatedly, Farber, Bohart, and Stiles, in Chapter 7, noted that Gloria (in the *Three Approaches to Psychotherapy* videos; Shostrom, 1965) appeared to feel close to Carl Rogers when she disclosed that she would have welcomed him as her father. He responded that she "would make a pretty good daughter." This moment seemed very meaningful for Gloria, disconfirming her expectations of men.

In *Type 2 CEs*, the client actively does something different in situations that typically have triggered apprehension and negative emotion, leading to a new outcome. In support of this type of CE, Heatherington et al. (Chapter 10) reported that 41% to 48% of clients undergoing primarily cognitive behavior therapy (CBT) and combined CBT and integrative therapy identified a change in behavior as a significant shift event. Although both CE subtypes involve outcomes that challenge previously negative expectations, Type 2 CEs involve clients taking action and trying out new behaviors outside of the therapeutic relationship. Type 2 CEs can occur with others outside of therapy and can involve situations in which individuals face their fears (e.g., in exposure) and learn that nothing bad happens. They learn that they can handle the feared situation and are thus more likely to approach such situations in the future.

The two types of CEs can certainly be interrelated. Type 1 CEs may have a motivating effect that allows clients to try out new behaviors, as the therapist's reactions result in a greater sense of trust. In an analogous manner, the ongoing experiencing of Type 2 CEs, either repeated in a single context or across a broad range of interpersonal relationships, may catalyze significant emotional or cognitive shifts. Behaving differently thus disconfirms a client's

previously held negative expectations of self and others. This disconfirmation of negative self–other expectations, as well as positive shifts in emotion and self-concept, contributes to what is corrective in a CE event. In short, CEs can lead to behavioral changes, and behavioral changes can lead to significant shifts in cognition and emotion.

We also discussed the potency of CEs. Whereas the classic characterization views CEs as sudden and immediately life changing, some of us thought that CEs result in lasting change only if repeated or only if one CE leads to other CEs in a synergistic way. For example, an in-session CE may be followed by the client trying out new behaviors outside the session, which then might result in another CE, and so forth, promoting an eventual consolidation of changes (e.g., the case presented by Berman et al. in Chapter 12, in which "Kate" became progressively more assertive in confronting relationship issues). There may thus be a tipping point at which CEs result in lasting change.

Some of us were also mindful that the change evoked through CEs is not always linear, given that clients often take one step back after taking two steps forward. As Caspar and Berger noted in Chapter 9, clients have a tendency to return to familiar ways of reacting and behaving, which impedes change and requires therapists to recreate favorable conditions under which clients can again seek to tolerate previously intolerable experiences. Therapists often have to follow up and help clients identify the personal impacts and meanings of their CE experiences to help them consolidate their gains and articulate or solidify their new views of self (Chapter 2, by Goldfried), which could increase their hopes and expectations for positive future outcomes (White, 2007).

We did not reach consensus as to whether a CE is a discrete event or an accretion based on an overall therapeutic relationship. Some empirical evidence that a majority of CEs are discrete events comes from Anderson, Ogles, Heckman, and MacFarlane (Chapter 14), who found that 14 of 21 (66%) clients identified a CE that was a discrete enough event that it could be located in a session (or in a distinct moment if it occurred outside of therapy). Castonguay et al. (Chapter 13) also identified four specific CE events, two in each of the treatments (CBT and interpersonal–emotional processing) conducted by the same therapist with the same client. In contrast, Knox et al. (Chapter 11) found several events that were very broad and transpired across multiple sessions (with one taking place over 2 years).

We also debated how to distinguish CEs from insight or awareness. Many of us believed that insight can precede, be part of, or follow CEs but that there could also be CEs without awareness or insight into the new reactions to previously feared or apprehended situations. Similarly, we debated and then concluded that CEs could be an outcome of therapy, a mechanism of change leading to an outcome, or simply the process of successful treatment, such that good therapy is a succession of CEs.

Thus, although we reached some shared understanding of the nature of CEs, we by no means came to a clear consensus, reflecting the complexity of this construct and the heterogeneity of our theoretical perspectives. For the remainder of this chapter, however, we continue to define CEs as events or experiences that are unexpected and result in a major shift of some kind.

