Beyond Integration: the Triumph of Outcome Over Process in Clinical Practice

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The empirically validated, integrative and evidence-based practice movements share in the belief that specific therapeutic ingredients, once isolated and delivered in reliable and consistent fashion, will work to improve outcome. Yet research and clinical experience indicates otherwise. How best to proceed in the light of such findings? Miller, Duncan and Hubble argue that the best hope for integration of the field is a focus on the common goal of change and the use of outcome to inform the clinical process. Significant improvements in client retention and outcome have been shown where therapists have feedback on the client's experience of the alliance and progress in treatment. Rather than evidence-based practice, therapists tailor their work through practice-based evidence.

'The proof of the pudding is in the eating'. **Cervantes, Don Quixote (IV. 10, p. 322)**

Three basic approaches characterize the psychotherapy integration movement (Saltzman & Norcross, 1990). The first, *technical eclecticism*, refers to the use of a variety of techniques *'without necessarily subscribing to the theories that spawned them'* (Norcross & Newman, 1992, p.11). Emphasis is placed on selecting the most useful procedures for a given individual on the basis of demonstrated efficacy (Norcross, 1997).

In contrast, the second, *theoretical integration*, as the name implies, refers to efforts aimed at synthesizing the underlying theories of different approaches (Saltzman & Norcross, 1990). Here, the focus is more theoretical than pragmatic. The best aspects of different approaches are combined into a superordinate theory that hopefully, '*leads to new directions for practice and research*' (p. 12, Norcross & Newman, 1992). The third and final approach to integration is called the *common factors*. Dating back to 1936 and the work of Saul Rozenzweig, this perspective might rightly be considered the earliest attempt at psychotherapy integration. Emphasis is placed on identifying the core ingredients '*shared by all effective therapies*' (p. 7, Hubble, Duncan, & Miller, 1999a).

While definitions of the three dominant approaches are straightforward, since the formation of the *Society for the Exploration of Psychotherapy Integration* (SEPI) nearly two decades ago, one finds little reason to be sanguine. As Norcross (1997) noted with open distress, '*psychotherapy integration has stalled…the meaning…remains diffuse, its commitment typically philosophical rather than empirical, and its training idiosyncratic and unreliable*' (p. 86). More troubling, available evidence calls the validity of the entire project into question.

In 1990, Jensen, Bergin, & Greaves concluded that the integration movement '*will have been wasted unless it can be shown that specific combinations of techniques produces superior outcomes with given disorders*' (p.129). On this score, consider the data on *technical eclecticism*. The pragmatic blending of various approaches remains the most popular clinical orientation among practicing therapists despite the fact that the research clearly shows no therapist is truly eclectic (Jensen, Bergin, & Greaves, 1990; Norcross, 1997; Smith, 1982; Watkins, Lopez, Campbell, & Himmel, 1986). As it is, the modal '*eclectic*' therapist uses only 4 of the existing 250-1000 (depending on how one counts) different treatment models and techniques. Those used frequently have a strong family resemblance (i.e. the combination of techniques from solution-focused and narrative approaches) or are applied in accidental, hit or miss combinations. This practice hardly qualifies as eclecticism!

Though not for lack of trying, no evidence of differential effectiveness exists for the perspective. For instance, significant attempts have been made to identify, '*what kind of therapy, or elements thereof, benefits what kind of client*' (p.219, Shoham-Salomon & Hannah, 1991). Beyond complaints that the resulting 'matching matrices' are either too simplistic or too complex to be of much value in modern clinical work, comparative, component (e.g. dismantling), and person by treatment interaction studies have failed to provide any consistent or compelling empirical support (Ahn & Wampold, 2002; Baker

& Neimeyer, 2003; Dance & Neufeld, 1988; Smith & Sechrest, 1991). Such might be expected given that technical eclecticism focuses on what is arguably the weakest contributor to outcome - technique - which data indicate accounts for between 8-15% of the variance (Duncan & Miller, 2000; Wampold, 2001).

Turning to *theoretical integration*, both the field and practitioners appear, in theory, to be committed to blending ideas from different therapeutic modalities. As Norcross (1997) notes, *'every third or fourth volume on psychotherapy now touts itself as integrative'* (p. 86). The same may be said of continuing education events and journal articles where everything from cognitive-behavioral and strategic (Yapko, 2001), depth-oriented and brief therapies (Ecker & Hulley, 1996), to string theory and energy meridians (Callahan & Mindell, 2000) are combined. However, rather than improving outcomes or offering new avenues for research and treatment, the many offerings have exacerbated the very confusion the integrative movement was designed to stem.

One notable exception to this bleak state of affairs may be found in the work of Prochaska and colleagues on the transtheoretical approach (Prochaska, 1999; Prochaska & Norcross, 2002). While often cited as an example of theoretical integration (Norcross & Newman, 1992), Prochaska's own description suggests that the model is less about amalgamating theories of therapy than understanding how change occurs (Prochaska, 1999). More will be said later about why this approach lies beyond traditional integrative frameworks.

Outside of the laboratory and halls of higher education, it remains so very true that techniques and models are accumulated rather than integrated, employed idiosyncratically rather than systematically.

Last, but not least, is the *common factors approach*. Of the three, this perspective has the strongest empirical support (Hubble, Duncan, & Miller, 1999b). As Beutler & Consoli (1992) noted in the first edition of the *Handbook of Psychotherapy Integration*, *'most of the effectiveness of psychotherapy can be attributed to factors that are common'* (p. 264). Nothing has changed in the interim. The evidence that specific ingredients account for treatment effectiveness remains weak to non-existent. Indeed, Wampold (2001) concludes in his meticulous review of the literature, *'Decades of psychotherapy research have failed to find a scintilla of evidence that any specific ingredient is necessary for therapeutic change'* (p.204).

While a core group of common factors has been identified and defined (Frank and Frank, 1991; Miller, Duncan, & Hubble, 1997; Hubble, Duncan, & Miller, 1999b; Rosenzweig, 1936; Wampold, 2001), their utility in day-to-day clinical work is questionable. To begin, a paradox is created the moment any attempt is made at operationalization. Logically, there is and can never be a 'common factors' model of therapy because all models by definition already include the factors. Even the usefulness of the factors as general organizing principles for clinical practice is uncertain. A case in point is the therapeutic alliance - widely thought of as a fundamental ingredient of all approaches (Hubble, Duncan, & Miller, 1999b). And yet, research to date shows that training therapists to focus on the alliance has not been productive (Horvath, 2001).

Whither Integration?

'This is it! You can't get there from here, and besides there's no place else to go.'
'Sheldon Kopp (1975)

Though it is tempting to blame the current problems in the integrative movement on a lack of information, proper education, or inadequate training, a simpler, more parsimonious, explanation exists. As worthy as the aims may be, the movement fails to capture the essence or reflect the exigencies of psychotherapy as it is practiced in the real world. Outside of the laboratory and halls of higher education, it remains so very true that techniques and models are accumulated rather than integrated, employed idiosyncratically rather than systematically. Like it or not, that is the reality on the ground. As opposed to imposing order from without, perhaps the time has come to surrender to the seeming chaos within.

Looking back, the field of psychotherapy has long sought to establish itself on solid ground through the creation of a reliable psychological formulary - prescriptive treatments for specified conditions. In this respect, the integration movement shares many of the goals and ambitions of the 'empirically supported treatments' (EST) initiative. The assumption inherent in both efforts is that a unified or systematic application of scientific knowledge leads to a universally accepted standard of care that, in turn, leads to more effective and efficient treatment. Everyone in the story wins: patients, practitioners, and payers!

On reflection, few would debate the success of the perspective in medicine where an organized knowledge base, coupled with improvements in diagnosis and pathology, and the development of treatments containing specific therapeutic ingredients, have led to the near extinction of a number of once fatal diseases. Unfortunately, for all the claims and counterclaims, and thousands of research studies, psychotherapy in general and the integrative movement in particular, can boast of no similar accomplishments in spite of a numerous years of research and development.

