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When Styles Align: Compatibility Between Patient and Healthcare Professional Approaches in Clinical Contexts

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Abstract

The Systematic Treatment Selection method has its origins in the integration movements that aim to help clinicians achieve effective interventions derived from different theories and models in order to implement treatments that are appropriate to the characteristics of the patient and the characteristics of the therapist/health professional. This method considers that therapeutic effectiveness is closely linked to the way in which treatments are adapted to the characteristics of the patient.

Keywords: patient; health care professionals; Treatment; style compatibility

1.Introduction

Personal variables such as the index of stressful events (Luborsky, Crits-Christoph, Alexander, Morgolis and Cohen, 1983), the client's social and family relationships (Kokotovic and Tracey, 1990; Mallinckrodt, 1991), interpersonal variables such as the quality of object relationships (Bordin, 1994; Piper, Azim, Joyce, McCallum, 1991), motivation, expectations (Gaston, Marmar, Gallagher and Thompson, 1989; Pelletier, Tucson and Haddad, 1997) and attitudes (Kokotovic and Tracey, 1990) significantly influence the treatment process and the therapeutic alliance with the health professional. Some studies report convergent results (Eames & Roth, 2000; Mallinckrodt, Coble & Gantt, 1995) regarding patients who present an anxious attachment relationship: they obtained worse results in the therapeutic alliance than clients with a secure attachment relationship. Interestingly, Satterfield and Lyddon (1998) found a highly significant relationship between the dependent attachment pattern and the therapeutic alliance, that is, the more dependent the patient's attachment pattern, the better the therapeutic alliance. Studies by Crowley (2001) and Horvath and Symonds (1991) on the severity of the symptoms presented by the client and the therapeutic alliance explain that severity has little impact on the construction of a positive alliance. The results of Hersoug, Monsen, Havik and Hoglend (2002) on the client's diagnosis and the therapeutic alliance are in the same sense, and they do not present a significant correlation. However, on the other hand, Eaton, Abeles, and Gutfreund (1988) present somewhat contradictory results when they state that the client's symptoms negatively influenced the therapeutic alliance. However, not all negative feelings expressed by the patient are necessarily indicators of a negative alliance (Santos & Soares, 2024; Soares, 2024; Corbella and Botella, 2003), Gaston, Marmar, Thompson and Gallagher (1988), Kiesler and Watkins (1989), Muran, Segal, Samstag and Crawford (1994), Strupp and Hadley (1979), state that the patient's feelings of defensiveness, hostility and dominance are related to their difficulty in creating a good relationship of therapeutic collaboration. Another patient attitude identified by Blatt, Quintlan, Pilkonis and Shea (1995) and Blatt, Zuroff, Bondi, Sanislow and Pilkonis (1998) that could hinder the construction of the alliance was the levels of perfectionism presented by the patient throughout a treatment process that was negatively related to the outcome of the therapy. As Corbella and Botella (2003) refer, based on the studies of Mongrain (1998), Zuroff and Fitzpatrick (1995), self-criticism is related to perfectionism and has been associated with negative relational schemes and avoidant attachment styles. One can safely agree with the opinion of Corbella and Botella (2003) that, if the client's interpersonal functioning influences the outcome of the therapeutic alliance, then the style of the therapist/health professional and, consequently, their interventions during the consultation, are key dimensions for understanding how the relationship between the therapist and the patient unfolds and develops, and how the alliance between the two is established. For example, the therapeutic alliance and the compatibility between therapist/health professional and patient are two variables that have shown statistically significant relationships in several studies (Corbella and Botella, 2003; Corbella, 2003) and several studies report that it is from the first sessions that complementarity is established (or not) between the health professional and the patient (Quintana and Meara, 1990; Henry Schacht and Strupp, 1990): it can facilitate or hinder the construction of the therapeutic alliance. For example, Reandeau and Wampold (1991) reported that complementarity between the therapist/healthcare professional and the patient was significantly related to the alliance. In 1994, Luborsky stated that certain similarities between the therapist/healthcare professional and the patient

could favor the therapeutic alliance, namely a similar age between the two and the fact that they are of the same gender. The results observed in the studies by Al-Darmaki and Kivlighan (1993) and Gelso and Carter (1994) added to Luborsky's idea of two variables that contribute positively to the formation of a positive therapeutic alliance, the congruence between expectations and perspectives of the therapist/healthcare professional and the patient. In 2001, Lupini added to these variables the fact that if the personal values of the therapist/healthcare professional and the patient are close, the therapeutic alliance tends to be more positive.

