Common Factors and the Uncommon Heroism of Youth

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Fifty years of outcome research shows that change doesn't result from focusing on the disorders, diseases, or dysfunctions of youth. Change is spurred by what's right with children and adolescents—their resources, creativity, and relational support networks—not the labels they carry or even the techniques employed by professional helpers. Indeed the factors common to all treatments, fueled by the uncommon heroism of youth, are the mainstay of positive outcomes. This article reviews not only what is known about what works with youth, but also demonstrates how to improve effectiveness via outcome management—giving youth a voice in their own treatment while implementing the common factors one client at a time.

'The great tragedy of science—the slaying of a beautiful hypothesis by an ugly fact.' **Thomas Henry Huxley**

Recent estimates attest to growing numbers of children and teens receiving mental health services. Paradoxically, many youth who find themselves on the expanding rolls of mental health treatment do not even know why they are in treatment, while others recognize painfully that they are mandated to treatment, not unlike those clients who find themselves forced into treatment by the courts or other authorities. Unfortunately, children and adolescents do not have a voice in their own treatment, especially in those treatments conceptualized through the medical model lens.

This article critically evaluates the medical model as it applies to the common problems of children and adolescents. We argue that the fixation with diagnostic groupings is largely a waste of time. Instead of growing orderly and yielding a nourishing bounty, diagnosing child mental disorders has multiplied like a weed. They choke alternative, hopeful ways of understanding and encouraging change. Further, we debunk evidence based treatments and their alleged scientific superiority, and demonstrate that change in therapy does not come about from the special powers of any particular treatment. Rather, change results principally from factors common to all approaches and from the client's preexisting abilities and participation—the client is the hero of the therapeutic drama [1]. Finally, this article demonstrates how to improve services to children and adolescents via outcome management—giving youth a voice in their own treatment while implementing the common factors one client at a time.

The Medical Model

'Seek facts and classify them and you will be the workmen of science. Conceive or accept theories and you will be their politicians.' **Nicholas Maurice Arthus**

The medical model, emphasizing diagnostic classification and evidence based practice, has been transplanted wholesale into the field of human problems (Duncan, 2001). Psychotherapy is almost exclusively described, researched, taught, practiced, and regulated in terms of the medical model's assumptions and practices—but does it merit its apparent dominance?

Diagnostic Disorder

'I have found little that is good about human beings. In my experience, most of them are trash.' **Sigmund Freud**

There are several important ways the medical model and its starting point, diagnosis, are ill suited templates for therapy. From a medical standpoint, the first step in determining what needs to be done is to determine what is wrong. The way to determine what is wrong is to have a clear picture of health. Medicine is able to define those conditions that can be considered optimal or disease free. For example, physicians know the normal range for glucose levels in the blood. They are therefore able to discern deviations and can diagnose diabetes confidently. In mental health, the concept of normalcy is significantly more problematic. Ideas of normal behavior are shaped by social and cultural norms including arrangements of power, hierarchy, inclusion, and exclusion. Human behavior exhibits a significant range

of variation, made even more complex by social systems that either condone or condemn difference. Mental health works in reverse—we define deviation, but have considerably more difficulty defining normalcy (Watzlawick, 1976).

Second, diagnosis in mental health lacks reliability and validity, cornerstones of any respectable measurement system. In a recent interview, Robert Spitzer, the architect of the DSM, confessed candidly: *'To say that we've solved the reliability problem is just not true. . . It's been improved. But if you're in a situation with a general clinician it's certainly not very good.'* (Spiegel, 2005, p. 63). The last major study of the DSM, using highly trained clinicians at multiple sites under supervision of some of the most experienced diagnostic specialists in the world (Williams et al., 1992), found reliability coefficients not much different from studies in the 50's and 60's. In fact, Kirk and Kutchins (1992) noted that some reliability coefficients in this study were worse than earlier attempts. When trained clinicians in highly controlled settings cannot agree on even general categories of diagnosis, how much credence can we give to the specific diagnoses everyday clinicians ascribe routinely to their clients?