As one example, consider the evidence regarding treatment manuals. While admittedly limited to single treatment modalities, manuals are the quintessence of an organized and systematic approach to treatment - the idea that specific factors, once identified and then reliably delivered, will enhance outcome. At this juncture, the data clearly show that training therapists to deliver 'manualized care' (R. Klekar, 2003, personal communication) increases adherence to the manual. Not withstanding, the same research shows no resulting improvement in outcome and the strong possibility of untoward negative consequences (Beutler, Malik, Alimohammed, Harwood, Talebi, Noble, & Wong, 2004; Lambert & Ogles, 2004). With regard to the former, researchers Shadish, Matt, Navarro, & Phillips (2000) found non-manualized psychotherapy as effective as manualized in a meta-analysis of ninety studies. As for the latter, Adis, Wade, & Hatgis (1999) showed that manuals negatively impacted the quality of the therapeutic relationship, unnecessarily and inadvertently curtailed the scope of treatment, and decreased likelihood of clinical innovation. It is hard to imagine any empirical reason why the systematic or theoretical blending of equally efficacious approaches would, once manualized, result in markedly different findings.

For all that, attempting to fit the round peg of psychotherapy into the square hole of medicine remains attractive for several reasons, including the general acceptance of the medico-scientific view in Western society and harsh economic realities of our healthcare system (Hubble & Miller, in press; Norcross & Newman, 1992). Mental health care benefits in the USA dropped by a startling 54%, for example, between 1988 and 1998 - the last decade for which data is available. Moreover, this decrease was not part of an across the board cut in health care as visits to physicians increased by a third during the same period (Hay Group, 1999).

Given such developments, it is easy to see how anything short of emulating the field's more scientifically minded and financially successful cousins in medicine would be viewed as courting further marginalization. As Nathan (1997) argued in the Register Report, therapists need to *'put [their] differences aside, find common cause, and join together to confront a greater threat securing the place of psychological therapy in future health care policy and planning'* (p. 5).

Still, the facts are difficult to ignore: psychotherapy does not work in the same way as medicine. The improvements in outcome hoped for and promised by the identification, organization, and systematization of therapeutic process have not materialized. The question that remains unanswered, of course, is how best to proceed in the light of such findings? What are the alternatives for guiding clinical practice? To find the answers, an analysis from a classic work in the field of business is now examined.

Thriving on Chaos: Elements of an Outcome-Informed Approach to Clinical Practice

'Confusion is a word we have invented for an order which is not understood.'
Henry Miller (1938)

Throughout much the 1800's and the century that followed the railroad industry was the most successful business in America. Various companies raced to lay track from city to city and across the continent, speeding up the pace of life and making millions in the process. By the 1960's, however, this once great stalwart of American commerce was in serious decline - in truth, dying. When asked about the cause, business executives usually answered that the need was being filled in other ways (i.e. cars, trucks, airplanes, and new and expanding technologies like the telephone and thermal fax machine). It was hard to argue with such logic. Where transportation was concerned, consumers were seeking faster, easier, more flexible and individualized alternatives.

For Harvard business professor Theodore Levitt, the conventional held wisdom made no sense and, in fact, begged the question. The industry, Levitt (1975) argued, was not in trouble *'because the need was filled by others…but because it was not filled by the railroads themselves'* (p. 19). Why did the industry not diversify when it had the chance? Because, as it turns out, railroad executives had come to believe they were in the train rather than transportation business. Consequently, trucking and airfreight industries flourished while the old iron horse rusted away on the back lots of abandoned railroad yards.

In what has become one of the most cited articles in the business literature, Levitt (1975) shows how various industries, including everything from the railroads to Hollywood, suffered dramatic reversals in fortune when they became '*product-oriented instead of customer-oriented'* (p.19). Movie moguls, for instance, were caught totally off guard by the television industry because they wrongly thought themselves in the movie rather than entertainment business. And so famed director and studio executive, Darryl F. Zanuck, boldly asserted, '*Television won't be able to hold onto any market it captures after the first six months. People will soon get tired of staring at a plywood box every night*' (Lee, 2000). Such extraordinary lack of foresight eventually forced the closure of once powerful studios and bankrupted numerous high rollers in the trade. The empire never recovered its once and former greatness.

Psychotherapy does not work in the same way as medicine. The improvements in outcome hoped for and promised by the identification, organisation and systemization of therapeutic process have not materialised.

Applying these ideas to the field of psychotherapy suggests that the decades long debate between this or that model of therapy, specific versus common factors, or integration versus the chaos of diversification misses the point in a major way. Put bluntly, it has proceeded as though the field were in the therapy business rather than the business of change. '*The illusion*', according to Levitt, is '*that continued growth is a matter of continued product innovation and improvement*' (p.27). For their part, consumers (and payers) care little about how change occurs - they simply want it. As such, the field's exclusive focus on the means of producing change (i.e. models, techniques, therapeutic process) is on the wrong track. Like their counterparts in the railroad and movie business, therapists are in danger of losing their customer base.

In this regard, the data indicate that consumers are already abandoning psychotherapy. As noted, mental health benefits are down significantly over the last decade. During that same period, visits to outpatient therapists dropped by as much as 30% (Duncan & Miller, 2000). And, while it might be tempting to attribute the decrease to restrictions imposed by managed care, other studies suggest something more unsettling. Last year, Americans spent 13.7 billion dollars out of pocket on alternative healthcare - a figure that does not include memberships in health clubs, purchases of vitamins and supplements, or visits to a masseuse. Clearly, the flagging fortunes of psychotherapy are not caused by a decline in consumers' desire for fulfillment or personal change. On the contrary, the field is perceived as not viewed as fulfilling that need.

Take the results of focus groups conducted by the American Psychological Association (APA, 1998). When asked, 76% of potential consumers of psychotherapy identified low confidence in the outcome of therapy as the major reason for not seeking treatment, far eclipsing variables traditionally thought to deter people from seeing a therapist (e.g. stigma, 53%; length of treatment, 59%; lack of knowledge, 47%). Such a 'no confidence' vote is especially difficult to accept given decades of research showing that the average treated client is better off than 80% of the untreated sample in most studies (Asay & Lambert, 1999; Wampold, 2001). Nonetheless, this is the perception of consumers.

According to Levitt (1975), in business, industries that thrive *start* with the customer's needs and work *backwards*, '*...first concerning itself with the…delivery of customer satisfactions. Then it moves back further to creating the things by which these satisfactions are in part achieved*' (p.27, italics in original). Less time and resources are spent identifying, codifying, and controlling the means of production and more effort is expended in staying in touch with customer desires. Doing otherwise, Levitt warns, risks '*defining an industry, or a product, or a cluster of know-how so narrowly as to guarantee its premature senescence*' (p.20).

From this perspective, eclecticism - however defined and operationalized- can be viewed as an attempt on the part of practicing clinicians to pay attention to and meet the diverse preferences and needs of their clientele. Observers suggest, in fact, that therapists have, whatever the popular trends, always worked in this fashion anyway; that is, drawing on their personal as well as professional knowledge, being '*sensitive to the particular, contextual, and changing situation characteristic of therapy practice*' (p.1429, Polkinghorne, 1999). In business terms, eclecticism is the 'five-and-dime' of the mental health marketplace. What may appear chaotic and disorganized to theoreticians and researchers is, from the clinician's point of view, a little of this, a little of that, organized and collected in response to the interests of the local customer base.

Indeed, according to Levitt, the realities of the marketplace also account for the frequently cited and forever growing split between researchers and clinicians. Both groups, he would argue are responding to the actuality that, '*consumers are unpredictable, varied, fickle, stupid, shortsighted, stubborn, and generally bothersome*' (Levitt, 1975, p. 27). Where practitioners, as noted above, respond by utilizing whatever means are at their disposal - as inelegant or haphazard as they may seem - researchers and theoreticians '*concentrate on what they know and what they can control, namely, product research, engineering, and production*' (Levitt, 1975, p.27). Contrary to popular wisdom, Levitt (1975) maintains that the split is not between science and practice. It is between being more '*oriented toward the product rather than the people who consume it*' (p.27).

Still, neither researchers nor clinicians go far enough as both remain focused on the means of production (i.e. therapy) rather than the product that consumers seek (i.e. outcome). The important

question is not what constitutes effective therapy practice - eclectic or empirically validated, integrated or diversified - but whether consumers are experiencing the changes they desire by whatever means. Instead of assuming that the right process leads to favorable results, the field needs to use outcome to guide process and inspire innovation.

