

Losing Faith: Arguing for a New Way to Think About Therapy

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Do you ever wonder if you missed the one crucial day in your psychotherapy training that told you the secret to making it all work? SCOTT MILLER assures us that no amount of clinical experience, training or research material can provide any guarantee of a successful or effective therapeutic outcome. In this personal account, Miller describes his 'loss of faith in therapy' - in the belief that with experience, a knowledge of the literature and research and further training we can gain the confidence to help those struggling for a better, happier and more fulfilling life. Instead, reports Miller, his experience has shown there is no way to predict if an interaction with a particular person on a given day will result in a good outcome. To think otherwise, suggests Miller, is not a demonstration of faith, but of conceit. He argues for a change in the entire way we think about and conceive of therapy. Readers are advised to read the previous article, 'Beyond Integration', first.

'The distance between what we know and what we wish we knew is too great to bear, and we fill it with believing. To believing we add doing, and to both we add institutions that elaborate, justify, enforce, and perpetuate these ways of ours.'

Robert T. Fancher (1995), *Cultures of healing*.

The Taxi Ride

Last March I was in Washington D.C. for the annual *Networker* symposium. Having finished my final presentation, I hurried through the lobby of the Omni Shore Hotel. A huge line of people waiting for cabs quickly forms at the conclusion of the meeting. Because my connection back to Chicago was uncomfortably tight, I'd reserved a taxi the night before.

When I finally made my way to the curb, my taxi was nowhere to be found. Luckily, a group of attendees kindly offered to let me squeeze into the back seat of their already overly cramped cab. I jumped in and we sped off, weaving our way through downtown traffic to Washington Reagan Airport.

From the lively conversation, I surmised that the people in the cab worked together or at least knew one another. I wasn't paying close attention to what was being said - still thinking about whether or not I would catch my flight - but their sense of enthusiasm was so infectious that to not listen quickly became a chore.

The topic was the diagnosis of *Post*

Traumatic Stress Disorder (PTSD) that had enjoyed a renaissance of popular and professional interest in the wake of 9-11. A new theory about the condition had been presented in one of the breakout sessions at the symposium. Something about how humans deal with trauma differently to animals and how this accounted for why our species developed PTSD and animals did not.

'Yeah', one of the people went on to explain, *'The presenter showed these excerpts from National Geographic films. You know, animals in Africa, on the Serengeti and stuff...'* Eager to participate, another chimed in before the first could finish his thought, *'Most of those animals are under constant threat by larger predators. But, even though they are hunted and chased relentlessly they don't get post-traumatic stress disorder!'*

Something about that last statement piqued my attention. I was feeling skeptical already and wondered, *'Just how did they, or the workshop leader for that matter, know that animals did or did not have PTSD?'* Anyone familiar with the literature knows that the diagnosis of the disorder in humans is tricky, with

agreement between clinicians notoriously low. How could it be otherwise? There are 175 combinations of symptoms by which PTSD can be diagnosed. In fact, using the DSM criteria, it is possible for two people who have no symptoms in common to receive the same diagnosis!

'No, they don't', the first continued butting his way back into the conversation, *'Because they shake it off.'*

'Shake it off?' one of the others asked without a hint of skepticism in her voice.

'Yeah, they don't repress their natural physiological response to traumatizing events the way we humans have been conditioned to.'

I could feel myself becoming agitated. 'Here we go again', I mused, *'that old Freudian bogeyman, repression, dug up and represented in different words.'* It was easy to see that I was the odd man out.

My mind raced back to lazy Sunday afternoons spent with my family watching Mutual of Omaha's *Wild Kingdom*. I wondered, *'Had none of these people ever watched that program?'* Most of the animals on that and every other nature show I'd ever seen were so jittery from life on the plains it made me want

to take medication. Heads up and heads down, constantly checking, first here and then there, always on the lookout for the thing that might eat them. If anyone on the planet suffered from PTSD, it was those animals.

I turned back to the window, distracted by my inability to recall the name of the host of *Wild Kingdom*.

'So, what did he say you should do?' one of the group asked, and the second speaker began describing the treatment. To me, it sounded like a variation of the old abreaction technique. You know, helping people 'discharge strangulated affects' by having them revisit unresolved traumas. The only difference was the shaking that followed the recollection or reliving of a traumatic event.

At this point, I started shaking - my head that is, from left to right, and back again. 'No, no, no, no, NO', I was thinking to myself with each turn. And if my response was any indication, it was clear that the 'shaking' theory was bogus. I certainly didn't feel any better. In fact, I was feeling more agitated.

