Therapeutic Change and the Experience of Joy: Toward a Theory of Curative Processes

Andreas Dick-Niederhauser
University of Redlands

This article builds an argument for a line of psychotherapy research aimed at uncovering the universal curative processes of change that can occur in many different circumstances, not only in psychotherapy. On the basis of theories and findings from psychological research on happiness, the experience of joy is regarded as a core indicator of therapeutic change leading to an increase in intrapsychic resources and life satisfaction. By studying experiences that trigger joy, a number of curative processes can be identified with a high potential for explaining why and how psychotherapy works. Hypothetical links between these curative processes and therapeutic interventions and conditions are explored.

Keywords: psychotherapy, process-outcome research, curative processes, self-healing, joy

Findings from more than half a century of psychotherapy research lead to two major conclusions: (a) Psychotherapy sometimes works and sometimes fails, and (b) there are few differences in treatment efficacy among different therapeutic approaches. As regards the evidence for the first of these two conclusions, despite the very well-replicated finding about the general efficacy of psychotherapy, some therapists appear to be unusually effective, and others may not even help the majority of their patients (Lambert & Ogles, 2004). Moreover, 30% to 60% of patients do not show any substantial treatment benefits in clinical trials, and far more do not profit from treatment in routine practice (Lambert & Ogles, 2004; Westen, Novotny, & Thompson-Brenner, 2004). What is worse, a relatively consistent portion of individuals (approximately 5% to 10%) actually deteriorates while participating in treatment (Lambert & Ogles, 2004; Mohr, 1995).
As regards the evidence for the second conclusion, the results of general meta-analyses (e.g., Wampold et al., 1997), meta-analyses focusing on particular disorders (e.g., Robinson, Berman, & Neimeyer, 1990), specific comparison studies (e.g., Elkin, 1994), and consumer surveys (Seligman, 1995) all show that there are, on average, no major differences in treatment success among different therapies. There is little evidence that specific ingredients are necessary to produce psychotherapeutic change (Wampold, 2001). The Dodo Bird verdict (Rosenzweig, 1936) that “everybody has won and all must have prizes” still holds true.

Albeit widely known, these findings are surprising and not easy to accept for practitioners and researchers alike. They contradict a fundamental assumption underlying the education and training of psychotherapists and counselors: that psychotherapy is a reliable method for helping patients change due to the skillful application of the right therapeutic techniques and the creation of a supportive therapy relationship (e.g., Gelso & Fretz, 2001). But if psychotherapy does not reliably lead to therapeutic change, and if it does not seem to matter what kind of techniques therapists use to attempt change in patients, then this view must be flawed.

Psychotherapy researchers need to find answers to the intriguing questions of why psychotherapy sometimes works and sometimes fails and why there are so few differences in outcome among different treatment approaches. The search for these answers is identical to trying to identify the curative processes responsible for therapeutic change. If therapeutic change can occur, as has been amply shown (see Lambert & Ogles, 2004, for a review), there must be reasons for this. However, researchers still know very little about the mechanisms of change in psychotherapy (Kazdin, 1999; Kopta, Lueger, Saunders, & Howard, 1999). Moreover, little agreement exists as to what constitutes therapeutic change and how it should be examined (Doss, 2004).

In the following sections, I search for answers to the questions of what therapeutic change is and what kind of mechanisms lead to therapeutic change. In the first section, I explore which types of processes studied by psychotherapy researchers in the past will most likely not lead to a better understanding of the reasons for therapeutic change and which types of processes most likely will. In the second section, I consider what therapeutic change actually means and what the indicators of improved mental health are. In the third section, I try to show how we can find the causes of therapeutic change and develop a preliminary theory of curative processes on the basis of research on the experience of joy. In the final section, I discuss how these curative processes can be encouraged in therapy and how they can contribute to a more integrative understanding of psychotherapy. The purpose of this article is to open new ways of conceptualizing and
investigating mechanisms of change in psychotherapy and to help make the search for curative processes more efficient.

**WHERE CAN THERAPEUTIC CHANGE (NOT) BE FOUND?**

Let me first illustrate with a joke why I believe that psychotherapy research has not been very successful so far in identifying predictors of treatment outcome or the “active ingredients” in therapy: A man is standing at night under a street lamp and appears to be looking for something on the ground. Somebody walks by and asks, “What have you lost?” – “My watch.” – “Where did you lose it?” – “Well, back there in that dark alley.” – “But why on earth are you looking for it here?” – “Because there’s more light here,” the man replies.1

Psychotherapy researchers, by and large, have not looked for the causes of therapeutic change where one would expect to find them, but instead have been searching mostly in well-lit places. There are actually two of these well-lit places, representing two opposing camps of psychotherapy researchers (Doss, 2004). On the one side are the outcome researchers, with their focus on randomized controlled trials, trying to link treatment approaches, general treatment methods or global therapeutic conditions to patient change. On the other side are the process researchers, with their focus on the myriad elements of the therapy process that may affect outcome. Both of these groups of researchers typically study concepts first developed by pioneering clinicians to describe what happens in psychotherapy from the therapist’s point of view. Examples of such concepts are “cognitive therapy,” the “therapy relationship,” or “therapist interpretations.”

Both of these polarized camps of researchers have run into considerable problems. Outcome researchers are confronted over and over again with the finding that, when comparing different therapeutic approaches or techniques, “all must have prizes.” Process research, on the other hand, has not yielded very many meaningful findings. As Hill (1990) has observed, exploratory process research “often generates a vast amount of data, making it hard for researchers to see the forest for the trees” (p. 288). The reason for this failure to find the causes of therapeutic change lies in the fact that both of these opposing camps of psychotherapy researchers have largely searched in the wrong places by studying variables that are unlikely to be directly related to therapeutic change.

