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Client Strengths and Resources: Helping Clients Draw on What They Already Do Best

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Until lions have their historians, tales of hunting will always glorify the hunter.

African Proverb

THIS CHAPTER DISCUSSES

- The empirical evidence supporting a strengths-based approach
- Specific practice guidelines for recruiting client resources to promote change
- The link between pluralistic counselling and a focus on client strengths

Have you ever noticed that the field of psychotherapy is egocentric or, more to the point, therapist-centric? Therapist theories and models fill textbooks and journal articles, dominating everyday practice procedures. From the first days of training, students learn about superstar theorists and therapists. Meanwhile, seasoned clinicians seek out expert-led workshops on the latest techniques. Where does the other half of therapy, the client, come in? True, client problems are well represented in the literature. But the talk is mostly about what *we* do – or what *we* do to *them*. In this drama, clients are little more than passive recipients of therapist interventions, or their contributions are characterized by problematic transference, resistance, cognitive distortions and the like (Bohart & Wade, 2013; Duncan, 2014).

This chapter challenges this view and makes the case that clients are the centre-pieces in the counselling process; therapists' interventions succeed to the degree they engage clients and their inherent abilities. To do this, the chapter explores the empirical

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evidence supporting a strengths-based approach and offers specific practice guidelines to help clinicians recruit client resources to promote change. The consistency between pluralistic counselling and a strengths-based approach is noted, and it is suggested that adopting this way of seeing and doing therapy can enhance psychotherapy outcomes.

EVIDENCE SUPPORTING A STRENGTHS-BASED APPROACH

A strengths-based approach views clients as the engines of change (Bohart & Tallman, 2009). Specifically, strengths-based therapists seek and utilize clients' personal, interpersonal, social and cultural resources to assist them in reaching their goals. This requires that clinicians first believe that clients have strengths that are available to resolve difficulties. Second, therapists must be able to recognize client strengths or elicit them when needed. Finally, therapists need to know how to integrate client strengths into effective treatment strategies. The first step is perhaps the most difficult as it involves therapists stepping out of ingrained ways of thinking, engendered, in particular, by psychotherapy's emphasis on client dysfunction. Without this conceptual shift, the ability to perceive and respond to what clients contribute is diminished.

While believing in client strengths may be inherently appealing, without empirical support, it can be easily dismissed as naïve or unrealistic. Researching client contributions to therapy is hampered by the magnitude of idiosyncratic client characteristics and responses to therapy which are difficult to manipulate experimentally. Nevertheless, two primary bodies of research shed light on the extent and quality of client contributions to the therapy process. The first consists of five decades of exploration into factors responsible for change, best known as common factors since they are shared by all bona fide treatment approaches. According to Duncan (2014), as much as 86% of psychotherapy outcome can be attributed to one of these, client/life factors. Client/life factors include all aspects idiosyncratic to the specific client and incidental to the treatment delivered (Lambert, 2013). In other words, they are anything having to do with the client and his or her life that aids in recovery apart from participation in therapy. For example, clients may have successfully negotiated life dilemmas in the past and have a stored set of usable strategies for dealing with their current dilemma. Or, a client may have a supportive grandmother, a strong religious affiliation, or a steady job. Client/life factors also include serendipitous events in clients' lives which create conditions that help them move toward recovery, as illustrated by the following:

A mother who sought help for her eight-year-old son, Andrew, who regularly wet his bed, described a shift in the family structure when her ageing mother moved into their home. The extra time the mother now needed to tend to this new addition to the household catapulted her son into a new life stage. At his final session, Andrew proudly proclaimed that he could not keep depending on someone else all his life. He had assumed a more 'grown-up' role in the home, including managing his own laundry and his bed-wetting.

In contrast to client/life factors, the proportion of outcome variance attributable to treatment is modest. A casual inspection of Figure 6.1, with the small circle nested within the larger upper left circle representing treatment effects, reveals the disproportionate influence of what the client brings to therapy.