'Are you all daft?' I wanted to scream. 'Use your heads, THINK CRITICALLY for Heaven's sake!' Instead, looking out the window of the cab, I started imagining these well-intentioned practitioners trying out this 'new technique'. 'Let me see if I understand your new approach,' the sarcasm now dripping from my thoughts, 'you are working on a disorder that no one can diagnose with any reliability, using a method for which there is no evidence of effectiveness, based on an animal analog that in all likelihood does not happen in nature, and organized around an old Freudian idea that was discredited years ago.' I was on a roll now, the invective flowing out of me. 'Hmm. Sounds great. Sounds like the history of 'psycho' therapy... a never ending list of ephemeral fads applied to unspecified problems with unpredictable outcomes for which rigorous training is required. Great. Give it a go.'

The intensity of my reaction took me by surprise. 'What was the matter with me?' I wondered. It's not as if I'd never heard such things before. Our field was full of this stuff: lay on this couch, talk to an empty chair, sit on this person's lap, watch my finger wave back and forth, or one of my own contributions to the kooky cacophony, 'Pretend a miracle happens...'

Where I was cynical, however, my fellow travelers were inspired. In response to any objection I might raise, I could hear them say, 'Well, maybe you just don't work with enough of these people to see the value of the treatment.' Then they would continue with the typical citation of the evidence used by clinicians to mute all such criticism: the much vaunted 'personal experience'. 'Have you tried it? I did, and it works.' At least that had been my experience whenever I made my doubts public.

I wasn't burned out, depressed, or in the grips of a mid-life crisis. It was something much worse.

I'd lost my faith. I no longer believed in therapy...

We pulled up to the curb at the airport. After paying my fare, I muttered a quick 'Thank you', and bolted for the terminal. Sure, my connection was tight but I also wanted to escape. Believe me, it was nothing personal. Of late, I'd been avoiding conversations about therapy whenever I could.

The Epiphany

Seated aboard the plane I wondered, 'Was I depressed? In the midst of a mid-life crisis perhaps?' Then, watching the flight attendants run through the same safety demonstration I'd seen many times before, I thought 'Hell, maybe I'm just burned out.' After wracking my brain

unsuccessfully for an answer, I pulled the airline magazine out of the seatback in front of me and began flipping through the pages. It was a mindless way to pass the time.

Before I knew it the pilot was announcing our 'final approach' into O'Hare. And that's when it hit me. I could feel my chest tighten at the thought. I wasn't burned out, depressed, or in the grips of a mid-life crisis. It was something much worse. I'd lost my faith. I no longer believed in therapy ...

The weeks and months following my epiphany were particularly bleak. If I hadn't been depressed before, I was certainly on the verge now. I'd been in love with the field. Now, the passion and commitment that had sustained me for nearly two decades of work as a therapist was gone. I had no energy, no zest. I felt completely adrift, purposeless.

Looking Back, Moving Forward

On reflection, I realized my struggle was nothing new, the conclusion I'd come to aboard the plane, foregone. From my earliest days in the field, I'd marveled at, envied even, the confidence that most therapists seemed to bring to