1 The unfortunate man in this joke who lost his watch is allegedly Dallebach Kari, a notorious barber who lived from 1877 to 1931 in Berne, Switzerland, and a protagonist in numerous Swiss jokes.
Therapeutic change happens in the patient or, more precisely, in the patient’s subjective experiences and observable behaviors. The subjective experiences of the patient include phenomena such as thinking, feeling, perceiving, sensing, remembering, evaluating, intuiting, wishing, and wanting. The “three-tier” model of personality proposed by Gold and Stricker (1993) emphasizes the complex, multidirectional, and circular interconnections among overt behaviors (Tier 1); conscious cognition, affect, perception, and sensation (Tier 2); and unconscious mental processes (Tier 3). Change can occur at any of these three tiers of psychological life, and it is often difficult to identify which of these processes precede a patient’s gains given that they are closely linked. However, very few variables studied by outcome or process researchers searching for potential mechanisms of change in psychotherapy are actually related to any of these three tiers. Instead, most researchers focus on therapeutic techniques or interventions, on aspects of the therapy relationship, on characteristics of the therapist, or on patient variables that have little to do with the patient’s psychological experiences such as diagnosis, comorbidity, severity of symptoms, functional impairment, or sociodemographic variables (Clarkin & Levy, 2004; Hubble, Duncan, & Miller, 1999).

In their seminal review, Elliott and James (1989) identified nine types of client experiences in psychotherapy: intentions, feelings, self-relatedness, relating to the therapist, central concerns, perceptions of therapist intentions, perceptions of therapist characteristics, therapeutic impact, and perceived helpful aspects of therapy. The client experiential variables studied have not changed much in the past 20 years, but new process analysis tools have been developed (see Clarkin & Levy, 2004; Elliot & Wexler, 1994; Garfield, 1994; Hill, 1990). Although these client variables studied by process researchers are related to the client’s subjective experience, many of them are also unlikely to reveal the mechanisms of change in psychotherapy because they fail to take into account an important distinction between two different types of client processes: (a) client experiences that are related to therapeutic interventions or conditions within therapy sessions or to therapeutic homework assignments, and (b) client experiences that are not under the direct control of the therapist but that are much more directly linked to therapeutic change or to the ultimate outcome of treatment. I have referred to these two types of processes as effective therapy processes and curative processes (Dick, 2003); Doss (2004) has called the first type of processes (client) change processes and the second type change mechanisms.

Most experiential client variables studied by process researchers focus on client change processes within treatment sessions rather than on cura-
tive processes as the more proximal causes of therapeutic change (see Orlinsky, Rønnestad, & Willutzki, 2004). The major problem with searching for curative processes in client change processes resulting from therapeutic interventions or conditions (and reciprocally influencing these therapist-induced processes) lies in the fact that therapeutic change does not have to be related to psychotherapy at all. There is ample evidence that therapeutic change can be triggered under many different extratherapeutic conditions (Bohart, 2000; Bohart & Tallman, 1999).

Numerous empirical studies have found a significant positive impact of spiritual experiences on mental and physical health (Richards & Bergin, 2000). Other examples of possible change-inducing contexts outside of psychotherapy and counseling include reading self-help literature (e.g., Gould & Clum, 1993; Gregory, Canning, Lee, & Wise, 2004), journaling (e.g., Segal & Murray, 1994), experiencing nature (Pollio & Heaps, 2004), developing or reestablishing meaningful social relationships (e.g., Granfield & Cloud, 2001), experiencing family pressure to change (e.g., Cameron, Manik, Bird, & Sinorwalia, 2002), having a near-death experience (Morris & Knafl, 2003), and using leisure productively in transcending negative life events (Kleiber, Hutchinson, & Williams, 2002).

In addition, many individuals are able to overcome problems on their own (e.g., Prochaska, Norcross, & DiClemente, 1994), and approximately 40% to 60% of people who experience trauma either recover without professional help or even grow from the trauma (Tedeschi, Park, & Calhoun, 1998). Moreover, self-administered treatment programs have been found to be no less efficacious than therapist-administered programs (Sco- gin, Bynum, Stephens, & Calhoon, 1990). Finally, patients sometimes actively integrate a sequence of therapies, two concurrent therapies, self-therapy with ongoing psychotherapy, or different therapeutic methods within sessions without any stimulation by the therapist (Gold, 1994).

All of these findings support the view that in their search for curative processes researchers should not look primarily at what happens in psychotherapy but at what happens with the person experiencing positive change. Psychotherapists attempt to make use of the universal curative processes that can occur under many different conditions, but they do not hold any dominion over these processes. It is no surprise that psychotherapy has gained cultural significance as other forms of support (e.g., family and communal ties) have declined (Cushman, 1996).

If a specific psychotherapy has worked in achieving therapeutic change in a particular patient, the psychotherapist has made successful use of the healing factors within that patient, which could also have been activated by different means. Bohart (2000; Bohart & Tallman, 1999) has referred to the curative processes inside and outside of psychotherapy as the client’s self-healing capacities. According to Bohart, all
human beings, including clients, have built-in capacities for learning and creative problem solving. Clients come to therapy when their self-healing capacities are inaccessible or blocked, and therapy is most effective when it makes use of them.\(^2\)

If a therapeutic intervention is related to positive treatment outcome, it must activate a curative process in the patient. However, the curative process can also be activated through means other than a psychotherapeutic intervention. For example, exposure has been found to be highly efficacious as a treatment for certain anxiety disorders (e.g., Abramovitz, 1996). It is likely that exposure, if properly implemented as a therapeutic intervention, activates a curative process in the patient (e.g., growth in courage and personal strength). However, the same experience could also be brought about through other, extratherapeutic means (e.g., reading and self-motivation, a sudden emergency forcing the patient to take action). Exposure is in fact part of common folk wisdom, with people suffering from an anxiety disorder often being encouraged by significant others to “face their fears.”