In addition to questionable reliability, psychiatric diagnosis lacks an even more critical dimension, validity. Here, we ask, does a DSM diagnosis actually represent some defined entity in the real world? Kendell and Zablansky (2003, p. 7), writing in the American Journal of Psychiatry, conclude that *'At present there is little evidence that most contemporary psychiatric diagnoses are valid, because they are still defined by syndromes that have not been demonstrated to have natural boundaries.'* The authors make the point that psychiatric diagnoses fail the most basic definition of validity—they lack empirical standards to distinguish the hypothesized pathological states from normal human variation to the problems of life. The result is a set of murky over-inclusive criteria for an ever growing list of disorders (Duncan, Miller, & Sparks, 2004). Unfortunately, constant, uncritical repetition in scientific journals and lay press backed by unchallenged science produces an illusion of sound validity, engendering a confidence that far overreaches the DSM's deeply flawed infrastructure (Sparks, Duncan, & Miller, in press).

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Attributing problems in living or the ranges of human inner experience to individual disorders radically dismisses the essence of what it means to be human and ultimately constructs the identities of youth as either 'ill, bad, or victim'. Humans are first and foremost members of social communities, and their behaviors and states of mind are fundamentally connected to and influenced by these contexts. Psychiatric diagnoses represent pathologies that presumably transcend time, place, and culture. For example, rather than viewing the fearfulness of a child as the product of a specific set of environmental conditions, a diagnostic system may assign non-context bound descriptors such as phobia, anxiety, or paranoia. The pervasiveness and non-contextual nature of diagnosis locates the problem inside the child and overlooks other possible explanations such as whether the child has been harassed or oppressed, has been taught to be wary by a parent or sibling, is isolated from support, or is attempting to engage the interviewer in a particular way.

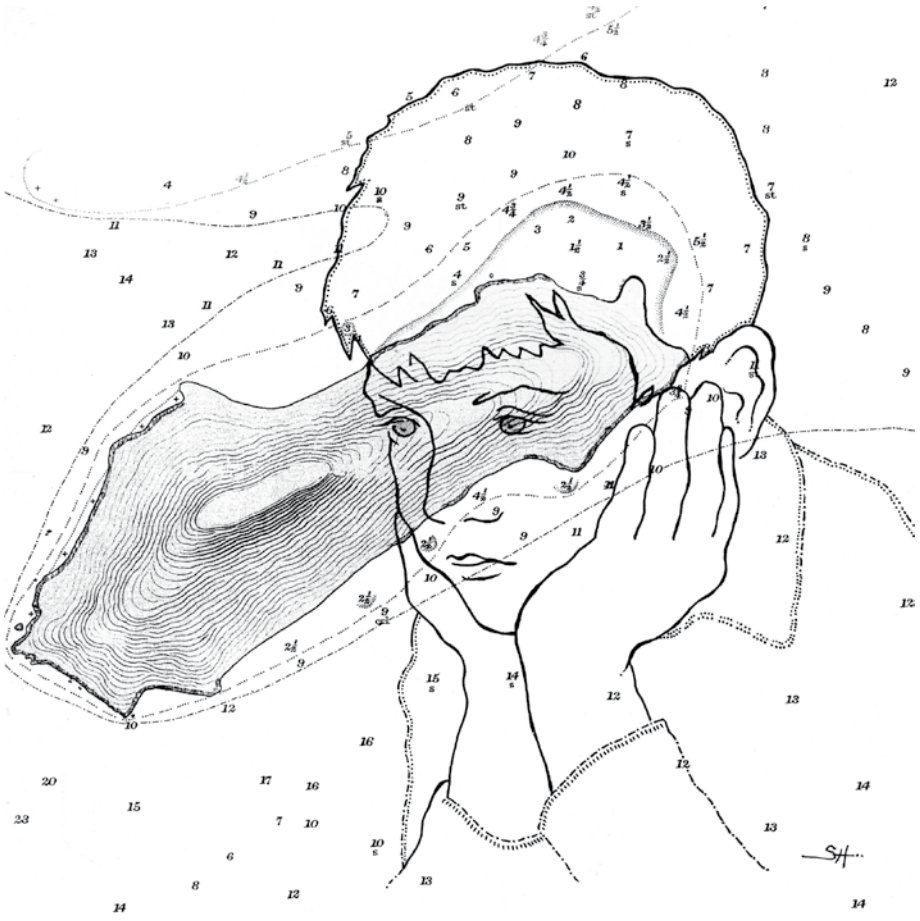

Illustration: Savina Hopkins

Finally, diagnosis tells us little that is relevant to the process of change—it has no predictive validity. Diagnosis is not correlated with outcome or length of stay, and given that no approach has demonstrated reliably any superiority, it cannot tell clinicians or clients the best approach to resolving a problem (Brown, Dries, & Nace, 1999; Wampold, 2001). The importation of medical diagnosis into psychotherapy positions clients as passive holders of disease to be fixed by the skilled interventions of the clinician. This positioning of clients is particularly unhelpful and flies in the face of what is know about the importance of client factors in psychotherapy. The bulk of outcome research in the past 45 years confirms the critical role clients play in their own change (Asay & Lambert, 1999; Karver, Handelsman, Fields, & Bickman, 2005)—research makes abundantly clear that clients are the heroic ones in the drama called therapy (Duncan et al., 2004).

