Barry L. Duncan
Scott D. Miller
Jacqueline A. Sparks

The Heroic Client

A Revolutionary Way to Improve Effectiveness Through Client-Directed, Outcome-Informed Therapy

Revised Edition

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Foreword to the Revised Edition

Every society, historical or contemporary, has a culturally embedded set of healing practices. These practices are so ingrained into people's thinking that they go unquestioned. Receiving acupuncture as part of Chinese care would not be astonishing to a Chinese person living in the culture. To an ancient Greek, the acupuncture ritual would be all wrong: the idea of *chi* would be foreign, but temple rituals based on mythical gods would be comfortable and accepted. Simply, we do not question the predominant healing models of our culture.

The predominant healing practice in our culture is modern medicine. We may question a particular diagnosis or procedure, but most Westerners unquestioningly accept the basic premise that disease is caused by some physiochemical abnormality that can be corrected through the administration of medicine or physical procedure. In the most simple example, bacteria causes pneumonia; antibiotics kill the bacteria; and the pneumonia is cured. Sufficient evidence exists that bacteria are real (we can see them with a microscope) and that antibiotics are effective. Modern medicine has a distinct distaste for healing practices that have "strange" explanations (that is, involve processes not verifiable by scientific means) such as those involving animal magnetism (the basis of Mesmer's treatments), *chi,* spirits, and so forth, whether or not the healing practices are effective.

Barry Duncan, Scott Miller, and Jacqueline Sparks have cogently examined the research on psychotherapy and concluded that the medical model does not apply to this healing practice (see Chapter Two). This conclusion is

controversial, not because it is not supported by the research but because it challenges the predominant cultural understanding. There is convincing evidence that psychotherapy does not act specifically on disorders in the way in which medicine is purported to work. It is not the cognitive interventions in cognitive therapy that make it effective; more likely, the benefits are due to the explanation given to the clients; the rituals consistent with that explanation, which remoralize the client; the relationship between the therapist and the client; the skill of the therapist; the healing context; the client's expectation and hope; and so forth. Indeed, as Duncan, Miller, and Sparks explain, all psychotherapies competently administered are equally effective. People benefit from psychotherapy in ways that are not easily explained by a medical model. It is not surprising, therefore, that pharmacological treatments are not particularly effective and may work primarily through means other than the specific effects on the brain. Chapter Six (coauthored with Grace Jackson, Roger P. Greenberg, and Karen Kinchin) is a stunning indictment of drug treatments for most conditions that we label as mental disorders.

It is important to note, as Duncan, Miller, and Sparks have, that the medical model permeates the treatment of clients. Television is saturated with advertisements for medicines for physical ailments (e.g., allergies, constipation, diarrhea, heartburn, chemotherapy-induced nausea) as well as mental disorders (e.g., depression and anxiety). Psychotropic medications are among the most widely sold drugs in the United States. However, the helping professions have shared in applying the medical model to assisting clients, partly from the pressures of managed care, partly from competition from biological psychiatry, and partly from our reverence of science and the medical model. We diagnose clients; we formulate treatment plans; we

administer diagnostics (e.g., personality tests); we maintain medical charts; and we think of ourselves as the agents of change. Our leaders in academia are busy developing empirically supported treatments so as to establish our treatment authority. Duncan, Miller, and Sparks have cogently and refreshingly presented an alternative: client-directed and outcome-informed therapy.

The Heroic Client is not simply an humanistic tilting at the medical-model windmill. Duncan, Miller, and Sparks's contribution may be thought of as proposing a scientific alternative to the medical model. One of the distinguishing features of modern medicine is that it has resulted in treatments that are demonstrably effective. Over the history of the world, the effectiveness of thousands of healing practices adopted by various cultures has not been established. Although it is not clear whether or not such practices have been beneficial, there is no doubt that some have been harmful (see Duncan, Miller, and Sparks's description of the iatrogenic effects of George Washington's physicians' treatments of his respiratory disorder in Chapter One). Psychotherapy has been scientifically established as a remarkably effective practice, more effective than many accepted medical treatments. Duncan, Miller, and Sparks take a further and vital step down the empirical road by demonstrating the usefulness of monitoring client progress. Monitoring client outcomes is such an obviously important activity that knowing it has not been standard practice since the inception of talk cures boggles the mind. We have for decades attempted, albeit unsuccessfully, to identify the characteristics of successful therapists—Duncan, Miller, and Sparks propose the eminently reasonable solution that we evaluate the effectiveness of therapy based on the outcome and not on the adherence of the therapist to a treatment protocol, an expectation of a supervisor, or other implicit aspects of the therapy.