IN WHAT CONTEXTS DO CORRECTIVE EXPERIENCES OCCUR?

We agreed that for CEs to occur, there generally needs to be a well-established therapeutic alliance that provides safety and trust. At times, a positive alliance is established rapidly, and CEs occur even during the first therapy session; at other times, they may take longer to happen. There may even be instances in which a CE occurs in the context of an initially poor alliance and then facilitates the development of a better alliance (see Christian, Safran, & Muran, Chapter 4). In addition, most of us believe that CEs also occur in contexts other than the therapeutic relationship. For example, CEs often occur in relationships with friends, family, and significant others, and sometimes people can have CEs based on their own internal experiences.

WHICH CLIENT FACTORS CONTRIBUTE TO CORRECTIVE EXPERIENCES?

Berman et al., in Chapter 12, provided evidence that three different clients seen by the same therapist had very different amounts and types of CEs. This finding suggests that client variables need to be considered when we think about CEs.

We all strongly believed that clients are active agents in the generation of CEs. Therapists may set the stage for CEs (by providing the facilitative conditions, challenging, interpreting, providing necessary information), but they do not provide the experiential changes associated with a CE. Clients must be motivated to change; willing to face difficult situations; and willing to take risks to overcome avoidance, ambivalence, or reluctance. In addition, clients must be actively engaged in the therapeutic interaction; attend to their own and their therapist's reactions; and be willing to learn and practice new, more adaptive responses to previously avoided experiences. Of course, clients' active involvement in activities outside of sessions could also promote CEs and help them apply what they learned in therapy to their lives.

Some of us also thought that for CEs to take place, clients' fears, expectations, and maladaptive emotional responses must be activated and

challenged in some way. Such a process is often associated with a period of disjunction, turbulence, anxiety, or other negative emotions (see Hayes, Beck, & Yasinski, Chapter 5; and Caspar & Berger, Chapter 9). The turbulence could arise either inside or outside of session, setting the stage for the occurrence of a CE. On the other hand, the level of arousal should probably not be too high, so as not to exceed what clients can currently tolerate. Relatedly, some authors argued that clients' awareness of, and insight related to, their maladaptive expectations, emotions, and/or patterns of reacting could facilitate their willingness to take risks and engage in new and corrective experiences.

We debated how much clients must verbalize and overtly make sense of CEs (including CEs that happen outside of sessions) for such experiences to have lasting impact. As mentioned earlier, we speculated that some CEs happen outside of client awareness (as in latent learning) and yet could still be manifested through behavioral change. This reasoning suggests that some CEs may become fodder for therapy discussions, whereas others may not, yet both types potentially can be therapeutic for clients.

WHICH THERAPIST VARIABLES SET THE STAGE FOR CORRECTIVE EXPERIENCES?

Therapists can set the stage for CEs by providing facilitative conditions (e.g., acceptance, empathy, genuineness, openness, willingness to engage with the client) and by implementing specific interventions (e.g., reflections of feeling, self-disclosure, support, normalizing fears, reinforcing change, two-chair role plays, educating clients about the therapy process and their contribution to their difficulties, interpretation, immediacy, exposure exercises, modeling, skill training, cognitive restructuring). We all agreed, however, that there are no particular therapist behaviors that inevitably lead to CEs.

Some authors thought that CEs are particularly likely to occur when the therapist takes a risk to do something unusual, bold, or perhaps even benevolently shocking, such as using reframing interventions or giving personal disclosures that convey emotionally immediate and empathic attunement to the client's present need (e.g., when the therapist said "Let me" to a client when she wanted the therapist to take care of her; Knox et al., Chapter 11). In contrast, some authors argued that therapists might facilitate a CE simply by being different from important others in clients' lives or by behaving differently from what clients expect (e.g., using supportive rather than confrontational interventions early in treatment). Similarly, the CE taxonomy presented by Anderson et al. in Chapter 14 included categories of CEs prompted

externally by dramatic therapist behaviors or by therapists who, in a variety of more benign behaviors, facilitated the unfolding of the client's internal discovery. Whether by using disarming interventions or by enacting a general way of being and relating, therapists may introduce a sense of uncertainty, dissonance, or the unexpected, and thus foster CEs. The overarching notion, then, is that therapists pose an alternative, a disconfirmation, a challenge, or an unexpected frame of reference to the client's personal understanding of self and other that within the context of the healing therapy relationship enables the client to change to resolve the dissonance.

