

Client-Directed Outcome-Informed Work: An Overview

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Considerable research supports the notion that regardless of specific treatment modality and in some instances, treatment provider or format, clients are likely to benefit from psychotherapy. The psychotherapy literature appears to have shifted its focus from simply evaluating comparative treatments—and the resultant equivalence of outcome—to identifying the hypothesized underlying mechanisms or common factors found to account for client improvement. An alternative perspective to the traditional philosophy of psychotherapy research and practice, in which researchers strive to delineate disparities between various treatment modalities and identify the most efficacious or effective for a given disorder, involves examining the commonalities. The common factors perspective is the basis from which the Client-Directed Outcome-Informed (CDOI) approach was derived. This paper presents a general overview of CDOI and reviews the empirical evidence supporting the relative contribution of the various factors responsible for client improvement. Implications for routine clinical practice are also described. The CDOI approach may best be conceptualized as an underlying framework to which all clinicians, regardless of theoretical orientation or scientific discipline, may ascribe.

Keywords: psychotherapy, common factors, client-directed, outcome-informed

Saul Rosenzweig first introduced the notion of the “Dodo Bird Verdict” in 1936, and subsequently ignited the field’s lasting interest in the topic (e.g., Luborsky, Singer, & Luborsky, 1975; Luborsky et al., 2002). The Dodo Bird Verdict was coined to illustrate Rosenzweig’s supposition that (1) virtually all active psychotherapies were equally effective, and (2) the common factors across the various psychotherapies were so pervasive that differences in the outcomes derived from comparisons of various treatment modalities would be minimal. The Dodo Bird Verdict is based on a scene from Lewis Carroll’s (1865/1920) classic tale, *Alice’s Adventures in Wonderland*, involving a fictional character, the Dodo. In the story, the Dodo proposed that a number of additional characters run a Caucus race in an effort to dry themselves after they had become wet by Alice’s tears. The participants then all ran around at different rates and in different directions until they were dry. When the Dodo was asked who had won the competition, his now famous verdict was simply that given all participants were dry, “Everybody has won and all must have prizes” (Carroll, 1865/1920, p. 33). It is important to note, however, that the Dodo failed to measure how far each participant had ran or for how long. This passage has several important

implications for clinical practice, psychotherapy research (e.g., the need for scientific rigor), and the multitude of psychotherapy treatments available to clients. The Dodo Bird Verdict has since served as a metaphor for the state of psychotherapy treatment outcomes research (Duncan, 2002).

Some 40 years later, Rosenzweig’s (1936) initial hypothesis was confirmed and for the first time, an empirical basis in support of a common factors approach among psychotherapies was presented (Luborsky et al., 1975). Luborsky et al.’s (1975) seminal review of the comparative psychotherapy treatment literature found that although most clients benefited from psychotherapy despite differences in the specific treatment modality, there were relatively small differences in outcome comparisons between different treatment modalities.

Accumulating evidence has since emerged to provide additional support for the existence of the Dodo Bird Verdict in the context of differing psychotherapy modalities (e.g., Barth et al., 2013; Driessen et al., 2013; Joyce, Wolfaardt, Sribney, & Aylwin, 2006; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Stevens, Hynan, & Allen, 2000; Stiles, Shapiro, & Elliot, 1986; Wampold et al., 1997). Luborsky et al. (2002) replicated and extended

their initial findings almost three decades later and concluded that Rosenzweig's hypothesis was not only still fitting but was "alive and well." Specifically, Luborsky et al. (2002) examined 17 meta-analyses of active treatment comparisons to determine the relative efficacy of pairs of different active psychotherapies in comparison with each other. The authors reported a mean uncorrected absolute effect size for Cohen's d of .20 (i.e., an average difference between any two group means of 20% of the standard deviation), which was small and non-significant. Interestingly, after accounting for the role of the therapeutic allegiance of the researchers, the effect size differences in outcomes between the various active psychotherapies were even further reduced, indicating that the observed group differences may be attributed to the influence of a strong therapeutic alliance.

