

# Client Characteristics and Psychotherapy: Perspectives, Support, Interactions, and Implications for Training

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**A**n overview and rationale for emphasising interventions based on tailoring treatments to relevant client characteristics is presented. Also emphasised is the importance of the therapeutic alliance and how the development and maintenance of this alliance is enhanced through effective technique, especially when the techniques are tailored according to relevant client characteristics. Implications for training are discussed.

"Sometimes it is more important to know what person has the disease, than what disease the person has."  
— Sir William Osler

Every professional psychologist works to determine what factors they consider to be essential for client change. Since there are now well over 400 "brand name" therapies, each with various positions on what is most important, this can be a difficult process. However, the answers that emerge from this process determine a wide range of behaviours, including how a psychotherapist will interact with clients, the design of training programs, the type of training they become interested in, what they read, how they explain what they do, and the level of intervention (individual, couples/family, group, community) they focus on. The following article will emphasise and provide empirical support for the importance of tailoring interventions based primarily on relevant client characteristics. It will also emphasise the importance of understanding the interaction between client characteristics, therapy technique, and the therapeutic relationship.

In a perfect world, it would be possible to know "what treatment, by whom, is most effective for *this* individual with *that* specific problem under *which* set of circumstances" (Paul, 1969). Given that this is perhaps an unattainable goal, the following three major perspectives have evolved: empirically supported treatments (also referred to as differential therapeutics), common ingredients, and client characteristics. Each of these approaches emphasises different therapeutic strategies, methods of conducting research, and conceptualisations of the change process. In particular, the various approaches highlight variations on whether it is best to focus on identifying and enhancing the personal qualities of the therapist

or on learning new treatment procedures. It is important to briefly review and comment on aspects of each of these three approaches with an emphasis on their core premises, level of empirical support, and relevant issues.

## Empirically Supported Techniques (Differential Therapeutics)

The empirically supported techniques (EST) approach (or differential therapeutics) is similar to medicine in that it refines intervention techniques based on a specific diagnosis, combined with additional information related to aspects of the problem (see Richards, 2001, in this issue). Crucial to this approach is disorder-specific or *DSM-IV*-based (*Diagnostic and Statistical Manual of Mental Disorders*; American Psychiatric Association, 1994) manualised procedures. Those who have supported this approach have worked to identify treatments that are empirically supported and emphasise that some treatments may be better than others. To these scholars and practitioners, the best practice will consist of learning the variety of treatment manuals that have been researched and demonstrated to produce effects that surpass those of a control or nontreatment group (i.e., Nathan & Gorman, 1998). Logically, these proponents have suggested that a treatment manual helps to ensure that a constant set of effective interventions is delivered to each client. There should also be some assurance that a client receives an active and effective treatment rather than simply a believable equivalent of the sugar pill or, more insidiously, a treatment that is harmful. In this perspective, the unique contributions of the therapist are the equivalent of noise. An ideal treatment is one that can be delivered in the same way by any therapist. Accordingly, the Task Force on the Promotion and Dissemination of Psychological Procedures of the Division of Clinical Psychology, has tendered lists of different brand name therapies and the associated types of conditions on which they are thought to be effective (Chambless et al., 1996, 1998; Task Force, 1995). Taken to its extreme, this approach to understanding therapeutic effectiveness reduces all therapies to manuals and all clients to diagnoses, eliminating consideration of the individual therapist or the individual idiosyncrasies of the client.

Various types and levels of empirical support have been provided for differential therapeutics. Probably the most noteworthy success among these treatments has been

focused, targeted cognitive interventions for the anxiety disorders (Barlow, 1988; Beck & Zebb, 1994; Gould, Otto, & Pallack, 1995). At their optimum, there is ample evidence that well constructed interventions, especially when tailored towards relevant client characteristics, account for 25% to 30% of the variance in treatment outcome (Beutler, Clarkin, & Bongar, 2000; Clark et al., 1999; Feeley, DeRubeis, & Gelfand, 1999; Oei & Shuttlewood, 1997). However, significant questions have been raised regarding the *relative* superiority of most of such interventions. Even among the anxiety and depressive disorders, in which a very specific treatment is highly touted as being effective, direct research comparisons have failed to yield evidence of this treatment's superiority over those that are less focused and widely assumed to be inferior (e.g., Barber & Crits-Christoph, 1995; Gallagher-Thompson & Steffen, 1994; Shapiro et al., 1994; Shear, Pilkonis, Cloitre, & Leon, 1994).