In addition, some authors emphasized the importance of therapist persistence. Because CEs require that clients face a situation from which they expect a painful and/or threatening outcome, resistance or defensiveness is to be expected. Thus, therapists need not retreat from clients' initial hesitance. Extremely important, however, is that therapists show tact and timing, remaining responsive and attuned to the client's immediate needs. To paraphrase Geller (2005), *therapeutic tact* is the capacity to tell clients something they do not want to hear in a manner in which they can hear it. Sometimes the combination of therapist persistence, tact, and attunement can also lead clients to recognize and voice maladaptive patterns that they have perpetuated out of fear; if such client recognition is acknowledged with support and empathy by the therapist, that in and of itself can be a powerful and potentially corrective experience. This effect was illustrated by Castonguay et al. in Chapter 13 when a therapist noted the impact of the client's repeated refusal to answer the therapist's questions. This challenge led the client to acknowledge that his controlling of the content and quality of what he revealed in therapy ("smoke screening") was his way of avoiding being criticized by the therapist. Compassionate persistence on the therapist's part was needed to help the client begin to approach a painful topic.

We also agreed that therapists need to responsively tailor their interventions to the client's needs, which may change over the course of therapy or even within a specific episode during treatment. For example, therapists may need to understand and validate a client's negative expectations before attempting to disconfirm these expectations (Constantino & Westra, Chapter 8). A therapist might, for instance, see potential in a client and be optimistic about treatment, but such hope may not necessarily resonate with the client; the therapist's positive view of the client might be too discrepant with the client's view of self, leading the client to refute, distort, and misinterpret the therapist's message. As suggested above, then, it may be that only after the client feels validated and understood that the therapist can be experienced as credible enough to provide a meaningful foundation for the occurrence of a CE.

HOW DO EXTERNAL FACTORS CONTRIBUTE TO CORRECTIVE EXPERIENCES?

We discussed the role of support networks in enabling clients to engage in and/or make use of CEs. Some authors thought, for instance, that the attachment to and support from significant others could be facilitative. In addition, for clients who lack good interpersonal relationships, a CE that involves changing maladaptive ways of being with and relating to others may help the client obtain a more adaptive social network.

External factors might also, however, restrict clients from making full use of CEs. For example, a client may have a CE in a treatment session but might not have the opportunity to generalize, elaborate, or consolidate the CE outside therapy. In addition, family structure, cultural traditions, and economic considerations may all impede the full realization of CEs (e.g., significant others might actively oppose the change or tacitly sabotage it). Thus, the input of others might undermine the therapist's input, and unless these powerful influences are addressed, the client's typical ways of relating to and experiencing self and other might remain intact despite the therapist's best efforts. Such stagnation may be particularly likely for clients whose difficulties are situated within the context of a strongly entrenched family system. From the perspective of the models proposed by Caspar and Berger in Chapter 9, the environment has a crucial impact on the chance that new patterns will have a lasting corrective effect.

On the other hand, some of us have observed that CEs in therapy often interact positively with clients' external life events or relationships with important others. For example, a CE involving greater awareness of primary emotions, such as sadness, love, or curiosity, can help a client open up to previously overlooked possibilities for deeper, more authentic relationships offered by significant others (Greenberg & Elliott, Chapter 6). Similarly, others may react positively to and thus reinforce tentative signs of client change emerging out of CEs. Indeed, Heatherington et al. (Chapter 10) found that clients spontaneously described external contributors to CEs about 5% of the time.

WHAT ARE THE CONSEQUENCES OF CORRECTIVE EXPERIENCES?