Research has demonstrated that the Dodo Bird Verdict prevails not only across different treatment modalities but extends across clinicians and treatment provision formats as well. That is, not only is no specific modality of psychotherapy consistently superior to any other for any particular presenting problem (e.g., generalized anxiety, panic, phobias, depression, alcohol or drugs, grief, disordered eating, marital or sexual problems, children or family, work, stress), but psychologists, psychiatrists, and social workers do not differ in their effectiveness as clinicians (Seligman, 1995). There were also no differences in outcome between clients receiving psychotherapy alone and those receiving both psychotherapy and medication. However, it is important to note that although the treatment sample from Seligman (1995) was relatively diverse in that it was comprised of clients with a wide array of presenting problems, the sample may be viewed as falling on the less severely disturbed end of the mental health continuum for clinical samples (i.e., it did not include clients with severe mental illness such as schizophrenia). Clients treated by paraprofessionals (e.g., university professors selected on the basis of their ability to form understanding relationships) have also been shown to experience, on average, comparable levels of improvement relative to clients treated by experienced professional psychotherapists (Bright, Baker, & Neimeyer, 1999; for review see Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010; Strupp & Hadley,

1979). Further, self-help materials have been shown to be as effective as group or individual treatment for select mood, anxiety, and substance use disorders (Cuijpers, Donker, Straten, Li, & Andersson, 2010; Heather, Whitton, & Robertson, 1986; Lidren et al., 1994; Miller & Taylor, 1980).

Common Factors Perspective

Now, more than 35 years after Luborsky et al.'s (1975) groundbreaking findings and an outpouring of studies conducted to support or refute the Dodo Bird Verdict (e.g., Barth et al., 2013; Poulsen et al., 2014), the literature appears to have shifted its focus. That is, researchers appear to have focused on identifying the common factors across treatments that are likely responsible for favorable clinical outcomes rather than simply evaluating comparative treatments. An important modern contribution to the common factors approach was Lambert's (1992) four-factor model of change derived from his extensive review of the diverse psychotherapy treatment outcomes literature. Lambert identified four therapeutic factors found to account for client improvement in the context of psychotherapy: (1) extratherapeutic, (2) common factors, (3) expectancy or placebo, and (4) techniques. Lambert's four-factor model was later modified to expand the term *common factors* from its original meaning of non-specific, relational factors to include all four factors under the overarching umbrella term of common factors (Miller, Duncan, & Hubble, 1997). Miller et al.'s (1997) modified common factors model was comprised of: (1) client/extratherapeutic factors, (2) relationship factors, (3) placebo, hope, and expectancy factors, and (4) model/technique factors. The following sections will describe the four common factors and briefly review the empirical evidence supporting the relative contribution of each of these factors to client improvement in the context of psychotherapy.

Client/Extratherapeutic Factors

Individual client characteristics (e.g., resilience, religious faith, motivation, openness), in addition to social support and unforeseen interactions and events thought to operate outside of the client's control prior to entering treatment, constitute client/extratherapeutic

factors (Miller et al., 1997). An empirical review of the vast psychotherapy treatment outcomes research found that 40% of improvement in clients may be attributed to these factors (Assay & Lambert, 1999). Thus, the Dodo Bird Verdict may hold true given one very important element is held constant in the context of all psychotherapies, regardless of orientation: the client (Bohart, 2000). Some authors (e.g., Miller et al., 1997) have suggested that the client may be the most important and influential contributor to outcome in psychotherapy.