As a result of such findings, a large number of psychotherapy researchers (e.g., E. Anderson & Lambert, 1995; Gallagher-Thompson & Steffen, 1994; Lambert, 1992; Patterson, 1989; Shapiro et al., 1994; Wampold, in press; Wampold et al., 1997) emphasise that while manualised therapies are better than placebo or no-treatment, they are seldom shown to be more effective than other manualised therapies. Indeed, less than 10% of the total variance among outcomes can be attributed to differences in the techniques used (Beutler, 1989; Lambert, 1992; Shapiro & Shapiro, 1982; Wampold et al., 1997). This significantly questions the wisdom of focusing the majority of training and treatment planning efforts on developing the optimum treatment given a client's specific diagnosis.

The similarity of effects among treatments has convinced many scholars that factors that are "common" across treatment approaches account for more of the actual changes that occur than the specific things that are advocated by different theoretical models. These scholars emphasise that the qualities that are related to aspects of client motivation and impairment and the quality of the therapeutic relationship itself are the most important factors in accounting for psychotherapy change.

### **Common Ingredients**

The *common ingredient* approach emphasises the importance of such factors as the type and quality of the relationship (see Andrews, 2001, in this issue). Early formulations of this approach were provided by Rogers' (1957/1992) "necessary and sufficient conditions of therapeutic change" (genuineness, unconditional positive regard, accurate empathy) and Frank's (1973) emphasis on providing a client with hope, overcoming demoralisation, and creating a corrective emotional experience combined with benevolent persuasion. Numerous variations on the above approach have evolved over the past two or three decades. However, the core premises are that psychotherapy is an interpersonal process that creates change only when a positive therapeutic alliance has been developed.

Stemming from the common ingredients approach are a number of clear implications for training. Specifically, efforts should be optimally placed into how to enhance the therapeutic relationship. Rather than emphasising specific techniques, the core issue is how to foster a positive therapeutic alliance. Thus, it would be crucial to understand how the relationship develops, is maintained, deteriorates, and can be repaired. Training should then optimally spend more time on the interpersonal process of therapy with less emphasis on content issues such as refining the optimal technique given the client's diagnosis.

The qualities of the therapist and personal development of the therapist would also be crucial.

Significant support for a common ingredients approach has been found in that studies suggest that such common factors account for 7% to 30% of the change that occurs in psychotherapy (Horvath & Symonds, 1991; Lambert, 1992). To expand this further, one of the original efforts to partition the general outcomes of psychotherapy and attribute proportions of outcome to various factors was provided by Lambert and DeJulio (1978). They proposed that 50% of the variance in outcome was a function of unknown variables, including measurement unreliability. A breakdown of the remaining 50% found that 15% of the variance was related to the therapeutic relationship, 5% to therapy technique, 25% to client factors, and 5% to therapist experience and training. The figures change somewhat given the client's level of impairment, but the variance attributable to the therapeutic relationship was typically 15%. However, Lambert and DeJulio found that it never exceeded this 15% figure. Horvath and Symond's (1991) meta-analysis also found that 'the therapist alliance accounted for a somewhat similar but slightly lower 7% of the outcome variance. In contrast, Wampold (in press) found that a much larger 30% of the outcome is a function of therapeutic qualities that are inherent within the treatment relationship, a figure that is consistent with recent writings by Lambert (1992). The percentages reported above clearly highlight the importance of the therapeutic relationship, and document that, overall, it is the most widely supported factor that has been empirically related to psychotherapy outcome. It also highlights the considerable range (7% to 30%) in the degree to which the therapeutic relationship accounts for therapeutic outcome.

Even though extant research evidence consistently reveals that relationship factors account for no more than 30% of the outcome variance, some authors have attributed as much as 80% of outcome to such variables (e.g., Andrews, 2000). It is difficult to determine where such estimates derive from. For example, even considering the more liberal estimates of relationship effects provided by Lambert (1992), one would have to include under "relationship", not only "nonspecific" effects but also specific motivational qualities of the patient and patient expectancy (i.e., placebo) effects, as well. In contrast, if Lambert and DeJulio's (1978) more conservative figures are used, one must include within the concept of relationship the 50% of the variance in outcome that is the result of error in measures and the 10% of outcome variance that is related to therapist experience and training.