2. Systematic Treatment Selection

Beutler (2001), Beutler, Clarkin and Bongar (2000), and Fisher, Beutler and Williams (1999) are authors who developed an effective and rapid method to better understand the patient's characteristics, namely in terms of coping styles and the client's resistance levels, together with other dimensions that are also involved in planning an intervention or Treatment. The method is called Systematic Treatment Selection and has its origins in the integration movements that aim to help clinicians achieve effective interventions derived from different theories and models in order to implement treatments that are appropriate to the patient's characteristics and the therapist/health professional's characteristics (Moreira, Gonçalves & Beutler, 2005). This method considers that therapeutic effectiveness is closely linked to the way in which treatments are adapted to the patient's characteristics. It argues that for Treatment to be effective, it cannot separate the patient's characteristics from the therapist/health professional's characteristics and the strategies used. Effectiveness is, therefore, a process and not a result, as it begins to be constructed even before the therapeutic process begins. It begins with the training of the therapist/health professional, with their flexibility in mastering various theories, principles and techniques and with their ability to identify the client's relevant variables for therapeutic success (Moreira, Gonçalves & Beutler, 2005). For these authors, therapeutic effectiveness depends on the therapist/health professional's flexibility in adopting a stance for each patient that meets their characteristics, as well as their ability to establish a therapeutic alliance that motivates the client to change. To this end, it is important to i) convey to the client in a realistic way what they can expect from that relationship; ii) involve them in establishing therapeutic objectives; iii) the therapist/health professional must able to decide to implement the techniques that the patient needs most at a given time, under certain conditions, and iv) the therapist/health professional must be able to evaluate the therapeutic process and reformulate it if necessary. Thus, for Moreira, Gonçalves and Beutler (2005), a treatment results from a sequence of decisions derived from the analysis of the patient, the therapist/health professional and the treatment procedures. The patient, therapist/health professional and procedures play a fundamental role in optimizing therapeutic results. The characteristics of the patient and the problem brought to the consultation that relates to adaptation to Treatment, according to Beutler (2001), are:

1) Degree of dysfunctionality
2) Subjective suffering
3) Experienced social support
4) Complexity of the problem
5) Levels of resistance
6) Coping styles

It is based on these characteristics that the various areas of Treatment can be systematized and monitored, namely: 1) the intensity and duration of Treatment; 2) psychopharmacological interventions; 3) supportive and support interventions; 4) interpersonal intervention therapies; 5) interventions focused on insight and relationship; 6) therapies focused on the problem; 7) nondirective interventions; 8) paradoxical interventions; 9) descriptive and interpretative interventions and, 10) interventions oriented towards symptoms (Beutler, Clarkin & Bongar, 2000). The literature indicates that some personality variations that exist among people predispose them to be receptive to different treatments, and these response patterns are similar to a wide range of problems. For example, two patients with depression (with the same diagnosis) may require different treatments according to their characteristics, and these individual characteristics may be good predictors of therapeutic success (Moreira, Gonçalves & Beutler, 2005). This view helped to reformulate the vision of health intervention in the late 20th century. Patient characteristics and the interaction of these characteristics with the characteristics of the intervention are seen as useful predictors of therapeutic results. They can be framed within the theoretical view of social constructionism in the field of health. Thus, the interaction of certain variables of the therapeutic scenario, namely the patient variables and the therapeutic intervention variables, are studied from a perspective of therapeutic co-construction in which it is possible to make strategic decisions regarding compatibility between the patient and the treatment processes and, in addition, it is possible to reformulate and adapt the intervention strategies as the therapeutic results are evaluated and monitored. Health treatment is not static and unidirectional. It is a dynamic process that evolves according to the nuances of the interactions between various factors: the patient's characteristics, the type of Treatment and the characteristics of the therapist/health professional. The Systematic Treatment Selection Model (Beutler, Clarkin and Bongar, 2000) presents a sequence of 4 levels of decision-making, with cumulative effects, aiming at the most effective Treatment for the uniqueness of each client (Moreira, Gonçalves and Beutler, 2005). Level 1, the patient's Predisposing Characteristics, includes the assessment of aspects of the problem presented (symptoms, severity), the patient's personality characteristics (coping style, interpersonal attitudes) and contextual characteristics (level of dysfunction, social support). The second level of decision-making concerns the scope of Treatment, namely the context in which the Treatment should take place (inpatient or outpatient), the intensity of the Treatment (how often it should occur), the type of Treatment (use of drugs, psychosocial intervention) and the format of the Treatment (whether individual or group). The Activity of the Health Professional and the Therapeutic Relationship – the third level of decision-making – includes decisions regarding the selection of therapists/health professionals whose personal styles of action and expectations are compatible with those of the client and who, above all, facilitate the construction of a good therapeutic relationship. Level 4, called Adapting Treatment to the Patient's Characteristics, consists of adapting interventions to the specific needs of each client and, to this end, the health professional must be able to manage several dimensions in parallel: i) decide the scope of Treatment according to the level of dysfunction and complexity/severity of the problem; ii) adapt the focus of the intervention according to the patient's interpersonal style and social support; iii) define the focus of the intervention, whether it is more directed at insight/awareness or symptoms/behaviors; iv) adjust the therapist's levels of directiveness to the patient's levels of resistance (for example, the intervention will be more effective if the therapist adapts the levels of directiveness to the client's levels of resistance); and v) define the type of therapy according to the patient's degree of subjective suffering. Two relevant variables were analyzed in this Systematic Treatment Selection (STS) model that fall within level 1 of the patient's predisposing characteristics, namely the patient's coping style and resistance levels. Thus, to characterize the patients, a fraction of the SST assessment instrument was used, that which concerns the scales for assessing the patient's coping style and the assessment of their resistance levels. These scales, although they have not yet been adapted and validated for the