The distinction between the process and outcome is implicit in the work of Prochaska (1999), where '*the content of therapy - such as feeling, fantasies, thoughts, overt behaviors, and relationships*' (p. 228) is clearly viewed as secondary to change. In much of their research, Prochaska and colleagues have bypassed traditional face-to-face therapy altogether, using a combination of telephonic solicitation, self-directed manuals, and consumer-driven, computer-based expert systems (Prochaska, DiClimente, Velicer, & Rossi, 1993; Prochaska & Norcross, 2001). Curiously, although over a 100 empirical investigations have documented the strength of Prochaska's perspective, the small number of published studies in which psychotherapy figured as the intervention was cited as a major weakness when determining whether the transtheoretical model warranted 'empirically-validated' status (Prochaska & Norcross, 2001). What is lost in such criticism is that the approach is more outcome than process oriented in focus. As such, psychotherapy-as-method is not accorded a preferential or privileged status. It is simply one among a potentially infinite number of ways for meeting the needs and preferences of consumers. Accordingly, Prochaska's work is, to turn a phrase, beyond integration.

The following section presents the historical development of an approach based exclusively on using consumer feedback to guide treatment process. As will be shown, research to date has documented significant improvements in the outcome of psychological care without the traditional preoccupation with therapeutic process.

From Process to Outcome: History and Development

'…frothy eloquence neither convinces nor satisfies me…you've got to show me.'
Willard Duncan Vandiver (1899)

In 2002, the *Comprehensive Handbook of Psychotherapy* was published. Covered in the 4 volume, 2400 plus double-columned pages was '*the most current extant knowledge*' on psychodynamic, cognitive and cognitive-behavior, existential and humanistic approaches.

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One volume of some 600 pages was devoted to integrative and eclectic approaches alone. Curiously absent from the ambitious series was any mention of outcome. With one exception, the word does not even appear in the index (Miller, Duncan, & Hubble, 2002). As Kalsow (2002) notes in the preface, most of the materials, '*deal with assessment and diagnosis as well as treatment strategies and interventions*' (p. xiii).

For a field as intent on identifying and codifying the methods of treatment as therapy is, abandoning process in favor of outcome may seem radical indeed. Nonetheless, an entire tradition of using outcome to inform process exists. We begin by exploring the empirical antecedents of outcome-informed clinical practice. Following this review, the development of our own work and perspective is presented.

Empirical Antecedents of Outcome-Informed Work

Outcome research indicates that the general trajectory of change in successful therapy is highly predictable, with most change occurring earlier rather than later in the treatment process (Brown, Dreis, & Nace, 1999; Hansen & Lambert 2003; Haas, Hill, Lambert, Morrell, 2002; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Smith, Glass, & Miller, 1980; Steenbarger, 1992; Whipple, Lambert, Vermeersch, Smart, Nielsen, Hawkins, 2003). In their now classic article on the dose-effect relationship, Howard, Kopte, Krause, & Orlinsky (1986) found that between 60-65% of people experienced significant symptomatic relief within one to seven visits - figures that increased to 70-75% after six months, and 85% at one year (Howard, Kopte, Krause, & Orlinsky, 1986) These same findings further showed, '*a course of diminishing returns with more and more effort required to achieve just noticeable differences in patient improvement*' as time in treatment lengthens (p. 361, Howard et al., 1986).

More recently, researchers have been using early improvement - specifically, the client's subjective experience of meaningful change in the first few visits - to predict whether a given pairing of client and therapist or treatment system will result in a successful outcome (Haas, Hill, Lambert, Morrell, 2002; Garfield, 1994; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001). To illustrate, Howard, Lueger, Maling, & Martinovich (1993) not only confirmed that most change in treatment took place earlier than later, but also found that an absence of early improvement in the client's subjective sense of well-being significantly decreased the chances of achieving symptomatic relief and healthier life functioning by the end of treatment. Similarly, in a study of more than 2000 therapists and thousands of clients, researchers Brown, Dreis, & Nace (1999) found that therapeutic relationships in which no improvement occurred by the third visit did not on average result in improvement over the entire course of treatment. This study also showed that clients who worsened by the third visit were twice as likely to drop out than those reporting progress. Importantly, variables such as diagnosis, severity, family support, and type of therapy were, '*<u>not</u> . . . as important [in predicting eventual outcome] as knowing whether or not the treatment being*

provided [was] actually working' (Brown et al., 1999, p. 404, emphasis added).

In the mid-nineties, a number of researchers began using data generated during treatment to improve the quality and outcome of care. In 1996, Howard, Moras, Brill, Martinovich, & Lutz (1996) demonstrated how measures of client progress could be used to '*determine the appropriateness of the current treatment… the need for further treatment…[and] prompt a clinical consultation for patients who [were] not progressing at expected rates*' (p.1063). That same year, Lambert & Brown (1996) made a similar argument using a shorter, and hence more feasible, outcome tool. Finally, Johnson & Shaha (1996, 1997) published a quasi-experimental, clinical case study combining feedback regarding progress and the strength of the therapeutic alliance. Other researchers had already documented that early ratings of the alliance, like progress, were '*significant predictors of final treatment outcome*' (p. 139, Bachelor & Horvath, 1999; Mohl, Martinez, Ticknor, Huang & Cordell, 1991; Plotnicov, 1990; Tracey, 1986). Building on this and their own earlier work (Johnson, 1995), Johnson & Shaha (1996, 1997) were the first to document the impact of outcome and process tools on the quality and outcome of psychotherapy as well as show how such data could foster a cooperative, accountable relationship with payers.

With regard to clinical practice, the conclusion to be drawn is clear: feedback from clients is essential and can even improve success. As for method, the diverse number of approaches encompassed in such data clearly hints that the particular brand of therapy employed is of less importance. Therapists do not need to know ahead of time what approach to use for a given diagnosis as much as whether the current relationship is a good fit and, if not, be able to adjust in order to maximize the chances of success. Assessment does not precede and dictate intervention but is an on-going component of the therapeutic relationship and change itself (Duncan & Miller, 2002).

The Heart and Soul of Change Project

The present authors interest in an outcome-informed approach to clinical practice began following a chance meeting at a professional conference in 1993. Concerned about the rapid proliferation of therapeutic models and resulting division of helping professionals along theoretical, technical, and disciplinary lines, initial efforts focused on developing a '*unifying language of psychotherapy practice*' that would enable the field to '*set aside [it's] many apparent differences and find a way to talk, to join together, and to share what…works*' (p.xi, Miller, Duncan, & Hubble, 1997; Duncan, Solovey, & Rusk, 1992; Miller, Hubble, & Duncan, 1995). Research and writing on the common factors - dating back to Rosenzweig's (1936) and Frank's (1961, 1973) publications and forward to Lambert's (1986, 1992) scholarly reviews of the literature - provided the foundation for a '*basic vocabulary*' (p.215, Miller, Duncan, & Hubble, 1997).

Of the various factors identified, the data indicated that the client and therapeutic alliance accounted for the majority of the variance in treatment outcome (Miller, Duncan, & Hubble, 1997; Miller, Hubble, & Duncan, 1995). Lambert (1986, 1992), for example, suggested that 40% was attributable to the client/extratherapeutic factors and 30% to the therapeutic relationship. By comparison, model and technique factors and placebo were thought to contribute a paltry 15% each. Later, meta-analytic research by Wampold (2001) confirmed and extended these findings, indicating that as much as 87% of the total variance in outcome was due to client/extratherapeutic factors, while relationship factors accounted for 50% of the variance in treatment effects (Hovarth, 2001).

Such data, when combined with '*the observed superior value, across numerous studies, of clients' assessment of the relationship in predicting the outcome*' (p.140, Bachelor & Horvath, 1999), made a strong empirical case for putting the client in the 'driver's seat' of therapy. Successful treatment, we argued, was a matter of '*tapping into client resources and ensuring a positive experience of the alliance*' (p.433, Hubble, Duncan, & Miller, 1999c). To these two elements, a third aspect was added; namely, the client's frame of reference regarding the presenting problem, it's causes, and potential remedies - what we termed, *the client's theory of change* (Duncan, Hubble, & Miller, 1997; Duncan & Moynihan, 1994; Duncan & Miller, 2000; Duncan, Solovey, & Rusk, 1992; Hubble et al., 1999b).

