CHAPTER ONE

Therapy at the Crossroads

The Challenges of the Twenty-First Century

. . . every man his greatest, and, as it were, his own executioner.

—*Sir Thomas Browne,* Religio Medici

One day, the ancient fable by Aesop goes, the mighty oaks were complaining to the god Jupiter. "What good is it," they asked him bitterly, "to have come to this Earth, struggled to survive through harsh winters and strong fall winds, only to end up under the wood-cutter's axe?" Jupiter would hear nothing of their complaints, how-ever, and scolded them sternly. "Are you not responsible for your own misfortunes, as you yourselves provide the handles for those axes?" The sixth-century C.E. storyteller ends the tale with a moral: "It is the same for men: they absurdly reproach the gods for the misfortunes that they owe to no one but themselves" (Duriez, 1999, p. 1).

Though removed by some 2,600 years, the perilous situation of the oaks described in Aesop's fable is not unlike that of the field of ther-apy today. Indeed, changes in virtually every aspect of the profession over the last ten years have left mental health practitioners with much to feel uncertain and unhappy about. Where once therapists were the complete and total masters of their domain, their power to make even the smallest of decisions regarding clinical practice has dwindled to nearly nothing. A recent survey found that a staggering 80 percent of practitioners felt they had lost complete control over aspects of

"care and treatment they as clinicians *should* control" (e.g., type and length of treatment, and so on; Rabasca, 1999, p. 11, emphasis added).

Of course, the loss of control does not mean there has been a corresponding decrease in the workload of the average mental health professional. Rather, in place of the responsibility therapists used to have are a host of activities implemented under the guise of improving effectiveness and efficiency. For example, where in the past a simple, single-page HCFA 1500 form would suffice, clinicians must now contend with preauthorization, lengthy intake and diagnostic forms, extensive treatment plans, medication evaluations, and external case management to qualify for an ever decreasing amount of reimbursement and funding for a continually shrinking number of sessions and services. The paperwork and phone calls these activities require make it difficult to imagine how they could ever save time, money, or increase the effectiveness of the provided services.

As far as income is concerned, the reality is that the average practitioner has watched the bottom line drop by as much as 50 percent over the last ten years (Rabasca, 1999)! Berman (1998), for example, found that the net income of doctoral-level psychologists in solo practice after taxes averaged $24,000—a salary that hardly seems to merit an average investment of six years of postgraduate education and a minimum of $30,000 in tuition costs (Norcross, Hanych, & Terranova, 1996). On the public side of things, case managers and other bachelor-level providers render more and more services, reducing the value and therefore salaries of master's-trained mental health professionals.

Furthermore, several studies have found that the field has twice as many practitioners as are needed to meet current demand for services (Brown, Dreis, & Nace, 1999). Indeed, since the mid-1980s there has been a whopping 275 percent increase in the number of mental health professionals (Hubble, Duncan, & Miller, 1999a). Consumers can now choose among psychiatrists, psychologists, social workers, marriage and family therapists, clinical nurse specialists, professional counselors, pastoral counselors, alcohol and drug addiction counselors, and a host of other providers advertising virtually indistinguishable services under different job titles and descriptions (Hubble et al., 1999a). The reality is, as former American Psychological Association (APA) president Nicholas Cummings (1986, p. 426) predicted, that nonmedical helping professionals have become "poorly paid and little respected employees of giant health care corporations."

In truth, those seeking mental health services have not fared any better than the professionals themselves. Consider a recent study that found that in spite of the dramatic increase in the number of practitioners between 1988 and 1998, actual mental health care benefits decreased by 54 percent during the same time period (Hay Group, 1999). This decrease, the research further shows, is not part of an across-the-board cut in general health care benefits. During the same period that outpatient mental health encounters fell by 10 percent, office visits to physicians increased by nearly a third. In addition, those seeking mental health services face a number of obstacles not present for health care in general (e.g., different limits, caps, deductions, etc.).

Moreover, most third-party payers now require the practitioner to provide information once deemed privileged and confidential before they will reimburse for mental health services (Johnson & Shaha, 1997; Sanchez & Turner, 2003). Unlike cost and numbers of visits, the impact of such obstacles is more difficult to assess. Nonetheless, in an exploratory study, Kremer and Gesten (1998) found that clients and potential clients showed less willingness to disclose when there was external oversight and reporting requirements than under standard confidentiality conditions.

Clearly, the future of mental health practice is uncertain. More troubling, however, like the mighty oaks in Aesop's cautionary tale, the field itself may be providing the very handle—not the ax head, mind you, but the handle—that delivers the cutting blows to the profession.