The final recommendation of *The Heroic Client* is to listen to the client to guide the therapy. The notion of client-directed therapy hits indeed at a central tenet of the medical model, which always proposes an external explanation for a disorder, located in scientific understanding. Client-directed therapy requires that we therapists give up our notion of "expertness," a proposition that is difficult to assimilate after the years of training we have endured in order to achieve our status. I suspect that many clients present to us because of the perceived expertness as well. However, Duncan, Miller, and Sparks make a convincing case that the humility required to become a client-directed therapist is worth the effort because of the benefit that clients will experience by participating in a healing practice that recognizes their wisdom and respects their understanding of themselves.

Duncan, Miller, and Sparks have it exactly right, to my mind, by focusing on effectiveness as well as respect. They have shown the courage to break free of the shackles of the medical model without sacrificing the values (and value) of science and evidence. It is not only the clients who are heroic—Duncan, Miller, and Sparks are heroic, as are the therapists who resist the temptation to conform to a medical model and thus assist clients in effective and respectful ways.

BRUCE E. WAMPOLD
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Foreword to the First Edition

Name a psychiatric condition, and it is likely that a document from one or another mental health agency or interest group maintains that this condition is “seriously underdiagnosed and unrecognized” in society. Often, it is asserted that it is underdiagnosed because it is malignantly asymptomatic (without symptoms), but if the truth were known, we are told, it would be revealed that this condition has reached epidemic proportions. And of course, all of these conditions require the services of an expert clinician, a magic pill, and months or even years of expensive treatment.

Factually, it is quite uncertain that the clusters of symptoms that we bind together under discrete diagnostic labels really represent discrete conditions or disease processes at all, and even more uncertain that even highly trained clinicians can identify them reliably or treat them discriminately when they are recognized. Diagnostic descriptors are proliferating at a much faster rate than the accumulation of supportive research or the expansion and growth of new symptoms, with every new edition of the *Diagnostic and Statistical Manual of Mental Disorders* adding new diseases to our vocabulary. The accumulation of these diseases, some might add, are more responsive to the vote of the American Psychiatric Association than to the findings from the research laboratory. Applications of democracy to eradicating disease, as done in psychiatry, should certainly be tried by those who treat cancer and heart disease.

In view of this, one has to wonder why and how both diagnoses and treatment approaches have proliferated so widely, there now being more than 400 of each. As one

inspects the peculiarly strong correlation between the number of new diagnoses and the number of professionals being trained to treat these disorders, he or she may secretly wonder, which came first—the diseases or the healers? Conventional wisdom portrays a struggling mental health system that is overrun by an ever expanding epidemic, straining under the press of emerging disorders—a system whose scientists are uncovering, daily, new sicknesses and problems, and whose weak efforts to amass an army to fight these diseases is inadequate to stem the tide.

But there is another view, one that suggests that new diseases have been manufactured in order to feed a social system that prefers to think of “diseases” needing treatment than of choices that imply personal responsibility and vulnerability. This latter view suggests that the expanding diagnostic system was created in order to support the needs of a growing array of mental health professionals and a burgeoning pharmaceutical industry—make it into a disease and you imply that it requires an expert, a pill, and a specialized treatment to fix it.

The evidence for this alternative perspective is compelling, as Barry Duncan and Scott Miller document. For example, in spite of an exponential increase in the number of new and novel theories of change, psychopathology, and treatment, it remains that even skilled professionals cannot agree on when a given condition is present. Even if they do agree, moreover, they assign different treatments. And finally, the treatments they assign, while different in assumed mechanism and form—both chemical and psychological—are nonspecific. That is, they produce similar effects, and most of the effects take place early in treatment. It seems that every new practitioner develops his or her own theory of how behavior develops and changes, which often is no more than a rationale for why his or her

special skills are needed. The evidence available indicates that factors that are incidental to most of these theories account for most of the benefits of the treatments. Most of the factors that help people are inherent to the patient and involve his or her resources, expectancies, and faith. What change is not accounted for by these qualities of the person who seeks treatment is largely accounted for by how well the therapist can relate to the patient. Indeed, in this day of trying to identify empirically supported treatments, the treatment that has earned the strongest research support is any specific one in which therapist and client/patient collaborate, the therapist is supportive and caring, and both or all participants share a perspective of where they are going. A therapy that capitalizes on creating this type of environment is what is advocated and described by Duncan and Miller in espousing “client-directed, outcome informed” therapy.