Portuguese population, were translated into Portuguese by Moreira, Gonçalves and Beutler (2005) and the Spanish version was adapted and validated by Corbella, Beutler, Fernández-Álvarez, Botella, Malik, Lane and Wagstaff, (2003).

2.1. Internalized/Externalized Coping Style

According to Beutler and Harwood (2000), the patient's coping style is the person's typical way of responding to a threat of loss of safety and well-being. Corbella, Beutler, Fernández-Álvarez, Botella, Malik, Lane and Wagstaff (2003) use the definition of Beutler, Harwood, Alimohamed and Malik (2002) and define coping style as a persistent pattern of behavior that is characterized by, at one extreme, by low assertiveness, action-oriented, socially extroverted and with aggressive behavior. At the other extreme, there is an opposite pattern of behavior, namely distrust and restlessness, social isolation, introversion and self-critical behavior. The limits of the two dimensions of coping style are characterized, according to Beutler and Clarkin (1990), by the externalized style and the internalized style, and consider that internalization is at one pole and externalization is at the opposite pole. According to Corbella and Botella (2004), the bipolar dimensions result from several studies on personality, namely Introversion-Extroversion by Eysenck (1970) and Jung (1941); sociotropic-autotropic and active-passive by Anderson (1998) and Goldberg (1992). Externalizing styles are characterized by extroversion, impulsivity, orientation or direction of action towards the task, hedonism and projection (Beutler, 1983; Beutler & Clarkin, 1990; Gaw & Beutler, 1995). Internalizing styles are characterized by introversion, self-reflection, self-criticism, inhibition, internal direction and over-control (Costa & Widiger, 1994; Eysenck, 1970, 1976; Gaw & Beutler, 1995). According to Corbella and Botella (2004), all people, at some point in their lives, act in an internalizing and externalizing manner. However, it is possible to find a general and habitual pattern of functioning for each subject. Corbella and Botella (2004) also state that the variety of strategies and methods that people use to reduce the negative effects of anxiety is manifested through their coping style, and these strategies directly influence the personal characteristics of interaction with other subjects, especially when this interaction occurs in an anxiety-provoking context for the individual. Patients with an internal direction of interest are more open to the treatment experience. Patients with an external focus of interest prefer psychopharmacological or more behavioral treatments (Corbella, 2005). Bellow (Table 1), we present the typical characteristics of each of the Externalized and Internalized Coping Styles.