The Heroic Client

'It is easier to discover a deficiency in individuals, in states, and in Providence, than to see their real import and value.' **Hegel**

Youth and their caretakers are actually the single, most potent contributor to outcome—the resources they bring into the therapy room and what influences their lives outside it (Hubble, Duncan, & Miller, 1999). These factors might include persistence, openness, faith, optimism, a supportive grandmother, or membership in a religious community: all factors operative in a client's life before he or she enters therapy. They also include serendipitous interactions between such inner strengths and happenstance, such as attending a new school or a crisis negotiated successfully. Asay and Lambert (1999) ascribe 40 percent of improvement during psychotherapy to client factors. Wampold's (2001) meta-analysis attributes an amazing 87% to these so called extratherapeutic factors (including error variance). This perspective about how change occurs suggests a radical revamping of our ideas about clients, and about what therapy should look like.

Therapists can begin to cast their youthful clients in the role of the primary agents of change by first listening for and being curious about their competencies—the heroic stories that reflect their part in surmounting obstacles, initiating action, and maintaining positive change. There is no formula here; rather the key is the attitude the practitioner assumes with regard to the client's inherent abilities and resiliencies. Karver et al. (2005) report that therapists are most likely to point out strengths in those youths who enter therapy with obvious pre-treatment strengths. But beyond the obvious, attending to heroic stories requires a balance between listening empathically to difficulties with mindfulness toward strengths and resources that you know are there. Listening for and being curious about client competencies, resources, and resiliencies does not mean that the therapist ignores clients' pain or assumes a cheerleading attitude. Rather, it requires that the therapist listens to the whole story: the confusion and the clarity; the suffering and the endurance; the pain and the coping; the desperation and the desire.

In essence, listening for heroic stories only suggests that counsellors open themselves to the existence of several competing stories about the client's experience. Diagnosis tells but one story, a problem description tells another. Many other stories of survival and courage exist simultaneously. Whatever path the therapist takes, it is important to remember that the purpose is to identify not what clients need, but what they already have that can be put to use in reaching their goals.

In summary, diagnosis paints a flat and colorless picture that highlights weakness, stigmatizes, and renders invisible vital capabilities and life resources that can be brought to bear in resolving problems. When diagnosis does not dominate the picture, clinicians have greater permission to search with clients for explanations other than illness to the problems in their lives, and to engage in an active pursuit of a broader array of options for alleviating the distress. Rather than constructing a patient in need of correction—an ill, bad, or victim child—we have the possibility of constructing resourceful, active agents deciding how they wish to re-organize their lives and relationships.

…therapy works if clients (youth and parents) experience the relationship positively, perceive therapy to be relevant to their concerns and goals, and are active participants.

Evidenced Based Practice

'I admire those who search for the truth. I avoid those who find it.' **French Motto**

Evidence based practice (EBP) is another unfortunate idea from the medical model that has been shoe-horned into mental health practice. Of course, there is nothing wrong with wanting to know which approaches are effective for the problems of youth. However, one should always ask, *'Whose evidence is it and what kind of evidence is it really?'* Only then can it be determined whether this evidence warrants privilege of this approach or any mandate of its practices.

An assumption that underlies EBP is that specific technical operations are largely responsible for client improvement—that active (unique) ingredients of a given approach produce different effects with different disorders. In effect, this assumption likens psychotherapy to a pill, with discernable unique ingredients that can be shown to have more potency than other active ingredients of other drugs.

There are three empirical arguments that cast doubt upon this assumption (Duncan & Miller, 2005). First is

the well-known dodo bird verdict, which summarizes colorfully the robust finding that specific therapy approaches do not show specific effects or relative efficacy. For readers not yet familiar with this idea, in 1936 Saul Rosenzweig first invoked the dodo's words *'Everybody has won and all must have prizes',* from *Alice's Adventures in Wonderland*, to illustrate his observation of the equivalent success of diverse psychotherapies. Almost 40 years later, Luborsky, Singer, and Luborsky (1975) empirically validated Rozenzweig's conclusion in their now classic review of comparative clinical trials. The dodo bird verdict has since become the most replicated finding in the psychological literature, encompassing a broad array of research designs, problems, populations, and clinical settings (Asay & Lambert, 1999), including marriage and family approaches (Shadish & Baldwin, 2002), and child and adolescent therapies (Dennis et al., 2004; Spielmans & Pasek, 2005; Varhely & Miller, 2005).