In conclusion, before conducting empirical studies on predictors of treatment outcome, researchers should consider what types of variables are most promising for the purpose of finding the mechanisms of change (instead of considering which types of variables can be most easily assessed). Among the thousands of theoretically possible process variables, it is only the client variables that can contain the curative processes leading to therapeutic change because it is the client who shows changes in psychological functioning. Among all possible client variables, it is only those client variables that refer to the client’s experiences and behaviors that promise to reveal the curative processes. And finally, because therapeutic change can occur under many different circumstances, the universal curative processes of change in the patient should not be regarded as ingredients of the therapy process but as more general psychological mechanisms of change not limited to psychotherapy.

\(^2\) Even though the ideas and evidence put forth in this article are, for the most part, perfectly compatible with Bohart’s (2000) notion that it is ultimately the client who makes therapy work, the term *self-healing* might suggest that any client is able to heal through his or her own efforts, an assumption that contradicts reports of some patients suffering for years without major changes (Bowker, 1986; Looney, 1987). Moreover, there are indications that some clients can begin to heal only after they accept that it is not in their own power to recover but that they need to accept help from others or from a higher power (cf. “powerlessness” as a component of the Twelve-Step Program; e.g., Gorski, 1989). Thus, I prefer to use the more general terms *curative processes* and *healing processes* rather than *self-healing processes* to avoid possible misconceptions.
WHAT ARE THE CONSEQUENCES OF THERAPEUTIC CHANGE?

If we accept the view that therapeutic change occurs in the patient, it is then necessary to investigate further what the characteristics of these patient experiences and behaviors are. This leads to two questions: (a) How can we recognize that a patient has experienced therapeutic change? Or in other words, What are the consequences of therapeutic change? (b) Which patient experiences and behaviors lead to therapeutic change? Or in other words, What are the causes of therapeutic change? I address the first of these two questions in this section; the second question, which aims at finding the curative processes, is addressed in the next section.

Therapeutic outcome has traditionally been defined as a reduction of psychopathological symptoms and a remission of diagnoses (Hill & Lambert, 2004). It has been suggested that this negative approach to outcome ought to be complemented with a positive approach focusing on an increase in patients’ subjective well-being, life satisfaction, and mental health (Wright & Lopez, 2002). In recent years, numerous measures have been developed that assess positive characteristics of functioning and mental health going well beyond symptom relief (see Lopez & Snyder, 2003, for a review). This distinction between negative and positive indicators of treatment outcome in psychotherapy research is related to two fundamental approaches taken by founders of different therapeutic schools in defining the goals of psychotherapy: either as a reduction or removal of symptoms, diagnoses, disorders, maladaptive behaviors, neurotic suffering, discrepancies between ideal self and real self, and so forth—or as an encouragement or attainment of adaptive behaviors, an integrated self, a healthy personality, greater autonomy, a stronger ego, and so forth (Dick, 2003). The first category of therapeutic goals stems from a problem-oriented approach to psychotherapy; the second category stems from a resource-oriented approach.

With regard to mental health, resources are defined as positive factors in the life of a patient such as skills and abilities, constructive motivations, character strengths and virtues, supportive relationships, and positive life circumstances. Resources are related to an individual’s health and life satisfaction. Problems, on the other hand, are conditions of deficiency in the life of an individual and related to emotional suffering (Grawe, 2004). Therapeutic change thus means progress away from problems, mental illness, and mental suffering toward resources, well-being, and mental health. But what actually is mental health?

The concept of mental health has been studied for several decades (e.g., Bryant & Veroff, 1982; Jahoda, 1958; Keyes & Lopez, 2002). Gen-
erally, the different components of mental health that have been put forward in the literature can be classified into at least six distinct categories: 
(a) feelings of subjective well-being, emotional vitality, and life satisfaction; 
(b) self-actualization, self-development, realization of one’s potentials and abilities, and growth and integration of the personality; (c) self-acceptance, high and stable self-esteem, a positive self-image, self-determination, and self-confidence; (d) acceptance of others, a positive view of others, positive relations with others, and social contributions; (e) environmental mastery, adaptive coping, and social integration; and (f) a sense of purpose, direction, and coherence in life.

It is rather intriguing how closely these criteria of mental health match the characteristics of happy people. The word happiness refers to two distinct states of mind. The first one, which can be regarded as the affective–experiential component of happiness or happiness as an emotional state, is often called joy. This is an intense but usually short-lived feeling of bliss and overflowing gladness. The second component of happiness, which can be regarded as the cognitive–evaluative component of happiness or happiness as a personality trait, is often called life satisfaction or subjective well-being. There is a large body of research in psychology on subjective well-being or life satisfaction (i.e., happiness as a trait); psychological research on joy (i.e., happiness as an emotional state), on the other hand, is extremely sparse (Dick, 2003; Diener, Lucas, & Oishi, 2002; Mayring, 1991; Seligman, 2002).

Happiness research has revealed that there are consistent differences between happy and unhappy people. The reported level of subjective well-being has been found to be consistently related to certain character strengths (or virtues; see Peterson & Seligman, 2004), personality factors, and interpersonal resources, in particular, hope, optimism, expectancy for control, low neuroticism, low tendency for harm avoidance, high energy level, high productivity and sociability, a satisfying intimate relationship and good social relations, job satisfaction and satisfaction with the general standard of living, participation in religious activities, and—in individualistic, but not in collectivist cultures—high self-esteem and extraversion (Dick, 2003; Diener et al., 2002; Diener & Seligman, 2002; Stewart, Ebmeier, & Deary, 2005). Thus, happy people not only seem to feel better, they also have better relationships with others, show a more favorable view of themselves, have a more positive outlook on life in general, have a higher ability for successful coping, and are more productive than unhappy people, all of which are highly similar to the characteristics of mental health.