Thus, understanding the meanings of terms is crucial. For example, the term *therapeutic alliance* can and is loosely defined, and the "net" that is used to include various activities and qualities can be wide or narrow. Sometimes the term *factors related to the therapeutic alliance* is used as a highly inclusive term that casts a wide net. But then the net becomes so broad as to encompass almost anything about the therapeutic interaction (after all, any well-used technique is certainly *related* to the therapeutic alliance). Stating, for example, that 50% of outcome is associated with factors *related* to the therapeutic alliance is not saying that the therapeutic alliance in and of itself *accounts* for this percentage.

### **Client Characteristics**

The main focus of this article is to elaborate on and provide a rationale for psychotherapy interventions and training based on relevant client characteristics. The client

characteristics approach emphasises that, within any treatment, there are wide differences in outcomes. All treatments produce both good and poor effects that cannot be explained by nonspecific therapist qualities. Likewise, it emphasises that the failure to find differences among different brands of treatment may be because brand names misleadingly suggest that there are more differences among approaches than is true and because client diagnosis misleadingly suggests more client similarity than is actually true. Scholars who accept this point of view emphasise that, while there are many qualities that are common to all psychotherapies, there are differences in the amount and pattern of their delivery. Stated another way, therapies may differ in their focus on direct symptom change, skill development, and self-awareness as the mechanisms of change; they may advocate different levels of therapist activity and guidance; and their view of the role of client arousal may differ, but these are issues of amount rather than being present or absent. From this view, categorical distinctions among the psychotherapies are somewhat arbitrary, and a more direct observation of how therapy works may attend to these dimensional differences rather than to brand names and labels.

Out of 200 possible characteristics, approximately 100 have been subjected to empirical investigation. Various authors have extracted relevant client variables, including coping style, resistance level, social support (Beutler, Clarkin, & Bongar, 2000), the stage of readiness for change that characterises the client (Prochaska & DiClemente, 1984, 1992) and specific qualities such as hypnotisability, sympathetic reactivity (neuroticism), or coping ability (Wickramasekera, 1995). Based on preliminary studies (Beutler, Clarkin, & Bongar, 2000; Beutler, Moleiro, Malik, & Harwood, 2000), the fit between the client and the specific qualities of the intervention may double the accuracy of predicting treatment outcome beyond the contributions of the client, therapy procedures, and therapeutic relationship alone. Using a priori defined principles for matching treatment to client and adding them to the contributions of client, treatment method, and therapeutic alliance, Beutler and colleagues have reported being able to account for more than 90% of the variability among client outcomes (Beutler et al., 1999).

The most strongly supported variables have then been used in treatment planning to see if such prospective arrangements organised around the particular needs, personalities, and problems of a client can indeed enhance treatment outcome. These models have been developed independent of a particular school of psychotherapy.

One such model for systematically planning treatment has isolated the following six client variables: functional impairment, subjective distress, experienced social support, problem complexity/chronicity, resistance, and coping style (Systematic Treatment Selection; Beutler & Berren, 1995; Beutler & Clarkin, 1990; Beutler, Clarkin, & Bongar, 2000). These primarily relate to individual adult psychotherapy and are particularly relevant for depression, anxiety, and substance abuse, or when these conditions co-occur (i.e., comorbidity). A large number of studies was reviewed and consensually defined to determine these variables. For example, in determining guidelines for treating depression, 375 studies were reviewed. Various combinations of these variables have been able to predict substantial portions of the variance in treatment outcome in both retrospective analyses as well as through prospective planning (Beutler, 1989; Beutler, Machado, Engle, & Mohr, 1993; Beutler, Moleiro, et al., 2000). A rating scale is available to assist with assessing each of these dimensions

(STS Rating Scale; Fisher, Beutler, & Williams, 1999) as well as a computer program that develops a narrative report that indicates interventions likely to be optimal (Beutler & Williams, 1999).

Each of the systematic treatment selection variables has implications for treatment planning (see Table 1). Some of these relate to decisions related to basic case management. For example, clinicians working with clients having high levels of *functional impairment* are confronted with making decisions related to hospitalisation, use of medication, length of treatment, treatment frequency, and the urgency of achieving goals.

The remaining variables are relevant to the particular type of treatment. A client with high *subjective distress* is most likely to benefit from strategies that reduce this distress (support, hypnosis, meditation). In contrast, clients who experience minimal amounts of distress are likely to be insufficiently motivated and will therefore benefit from strategies that increase their level of arousal (confrontation, peer evaluation, increased expressiveness). Clients with high *experienced social support* are likely to require relatively brief interventions and are less likely to relapse. In contrast, persons with low social support need longer treatment and have poorer prognoses. This suggests that more effort needs to be placed into relapse prevention. *Problem complexity* refers to the degree to which the problem is narrow (i.e., specific phobia, pure panic disorder) versus broad (personality disorder, dual diagnosis). Clearly, circumscribed problems only need interventions targeted at the symptom, whereas a more complex expression of difficulties might require combined medical and psychosocial interventions particularly directed at resolving interpersonal themes related to unresolved conflicts.