Ushering in the age of the RCT (randomised controlled trial), the landmark *Treatment of Depression Collaborative Research Project* (TDCRP) (Elkin et al., 1989) assigned 250 depressed participants randomly to four different conditions : cognitive therapy, interpersonal therapy, antidepressants, and, a pill placebo plus clinical management. After all the effort that went into designing a study that represented the state-of-the-art in outcome research, the four treatments—including placebo—achieved about the same results. Particularly germane is the cannabis youth treatment (CYT) study. The CYT found that neither the best practice nor researched based intervention was superior (Godley, Jones, Funk, Ives, & Passetti, 2004).

A meta-analysis, designed specifically to test the dodo bird verdict (Wampold et al., 1997), included some 277 studies conducted from 1970 to 1995. This analysis verified that no approach has demonstrated reliable superiority over any other. At most, the effect size (ES) of treatment differences was a weak .2. This also holds true in a recent meta-analytic study of child and adolescent approaches (Varhely & Miller, 2005). *'Why,'* Wampold et al. ask, *'[do] researchers persist in attempts to find treatment differences, when they know that these effects are small?'* (p. 211). Finally, an enormous real-world study conducted by Human Affairs International of over 2000 therapists and 20,000 clients revealed no differences in outcome among thirteen approaches, including medication, as well as family therapy and child approaches (Brown et al., 1999). The preponderance of the data, therefore, indicate a lack of specific effects and refute any claim of superiority when two or more bona fide treatments intended to be therapeutic are compared. It is noteworthy that although there are countless outcome studies in youth treatment, over 1500 by some estimates, only 23 examine differential efficacy of two or more bona fide treatments (Miller, Wampold & Varhely, in press).

The second argument shining a light on the empirical pitfalls of evidence based practice emerges from estimates regarding the impact of specific technique on outcome. After an extensive, but non-statistical analysis of decades of outcome research, Lambert (1992) suggests that model/technique factors account for about 15% of outcome variance. An even smaller role for specific technical operations of various psychotherapy approaches is proposed by Wampold (2001). His meta-analysis assigns only a 13% contribution to the impact of therapy, both general and specific factors combined. Of that 13%, a mere 1% is portioned to the contribution of model effects. Of the total variance of change, only 8% (or 1 out of 13) can be assigned to specific technique. This surprising low number is derived from the 1997 meta-analytic study, in which the most liberally defined effect size for treatment differences was .2—indicating that only 1% of the variance in outcomes can be attributed to specific treatment factors. Again, the Miller, Wampold & Varhely (in press) meta-analysis of the child/adolescent literature found an ES of .22, similarly indicating a miniscule portion of the variance in youth treatment attributable to specific factors. A consideration of these estimates of variance reveals that EBPs arise from factors that do not account for 85% and 99%, respectively, of the variance of outcome. EBP, because of the limited amount of variance accounted for by specific technical operations, simply do not map enough of the landscape to make them worthwhile guides to the psychotherapy territory.

Finally, component studies, which dismantle approaches to tease out unique ingredients, similarly have found little evidence to support any specific effects of therapy. A prototypic component study can be found in an investigation by Jacobson et al.

(1996) of cognitive behavioral therapy (CBT) and depression. Given the predominance of CBT on the list of youth EBP, this study is particularly telling. Clients were assigned randomly to (1) behavioral activation treatment, (2) behavioral activation treatment plus coping skills related to automatic thoughts, or (3) the complete cognitive treatment (the above two conditions plus identification and modification of core dysfunctional schemas). Generally, results indicated no differences at termination and follow-up. Perhaps putting this issue to rest, a recent meta-analytic investigation of component studies (Ahn & Wampold, 2001) located 27 comparisons in the literature between 1970 and 1998 that tested an approach against that same approach without a specific component. The results revealed no differences. These studies have shown that it doesn't matter what component you leave out—the approach still works as well as the treatment containing all of its parts. When taken in total, comparative clinical trials, meta-analytic investigations, and component studies point in the same direction. There are no unique ingredients to therapy approaches and little empirical justification for privileging EBP.