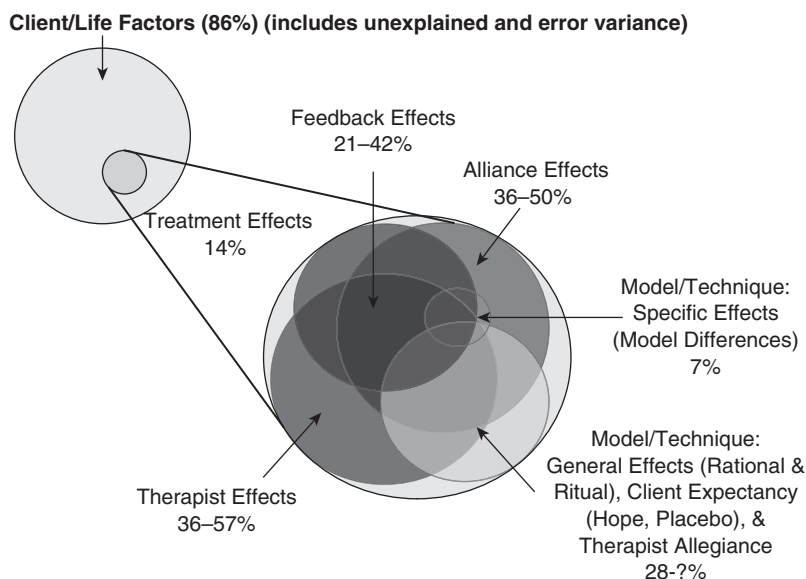


FIGURE 6.1 Relative outcome variance of client/life factors and treatment effects.

Note: Percentages of common factors for the large bottom right circle reflect percentages relative to treatment effects (the small circle embedded in the large top left circle depicting 14%), not overall outcome variance. They are best viewed as meta-analytic estimates of each factor's contribution to treatment effects. Because of the overlap among these common factors, their separate percentages will not add to 100%.

Other common factors depicted in the lower right circle include therapist, alliance, feedback, and the general effects of models and techniques, including hope and expectancy. Compare these factors to the specific effects of the differences between models and techniques. In all these factors, clients play major roles. Regarding therapist effects, those effects that represent the variance attributable not to a model but to whom the therapist is, studies have found that clients often assist therapists to meet their needs by such activities as redirecting them when they are not being helpful or modifying therapist blunders that threaten the process (Bohart & Tallman, 2009). Similarly, studies describe how clients use what therapists say or do to fit their unique goals and preferences for help (Bohart & Wade, 2013). Between sessions, therapists' interventions serve as triggers for client generativity, including personal reflection, self-questioning, or preparation for sessions that promote change in clients' everyday lives (Bohart & Wade, 2013).

Clients also play pivotal roles in the formation and maintenance of the therapeutic alliance, the partnership between the client and therapist to achieve the client's goals (Bordin, 1979). For example, instead of the alliance being created by therapists to benefit clients, clients actively participate in alliance-building, including expressing vulnerability, thereby eliciting therapist empathy, being willing to self-reveal to

enhance connection, and engaging in prosocial behaviours such as humour and accommodation (Bohart & Wade, 2013). Client cooperation and collaboration have been cited as pivotal in the creation of change (Orlinsky et al., 2004). Additionally, clients' perceptions of the therapeutic alliance, not therapists' or observers', are the best predictors of outcome (Bohart & Tallman, 2009; Duncan, 2014). Rather than their views being distorted by pathology, clients accurately assess what is most helpful for them. From this standpoint, it makes sense to gather client feedback about the alliance rather than rely on clinician judgements.

Finally, client hopefulness, sometimes referred to as the placebo effect, is a potent common factor that intersects with therapist and alliance factors to energize and sustain positive therapeutic momentum. Placebo effects involve the belief on the part of clients that therapy will be helpful. According to a review of 40 meta-analytic studies, the placebo effect has an effect size of .44 compared with no-treatment controls (Bohart & Tallman, 2009). Again, this important common factor centrally involves clients – their ability to enter therapy with the belief that it will be helpful and their propensity to maintain that belief as therapy progresses.

An additional body of literature speaks to the capacity of clients to self-heal. This research draws on both clinical and non-clinical studies. As an example, Gurin (1990) surveyed people who had experienced significant health, emotional, addiction, or lifestyle problems in the prior year and found that the vast majority (90%) reported having dealt with these difficulties successfully. Another study revealed that of the 50–60% of persons in the USA exposed to some type of trauma, only 5–10% actually develop posttraumatic stress; the rest find a way to move forward without major life disruption (Ozer, Best, Lipsey, & Weiss, 2008). In many instances, it appears that people never receiving professional help successfully use methods similar to those employed by psychotherapists (e.g., re-exposure after trauma) to restore well-being, without formal knowledge of what they are doing (Bohart & Tallman, 2009).