Externalized	Internalized
1. Sociable and outgoing.	1. You are more likely to feel pain/suffering than irritation.
2. Seeks to impress others.	2. You are quiet in social gatherings.
3. Seeks novelty, activity, or stimulation to avoid boredom or inactivity.	3. You think and worry a lot before acting.
4. Seeks to improve social status.	4. You feel shame or regret over minor things (rather than fleeting guilt).
5. Is insensitive to the feelings of others.	5. You let things happen.
6. Considers himself/herself to be overly important.	6. You lack self-confidence.
7. Is impulsive.	7. You like to be alone.
8. Is bossy with others.	8. You are shy.
9. Usually speaks without thinking about the consequences of his/her words.	9. You are reluctant to show your displeasure.
10. React to frustration by showing open irritation.	10. You are introverted.
11. Is not very interested in what others think of him/her.	11. You do not go to parties often.
12. Sometimes gets into trouble because of his/her lack of patience.	12. You do not let others notice your feelings.
13. Gets frustrated very easily.	
14. Gets bored very easily.	
15. Enjoys loud parties.	
16. Is immature emotionally and in his/her behavior.	
17. Always trying to be active.	
18. Does not take responsibility for problems that arise.	
19. Does not take into account the feelings of others.	
20. Shows little empathy for others.	
21. Gets into trouble quite often because of his/her behavior.	

Table 1: General Characteristics of Coping Styles: Externalized and Internalized (adapted from Beutler & Howard, 2000, In Corbella & Botella, 2004).

Patients with a more externalized style (extroverted, impulsive) had better therapeutic results with cognitive-behavioral treatments (Corbella, 2005) directed at the symptom or aimed at stimulating the client's competence than with more introspective treatments (Beutler & Harwood, 2000). Clients with a more internalized style (introverted and restrictive) responded better to treatments oriented towards insight and self-awareness (Corbella, 2005).

2.2. Levels of Resistance

Resistance is defined, according to Corbella (2005), as the interpersonal conflict between different parts or voices of the self that impede change and hinder the patient's involvement and action toward change. According to Brehm and Brehm (1981), resistance reflects an aspect of personality that manifests itself through a strong and particular reaction to certain situations and circumstances that threaten the subject's autonomy or that cause him/her to lose personal power. It can be seen as an exaggerated tendency to perceive oneself as being attacked or a tendency to interact with others in a hostile and aggressive manner. According to the authors, observable resistance

behaviors can range from affronting authority to oppositional behaviors, in which the subject does exactly the opposite of what is asked or expected of him/her. Resistance can be observed as a situational state or as a personality trait. Since it requires a high degree of openness and self-exposure, it is not easy to assess using self-assessment measures (Corbella, Beutler, Fernández-Álvarez, Botella, Malik, Lane & Wagstaff, 2003). Strupp, Horowitz and Lambert (1997) report that the characteristics of self-assessment measures correlate poorly with clinicians' judgments. These self-assessment measures of patients themselves suffer from great variability due to the patient's motivation and capacity for insight (Fisher, Beutler & Williams, 1999). The first self-assessment measures of resistance were "The Therapeutic Reactance Scale – TRS" (Dowd, Milne & Wise, 1991) and the MMPI/MMPI-2 (Butcher & Beutler, 2003) and these measures are usually complemented by the therapist/health professional's assessment, precisely to increase their degree of reliability. Next, we present typical situations described by clients that indicate a high level of resistance (Adapted from Beutler & Harwood, 2000, by Corbella, 2005).

1. Frequently expresses resentment toward others.
2. Seems to expect others to take advantage of him/her.
3. Has been controlling in relationships.
4. Is distrustful and suspicious of others' motives.
5. Expresses resentment for not having the advantages and opportunities that others have.
6. Frequently breaks "the rules."
7. Is competent.
8. Behaves in oppositional ways when others try to control him/her.
9. Frequently is domineering in relationships.
10. Resents those who set the rules.
11. Is most satisfied when he/she is in charge.
12. Often feels guilty for other people's mistakes and shortcomings.
13. When provoked, responds provocatively as well.
14. Often avoids being the "loser" in disagreements. Table 5: Examples of Typical Situations Indicating Resistance in the Client (Adapted from Beutler & Harwood, 2000, by Corbella, 2005).

According to Corbella (2005), the presence of measurable levels of resistance in the patient is a good indicator of the type of Treatment that will benefit him/her most, taking into account the level of directiveness of the treatment procedures proposed by Beutler and Harwood (2000). Minimally structured interventions, self-instruction training, nondirective procedures or paradoxical indications are more effective with clients with high levels of resistance. On the other hand, directive interventions and treatments more guided by the clinician are more effective with clients with low levels of resistance (Beutler & Harwood, 2000). According to Beutler and Harwood (2000), ten basic principles of Prescriptive Therapy are used in individual therapy to promote change and to induce different degrees of response in the client. The authors defend the idea that the selection of certain strategies and techniques can increase or reduce the possibility of change and improvement in the patient. These principles are the guiding principles for the treatment selection that the therapist/health professional should provide to the patient, choosing the therapeutic strategies most appropriate to the client's characteristics. Below, we present these ten principles.