THE FUTURE OF MENTAL HEALTH

The greatest enemy of the truth is not the lie—deliberate, contrived, and dishonest—but the myth—persistent, pervasive, and unrealistic.

—John F. Kennedy, Commencement Address,
Yale University

Imagine a future in which the arbitrary distinction between mental and physical health has been obliterated; a future with a health care system so radically revamped that it addresses the needs of the whole person—medical, psychological, and relational. In this system of integrated care, mental health professionals collaborate regularly with M.D.'s, and clients are helped to feel that experiencing depression is

no more a reflection on their character than is catching the flu. This new world will be ultraconvenient: people will be able to take care of all their health needs under one roof—a medical superstore of services. Therapists will have a world of information at their fingertips, merely opening a computer file to learn the patient's complete history of treatment, including familial predispositions, as well as compliance issues or other red flags.

Now imagine a future in which every medical, psychological, or relational intervention in a "patient's" life is a matter of quasi-public record, part of an integrated database. Here, therapy is tightly scripted, and only a limited number of approved treatments are eligible for reimbursement. In this brave new world, integrated care actually means a more thoroughly medicalized health care system into which therapy has been subsumed. Yes, counselors will work alongside medical doctors but as junior partners, following treatment plans taken directly from authorized, standardized manuals. Mental health services will be dispensed like a medication, an intervention that a presiding physician orders at the first sign of "mental illness" detected during a routine visit or perusal of an integrated database.

These are not two different systems; rather, they are polarized descriptions of the same future, one that draws nearer every day. Noted psychologist Charles Kiesler (2000)—who in the mid-1980s predicted that fledgling managed care organizations would dominate the U.S. health care industry—predicts that mental health services will soon be integrated into medical patient care and administered accordingly. The reason for this coming change, of course, is the tremendous pressure on health care administrators to reduce spiraling costs. Many health care prognosticators believe that the cost-cutting measures of managed care have already realized all possible benefits and only a total reconfiguration will bring the critical savings required (Strosahl, 2001). Integrated care is a product of this realization.

And it is not hard to see their point. Over the last four decades, studies have repeatedly shown that as many as 60 to 70 percent of physician visits stem from psychological distress or are at least exacerbated by psychological or behavioral factors. In addition, those diagnosed with mental "disorders" have traditionally overutilized general medical care and have incurred the highest medical costs (Tomiak, Berthelot, & Mustard, 1998). Combine these well-known facts with the rather extensive evidence that the delivery of psychological services offsets the cost of medical care (Sanchez & Turner, 2003)—and

voilà, integrated care is the greatest thing since sliced bread. Cummings (2000) suggested that a mere 10 percent reduction in medical and surgical care resulting from behavioral care intervention would exceed the entire mental health care insurance budget! Bottom line: according to its supporters, integrated care increases collaboration, improves care, and makes psychotherapy more central to health care—and of course, saves insurance companies and public funders a ton of money.

What the proposed advantages obscure is the inevitability that, in the name of integration, psychotherapy will become ever more dominated by the assumptions and practices of the medical model; that much like an overpowered civilization in the sci-fi adventure *Star Trek,* we will be assimilated into the medical Borg. The mental health professional of the coming integrated care era, Kiesler (2000) predicts, will be a specialist in treating specific disorders with highly standardized, scientifically proven interventions. At issue here are not the advantages of greater collaboration with health care professionals or of bringing a psychological or systemic perspective to bear on medical conditions. Rather, at issue is whether we will lose our autonomy as a profession by becoming immersed in the powerful culture of biomedicine, breaking the already tenuous connection to our nonmedical, relational identity.

The resulting influx of potential mental health clients into the primary care setting will further promote the conceptualization of mental "disorders" as biologically based and increase current trends toward medication solutions. Indeed, a recent large national survey of primary care physicians revealed that antidepressants were the treatment of choice for depression 72 percent of the time, compared to only 38 percent for mental health referrals (Williams et al., 1999). This is a disturbing trend, especially given what is known about the relative merits of antidepressants (see Chapter Six). Parenthetically, physicians typically diagnose depression in a thirteen-minute visit in which they discuss with patients an average of six problems (Schappert, 1994).

