

Paradigm Lost:

From Model-Driven to Client-Directed, Outcome-Informed Clinical Work

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Abstract

Over the past decade, solution-focused therapy has undergone dramatic growth in interest and popularity. At the same time, there continues to be a dearth of empirical evidence of its purported effectiveness. Moreover, available data indicates that any effectiveness of solution-focused therapy is likely due to both the shared and unique ways the approach empowers factors long associated with positive treatment outcome for *all* models of therapy. In this paper, the factors common to all therapies are reviewed and a strong argument made for shifting from model-driven to a client-directed, outcome-informed therapeutic paradigm.

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“The meaning of the world is the separation of wish and fact.”

Kurt Godel (Barrow, 1998)

Solution-focused therapy has undergone dramatic growth in interest and popularity since the appearance in 1986 of the first article--“Brief Therapy: Focused Solution Development”-- setting forth the principles and techniques of the approach (de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, and Weiner-Davis, 1986). For example, in the short period of time between the publication of the first comprehensive bibliography (S. Miller and Hopwood, 1993) to the present (Triggiano, 1999), there has been a whopping 350% increase in the number of books, articles, video and audiotapes dedicated to solution-focused work. Hundreds of therapists from all over the globe regularly participate in a listserv² dedicated exclusively to solution-focused therapy (SFT). And while the annual East Coast Conference on SFT is no longer being held (S. Miller, Hubble, and Duncan, 1996), international attendance at the meetings of the European Brief Therapy Association--an organization dominated by therapists interested in SFT--continues to grow at a phenomenal rate (Beyebach, personal communication, 1998).

Research on the approach has been slower in growth and appearance. As Beyebach, Rodriquez-Sanchez, Arribas de Miguel, Herrero de Vega, Hernandez, Rodriguez-Morejon (1999) point out in their article, “although solution-focused brief therapy (SFBT) has grown in popularity, there is little empirical evidence of it’s purported effectiveness” (p. x). Nevertheless, results from published demographic reports--studies which, by their very nature, are likely to be the *most* favorable to the method being investigated--are *more similar* than different from other extensively researched and established treatment approaches (de Jong and Berg, 1997; Hopwood

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and de Jong, 1996; McKeel, 1996; S. Miller, Duncan, and Hubble, 1997; Duncan, Hubble, and Miller, 1997; Duncan, S. Miller, and Hubble, 1997).

Specifically, available studies indicate that the outcome, duration, and process of change in SFBT corresponds with approaches developed during the same period of time (i.e., cognitive therapy [CT], cognitive-behavioral therapy [CBT], problem-focused brief therapy [PFBT]). For example, in their study of outcomes at the Brief Family Therapy Center, Hopwood and de Jong (1996) noted that 70% of their clients came 3 sessions or less, a figure not statistically different from those reported in other studies with samples matched for economic status and cultural background (Garfield, 1994). Additionally, in this issue of the *Journal of Systemic Therapies* Beyebach et al. (1999) report a “success” rate virtually identical to that reported a quarter century ago by Weakland, Fisch, Watzlawick, and Bodin (1974) for PFBT (74% versus 72%). Several reports (Beyebach, Rodriguez-Morejon, Palenzuela, and Rodriguez-Arias, 1996; Beyebach et al., 1999; de Shazer, 1991; Kiser, 1988; Kiser and Nunnally, 1990) note that the trajectory of change in SFBT is similar to other approaches where the majority of client improvement has consistently been found to occur *earlier* rather than later during treatment (Howard, Kopte, Krause, and Orlinsky, 1986). And finally, as is true of psychotherapy-in-general, there is substantial and credible evidence of a positive correlation between treatment outcome and the number of SFBT sessions a person receives (Beyebach et al, 1999; McKeel, 1996).

The finding of similar outcomes strongly suggests that any effectiveness of SFBT is likely due to both the shared and unique ways the approach empowers factors long associated with positive treatment outcome for *all* models of therapy (S. Miller, Hubble, and Duncan, 1995; S. Miller, Duncan, and Hubble, 1997). These so-called “common” factors include: (1) *extra-therapeutic factors*, including the client’s strengths and resources, their beliefs about the change process, as well as the occurrence of any chance change-producing events in their lives (40%); (2) *the client-therapist relationship*, including the client’s experience of the therapy as empathic and affirmative, as well as collaborative in terms of the goals, method and pace of the treatment (30%); (3) *hope and expectancy*, including client belief in themselves and possibility of change (15%); and (4) *structure and focus*, including any unique ways an approach organizes the treatment process in a manner acceptable to the client (15%).