Clients seeking psychotherapy treatment rarely experience impairment in a single domain of functioning (e.g., Barkham, Stiles, & Shapiro, 1993; Markarian et al., 2010), and present with a variety of client/extratherapeutic factors that may complicate treatment and potentially lead to a poorer prognosis if left unaddressed (Appleby, Dyson, Altman, & Luchins, 1997; Carroll, Powers, Bryant, & Rounsaville, 1993; McLellan et al., 1994; McLellan, Arndt, Metzger, Woody, & O'Brien, 1993; McLellan, Grissom, Zanis, & Randall, 1997). Thus, it is important that clinicians incorporate techniques that consider and address such factors. For instance, the perception and receipt of social support have been regarded as important extratherapeutic and common factors that may serve as meaningful areas to focus on in the course of psychotherapy treatment (Hogan, Linden, & Najarian, 2002). Several prognostic indicators or predictors of response to psychotherapy treatment have also been identified, and point to the value of addressing the client's environment and related extratherapeutic factors (e.g., marital status, legal involvement, employment, cultural factors, acculturation) in the context of psychotherapy (Alvidrez, Azocar, & Miranda, 1996; Chan, Shaw, McMahon, Koch, & Strauser, 1997; Hamilton & Dobson, 2002; Jarrett, Eaves, Grannemann, & Rush, 1991; Knight, Hiller, Broome, & Simpson, 2000).

Relationship Factors

Relationship factors represent a wide range of relationship-mediated variables that occur between the clinician and client, and are present among all psychotherapies regardless of the clinician's theoretical orientation. Relationship factors include the core clinician-provided variables (e.g., warmth,

genuineness, unconditional positive regard, empathy) described by Carl Rogers (1959), client-provided variables (e.g., perception and client-rated quality of the relationship), and, most notably, the broader concept of the therapeutic alliance. The therapeutic alliance (i.e., the collaborative relationship between the client and clinician; Bordin, 1979), which encompasses both clinician and client contributions, has been found to have a significant effect on clinical outcome and is a significant predictor of psychotherapy treatment success with respect to clinical improvement, treatment engagement, and retention (Connors, DiClemente, Carroll, Longabaugh, & Donovan, 1997; Krupnick et al., 1996; Meier, Barrowclough, & Donmall, 2005). Relationship factors as a whole have been found to be the most important clinician-related contributing factor and account for 30% of successful outcome variance in psychotherapy (Assay & Lambert, 1999). In order to improve outcomes, additional work in the area of evaluating the potential mediators and moderators of treatment effectiveness, as they relate to relationship factors, is warranted.

Placebo, Hope, and Expectancy

Placebo, hope, and expectancy factors refer to the portion of client improvement that occurs simply because the client is receiving treatment of some kind. In other words, these three therapeutic factors reflect the level of change presumably due to both the client's knowledge of being treated and his or her beliefs derived from an assessment of the credibility of the psychotherapy itself and related techniques. Therefore, client improvement, as it relates to placebo, hope, and expectancy, is believed to be the product of the positive and hopeful expectations associated with the use and implementation of a particular psychotherapy (Miller et al., 1997). The relative contribution of these factors to psychotherapy outcomes has been shown to account for 15% of client improvement (Assay & Lambert, 1999). Although the assessment of the client's expectations for treatment may prove useful from a clinical perspective, it also has the potential to strengthen future research efforts in this area given the availability of relevant treatment expectancy data.

Model and Technique Factors

Model and technique factors are unique to specific psychotherapies and their respective theories of change. For instance, cognitive-behavioral therapy (CBT) for alcohol use disorders is a structured treatment approach based on the principles of social learning theory that focuses on understanding a client's drinking behavior in the context of his or her environment, cognitions, and feelings (Kadden et al., 1999). Cognitive-behavioral therapy for alcohol use disorders posits that clients who manifest maladaptive beliefs and behaviors may be able to learn appropriate coping strategies that would allow them to more effectively manage negative affect and ultimately cut down or abstain from alcohol use. The main techniques utilized include developing basic drink refusal skills, coping with cravings and high-risk situations, challenging maladaptive cognitions, managing thoughts about alcohol and drinking, and establishing a social network that will support recovery (Kadden et al., 1999). Likewise, CBT for social anxiety disorder includes various cognitive and behavioral strategies such as cognitive restructuring, development of a fear and avoidance hierarchy, exposure to feared situations, social skills training, and applied relaxation techniques (Hope, Heimberg, & Turk, 2010). Thus, the specific techniques (e.g., cognitive restructuring of maladaptive beliefs) and associated underlying model of behavior change distinctive to a particular psychotherapy represent the fourth class of common factors, and have been found to account for 15% of client improvement (Assay & Lambert, 1999).