1. The therapist/healthcare professional must be familiar with different therapeutic procedures and work to convey trust, collaboration, acceptance, and respect for the client while providing a supportive environment for change with great safety.
2. The therapist/healthcare professional must keep the client informed about the duration of Treatment and its effectiveness, providing support and ensuring that the client clearly understands his or her role and the activities that he or she is expected to perform during Treatment.
3. Significant functional impairment indicates the need for relatively intensive Treatment.
4. Therapeutic change is most likely to occur when the patient is exposed to the object or stimuli of behavioral and emotional avoidance.
5. Therapeutic change is greatest when the internal or external focus of the selected interventions is consistent with the internal or external avoidance methods typically used by the patient to cope with stress (personality style).
6. Therapeutic change is most likely to occur if the focus of initial change efforts is on symptom reduction. 7. Therapeutic change is more likely to occur when therapeutic procedures do not generate resistance in the client.
7. Therapeutic change is greater when the directness of the interventions corresponds inversely to the patient's level of resistance.
8. When the patient's level of emotional stress is moderate, the likelihood of therapeutic change is greater.
9. Therapeutic change is greater when the patient is stimulated in his/her emotional dimension in a comfortable and safe environment until the problematic response is extinguished or diminished.

Corbella (2005) also highlights some important principles for Treatment that aim to promote a more in-depth reflection on the compatibility between the therapist/healthcare professional and the patient:

1. Assigning a patient to a specific therapist/healthcare professional is very important for the treatment process and outcome.
2. When choosing a therapist/healthcare professional for a specific patient, we must take into account the patient's resistance and the therapist/healthcare professional's style. It is recommended that the most resistant patients be assigned to a therapist/healthcare professional with a less directive style.
3. Take into account the patient's style and the therapist/healthcare professional's style: internalizing patients should be treated by therapists/healthcare professionals with a style more focused on insight, and externalizing patients should be treated by therapists/healthcare professionals with a style more focused on patient action. 4. The patient's resistance should be taken into account in the initial assessment process, and the therapist/healthcare professional should work on this resistance to benefit the patient. Resistance is not a difficulty for the patient, but rather an opportunity for joint work between the patient and the therapist/healthcare professional.
4. The therapist/healthcare professional should know his/her style to facilitate the optimization of his/her resources and skills.
5. The therapist/healthcare professional should adapt his/her mode of communication and his/her therapeutic style to the patient's characteristics. If the patient is resistant, the therapist should try to adapt his/her style so that it reverts to a style that is as nondirective as possible.
6. The therapist/healthcare professional's effort to adapt his/her style to the patient's characteristics should be reduced when it results in something uncomfortable for him/her, particularly if he/she feels that he/she loses some theoretical coherence in the implementation of the different procedures or communication

strategies. 8. Training should deepen the therapist/healthcare professional's style and foster self-reflection and a flexible style.

7. 9. During the treatment process, especially during the first 8 sessions, the therapist/healthcare professional should be attentive and work towards building a good therapeutic alliance with the patient.

In summary, within the scope of knowledge of the patient's characteristics framed in the therapeutic process, it can be stated that a set of variables have already been investigated, which significantly influence the process and the therapeutic alliance (see Table 2):