Adopting the client's frame of reference as the defining 'theory' for the therapy fit with several major findings from the extant, process-outcome literature. For example, in 1994 researchers Orlinsky, Grawe, and Parks (1994) reported that, '*the quality of the client's participation in treatment stands out as the most important determinant of outcome*' (p.361). What better way to enlist clients' partnership, we reasoned, than by accommodating their pre-existing beliefs about the problem and the change process? Follow up research on the landmark *Treatment of Depression Collaborative Research Project*, in fact, confirmed as much. Recall that the study found '*no evidence of any differences*' between the various treatments tested - a finding that generated no small amount of controversy in spite of mostly similar findings from other randomized clinical trials (p.119, Elkin, 1994; Miller, Duncan, & Hubble, 1997; Wampold, 2001). The research further confirmed that the strength of the therapeutic alliance was a better predictor of outcome than either the type of treatment received or the severity of the presenting problem (Blatt, Zuroff, Quinlan, and Pilkonis, 1996; Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins, and Pilkonis, 1996). More to the point, a post hoc analysis of the data found that congruence between a person's beliefs about the causes of his or her problems and the treatment approach offered resulted in stronger therapeutic alliances, increased duration, and improved treatment outcomes (Elkin, Yamaguchi, Arnkoff, Glass, Sotsky, & Krupnick, 1999).

To explain the basic components of a client-directed approach to students in graduate school programs and seminars, an analogy to a three-legged stool was employed (see Figure 1). Set against a backdrop of client strengths and resources, each leg of the stool stood for one of the core ingredients of the therapeutic alliance as identified in the research literature: (1) shared goals; (2) consensus on means, methods, or tasks of treatment; and (3) an emotional bond (Bachelor & Horvath, 1999;

Bordin, 1979; Horvath & Bedi, 2002). Holding everything together was the client's theory of change. Consistent with the metaphor, goals, methods and a bond that were congruent with the client's theory were likely to keep people comfortably seated (e.g. engaged) in treatment. Similarly, any disagreement between various components destabilized the alliance making the stool uncomfortable or toppling it completely.

As much empirical and clinical sense as these ideas may have made, they were still out of step with the cold, hard facts from the psychotherapy outcome literature. Yes, at first blush, tapping into client resources, ensuring the client's positive experience of the alliance, and accommodating treatment to the client's frame of reference appeared to capitalize on the two largest contributors to success. At the same time, no matter how abstractly the ideas might be presented, whether defined as principles rather than mandates, closer examination made clear that any operationalization merely led to the creation of another model for how to do therapy. The research was clear, whether client-directed or not, models ultimately matter little.

Other problems became manifest. As noted in the introduction, research provided little reason to believe that training therapists to focus on alliance building improved treatment outcome (Horvath, 2001; Horvath & Bedi, 2002). Data on the relationship between therapist experience and the quality of the alliance was at best equivocal (Dunkle & Friedlander, 1996; Bein, Anderson, Strupp, Henry, Schaht, Binder, & Butler, 2000; Mallinckrodt & Nelson, 1991). Finally, clinical experience further undermined the supposition that therapists could be coached to accommodate treatment to the client in the way envisioned.

On further examination, we realized that our own efforts, albeit unintentionally, had subtly but surely continued to privilege the therapist's role and perspective regarding treatment process (Duncan & Miller, 2000). As had been true throughout much of the history of psychotherapy, the therapist was still 'in charge' - in this case, finding client strengths, determining the status of the alliance, understanding the nature of the client's theory, and choosing which, if any methods, might be congruent with that theory. To remedy this problem, and give clients the voice in treatment that the research literature said they deserved, we began encouraging therapists to 'check in' with clients on an ongoing yet informal basis regarding both the nature of and progress in treatment (Miller & Duncan, 2000a). For example, from session to session, therapists could explore:

- how/does the treatment fit with the client's view of the problem and the change process?
- how/does the treatment fit with the client's goals, expectations, and desired pace for treatment?
- how/does the client experience the therapist as respectful, empathic, affirmative, and collaborative?
- how/does the treatment capitalize on what the client can do?
- does the client believe that treatment is utilizing all of the resources available to bring about change?
- how/does the treatment result in an increase in the client's sense of hope and personal control?
- how/does the treatment contribute to a growing sense of self-esteem, self-efficacy, and self-mastery?
- does the client believe the treatment is working?

Next, in early 1998, a research project was initiated to investigate the impact of seeking client feedback on treatment outcome (Duncan & Miller, 2000). Several conditions were included. In one, therapists were supposed to seek client input in an informal manner (i.e. using the questions described above). In another, building on the work of Lambert (Lambert & Brown, 1996; Lambert, Okiishi, Finch, & Johnson, 1998) and Johnson (1995; Johnson & Shaha, 1996) results from standardized, client-completed outcome and alliance measures were fed back to the therapists during treatment. Treatment-as-usual served as a third, control group.

As reported by Duncan & Miller (2000), initial results of the study '*point[ed] to an advantage for the feedback conditions*' (p. 183). Ultimately, however, the entire project had to be abandoned. First of all, a review of the videotapes showed that the therapists in the first condition routinely failed to ask clients for their input - even though, when asked, the clinicians maintained they had

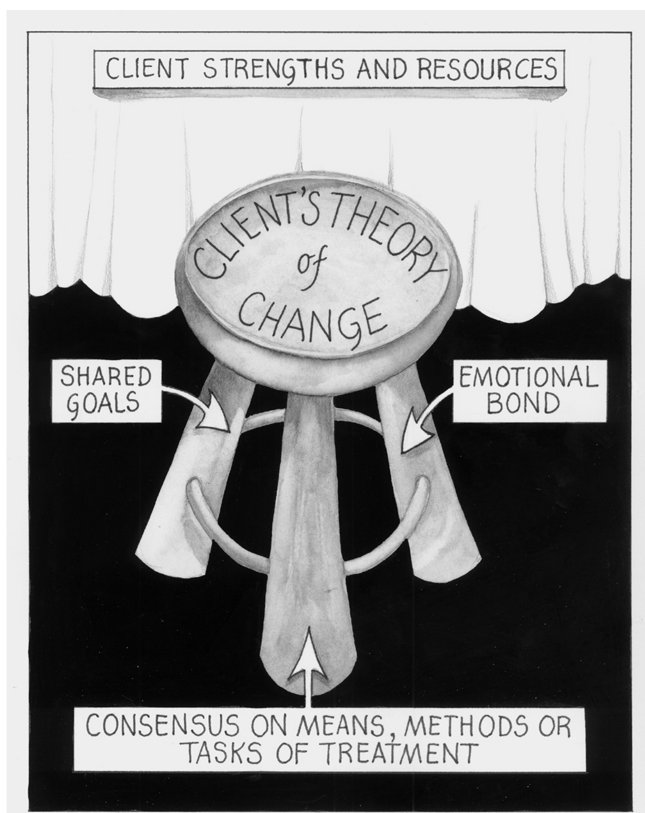

FIGURE 1. Basic Components of a Client Directed Approach

sought feedback. At the same time, 75% of the therapists in the formal feedback condition dropped out of the study, citing both the length and cumbersome nature of the measures as reasons for their departure. Therapists, it appeared, had difficulty appreciating client feedback unless a formal and feasible process for bringing the client's view into treatment was in place [2].

Over the last several years, we have worked to develop a set of clinical tools that are feasible as well as valid and reliable (Duncan & Miller, 2004). Two measures have emerged from this effort. *The Session Rating Scale 3.0 (SRS)* Johnson, Miller, & Duncan, 2000, (download from www.talkingcure.com/measures.htm) is a brief, four-item measure of the therapeutic alliance completed by the client and discussed with the therapist at the end of each session. Generally, the scale takes less than a minute to complete and score and is available in both written and oral forms in several different languages. Research to date has shown the measure to have sound psychometric qualities (Duncan, Miller, Reynolds, Sparks, Claud, Brown & Johnson, in press). The second measure, the *Outcome Rating Scale* (*ORS*), Miller & Duncan, 2000, is a brief, four-item measure of change completed by the client and discussed with the therapist at the beginning of each visit. As with the *SRS*, this scale takes less than a minute to administer and score, is available in both written and oral forms in a number of languages, and has good psychometric qualities (Miller, Duncan, Brown, Sparks, & Claud, in press).[3]

At this point, the two tools have been employed in a number of clinical settings with positive effect. For example, given the brief, clinician and client friendly nature of the scales, the number of complaints regarding the use of the tools has plummeted and compliance rates have soared (Miller, Duncan, Brown, Sparks, & Claud, in press). Providing feedback to therapists regarding clients' experience of the alliance and progress in treatment via the *SRS* and *ORS* has also been shown to result in significant improvements in both client retention and outcome (Miller, Duncan, Brown, Sorrell, & Chalk, in press). For example, clients of therapists who opted out of

SESSION RATING SCALE (SRS)

Please rate today's session by pacing a hash mark on the line nearest to the description that best fits your experience.