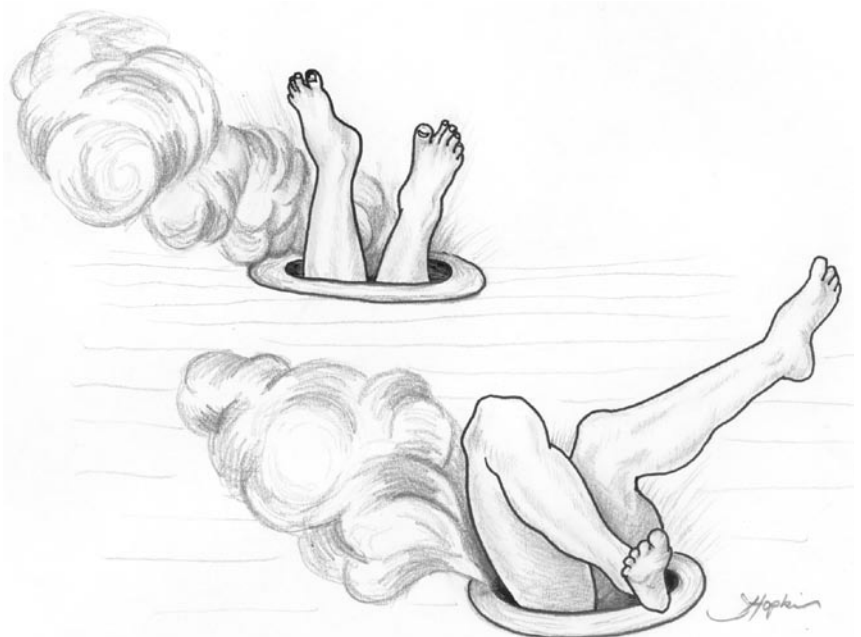


Illustration by Savina Hopkins

their work. I had always been plagued by doubt, feeling, as I met with clients, that I'd missed the one crucial day in graduate school where they told you the secret to making it all work.

'Just stick with it', my clinical supervisor, Bern Vetter, would say whenever I voiced my uncertainty, 'everybody feels that way in the beginning.' At that point in my career the little experience I had made it abundantly clear that the practice of psychotherapy was a highly nuanced and complicated affair, requiring years of dedication and study to master. In short, it was not a profession for the impatient. The learning curve was long and steep. Given time, experience and, of course, further training, I had faith that the mountain could be scaled. Once on top, I'd be able

time, it'll come.' I appreciated Bern's patience and openness as my experience with other therapists wasn't always as sympathetic.

I continued to explore, reading books and combing through the research literature. I also went to see everybody who was anybody on the lecture circuit: Barber, Ellis, Haley, Satir, Minuchin, Michenbaum, Yalom, and Zeig - the entire therapeutic alphabet. As hard as I tried, however, my own work never seemed to equal that of these clinicians. Sometimes what I learned worked and other times it did not. On a few occasions, the new stuff I tried ended in unmitigated disaster.

Why wasn't I getting 'it' the way others - my co-workers, supervisors, book authors and workshop presenters

process at BFTC was fluid and dynamic, the atmosphere positively electric. We spent hours watching each other's work, staying late most evenings, and even showing up on the weekends to record, review and discuss sessions.

As time passed, the confidence I had long sought gradually began to build. I thought about my old supervisor, Bern. Now I recognized, or thought at least, he'd been right all along. With experience, it'd become easier to see patterns in the process, markers that helped me to understand what was going on, told me what would be best to say and do. Together with Insoo Berg, the co-director of BFTC, I even wrote about what I had learned in my first book, *Working with the Problem Drinker: A Solution-Focused Approach*. In what would become a pattern for me, I used the writing process to 'work through' and clarify my feelings about and understanding of the work.

I can still remember one of the first cases I watched at the Center. Brother Joel, a capuchin living and working with the downtrodden in Milwaukee, brought a thirty-something homeless man in for a session. The guy was so high that several team members and I actually had to come out from behind the one-way mirror and walk him around the room in order to keep him awake. All the while, Insoo continued to work, skillfully and patiently weaving a therapeutic conversation into the client's brief moments of lucidity.

Two years later, the man returned for a follow up interview. Honestly, we didn't even recognize him. Gone were the dirty and disheveled clothes, the smell and grime of the streets. In their place was a clean-shaven, even dapper looking, businessman. We learned that he was in a committed relationship and planning to marry in the near future. He was now the owner of a small business, had a home, his own car, and money in the bank. I can remember thinking that our former client was, in many respects, better off than me. And, all in a handful of sessions!

With experiences like these a regular occurrence, you can imagine my surprise when, in 1992, two independent studies failed to provide much empirical support for the work we'd been doing. Mind you, the reports did not say we were ineffective, merely that we were no

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to reach out with confidence and offer a helping hand to those struggling on their way up to a better, happier and more fulfilling life.

Looking back, I don't believe my work as a beginning therapist was necessarily bad. I made a concerted effort to do all the appropriate therapist-like things I'd been taught - maintaining an 'open' posture, reflecting feelings, avoiding advice giving, and so on. I arranged my office to resemble those of experienced therapists I knew and admired, adding warmth and ambience to the room.

For their part, my clients didn't complain. Still, I wondered, 'Could they tell that I didn't really know what I was doing? Did other therapists feel this way? If so, then why the hell didn't they talk about it? Was their seeming self-assurance merely a confidence game? If not, then what was the matter with me? Why didn't I get 'it' the way others seemed to?'

Bern would always counter, 'This is a time to experiment', in a reassuring voice. 'Try some things on for size, see what fits, what the client likes and doesn't like. In

- appeared to? Having always had a strong work ethic, I resolved to continue, reasoning that persistence would, as it often had in my life, eventually win the day. I still had faith.

