The Inversion of Therapeutic Responsibility

Perceived Client Vulnerability, Protective Practice, and the Strange Abandonment of the Client in Contemporary Psychotherapy

Sarah Ozol Shore, MS

Clinical Trainer, Clinical Effectiveness Institute

September 2026

ABSTRACT

Ordinary psychotherapy practice contains consistent contradictions. Therapists who are reluctant to tell clients what to do readily prescribe behaviors, and clients who are protected from therapist authority are left to track their own treatment. These contradictions reveal a paradigm of good and ethical practice that clinicians experience as ordinary competence rather than as one position among several. The paradigm rightly protects clients from the misuse of professional authority. The paradigm is also selective about where therapist authority is permitted: it allows authority freely when the therapist recommends behavior and treats it as presumptuous when the therapist exercises clinical judgment. Clinical judgment is where the therapist's professional contribution lies. Its functions, including formulating the problem, tracking recurrence, and noticing when treatment is not moving, therefore come to rest with the client, and the person whose vulnerability generated the protective commitments ends up carrying the clinical coherence of his or her own treatment. The correction this paper proposes is professional responsibility for the psychotherapy, held explicitly by the therapist, alongside undiminished client authority over the client's life.

A NOTE ON EPISTEMIC LEVELS

Established evidence refers to published findings and professional standards, and carries a citation. *Interpretation* refers to the Clinical Effectiveness Institute's reading of the pattern that the evidence and field observation create. *Position* refers to what the Institute argues professional responsibility should require. The inversion of therapeutic responsibility described in this paper is an interpretation and a position.

I. THINGS THAT DO NOT FIT TOGETHER

A therapist may be genuinely reluctant to tell a client what to do, holding that reluctance as an ethical commitment, while recommending meditation, grounding, journaling, exercise, boundaries, communication strategies, and coping skills in the ordinary course of treatment. The same therapist may hesitate to offer an interpretation because it would impose meaning on the client's experience, and feel no comparable hesitation about recommending a behavior before the psychological problem has been understood. The therapist's hesitation attaches to understanding the client and is absent from prescribing for the client.

Respect for autonomy can become an arrangement in which the client determines what is discussed, what is dropped, and what is returned to, even in a treatment that has not advanced in months. A therapist may find it difficult to say, "I think we need to come back to this, because it keeps happening," because redirecting the session feels controlling, and find it comfortable to assign homework at the end of the same session. Redirecting the session and assigning homework both direct the client. Only redirecting registers, for the therapist, as directing.

A client may be regarded as vulnerable enough to require protection from the therapist's authority and, in the same treatment, be the person who must recognize what matters, remember what was said months earlier, bring that material back, and often work out what the problem is.

Safety is given enormous weight, while the moments that would put safety to use arise infrequently: disagreement, challenge, redirection, rupture, and the therapist holding a view distinct from the client's. Clinicians often define a good alliance in two ways at once. The first definition names trust, comfort, disclosure, and continued attendance. The second names the client's capacity to disagree, become angry, reject an interpretation, and repair a rupture. The first definition describes a relationship that has not been tested. The second describes a relationship that can withstand challenge.

When a recommendation fails, the explanation frequently moves into the client: readiness,

motivation, regulation, capacity, adherence. A second explanation, that the therapist has not yet understood what maintains the problem, is recognized less often. A client may leave a session feeling heard and eager to return while the difficulty that brought him or her to treatment remains unchanged, and the client's attendance and disclosure may be taken as evidence of progress.

Therapy is often described as client-led. When the therapist is not organizing a session, the session is still organized: by urgency, recency, anxiety, avoidance, storytelling, appeasement, or the patterns that brought the client to treatment. The alternative to organization by the therapist is organization by the client's problem.

These contradictions recur, recur together, and recur in thoughtful, well-trained, ethically serious practitioners. Inconsistency that reliable points to a coherent set of assumptions organizing it, which the next section names.