This does not mean, however, that mental health and happiness are the same. Although the characteristics of life satisfaction and mental health are normally indistinguishable, under certain conditions mentally healthy in-
dividuals can be quite unhappy, namely, when their environment or current life situation is hostile to their pursuit of happiness. For example, any mentally healthy person will typically feel unhappy if a tragedy occurs, such as the death of a loved one, a natural disaster, or the outbreak of violence. On the other hand, although life events can influence subjective well-being, people will eventually adapt to these changes. Costa, McCrae, and Zonderman (1987) reported that people who lived in stable circumstances were no more emotionally stable than people who experienced major life changes, such as divorce, widowhood, or job loss. In addition, mentally healthy individuals can sometimes even find a sense of purpose under very adverse conditions (e.g., Frankl, 1984), whereas a person suffering from a mental disorder often cocreates unfavorable events in his or her environment (e.g., when a negative self-image leads to awkward interpersonal behaviors and subsequently to social rejection; e.g., Alsaker & Dick-Niederhauser, 2006). It seems that the way people perceive the world is more important to happiness than the objective circumstances they live in.

This means that, most of the time, people are not unhappy because of adverse life circumstances but because of problems with how they perceive the world, their life, and themselves. Whenever psychotherapy is called to remedy unhappiness and mental suffering, it is because the patient feels that his or her hopes and wishes remain unfulfilled, even though the environment he or she lives in may not be particularly hostile. A mentally healthy person is at the same time a happy person as long as restricting conditions beyond the person's control do not prevent the pursuit of happiness. A person suffering from impaired mental health, on the other hand, is not able to experience lasting happiness, even though there may not be any uncontrollable external circumstances preventing the pursuit of happiness. Therefore, a consistently happy person must at the same time be mentally healthy, and mental illness is not compatible with happiness.3

By investigating the conditions and processes responsible for life satisfaction and joy, we can learn a great deal about the conditions and

3 Considered at a superficial level, some clinical conditions may seem to be compatible with happiness (e.g., antisocial personality disorder, narcissistic personality disorder, manic episode), but actually only exhibit certain isolated features of happiness (e.g., high expectancy for control in antisocial personalities, high energy level in a manic episode), with many essential characteristics of happiness lacking (e.g., productivity, good social relationships). Clinical conditions such as these may try to imitate happiness, but they are not compatible with real happiness. Keyes and Lopez (2002) have suggested that subjective well-being and mental health are two independent dimensions. However, if mental health is not merely defined as a lack of psychopathological symptoms but as a state of functioning that includes characteristics such as self-actualization and finding a purpose in life, then the concept of mental health proposed here is identical to Keyes and Lopez' state of flourishing (i.e., high mental health and high well-being).
processes that bring about mental health, because life satisfaction and joy are core indicators of mental health. Happiness as a trait (i.e., life satisfaction) is the result of environmental resources (e.g., living in a free and democratic state, in a safe and friendly neighborhood), interpersonal resources (e.g., living in a stable and loving relationship, having good relations with friends and coworkers), and intrapsychic resources (e.g., social competence, expectancy for control). If a person suffering from a mental disorder is able to develop and attain the resources he or she lacks the most, the disorder and the symptoms cannot be maintained any longer. For example, a depressed patient may suffer from low self-esteem, a bleak outlook into the future, and a history of being abandoned in close relationships. If this patient were somehow to succeed in developing a high and stable self-esteem, an optimistic outlook, and improved interpersonal competence, the depressive symptoms would most likely disappear.

It is primarily the intrapsychic resources that are most intimately linked to psychological functioning. Good interpersonal and environmental resources are often the result of good intrapsychic resources (e.g., high self-esteem makes satisfying relationships more likely). On the other hand, environmental and interpersonal resources may also strengthen intrapsychic resources (e.g., having a satisfying relationship can lead to increased self-esteem). Although some therapists may at times work directly on enhancing certain interpersonal or environmental resources of their patients (e.g., helping clients get a date), psychotherapists and counselors, as opposed to social workers, are typically much more interested in enhancing clients’ intrapsychic strengths (e.g., self-esteem and assertiveness) than directly targeting interpersonal and environmental resources.

Before concluding that the consequence of therapeutic change is a state of increased life satisfaction attained by developing intrapsychic resources, an important caveat needs to be addressed. There is a certain danger of setting up a false dichotomy between problem-oriented and resource-oriented approaches to therapeutic change, arguing for the latter over the former. Clinical experience suggests that it is sometimes necessary to first work on clients’ problems, defenses, and obstacles before growth in resources can be experienced. Pain and suffering are real and need to be acknowledged and worked through, and by doing that, resources can

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4 It should not be inferred from this example that specific mental disorders or psychological problems are always characterized by a lack of the same resources. Such a view would give too much weight to the current diagnostic classification system of mental disorders, which is mostly descriptive. Judging from clinical experience, every patient, regardless of his or her diagnosis, needs to be assessed individually in terms of the resources he or she lacks. However, future research might reveal that some resources may indeed play a more prominent role in certain kinds of disorders than in others.
develop. For example, the important intrapsychic resource of courage can increase only by taking risks. It is not possible to build up courage without facing challenges squarely (Dick-Niederhauser, 2007). As will become clearer in the next section, many processes of healing first involve accepting and working through suffering in order to achieve release from pain and to feel subsequent joy, according to the Latin dictum per aspera ad astra.5

In conclusion, the consequence of therapeutic change is the state of having attained those resources that correspond to mental health, enable happiness (life satisfaction), and neutralize negative emotional states and psychopathological symptoms. Both mental health and happiness are characterized by subjective well-being, self-actualization, self-acceptance, acceptance of others, environmental mastery, and a sense of purpose in life. Of particular importance are intrapsychic resources (character strengths, virtues) because they enable life satisfaction despite adversity and help enhance interpersonal and environmental resources. To find the therapeutic processes of change in the patient, we need to study the experiences that lead to the development of intrapsychic resources and life satisfaction.

WHAT ARE THE CAUSES OF THERAPEUTIC CHANGE?