I thought I'd died and gone to heaven when, shortly out of graduate school, I landed a job at the *Brief Family Therapy Center (BFTC)* in Milwaukee, Wisconsin. I'd been dreaming about working at the small, inner-city clinic ever since I read Steve de Shazer's *Key's to Solution in Brief Therapy* in one of the supervision groups I'd attended. In the first chapter of that book, de Shazer described being 'plagued' by the same question I struggled with, 'how do you know what to do?' Seeking to answer that question was his stated *raison d'être*, the focus of his career and work at the center. I couldn't imagine a better workplace.

Forget what you know or have come to believe about solution-focused therapy. The mechanical version that exists today bears precious little resemblance to the work being done at the time I joined the staff. On the contrary, the

more effective than any other group or treatment approach. Adding insult to injury, the same studies showed that we were not any more efficient either. In other words, we accomplished what we had in the same amount of time it took everyone else - a major blow, you can imagine, for a group known around the world as the *Brief Family Therapy Center*.

The bad news continued. In depth interviews with our successful clients revealed that the therapeutic map we'd spent so much time developing - including interviewing strategies, techniques, and end of session homework assignments and interventions - mattered little in terms of outcome. Indeed, although not reported in the published study, the only time our clients appeared to remember the technical aspects of our work was when they were experienced as intrusive and ineffective!

Needless to say, the sense of assurance that had been building since I'd joined the team at the Center was badly shaken. For months, I struggled to make sense of the results. The challenge, or so it felt to me at the time, was not to throw the proverbial baby out with the bath water.

I vowed not to let the results obscure the bigger picture. What therapists did worked. I'd seen it myself on numerous occasions. My faith in the process of therapy was not misplaced. The problem was that the particular way we worked appeared to have little or nothing to do with our effectiveness.

In this regard, the two studies at *BFTC* had left me far from clueless about the ingredients of successful therapy. High on the list of strong predictors of a good outcome were the quality of the therapeutic relationship, the strengths and resources of the client, and the person of the therapist. The latter finding was particularly interesting. Despite the fact that all of the therapists at the center were practicing the same approach, outcomes varied considerably and consistently from one therapist to another. Most surprising of all, the two most effective therapists at the clinic were graduate students!

Revisiting Old Ground

Spending time in the stacks and periodical section at the University of Wisconsin, Milwaukee, I soon rediscovered a whole body of research confirming what we'd found at *BFTC*.

I say rediscovered because I had been exposed to the findings as a graduate student: the particular model a clinician used simply didn't matter. Dating back over fifty years, with few exceptions, partisan studies originally designed to prove the unique and specific effects of a given method found no difference in outcome between approaches.

Writing on this very subject back in 1936, Saul Rosenzweig, a psychologist in the same graduating class at Harvard as B.F. Skinner, suggested that the similarities rather than the differences between competing treatment models accounted for their effectiveness. Being a Lewis Carroll scholar, he labeled his findings, '*The dodo bird verdict*', borrowing a line from *Alice's Adventures in Wonderland* that reads, '*All have won and therefore all deserve prizes.*'

Picking up where Rosenzweig left off, Jerome Frank argued in 1963 in his highly influential book, *Persuasion and Healing: A Comparative Study of Psychotherapy*, that Western therapies worked in precisely the same way and for the same reasons as healing rites across a variety of cultures. Whether practicing as a licensed therapist in Milwaukee or a shaman in the jungles of Papua, New Guinea, healers inspired hope, giving people plausible explanations for their pain and rituals to ease their suffering.

By the 1980's, the quest to identify a group of common factors underlying effective psychotherapy had come full circle. Based on forty years of data, researcher Michael J. Lambert identified and even estimated the contribution of four pantheoretical contributors to success. As we'd found in the studies at *BFTC*, the therapeutic relationship and client emerged as large contributors to success - accounting for a stunning 70% of the variance in treatment outcome. Coming in last place - tied for insignificance with placebo factors - was the particular model or technique a therapist happened to use, contributing a paltry 15%.

Early in my training, I'd been exposed to and dismissed the research on the common factors view for a number of reasons. First, it wasn't sexy. After all, how stimulating is the idea that all models work equally well and for essentially the same reasons? What about transference? The Oedipal complex? Denial? What about defense

mechanisms, insight, family structure, systems theory, double binds, indirect suggestions, paradox, self-disclosure, the DSM, confrontation, empathy, congruence, getting in touch with your feelings, talking to an empty chair, dysfunctional thoughts, self sabotage, and the biochemical imbalance? What about all those important things they taught me in school?