In this nightmarish vision of the future, the woodcutter in the Aesop fable has already cut us down into fireplace-sized pieces, hauled us off, and neatly stacked us for consumption in the fires of the medical model of integrated care. And what is so bad about the medical model? Nothing when it is applied to medical conditions and nothing as one among many options to address the concerns that clients bring to our doorsteps. But as a privileged or mandated practice in

mental health, it is a myth, "persistent, pervasive, and unrealistic." The medical model works with the following equation:

PROPER DIAGNOSIS + PRESCRIPTIVE INTERVENTION = EFFECTIVE TREATMENT

Or

TARGETED DIAGNOSTIC GROUPS + EVIDENCE-BASED TREATMENTS = SYMPTOM REDUCTION

Consider the left side of the first equation: proper diagnosis and prescriptive intervention. A cursory review of professional publications and training offerings strongly suggests that the medical model of mental health already rules, that integrated care will only add icing to a cake of foregone conclusions. For example, of all the continuing education workshops to appear in a recent ad for the American Healthcare Institute (2003)—one of the nation's largest sponsors of training for therapists—nearly 90 percent were organized around a psychiatric diagnosis. Of these, 70 percent taught specific treatments for specific disorders as defined in the *DSM-IV* (American Psychiatric Association, 1994). As another example, consider that nearly two-thirds of the articles appearing in the prestigious *Journal of Consulting and Clinical Psychology* during 2002 were organized around a psychiatric diagnosis, and more than a quarter reported on specific treatments for specific *DSM* disorders. In fact, funding for studies not related to a specific *DSM* diagnosis dropped nearly 200 percent from the late 1980s to 1990 (Wolfe, 1993), and the trend continues. The bottom line: the medical model of mental health prevails and is so much a part of professional discourse that we do not notice its insidious influence.

Further, on a national level, mental health professional organizations, drug manufacturers, and hospital corporations design and support campaigns aimed at informing the public about the nature of psychiatric illness and benefits of professional treatment. National Anxiety and Depression Awareness Day is a good example. Advertising on radio, on TV, and in print lay out the signs and symptoms of these two "common colds" of mental health and then tell people where they can go to be evaluated and speak with a professional. At least one study found that more than 50 percent of those who are screened end up in some form of treatment—a considerable return on the investment of a single day (APA, 1998a)! In truth, diagnosis and psychopathology are now part of the American vernacular. Almost

everyone knows, thanks to the Zoloft television ad and that cute happy face guy, that depression is a serious medical condition caused by an imbalance of chemicals in the brain.

Concurrently, evidence-based practice has become the buzz word du jour. They represent those treatments that have been shown, through randomized clinical trials, to be efficacious over placebo or no treatment (or in psychiatry's case, via research review and clinical consensus). Hardly a day goes by without some publication crossing therapists' desks announcing the latest in evidence-based fashion. Consider the opening line in a recent guide to evidence-based practices: "Good clinicians understand that medical care must be based on the skillful use of scientifically valid and evidence-based information" (McGuire, 2002, p. i). Such pronouncements are not only a part of the everyday information barrage but also have become institutionalized in training programs and licensing boards. For example, APA's executive director for education, Cynthia Belar, asserts: "Health professionals must learn evidence-based practice. Although APA accreditation criteria require this in training, psychologists must also develop the capability to deliver evidence-based care throughout their careers" (Belar, 2003, p. 38). Such statements imply that you will be left at the station if you don't jump on board the evidence-based train. They play on our desires to be good clinicians as well as on our fears about surviving financially in an era that promises that insurance or public funds will reimburse only such treatments.

Among physicians, the concept of evidence-based practice has tremendous appeal. For example, an editorial in the *New England Journal of Medicine* advised physicians to refer patients to therapists proficient at manualized cognitive-behavioral therapy (Scott, 2000), the crown prince of psychology, for chronic depression. The integrated care system will only increase evidence-based treatment because primary care doctors will be the ultimate gatekeepers. Physicians, of course, are not at fault here. Unfortunately, we have not educated the health care system that success depends far less on the type of treatment provided than on the strengths and resources that the client brings and the quality of the alliance the client forms with the therapist.

The development of evidence-based therapies has in fact become a growth industry, paralleling the growth of therapies in general. Since the mid-1960s, the number of talk therapy approaches has mushroomed from 60 to more than 250 at last count (Hubble et al., 1999a). Similarly, since the birth of evidence-based treatments in the early

1990s, these have expanded to well over 100, depending on whose "evidence" from which professional organization you include. Ironically, the effectiveness of psychotherapy has not improved one scintilla, not one percentage point, despite this exponential growth of new treatment technologies and the purported advantages of the so-called scientifically validated approaches. In truth, therapy is no more effective now than it was in the 1960s.