Whereas the outcome or consequence of therapeutic change is an increase in happiness and life satisfaction, which is related to a gain in intrapsychic and (to a lesser extent) interpersonal and environmental resources, short-term progress in clients’ mental functioning are related to positive emotions. Not all positive emotions, however, need to be indicators of growth in mental health and life satisfaction given that repeated experiences of pleasure and even ecstasy can be routinely followed by intense negative emotions, as is the case, for example, in substance abuse and dependence or in other addictive disorders. Joy (i.e., happiness as an emotional state) is not the same as pleasure. Joy is subjectively experienced as a much “deeper” emotion than pleasure, and has been characterized as resulting from an existential self-transformation (Groskurth, 1988) or a synthesis of what has been perceived previously as separated or conflicting (Popovic, 2002).

Although the research evidence is rather sparse, I briefly summarize what is currently known in psychology about the conditions related to the experience of joy. These findings are based on studies initially stimulated by the phenomenological psychologists Felix Krueger (1953) and Philipp Lersch (1970), who were interested in exploring the subjective experiences

5 Through difficulties to the stars.
associated with different emotions. In this tradition, several researchers investigated the phenomenology of joy by asking participants to visualize a specific instance of joy they had experienced in the past and to then describe it or to fill out a joy-related self-report scale (Hoffmann, 1984; Mayring, 1991; Meadows, 1975; Wlodarek-Küppers, 1987).

Meadows (1975) identified several typical experiences of joy on the basis of participants’ responses on the Joy Scale such as being together with others, recognizing one’s individuality; having confidence in oneself; engaging in physical activity; and having achieved conditions of joy through personal actions, peace and relaxation, affirmation of the world, contemplation, enjoying beauty, and experiences of ecstasy. Similar findings were reported by Hoffmann (1984), Wlodarek-Küppers (1987), and Mayring (1991) with German participants. These authors particularly highlighted the following experiences as important triggers of joy: positive self-evaluation; acceptance of emotions; feeling close to oneself and to one’s body; accepting, trusting, and understanding others; tolerance; self-disclosure; compassion; love; feelings of self-assurance and personal strength; liberation from restrictions of the past; overcoming anxiety; and experiencing freedom and self-determination.

Based on his cognitive–motivational theory of emotions, Lazarus (1991) explained the emotional state of happiness (i.e., joy) as the result of successful actions. According to Lazarus, the common denominator of all situations that elicit an emotional response of happiness is receiving what we have wished for and expecting the same for the future. For Czikszentmihalyi (1990), people who experience fulfillment and joy are in a state of “flow” that arises when they are engaged in a creative unfolding of something larger, with time seemingly standing still and conscious thinking and effort no longer existing. Finally, in his classic work *The Varieties of Religious Experience*, James (1902/2005) provided a wealth of material demonstrating the close link between joy and religious transformation and conversion.

On the basis of these findings and theories, I have composed a tentative list of experiences that evoke joy (see Figure 1, left column). The first three types of experiences are related to being able to accept previously rejected aspects of oneself, others, and life in general. This includes, for example, being able to grieve losses and to let go of resentment, acknowledging one’s past and accepting present limitations, or forgiving “God” for having let horrible things happen. The fourth type of experience is related to overcoming previous difficulties and moving beyond the scope of past

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6 The first three types of experiences in Figure 1 show similarities to the three factors “Love of Self,” “Love of Others,” and “Love of God” of the Theistic Spiritual Outcome Survey by Richards et al. (2005).
restrictions. This includes, for example, experiencing self-assertion and mastery, mustering the courage to face one’s fears, expressing suppressed emotions, or successfully setting limits.

The fifth type of experience is related to opening up, trusting others, and accepting and expressing love. Through these kinds of experiences, the isolation of the self is overcome and barriers are broken down that have previously prevented openness, mutuality, and vulnerability in close relationships. The sixth type of experience is related to the direct sensation of one’s vital and physical self without the interference of critical and judgmental thinking. The self can be experienced in its physical wholeness and immediate presence, allowing spontaneous expressions that are normally

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**Table:**

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<tr>
<th>Curative Processes</th>
<th>Examples of Therapeutic Conditions and Techniques</th>
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<tr>
<td>(1) Self-acceptance; acceptance of feelings and wishes; acceptance of problematic aspects of self</td>
<td>Therapist empathy, genuineness, and unconditional positive regard; therapist patience and humor; integrating rejected aspects of self (empty chair technique, paradoxical intention)</td>
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<td>(2) Acceptance of others the way they are</td>
<td>Encouraging client empathy and perspective taking (anger management); structural family therapy; transactional analysis; encouraging client forgiveness</td>
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<td>(3) Acceptance of the individual course of life; finding meaning in life or in certain life experiences</td>
<td>Logotherapeutic search for meaning; Socratic dialogue; mindfulness-based cognitive therapy; Morita therapy</td>
</tr>
<tr>
<td>(4) Self-liberation from anxieties and restrictions of the past; experiencing courage, personal strength and self-assurance</td>
<td>Behavioral exposure; self-assertiveness training; Gestalt-techniques and group therapy rituals encouraging emotional expression/catharsis</td>
</tr>
<tr>
<td>(5) Being able to trust and rely on others; self-disclosure; giving and receiving love and support</td>
<td>Trustful therapy relationship; psychoanalytical analysis of transference; attachment oriented therapy</td>
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<tr>
<td>(6) Being able to enjoy sensual experiences; sensation of one’s vitality and energy without interference of the critical mind; being fully present</td>
<td>Body oriented psychotherapy; creative therapies; behavioral activation; meditation; relaxation therapies</td>
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<tr>
<td>(7) Creativity and self-expression</td>
<td>Interventions aimed at uncovering hidden talents and needs (e.g., dream analysis)</td>
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<tr>
<td>(8) Fulfillment of wishes; attainment of much valued goals</td>
<td>[corresponds to both curative processes #8 and #9:] Generating more realistic interpretations (e.g., rational emotive therapy, cognitive therapy); focusing; analysis of life plan (Adlerian therapy); problem solving; behavior modification</td>
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<tr>
<td>(9) Letting go of old or harmful goals and values and making room for more authentic needs</td>
<td>Prayer and meditation; transforming the client’s image of God (e.g., psychodrama, Socratic dialogue, Gestalt techniques)</td>
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<tr>
<td>(10) Experiencing the care and benevolence of a higher power</td>
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**Figure 1.** Curative processes of change with hypothetical links to therapeutic conditions and techniques.
suppressed by the rational mind as well as disassociation from self-defeating thoughts and corresponding negative emotions. The seventh type of experience is related to self-expression by engaging in creative activities. Both the sixth and the seventh types of experience can lead to a state of “flow.”