Being cast as our culture's equivalent to a shaman was another reason for dismissing the common factors perspective. Sure, I knew there were those in the field who readily identified their work with native forms of healing, but I didn't see these people accepting chickens in lieu of cash for their services. No sir, they were right there alongside all the other therapists, trading on their professional credentials, and filling in their forms in order to receive insurance reimbursement. Anyway, I was a scientist. I'd been to college and I was going to graduate school. When I finished, my diploma would read 'Doctor', not witch doctor.

With each of my professors committed to one model or another - eclecticism was especially disdained - I'd quickly forgotten about the research supporting the common factors. Yet, there I was, some nine years after starting graduate school and three years post Ph.D., feeling a little like a kid who has just learned that his parents bought and placed all those presents under the Christmas tree. Sure, the end results were the same but Santa was dead, better said a fiction. In short, there simply was no magic in the method, no missing ingredient, no right way to do therapy.

The Comfort of Companions

As luck would have it, three months before my tenure at *BFTC* came to an end, I met Mark Hubble and Barry Duncan. We all happened to be in Washington D.C. attending and presenting at the annual *Family Therapy Networker* conference. Listening to them speak was like finding my two long lost brothers. Several times during their presentation, I was tempted to jump up and scream, 'GROUP HUG!' and lead the audience in several rounds of 'Kumbya'. Thankfully, I resisted the urge. Instead, I asked them to join me for a beer at Murphy's Bar across the street from the conference venue.

We talked about the problems and challenges facing the field including, the rapid proliferation of new methods and techniques, claims about the effectiveness of particular approaches, and the ever-widening number of behaviors and concerns cast as problems requiring treatment. We also talked about the field's flagging fortunes. By this time, many therapists were feeling the pinch, struggling to make ends meet. The golden age of reimbursement had vaporized in the mushroom cloud of managed care. As a result, psychotherapists were fast becoming what Nicholas Cummings had predicted nearly a decade earlier, that is 'poorly paid and little respected employees of giant healthcare corporations.'

The public's appetite for mental health services also appeared to be changing. For example, the self-help section at local bookstores - once jammed with latte-sipping, self-help junkies - suddenly dwindled, within a short period going from several aisles to one frequently disorganized and poorly stocked shelf. Meanwhile, average Americans were trading away their mental health benefits at alarming rates during contract negotiations with employers. Apparently, change in the pocket is worth two therapists in the bush.

In relatively short measure, the discussion shifted. We were not cynics. We were pragmatists who believed in therapy. So, in relatively short measure, we were talking about solutions. All agreed that the field did not need another model of therapy. Depending on how one counted, anywhere from 250 to 1000 approaches already existed. What clinicians from differing therapeutic orientations might benefit from, we reasoned, was a way of speaking with each other about the critical ingredients - about what works - in helping relationships. Our different cultures and languages had left us Balkanized as a field, unable to share, fearful of crossing theoretical boundaries, even distrustful of one another.

Notes scribbled on a cocktail napkin turned into a flurry of articles and three books, including *Escape from Babel*, *Psychotherapy with 'Impossible' Cases*, and *The Heart and Soul of Change*. To be sure, all were works in progress, as much statements about our development as clinicians, as they were summaries of the

research about 'what works in treatment.'

Using the common factors as a bridge between treatment approaches, we spelled out a basic vocabulary for 'a unifying language for psychotherapy practice.' In essence, we were advocating for a kind of informed eclecticism. Rather than being dedicated to a single model or approach, we argued that therapists could avail themselves of any technique, strategy, or theory as long as it empowered one or more of common factors and, importantly, made sense to the client. With regard to the latter, the research was clear: therapy was much more likely to be successful when it was congruent with the client's goals for treatment, ideas about how change occurs, and view of and hopes for the therapeutic relationship.

Our message apparently struck a chord with clinicians. The books sold very well. In fact, the *Heart and Soul of Change* became one of the publishers best selling volumes ever - going on to win the Menninger prize for scientific writing. Feedback at workshops was also positive - glowing even. Heady stuff. On reflection, however, I decided that the response was not all that surprising. After all, figuring out how to use the knowledge and skills one had to meet the needs of individual clients was what practicing therapists did. If nothing else, it was good business practice.