Some of the unique ways that SFBT likely empowers the contribution of the common factors include asking questions about exception periods, coping strategies, and pre-treatment change (Berg and S. Miller, 1992). Indeed, solution-focused therapists de Jong and Berg (1997) have said that the very purpose of such questions is to, “initiate conversations about client-based strategies, strengths and resources” (p. 9)--in other words, to highlight the single largest contributor to change, the extra-therapeutic factors. In another place, co-developer de Shazer (1994) notes that the, “miracle question is designed to allow clients to describe what *they* want out of therapy” (p. 273, emphasis added)--in other words, to invite a collaborative focus on the client’s goals, part of the second largest contributor to change, the therapeutic relationship.³

Over the last 40 years, literally hundreds of treatment approaches have been created around innovative and unique ways for tapping into the ingredients that make therapy effective (S. Miller, Duncan, and Hubble, 1997). For example, the concept of “unique outcomes” in narrative-informed therapy obviously capitalizes on client strengths and resources while techniques which encourage the recollection of interpersonal successes combined with assignments to act “as if” those successes are occurring invite the contribution of extra-therapeutic as well as hope and expectancy factors in social-learning based treatment (Chang and Phillips, 1993; Stuart, 1980). Similarly, the emphasis on attending to and utilizing “client position” in PFBT is a unique and helpful way of building an alliance while the process of challenging pessimistic patterns of thinking in cognitive therapy increases client belief in the possibility of change (Beck, Rush, Shaw, and Emery, 1979; Fisch, Weakland, and Segal, 1983).

When viewed from the perspective of the common factors, such innovative and unique techniques cease being a reflection of a particular model or theoretical school (e.g., solution-focused, cognitive-behavioral, narrative, etc.). Instead, they become ideas and possibilities for fitting treatment to the makeup and characteristics of the individual client. Of course, the

³Though neither unique to nor developed by SFBT, the use of a team can also be seen as a way to empower the contribution of the common factors. For example, having so many people involved may lead to the belief that something big will happen. Here again, the data indicate that the team itself is *not* important but rather the client’s perception of the team. Burr (1995) found *no* overall difference in outcome with cases treated with SFBT that included a team and those cases not seen by a team.

challenging question, given the large number of choices available, is which techniques to adopt when working with a particular client? For most of the history of the field, therapists have been trained and research conducted “as if” treatment models were useful in organizing clinical work. The data, however, are clear: they neither explain nor contribute to effective treatment (S. Miller, Duncan, and Hubble, 1997).

Over the last 40 years, literally hundreds of studies have been conducted--so-called “horse-race” or “grand prix” designs--pitting one approach against another in an attempt to identify which is the most effective. The resounding conclusion of this research is that in terms of outcome it simply doesn’t matter whether one exclusively practices cognitive-behavioral, psychodynamic, psychopharmacology, or--as the research cited in this issue makes clear-- solution-focused therapy (Hubble, Duncan, and S. Miller, 1999). The finding of equal outcomes makes clear that the various competing and disparate theories of therapy, like mirrors in a carnival fun house, distort more than accurately reflect the change process. As senior psychotherapy researcher has observed, existing models “do not specify the essential components *nor the psychological mechanisms responsible for their respective success*” (p. 98).

In any event, as noted earlier, even under the most optimal circumstances, models contribute only 15% to outcome variance (Lambert, 1992). Moreover, there is actually growing evidence that strict adherence to a single approach has a negative effect on outcome (Castonguay, Goldfried, Wiser, Raue, and Hayes, 1996; Henry, Schacht, and Strupp, 1986; Lambert and Bergin, 1994). This latter point is obviously *not* lost on experienced clinicians who, surveys have consistently found, tend to identify *less* with any one approach the longer they have been in practice (Garfield and Bergin, 1994). The question remains, however, on what basis to organize and direct treatment? Research on the common factors points directly to the client.