Finally, the last three types of experiences are closely related: For many goals we highly cherish, conscious efforts are necessary to achieve them; when we finally do achieve them, joy will result. However, not all events are under individuals’ conscious control. We can experience a sense of relief and joy by being able let go of false goals and values that may have served a purpose in the past but are no longer related to our true motivations. These old strivings have to vanish for more authentic goals and values to emerge. Finally, joy is sometimes experienced when we give up conscious efforts of control and trust in the providence and benevolence of a higher power (see footnote 2). To feel joy, some people need to admit to themselves and others that they do have some much valued goals in life and they need to find the belief and courage to work toward these goals; others need to take a step back, let go of false goals, or develop trust that they can have a good life even if they do not constantly worry about their goals, resulting in relaxation and inner peace.7

Many of these experiences of joy are related to constructs studied by positive psychologists such as, for example, emotional approach, self-disclosure, forgiveness, creativity, meaningfulness, or spirituality (see Snyder & Lopez, 2002). This tentative list of curative processes, derived from studying the conditions of joy, shows considerable overlap with schematics of therapeutic factors derived from clinical experience (e.g., self-healing processes: Bohart & Tallman, 1999; therapeutic factors of group therapy: Yalom, 1995), literature reviews (e.g., Lambert & Ogles, 2004), assessments of how therapists think about common factors (e.g., Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003), and empirical analyses of “very good moments” in psychotherapy sessions (Mahrer, White, Howard, Gagnon, & MacPhee, 1992).

However, one important difference between the curative processes in Figure 1 and other systems of therapeutic factors lies in the proposition that the processes listed here are directly related to therapeutic change, triggering joy and enhancing the character strengths and virtues necessary for the attainment of mental health and long-term life satisfaction. In other

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7 Experiences 8, 9, and 10 in Figure 1 are reminiscent of the first verse in the “serenity prayer” adopted by Alcoholics Anonymous: “God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.” The origins of the prayer remain uncertain; some people attribute it to the theologian Reinhold Niebuhr. (http://www.a-1associates.com/AA/serenity_prayer.htm)
systems of therapeutic or common factors, many of the factors will sometimes lead to healing and sometimes not. For example, imitative behavior in the group (Yalom, 1995) will lead to therapeutic change only if the right kinds of behaviors are imitated (not, e.g., self-blame or acting out), and patience (Bohart & Tallman, 1999) may be an important precursor for therapeutic change, but does not always lead to improved well-being. Figure 1 is not, however, intended to present an exhaustive or final list of curative processes but merely a first approximation. As research progresses, it is likely that additional processes will be identified that are related to the experience of joy and to improved mental health or that a clearer picture will emerge about the relations among the different curative processes.

In conclusion, the experience of joy is a core indicator that a healing process is occurring, resulting in an activation of intrapsychic resources, which will enable an increase in life satisfaction and mental health. Joy results when previously opposing mental processes are overcome and a transformation toward more unity and stability of the self occurs. The psychological processes leading to joy are identical to the curative processes. Psychotherapists should thus try to activate and encourage processes in their patients that will eventually result in the emotional experience of joy.

ENCOURAGING CURATIVE PROCESSES THROUGH PSYCHOTHERAPY

The curative processes should not be viewed as simple “factors” that can be produced at will, but as complex psychological processes with many precursors and many different manifestations. Sometimes a certain curative process may need considerable preparation. For instance, one of the most widely discussed common factors of psychotherapy, remoralization of the patient or the therapeutic instillation of hope (Frank & Frank, 1991), can be viewed as an important precursor to any of the curative processes listed in Figure 1. Remoralization may be an explanation of the placebo effect, leading to early change in psychotherapy and to positive expectancies for future improvement (Snyder, Michael, & Cheavens, 1999). Although the subjective experience of hope does not directly lead to joy, hope may counteract pessimistic thinking typical for a variety of mental disorders and open up the possibility for further curative processes (Snyder, Rand, & Sigmon, 2002).

Another psychological intervention, confrontation, may be an equally important precursor for enabling curative processes without directly lead-
ing to a reduction in suffering or an increase in well-being (Klein, 1989). Oftentimes, patients cling to their maladaptive responses and find nobility in their suffering and their defenses. The therapist is usually the only person in the patient’s life who will have the stamina and skills to wrestle with the patient’s blockages and to prepare the patient for healing processes. However, neither confrontation nor remoralization has any relevance in psychotherapy if they do not point to the curative processes. What would be the use of dismantling patients’ illusions or of erecting hope if nothing else were to follow? Without the curative processes, there is no clear direction in psychotherapy and there are no guiding principles for productive change.

These two examples are illustrative of the possible connections between effective elements of the therapeutic process and the curative processes in the patient. Because of the reasons discussed in the first section of this article, psychotherapy research has a long way to go to demonstrate consistent associations between certain therapy process elements (such as specific therapeutic techniques) and certain curative processes (see also Doss, 2004). However, on the basis of clinical experience and case studies, it is possible to hypothesize about the links between therapeutic conditions and techniques on the one hand and curative processes in the patient on the other hand. Some of these hypothetical links are shown in Figure 1, with the curative processes in the left column and the conditions and techniques of psychotherapy in the right column.