In my own work, I was making a concerted effort to follow the advice we were giving to others: literally, to put the client in the driver's seat of treatment. More than ever before, I worked hard at setting aside my own ideas and objectives, purposefully attempting to organize the treatment around the client's goals and beliefs. I spent more time listening and less time talking or asking 'purposeful' questions. I also made sure that the suggestions I gave, and any interventions I used, were derived from the interaction.

The Illusion of Progress

As much clinical, empirical, and even common sense as our ideas made, ultimately, they did not make that much difference. Outcomes did not improve. Why? To begin, we'd forgotten, or at least set aside, some troublesome facts. From the outset, we'd been aware of the paradox inherent in any attempt to use the common factors to make specific

decisions about day-to-day practice.

In truth, there is and can never be an approach to therapy based on the common factors because the factors are, by definition, common to all approaches!

Of course, we'd hoped that presenting the factors as principles rather than mandates would circumvent the problem, providing therapists with a flexible framework for tailoring treatment to the needs of the individual client without creating yet another model of treatment. After all, the research showed that clinicians believe that their skill in selecting therapeutic techniques and applying them to the individual client is responsible for outcome. Unfortunately, the data indicate otherwise. Confidence in our ability to choose the right approach for a given client is simply misguided. Indeed, when combined with other studies showing little or no effect for training or experience on treatment outcome, the hope we'd felt at the outset of our work began to feel painfully naïve.

Around this time, I stumbled across an article I'd read a few years earlier while preparing to write *Escape from Babel*. A psychologist named Paul Clement had collected and published a quantitative analysis of outcomes from his 26 years of work in private practice. The results had alternately intrigued and frightened me. The good news was that 75% of his clients rated improved at the end of treatment, and quickly. The median number of sessions over the course of his long practice was 12. The bad news, however, was particularly bad in my opinion. In spite of believing - in fact 'knowing' that he'd 'gotten better and better over the years' the cold, hard fact of the matter was that he was no more effective at the end of his career than he'd been at the beginning.

At this point, I recognize some readers might be thinking, 'Hey, Scott, don't miss the big picture here! What Clement did with his clients not only worked, but also worked in a relatively short period. So what if this clinician did not improve over time?' Who can argue with success? However, if we are to move forward to better, more effective practices, we need to understand why therapy works. The devil or for that matter, the saint, is in the details. The tradition of the field to pile model upon model and technique upon technique, year after year, has not

answered the question. It deceives all of us into believing, as did Clement, that we are getting better when in fact we are not. An illusion of progress, in the end, is hardly progress.

And then the cab ride. The lightning rod. The flashpoint. The final straw that broke this therapist's back. Alas, it seemed that we therapists would believe almost anything. The 'shaking treatment' notwithstanding, the entire history of our field was proof.

Fashions of the Field

So, in the 60's, the royal road to mental health was 'getting in touch with your feelings'. Carl Rogers was the man of the moment, the Carkuff and Truax Scales, the standard of good care. Approaches that promised to liberate people's emotions from what experts claimed was 'culturally imposed bondage' to the intellect - T-Groups, Nude Marathon Group Therapy, Gestalt, Primal Scream and the like - emerged and flourished.

Just as studies were beginning to show a high casualty rate among clients in some of these popular experiential

treatments, the field's interest in 'letting it all hang out' was reigned in and zipped up. From feelings, the field switched to behaviors and thoughts, then to dysfunctional families. Skinner, Beck, Minuchin, Palazolli, and Beatty among others, became icons; systematic desensitization, confrontation of dysfunctional thoughts, and self-help groups the best practice. The process only continues, morphing most recently from the 'decade of the brain', into a 'greatest hits of the field' version known as the 'biopsychosocial' approach. The so-called 'energy therapies' are all the rage; drugs plus evidence-based psychotherapies now considered the 'brew that is true'.

With the speed of therapeutic 'developments' rivaling changing skirt lengths and lapel widths on a French fashion runway, who could trust anything the field said? We were like the weather. If you didn't like the way things were, all you needed to do was wait five minutes. Chances are we'd be saying something different. Remember the multiple personality disorder craze? Where have they all gone anyway?

I'd completed one of my first clinical placements at a hospital that had an entire wing of an inpatient unit dedicated to treating people with 'Dissociative Disorders'. The 'multiples' were coming out of the woodwork. It seemed like an epidemic with the average daily census at the unit exceeding the total number of cases reported in the literature over the last 100 years!