More damning to EBP, perhaps, is that the repeated demonstration of superiority over placebo or treatment as usual is not really saying that much; psychotherapy has demonstrated its superiority over placebo for nearly 50 years! Therapy is about twice as efficacious as placebo and about four times better than no treatment at all. This research, for all its pomp and circumstance, tells us nothing that we already do not know: Therapy works. Further, demonstrating efficacy over placebo is not the same as demonstrating efficacy over other approaches. Why do EBT proponents seem to pretend that efficacy over placebo means that they are better than other treatments?

When differential efficacy is claimed, be suspicious. First, the amount of studies finding differences are no more than one would expect from chance. Further, closer inspection of studies that claim superiority reveals two major issues that must be considered: allegiance effects (whose evidence?) and indirect comparisons (what kind of evidence?) (Wampold, 2001). Allegiance effects are those that are attributable to the therapist or researcher's affinity toward the treatment at hand; Wampold (2001) suggests that allegiance accounts for up 70% of any treatment effects.

For example, though some reviews have found a very small advantage for cognitive-behavioral approaches, later studies found that the differences disappeared completely when the allegiance of the experimenters to the methods being investigated was taken into account (Lambert & Ogles, 2004; Miller, Wampold & Varhely, inpress). As a point of comparison, consider that in the TDCRP, the principle investigator, Irene Elkin, did not have an affiliation to any of the researched approaches. Further, each of compared treatments was provided by clinicians who had allegiance to the models they were administering. Allegiance effects, therefore, were controlled. Any reported treatment differences must always be tempered by knowledge of the allegiance of the researchers and the therapists in the study.

Another important issue in evaluating claims of differential efficacy is whether the study really presents a fair contest—is the comparison offered actually a contrast between two approaches intended to therapeutic? Or is it, in fact, the pet approach of the experimenters pitted against a treatment as usual or less than ideal opponent? Wampold (2001) calls such unfair matches indirect comparisons. Consider Multisystemic Therapy (MST), which has shown impressively that it is superior to no treatment or treatment as usual for the reduction of criminal acts of juveniles and other benefits (e.g., Henggeler, Melton, & Smith, 1992). To imply, however, that it has proven to be better differentially because of comparisons to individual therapy, is analogous to male and female bikini wear—notable for what is concealed rather than what is exposed.

An inspection of one such comparison involving serious juvenile offenders (Borduin, Mann, Cone, et al., 1995) reveals MST conducted in the home, involving parents and other interacting systems, by therapists in regular supervision with founders of the approach. MST is compared with therapy of the adolescent only, with little to no outside input of parents or others, conducted in an outpatient clinic by therapists with no special supervision or allegiance. This type of comparison is really a treatment as usual contrast rather that a bona fide treatment comparison. If a comparison were made of another home based approach that controlled for allegiance effects (had persons with equal conviction conducting the alternative treatment), delivered in similar doses, and involved relevant parties, it likely would fit the dodo bird verdict.

EBP and the Known Sources of Variance

'Whoever acquires knowledge and does not practice it resembles him who ploughs his land and leaves it unsown.' **Sa'di**

There is a certain seductive appeal to the idea of making psychological interventions dummy proof, where the users—the client and the therapist—are basically irrelevant. This product view of therapy is perhaps the most empirically vacuous aspect of EBP because the treatment itself accounts for so little of outcome variance, while the client and the therapist—and their relationship—account for so much.

Starting with the variance attributed to the alliance—a partnership between the client and therapist to achieve the client's goals—researchers repeatedly find that a positive alliance is one of the best predictors of outcome in both adult and youth treatment (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). Specifically related to youth treatment, child-therapist and parent-therapist alliances are both related to positive changes in the child; parent-therapist alliance is related to improvement in parenting skills and interactions at home; and child and parent evaluations of the alliance produced more consistent findings than therapist evaluations (Kazdin, Whitley, & Marciano, 2005; Shirk & Karver, 2003). In the CYT, the alliance predicted outcome as well as both drop outs and post treatment cannabis use

(Shelef, K., Diamond, G., Diamond, G., Liddle. H. (in press).

Research on the power of the alliance reflects over 1,000 findings, and counting (Orlinsky, Rønnestad, & Willutzki, 2004). For example, Krupnick et al. (1996) analyzed data from the TDCRP and found that the alliance was predictive of success for all conditions—the treatment model was not. Similarly, treatment characteristics (family, individual, behavioral, non-behavioral, etc.) in youth treatment did not predict outcome or moderate associations between the alliance and outcome. (Shirk & Karver, 2003).