We had fairly good consensus that the changes that clients make as a result of CEs include the full range of changes seen in successful therapy. One way of summarizing such changes is to note that clients often move from a position of being (a) unconsciously incompetent to (b) consciously incompetent to (c) consciously competent to (d) unconsciously competent

(Bateson, 1973; see also Goldfried, Chapter 2, this volume). Similarly, Caspar and Berger, in Chapter 9, proposed that the change process involves a deautomatization, followed by an increased awareness and conscious functioning, and then a reautomatization in a more adaptive way.

Many CE-related changes are intrapersonal. Some of these changes are immediate, such as a client gaining a sense of relief or acquiring sudden insight. Yet CEs may also lead to more gradual internal changes, such as greater self-control, increased sense of agency and choice, increased willingness to take risks, empowerment, and hopefulness. These changes may involve acceptance (e.g., when circumstances cannot be changed or one cannot repair a relationship). Such acceptance could correct the client's illusion that the world inevitably thwarts what he or she seeks, that a person can be happy all of the time (i.e., never feel anxious or sad), or that a person can have complete control over his or her life. There are also likely to be longer term intrapersonal changes, such as symptom reduction, especially when reduction of anxiety and avoidance occur after CEs. A new view of self, increased cognitive and emotional flexibility, and personality change may also emerge. As part of such longer term changes, clients may learn to tolerate mistakes and accept that not only do they not need to be perfect but that life itself is inherently imperfect. They may also allow themselves to experience previously disavowed affects, have greater tolerance of unacceptable thoughts, be more able to self-soothe, and accept themselves in appropriate ways (Greenberg & Elliott, Chapter 6; and Farber et al., Chapter 7).

Another set of consequences associated with CEs involves positive changes in the therapeutic relationship and therapy process. CEs may lead to increased client confidence in the therapeutic relationship and a deepening of the bond and greater intimacy, which then allow the therapist and client to work together in more profound ways. In addition, CEs may lower client anxiety and heighten client self-efficacy in session, which may enhance the client's willingness to disclose and communicate, as well as decrease the likelihood of terminating prematurely.

Relatedly, client CEs may affect the therapist by providing a better understanding of the client's internal world and interactions with others (Sharpless & Barber, Chapter 3). In addition, CEs can help the therapist become more responsive to clients, better identify and process client maladaptive patterns, and more effectively teach and/or reinforce adaptive patterns of client behavior. Furthermore, the awareness of a client's CE may feel personally and professionally affirming, providing a powerful reinforcer of the therapist's efforts.

In addition, CEs can lead to adaptive client changes in relationships with others. Clients may modify their expectations of others and revise their self–other models, enabling them to be more adaptive and flexible in

relationships, which may increase the likelihood that others will respond to them in ways that reinforce these new behaviors. CEs might also afford clients an improved ability to receive and initiate a range of relationship overtures without a significant threat to self. And, for clients who are therapists-in-training, CEs may help them empathize more and be more able to facilitate CEs in their role as therapists with their own clients.

With regard to long-term consequences of CEs, we believed that CEs can build on each other but that it may take a while for a client to have the opportunity (or the willingness) to make use of a CE. Furthermore, small or preliminary experiences that are inconsistent with previous ways of reacting to threatening or difficult events can set the stage for later and more dramatic, explicit, and enduring shifts in being or relating with others. Conversely, CEs may fade if clients do not use and elaborate upon them. Even emotionally powerful epiphanies tend not to be lasting unless they are consolidated. In addition, for CEs to be consolidated or generalized, not only do clients have to react differently (cognitively, emotionally, and/or behaviorally), but others (including the therapist) may need to consistently respond differently to clients' new behaviors, and clients may need to realize that others have indeed changed in how they respond.

IMPLICATIONS FOR DEFINITION, RESEARCH, PRACTICE, AND TRAINING

Implications for the Definition of Corrective Experiences

The chapters in this book represent a considerable range of alternative conceptualizations of CEs. Unsurprisingly, then, our discussions left us with many questions regarding the definition and theoretical understanding of CEs. For example, how do CEs differ from insight, perceived helpfulness, good therapy, or mastery? Are most CEs observable, or do many of them develop more covertly over time? What is the threshold for considering an event to be a CE? That is, when does an in-session event rise to the level of a CE? What intensity is needed to be considered a CE? What are the necessary components of CEs, and do these differ for Type 1 CEs (resulting from encountering an event that disconfirms one's expectations or fears) and Type 2 CEs (resulting from doing something that disconfirms one's expectations or fears)? In other words, what are the outer boundaries of CEs?