I did not feel heard, understood and respected	**Relationship:** I -------------------------------------- I	**I felt heard, understood and respected**
We did not work on or talk about what I wanted to work on or talk about	**Goals and Topics:** I -------------------------------------- I	**We worked on and talked about what I wanted to work on or talk about**
The therapist's approach is not a good fit for me	**Approach or Method:** I -------------------------------------- I	**The therapist's approach is a good fit for me**
There was something missing in the session today	**Overall:** I -------------------------------------- I	**Overall, today's session was right for me**

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Visit www.talkingcure.com/measures.htm to download a free working version of each of these instruments

OUTCOME RATING SCALE (ORS)

Looking back over the past week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Overall:
(General sense of well-being)
I --- I

Individuality:
(Personal well-being)
I --- I

Interpersonally:
(Family, close relationships)
I --- I

Socially:
(Work, School, Friendships)
I --- I

completing the *SRS* were twice as likely to drop out of treatment and three to four times more likely to have a negative or null outcome. On the whole, the average effect size of services at the agency where both measures were employed shifted from .5 to .8.

A detailed analysis of the 12,000 cases included in the study showed that this improvement was due to a combination of decreasing negative outcomes, increasing positive outcomes, and an overall positive shift in the outcome for therapists working at the clinic.

otherwise diverse and chaotic treatment environment.

Such findings, when taken in combination with the field's obvious failure to discover and systematize therapeutic process in a manner that reliably improves success, have led us to conclude that the best hope for integration of the field will be found in outcome. As is the case with religion, there is little hope of resolving doctrinal differences between members of different faiths by pointing out similarities or advocating integration. People believe what they will believe. Almost all, however, agree on the final outcome: salvation. Similarly, in psychotherapy, the time has come to move beyond efforts aimed at seeking consensus on how therapy is to be conducted. Clinicians, researchers, and consumers believe what they will believe.[4] Nevertheless, no matter the many, varied, and often contradictory beliefs regarding effective psychotherapy, nearly everyone agrees on the ultimate goal: change.

... clients whose therapists had access to outcome and alliance information were less likely to deteriorate, more likely to stay longer, and twice as likely to achieve a clinically significant change.

As incredible as the results may appear at first glance, they are entirely consistent with findings from other researchers. For example, using a different set of scales, Lambert, Whipple, Smart, Vermeersch, Nielsen & Hawkins (2001) found an effect size of .65 associated with providing therapists with formal feedback regarding their clients subjective experience of progress in treatment - a figure largely equivalent to that reported by Miller, Duncan, Brown, Sorrell, & Chalk (in press; .3/.5 = .60). In another study, Whipple, Lambert, Vermeersch, Smart, Nielsen & Hawkins (2003) found that clients whose therapists had access to outcome and alliance information were less likely to deteriorate, more likely to stay longer, and twice as likely to achieve a clinically significant change.

The results of our own research as well as that of Lambert and colleagues were obtained without any attempt to organize, systematize or otherwise control treatment process. Neither were the therapists in these studies trained in any new therapeutic modalities, treatment techniques, or diagnostic procedures. Rather the individual clinicians were completely free to engage their individual clients in the manner they saw fit. Availability of formal client feedback provided the only constant in

In the pages that follow, the nuts and bolts of an outcome-informed approach to clinical practice are spelled out and illustrated with case material. Particular attention is paid to demonstrating how a system for obtaining client feedback can be developed that is valid, reliable, and feasible for the specific context in which it is used. Consideration is given to the many implications of this perspective for the future of the field.

Becoming Outcome-Informed in Clinical Practice: The Nuts and Bolts

Three basic steps are involved in becoming outcome-informed: (1) selecting instruments; (2) piloting the tools chosen and gathering data; and (3) developing a feedback process. Each step is discussed in turn.

1. Instrument selection

Where the practice of therapy usually begins with diagnosis and selection of treatment modality, an outcome-informed approach to clinical practice starts with finding measures of process and outcome that are valid, reliable, and feasible for the context in which the tools will be employed (Duncan & Miller, 2000, 2004; Johnson & Shaha, 1996). Diagnosis as most recently codified in the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1994, 2000) has a long and problematic relationship with the practice and outcome of psychotherapy. While a detailed review is beyond the scope of this article, suffice to say that despite widespread use of the DSM, the diagnosis a person receives at the outset of treatment bears little or no relationship to the outcome of that care (Brown et al., 1999a; Duncan & Miller, 2004; Wampold, 2001). The lack of specific curative factors in psychological therapies, and questionable validity and reliability of the diagnostic categories, figure prominently among reasons for this poor correlation (Duncan & Miller, 2004; Wampold, 2001).

Of course, there is no such thing as a 'perfect' measure. Finding the right set of tools for a particular setting means working to strike a balance between the competing demands of validity, reliability, and feasibility. A simple, brief, and therefore highly feasible measure, for example, is likely to be less reliable. At the same time, any gains in reliability

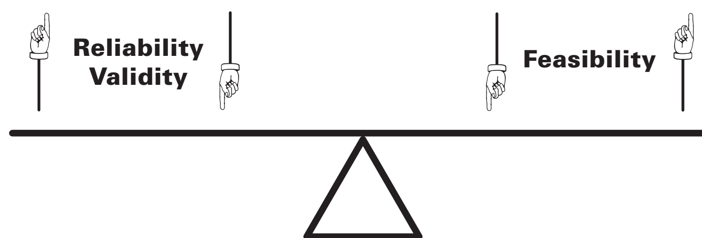

FIGURE 2. The relationship between reliability, validity and feasibility in the selection of clinical tools

and validity associated with a longer and more complicated measure are likely offset by decreases in feasibility (see Figure 2). As a general rule, Brown et al. (1999) found that any measure or combinations of measures that took more than five minutes to complete, score, and interpret was not considered feasible by the majority of practitioners. Time is not the only factor. Simplicity, immediacy of results, low cost, and broad applicability also affect the likelihood of therapists and clients making use of the scales (Duncan & Miller, 2004).

In the now classic text, *Essentials of Psychological Testing* (1970), Cronbach noted that, '*A test that measures the wrong thing…is worthless…. Validity is high if a test gives the information the decision maker needs*' (p. 121). To select a valid measure, careful thought must be given to the kind of information needed to facilitate decision-making. In psychotherapy, this means taking the time to define the intended effect of the treatment as well as the qualities known to be associated with effective service prior to surveying available process and outcome measures.

In our own research, the *SRS* was chosen because of the strong empirical support for the role of the client's view of the therapeutic alliance in predicting retention in, and outcome of, treatment. Similarly, the *ORS* was adopted both because it measured the outcomes most likely to result from the treatment offered at the settings in which we worked, and was a more feasible alternative to the longer measure employed in our original research (Duncan & Miller, 2000; Hubble, Duncan, & Miller, 1999; Kadin, 1994; Lambert, 1983; Lambert & Hill, 1994; Miller, Duncan, Brown, Sparks, & Claud, in press). The *ORS* has further proven to be sensitive to change in those undergoing treatment while being stable in a non-treated population - a critical issue in selecting a valid measure of psychotherapy outcome (Miller, Duncan, Brown, Sparks, & Claud, in press). As Vermeersch, Lambert, & Burlingame (2000) point out, many scales presently in use were not designed to measure change, but rather stable personality traits or enduring patterns of problematic behavior (e.g. the MMPI, DSM diagnostic categories).

While the *SRS* and *ORS* may be valid for a practice providing individual treatment, they are less likely to be the best choice for a setting that provides case management services over a long period or specializes in family therapy. In such instances, finding the right set of tools would require reviewing the literature and evaluating the local customer base to determine the nature (e.g. families versus individuals, psychotherapy versus case management) and intended outcome of the service (e.g. number of hospitalizations, increased activities of daily living).