Patient Characteristics	Research study
Index of stressful events	Luborsky, Crits-Christoph, Alexander, Morgolis e Cohen, (1983).
Social and family relations	Kokotovic e Tracey, (1990); Mallinckrodt, (1991).
Quality of object relations	Bordin, (1994); Piper, Azim, Joyce, McCallum, (1991). Soares, (2023).
Motivation and expectations	Gaston, Marmar, Gallagher e Thompson, (1989); Pelletier, Tucson e Haddad, (1997). Soares, Lemos, Oliveira, Lucas & Roque, (2013)
Attitudes	Kokotovic e Tracey, (1990).
Securing attachment relationships	Eames e Roth, (2000); Mallinckrodt, Coble e Gantt, (1995).
Dependent attachment patterns	Satterfield e Lyddon, (1998).
Complementarity between therapist and client	Reandeau e Wampold, (1991)
Approximate age between therapist and client and the fact that they are of the same gender	Luborsky, (1994)
Congruence between expectations and perspectives of the therapist/healthcare professional and the patient	Al-Darmaki e Kivlighan, (1993) e Gelso e Cárter, (1994).
Closeness between the personal c+values of the therapists/healthcare professionals and the patient	Lupini, (2001).
Patients with an internal direction of interest are more open to the therapeutic experience; patients with an external direction of interest prefer psychopharmacological or behavioral treatments.	Corbella, (2005)
Patients with a more internalized style (introverted and restrictive) responded better to insight-oriented therapies.	Corbella, (2005).
Patients with a more externalized style (extroverted, impulsive) presented better therapeutic results with cognitive-behavioral treatments.	Corbella, (2005).
Patients with high levels of resistance do better with minimally structured interventions, self-instructional training, nondirective procedures, or paradoxical prompts.	Beutler e Harwood, (2000). Rosario & Soares (2023).
Patients with low levels of resistance do better with structured interventions and more directive procedures,	Beutler & Harwood, (2000). Soares & Fernandes, (2024)
Patients with high levels of self-determination for therapy respond better to an exploratory intervention that emphasizes self-control.	Pelletier, Tucson e Haddad, (1997). Leal, Vieira, Soares (2024) Soares (2024)
Patients with low levels of self-determination for Treatment may do better with therapists who feel more comfortable controlling and directing therapeutic interventions.	Pelletier, Tucson e Haddad, (1997) Soares, Gomes & dos Santos Silva, (2024)

Table 2: Research studies show variables associated with patient characteristics that significantly influence the therapeutic process and alliance.

Likewise, there are also some factors associated with the patient that negatively influence the therapeutic alliance, that is, characteristics of the patient that contribute to a less positive construction of the therapeutic alliance (see Table 3):

Patient Characteristics	Research Study
Patient symptomology	Eaton, Abeles e Gutfreund, (1988).
Defensiveness, hostility and dominance by the patient	Kiesler e Watkins (1989); Muran, Segal, Samstag e Crawford (1994); Strupp e Hadley (1979).
Levels of perfectionism	Blatt, Quintlan, Pilkonis e Shea, (1995) e Blatt, Zuroff, Bondi, Sanislow e Pilkonis, (1998).

Table 3: Research studies showing variables associated with patient characteristics that negatively influence the therapeutic process and alliance.

3. Conclusion

Research on effective treatments for patients can be divided into two main approaches: process-centered research and outcome-centered research (Machado, 1994). These two approaches offer distinct but complementary ways of evaluating the effectiveness of therapeutic interventions. Process-centered research focuses on the steps and methods used during Treatment. The goal is to understand how different variables throughout the therapeutic process contribute to the success or failure of Treatment. This may include analyzing:

- Specific techniques applied by the professional.
- The quality of the relationship between therapist/healthcare professional and patient.
- The level of patient engagement and adherence to Treatment.
- Contextual factors, such as the environment where the Treatment takes place.

Process-centered research is valuable because it allows us to identify which components of Treatment are most effective, helping to adjust interventions to maximize efficiency and improve the patient's experience throughout the therapeutic journey. Furthermore, by understanding the process, professionals can individualize treatments and adjust interventions based on the patient's characteristics and needs.

On the other hand, outcome-focused research focuses on the outcomes of treatment, such as:

- Improvement of the patient's symptoms.
- Functional recovery.
- Satisfaction with Treatment.
- Success or relapse rates.

This type of research focuses less on the steps that make up the Treatment and more on the observable and measurable effects at the end of the intervention. The main objective is to determine whether a treatment is effective, comparing results in different groups or measuring the change in the patient's state over time. In this context, metrics such as quality of life, symptom reduction and duration of therapeutic effect are evaluated. This facilitates evidence-based decisions about which treatments offer the best benefits for different conditions.

The combination of both approaches – process-focused and outcome-focused – allows for a more complete view of the effectiveness of treatments. While outcome-focused research answers "what works?" process-focused research helps to understand "how it works?" allowing for a richer and more personalized approach to patient care.

In this way, by investigating both the how and the what, researchers and health professionals can develop more effective practices, better adapted to the specific needs of patients, in addition to improving the therapeutic relationship and ensuring the implementation of interventions with higher success rates.

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