Client-Directed Outcome-Informed Work

An alternative perspective to the traditional medical model of psychotherapy research, in which researchers strive to delineate disparities between various treatment modalities and identify the most efficacious (i.e., performance under controlled conditions) or effective (i.e., performance under "real-world" conditions) for a given disorder, involves examining the commonalities. The common factors perspective, as described above, is the basis from which the Client-Directed Outcome-Informed (CDOI; Miller & Duncan, 2000b) approach was derived.

The CDOI approach may be best conceptualized as not just another contestant in the race, but rather an underlying framework to which all clinicians, regardless of theoretical orientation or scientific discipline, may ascribe. The CDOI approach involves tailoring psychotherapy treatment to each client based on the systematic collection and incorporation of client feedback. Clinicians, therefore, may use CDOI to guide their clinical work while creatively using whatever model is deemed to best fit the individual needs of the clients they serve in an effort to achieve successful outcomes. According to Miller, Duncan, and Hubble (2002), any form of psychotherapy may be considered client-directed and outcome-informed when clinicians purposely incorporate three important elements into their practice: (1) enhancing the factors across theories that account for successful outcome, (2) using the client's theory of change to guide their selection of techniques and integration of various treatment models, and (3) informing treatment through the utilization of psychometrically sound assessment measures of the client's experience of process and outcome.

The Enhancement of Factors across Theories

Research findings from numerous quantitative comparisons of different active psychotherapy treatments all point to the value of highlighting the commonalities across psychotherapies, particularly the single largest contributor to change, extratherapeutic factors (e.g., Berman, Miller, & Massman, 1985; Crits-Christoph, 1992; Luborsky et al., 1975; Luborsky et al., 1999). An investigation of the contribution of unique and shared process variables to outcome found that client's improvement was predicted by two shared factors: the therapeutic alliance and the client's emotional involvement (Castonguay, Goldfried, Wisner, Rague, & Hayes, 1996). As previously noted, specific models and techniques accounted for only 15% of outcome variance (Assay & Lambert, 1999). Available models, therefore, provide limited insight into the essential elements or underlying psychological mechanisms responsible for their respective success. Interestingly, strict adherence to a particular model and associated techniques, in an attempt to correct problems in the therapeutic alliance, has been found to correlate

negatively with outcome (Castonguay et al., 1996). In other words, the emphasis of psychotherapy should not be on the specific model and techniques, but rather the alliance formed between the clinician and the client, and perhaps most importantly, the client's ongoing evaluation of the treatment experience as a compass to better inform treatment techniques.

In fact, a call for a paradigm shift has been proposed from the traditional model-driven approach to one focused on translating the vast comparative psychotherapy outcomes literature into pragmatic practice (Duncan & Miller, 2000a, 2000b; Duncan, Miller, & Sparks, 2004; Duncan, Sparks, & Miller, 2000; Miller & Duncan, 2000a). Rather than matching clients to specific treatments, the focus should be on matching treatments to the individual needs of clients through the incorporation of a systematic assessment of clients' perceptions of process and outcome. Such a shift involves assigning clients a key role in determining and informing the delivery of their own treatment and is needed to enhance the benefit of any particular model of treatment (Miller & Duncan, 2000a). Thus, placing clients at the forefront of their change via the provision of feedback regarding treatment progress and alliance information into standard psychotherapy practices has been shown to improve clinical outcomes (Anker, Duncan, & Sparks, 2009; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Reese, Norsworthy, & Rowlands, 2009). Operating from a client-informed perspective, or simply conducting psychotherapy within the context of the client's own theory of change, also provides for the additional benefit of allowing a clinician to integrate multiple theoretical orientations and related techniques (Duncan & Miller, 2000a).