Even for diagnoses considered chronic and lifelong, recovery is not only possible but common (Bohart & Tallman, 2009). For example, studies show as much as an 88% recovery rate for persons diagnosed with the borderline personality disorder over a 10-year period (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006). In a study of persons experiencing a first psychotic episode treated with the open dialogue approach (Seikkula et al., 2006), 79% were asymptomatic at 5 years. Eighty per cent were working, in school, or looking for work; two-thirds never took medications and only 20% regularly took psychiatric drugs. The possibility of return to health from even dire difficulties is underreported, likely engendering a pessimistic atmosphere among helpers as well as clients. Similarly, the idea that the more difficult the problem, the longer and more arduous the recovery, appears far from universal. The experience of sudden, significant personal transformation is, in fact, well documented and less rare than one would think (Bohart & Tallman, 2009). Prochaska, Norcross and DiClemente (1994) conclude that, in or out of therapy, all change is self-change; therapy change simply has the benefit of a coach.

Far from cardboard cut-outs that therapists target with their interventions, the research makes clear that clients are active, inventive players, pivotal in fashioning a successful psychotherapy process. Despite the evidence, clients still fail to register on the radar screen of most theoretical models of change. Unfortunately, this represents

missed opportunities to capitalize on the most potent therapy resource. Given the literature, it only makes sense that counsellors recruit client idiosyncratic contributions to outcome in service of client goals. Indeed, Orlinsky et al. (2004), after a review of more than 1,000 process–outcome studies, observed that ‘the quality of the patient’s [*sic*] participation [emerges] as the *most* important determinate of outcome’ (p. 324; emphasis added). It’s the client’s resources and strengths, the client’s view of the alliance, the client’s hope and expectation for change, and the client’s preferences for intervention that drive therapy (Duncan, Solovey, & Rusk, 1992).

IMPLICATIONS FOR CLINICAL PRACTICE

With this knowledge in hand, clinicians can believe in their clients and learn how best to learn from them to construct effective treatment goals and strategies. The following example illustrates just what it means to believe in client strengths, even when it seems counter-intuitive:

Ty called to make an appointment for himself and his wife, stating it was his last hope for his marriage. At the first session, he and Lisa, who made it quite clear she believed the meeting was a waste of time, described the depressing circumstances of their 10-year marriage. From their wedding day onward (with the exception of the past month), Ty would drink until he passed out. Numerous in-patient treatment programmes, AA meetings, and near misses with accidents and the law, did not deter his addiction. Now, believing that Lisa would leave him for sure this time, he claimed to be on a new path.

Given this couple’s presentation, it might be easy to entertain thoughts that go something like: ‘Don’t get sucked in. Sure, he sounds sincere, they all do. As for Lisa, sounds like a serious case of co-dependency. He won’t change unless she does.’ A strengths-based narrative allows consideration of other possibilities. First, it makes room for heroic stories (Duncan, 2014). In this case, the counsellor (J.S.) wondered at Lisa’s fortitude in the face of great disappointment, even abandonment. This position replaced a deficit-based view that would have communicated to her that she had done something wrong in holding their lives together for so long. Second, the counsellor entertained the possibility that Ty was genuinely remorseful for the hurt he had caused and desired to make amends. Importantly, the counsellor never once believed either was not capable of transforming their lives. This fundamental belief grounded all that was done from the first session forward.

Research indicates that therapists who choose to centre resources rather than problems in their conversations are more effective (Gassman & Grawe, 2006). There are several systems of therapy that include specific questions to help therapists tap into and amplify client strengths (e.g., Cooper & McLeod, 2011; de Jong & Berg, 2008; Duncan & Sparks, 2010). Solution-focused frames locate exceptions to problems and enquire about

how those can become more frequent. With Ty, the therapist enquired into the details of how he had achieved an entire month of sobriety. She did this as a resource-based therapist, but also because of her desire to learn why and how people take radically different paths in their lives. She was asking him to teach her. These types of questions and listening to the responses they generate are undertaken in a spirit of genuine appreciation for people's struggles and their triumphs, even if it is a one-month hiatus from addiction.