Trying to adjust to yet another fad, mental health agencies and individual professionals spend thousands of dollars on workshops, conferences, and books to learn designer diagnostics and brand-name miracles purportedly based on empirical science. Stepping back, we see that this process differs little from the rush to be brief when managed care first appeared or the stampede to learn about the infamous borderline personality disorder when it first frightened the mental health scene. Unfortunately, similar to all the prior claims of the latest and greatest approaches, the promised advantages always seem just out of reach for most of us, even with those models that supposedly have scientific, valid, and evidence-based information. Why won't the powerful evidence-based sword slay the dragon of misery of the client in my office now? Why doesn't the state-mandated empirically supported treatment work in our agency as its proponents insist?

At this point, one might reasonably wonder what could possibly be wrong with the medical model applied to mental health. What's so bad, for example, about a day of psychoeducation aimed at informing people about the nature of mental illness and helping them overcome the stigma and natural resistance to treatment? For that matter, what's wrong with diagnosis and an emphasis on pathology? After all, people don't go to therapy when they are doing well! Doesn't it just make sense that to help a person, the therapist must first figure out what's wrong with that person? And isn't interest and growth in medication treatment and the number of available therapy approaches a useful development in the field? For far too long, the mental health professions were dominated by the one-size-fits-all approach based on the thinking and techniques of Sigmund Freud. And finally, doesn't the fact that there is more and more demand for treatments that have demonstrated their effectiveness represent a bold step forward from the days of "anything goes" as long as somebody will pay for it? Doesn't the push for evidence-based treatments indicate that the field of mental health has finally arrived as a credible scientific profession?

The problem with the common beliefs and practices of the medical model shoehorned into mental health emerges when we examine them in the light of empirical research. Data from over forty years of increasingly sophisticated research shows little support for

- The utility of psychiatric diagnosis in either selecting the course or predicting the outcome of therapy (the myth of diagnosis)

- The superiority of any therapeutic approach over any other (the myth of the silver-bullet cure)

- The superiority of pharmacological treatment for emotional complaints (the myth of the magic pill)

In fact, as Chapter Two will detail, diagnosis, via the *DSM,* has notoriously poor reliability and has yet to prove any substantial validity. A closer look at evidence-based practice shows that a psychotherapy model claiming superiority over placebo is not front-page news and should not be taken to mean that the approach is better than any other, especially not over the client's own sensibilities of what is helpful. Finally, surprisingly sparse support exists, as Chapter Six will detail, for the widespread use of medication for client complaints, especially children's, arguing for a balance of options for the clients we serve.

The research literature is clear: therapists can assign diagnoses, use the latest evidence-based treatments, and dispense all the new varieties of psychoactive drugs from now until doomsday; and the overall effectiveness and efficiency of therapy will not improve in the least (Hubble, Duncan, & Miller, 1999b). These factors are simply not critical to the outcome of therapy. Importantly, this does not mean that therapy doesn't work. Indeed, available research provides strong evidence for the overall effectiveness of therapy. Most studies, for example, find the average treated person is better off than 80 percent of those without the benefit of therapy (Asay & Lambert, 1999; Wampold, 2001). Daily, clinicians can see the difference our work makes in people's lives.

The lack of empirical support for the medical model is especially disconcerting because it is now enforced by government funding agencies and managed care entities. As early as 1982, Parloff warned the field about the consequences of policymakers misusing such practices. Now, virtually no third party will pay for services without a qualifying

DSM-IV diagnosis. Many will not pay unless the person being served agrees to take medication (e.g., stimulant drugs for children with attention problems, antidepressants for those suffering with depression) or at least submits to evaluation for medication. Finally, several managed care companies and public funds distributors explicitly dictate the treatment approach that clinicians or agencies must use to qualify for reimbursement (e.g., cognitive-behavioral treatment for anxiety disorders, dialectical behavior therapy for borderline personality disorder, multifamily group and psychoeducation for schizophrenia).

Despite this movie trailer setup, replete with the husky voice-over promising a classic struggle of good versus evil, the medical model is not evil. Captain Picard is not really battling the Borg in this tale of Starship Psychotherapy. The medical model is a viable way, among many, of understanding and helping human suffering. The medical model, then, is not the problem. Privileging the medical model over clients and the data is the problem.

To ensure quality mental health services for clients and to be treated as valued professionals, therapists must lead the way and provide alternatives to the medical model. In particular, leadership entails abandoning the empirically vacuous practices of the field's past and directing attention to what works. Furthermore, taking the helm of the good ship mental health requires a full recognition of who is really the captain of the vessel.

BECOMING CLIENT DIRECTED

To exchange one orthodoxy for another is not necessarily an advance. The enemy is the gramophone mind, whether or not one agrees with the record that is being played at the moment.