Considering contemporary literature about the contributors to effective amelioration of problems in living and personal discomfort, one would be hard pressed to imagine that client-directed therapy would be ill advised for anyone. It is an approach that respects the patient and stimulates collaboration toward patient-initiated goals. And it addresses the area about which we know the most regarding how to maximize the effects of psychotherapeutic efforts, the therapeutic relationship. It acknowledges the importance of patient preparation, of session-by-session evaluation, of early change events, and of monitoring and correcting the quality of the therapeutic alliance.

Duncan and Miller and I agree about the problems of diagnosis, the fallacy of the magic pill, the importance of early change, and the value of working through the treatment relationship to construct a treatment plan. At this juncture, however, we also have some divergent views. The snag is in the question of whether improvement beyond the

relationship can be achieved by the use of specific techniques in any way that will allow pretreatment and presession planning. Duncan and Miller argue that specific procedures applied on the basis of group algorithms add little to treatment benefit and that any implementation of specific procedures should be decided in response to immediate feedback from patients about the relationship, their expectations, their wants, and their progress. They critique those like me who advocate adding to the relationship enhancement processes a prescriptive or preplanned intervention, tailored to patient qualities. Duncan and Miller fear, with some justification, that such preplanning places too much faith in the skill of the therapist and introduces a status rift into the relationship. I, on the other hand, fear that patients may, just as therapists clearly do, come to reify beliefs and theories to their disadvantage. There are instances, I believe, such as that of Stacey (Chapter Five) in which working from only the patient's theory tacitly reinforces the tendency to assume that one's memories, especially those induced by treatment, are accurate representations of real events from the past, and freezes our views of what is real. I believe that a therapist's responsibility is partially to provide a check against reification of memories and cementing of constructed theories that are or may be damaging to people and relationships in the long run.

But the differences in our views represent hypotheses that are in need of further test. Science will eventually reveal the path to follow. But whatever we ultimately determine the effect to be of specific psychotherapeutic interventions based on diagnosed disorders, I am convinced that we will continue to find that they are of lesser importance than those things whose objectives are to enhance and facilitate the quality of the relationship between client and clinician. This relationship is enhanced when the therapist is able to

move within the patient's view and world. It is these things that this book addresses most completely and thoroughly. It is the descriptions of how to treat a "patient" as an equal, how to facilitate the quality of the relationship, and how to establish collaboration and cooperation that are the most valuable and enduring facts. And in this, one cannot go wrong by following Duncan and Miller's lead. But more, you can do much that will be good and helpful.

LARRY E. BEUTLER
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To
The memory of Lee Duncan—
Who taught Barry about Heroism

Preface

About twenty-four years ago, I (Barry Duncan) began my mental health career at a state hospital. I experienced firsthand the facial grimaces and tongue wagging that characterize the neurological damage (tardive dyskinesia) caused by antipsychotics and sadly realized that these young adults would be forever branded as grotesquely different, as “mental patients.” I witnessed the dehumanization of people reduced to drooling, shuffling zombies, spoken to like children and treated like cattle. I barely kept my head above water as hopelessness flooded the halls of the hospital, drowning staff and clients alike in an ocean of lost causes.

Shortly thereafter, I began working in a residential treatment center for troubled adolescents. So “disturbed” were these kids that every one “required” at least two psychotropic medications and a minimum of two diagnoses. One time when the psychiatrist was on vacation and the center director was unable to cover him, a sixteen-year-old, Ann, was admitted to the center. I was assigned her case and saw her every day in individual therapy as well as in the groups I conducted. Ann was like many of the kids, abused in all ways imaginable, drop-kicked from one foster home to another, with periodic suicide attempts and trips to hospitals and runaway shelters. In spite of all that, Ann was a pure delight—creative, funny, and hopeful for a future far different than her childhood. The therapy went great: we hit it off famously, and Ann settled in and started attending high school for the first time in several months.