One resource-based approach for counselling recommends that counsellors serve as witnesses to unrecognized aspects of clients' lives. What counsellors enquire about helps people identify events in their lives not included in 'problem saturated' stories (White & Epston, 1990: 16). For example, Ty's therapist asked who in his life would not be surprised that he could go another month without a drink. In response, Ty thought for a moment and settled on one friend. 'And what is it about you that your friend sees, that perhaps others don't, that tells him you can make it?' The discussion that followed rekindled Ty's faith in himself. Ty and the therapist then speculated whether those attributes could be harnessed to reclaim his life and his marriage. This conversation allowed Ty, with the therapist and Lisa as witnesses, to create a new story about who he was and what might be possible for his future.

The therapeutic alliance serves as a context for implementing a strengths-based approach. Bordin's (1979) classic definition of the alliance – the client's felt connection to the therapist and the agreement on the goals and tasks of therapy – helps to understand how the alliance and a resource focus complement one another. A strengths-based approach begins by respecting what clients bring to the counselling process and their inherent worth as a human being. This is Roger's unconditional positive regard. A recent meta-analysis of 18 studies examining positive regard and outcome found a significant relationship, an r of .27 (Farber & Doolin, 2011), more potent than any technique. It stands to reason that when clients feel valued by their therapist, they are more likely to participate in therapy and also to revise negative beliefs about themselves. Recall, also, that this participation is the most crucial element of a positive outcome in psychotherapy.

The warm regard between the therapist and client is not enough, however. There must be a match between client goals and the therapist's focus in treatment, as well as agreement between client preferences in therapy and therapist activities. Establishing an understanding of what clients want and what tasks appropriately fit those wants is a crucial early stage of successful therapy (Cooper & McLeod, 2011), one especially challenging with couples:

Ty wanted Lisa to move on from the past. Lisa's face, in response to this, said it all – 'Seriously?!' The therapist had to find a way to reconcile her view that Ty's recovery might be real, while also appreciating Lisa's reticence to 'just get over it'. She validated both their positions first and then stood in solidarity with Lisa. At the same time, she joined with Ty's goal by suggesting that proving to Lisa that this time was different would be the only way to begin to move toward normalizing his relationship with his wife. This strategy involved many detailed conversations where the balance of her alliance with each of them was always being negotiated.

A key factor in these conversations is the clinician's ability to maintain faith in the client's ability to change while matching their views of how this might happen. Routine tracking of the therapeutic alliance at each session enables therapists to determine if their approach fits for each client and to adjust it as needed (see Chapter 5, this volume). It also ensures clients' goals and preferred ways of working are honoured, thereby securing their active participation.

Finally, highlighting client progress is a hallmark of a strengths-based perspective. Counsellors working from this point of view are hyper-vigilant toward change, however small. Contrast this with deficit-based approaches where incidental mention of change generally gets overlooked as therapists focus on difficulties or setbacks.

For Ty and Lisa, changes were hard to miss. Ty stopped seeing his drinking friends, painted the bedroom Lisa's favourite colour, and did not drink. Despite a 'wait and see' attitude the therapist adopted to match Lisa's, she commented on Ty's efforts, explored what differences they made, and asked about how he might continue them. She punctuated Ty's change rather than viewing it as insubstantial in light of the severity of his longstanding addiction.

In sum, capitalizing on client momentum means listening for, commenting on and exploring even the smallest change.

Change conversations are facilitated by use of systematic client feedback regarding progress:

Within 4 weeks, Ty's reported distress level on the Outcome Rating Scale (see Chapter 5, this volume) reached the non-clinical range. At the same time, the therapist tempered her enthusiasm, appreciating the difficulty of the road ahead and not wishing to alienate Lisa who had every reason to be wary of a premature victory lap. Nevertheless, Ty's scores were visual gauges of something happening, prompting the therapist to discuss in session what they meant and how they might be sustained.

This dramatic improvement might easily be dismissed based on common views about recovery from entrenched addiction. Alternatively, it can be considered in light of the literature that attests to early change in psychotherapy (Howard, Kopta, Krause, & Orlinsky, 1986). Self-generated and spontaneous recovery have been identified in numerous studies of personal change apart from professional help (Bohart & Tallman, 2009).