The Client's Theory of Change

Many commonly accepted and frequently used empirically-supported psychotherapy treatments operate from the perspective of the medical model of psychopathology, in which the clinician (e.g., psychiatrist, psychologist, social worker) adheres to a standard set of procedures and administers a battery of assessments designed to identify symptoms in an effort to arrive at a formal diagnosis (McManus, 1992). Diagnosed symptoms and disorders are then matched to particular treatments as determined by

both the psychotherapy outcomes literature (e.g., randomized controlled trials) and the clinician's extensive training and experiences. Although this particular approach has the ability to more efficiently match available resources to client needs, limitations include, most notably, that it may be overly restrictive (McGee & Mee-Lee, 1997). In fact, strict adherence to such an approach may inadvertently conceptualize clients as passive, and appear to have omitted one very important element essential to prognosis—the client's personal theory of change.

When operating from a client-directed perspective, however, clients are encouraged to be an active, collaborative participant in their treatment and serve an integral role in the formulation of their treatment plan (Hubble, Duncan, & Miller, 1999). Specifically, this collaborative approach should extend beyond simply including the client in the development of their treatment plan to an ongoing process present at the outset of each session and continuing throughout the duration of treatment. Given that a client-directed approach considers the client's thoughts and ideas most important, time should be allocated to jointly set the agenda, agreeing on the topics to be discussed each session. Thus, the client's concerns are solicited and discussed prior to those of the clinician. After exploring and attending to the client's thoughts and concerns, the clinician may proceed with offering his or her own reflections and observations in response. Further, when working from a client-directed perspective, a skilled clinician will not only respond to the client's thoughts, but will build on the client's ideas in an effort to work together and collaboratively create a better, more useful understanding of the client. This pattern of having the clinician first attend to the client's needs before offering advice or direction should occur across all areas of the client's treatment including decisions regarding length of treatment and an action plan that may be carried out between sessions.

Although it is of paramount importance that clients maintain an active role in their treatment, the clinician's training and experience in creating appropriate individualized treatment plans should not be diminished. That is, when working from a client-directed perspective, the clinician is best suited to put into practice the extensive research findings

from outcomes research on treatment compliance (i.e., ideas and plans generated by clients are those most likely to be followed and ultimately bring about change; Hubble et al., 1999; Duncan & Miller, 2000b). However, as noted previously, this approach may not be appropriate in the context of treatment with clients experiencing symptoms of severe mental illness (e.g., delusions, hallucinations). Finally, by including the client as an active, collaborative participant in their own treatment via the encouragement of client reflection and planning, the client may develop an increased level of self-efficacy, recognizing their central role in any therapeutic change (Ryan, Lynch, Vansteenkiste, & Deci, 2011).

The Utilization of Measures of Treatment Process and Outcome

The third element described by Miller, Duncan, and Hubble (2002) relates to the ongoing routine assessment and feedback derived from reliable and valid measures of the client's progress. Indicators of progress may include both outcome and process measures. When clinicians administer such measures on a routine basis (e.g., weekly, bi-weekly), they are afforded with the opportunity to create a more collaborative and effective alliance with their clients (Saggese, 2005). That is, routine monitoring of client outcomes provide clinicians with the empirical means to accurately identify not only those clients evidencing favorable treatment response, but also clients that may not be responding as well to the selected treatment (Howard et al., 1996). The latter group is of particular interest to clinicians working from an outcome-informed perspective given that adjustments to the treatment plan may be indicated for these clients. That is, working from an outcome-informed approach allows clinicians to shift perspectives and interventions to best suit the clinical needs of their clients.