—*George Orwell,* Inside the Whale and Other Essays

During the 1980s, the attention of the field was riveted on psychiatrist Milton H. Erickson. Clinicians couldn't seem to get enough information about the hypnosis pioneer whose intriguing methods defied conventional practice and seemed to work with the most intractable cases. Learning to do what Erickson did was not an easy task, however, because he steadfastly resisted the temptation to develop an organizing theory for his work. He summed up his reason for this, saying, "I think any theoretically-based psychotherapy is mistaken because each

person is different" (Zeig, 1980, p. 131). Curiously, this did not stop Erickson's students from attempting to understand the magical mysteries underlying his work. Indeed, in the years immediately following his death, a plethora of books and articles were published, each purporting to have deciphered the secret code.

Unsatisfied with available theories and caught up in the excitement of the time, a group led by the brief therapist Steve de Shazer made its own attempt at figuring out how Erickson did what he did (de Shazer, 1994). After gathering as many case reports as possible, the group began sorting them into piles based on characteristics each shared. Eventually, they organized all the cases into six different piles—five of which contained cases sharing a basic pattern that enabled the team to replicate Erickson's interventions. The sixth—known as "miscellaneous"— was for "unusual interventions" (p. 247), clever things Erickson did one time and never repeated. These cases did not share any identifiable characteristic with each other or with those in the other five piles. Unfortunately, no matter how the group sorted the cases, this motley pile ended up with the largest number! Fearing they were not clever enough to discern the real patterns in Erickson's work, the group members abandoned the project.

Over a decade would pass before de Shazer discovered the fatal flaw in the earlier project, something so obvious he later wondered how they had missed it. In studying Erickson's cases, they had focused on the wrong person in the therapeutic dyad—namely, Erickson. They had, like everyone else trying to crack the secret code, left the client out of the equation! In truth, the case reports convey little information about the people in them. Rather, the individuals are largely two-dimensional figures whose primary purpose in the unfolding drama seems to be playing a supporting role to Erickson's lead (Sparks, 2000).

Recognizing this gross oversight led de Shazer to a new conclusion, "Most of the ideas for 'unusual interventions' in the miscellaneous pile came from the clients themselves!" (1994, p. 249). In other words, in the majority of his work, Erickson was not the more clever one in the therapeutic dyad. Rather, it was the client. Most of the time, Erickson simply listened carefully and then did what his clients told him to do. Alas, this seems to have been his message all along. "What is needed is the development of a therapeutic situation permitting the patient to use his own thinking, his own understandings, his own emotions in the way that fits him in his scheme of . . . life" (Erickson, 1980, p. 223).

Research on outcome in psychotherapy suggests that Erickson's observations were right on target. Indeed, data from forty years of

outcome research provide strong empirical support for privileging the client's role in the change process (Hubble et al., 1999b). In short, clients, not therapists, make therapy work. As a result, therapy should be organized around their resources, perceptions, experiences, and ideas. There need be no a priori assumptions about client problems or solutions, no special questions that are best to ask, and no invariant methodology to follow in order to achieve success. Rather, as the chapters that follow will illustrate through multiple client examples, therapists need only take direction from clients: following their lead; adopting their language, worldview, goals, and ideas about the problem; and acknowledging their experiences with, and inclinations about, the change process.

Just as earlier theorists left the client out of understandings of Erickson's work, the most potent factor of successful outcome, the client and his or her own propensities for change, are conspicuously absent from the medical model equation. Given the data presented in this book, which reflects the importance of the client's strengths and perceptions of therapy, it is time to recast the client as not only the hero or heroine of the therapy drama but also the director of the change endeavor.

Becoming client directed, however, will not be enough to ensure clients' rightful place on the therapeutic stage or the vitality of the field. Mental health professionals must also be capable of proving that their work is effective and efficient. Traditionally, the effectiveness of therapy (symptom reduction or cure) has been left up to the judgment of the provider of the treatment. We will propose something very different: proof of effectiveness can emerge from the systematic recruitment of the client's perception and experience of outcome as a routine part of therapy—enlisting the client as a full partner in both the therapeutic and accountability process.

BECOMING OUTCOME INFORMED

The dogmas of the quiet past are inadequate to the stormy present.

—*Abraham Lincoln,* Annual Message to Congress, 1862

On a cold, blustery December day in 1799, the sixty-seven-year-old former president of the United States, George Washington, returned

to his mansion from his usual morning ride on the grounds of his Mount Vernon estate. The day continued in normal fashion. The former president and first lady read newspapers together in the parlor while the household staff performed the usual duties. As the day wore on, however, a minor sore throat the president had experienced since his morning ride worsened. By early the next morning, his condition was so grave that a doctor was summoned.