From Model-Directed to Client-Directed Clinical Practice

“The eventual disappearance of [differing schools of thought] comes about either when the issues are settled by the research evidence, or when both types of hypotheses are absorbed into some new and more penetrating view . . . redefining the issues in a way not hitherto perceived.”

Carl Rogers (1951, p. 8)

Recall that clients' skills and resources, view of the change process, and experience of chance change-producing events ([40%] Tallman and Bohart, 1999), their perceptions of the therapeutic relationship, goals for treatment, and frame of reference regarding the presenting complaint ([30%] Bachelor & Horvath, 1999; Duncan, Hubble, and Miller., 1997; Duncan and Moynihan, 1994 [30%]), and, finally, their hopefulness and expectations for change (Snyder, 1999) account for 85% of the variance associated with treatment outcome. Even the particular model of therapy employed--at best accounting for 15% of outcome variance--must be acceptable *to the client* in order to have a chance of being successful (Hubble, Duncan, and S. Miller, 1999).

Such data make clear that rather than squeezing the client into the language and theoretic bias of a particular model, treatment should be organized according to the client's perceptions, experiences, and ideas. As Erickson (1965) once noted, "The therapist's task should not be proselytizing of the patient with his own beliefs and understandings . . . What is needed is the development of a therapeutic situation permitting the patient to use his own thinking, his own understanding, his own emotions in the way that best fits his in his scheme of life" (p. 65).

From this perspective, there are no a priori assumptions about client problems *or* solutions, no special questions or series of questions that are best to ask, and no invariant therapeutic methodology that need be followed. Rather, the therapist follows the client's lead, listening for and adopting their language, world view, goals, ideas about the problem, and experiences with the change process. In particular, the therapist is curious about:

- How does the client talk about the concerns that bring them into treatment?
- What does the client want from therapy? the therapist?
- How does the client define the therapist's role in the change process?
- What are the client's thoughts, hypotheses, hunches about the problem? Causes? Cure?
- How does change usually happen in the client's life? When? Where? Who?

- What role does the client play in initiating/maintaining change?

Over time, an approach develops that is uniquely suited for the client based on a process-determined synthesis of their stories, experiences, and interpretations of the problem and the change process. Importantly, the degree and intensity of the therapist's input and involvement in the process varies and is driven by the client's expectations of the therapist's role.

S. Miller and Berg (1995)⁴ described this very process of developing what might usefully be termed a "client-directed" approach when recounting the history of the "Miracle Question" in SFBT:

A woman called us for an appointment demanding that she be seen that day because it was an emergency. She began sobbing as she told the receptionist how her husband's drinking was out of control and that he had even been violent toward her. As [the client] entered the therapist's office and began to sit down, she said, "My problem is so serious that it would take a *miracle* to solve it!" (p. 37)

No attempt was made to fit the client into the theoretic or methodologic bias of a particular treatment approach--this case was seen two years before the publication of the first article spelling out the basic tenets of SFBT (de Shazer et al., 1986). S. Miller and Berg (1995) report that the therapist simply "*followed [the client's] lead*, [and] said, "Well, . . . , suppose one happened . . ." (p. 37; emphasis added)? Immediately, the client:

. . . began to describe what she wanted to be different about the situation that was troubling her. As she described what she wanted in more detail, a smile began to creep into her face and the tone of her voice became more hopeful As she stood to leave the office, she told the therapist she was feeling "much better." (p. 37)

The impact of this skillful attending to the client's language carried over to the next session. According to S. Miller and Berg (1995), "The following week [the client] returned and reported that she had turned that feeling into some small but significant changes in her life and her marriage. (p. 37).

⁴Later, G. Miller and de Shazer (1998) published an account of the development of the miracle question that is similar in all respects except the nature of the complaint presented by the client.

However, rather than seeing this case as an example of the importance of adopting the client's view of the problem and change process--"it will take a miracle to solve my problem"--the client's unique language became part of a general formula for initiating conversations about goals with *all* clients--"pretend a miracle happens" (de Shazer and Berg, 1997; G. Miller and de Shazer, 1998; SFT-L postings #117-175, March 1998).⁵ As S. Miller and Berg (1995) note, "The success we experienced with [this client] led us to begin asking *all* our clients to pretend during the session that a miracle had solved their problem" (p. 37).