Utilization of standardized measures in the context of an outcome-informed approach to psychotherapy allows clinicians to predict with a high degree of accuracy the value of their services and continuity of care. In fact, the main objectives of any outcome-informed treatment approach should be to document the overall effectiveness of treatment, decrease dropout rates, and increase client

satisfaction (Saggese, 2005). Finally, it is important to note that in addition to creating a collaborative and accountable alliance, clients asked to routinely provide feedback on process and outcome via formal assessment instruments have been found to experience a twofold increase with respect to the effectiveness of psychotherapy (Lambert et al., 2003). Two such instruments that may be used for this purpose include the Outcome Rating Scale (ORS; Miller & Duncan, 2000b) and the Session Rating Scale 3.0 (SRS; Johnson, Miller, & Duncan, 2000). Collectively, the ORS and the SRS are employed in the Partners for Change Outcome Management System (PCOMS; Miller, Duncan, Sorrell, & Brown, 2005), which is a client feedback program designed to improve treatment outcomes among clients participating in a behavioral health care intervention.

Measures. Both the ORS and the SRS are brief, 4-item visual analogue scales that may be used in the context of a CDOI approach. A visual analogue scale is a measurement instrument that attempts to quantify a particular characteristic or attitude that is believed to lie on a continuum of values and cannot be directly measured. In the context of psychotherapy, there appear to be two basic types of outcomes of interest to clinicians: clinical and treatment process. As described by Miller and Duncan (2000b), measures of clinical outcome inform clinicians regarding how they are doing, while measures of treatment process provide clinicians with feedback regarding what they actually did to obtain a particular result.

The first scale is the ORS and may be considered an indicator of clinical outcome. The ORS is to be administered at the outset of every treatment session to assess the relative progress that a client has made since his or her last session. Each ORS item covers a separate domain of functioning commonly used to assess client change in the context of psychotherapy treatment (i.e., individual, interpersonal, social, and overall functioning). As noted earlier, the benefits of beginning each treatment session with an allotted time slot for the client to describe any concerns or issues are twofold; it provides the clinician with useful information to determine whether any external or environmental influences may have impeded or enhanced the client's progress, and it allows the client to become a more active participant in the treatment

plan and recognize his or her central role in any therapeutic change.

The second scale is the SRS and may be considered an indicator of treatment process. The SRS is to be administered at the completion of every treatment session to assess the client's overall experience with that particular session. The SRS assesses the client's perceived satisfaction in four areas (i.e., relationship, goals and topics, approach or method, and overall satisfaction). Similar to the ORS, the SRS provides important clinical data, which may be of interest to both the clinician and the client (Reese et al., 2009). Routine administration of the SRS provides the clinician with an opportunity to evaluate the current treatment plan and determine whether tailoring the plan would be more prudent for the client in better achieving positive change. Additionally, the client benefits from being afforded an opportunity to voice any concerns he or she may have regarding that particular session and further reinforces the collaborative nature of the client's treatment. For example, should a client rate that he or she did not feel "heard" following a particular treatment session, the clinician may modify the selected treatment method in light of the provided feedback. Low session ratings from the client's perspective also afford the clinician with an opportunity to generate hypotheses regarding the potential mechanisms responsible for the client's negative perception of his or her treatment session experience (e.g., clinician characteristics, specific techniques or model utilized).

In terms of the empirical support for the psychometric properties of the ORS and SRS, both scales have been used as global measures of distress and alliance, respectively, among clinical and non-clinical populations and have evinced adequate construct validity with longer measures purported to assess similar constructs (Bringinghurst, Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Duncan et al., 2003; Duncan, Sparks, Miller, Bohanske, & Claud, 2006; Miller, Duncan, Brown, Sparks, & Claud, 2003). Internal consistency reliability estimates of the four items comprising each of the scales have yielded Cronbach's alphas ranging from .90-.93 for the ORS and from .88-.93 for the SRS (Campbell & Hemsley, 2009; Duncan et al., 2003; Miller et al., 2003), which are above

the acceptable range in regard to Nunnally's (1978) established benchmark of a minimum level of .70. Thus, the reported Cronbach's alphas for each scale evidence a high level of interrelatedness among the items and suggest that the individual items appear to measure a common, underlying construct.