We also wondered about good-enough moments that might produce CEs, when CEs may generalize to life outside of therapy, and what maintains a CE or makes it enduring. Is affect needed for a CE to occur or endure? How might CEs occur differently in diverse therapeutic orientations (e.g., psychodynamic,

cognitive–behavioral, experiential) or different modalities (e.g., group therapy, conjoint family therapy, child therapy)? Can we predict when CEs will occur? How does the therapeutic relationship interact with CEs? Do CEs need to occur rarely to have power, or can "good therapy" simply be understood as a continuous CE?

Ladany et al., in Chapter 16, offered perspectives on how CEs are manifested within the supervisory process. It is interesting to note that many of the aforementioned process variables identified (e.g., members in the dyad, outcomes) were evident in the supervision CEs, although the content of CEs in supervision seemed different from those in therapy. Hence, further exploration of how CEs differ in psychotherapy and supervision is warranted.

Implications for Research on Training

Methodological Challenges

A major methodological issue is the perspective from which the data are gathered. Would we obtain different results if CEs were assessed by clients, therapists, and observers? It was also suggested that when we ask clients about CEs could make a difference (i.e., the longer after the event the questioning occurs, the more likely that the client's memory would be a reconstruction of events rather than a recall of the experience).

Several of us conducted studies in which clients were asked about their CEs; however, specific procedures varied across studies, so results also likewise varied. For example, Heatherington et al. (Chapter 10) used an open-ended self-report questionnaire to ask clients the following:

> Have there been any times since you started the present therapy that you have become aware of an important or meaningful change (or changes) in your thinking, feeling, behavior, or relationships? . . . If yes, what do you believe took place during or between your therapy sessions that led to such change (or changes)?

In contrast, Knox et al., in Chapter 11, used a semistructured interview to ask clients to reflect retrospectively about CEs after therapy was over; similarly, in Chapter 16, Ladany et al. used a semistructured interview to ask supervisees about their experiences of CEs in supervision. In Chapter 14, Anderson et al. combined these methods by interviewing clients posttherapy and then having judges search through sessions to find the CEs. Finally, Berman et al. and Castonguay et al. (Chapters 12 and 13, respectively) had observers examine sessions to identify and analyze CE or corrective relational experiences.

Obviously, these different methods yield different types of results. We acknowledged the possible impact of differing demand characteristics posed

by the study questions and procedures and noted that simply asking about CEs may bring them into awareness for clients in a way that might not otherwise occur. At the same time, we wondered to what extent the researchers' and the clients' understanding of the term *CE* was similar.

We also wondered whether the best way to investigate CEs is by having trained judges observe live or videotaped sessions. Farber et al. (Chapter 7) suggested that one could tell that Gloria had a CE by a change in her eyes and tears welling up, but we cannot count on similar evidence arising across all clients. Furthermore, trained judges may not be able to observe all the CEs that take place in the treatments and are undoubtedly biased by their own personal reactions as to what a CE would be like for them.

One suggestion to address some of these methodological concerns was to use interpersonal process recall (Kagan, 1975) or brief structured recall (Elliott & Shapiro, 1988) to help clients describe what occurred for them at the time of the CE. Thus, for example, researchers could use the Helpful Aspects of Therapy Form (Llewelyn, 1988) to identify sessions in which CEs are likely to have happened and then interview clients and therapists using interpersonal process recall about the CE precipitants and consequences. As one possible multiperspective design, researchers could videotape sessions and have clients observe the video and recall their CE-related experiences, have trained judges code those events, and have therapists recall them as well. Likewise, researchers could use consensual qualitative research for cases (Jackson, Chui, & Hill, 2012) to analyze the richness of event-based data. Task analysis (see Greenberg, 2007) is also likely to be a good approach for developing, refining, and testing theories about the developmental process of CEs. In addition, observer-based coding systems that explicitly focus on the emergence of unexpected outcome narratives (White, 2007) in videotaped therapy sessions (Boritz, Angus, & Bryntwick, 2010; Gonçalves, Matos, & Santos, 2009) might also provide a promising research strategy for identifying what contributes to CEs.