In sum, being strengths-based requires that clinicians align with a strengths-based philosophy, be adept at identifying strengths, and adopt a particular set of strategies. Thus, the approach requires both conceptual, perceptual and executive aspects, each being crucial to successful implementation. The following guidelines summarize these components:

1. *Believe in clients.* Cultivate through study of the literature and clinical experience the belief that all people have invaluable resources waiting to be tapped in the interest of achieving desired goals.
2. *Listen for heroic stories.* Develop an ear for client reports of successes and unique achievements, whether directly related to the presenting problem or to other life experiences, past and present.
3. *Punctuate client strengths.* Comment on client resources when you hear them and enquire more about them. Whether directly connected to the presenting problem or not, consider and discuss how these attributes might shed light on potential solutions.
4. *Ask about client strengths.* Enquire about life events not generally presented in clients' accounts of the problem to help clients re-story their life narratives to include strengths.
5. *Develop a change orientation.* Become attuned to any mention of change and, when hearing it, enquire more about it.
6. *Utilize progress and alliance measures routinely.* Use client self-report progress measures routinely to serve as visual tools for noticing client progress and enquiring about different strategies to begin progress or reverse deterioration. Use alliance self-report measures routinely to ensure fit of therapist focus with clients' preferred modes of help and goals.

IMPLICATIONS FOR POLICIES AND TRAINING

Adopting a strengths-based perspective requires a re-configuring of procedures in most clinical settings. Therapists who naturally gravitate to this way of working as well as those who simply wish to test the waters inevitably will encounter obstacles. For example, the requirement in many settings to diagnose makes it difficult to be strengths-based. Additionally, rote inclusion of strengths assessments that figure little in treatment plans and interventions give mere lip service to being strengths-based. To challenge these practices, clinicians can join together to voice their discontent with deficit-based diagnostic systems. More immediately, clinical staff, from case managers to supervisors and upper management, must believe that clients can succeed. When this is so, paperwork and procedures involve practices that match a strengths-based perspective. As a result, a culture is created that is optimistic, respectful and empowering for all.

While such a transformation may appear 'pie in the sky', movements are under way that offer alternatives to business as usual (e.g., <https://heartandsoulofchange.com>; Cooper & McLeod, 2011). Centralizing a strengths-based approach throughout graduate training will be required to reconfigure future mental health care. As with client-directed practice, a pluralistic approach instils in trainees a fundamental respect for therapy service users as human beings and as experts in their own lives, possessing both the desire and ability to resolve their difficulties (Cooper & McLeod, 2011). This stance is critical for creating successful client-therapist collaborations. Until clinical practice infrastructure, including policies, procedures and paperwork, is aligned with a fundamental valuing of client strengths, clients, and all they bring to the table, will remain an underutilized force for positive therapeutic change.

CHALLENGES

Therapists committed to seeing clients as prime movers in therapy are likely to encounter two pitfalls that can jeopardize the success of treatment. First, in their zeal to highlight strengths, counsellors may downplay clients' struggles. While some clients respond well to hearing hurrahs and compliments, others may believe that their story has not been fully understood or appreciated. Listening for and highlighting strengths cannot be done at the expense of the alliance. First and foremost, counsellors need to listen to clients' stories and acknowledge their dilemmas. With this as a foundation, a more multi-storied account can enter the conversation and take shape.

Second, while it is true that many clients discover their own solutions via active listening and validation as well as eliciting heroic stories, other clients want something else. Here is where the hard work of learning multiple interventions pays off. Counsellors select an approach that resonates with client preferences, a key element of pluralistic and client-directed practice. Recall that there can be no positive alliance without an agreement regarding the tasks of therapy; this cannot happen without a task or method. Clients often expect their therapist to offer a particular explanation for their problem and a ritual (or intervention) that will resolve it (Frank & Frank, 1991). At the same time, the explanation and intervention must fit the client's theory of change – his or her view about the origins of the problem and a general idea of how it can be resolved (Duncan et al., 1992).

DISCUSSION

In their eighth (and last) session, Ty and Lisa described their lives as rather boring. Gone was the constant tension of trying to maintain a sense of normalcy amidst the unpredictability many families with active drinkers face. Now, Ty and Lisa went to work, ate their evening meal, watched TV, then settled into bed together at the end of the day – just your average domestic couple. This is what had been missing and this is what they now rejoiced in having. At the last session, they discussed their plans to 're-marry,' followed by a real (sober) honeymoon.