To be sure, a highly stylized approach to treatment is not unique to solution-focused work but rather is characteristic of most therapeutic work driven by models rather than clients. The old saying, "Jungian therapists have clients with Jungian Dreams while Freudian therapists have clients with Freudian dreams" is a reflection of this same observation. With the explosion in the number of treatment approaches, the old saying could be expanded to include: systemic therapists have clients that are problematically homeostatic, narrative therapists have clients who are oppressed by their problems, cognitive therapists have clients that are plagued by negative, automatic thoughts, and so on.

Data reflecting the importance of the client's perceptions of the treatment process indicate that the time has come to move beyond the provincialism and schoolism that has dominated professional discourse and practice for the last 100 years. As Rogers (1951) predicted, empirical research has absorbed these many rival therapeutic approaches into "a new and more penetrating view," placing the client at the center of the drama known as therapy. Rather than following models, clinical practice would benefit from putting the client in charge. Specifically, by making the process of inviting feedback regarding the client's experience of therapy a routine part of the treatment process. For example, from session to session the practicing therapist can informally explore:

- How/Does the treatment fits with the client's view of the problem and the change process?

⁵Indeed, de Shazer and Berg (1997) indicate that therapy cannot rightly be considered "solution-focused" if the therapist fails to ask the "miracle question" at "some point in the first interview" (p. 123).

- How/Does the treatment fit with the client's goals, expectations, and desired pace for treatment?
- How/Does the client experience the therapist as respectful, empathic, affirmative, and collaborative?
- How/Does the treatment capitalize on what the client can do?
- Does the client believe that treatment is utilizing all of the resources available to bring about change?
- How/Does the treatment result in an increase in the client's sense of hope and personal control?
- How/Does the treatment contribute to a growing sense of self-esteem, self-efficacy, and self-mastery?
- Does the client believe the treatment working?

Answers to such questions indicate the degree to which the therapy being provided is with congruent with what the research says clients value in treatment (Miller, Duncan, and Hubble, 1997). Obviously, the information received in response to such queries can be used to alter the therapy in ways that maximize both the fit with the client and the contribution of the common factors (Johnson and Shaha, 1996, 1997). Therapists might even find a particular *idea* or *technique* from one or more of the over 250 available treatment approaches for operationalizing the client's feedback in clinically meaningful ways.

As just one example of using client feedback to guide therapy, consider the case of Julian, a 35 year old man who sought treatment for what he called "obsessive-compulsive disorder" after reading a self-help book based on solution-focused therapy (Miller and Berg, 1995). On the phone, Julian indicated that he liked the "positiveness" of the approach and believed that the method might help him "handle" the "intrusive" thoughts and behaviors that had been "plaguing" him for last 15 years. Answers to the scaling questions confirmed Julian's report of "feeling better in general" after three sessions of model-driven SFBT. Simultaneously, however, Julian indicated that *no* change whatsoever had occurred in his presenting complaint.

At the conclusion of the visit, team members joined Julian and his therapist in front of the one-way mirror to share ideas and explore options. In particular, the group considered whether

the treatment being offered fit with Julian's view of the problem and ideas about the change process. After some discussion, a consensus began to emerge around the notion that the language of treatment was at odds with the language Julian most often used when talking about his problem.

Specifically, the language of the therapist, following the rationale and techniques of the SFBT model, seemed to be oriented primarily toward a time in the future when the problem was solved (e.g., "Suppose a miracle . . .," "How will you know when this problem is solved," etc.). Nearly all of Julian's descriptions, on the other hand, were oriented toward the present (e.g., "How do I get this thought out of my head"). In addition, the therapist's language favored an internal locus of control (e.g., "how did *you* do that?") while Julian's reflected an external view of events (e.g., "these *intrusive* thoughts have been *plaguing* me for 15 years). In the sessions that followed, the therapist adopted Julian's language and view of the problem and change process. An approach to change gradually evolved in which Julian learned to "outsmart," "stand up to," and, on occasion, "give into" the thoughts and behaviors that had "bullied" him for so long. Along the way, ideas from the narrative school were used to operationalize Julian's emerging theory of change.

Putting clients in charge of treatment can also be done in a more formal and systematic way.

From Model-Directed to Outcome-Informed Clinical Work

"Data talks and bullshit walks."