II. THE PARADIGM THESE CONTRADICTIONS REVEAL

Interpretation: contemporary psychotherapy appears to operate inside a paradigm of good and ethical practice whose commitments are to protect the client, respect autonomy, avoid imposing, create safety, follow the client, validate, center the relationship, avoid the misuse of therapist power, and collaborate rather than dominate. The paradigm is invisible because clinicians experience these commitments as ordinary good practice rather than as a theoretical position. A clinician working within the paradigm does not experience himself or herself as having adopted a model, and a clinician who departs from it experiences the departure as an ethical risk rather than a clinical choice.

Several traditions converged to form the paradigm: Rogers's (1957) account of therapist-provided relational conditions as necessary and sufficient for change; trauma-informed frameworks emphasizing safety, collaboration, and "the leveling of power differences between staff and clients" (SAMHSA, 2014); ethics codes organized around self-determination (APA, 2017, Principle E; NASW, 2021, Standard 1.02); and alliance research establishing that relationship quality predicts outcome (Flückiger, Del Re, Wampold, & Horvath, 2018). No single tradition produced the

paradigm.

III. WHAT THE PARADIGM PROTECTS

The paradigm addresses a real danger: the misuse of professional authority over a person in a vulnerable position. A client describes material rarely spoken elsewhere, in a structurally asymmetrical relationship, to a practitioner with considerable influence over how the client understands his or her own experience. The profession accordingly calls for "special safeguards" for "persons or communities whose vulnerabilities impair autonomous decision making" (APA, 2017, Principle E) and requires explicit disclosure of "the nature of all services provided" (ACA, 2014, A.2.b). Clients should not be coerced, overridden in decisions about their own lives, or handed a meaning they cannot refuse. These protections are correct. This paper concerns something the paradigm has difficulty seeing: the therapist's separate responsibility for the psychotherapy itself.

IV. AUTHORITY OVER A LIFE, RESPONSIBILITY FOR A TREATMENT

The client holds authority over the client's life. The therapist holds professional responsibility for the psychotherapy. The therapist is not the authority on what the client should value, whom the client should love, whether the client should leave a relationship, what life the client should build, or what meaning the client should assign to an experience. The therapist is responsible for understanding the psychological problem, forming and revising a formulation, tracking recurrence, maintaining continuity across sessions, determining what warrants attention and what requires return, holding the purpose of treatment, noticing when treatment is not moving, and exercising clinical judgment openly enough that the client can question it and disagree with it.

Interpretation: the paradigm protects the client's authority over his or her life with great care, and has difficulty seeing the therapist's responsibility for the psychotherapy as a distinct obligation. Because the paradigm has not separated the two, a therapist who holds a clinical view about what the treatment needs can appear to be encroaching on the client's authority over the client's life.

V. WHERE THERAPIST AUTHORITY IS PERMITTED

The paradigm does not oppose therapist authority. The paradigm is selective about where therapist authority is allowed. Therapist authority flows without friction toward preferred behaviors, coping strategies, skills, psychoeducation, wellness practices, boundaries, regulation, and homework. Therapist authority meets resistance in the domain of clinical judgment: formulation, therapeutic focus, recurrence, hypotheses about meaning, treatment direction, the evaluation of progress, and the decision that something requires return.

Interpretation: authority is permitted in the first domain and resisted in the second because a recommendation can be framed as an option the client may decline, as health-promoting rather than interpretive, and therefore as consistent with self-determination. Clinical judgment cannot be framed as an option the client may decline. Clinical judgment requires the therapist to hold a view about the client's psychology that the client has not yet arrived at and may not welcome, and to keep holding that view over time. Within the paradigm, holding such a view looks like imposition.

The paradigm therefore licenses therapist authority most freely where professional expertise adds least, and constrains therapist authority where professional expertise is the reason the client came. An overwhelmed client generally knows that rest would help, and a client caught in a painful relational pattern generally knows which behavior would be healthier. What the client cannot supply is an account of what organizes and maintains the pattern well enough to guide lasting change.

The paradigm's distribution of permission also runs contrary to risk. A recommendation made before the problem is understood commits the therapist to a view of what this client needs at the point of least information. A formulation offered as provisional, with its reasoning shown, commits the therapist to a view the client can examine and reject. The early recommendation, which the paradigm treats as safe, is the more presumptuous of the two acts.