The doctor—along with two other physicians who eventually made it through the snowy weather to Mount Vernon—skillfully and competently administered the accepted therapy of the day. Observing no results, the three agreed that more of the same treatment was indicated. Several hours and two additional treatments later, the president was dead. The cause of death? Whatever course the disease might have taken, historians agree that the treatment Washington received while in an already weakened state likely hastened his demise. This intervention, of course, was the accepted "standard of care" for late eighteenth-century medicine—bloodletting (Flexner, 1974).

Although it might be tempting to believe that the modern healing arts have evolved beyond such primitive practices, strong evidence exists that the very same forces that led Washington's physicians to administer (and then readminister) an ineffective (and ultimately lethal) treatment continue to guide the practice of therapy—specifically, an emphasis on the competence of service delivery rather than the effectiveness of the services delivered. Nowhere is this more evident than in the ethical codes of the three largest mental health provider organizations: National Association of Social Workers (NASW), APA, and the American Association for Marriage and Family Therapy (AAMFT). None of these existing codes explicitly require social workers, psychologists, or marriage and family therapists to practice effective therapy. Neither do they require therapists to subject their practices to any systematic assessment of outcome. Rather, the codes mandate only that therapists practice, "within the boundaries of their *competence* based on their education, training, supervised experience, consultation, or professional experience" (APA, 2002, [Principle A], p. 1063 [principle 2.01a], emphasis added; NASW, 1999 [Principle 1.04]; AAMFT, 2001 [Principle 3.6]). A refreshing exception can be found in the American Counseling Association (ACA) ethical code, which states: "Counselors continually monitor their *effectiveness* as professionals and take steps to improve when necessary" (ACA, 1995 [Section C2d], emphasis added).

Conventional wisdom suggests that competence engenders, if not equals, effectiveness. As the death of George Washington illustrates, however, competence is no guarantee of effectiveness because providers can use even ineffective or dangerous treatments competently. More important, perhaps, the story shows that having no systematic method for evaluating the outcome of an approach may create an illusion of success that blinds practitioners to corrective feedback.

As just one example of the conflation of competence with effectiveness in mental health, consider the continuing education workshops therapists must attend to maintain their professional licenses. In theory, the continuing education requirement is designed to ensure that clinicians stay abreast of developments that enhance treatment outcome. In practice, however, the vast majority of approaches taught at these workshops do not include any systematic method for evaluating the effectiveness of the approach. Rather, workshop leaders place sole emphasis on the attendees becoming proficient at using the skills or techniques of a particular brand or style of treatment. In the world of continuing education, competency is king.

Far from benign, this emphasis on competence versus outcome decreases effectiveness and efficiency, and it limits the growth of individual therapists. For example, although most would say their clinical ability has improved with experience, a sizable body of research finds little or no relationship between the experience level and effectiveness of therapists (Clement, 1994). If anything, the data indicate that increasing the amount and type of training and experience that most therapists receive may lessen therapeutic effectiveness (Lambert & Ogles, 2004).

Consider a study on the qualities of effective therapists (Hiatt & Hargrave, 1995). Using client self-report and peer ratings, researchers successfully distinguished between least and most effective therapists (as determined by outcome). In brief, they found that therapists in the low-effectiveness group tended to have been in practice for more years than those in the high-effectiveness group (18.2 versus 12.9 years, respectively). More distressing, however, was their finding that the ineffective therapists were unaware that they were ineffective. Even worse, they considered themselves as effective as the truly helpful therapists in the study!

Although these findings are discouraging, awareness of them affords frontline practitioners a critical window of opportunity. Chapter Four will show that therapists can improve the quality of their

therapy while simultaneously proving the value of their work by becoming outcome informed. They can be more effective by gathering valid and reliable feedback about the process and outcome of their clinical work and then using that data to inform therapy. Studies now show that providing therapists with such feedback affects outcome, with improvement rates up to 65 percent (Miller, Duncan, Brown, Sorrell, & Chalk, in press; Whipple et al., 2003).

As is news to no one, third-party payers are increasingly cost-conscious and are now stridently insisting that therapists must substantiate the effectiveness of their services before they will be paid. This interest in outcome is not specific to any particular professional discipline (e.g., mental health versus medicine) or type of payment system (e.g., managed care versus public funds) but is rather part of a worldwide trend (Lambert, Okiishi, Finch, & Johnson, 1998; Sanderson, Riley, & Eshun, 1997).