Whether Ty's sobriety continued is not known, though, based on alliance feedback, he likely would have returned in the event of relapse. The point is, believing in clients, trusting in their views of what is needed and in a process that honours those views is not just for some clients; it applies to all, even those with severe distress. Diagnoses like schizophrenia, for example, should not deter a strengths-based approach. People respond to human relationship regardless of diagnosis and extent of symptomatology. While adaptations may be needed (e.g., patience during psychotic episodes until meaningful communication can be established), therapists can feel confident that a focus on strengths is a valid, research-informed position likely to enhance outcome.

The lure of expert diagnosis and prescriptive treatment risks diminishing clients' critical contributions to therapy. Instead, psychotherapy can embrace its own evidence base that supports an idiosyncratic interweaving of therapist and client in relationship, informed by client feedback, with clients in the lead. Consistent with a pluralistic approach, being strengths-based means creating strong alliances by honouring client goals and preferences. And this cannot happen without valuing client resources. Choosing this path, psychotherapy adheres to empirically established and humanistic principles to provide effective and culturally responsive services.

SUMMARY

The key points of this chapter are:

- Client factors comprise the bulk of common factors across all bona fide treatments, accounting for as much as 86% (including client/life factors, measurement error and unexplained variance) of outcome.
- People have a strong propensity to self-heal, including recovery from trauma with and without formal intervention, recovery from serious disturbances such as schizophrenia and personality disorders, and spontaneous and transformative change.
- Clients are not passive recipients of therapist intervention but actively make therapy work for them.
- Believing that clients have resources and can change is the foundation of a strengths-based approach.
- Counsellors who foster hope and who tailor treatments to fit clients' preferences enhance the therapeutic alliance and increase client engagement, the most significant determinant of psychotherapy outcome.
- Strategies such as listening for and punctuating heroic stories, helping clients uncover submerged strengths, attending to and amplifying small changes, and using progress and alliance instruments to demarcate change and ensure fit are key strategies for strengths-based practice.
- Policies, procedures and paperwork either support or undermine a strengths focus in practice settings.
- Therapist cheerleading and passivity are challenges of a strengths-based approach.

EXERCISES/POINTS OF REFLECTION

- 1 In groups of four or five, choose a client and two counsellors. The client decides on a presenting problem and talks with the first therapist (about 5–7 minutes) who assumes a deficit-based perspective. This counsellor believes the client is defined by his/her pathology and failures and actively searches for and asks about them in the interview. Next, the same client is interviewed by a second counsellor who assumes a strengths-based perspective. The group debriefs by first asking the client about his/her experience in each interview. Counsellors

- and observers then offer their experiences of the role plays. Final points for discussion include contrasting the two experiences and considering the therapists' fit with the client, ability to validate the client's concern and provide hope.
- 2 A front-line counsellor at a busy community mental health agency is attending a routine agency staffing. The team is discussing a mother's diagnosis of bipolar disorder and the impact of this on her family. What obstacles does the counsellor face in being strengths based in this meeting? What protocols might be instituted to incorporate client strengths into the discussion? Into the agency? What obstacles do you encounter in your workplace being strengths-based? What steps might you take to integrate a strengths-based approach at your workplace?

FURTHER READING

<https://heartandsoulofchange.com>. The Heart and Soul of Change Project is an international consortium articulating the research and practical objectives of a client-directed, strengths-based, therapeutic paradigm.

Bohart, A. (1999). *How clients make therapy work: the process of active self-healing*. Washington, DC: The American Psychological Association. This book elaborates the essence of a client- and strengths-based therapeutic paradigm, with suggestions for how therapists can promote what clients already do best.

Duncan, B.L. (2014). *On becoming a better therapist*. Washington, DC: American Psychological Association. For therapists and educators, this book details how to use systematic client feedback and incorporate client resources to make clients true partners in therapy and improve outcomes.

Duncan, B., & Sparks, J. (2010). *Heroic clients, heroic agencies: partners for change* (2nd ed.). Jensen Beach, FL: Author. This book is a practical, hands-on manual for including clients in each step of therapy.

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