I could go on and on. In fact, all the way back to Benjamin Rush's time more than 300 years ago. With the same aplomb that we modern helpers tout the benefits of passing fingers back and forth in front of peoples eyes at regular intervals - don't forget the 'cognitive weave' now or it won't work - the experts of the day were reporting 'significant improvement' and 'a return to normal life' in the majority of sufferers tied to a wooden plank and spun into unconsciousness, or blindfolded and dropped unexpectedly through a trap door into a tank of freezing water. Of course, we'd like to think that we're different, that we've come along way since then, are more advanced now. And yet, that has been the claim of every generation to come along. Simply put, it is an illusion. The same research that proves therapy works shows no improvement in outcomes over the last 30 or so years. In short, we keep inventing the wheel; each era framing the causes and cure within the popular language and science of the day.

More Placebo Than Panacea?

In the weeks and months following that fateful cab ride, I seriously considered leaving the field. But what, I wondered, would I do for a living? I was in a dilemma. Faith is an important component of effective clinical work. Researchers refer to it's role in treatment as 'allegiance effects', noting that therapists' belief in the efficacy of their particular approach has an 'enormous impact on outcome' - three to four times that of adherence to a particular model or approach! Alas, therapy was more placebo than panacea, its power vested almost completely in the participants rather than the methods. My problem, of course, was I no longer believed.

Initially, I was hesitant about sharing my experience with other clinicians. I'm glad I eventually did as I quickly learned I was not alone. A few were even



more discouraged than I was. Others still believed in therapy, but had grown weary of the hype attached to it. To these experienced therapists, the field lacked a memory. The old and forgotten frequently passed as new and the new just wasn't that different. For many, what had started out as much a calling as a vocation had in time become drudgery, just another job.

The Therapist's View

Although such findings may seem contradictory given the general efficacy of psychotherapy, they are not all that surprising. As a field, we have been preoccupied with ourselves, with what we're doing or supposed to do. As such, professional discourse has been and continues to be dominated by questions about the best, the right and the most effective way to do therapy, about the latest and greatest theory or technique, or about what will give us an edge in the mental health marketplace? Put bluntly, almost everything written by and for clinicians gives the mistaken impression that we are in the therapy rather than client satisfaction and change business.

Sadly, for all the competition, genuflecting, and moaning about what therapy is, precious little attention has been paid to the client's experience. No one in the cab that day, for example, asked, or even considered, what a client might feel about shaking like a wild animal. Would it be humiliating? Degrading? Helpful? Or, just plain nonsensical? Neither was there any discussion of what the client wanted, what they might like. No, it was all about us. Now, we knew what to do, what they needed. Even all the recent talk about client strengths and collaborating with clients smacks of 'us'. Again, we are in charge, this time liberating client strengths and deciding that collaboration is a good idea. In fact, that's what my journey as a therapist had been about from the outset: me, me, me.

Frankly, shifting my attention, changing the focus of my search away from me and toward the client, is what kept me from abandoning the field.

Is Client Feedback the Key?

Over the last few years, my colleagues, Barry Duncan and Mark Hubble, and I have been working on formal ways for bringing the client's experience into the

process of therapy. It's not a new idea, I'll admit. For decades, successful businesses have been seeking and utilizing feedback from their consumers to develop, design, and improve existing products. They know that being out of touch with consumers - even for a moment - risks losing out to the competition. And yet, aside from repeated admonitions to 'listen' and the occasional pre and post satisfaction questionnaire, day-to-day clinical practice lacks any formal, ongoing, or systematic use of client feedback.

I'm arguing for nothing less than a change in the entire way we think about and conceive of therapy.

Our own work is based on two consistent findings from the research literature:

1. clients' ratings of the therapeutic relationship have a higher correlation with engagement in and outcome from psychotherapy, than the ratings of therapists;

2. a client's subjective experience of change early in the treatment process is one of the best predictors of outcome between any pairing of client and therapist, or client and treatment program.

Given these results, we simply ask clients to complete two very brief, but formal scales at some point during each session - one, a measure of the client's experience of change or progress between visits, the other an assessment of the relationship. The entire process takes about 2-3 minutes per visit.

At this point, we've collected client feedback on some 12,000 cases - significantly more when our data is combined with that of other researchers following a similar line of inquiry using different measures. Consistent with the results from previous studies, we've found that the particular approach a clinician employs makes no difference in terms of outcome, including medication. On the other hand, providing real time feedback to clinicians has had a dramatic effect. Over a six-month period, success rates skyrocketed, improving by 60%. More important, these results were obtained without training therapists in any new therapeutic modalities, treatment techniques, or diagnostic

procedures. In fact, the individual clinicians were completely free to engage their individual clients in the manner they saw fit, limited only by their own creativity and ethics.