Based on the Horvath and Symonds (1991) meta-analysis, Wampold (2001) portions 7% of the overall variance of outcome to the alliance. Putting this into perspective, the amount of change attributable to the alliance is about seven times that of specific model or technique. As another point of comparison, in the TDCRP, mean alliance scores accounted for up to 21% of the variance, while treatment differences accounted for at most 2% of outcome variance (Wampold, 2001), over a ten-fold difference.

Turning to variance attributed to the therapist, the explosion of EBPs has not eliminated the influence of the individual therapist on outcomes. Treatment still varies significantly by therapist (Miller, Duncan, Brown, Sorrell, & Chalk, in press; Lambert et al., 2003). Conservative estimates indicate that between 6% (Crits-Christoph et al., 1991) and 9% (Project MATCH Research Group, 1998) of the variance in outcomes is attributable to therapist effects. These percentages are particularly noteworthy when compared with the variability among treatments (1%).

And as already noted, the largest source of variance, virtually ignored by the move toward EBP, is accounted for by the so-called extratherapeutic factors—those variables associated with the client, including unexplained (and error) variance. These variables are incidental to the treatment model and idiosyncratic to the specific client—factors that are part of the client and his or her environment that aid in recovery regardless of participation in therapy (Lambert, 1992). What clients bring to the process—their attributes, struggles, motivations, and social supports—accounts for 40 percent of the variance (Lambert, 1992); Wampold's (2001) meta-analytic perspective assigns an 87% contribution to extratherapeutic factors.

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Among the client variables mentioned frequently for youth treatment are youth age/developmental status, youth/parent interpersonal functioning, parent mental health, parental intelligence, family environment, youth/parent expectancies of efficacy, treatment acceptability, etc. (Karver et al., 2005). In the absence of compelling evidence for any of these specific client variables to predict outcome or account for the unexplained variance, this most potent source of variance remains largely uncharted. This suggests that the largest source of variance cannot be generalized because these factors differ with each client. These unpredictable differences can only emerge one client at a time, one alliance at a time, one therapist at a time, and one treatment at a time.

In summary, EBP neither explains nor capitalizes on the sources of variance known to effect treatment outcome. Given the data, continuing to invest precious time and resources in the development and dissemination of EPB is misguided.

Reliance on the Alliance

***'It is the familiar that usually eludes in life. What is before our nose is what we see last.'* William Barrett**

Therapy works, but our understanding of how it works cannot be found in the insular explanations of the different theoretical orientations, but rather in the factors common to all approaches. The alliance data suggests that therapy works if clients (youth and parents) experience the relationship positively, perceive therapy to be relevant to their concerns and goals, and are active participants. Influencing the client's perceptions of the alliance represents the most direct impact that therapists can have on change. Given that 40–60% of youth who begin treatment drop out against advice (Kazdin, 2004), the alliance is particularly important. Bordin (1979) classically defines the alliance with three interacting elements: 1) the development of a relationship bond between the therapist and client; 2) agreement on the goals of therapy; and 3) agreement on the tasks of therapy.

As with listening for heroic stories, therapist attitude is also critical to developing a relational bond. Part and parcel to this attitude is the belief that the alliance, not model, is the master to be served. To implement this attitude, it is useful to think of each meeting as a first date (without the romantic overtones), in which the therapist puts his or her best foot forward consciously, woos the client's favor actively, and entices his or her participation. Clients' active engagement in the process, the quality of their participation, is the single best indication of the likelihood of success. Since the relationship is formed early, it only makes sense that close attention should be paid to the client's initial perceptions and reactions.

In addition to continual monitoring and flexibility, a helpful way to think about therapist relational responses is the idea of validation—a process in which the client's struggle is respected as important, perhaps representing a critical juncture in the client's life, and his or her thoughts, feelings, and behaviors are accepted, believed, and considered completely understandable given trying circumstances (Duncan & Sparks, 2002). This has particular relevance to parents who often feel blamed for youth problems. Validation reflects a genuine acceptance of the client at face value and includes an

empathic search for justification of the client's experience. The therapist legitimizes the client frame of reference and thereby replaces the invalidation that may be a part of it.