The final variable to consider is reliability. Differences in scores between administrations of a scale must be attributable to the variable being measured in order for a scale to be considered reliable. In the assessment of process and outcome, highly reliable measures translate into trustworthy findings. On the other hand, scores that vary in spite of little or no real difference in the treatment or client provide no trustworthy information about the effectiveness of the therapy or whether that therapy contains the qualities of an effective service. To date, research on the *SRS* and *ORS* has returned solid estimates of internal consistency and test-retest reliability (@ = .88 and .93, and .74 and .66, respectively).

2. Piloting and Data Gathering

The next steps in the process of becoming outcome informed involve piloting the selected instruments, collecting data, and establishing norms for the particular setting in which the results will be applied. Among the factors critical to success, Miller, Duncan, Brown, Sorrell, & Chalk (in press) identify a strong emphasis on an open, trial-and-error, learning environment and regular feedback from clients and therapists using the scales. In agencies, group practices, or other large healthcare organizations, the presence of an executive leader who understands and actively supports the shift from process to outcome aids considerably in facilitating compliance with data gathering as the system is adjusted and modified. (Miller & Chalk, 2003).

Options for data analysis run from simple to complex. For example, the average practitioner working in a private practice setting could adopt a single-subject design, graphing and discussing the measures with the individual client at each session. In this instance, the psychometric properties of the scales and the general pattern of change in treatment as established by existing outcome research would be the best guide for interpretation of the results. Scores of 36 or below on the *SRS*, for example, are ordinarily considered cause for concern as they fall at the 25th percentile of those who complete the measure. Since research indicates that clients frequently drop out of treatment before discussing problems in the alliance, a therapist would want to use the opportunity provided by the scale to open discussion and remedy whatever problems exist (Bachelor & Horvath, 1999).

As an illustration, consider the case of Linda, an executive and mother of two in her 40's who presented for treatment with complaints of depression (Miller, Duncan, Johnson, & Hubble, 2002). In the first interview, she explained how her current symptoms resulted from serious problems she was having at work. She related how once friendly co-workers had recently turned on her, accusing her of having sex with a senior executive in order to gain a promotion.

At the conclusion of the first session, Linda completed the *SRS*. However, the scale was neither scored nor discussed because both the therapist working with Linda and another observing from behind a one-way mirror thought the session went quite well. When the *SRS* was scored later that day, the therapist learned that Linda had, despite all appearances, been quite dissatisfied with the session. Her answers indicated that she had expected the therapist to give her some advice and suggestions for dealing with the situation at work - something that had not taken place during the visit.

The therapist immediately phoned Linda and offered to meet the following day during the lunch hour. She agreed, showing up on time for the appointment. Together, they worked on specific strategies for addressing the problems at work. Linda's scores on the outcome scale were already improving. At the same time, results on the *SRS* documented a significant shift in the alliance, remaining high throughout the treatment process. When discussing her

progress at the conclusion of treatment, Linda confirmed the importance of the call following the first visit, saying she was uncertain whether she would have returned otherwise.

With regard to outcome, the research literature, as reviewed earlier, shows that the majority of change in treatment occurs earlier rather than later. Thus, an absence of improvement in the first handful of visits could serve as a warning to the therapist, signaling the need for opening a dialog with the client regarding the nature of treatment. Lebow (1997), for example, using Howard and colleagues' work as a guide, recommends a change of therapists whenever a client deteriorates in the initial stages of treatment or '*is responding poorly to treatment by the eighth session*' (p.87). The same data gives some general guidance regarding the proper frequency of sessions, with more visits scheduled in the beginning of contact when the slope of change is steep and fewer as the rate of change decelerates (Brown et al., 1999).

Consider the case of Steven, a man in his thirties who presented for treatment with complaints of chronic depression, lethargy, and low self-esteem (Miller & Duncan, 2000). Steven reported having been in treatment numerous times - on at least two occasions for a period lasting several years. While he believed that each of these experiences had been helpful, his continuing struggle with depression left him feeling that some 'underlying issue' remained unresolved from his childhood. He expressed a strong desire to finally 'get to the root' of the matter in the present treatment. The therapist agreed and, over the course of the next few sessions, worked in a psychodynamic framework with Steven exploring various experiences from his childhood, and attempting to make connections to his current problems.

Steven's ratings on the alliance measure given at the end of each visit could not have been higher. According to his answers, the therapy he was receiving matched what most clients associate with successful treatment. Yet, his scores on the clinical outcome measure told a different story. From week to week, the measure showed that not only he was not improving, but also slowly getting worse. Where in the past more of the same treatment may have continued for several more sessions, the therapist worked with Steven in conjunction with a team of clinicians that had been observing from behind the one-way mirror. In what amounted to a free-for-all of unedited speculations and suggestions, a range of alternatives was considered including: changing nothing about the therapy, to taking medication, to shifting treatment approaches.

Out of everything, Steven expressed the most interest in an idea presented at the start of process. Perhaps some 'underlying issue' did not cause his recurring problems with depression. Instead, he had learned to downplay his strengths and abilities as a way of dealing with his insecure and overly critical parents. In the four sessions that followed, the focus of treatment shifted. Rather than 'rooting' around in the past for something that might explain his present problems, Steven and the therapist started exploring the strengths and character traits he possessed that could be of use when he was 'tempted to give into the depression.' His scores on the outcome measure reversed and began improving. When re-contacted a year after the therapy ended, Steven reported that while tempted several times, he had used what he learned about himself in treatment to avoid becoming depressed.

While the single subject design offers ease and simplicity of use, it suffers in terms of precision and reliability. The broad guidelines for evaluating progress are based on data pooled over a large number of clients. Because the amount and speed of change in treatment varies depending on how a client scores at the first session, such suggestions are likely to underestimate the amount of change necessary for some cases (i.e. those starting treatment with a lower score on the outcome measure) while overestimating it in others (i.e. those with a higher initial score).

The simplest method for dealing with this problem is to disaggregate the data and compare clients with similar outcome scores at intake. For instance, test scores at the initial session could be assigned to one of four different levels (i.e. quartiles). The average change score could then be calculated for each of the four levels. The final step would be calculating the difference between the average and actual outcome for a given individual in order to determine if the outcome was better or worse than the average client in that range.

A more precise method is to use a simple linear regression model to predict the score at the end of treatment (or at any intermediate point in treatment) based on the score at intake. Using the slope and an intercept, a regression formula can be calculated for all clients in a given sample. Once completed, the formula can be used to calculate the expected outcome for any new client based on the intake score.

An important caveat to this otherwise rosy picture needs to be mentioned. While such strategies are helpful in improving precision and reliability, they will not resolve the problem known as 'regression to the mean.' Briefly, this is the tendency for extremes to become more average over time. If this problem is not resolved, it becomes difficult to determine whether any measured changes are in fact due to treatment. Correction involves a statistical procedure known as time reversal (Kenny and Campbell, 1999).

3. Developing a Feedback System

The last step in becoming outcome-informed is developing a feedback system. Using feedback from outcome and process tools can be as simple as scoring and discussing results together with clients at each session or as complex as an automated, computer-based data entry, scoring, and interpretation software program. Of course, the choice of approach will depend on the needs, aims and resources of the user.

One advantage to automated data entry and feedback is the ability to easily compare the customer service (e.g. alliance) and effectiveness levels of different clinicians and treatment sites. Research indicates, for example, that 'who' the therapist is accounts for six to nine times as much variance in outcome as 'what' treatment approach is employed (Lambert, 1989; Luborsky, Crits-Christoph, McLellan, Woody, Piper, Liberman, Imber, & Pilkonis, 1986; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Wampold, 2001). Similar variations in outcome have been found between different treatment sites within studies employing the same approach (Miller, Duncan, & Hubble, 2002).

Being able to compare therapists and settings not only allows for the identification of under performers, but also those with reliably superior results - an obvious benefit to both payers and consumers (Lambert, 2002).

Several research projects are currently underway attempting to identify any differences in practice between the effective and ineffective providers and treatment settings that might serve to inform therapy in the future (Johnson & Miller, in preparation). Interestingly, while having documented tremendous improvements in cases at risk for a negative or null outcome, Lambert (2003, personal communication)[5] has not found that the overall effectiveness of individual therapists improves with time and feedback. Rather, from year to year, the number of 'at risk' warnings a given clinician receives remains constant. Perhaps these preliminary findings can be explained by the brief duration of the study - Lambert has only been following the clinicians for three years. Studies documenting a small but consistent advantage in outcome for experienced therapists - especially with complicated cases - may indicate that effective practice can be learned but not taught (Bergin & Lambert, 1978; Atkins & Christensen, 2001; Lambert & Bergin, 1994; Weisz, Weiss, Alicke, & Klotz, 1987). If confirmed, however, such findings, when taken in combination with the weak historical link between training and outcome in psychotherapy (Lambert & Ogles, 2004), further underscores the need to shift away from process and toward an outcome-informed approach to clinical practice.