Three weeks later, the psychiatrist returned and prescribed an antidepressant and lithium for Ann. She

adamantly opposed taking the medication—she said she had been down that path already. But her voice went unheard. More accurately, she had no voice at all in her own treatment. I protested to the psychiatrist, citing evidence of how well she was doing, but to no avail. I was only a mental health grunt and a student to boot. I argued that forcing meds on Ann could be harmful, but he did not listen. And it was.

Ann became a different person—sullen, hostile, and combative. She soon ran away and went on a three-day binge of alcohol and drugs. A carload of men picked her up while she was hitchhiking and ended the ride with a gang rape. Adding insult to injury, Ann was forcefully injected with an antipsychotic when the police brought her back to the center. When Ann described this experience, she saw the horror on my face and reassured me that she had suffered far worse indignities than being forcefully tranquilized. It was little solace for either of us.

When Ann persisted in her ardent protests against the medication, I encouraged her to talk to the center director. Rather than listening, however, the director admonished me for putting ideas into Ann’s head and told me to drop it. Instead, I spent days researching the literature. What I found surprised me. In contrast to what most clients were told, little was known about how psychotropic drugs actually worked. Drugs like cocaine, for example, blocked the reuptake of the brain chemicals believed critical to depression in exactly the same way as antidepressants but did not have any so-called therapeutic effect. Furthermore, although increases in these supposedly critical neurotransmitters were present within hours of the first dose, they did not result in any therapeutic benefit for four to six weeks! Moreover, there was no empirical support for prescribing these drugs to children—let alone multiple drugs.

Finally, I was shocked to find that the very helpfulness of medication was suspect. I discovered a 1974 review (Morris & Beck, 1974) of ninety-one studies that showed antidepressants to be no more effective than a sugar pill in one-third of the published reports. This finding is particularly noteworthy because the studies eliminated participants who showed rapid improvement to the fake pill (called placebo responders). Furthermore, because research with negative results is less likely to be published, this review likely underestimated the extent of the placebo response rate.

Simply put, I had unexpectedly discovered that the emperor had no clothes. What did I get when I challenged the psychiatrist with these facts? Fired. Ann survived as usual, resisting when she could, and unfortunately viewed this experience as just another cog in her wheel of abuse from her "helpers." I left demoralized but determined never to be in the dark again, complicit by virtue of ignorance. Later, Ann wrote me and thanked me for supporting her resistance. Ann's resilience gave me hope.

These many years later, the same practices that diminished and excluded Ann, as well as dictated her options, still thrive. This book seeks to undermine those practices that oppress clients and provide therapists with the information necessary to question the mental health status quo. Consequently, this book is decidedly political. We critically examine and slaughter the sacred cows of the medical model as it applies to the human dilemmas clients and therapists routinely face.

But that is not enough. Therapists have whined about the mental health system for many years. More important, we also suggest an alternative that we believe fits therapist's values more and releases therapists and clients alike from practices in which they do not believe. At the core of our proposal is the heroic client. This book recasts the drama of

therapy and places clients in their rightful role as heroes and heroines of the therapeutic stage.

We argue that attending to clients' centrality to change by monitoring the client's view of progress and fit dramatically improves effectiveness and makes psychotherapy accountable to both consumers and payers. We call this approach "client directed and outcome informed."

We, however, are not laying the cornerstone of a new model or concocting a tag line for selling a new and improved brand of therapy. Any therapy can be client directed and outcome informed; the only requirement is that ongoing client perceptions about the fit and progress of therapy direct options and provide the ultimate litmus test for success. Consequently, we dictate no fixed techniques, no certainties or invariant patterns in therapeutic process, and offer no insightful explanations for the concerns that bring folks to therapy. We are certain that you have "been there, done that." Instead, we suggest principles that therapists of any orientation can consider to enhance those factors identified by research to account for successful outcome—but only the client can determine the benefit of any particular application. Therefore, we suggest a way that therapists of any theoretical preference can elicit clients' "real-time" feedback about the benefit of the services received to inform and modify their work—not only to improve effectiveness but also to form an identity separate from the medical model.