Research Ideas

The following listing describes a few of the many research ideas we generated.

1. Researchers could assess whether hope is both a crucial indicator and an outcome of CEs.
2. Researchers could assess to what extent CEs relate to therapy outcome. For example, are CEs necessary and sufficient for change or improvement at termination and follow-up evaluations? What is the relative contribution of singular CEs, the number of CEs, and the timing of CEs in predicting outcome?

What are the mechanisms or pathways by which CEs lead to positive outcomes?

3. Rates of occurrence of Type 1 CEs versus Type 2 CEs could be compared, along with any differences in impact over time. Researchers could also compare rates of Type 1 and Type 2 CEs in different theoretical approaches to therapy. Do Type 1 and Type 2 CEs build on one another in a continuous and linear fashion? Do clients develop a new view of self and others as a consequence of experiencing either a Type 1 or Type 2 CE in therapy?
4. Are there other types of CEs? Can these types be distinguished empirically?
5. Researchers could assess the relationship between insight and CEs.
6. The sequence of steps leading to CEs could be examined to construct models of the process of CEs. Researchers could investigate which client and therapist characteristics are most predictive of CEs, as well as whether there are interactions among client, therapist, technique, and relationship variables that foster CEs (i.e., aptitude–treatment interactions).
7. Researchers could interview people who had successful therapy but who identify no CEs to determine what occurred in therapy that was helpful in the absence of CEs.
8. Researchers could test the assumption that CEs must involve new and unexpected reactions, perhaps by having judges observe nonverbal or verbal indicators of surprise as markers (e.g., "feels strange") or through client reports of surprise or newness.
9. Researchers could examine the relationship of the occurrence of CEs inside and outside of sessions. The nature, frequency, and impact of CEs occurring inside and outside therapy settings could be compared.
10. The effects of clients' CEs on friends and family members could be studied.
11. Researchers could investigate the impact of discussing CEs. Do clients need to explicitly process CEs to consolidate them? Are there individual differences in the impact of focusing attention on CEs? For example, some clients may feel that the therapist is taking the experience away if CEs are discussed too much, whereas other clients may need to process CEs to consolidate them or to help them happen again.
12. Researchers could search for a tipping point in the accumulation of CEs: How many CEs are needed, and does subtype

matter (Type 1 and/or Type 2)? Do CEs involving a small accretion or a "big bang" have different effects (see Chapter 15)?

13. Researchers could look for associations between CEs and other productive process variables, such as good moments (Mahrer, Dessaulles, Nadler, Gervaize, & Sterner, 1987), helpful significant events (Elliott, 2010), innovative moments (Gonçalves et al., 2009), unexpected outcome stories (Angus & Greenberg, 2011), rupture resolution (Safran & Muran, 1996), or relational depth events (Wiggins, Elliott, & Cooper, in press). Findings would provide evidence of construct validity for CEs.

Implications for Practice

Therapists across many approaches view CEs as desirable events to be encouraged or facilitated. Not all of the consequences of CEs, however, are positive, and thus therapists need to be aware that they may need to help clients manage the powerful experiences evoked by CEs.

Furthermore, the notion that CEs are client experiences that are often cocreated by the client and therapist has implications for practice. Given that these events are not something a therapist does to a client (i.e., metaphorically, therapists are midwives of CEs, not surgeons), the therapist works to set a favorable atmosphere in which CEs might take hold. The therapist's objective is thus to create favorable conditions (e.g., a safe relationship, implementation of specific techniques) for effective work to take place, and then to validate and encourage the client to grow and change. In such fertile soil, CEs may grow.

Once these favorable conditions are in place, however, there may still be times when the therapist needs to intervene to destabilize the client in order to facilitate the occurrence of CEs. How might this be done? Therapists might, for instance, facilitate CEs by providing clients with a rationale for intervening in a way that may be incongruent with the client's expectation for how people typically react to him or her. Furthermore, it may be useful to process CEs with clients (Hill & Knox, 2009).