Research has typically indicated that clients high in *resistance* (therapeutic reactance) benefit most from either supportive, nondirective approaches or paradoxical intention (therapeutic double bind). In contrast, clients low in resistance show better outcomes with more directive approaches. Finally, *coping style* relates to whether the client uses an external style (impulsive, extroverted, acting out) or a more internal (introverted, reflective, restrictive) style. Whereas externalisers demonstrate more benefit from interventions designed to directly affect symptoms or build specific skills, internalisers have been found to have greater

**TABLE 1**

**A Systematic Approach to Treatment Planning**

Client characteristics	Treatment implications
Functional impairment	Restrictiveness (inpatient/outpatient) Intensity (duration and frequency) Medical vs. psychosocial intervention Prognosis Urgency of achieving goals
Subjective distress	Increase/decrease arousal Format (individual vs. family/group)
Social support	Length of treatment Prognosis and likelihood of relapse
Problem complexity	Broad vs. narrow focus of treatment
Resistance	Supportive, nondirective, or paradoxical vs. structured, directive interventions
Coping style	Understanding, exploration, and awareness vs. overt behavioural or interpersonal change

improvement with therapist interactions designed to enhance insight and awareness.

A further client-treatment matching strategy is to take into consideration the various stages clients go through during the process of change (Prochaska & DiClemente, 1992). Some clients, especially if involuntary, might be tentatively considering the possibility of change. This may coincide with low motivational distress and high resistance. Other clients might have made a clear decision to change and enter therapy wanting specific, concrete methods of how to implement this change. Prochaska and DiClemente (1984, 1992) have summarised these stages of change as precontemplation, contemplation, preparation, action, and maintenance. Tailoring interventions around these problem-solving phases has been found to optimise treatment outcomes (Pallonen, Leskinen, Prochaska, & Willey, 1994; Prochaska, DiClemente, & Norcross, 1992). For example, a crucial aspect of intervening with a client in the pre-contemplative stage would be building rapport, increasing motivation, and discussing reasons for and against changing. In contrast, relapse prevention (social contracting, increasing social support, anger management) would be the most crucial issue to address for a client in the maintenance stage.

A further example of client-treatment matching is Howard, Nance, and Myers's (1986) adaptive counselling and therapy model. This model stresses the importance of matching the therapeutic approach to the client's maturity and readiness to make changes at that point in time. The work of Castonquay, Goldfried, Wisner, Raue, and Hayes (1996) illustrated how alliance problems tend to arise when due consideration is not given to the client's readiness to engage in specific psychotherapeutic tasks.

Another aspect of client characteristics is to consider qualities that predict early termination or unilateral termination (UT) of therapy by the client. Reis and Brown's (1999) extensive review of factors related to UT revealed that some of the most important predictors of UT were low frustration tolerance, poor motivation, and high defensiveness on the part of the clients. Further, whilst counselling readiness and psychological mindedness was related to continuation, non-psychological mindedness was related to UT in 92% of studies reviewed. In addition to these personal variables, a number of relationship variables were found to be related to UT. When the client and therapist perspectives of the nature of the problem and the cause of the problem were alike, the rate of UT was significantly lower. Reis and Brown argued that, just as therapists expect clients to come to therapy with different types of problems, they should also expect them to come with different *perspectives* of that problem. Failure to acknowledge this can lead to a downward spiral where therapist's attempts to intervene are met with increasing resistance and withdrawal.

### Perspectives on an Integration of the Three Major Approaches

Even though categorising psychotherapy around the above three major approaches is conceptually useful, it ignores the potentially important overlap and interaction between them. This is most clearly represented when trying to distinguish between *technique* and therapeutic alliance. One way of illustrating this is by considering the client's central questions on entering therapy. The first of these is clearly one of whether they can be helped in changing their symptoms and problems and the second is likely to resolve around their feelings about the particular therapist. That is, they are likely to make judgments based on their feelings

about the therapist (is the therapist perceived as warm, caring, interested?) and by their assessment of the therapist's competence (will the therapist really work with them to enable change?). It is the intricate and delicate emergence of answers to these questions as therapy progresses that characterises treatment and determines, to a large extent, its outcome. In this regard, effective technique (therapist competence) enhances the relationship. Conversely a positive relationship enhances the effectiveness of technique.