Failing Successfully: A Case Example of Outcome-Informed Clinical Work

'Research participation is an issue of consumer protection as well as protection for practitioners from fad and fashion.'
Symour and Towns (1990)

Robyn was a 35 year old, self-described 'agoraphobic' brought to treatment by her partner because she was too frightened to come to the session alone. [6] Once an outgoing and energetic person making steady progress up the career ladder, Robyn had over the last several years grown progressively more anxious and fearful. *'I've always been a 'nervous' kind of person,'* she said at some point during her first visit, *'now, I can hardly get out of my house.'* She added that she had been to see a couple of therapists and tried several medications. *'It's not like these things haven't helped,'* she said, *'it's just that it never goes away, completely. Last year, I spent a couple of days in the hospital.'*

In a brief telephone call prior to the first session, the philosophy of an outcome-informed approach to clinical practice had been described to Robyn and her partner, Gwen. As requested, the two arrived a few minutes early for the appointment, completing the necessary intake and consent forms, as well as the outcome measure in the reception area while waiting to meet the therapist. The intake forms requested basic information required by the state in which services were offered. The outcome measure used was the ORS (Miller & Duncan, 2000). In this practice, the entire process takes about five minutes to complete.

One attractive feature of an outcome-informed approach is an immediate decrease in the process-oriented paperwork and external management schemes that govern modern clinical practice. As is news to no therapist on the front lines of treatment in the USA, the number of forms, authorizations, and other oversight procedures has exploded in recent years, consuming an ever-increasing amount of time and resources. Where a single form once sufficed, clinicians now have to contend with pre-treatment authorization, intake interviews, treatment plans, and ongoing quality assurance reviews - procedures that add an estimated US$200 to $500 to the cost of each case (Johnson & Shaha, 1997). The addition of all this paperwork presumably is based on the premise that controlling treatment process will enhance outcomes.

On a positive note, two large behavioral healthcare organizations recently have eliminated virtually all paperwork, and automated the treatment authorization process based on the submission of outcome and process tools (Hubble & Miller, 2004). In finding what fits and works for a given client, therapists within these systems are limited only by practical and ethical considerations and their creativity. Given the superiority of both client ratings and allegiance factors (e.g. therapist belief) over adherence to a particular model, such process freedom can only work to enhance therapeutic effects.

Returning to the case, the therapist met Robyn and Gwen in the waiting area. Following some brief introductions, the three moved to the consulting room where the therapist began scoring the outcome measure.

Therapist: **You remember that I told you on the phone that we are dedicated to helping our clients achieve the outcome they desire from treatment?**
Robyn: Yes.
T: **And that the research indicates that if I'm going to be helpful to you, we should see signs of that sooner rather than later?**
R: Uh huh.
T: **Now, that doesn't mean that the minute you start feeling better, I'm going to say 'hasta la vista, baby'...**
R and Gwen: (laughing). Uh huh.
T: **It just means your feedback is essential. It will tell us if our work together is on track, or whether we need to change something about the treatment, or, in the event that I'm not helpful, when we need to consider referring you to some one or some place else in order to help you get what you want.**
R: (nodds).
T: **Does that make sense to you?**
R: Yes.

Once completed, scores from the *ORS* were entered into a simple computer program running on a PDA. The results were then discussed with the pair.

T: **Let me show you what these look like. Um, basically this just kind of gives us a snap shot of how things are overall.**
R: Uh huh.
T: **...this graph tells us how things are overall in your life. And, uh, if a score falls below this dotted line...**
R: Uh huh.
T: **Then it means that the scores are more like people who are in therapy and who are saying that there are some things they'd like to change or feel better about...**
R: Uh huh.
T: **...and if it goes above this dotted line that indicates more the person saying you know 'I'm doing pretty well right now.'**
R: Uh huh.
T: **And you can see that overall it seems like you're saying you're feeling like there are**

parts of your life you'd like to change, feel better about...

R: Yes, definitely.

T: *(***setting the graph aside and returning to the ORS form). Now, it looks like interpersonally, things are pretty good...**

R: Uh huh. I don't know how I would have made it…without Gwen. She's my rock…

T: **OK, great. Now, individually and socially, you can see...**

R and G: (leaning forward).

T: **...that, uh, here you score lower...**

Both Robyn and Gwen confirmed the presence of significant impairment in individual and social functioning by citing examples from their daily life together. At this point in the visit, Robyn indicated that she was feeling comfortable with the process. Gwen exited the room as the pair had planned beforehand and the session continued for another 40 minutes.

At the end of the hour approached, Robyn was asked to complete the *SRS*.

T: **This is the last piece...as I mentioned, your feedback about the work we're doing is very important to me...and this little scale...it works in the same way as the first one... (pointing at the individual items) with low marks to the left to high to the right...rating in these different areas...**

R: (leaning forward). Uh huh.

T: **It kind of takes the temperature of the visit, how we worked today...if it felt right... working on what you wanted to work on, feeling understood...**

R: All right, OK (taking the measure, completing it, and then handing it back to the therapist). (A brief moment of silence while the therapist scores the instrument)

T: **OK...you see, just like with the first one, I put my little metric ruler on these lines...and measure...and from your marks that you placed, the total score is 38...and that means that you felt like things were OK today...**

R: Uh huh.

T: **That we were on the right track...talking about what you wanted to talk about...**

R: Yes, definitely.

T: **Good.**

R: I felt very comfortable.

T: **Great...I'm glad to hear that...at the same time, I want you to know that you can tell me if things don't go well...**

R: OK.

T: **I can take it...**

R: Oh, I'd tell you…

T: **You would, eh?**

R: (laughing). Yeah…just ask Gwen…

In consultation with Robyn, an appointment was scheduled for the following week. In that session, and the handful of visits that followed, the therapist worked with Robyn alone and, on a couple of occasions, with her partner present, to develop and implement a plan for dealing with her anxiety. While her fear was palpable during these visits, Robyn nonetheless gave the therapy the highest ratings on the *SRS*. Unfortunately, however, her scores on the outcome measure evinced little evidence of improvement. By the 4th session, the computerized feedback system was warning that the therapy with Robyn was 'at risk' for a negative or null outcome.

The warning led the therapist and Robyn to review her responses to each item on the *SRS* at the end of the fourth visit. Such reviews are not only helpful in insuring that the treatment contains the elements necessary for a successful outcome, but also provide another opportunity for identifying and dealing with problems in the therapeutic relationship that were either missed or went unreported. In this case, however, nothing new emerged. Indeed, Robyn indicated that her high marks matched her experience of the visits.

T: **I'm just wanting to check in with you...**

R: Uh huh…

T: **...and make sure that we're on the right track...**

R: Yeah…uh huh…OK…

T: **And, you know, looking back over the times we've met...at your marks on the scale...about the work we're doing...the scores indicate that you are feeling, you know, comfortable with the approach we're taking...**

R: Absolutely…

T: **That it's a good fit for you...**

R: Yes…

T: **I just want to sort of check in with you... and ask, uh, if there's anything, do you feel... or have you felt between our visits...even on occasion...that something is missing...**

R: Hmm.

T: **That I'm not quite 'getting it.'**

R: Yeah…(shaking head from left to right). No…I've really felt like we're doing…that…this is good…this is right, the right thing for me.

In spite of the process being 'right,' both the therapist and Robyn were concerned about the lack of any measurable progress. Knowing that more of the same approach could only lead to more of the same results, the two agreed to organize a reflecting team for a brainstorm session. Briefly, this process is based on the pioneering clinical work of Anderson (1987, 1991, 1992a, 1992b) and is often useful for generating possibilities and alternatives. As Friedman and Fanger (1991) summarize:

'The views offered are not meant to be judgments, diagnostic formulations, or interpretations. No attempt is made to arrive at a team consensus or even to come to any agreement. Comments are shared within a positive framework and are presented as tentative offerings.' (p. 252)

As frequently happens, Robyn found one team member's ideas particularly intriguing. For the next three visits, Robyn and the therapist tried incorporating the team member's suggestions into their work to little effect. When these changes had not resulted in any measurable improvement by the eighth visit, the computerized feedback system indicated that a change of therapists was probably warranted. Indeed, given the norms for this particular setting, the system indicated that there was precious little chance that this relationship would result in success.