The second aspect of the alliance is the agreement on the goals of therapy. Attending to client's goals suggests that little time is spent developing diagnoses or theorizing about possible etiology of the presenting complaint, and even less on what therapeutic approach or technique will be most useful. Rather, the process is comprised of careful listening and alliance monitoring combined with questions aimed at defining and redefining the client's goals—the client's input, participation, and involvement determines the goals for therapy. When clients are asked what they want out of therapy, what they want to be different, it gives credibility to their beliefs and values regarding the problem and its solution. As simple an act as it is, it invites clients to see themselves as a collaborator in making their lives better. Regardless of how they sound, client's goals are accepted at face value because those are the desires that will excite and motivate the client to initiate action in their own behalf. If we are serving the alliance master, we know that agreement with the client about the goals of therapy is essential to positive outcome. It begins the process of change, wherever the client may travel ultimately.

The final aspect of the alliance is the agreement on the tasks of therapy. Tasks include specific techniques or therapeutic points of view, topics of conversation, interview procedures, frequency of meeting, etc. Another demonstration of respect for client's capabilities, and a conscious effort to enlist participation, occurs when clients help set the tasks of therapy. In a working alliance, the client perceives the tasks, what is actually taking place, as germane and effective. In a well functioning alliance, counsellors and clients work jointly to construct interventions that are in accordance with clients' preferred outcomes.

Traditionally, the therapeutic search has been for interventions reflecting objective truths that promote change by validating the therapist's favored theory. The search, when fostering a strong alliance, is for ideas and actions that promote change by validating the client's view of what is helpful, or what we call the client's theory of change. The client's theory of change is an 'emergent reality' that unfolds from a conversation structured by the therapist's curiosity about the client's ideas, attitudes, and speculations about change. We now consider our clients' worldview, their map of the territory, as the determining 'theory' for therapy (Duncan et al., 1992), directing both the destination desired and the routes of restoration, and all but ensuring the experience of a positive alliance.

Dangers of Common Factors

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

The data indicate that the client and therapeutic alliance account for the majority of the variance in treatment outcome. Successful treatment, we have argued, is a matter of tapping into client resources and ensuring a positive experience of the alliance. To these two elements, a third aspect was added; namely, the client's theory of change. What better way to enlist clients' partnership than by accommodating their preexisting beliefs about the problem and the change process?

Yes, at first blush, tapping into client resources, ensuring the client's positive experience of the alliance, and accommodating therapy to the client's theory of change capitalizes on the two largest contributors to success. At the same time, there is a danger—no matter how abstractly the ideas might be presented, whether defined as principles rather than mandates, closer examination made clear that any concrete application across clients merely leads to the creation of another model for how to do therapy. On this point, the research is clear, whether common factors or not, models ultimately matter little in terms of outcome.

To remedy the mere creation of yet another model and to give clients the voice in treatment that the research literature said they deserved, we began using formal measures to track our work with clients and embarked on a course of research to see if it made any difference. We have learned that a common factors approach can only be implemented one client at a time based on that unique individual's perceptions of the progress and fit of therapy—the client's experience of benefit must direct therapeutic choices. Rather than attempting to fit clients into evidence-based practice, we now recommend that therapists and systems of care tailor their work to individual clients through 'practice-based evidence.'

From Evidence-Based Practice to Practice-Based Evidence

'The proof of the pudding is in the eating.' **Cervantes, Don Quixote**

Early treatment benefit has emerged as a robust predictor of eventual outcome (e.g., Brown et al., 1999; Hansen & Lambert, 2003; Howard, Kopte, Krause, & Orlinsky, 1986). The CYT found similarly that response to treatment, regardless of its type and dose, occurred early (in the first 3 months) in the treatment process. In recent years, researchers have been using data about client progress generated during treatment to enhance the quality and outcome of care (Howard, Moras, Brill, Martinovich, & Lutz, 1996; Lambert et al., 2001; Whipple et al., 2003). Unlike treatment manuals, such approaches utilize the known sources of variance in psychotherapy outcome. For example, in one representative study of 6224 clients, Miller, Duncan, Brown, Sorrell, and Chalk (in press) provided therapists with ongoing, real-time feedback regarding two potent factors affecting outcome: the client's experience of the alliance and progress in treatment. The availability of this 'practice-based evidence' not only resulted in higher retention rates but also doubled the overall effect size of services offered (baseline ES = .37 v. final phase ES = .79; $p < .001$). Germane to the controversy of EBP, the findings were obtained without any attempt to control the treatment process—clinicians were not trained in any new techniques or

diagnostic procedures. Rather, they were free to engage their individual clients in the manner they saw fit.