Two large healthcare companies have moved in this direction and have eliminated the 'paper curtain' that has been drawn over modern clinical practice. All I can say is, 'It's about time', as none of these time-consuming activities have any impact on either the quality or the outcome of treatment.

Other intriguing results emerged.

Recall the study cited earlier about the superior outcomes of the two novice therapists at the *Brief Family Therapy Center*? Combing through our own data looking for factors accounting for success, we noticed dramatic differences in outcome between therapists. Most, by definition, were average. A smaller number consistently achieved better results and a handful accounted for a significant percentage of most of the negative outcomes.

Similar differences were observed between treatment settings. Clinics that were in every way comparable - same type and severity of cases, clientele with similar economic, cultural, and treatment backgrounds, staff with equivalent training and the like - differed significantly in terms of outcome. When it comes to psychological services, it appears that unlike medicine, 'who' and 'where' are much more important determinants of success than what treatment is being provided.

If you are wondering what accounts for the variation in outcome between therapists and treatment settings, you're not alone. We did too. Yet, after parsing the data in every conceivable way, we came up largely empty handed. We did notice that therapists who were the slowest to adopt and use the scales had the worst outcomes of the lot. If the feedback tools are viewed as a 'hearing aid' this may mean that such clinicians didn't listen, in fact were not interested in listening to the client. One therapist claimed that his 'unconditional empathic reception' made the forms redundant.

Truth is, however, we really do not know what accounts for the difference. And frankly, our clients, the consumers of therapeutic services, don't care - not a wit. They just want to feel better. For them, outcome is all that matters. It's what they are paying for.

Intriguingly, our experience, and that of other researchers such as Michael Lambert and Jeb Brown, indicates that client feedback may be the key.

Does the client think that the therapeutic relationship is a good fit? Do they feel heard, understood, and respected? Does the treatment being offered make sense to them? Does the type, level, or amount of intervention feel right? Do any modifications made by the therapist in response to feedback make a difference in the client's experience of the treatment? If so, is the client improving? If not, then who or where would be a better choice?

Let me say that I am not selling our scales. You can download the measures for free from our website, however, I'd be cautious about doing even that as finding the 'right' set of scales for a given context and population of clients requires time and experimentation.

The Future

No, it is not about the measures or statistics. I'm arguing for nothing less than a change in the entire way we think about and conceive of therapy. Throughout our history, we have attempted to fit the practice of psychotherapy into the medical model, assuming all along that specific treatments, containing unique therapeutic ingredients, and administered by qualified and competent professionals, would result in better outcomes. It has been an abysmal failure. Don't get me wrong. I wish therapy worked that way. It just doesn't. Rather, one-by-one, clients and therapists pair up to see whether this relationship at this time and this place will, in the eyes of the client, make that all important difference. Sometimes it'll sizzle, other times it'll fizzle. Sometimes we'll both want and be able to make the adjustments necessary to connect, other times we won't. In some instances, a perfect match on paper will simply lack the chemistry needed to sustain it in reality. That is the nature of relationships. In the end, no amount of training or experience will enable us to

'marry everyone we date'.

It's true. I've lost my faith in therapy. Better said, my faith was misplaced from the outset. In part, because of my training, in part because of the broader 'assembly line' culture in which we all live, I'd thought that day would come when, equipped with the tools of the trade, I'd finally be able to execute my job safely and effectively. We were like any other profession. Where physicians had a scalpel and prescription pad, we had insight and interventions; where a carpenter used a hammer and nails, I would use interviewing strategies, homework assignments, and the alliance to build my clients more satisfying lives. When that didn't work, having never found solace in attributing treatment failures to client resistance or pathology, I would wonder as any good journeyman, what critical skill I lacked.

At length, I've come to accept that I cannot know ahead of time whether my interaction with a particular person on a given day in my office will result in a good outcome. Neither is all my know-how, years of training and experience any guarantee. Our grand theories, clever techniques, even our best efforts to relate to and connect with others are empty - full of potential, yes, but devoid of any power or significance save that given to them by the person or people sitting opposite us in the consulting room. Thinking otherwise is not a demonstration of our faith, but actually conceit. The promises and potential notwithstanding, we simply have to start meeting and then ask, can they relate to us, to what we're doing together at the moment? I know they will tell us. I now also have faith that, no matter the answer, the facts will always be friendly.

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