The causal relationship between alliance and technique, along with the order in which they occur, is sometimes difficult to determine. For example Beutler et al. (1999) found that tailoring interventions according to session and client characteristics was activated and enhanced by a previously developed therapeutic relationship. If a positive therapeutic alliance had been developed, then high session intensity facilitated client change. In contrast, high session intensity actually impeded therapeutic progress if it was not associated with a high quality therapeutic alliance. This suggests that, at least insofar as the intensity of the session is involved, the therapeutic alliance must first be well developed in a positive manner. In other situations, effective technique seems to be a prerequisite to the development of a positive alliance. This point is illustrated by Tang and DeRubeis (1999), who found that significant alteration in relevant client cognitions preceded dramatic improvement, and these both *preceded* an enhanced therapeutic alliance in subsequent sessions. Similarly, Dolinsky, Vaughn, Leuber, Mellman, and Roose (1998) found that a therapist's activity was important in establishing a positive client-therapist match, which then resulted in a strong therapeutic alliance. This suggests that a therapist must interact in a competent manner (reflected in client change) as a prerequisite to a significant enhancement in the therapist relationship. The above studies are a small part of a significant literature that emphasises the intricate and interacting relationship between technique, therapeutic alliance, and client characteristics. Attempting to separate them, as is typically done in both randomly controlled studies and studies focusing on the quality of the relationship, is not only short sighted, but is also likely to result in limited guidance in how to optimally conduct therapy.

A further conceptual issue is how the terms alliance and technique are used. The therapeutic alliance can be considered as a conceptual net to include various activities and qualities. As mentioned previously, this net can be wide or narrow. For example, is a therapist who is acting in a warm and concerned manner and is accurately reflecting what the client says using effective technique (in which case it would fall under the technique net), or is this a core expression of a positive therapeutic alliance (in which case it would fall under the therapeutic alliance or common ingredients net). Taken a step further, if a therapist working with a client to alter their dysfunctional cognitions (traditionally considered squarely in the technique camp) does so in a way that is warm and supportive, should it be considered a technique or part and parcel of the therapeutic alliance?

The above conceptual confusion can potentially result in one "camp" of the technique versus alliance controversy staking claims to what the other camp might consider to be their own proportion of the variance in psychotherapy outcome. In contrast, a program of research and training that takes a more interactionist perspective removes the discussion from an either/or position to a both-and perspective. It is likely that such an interactionist perspective would result in more useful and accurate information related to psychotherapy.

## Implications for Training

There are a number of training and practice implications that emerge from the above findings. Simply stated, the most valid conclusion might be that the greatest pay-off for optimising treatment gain arises from a combination of matching treatments to relevant client characteristics and enhancing the therapeutic relationship ("treatments of choice" as well as "relationships of choice"; Norcross, 1993; Orlinsky & Howard, 1987). Treatments and relationships are also perceived as mutually interactive, in that they typically activate one another. Formal diagnosis is less important in that it typically does not have as much pay-off (accounts for less of the variance) than either client characteristic matching or relationship factors. However, it can be useful in that it has implications for a number of relevant client variables (functional impairment, subjective distress, problem complexity) and has had some success with tailoring treatment for some types of disorders (i.e., anxiety disorders).

Rather than focusing on "schools" of therapy, practitioners and students would most benefit from knowing which interventions work best with which type of person. Thus, students should learn an array of skills, including assessing (formal and informal) relevant client dimensions, case decision-making, methods of decreasing/increasing arousal/motivation, ability to resolve past/present conflicts, enhancing support, therapeutic double binds, directive/nondirective strategies, behavioural/cognitive methods of symptom reduction, methods of facilitating insight, and the ability to work directly with interpersonal/family relationships. If only a limited number of these strategies is learned, it will correspondingly limit not only the types of clients they can work with, but also reduce the likelihood of benefit to their clients. In addition, it is believed that it is both confusing to students and divisive for the field to present brand names of therapy and their related techniques as horse races in which there are winners and losers. Given certain client characteristics and the relative quality of the therapeutic relationship, the techniques related to behavioural models of interventions (symptom-focused techniques of cognitive restructuring) are more effective. In other cases, the focused expressive strategies (i.e., enhancing motivational arousal, increasing awareness) associated with humanistic models provide more effective skills in an intervention. Even if, for practical reasons, a program decides to emphasise some types of skills above others, there should at the same time be an acknowledgment of the place, potential value, and empirical support for other modes of intervention.