Clients vary in their response to a frank discussion regarding a lack of progress in treatment. Some terminate prior to identifying an alternative, others ask for or accept a referral to another therapist or treatment setting. If the client chooses, the therapist may continue in a supportive fashion until other arrangements are made. Rarely is there justification for continuing to work therapeutically with clients who have not achieved reliable change in a period typical for the majority of cases seen by a particular therapist or treatment agency. In essence, clinical outcome must hold therapeutic process 'on a leash.'

In the discussions with the therapist, Robyn shared her desire for a more intensive treatment approach. She

mentioned having read about an out-of-state residential treatment centre that specialized in her particular problem. When her insurance company refused to cover the cost of the treatment, Robyn and her partner put their only car up for sale to cover the expense. In an interesting twist, Robyn's parents, from whom she had been estranged for several years, agreed to cover the cost of the treatment when they learned she was selling her car.

Six weeks later, Robyn contacted the therapist. She reported having made significant progress during her stay and as well as reconciling with her family. Prior to concluding the call, she asked whether it would be possible to schedule one more visit. When asked why, she replied, '*I'd want to take that ORS one more time!*' Needless to say, the scores confirmed her verbal report. In effect, the therapist had managed to 'fail' successfully.

The Future of Clinical Practice: Implications of an Outcome-Informed Approach

'What is important…is not the right doctrine but the attainment of true experience. It is giving up believing in belief.'
Alan Keightley

Healthcare policy has undergone tremendous change over the last two decades. Among the differences, research and commentary has documented an increasing emphasis on outcome that is not specific to any particular professional discipline (e.g. mental health versus medicine) or type of payment system (e.g. managed care versus indemnity type insurance or out of pocket payment), but rather part of a worldwide trend (Andrews, 1995; Humphreys, 1996; Lambert et al., 1998; Sanderson, Riley, & Eshun, 1997). The shift toward outcome is so significant that Brown et al. (1999) argued, '*In the emerging environment, the outcome of the service rather than the service itself is the product that providers have to market and sell. Those unable to systematically evaluate the outcome of treatment will have nothing to sell to purchases of health care services*' (p. 393).

Currently, the most popular approach for addressing calls for accountable treatment practice has been to adopt or mold psychotherapy into the 'medical model.' The empirically validated (or supported), integrative, and evidence-based practice movements share in the belief that specific therapeutic ingredients, once isolated and delivered in reliable and consistent fashion, will work to improve outcome. Yet, research and clinical experience indicates otherwise. As summarized by Wampold (2001) in his thorough review of the outcome literature, '*the scientific evidence…shows that psychotherapy is incompatible with the medical model and that…conceptualizing [it] in this way…might well destroy talk therapy…*' (p. 2).

Fortunately, an alternative exists: shifting away from process and towards an outcome-informed approach to clinical practice. Evidence for this perspective dates back eighteen years, beginning with the pioneering work of Howard et al. (1986) and extending forward to Lambert et al., (1996, 1998), Johnson & Shaha (1996, 1997; Johnson, 1995), and our own studies (Miller et al., in press). The approach is simple, straightforward, unifies the field around the common goal of change, and, unlike the process-oriented efforts employed thus far, results in significant improvements in outcome.

At the same time, more research needs to be done. Most studies to date have focused on mental health services delivered to adults in outpatient settings or via the telephone. At least one study, for example, questions the applicability of an outcome-informed approach in children's services (Saltzman, Bickman, & Lambert, 1999). While two later studies found otherwise (Angold, Costello, Burns, Erkanli, & Farmer, 2000) Asay, Lambert, Gregersen, & Goates, 2002) projects aimed at determining the degree to which the approach applies across modes of service delivery (e.g. inpatient, residential, group), consumer groups (e.g. children, adolescents, elderly, mandated versus voluntary), and treatment issues (e.g. substance abuse, psychosis, etc.) are currently underway.

In spite of the shortcomings in the research, the evidence that does exist raises serious questions about professional specialization, training and certification, reimbursement for clinical services, research, and above all, the public welfare. While space does not permit a thorough examination of all, consider the implications of an outcome-informed approach for training and certification. Research from the last several decades documents a long and complicated relationship between professional training and outcome in psychotherapy. At best, the data indicate a small correlation (Berman and Norman, 1985; Clement, 1994; Garb, 1989, Hattie, Sharpley, and Roberts, 1984; Lambert & Ogles, 2004; Stein and Lambert, 1984). At worst, other research finds that increasing the amount and type of training and experience that most therapists receive may actually lessen therapeutic effectiveness (Christensen and Jacobsen, 1994).

Of course, standards are important - if for no other reason than to protect consumers of psychological services. Given current licensing and training standards, however, it is possible for therapists to obtain a license to practice and work their entire careers without ever helping a single person. Who would know? At present, market forces are the only control in place.

The process-oriented ethical codes of the mental health professional organizations are certainly of little help. With the exception of the American Counselling Association, the principles of the National Association of Social Workers, American Psychological Association, and the American Association of Marriage and Family Therapy neither require therapists practice effectively nor monitor the effectiveness of their work in any systematic or ongoing fashion. Instead, the codes only require that practitioners work, '*within the boundaries of their competence and experience*' (p. 1600, APA, 1997 [Principle A], emphasis added; NASW, 1997 [Principle 1.04]; AAMFT, 1991 [Principle 3.4]). In the real world, however, few care whether an ineffective treatment is delivered competently. And yet, competence has so regularly been conflated with effectiveness in professional discourse and training that it is no longer possible to tell them apart (Miller, 2002).

Adopting an outcome-informed approach would go along way toward correcting this problem, at the same time offering the first 'real-time' protection to consumers and payers. After all, training, certification, and standards of care would involve ongoing and systematic

evaluation of outcome - the primary concern of those seeking and paying for treatment. Instead of empirically supported therapies, consumers would have access to empirically validated therapists. Rather than evidence-based practice, therapists would tailor their work to the individual client via practice-based evidence. Liberated from the traditional focus on process, be it integrated or not, therapists would be better able to achieve what they always claimed to have been in the business of doing - assisting change. More important, clients would finally gain the voice in treatment that the literature has long suggested they deserve.

FOOTNOTES

1. Requests for reprints can be sent to: ISTC, P.O. Box 578264, Chicago, IL 60657-8264 or via email to: info@talkingcure.com.

2. Similar problems were observed in clinical settings where the authors provided training, consultation, and supervision. Therapists objected both to asking clients or using formal measures, either objecting to the time involved in completing the scales or citing an ability to track client experience via *'unconditional empathic reception'* (Bozarth, 2002). As one male therapist in a workshop remarked, *'When I make love to a woman, I don't have to ask her when we're finished if it was any good, I know.'* The audience, especially the women, exploded in laughter when we responded, *'we'd like to talk to the woman.'*

3. Both scales may be accessed and used for free at: www.talkingcure.com/measures.htm.

4. With regard to belief, it is important to note that allegiance effects account for almost four times as much of the variance in treatment outcome than model effects (4%/13% versus 1%/13%; Wampold, 2001). Such findings should give pause to efforts aimed at unifying therapeutic practice along either doctrinal or technical lines. Indeed, if the history of religion is any indication, such efforts are only likely to magnify differences and increase conflict.

5. In an email to the first author dated July 3, 2003, Lambert said: *'The question is - have therapists learned anything from having gotten feedback? Or, do the gains disappear when feedback disappears?* About the same question. We found that there is little improvement from year to year even though therapists have gotten feedback on half their cases for over three years. It appears to us that therapists do not learn how to detect failing cases. Remember that in our studies the feedback has no effect on cases who are progressing as expected--only the signal alarm cases profit from feedback.

6. This example is a composite of a number of cases. In order to insure anonymity, the details and presenting complaint have been changed and actual case dialogue blended from multiple clients.

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AUTHOR NOTES

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The revised edition of *The Heroic Client* by Barry Duncan, Scott Miller and Jacqueline Sparks will be available in March, 2004 from Jossey Bass.

Comments can be sent to the authors at www.talkingcure.com