Geraldo Riveria

During the 1950's and 60's, a series of intriguing experiments were conducted on the nature and effect of feedback on human activity. In one representative study, professor Alex Bavelas simultaneously exposed two participants to a series of pictures of either healthy or sick cells (Watzlawick, 1976). Neither person in the study could observe the other while the experiment was under way and each was given the assignment to learn to distinguish between the two types of cells through trial and error. Small lights marked "right" and "wrong" provided

feedback to the participants about their respective choices.

There was just one "wrinkle" in the experiment of which both participants were unaware. Only one of them received accurate feedback about their guesses. When the light in this person's cubicle indicated they had made the "right" choice, they had indeed guessed correctly. On the other hand, feedback for the second participant was not based on their own, but on the guesses made by the first participant! No matter their choices, this person was told they were "right" if the other person had guessed correctly and "wrong" if the other had been incorrect. Data collected without their knowledge showed, at the conclusion of the experiment, that the first participant had learned to distinguish healthy from sick cells with an 80% rate of accuracy. The second continued to guess at no better than a chance rate.

These were not the only results. The two types of feedback also had a distinct and interesting impact on the theories each participant developed during the study for differentiating between "healthy" and "sick" cells. The participant who received accurate, *reliable* feedback ended the experiment with a very simple, concrete, and parsimonious explanation. In contrast, the second participant, developed a complicated, subtle, and elaborate theory. This person, it is recalled, had no way of knowing the feedback they received was not contingent on their own responses. Sometimes, as luck would have it, their responses happened to coincide with the correct answer. However, given the inconsistent and *unreliable* feedback, this participant was prevented from learning anything about their own actions and choices.

Even these results are not all that surprising. Something more troubling occurred when the two participants shared their respective theories with each other. Contrary to what one might hope and expect, the first participant was impressed with the complicated, mysterious, and unreliable theoretical formulations of their co-participant. The second, on the other hand, dismissed the statistically accurate theory of the first as "naive and simplistic." In later retests during which both participants received accurate feedback about their own guesses, the second continued to guess at little better than a chance rate. The performance of the first, however, who was now attempting to put some of the insights of their co-participant into practice, significantly worsened.

The parallels between the results of this study and the practice of psychotherapy are

striking. For most of the history of mental health, therapeutic practice has been divorced from ongoing, systematic, reliable, and valid feedback about the outcome. The result is a jumble of competing, complicated, and often contradictory theories of treatment. The field in general, and practicing therapists in particular, can avoid continuing to run down the “cheese-less” tunnels of models and techniques by becoming more *outcome-informed* in clinical work.

Developing an outcome-informed therapeutic practice need not be complicated, time-consuming, or expensive. Neither is a background in statistics nor sophisticated research methodology required. Therapists can simply choose from among the many paper and pencil rating scales already available and then incorporate them into ongoing clinical practice. Several good sources exist which front-line practitioners can consult for information about existing instruments (c.f., Fischer and Corcoran, 1994a, 1994b; Froyd, Lambert, Froyd, 1996; Ogles, Lambert, and Masters, 1996). Importantly, however, all such measures have the advantage of being standardized, psychometrically sound, and accompanied by an abundance of normative data which can provide reliable and valid feedback about the progress of treatment.

The choice of instruments depends on the type of outcome one wants to measure. In this regard, there are two basic types of outcome: (1) clinical, and (2) treatment process. Clinical outcome measures, as the name implies, assess the impact or result of the service a therapist offers their client. Process measures, on the other hand, assess the strength of the therapeutic relationship, qualities of the treatment setting, and the client's personal experience of how well they were served (e.g., courteousness, timeliness, accessibility, professionalism, etc. [Hill, 1989; Lebow, 1982; Pasco, 1984]). In short, measures of clinical outcome tell the therapist how they are doing, while process scales provide feedback about what a therapist actually did to obtain a particular result.

As in the case of informal client feedback, information learned from the use of standardized instruments is “fed back” throughout the therapy process (Duncan, Sparks, and Miller, in press). Typically, clients are given the clinical outcome measure prior to each session and the customer satisfaction instrument toward the end (or at the break). In both cases, the instruments are scored and discussed *with* clients. This radical departure from traditional use of assessment instruments gives clients a new way to look at and comment on their own progress

and their on-going therapy. Assessment no longer precedes and dictates intervention, but weaves in and out of therapeutic process as a pivotal component of change itself. Obviously, clients who are informed, and who inform, feel connected to their therapist and the therapy process; their participation, the most significant contributor to positive outcome, is courted and secured.