The above empirically guided, eclectic approach places considerable demands on students/practitioners and challenges for training programs to develop a high level of relational flexibility. Since research has indicated discrepancies between what practitioners say they do and what they actually do, students need to have their work closely monitored (Beutler & Mitchell, 1981). This can ideally be accomplished through video review or live supervision. Thus, supervision in which students talk about their cases should take a second place to live/video supervision.

Empirically supported manualised treatments are useful in initial skill acquisition. In addition, manuals now include a broad number of options beyond the traditional cognitive-behavioural literature, including interpersonal (interpersonal therapy; Klerman, Weissman, Rounsaville, & Chevron, 1984), humanistic (focused expressive psychotherapy; Daldrop, Beutler, Engle, & Greenberg, 1988), and psychodynamic (time-limited dynamic psychotherapy; Strupp

& Binder, 1984) areas. As noted above, adherence to these treatments is important. At the same time, relational/therapeutic flexibility is essential in optimising outcomes. To persevere with an approach when it is not appropriate for the client, or when important aspects of the therapeutic relationship are in need of repair, is counterproductive. This latter point was confirmed by T. Anderson and Strupp (1996), who found that the most effective therapists departed from formal manuals when relevant situations arose.

Teaching should emphasise, and supervision should enhance, the crucial importance of the therapeutic relationship. In particular, this involves the therapist knowing the type of person they are and how this impacts the relationship. Thus, in addition to case management and content issues, video/live supervision should also focus on the process of how the therapeutic relationship is initiated, evolves, is impaired/enhanced, and ended. In particular, the impact of specific types of strategies on the therapeutic relationship should be explored. Just because a technique has been "empirically validated" in general does not then mean that it will work given the client's particular qualities, context, and relative stage of change.

## Conclusions

Training has been, and should be, informed by research into treatment outcome and efficacy. In the past, interpretations of research have helped to decide the extent to which programs emphasised teaching a wide array of techniques versus teaching aspects of the therapeutic relationship. However, the roles of pre-existing client variables as well as the relationship/alliance interaction have usually not been given sufficient attention. By not considering relevant client variables, training programs fail to adequately address three areas demonstrated as important predictors of treatment outcome: the role of pre-existing client factors, their interactive contribution with relationship variables, and their interactive contribution combined with technique variables.

Research into psychotherapy outcomes is roughly analogous to personality research, in that both try to understand and predict behaviour in specific situations. Magnusson and Endler (1977), in their review of personality research, reported that when predicting behaviour, personal variables accounted for 10.2% of the variance, and situational variables accounted for 12.2% of the variance. Most importantly, they reported the interaction of the two accounted for an additional 20.8% of the variance in behaviour. On this basis, they argued that too much attention in personality research was being paid to person variables and not enough to situational factors or the interaction of situational factors with personal variables. In psychotherapy research, the converse could be argued. That is, too much attention is being paid to situational factors (type of problem, techniques and procedures, therapeutic alliance, etc.), and not enough to pre-existing, personal factors (coping style, distress level, motivational arousal, resistance level, etc.) and therefore, not enough attention is paid to the interaction between these two.

When a client visits a therapist, there is essentially a reciprocal triadic relationship between the client, the problem, and the therapist. The success of the therapeutic intervention depends largely on the characteristics of each of these three variables, and the relationship between each of these three variables. The success of therapy, in large part, depends on the therapist's ability to respond appropriately to the problem and to the person with the problem. Responding to both the problem and the person is doubly important as the evidence indicates that

responding appropriately in one domain has reciprocal benefits in the other domains.

It is meaningless to argue which is more important, when therapeutic outcome is always a joint function of the characteristics of the client, the problem, and the therapist (who largely determines the specific interventions and the quality of the therapeutic relationship). Whenever an interaction takes place in one of these domains, a sequence of reciprocal interactions take place between the others. However, such an interactionist stance does highlight the importance of taking into account each of these factors.

Therapy training is usually quite effective at teaching trainees the importance of a therapeutic relationship, and to respond appropriately to different client problems via evidence-based treatments. However, systematic training in assessment, recognition, and responding appropriately to the unique characteristics of the client has largely been neglected in training programs. To develop more effective therapists and more effective therapies, the challenge is to not only train therapists to respond appropriately to what disorder the person has but also what person has the disorder.

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