Some of us thought it would be useful to develop manuals for facilitating CEs, although more research is certainly needed before doing so. Such manuals would describe the facilitative conditions and processes that nurture CEs. For example, specific CE-fostering interventions could be delineated and integrated into treatment manuals for different approaches with different types of clients. Of course, we acknowledge that such manuals involve generalizing and the uniqueness of CEs may well argue against such generalization.

Implications for Training

A good first step in teaching beginning therapists about CEs is to ask them to reflect on moments in their own experiences, whether as clients in therapy or in their lives outside of therapy, when they felt that something significant, even momentous, occurred for them. They could then try to reconstruct the antecedents and consequences of these CEs, including their own and their therapists' feelings, thoughts, and behaviors. It might also be helpful for trainees to remember or imagine not only in-session changes but also whether these identified CEs had intrapersonal or interpersonal ramifications outside the therapy room. It is important, too, that trainees could be asked to consider whether their experiences of CEs led to a desire or need for more CEs, or alternatively, the feeling that therapy has reached a desired consequence and that termination should now be considered. Trainees who have never experienced CEs might think about whether they are in some way envious of those who have had such experiences. An inspirational short story on this theme of envying those who have had CEs is Friedman's (1997) "Mr. Prinzo's Breakthrough."

A good follow-up exercise would be for students to learn to identify CEs, perhaps by viewing tapes of expert therapists (e.g., the American Psychological Association series of psychotherapy sessions; http://www.apa.org/pubs/videos/about-videos.aspx) or therapists in commercial movies (e.g., *Good Will Hunting*, *Ordinary People*). It is important, as part of such exercises, to emphasize to students that CEs typically occur organically in the context of good-enough conditions rather than being engineered or manipulated.

Reading about and watching videos of CEs may help students learn about CEs, but experiential learning (including role-playing attempts at facilitating CEs) is likely to be of even greater value. In this regard, we thought that students' knowledge of therapeutic CEs would be enhanced by having them compare such experiences with those of CEs that might happen outside of therapeutic settings. Included, for example, might be CEs that occur during the course of friendships and other intimate relationships or while listening to music or engaging in some artistic or spiritual activity.

Another key point related to training is that trainees need to learn to tolerate the client's potential strong reactions before, during, and after significant CEs. The therapist's ability to tolerate clients' uncertainty and distressing reactions may help clients stay with their new emerging experiences. Conversely, we thought that trainees also need to understand and accept that not all clients experience CEs, that not all effective therapies include CEs, and thus that trainees are not failing in their role if their clients do not experience CEs.

An additional way in which trainees might learn about CEs is through experiencing CEs in the context of supervision (Ladany et al., Chapter 16). In this case, the supervisor becomes a model of how one can facilitate a CE.

The trainee, in turn, learns how a CE may be experienced and can benefit a client. Making this learning explicit could help trainees understand the CE process more deeply. Similarly, and hopefully, trainees also themselves experience CEs in their role as supervisees and therapists. In this regard, Stahl et al. (2009) explored how therapists experience significant and dramatic learning from interactions with their clients.

Another CE-based possibility for training is simply to suggest that trainees monitor their clients' CEs by asking about them in session (see also Hill & Knox, 2009). Therapists could also ask clients to complete postsession questionnaires such as those used in the study discussed by Heatherington et al. in Chapter 10, thus raising trainees' awareness and appreciation of the CE phenomenon.

A final point is that training in case conceptualization is vital. Trainees need to be able to formulate good case conceptualizations, so that they can understand how a CE would be useful for the client and are able to recognize what facilitates and prevents the clients in having CEs.

CONCLUSION

In sum, there has been a broad consensus across therapists and therapy researchers of different theoretical orientations and generations that CEs are a central part of the therapy change process. At the same time, it is clear that much work remains to be done to better understand CEs. Although more than 60 years have passed since Alexander and French (1946) proposed CEs as a key change process in psychoanalysis and psychotherapy, this construct has failed to receive detailed conceptual and empirical scrutiny. We hope that we have sparked the imagination and curiosity of psychotherapy researchers and scholars to build on what we have examined here, and we urge them to continue these efforts to enhance our understanding and appreciation of CEs.

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