VI. HOW THE CLINICAL FUNCTIONS COME TO REST WITH THE CLIENT

Understanding the problem, formulating it, tracking recurrence, maintaining continuity, deciding

what requires return, holding the purpose of treatment, and noticing when treatment is not moving all remain necessary when the paradigm makes them difficult for the therapist to perform. If the therapist experiences performing these functions as encroachment, and no other structure, such as routine outcome measurement or supervision, performs them, the functions come to rest with the client, who is the only other person in the room.

Evidence bears directly on one of these functions: recognizing that a client is getting worse. In a study of 550 clients, therapists who had been told the clinic's 8% base rate of deterioration predicted three treatment failures, one of whom did deteriorate, and missed 39 clients whose measured outcomes showed deterioration; an actuarial method applied to the same clients identified 85% of those who went on to deteriorate (Hannan et al., 2005). Therapists' case notes mention worsening infrequently relative to measured functioning (Hatfield, McCullough, Frantz, & Krieger, 2010), while therapists' self-ratings of their own skill average the 80th percentile, with none below the 50th (Walfish, McAlister, O'Donnell, & Lambert, 2012). These findings establish only that recognizing deterioration frequently goes unperformed when no external structure performs it. *Interpretation:* the claim that understanding the problem, tracking recurrence, maintaining continuity, and the other clinical functions behave the same way rests on this paper's structural argument, and no study has tested it.

VII. THE INVERSION OF THERAPEUTIC RESPONSIBILITY

Interpretation: the therapist becomes intensely responsible for the conditions surrounding treatment: safety, validation, warmth, consent, noncoercion, collaboration, and alliance. The client becomes responsible for the clinical activity itself: raising what matters, remembering what to revisit, recognizing recurrence, maintaining focus, identifying the problem, and noticing that nothing is changing. The person whose vulnerability generated an extensive protective apparatus becomes the carrier of functions that belong to the professional role. No one decides on this redistribution or announces it, and it is compatible with a clinician who is conscientious about every obligation he or she can see.

Position: seeking psychotherapy establishes a professional service relationship. Once that relationship exists, the therapist cannot make the coherence of the treatment depend on the client independently raising what matters, tracking recurrence, and noticing when nothing is changing, since those are the functions the client sought a professional to provide. Clients think, remember, recognize patterns, and contribute indispensably to clinical understanding. The distinction is between contributing to these functions and being answerable for ensuring that they occur.

Responsibility for the clinical activity moves toward the very person whose vulnerability generated the protective commitments in the first place. The client may be deeply protected relationally and insufficiently protected clinically. That is the inversion.

VIII. STRANGE ABANDONMENT

The client's resulting situation does not resemble neglect. The therapist may be warm, empathic, ethical, attentive, reliably available, genuinely concerned, and deeply liked. Nothing that ordinarily signals abandonment is present, and the client can still remain alone with the central problem. What is happening to me? Why does this keep happening? What connects these experiences? Why have I been unable to change this? These are the questions the client brought to a professional for help. The client is accompanied and still alone with them. The client experiences a strange abandonment.

Strange abandonment is hard to detect for two reasons. The ordinary markers of good care, such as warmth, attentiveness, and the client's own satisfaction, are all present. And the client, who came because he or she could not resolve the difficulty alone, is poorly positioned to judge whether the difficulty is being worked on. Routine outcome data describe the surrounding landscape: across 6,072 patients in naturalistic settings, 14.1% recovered, 20.9% reliably improved, 56.8% showed no reliable change, and 8.2% deteriorated (Hansen, Lambert, & Forman, 2002). The outcomes those figures describe have many causes, and the figures do not demonstrate the inversion. They establish that substantial nonresponse coexists with a field that holds relational care in high regard.

IX. A GOOD RELATIONSHIP

The therapeutic relationship matters. An alliance-outcome correlation of r = .278 across 295 studies is a substantial finding (Flückiger et al., 2018), and the relationship "acts in concert with treatment methods, patient characteristics, and other practitioner qualities in determining effectiveness" (Norcross & Lambert, 2018). The difficulty lies in how loosely clinicians use the phrase "a good relationship." Rapport is ease of contact; bond is affective attachment; safety is the client's confidence that exposure will not be punished; trust is the expectation that the therapist is reliable and benign; relational durability is the capacity to survive friction and rupture. The working alliance, as it has been defined and measured for four decades, is narrower: agreement on the goals of treatment, consensus on the tasks of treatment, and the bond between client and therapist (Bordin, 1979).