In this revision of *The Heroic Client,* we intended at first to change only two chapters substantially to reflect the evolution of our thinking and simply update the others. But as Jacqueline Sparks, our new third author, commented, once you repaint one room in the house, suddenly all the rooms look in need of a coat of paint. Consequently, readers familiar with the first edition will notice many changes in

addition to updated references. The new version is decidedly more user friendly, replete with several more client examples to illustrate our points. This edition offers a more practical discussion of the most radical of our ideas: partnering with clients to change the way mental health services are delivered and funded. We lay out the details of becoming outcome informed to encourage not only more insurrection against those practices that marginalize clients but also to provide enough foundation for readers to begin an outcome project in their settings. Those desiring to implement these ideas can find support at our listserv, http://www.heroicagencies.org. We have also expanded our arguments about evidence-based treatments and psychotropic medication to enable the informed therapist to thoughtfully consider the controversies at hand.

Finally, we changed the subtitle to “A Revolutionary Way to Improve Effectiveness.” These are strong words. We mean “revolutionary way” to reflect two themes central to this book. One is our revolutionary desire to overthrow mental health practices that do not promote a partnership with clients in all decisions that affect their well being. The second theme is the revolutionary improvements that recent research about outcome feedback has demonstrated —using client-based outcome feedback increases effectiveness by an incredible 65 percent in real clinical settings. Such results, 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 improving effectiveness will be found in outcome management.

Any project of this kind reflects contributions by many, and to them we are deeply grateful. We remain indebted to our clients, who continue to teach us to do good work by depending on them. Several people deserve special mention. In addition to the influences mentioned in our previous publications, we would like to acknowledge the inspiration provided by therapists and leaders around the world who implement the ideas described in this book in the places that really matter, in the day-to-day world with clients in distress—Wenche BrunnLien, Dave Claud, Daniil Danilopoulos, Morten Hammer, Mary Susan Haynes, Tove and Andy Huggins, Bill Plum, Geir Skauli, Dave Stadler, Anne-Grethe Tuseth, and Jim Walt to mention just a few—and whose willingness to challenge the status of the emperor's fashions provide models for us all to emulate. We are grateful to Rita Benasutti, Joan Katz, Sara Klug, and Joe Rock for their feedback and ongoing support; and to the heroicagencies listserv, too many names to mention, for continued lively conversation and the inspiration to try to make a difference. Finally, we feel especially indebted to Alan Rinzler, executive editor at Jossey-Bass, for recognizing our passions and encouraging them to become manifest.

BARRY L. DUNCAN
SCOTT D. MILLER
JACQUELINE A. SPARKS

CHAPTER ONE

Therapy at the Crossroads

The Challenges of the Twenty-First Century

> *... every man his greatest, and, as it were, his own executioner.*
>
> —*Sir Thomas Browne,* Religio Medici

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

Though removed by some 2,600 years, the perilous situation of the oaks described in Aesop’s fable is not unlike that of the field of therapy today. Indeed, changes in

virtually every aspect of the profession over the last ten years have left mental health practitioners with much to feel uncertain and unhappy about. Where once therapists were the complete and total masters of their domain, their power to make even the smallest of decisions regarding clinical practice has dwindled to nearly nothing. A recent survey found that a staggering 80 percent of practitioners felt they had lost complete control over aspects of "care and treatment they as clinicians *should* control" (e.g., type and length of treatment, and so on; Rabasca, 1999, p. 11, emphasis added).

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

As far as income is concerned, the reality is that the average practitioner has watched the bottom line drop by as much as 50 percent over the last ten years (Rabasca, 1999)! Berman (1998), for example, found that the net income of doctoral-level psychologists in solo practice after taxes averaged $24,000—a salary that hardly seems to merit an average investment of six years of postgraduate education and a minimum of $30,000 in tuition costs (Norcross,

Hanych, & Terranova, 1996). On the public side of things, case managers and other bachelorlevel providers render more and more services, reducing the value and therefore salaries of master's-trained mental health professionals.

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

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

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

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

THE FUTURE OF MENTAL HEALTH

> *The greatest enemy of the truth is not the lie—deliberate, contrived, and dishonest—but the myth—persistent, pervasive, and unrealistic.*
>
> —*John F. Kennedy,* Commencement Address, Yale University

Imagine a future in which the arbitrary distinction between mental and physical health has been obliterated; a future with a health care system so radically revamped that it addresses the needs of the whole person—medical, psychological, and relational. In this system of integrated care, mental health professionals collaborate regularly with