As we will demonstrate, clients benefit from an alternative to the present system. First and foremost, using client feedback to inform the therapy would finally invite the users of our services to be full and equal participants in virtually all aspects of therapy. Giving clients the perspective of the driver's seat instead of the back of the bus may also enable consumers to gain confidence that a positive outcome is just down the road. Consider recent surveys that found that next to lack of insurance and cost, 76 percent of people identified low confidence in the outcome of therapy as the major reason for not seeking treatment (APA, 1998b). Indeed, the "no confidence" vote was far more important than variables traditionally thought to deter people from seeing a therapist (e.g., stigma, 53 percent; length of treatment, 59 percent; lack of knowledge, 47 percent).

Finally, the availability of outcome data could eliminate the need to assign pathological labels or transmit sensitive, personal information to third-party payers in order to qualify for reimbursement. Such information simply wouldn't be needed because third-party payers could tell from the measures of outcome whether the therapy was beneficial or not to the individual client. As Chapter Four will demonstrate, outcome management has the propensity, and has already started, to revolutionize mental health care.

In this book we advocate routine and systematic assessment of the client's perceptions of progress and fit so that the clinician can empirically tailor the therapy to the client's individual needs and characteristics. We therefore argue for practice-based evidence rather than

evidence-based practice. Such a process of becoming outcome informed, we believe, fits with how most therapists prefer to think of themselves: sensitive to client feedback and interested in results. Becoming outcome informed not only amplifies the client's voice but also offers the most viable, research-tested method to improve clinical effectiveness.

MARIA: A PREVIEW

Not long ago, Maria, a woman in her late thirties, came into therapy, searching for an identity that she believed that she had lost. All her life, Maria had wanted to be a police officer. As a teenager, she rode with state troopers; and as a young woman, she became the first female to graduate from the police academy.

Maria lived her dream as an officer for several years, until a car accident plunged her into a coma that lasted for two years. In a triumph of biomedicine, an experimental drug revived her, although it left her with some brain damage and seizures that made it impossible to work as a police officer. Without the identity she had devoted her life to achieving, she was no longer certain who she was.

Our first contact with Maria was founded not in just giving lip service to being respectful of clients and collaborative with them but in using the set of empirically supported findings that we will cover in this book. As we will see in Chapter Four, in all the research literature, perhaps the most clinically relevant finding is that the client's improvement early in therapy is one of the best predictors of successful outcome. So instead of regarding the first few sessions as a warm-up period or a chance to try out the latest technique, it is crucial to be accountable in the very first contact with clients. And given all we know about the importance of the therapeutic alliance, discussed in Chapter Three, such initial sessions offer a chance to discover how to make the best possible match with clients. Clients monitor the burgeoning alliance through session-by-session evaluations of their satisfaction with and progress in counseling. The guiding principle behind our work with clients is recognizing that all decisions must be directed by clients' engagement in the therapy process, their view of the quality of the therapeutic relationship, their theories of change, and—the gold standard—their assessment of whether change occurs.

When Maria came for her first appointment, she was intrigued by the therapist's comments that her perceptions were to be the light that

guided the coming process. She filled out a brief form about how she felt she was progressing individually, interpersonally, and socially. She then explained that she felt at a dead end in her life. Having recovered enough to go back to work of some kind, she could not even imagine a backup dream now that her career in police work seemed over. To complicate matters, Maria was also wrestling with the idea of being "disabled," a word she despised but that others suggested that she accept so that she could move on. She recognized that she had some limitations and could not perform the strenuous duties she had once dispatched with ease. Still, the word stuck in her craw. As she intimated her experience of her path to recovery, the therapist was amazed by her courage, resilience, and wisdom. Here was a woman who had it all and lost it—who defied others' expectations of what she could and could not do many times: early on when she became the first female to graduate from the academy and then the first to make detective; when she unexpectedly came out of a coma; and now once again. Despite her problems with seizures, vision, and balance, she was fighting the expectations of her "disabled" label. She knew there was much more to her than any description of her disability could begin to capture, as anyone who spent any time getting to know her would know. The therapist told Maria that one of the things he liked most about her was her refusal to accept her disability. She liked that comment very much.

A few minutes before the end of the meeting, the counselor again asked Maria to fill out a short form, evaluating the therapy and the therapist. Here, the key information was that she felt that the therapist was taking her problems and ideas seriously and that his approach seemed like a good fit. Maria indicated on the form that indeed things were on the right track. Checking the form with Maria and reflecting on how impressed he had been by her, the therapist jokingly asked her if she had ever thought about pursuing a career as a motivational speaker. It was an offhand tribute to the power of her story, but it struck a deep chord. Just as the conversation was about to end, Maria declared that it had occurred to her that she might pursue a career teaching police officers.