It is also important to note that the ORS and SRS are both highly subjective. As such, these scales are of most value when examining change within clients—a critical component of any outcome-informed approach, irrespective of treatment modality or theoretical orientation. However, caution is warranted in comparing across individual clients or specific subgroups of clients. Considering that the items comprising the ORS and SRS are readily accessible, and the estimated administration time and financial costs associated with implementing the scales are minimal, routine monitoring of treatment process and clinical outcomes can be both feasible and economical.

Conclusion

Considerable research supports the view that nearly all active psychotherapy treatments are more similar than different, and that differences in outcomes derived from comparisons of various treatment modalities are minimal (e.g., Luborsky et al., 2002; Smith & Glass, 1977; Smith et al., 1980; Stevens et al., 2000; Stiles et al., 1986; Wampold et al., 1997). This relatively new era of investigation into the pervasive influence of shared variables across psychotherapy treatments on clinical outcomes has led to the value of highlighting the common therapeutic factors found to account for client improvement. Previous research has demonstrated that only 15% of outcome variance may be attributed to specific models and techniques (Assay & Lambert, 1999). Furthermore, the client is arguably the only element held constant in the context of all psychotherapies (Bohart, 2000) and is regarded as the most powerful contributor to favorable treatment outcome (Miller et al., 1997). Thus, working from a client-directed perspective, which involves an enhancement of factors across theories that account for client change, is defensible.

Incorporation of ongoing routine assessment and feedback derived from reliable and valid measures of the client's progress is essential in the context

of outcome-informed work. Previous research has documented that two such measures, the ORS and SRS, appear to possess adequate psychometric properties (e.g., Bringham et al., 2006) and provide convincing support for the adoption of both scales in routine clinical practice (Anker et al., 2009; Reese et al., 2009). The administration of measures of treatment process and clinical outcomes has been identified as an effective method to enhance psychotherapy outcome and lends itself well to a CDOI approach. However, the opportunity to cultivate and maintain a strong therapeutic alliance may not be realized if such procedures are not properly implemented.

That is, some clinicians may be reluctant to administer both process and outcome measures during each treatment session due to time, effort, and cost concerns associated with a routine monitoring system. However, the required time and effort to administer such measures are minimal, and can be both feasible and economical. Additionally, if such measures are not administered on a consistent basis (e.g., weekly or bi-weekly), some clients may fail to appreciate the value of such a practice, which could potentially lead to clients believing they are not being “heard” (Lambert & Cattani, 2012; Shimokawa, Lambert, & Smart, 2010). Variable administration may also contribute to the client’s perception that the data derived from such measures are irrelevant and that the measures themselves serve limited clinical value. In this instance, it is imperative for clinicians to first provide adequate rationale for the clinical utility of incorporating such measures into the client’s treatment, and employ a careful, tactful approach in their presentation of the importance of using such a feedback system. In other words, clinicians are advised to spend ample time at the outset of treatment in an effort to avoid potential obstacles to the formation of a strong therapeutic bond later on in the treatment process due to inconsistent practices.

Together, tailoring psychotherapy in such a way that enhances the identified factors across theories that account for client change, and includes the routine administration of both process and outcome measures to inform and guide clinical practice, constitutes a CDOI approach. In light of the aforementioned potential limitations of a CDOI perspective, the relative benefits appear to outweigh

the associated costs of adopting and implementing a CDOI approach. If clinicians aspire to best meet the individual needs of the clients they serve and achieve successful outcomes, working from both a client-directed and outcome-informed perspective appears to be a requisite for such efforts.

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