These possible connections between therapeutic conditions and techniques on the one hand and curative processes on the other hand demonstrate the importance of an integrative conceptualization of therapeutic change. For example, some therapeutic approaches may be particularly effective in encouraging nonjudgmental acceptance of reality (e.g., logotherapy, mindfulness-based cognitive therapy); other approaches may be more effective in helping clients free themselves from past restrictions by facing challenges squarely (e.g., behavior therapy, strategic family therapy). However, it is highly unlikely that there is a one-to-one correspondence between certain therapeutic techniques and the curative processes. It is much more probable that the same curative process can be encouraged through many different therapeutic techniques or conditions, and that the same therapeutic intervention may lead to the activation of different curative processes.

The curative processes are not directly determined by therapeutic interventions, but they can be influenced by what happens in treatment as well as by many other factors in the client’s life that may or may not have anything to do with what goes on in therapy. It is also possible that certain therapy techniques, if they are not properly implemented, inhibit the occurrence of a healing process in the client. For example, in vivo exposure
ideally leads to an increase in courage and self-confidence. If, however, a client is repeatedly encouraged to engage in exposure to anxiety-provoking situations even though it may presently be more important for the client to acknowledge neglected needs or to express suppressed emotions, positive growth will probably not occur.

It is thus very likely that different clients who undergo the same treatment (e.g., a group treatment aimed at resolving problematic relationship patterns) for a certain condition (e.g., binge eating disorder) will show differences in outcome because of their personal characteristics, their resources at the outset of treatment, and the specific curative processes that they are most in need of experiencing. If, for example, a hypothetical client A, whose eating disorder is functionally related to her interpersonal problems, needs to develop more trust in relationships and more interpersonal competence, the treatment will likely be successful because it encourages the curative process of opening up and trusting others as well as facing the fear of rejection in a group setting. However, if client B, whose eating disorder is related to an automatic pattern of self-defeating cognitions, needs to learn how to distance herself from negative thoughts and to develop a better sense of her bodily needs, the treatment program with its strong focus on interpersonal issues will not result in significant change or may even lead to a deterioration of her problems.

This rather simplified example shows why in a randomized clinical trial comparing an interpersonally oriented treatment with a cognitive–behavioral treatment, no significant differences in treatment outcome between the two treatment conditions would probably be found. In both treatment groups, curative processes are occurring for some patients but not for others (see Tasca et al., 2006). Both treatment conditions would be somewhat more efficacious than a placebo control condition, where curative processes are not actively encouraged but where some patients might make similar extratherapeutic experiences. It is equally hindering not to work on resources a patient needs to develop as it is to work on resources a patient already has, thus neglecting those he or she would need instead.

Therapists cannot directly influence the curative processes in the patient, but they can try to encourage these processes by realizing those conditions or by applying those interventions that will ultimately encourage healing. Because it is the curative processes that cause therapeutic change most directly and not the therapeutic conditions and interventions, rather than treating patients with the same clinical disorder with one standard treatment, it would be much more desirable to train therapists to recognize for each individual patient (a) which resources the patient needs to develop for attaining mental health, (b) which curative processes may possibly enhance these resources, and (c) which therapeutic conditions and interventions may be helpful in activating these curative processes.
An example from my clinical work illustrates how the model presented in this article can guide the integrative practitioner. A female patient who at the outset of therapy was being treated in an inpatient substance withdrawal program and who had been suffering for decades from alcohol dependence reported feelings of guilt and shame as well as numerous disappointments in intimate relationships. The clinical interview revealed that she showed deficits in two important intrapsychic resources: emotional stability (or what Peterson and Seligman, 2004, call self-regulation, classified among the virtues of “temperance” that protect against excess) and self-acceptance. She and I agreed that these two resources should constitute the goal of treatment.

Rather than identifying deficits and disorders, resource-oriented therapy translates a problem into a resource in need of encouragement, directing the patient’s focus onto something productive and making the patient aware that he or she may already possess this strength to a certain degree. Moreover, by focusing on intrapsychic resources (i.e., internal strengths), the strategy used by those patients who put all the blame for their problem on external circumstances (e.g., their job, their boss, their mother) and who expect therapy to offer a magic solution can be circumvented.

Because of the nature of the patient’s tendency to use her drinking to avoid negative emotions, the curative process of unconditionally accepting herself, particularly certain negative feelings (Curative Process 1, Figure 1), was identified as the desirable process in the patient’s experience that would probably lead to productive change. To encourage this curative process, I taught mindfulness-based techniques to help the patient perceive her own emotions and bodily sensations in an alert and nonjudgmental way.

Moreover, the patient was encouraged to engage in those social activities she enjoyed the most to increase the amount of positive emotions. After she was released from the inpatient program and continued treatment as an outpatient with one weekly session, the patient tried to implement some of these behavioral changes (e.g., meeting friends, going to a neighborhood party). This increased the patient’s hope to eventually be able to meet new people and maybe even an intimate partner and thus worked toward the curative process of giving and receiving support and love (Curative Process 5, Figure 1). When the patient reported having attended a social gathering involving dancing, she showed the typical nonverbal signs of joy with shining eyes, an authentic smile, and a relaxed posture.

Through her continued application of the mindfulness techniques, the patient began to experience that negative emotions often decrease after a while even without drinking. She also realized that she enjoyed social activities much more than drinking. As a result, the patient developed a
stronger motivation to stop drinking, leading to a significant reduction in alcohol consumption and an increase in emotional stability. There were, however, relapses and the patient did not completely stop drinking. In particular, whenever she realized that she did not have an intimate partner, she began to generate a series of negative cognitions (e.g., “I will never find the love I am looking for”).