That pronouncement was a key step in Maria's journey toward reclaiming her life. She did not end up as a training officer but was able to reestablish her relationship with the work she loved by becoming a dispatcher. This satisfied her itch for reconnecting with police work, which, for her, was crucial to a meaningful life. She reported

improvement on the outcome measure, and therapy ended a few sessions later.

How might a medical model address Maria's concerns? Although her quest for a new identity does not neatly fit into *DSM* categories or evidence-based treatments, there is a good possibility that Maria would be abridged to a collection of symptoms and interventions. She might well be diagnosed as depressed and prescribed cognitive-behavioral therapy and an antidepressant, along with additional skills training for deficits left by her brain injury. In this process, the full-ness of Maria as a person could easily be lost, as well as her voice about treatment choices—reducing her to a description of an illness and its formulaic solutions.

We present Maria's case not as an example of a therapeutic mira-cle but just the reverse. In fact, the ordinariness of this kind of inter-action addresses the core of what we have to offer as mental health professionals. The therapist offered Maria no irresistibly powerful interventions, just a relationship structured around her goals and val-ues, one that showcased her talents and fortitude. And her therapist's repeated requests to tell him whether the therapy was serving her needs involved a kind of accountability that is very different from the accountability that managed care and government funders have tra-ditionally demanded from therapists and the kind that we may expect even more of under the assimilation into the medical model. Part-nering with clients to make our work effective and accountable stands in sharp contrast to a decision-making process predicated on psy-chiatric diagnoses and evidence-based treatments. It offers a viable alternative for revamping mental health services to reduce runaway costs.

THE TERRITORY AHEAD

Cautious, careful people, always casting about to preserve their reputation and social standing, never can bring about a reform. Those who are really in earnest must be willing to be anything or nothing in the world's estimation, and pub-licly and privately, in season and out, avow their sympathy with despised and persecuted ideas and their advocates, and bear the consequences.

—Susan B. Anthony, In Decisions

Let's confront the unpleasant reality and say it out loud, "The field of therapy is in trouble." More distressing but less obvious, popular clinical beliefs and practices are in large part responsible for the mess in which therapists presently find themselves. They have been reified into reality through the institutionalization of the medical model into mental health. But there are alternative visions of the twenty-first century.

Our vision subscribes to a relational rather than medical model, embraces change that is client directed rather than theory driven, and commits itself to successful outcome instead of competent service delivery (Duncan, 2002; Duncan & Sparks, 2002; Duncan, Miller, & Sparks, 2003; Miller, Duncan, & Hubble, 2004). In Chapter Two we challenge the medical model as it applies to mental health, those practices that cast clients as extras and exclude them from their own change efforts. No longer emphasizing exclusive and expert-derived theory as a basis for practice, Chapter Three proposes instead to invest in client ideas of change, client-initiated topics, and client priorities; to elevate, without reservation, local client theories over all those that the therapeutic community previously held sacrosanct. Chapter Three spotlights the heroic client's dramatic contribution to positive outcome and presents guidelines for tapping into the client's star power.

The medicalized milieu of present-day practice increasingly defines *service* as the appropriate application of empirically supported treatments. Instead, we argue for practice-based evidence as an alternative to evidence-based practice. Chapter Four shows the nuts and bolts of a surprisingly simple process of partnering with clients to make therapy both beneficial and accountable—how using client feedback in the form of reliable outcome and process tools makes it possible for therapists to improve their effectiveness.

Chapter Five explores the idea of the client's theory of change and illustrates the integration of diverse approaches through the client's inclinations about change. Given the meteoric rise in psychotropic prescriptions, particularly with children, Chapter Six addresses the thorny issue of medication. We explode the myth of the magic pill while simultaneously honoring client choices to be helped by them. We examine the controversy surrounding drug treatments to encourage reflection about the options offered to clients. In Chapter Seven we address commonly asked questions about our ideas but also deconstruct the unspoken assumptions and practices underlying those questions. We invite the reader to take an alien's look at the talk of

"mental health" and its implications. Finally, and appropriately, we end our discussion with a client's own words. The Epilogue highlights the advantages of an outcome-informed approach with a client who is not experiencing change. The client provides important commentary enabling an understanding usually missing in accounts of therapeutic stalemate and change.

If the surprises we encountered in our journey of the past eleven years are any indication of the terrain ahead, there are likely to be both pitfalls and opportunities as the field struggles to establish an identity based on empirical fact and client partnership rather than myth. As Hamlet says, however, we cannot let this undiscovered country "make us rather bear those ills we have than fly to others that we know not of" (3.1.24–27).