Paradoxically, practice-based evidence—at least when judged on the basis of measurable improvements in outcome alone—may be the most effective evidence-based practice identified to date. Indeed, Lambert et al. (2003, p. 296) point out, *'those advocating the use of empirically supported psychotherapies do so on the basis of much smaller treatment effects.'* There are other advantages. For example, Miller et al. (in press) showed how practice-based evidence could be used to identify reliable differences in outcome between clinicians. Such differences, it will be recalled, account for several times more of the variance in outcomes than method (Wampold, 2001). Current ongoing research is examining the ways that such information can be used to enhance training, supervision, and quality assurance. Preliminary data from one site document a slow but progressive decrease in the variability of outcomes between clinicians when they are provided with ongoing, real-time feedback regarding their effectiveness as compared to average effectiveness of the agency as a whole (Miller, Duncan, Sorrell, & Chalk, in preparation).

Outcome and alliance measures are now available for children and adolescents (free for personal use at www.talkingcure.com). It is interesting to note, and perhaps sad commentary on our field, that these self report measures represent the first outcome and alliance measures for children under 12. Although the validation study of these measures is still in progress, preliminary data suggests that outcome management functions similarly for youth as it does for adults (Sparks, Duncan, & Miller, in preparation). Giving youth a voice improves treatment outcome.

The Medical Model Map is not the Territory

***'At bottom every man knows well enough that he is a unique being, only once on this earth; and by no extraordinary chance will such a marvelously picturesque piece of diversity in unity as he is, ever be put together a second time.'* Friedrich Nietzsche**

The medical model provides an empirically incorrect map of the psychotherapy terrain that sends both research and practice in the wrong direction. EBP ignores the known sources of variance and equates the client with a diagnosis and the therapist with a treatment technology—both interchangeable and insignificant to the procedure at hand. Psychotherapy is not an uninhabited terrain of technical procedures. It is not the sterile, stepwise, process of surgery, nor the predictable path of diagnosis, prescription, and cure. It cannot be described without the client and therapist, co-adventurers in a journey across largely uncharted territory. The psychotherapy landscape is intensely interpersonal, and ultimately, idiographic. Monitoring the client's progress and view of the alliance—using practice-based evidence—and altering treatment accordingly, is one way to manage the complexity and wonderful uncertainty that accompanies the process of psychotherapy (Duncan et al., 2004).

The evidence raises serious questions about professional specialization, training and certification, reimbursement for clinical services, research, and above all, the public welfare. Of course, standards are important—if for no other reason than to protect consumers. Given current licensing and training standards, however, it is theoretically possible for therapists to obtain a license to practice and work their entire careers without ever helping a single person. Who would know?

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. More important, clients, youth in particular, would finally gain the voice in treatment that the literature has long suggested they deserve.

This would indeed be revolutionary because psychotherapy has operated outside the purview of the very people it intends to serve, resulting in unaccountable practices bordering on oppression—especially with youth. Imagine clients in charge of every aspect of therapy and receiving services based on their theory of change, using their feedback to guide all decisions. Imagine no more diagnostic workups, treatment plans, intake forms; no personal or confidential information divulged or electronically submitted for payment purposes—or any other form or practice that has no relevance to outcome. Imagine instead simply submitting outcome data that triggers payment automatically for unlimited meetings as long as clients are benefiting. You may say that we are dreamers, but we're not the only ones. In fact, all of these things are already happening.

Imagine for the first time in history that mental health professionals will have proof of the effectiveness and value of day-to-day clinical work and no longer need to rely on the medical model for legitimacy. Imagine no longer gaining acceptance by adopting the questionable language and practices of the medical profession only to secure the permanent second-class status to which therapy has been relegated since the time of Freud. Imagine establishing an identity separate from the field of medicine. It is easy if you try.

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Endnotes

1. The common factors provide the empirical backdrop for 'client-directed, outcome-informed' ways of working with clients. A client-directed, outcome-informed approach contains no fixed techniques, invariant patterns in therapeutic process, and no causal theory regarding the concerns that bring people to therapy. Any interaction with a client can be client-directed and outcome-informed. This comes about when therapists partner purposefully with clients: (1) to enhance the factors across theories that account for successful outcome; (2) to use the client's theory of change to guide choice of technique and model; and (3) to inform the therapy with valid and reliable measures of the client's experience of the alliance and outcome. For a full discussion, see: Duncan, B., Miller, S., & Sparks, J. (2004). *The Heroic Client: A revolutionary way to improve effectiveness via client directed outcome informed therapy.* San Francisco: Jossey Bass.

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