Therapy also focused on the second important resource in need of enhancement, self-acceptance. The patient had suffered from serious parental rejection and emotional abuse in childhood and adolescence. Once the extent of this victimization became clear, the therapeutic interventions were directed toward encouraging the patient to treat herself more like a “loved child,” nurturing herself in a way she never experienced from her parents (Curative Process 1, Figure 1). This was also done with the aim of trying to give herself more love rather than longing for it from an intimate partner. Several behavioral and experiential techniques (e.g., rewarding herself, empty-chair technique) were used to increase the patient’s awareness for being kind and gentle toward herself.

Moreover, because the patient was rather religious, therapy involved transforming her negative image of God into that of an accepting and providing deity, working toward the possibility for the patient to experience the care and benevolence of a higher power (Curative Process 10, Figure 1). Gestalt techniques (e.g., two-chair technique) were mostly used to work on a transformation of her image of God. The more the patient was able to experience God as loving and accepting, the more she was able to distance herself from feelings of guilt and shame related to her history of alcohol dependence. After 12 inpatient and 13 outpatient sessions, the therapy was terminated, and the patient began to see a different therapist closer to where she lived to continue working on her fears of rejection and abandonment in close relationships and to keep her from relapsing.

As this case example illustrates, curative processes can often only be initiated in psychotherapy. However, significant reductions in psychopathology usually occur in therapy as patients make progress toward realizing important intrapsychic resources if the right curative processes are activated. The case example also shows that there are many possibilities of initiating the curative processes in the patient, and that no one therapeutic approach can probably claim to offer tools for facilitating every kind of curative process.

It is essential for the therapist to think about the curative processes first and to then choose the appropriate therapeutic means for encouraging these processes rather than starting out with the technique and hoping that it will lead to the necessary changes. For example, the patient in the case study above might have gained a better understanding of her current emotional and relationship problems in a purely psychoanalytic treatment,
but she might not have been able to initiate the process of self-acceptance. Within a purely cognitive–behavioral approach, the patient may have made helpful experiences with positive activities, and she may have been able to use self-instructions to reduce her drinking, but she would probably not have felt the same relief of guilt and shame that occurred through working on a transformation of her image of God.

There are many ways to effectively activate curative processes, but it seems an unnecessary limitation to restrict a therapist in his or her use of therapeutic methods by focusing on one or two major therapy approaches only. The theory of curative processes presented in this article is integrative and not eclectic given that the therapeutic conditions and methods are derived from the necessary healing processes in the patient and not vice versa. Eclectic therapists typically start by thinking about the therapeutic methods and conditions that may bring about change without a clear model of the curative processes. Rather than using a collection of techniques in an atheoretical way to achieve realistic outcomes by applying what is known about the efficacy of treatment methods, as is the case in eclectic therapy, this treatment approach is integrative in its attempt to combine different techniques with a clear theory in mind to achieve idealistic outcomes and create a new therapeutic process with each individual patient (see Prochaska, 2007).

**CONCLUSIONS**

Research findings indicate that different psychotherapeutic methods do not result in significantly different outcomes and that psychotherapy generally leads to positive change in patients at least as often as it fails to do so. Because therapeutic change takes place in the patient, linking treatment outcome to different types of therapies, different interventions, different therapist characteristics, or different aspects of the therapy relationship is too superficial an approach to finding the causes of therapeutic change. Psychotherapy researchers need to distinguish between the effective elements of the therapy process and the universal healing processes in the patient. The effective therapy process elements encourage the healing processes, but they are only indirectly related to treatment outcome. The healing processes on the other hand are the direct causes of therapeutic change and can occur under many different circumstances, not only in psychotherapy.

Psychological healing is identical with a previously suffering person gaining access to his or her inner sources of strength and health, which are to be found empirically in the intrapsychic characteristics of happy people.
Intrapsychic resources are enhanced through experiences that are accompa-
nied by the emotion of joy, which include self-acceptance, acceptance of others
and of one’s life, liberation from past restrictions, self-disclosure, experienc-
ing and accepting love, the sensation of vitality, being fully in the present,
creativity and self-expression, goal-attainment, letting go of the false as-
pects of the self, and trust in a higher power. These are some of the change
mechanisms that may (or may not) occur in psychotherapy, and at the same
time they are the universal change processes in any kind of method or
practice, which purposefully or accidentally brings about an improvement
in people’s mental health.

According to the ideas developed in this article, three important
additions to psychotherapy research should be considered: First, experi-
ences triggering the emotional state of joy should be further explored. Sec-
ond, these processes triggering joy should be shown to mediate therapeu-
tic change and to enhance intrapsychic resources for them to truly merit
the status of curative processes. Finally, it should be investigated whether
therapists who are highly skillful in their ability to enable these curative
processes achieve consistently better treatment outcomes than less skillful
therapists.

The model of curative processes presented here is integrative in two
important ways: (a) It is not limited to any particular approach to psycho-
therapy, but originates in the question of which mental and behavioral
processes are related to experiencing joy. Joy is regarded as the emotional
correlate of healing, indicating a process of unification and self-
transformation. It is much more efficient to start the search for curative
processes on the basis of the experience of joy than on the basis of a
multitude of therapy process elements. (b) The therapist uses principles
and techniques from many different approaches to facilitate the curative
processes and to enhance intrapsychic resources in the patient. This process
of trying to facilitate healing in the patient is based on an individual
understanding of the patient and a universal theory of change. Different
therapeutic approaches and methods may activate different curative pro-
cesses in the patient, thus complementing each other.

In conclusion, efficacious psychotherapy is a creative art of facilitating
mental health and developing the disposition for happiness by encouraging
self-transformation and self-integration in the patient associated with the
experience of joy. Therapeutic approaches and methods are not directly
linked to curative processes but can only indirectly encourage them. Psy-
chotherapy should be based on an individual understanding of a particular
patient in order to recognize which universal curative processes need to
occur for the improvement of mental health and how these processes of
healing can be facilitated inside and outside of therapy sessions.
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