Consider the case of Steven, a man in his thirties who presented for treatment with complaints of chronic depression, lethargy, and low self-esteem. Steven reported having been in treatment numerous times--on at least two occasions for a period lasting several years. While he believed that each of these experiences had been helpful, his continuing struggle with depression left him feeling that some "underlying issue" remained unresolved from his childhood. He expressed a strong desire to finally "get to the root" of the matter in the present treatment. The therapist agreed and, over the course of the next few sessions, worked in a psychodynamic framework with Steven exploring various experiences from his childhood and attempting to make connections to his current problems.

Steven's ratings on the treatment process scale given at the end of each visit could not have been higher. According to his answers, the therapy he was receiving matched what most clients associate with successful treatment. His scores on the clinical outcome measure told a different story, however. From week to week, the measure showed that he was not only *not* improving, he was slowly getting worse. Such a decrease in client functioning in the early stages of treatment is, according to existing outcome research, a bad sign (Hubble, Duncan, and Miller, 1999). Indeed, in outcome research conducted over the last 40 years *clients' experience of meaningful change in the first few visits has emerged as one of the best predictors of eventual treatment outcome*. This data shows that the majority of people experience significant improvement *early* in the treatment process or do not improve at all. More specifically, most studies find that 60-65% of people should be measurably improved within one to seven visits--figures which increase to 70-75% after 6 months and 85% at one year (c.f., Howard, Kopte, Krause, and Orlinsky, 1986; Johnson and Shaha, 1996; Lebow, 1997).

Importantly, such results should not be construed as an indictment of all therapies which extend beyond a handful of sessions. On the contrary, they indicate that in cases where progress is being made, *more* treatment is better than less. At the same time, the data strongly suggest that

therapies in which little or no change (or even a worsening of symptoms) occurs *early* in the treatment process are at significant risk for a null or even negative outcome (Lebow, 1997). In one study of more than 2000 therapists and thousands of clients, for example, researchers found that clients reporting no improvement by the third visit on average showed no improvement over the entire course of treatment (Brown et al., 1999)! In addition, clients who worsened by the third visit were twice as likely to drop out of treatment than those experiencing improvement.

With Steven, the presence of valid and reliable outcome data helped circumvent a negative outcome. Where in the past more of the same treatment may have continued for several more sessions, team members now joined Steven and his therapist in front of the one-way mirror for a short, brainstorming session. In what amounted to a free-for-all of unedited speculations and suggestions, a range of alternatives were considered including: changing nothing about the therapy, to taking medication, to shifting treatment approaches.

Out of everything, Steven expressed the most interest in an idea bandied about near the start of process. In particular, that his recurring problems with depression might not be due to some as-yet-to-be-discovered “underlying issue,” but rather from having learned to downplay his strengths and abilities as a way of dealing with his insecure and overly critical parents. In the four sessions that followed, the focus of treatment shifted. Rather than “rooting” around in the past for something that might explain his present problems, Steven and the therapist started exploring the strengths and character traits he possessed that could be of use when he was tempted to give into the depression. The results were dramatic. His scores on the clinical outcome measure reversed and began improving. When re-contacted a year after the therapy ended, Steven reported that while tempted several times, he had used what he learned about himself in treatment to successfully avoid becoming depressed.

Conclusion

“Until lions have their own historians, tales of hunting will always glorify the hunters.”

African proverb

Historically, most professional research, writing, and training has situated change in models and their associated techniques. Volumes of research data and years of clinical experience indicate that each school of therapy possesses some unique suggestions and ideas for enabling client change. At the same time, no single model, method, or approach has emerged as clearly superior in terms of engendering or explaining the change process.

Available outcome research suggests that clients--*not* models--should organize the treatment process. In particular, the formal assessment and utilization of their perceptions, experiences, and ideas regarding change. Such a system, dependent as it is on client feedback would finally invite the users of therapy to become full and equal participants in the treatment process. Furthermore, such a client-directed, outcome-informed approach would enable therapists to work in a way that fits with how most prefer to view themselves (e.g., sensitive to client feedback and interested in results) and also how they typically work (e.g., on an individual, case-by-case basis).

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