Interpretation: by Bordin's definition, a treatment with no stated purpose and no stated approach has an incomplete working alliance, however warm it feels, because agreement on goals presupposes goals and consensus on tasks presupposes tasks. The indicators clinicians reach for most readily, comfort, disclosure, and continued attendance, are the indicators that most easily coexist with the inversion, since a client carrying the clinical activity may do so gratefully and with real affection for the therapist. A relationship that has withstood disagreement or rupture has produced evidence of its durability. A strong relationship is a professional responsibility and a predictor of outcome but professional accountability must include a clinically coherent psychotherapeutic process.

X. EXPLICIT PROFESSIONAL RESPONSIBILITY

Position: the therapist holds, explicitly and answerably, responsibility for understanding the problem, formulating and revising it, tracking recurrence, maintaining continuity, deciding what requires return, holding the purpose of treatment, and noticing when treatment is not moving. Two further responsibilities follow: evaluating movement with information not generated solely from the therapist's own impression of the session, and bringing a stalled case to supervision or consultation. Above all, the therapist exercises clinical judgment transparently enough that the client can see it, question it, and cause it to be revised. Transparency is what separates this position from clinical authoritarianism. A therapist who holds a formulation privately and steers by it has replaced one

opacity with another. A formulation the client can examine is a formulation the client can refuse. The requirement is that the therapist have a view, state it, and be accountable for whether it is any good.

The correction this paper proposes does not consist of better recommendations. A therapist who uses an understanding of the problem to advocate the same preferred behavior more persuasively has changed nothing that matters, since the client generally knew the preferred behavior already. Nor does the correction consist of measurement alone. Progress feedback improves outcomes by a small margin (de Jong et al., 2021), and only 13.9% of clinicians in one national survey reported monthly use of standardized measures (Jensen-Doss et al., 2018). Measurement instruments help a therapist notice what he or she has committed to noticing. They cannot supply the therapist's commitment to track the case in the first place.

XI. HOLDING BOTH TOGETHER

Position: the paradigm arose to keep clients from being harmed by professional authority. The paradigm did not anticipate that a client can be harmed by the absence of professional responsibility as surely as by its misuse, or that harm from absent responsibility is harder to see, because everything on the surface looks like care. The Clinical Effectiveness Institute holds that client authority and therapist responsibility were never in tension. The client retains full authority over his or her own life. The therapist remains answerable for the clinical conduct of the psychotherapy the client sought and is paying to receive. A profession that protects client authority and neglects therapist responsibility has left the person it meant to protect carrying the treatment.

REFERENCES

American Counseling Association. (2014). *2014 ACA code of ethics.* American Counseling Association.

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, amended effective June 1, 2010, and January 1, 2017). American Psychological Association.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory,*

Research & Practice, 16(3), 252-260.

de Jong, K., Conijn, J. M., Gallagher, R. A. V., Reshetnikova, A. S., Heij, M., & Lutz, M. C. (2021). Using progress feedback to improve outcomes and reduce drop-out, treatment duration, and deterioration: A multilevel meta-analysis. *Clinical Psychology Review, 85,* 102002.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316-340.

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, 61*(2), 155-163.

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*(3), 329-343.

Hatfield, D., McCullough, L., Frantz, S. H. B., & Krieger, K. (2010). Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology & Psychotherapy, 17*(1), 25-32.

Jensen-Doss, A., Haimes, E. M. B., Smith, A. M., Lyon, A. R., Lewis, C. C., Stanick, C. F., & Hawley, K. M. (2018). Monitoring treatment progress and providing feedback is viewed favorably but rarely used in practice. *Administration and Policy in Mental Health and Mental Health Services Research, 45*(1), 48-61.

National Association of Social Workers. (2021). *Code of ethics of the National Association of Social Workers*. National Association of Social Workers.

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy, 55*(4), 303-315.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-103.

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (HHS Publication No. SMA 14-4884). Substance Abuse and Mental Health Services Administration.

Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports, 110*(2), 639-644.

Sarah Ozol Shore, MS / Clinical Trainer