

## Chapter Seventeen

### The Future of Psychotherapy

By Barry Duncan

**Barry's Note:** *“The Future of Psychotherapy” first appeared July/August 2001 and is reprinted here by permission of the Psychotherapy Networker. I was moved to write this article after coming to grips with the predictions that many leading luminaries were making. The more I read about the future--integrated data bases and mandated protocols for client problems (the so called evidence based practices)--the more uncomfortable I felt. This article offers you a glimpse into a crystal ball of the future of mental health in hopes of stimulating your reflections about your identity and what you must do to preserve it. The identity theme continues in the Part Four.*

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 need of the whole person—medical, psychological, and relational. In this system of integrated care, psychotherapists collaborate regularly with MDs, and clients are helped to feel that experiencing depression is no more a reflection on their character than is catching a flu. This new world will be convenient: people will be able to take care of nearly all their health needs under one roof—a medical superstore of services. It will be great for therapists, too providing them with a seemingly inexhaustible stream of client referrals from the enormous pool of patients who, in earlier times (today), would have mistakenly identified their complaints as primarily physical.

Now imagine a future in which every medical intervention in a patient's life is a matter of quasi-public record. In which therapy is tightly scripted and only a limited number of “approved” treatments are eligible for reimbursement. A future in which recalcitrant patients can be tracked and forced to undergo treatment, and in which therapist must serve as compliance cops for health management organizations and insurance companies. In this brave new world, integrated care actually means a more thoroughly medicalized health care system into which psychotherapy has been subsumed. Yes, therapist will work alongside medical doctors, but as junior partners, following treatment plans taken directly from authorized, standardized manuals.

These are not two different systems; rather, they are polarized descriptions of the same future, one that draws nearer everyday. Make no mistake: A seismic change is coming to the American health care system. The age of integrated care is upon us, and psychotherapy may soon be incorporated in a way that will profoundly affect how and where it is practiced. But what will this new system really look like? How will therapists—and the therapeutic process—fit into it? What values will lie at its core? Although there is no question that a new system is coming, the nature and structure of this new system are still very much up for grabs. And this means that, for therapists, the future poses both tremendous opportunity and grave threat.

One version of the future—the one envisioned by such advocates of “reform” as the American Medical Association and the leading managed care companies—is of a seamless web of services that quickly identifies patients' true needs and efficiently delivers patients to the right professional for the correct treatment. The other vision—therapists' vision—has yet to be fully articulated, largely because most of us are still adjusting to the changes wrought by managed care and unaware of the implications of what's coming.

We have the opportunity now to present our vision, to argue for the holistic integration of medical and psychological services in a way that is true to the core principles of psychotherapy. We must resist the inevitable attempts to define therapy as, in essence, a treatment that gets dispensed by a professional to a patient and argue instead for therapy as a process of change that is entered into by client and therapist working together as allies. And it is critical to do so now, when psychotherapy is on the brink of another tectonic shift that could well discredit the majority of approaches therapists use today.

### **Carving In, Carving Out**

To understand what lies ahead for the field of psychotherapy, we must first review some basic principles of health care economics. To state the matter in accountants' terms, mental health services have traditionally been "carved out"—handled and paid for separately from general health care costs and considered to be distinct from patients' medical needs. Most of us have grown accustomed to the idea that the point of entry for taking care of our medical needs is different from that of our mental health. Currently 88 percent of the mental health cases are handled in this way. But experts such as noted psychologist Charles Kiesler—whose critical commentary on the accuracy of psychotherapy research and the expense of inpatient care has been a springboard for policy discussion for more than 30 years, and who, in the mid-80s predicted that fledging MCOs would soon dominate the American health care industry—see another sweeping change in the offing. Soon, they say, behavioral care, like most other medical specialties, will be "carved in"—that is, mental health services will be treated as an integral part of medical patient care and administered accordingly, with all the advantages and liabilities that entails. According to Kiesler, the changes to be ushered in by carve-ins will be "as dramatic as the computer revolution."

The reason for this coming change, of course, is the tremendous pressure on health care administrators to reduce spiraling costs, especially those that are racked up by patients who repeatedly seek medical treatment—often expensive specialty consultations—for complaints that are at least partly due to undiagnosed psychological issues. A typical scenario goes like this: A patient visits a physician or emergency room with a physical complaint, say neck pain. Doctors treat his physical symptoms, but don't refer him to a therapist, who might help him tackle the stress contributing to his symptoms. As a result, his neck pain flares regularly and he frequently asks for treatment from doctors. This pattern may repeat for years unless and until his behavioral problem is identified.

Over the last four decades, studies have repeatedly shown that as many as 60 to 70 percent of physician visits actually stem from psychological distress that finds somatic expression. Advocates of carving in behavioral care say it will not only save money, but will bring real advantages to therapists and patients alike. Imagine that before even meeting a client you could open a computer file and learn that her doctor put her on Prozac some years ago when her mother died of congestive heart failure. Curious about the mother's mental health history, you could click on the link to "familial predisposition" and find that the mother, too, had been treated for chronic depression. If such information were available to you in advance, argue advocates for carving in care, you'd obviously be better prepared to meet this person, and you'd have a deeper understanding of her situation.

And here is another apparent advantage of bringing together the medical and psychological disciplines: it becomes easier to provide care for people with disorders like chronic pain and insomnia that don't clearly fit into DSM categories; for people whose disorders are medical but clearly have psychological or relational components, such as irritable bowel syndrome and high blood pressure; and for people who fit into multiple categories, such as, alcoholics with renal system problems.

The advantages of this new, collaborative system are evident in the case of a woman I'll call Kathy, a 23-years-old retail worker. Kathy was a client of family therapist Tom Mahan at the innovative Marillac Clinic in Grand Junction, Colorado—a model of how the integrated health care system of tomorrow can function at its best. She went to the clinic complaining of nausea, fatigue, feelings of helplessness, and a constant burning in her chest. Kathy had seen six doctors in five years and each one had told her she had no medical problem. Most recommended that she see a therapist, but she had rejected the idea that she had a “mental problem” and never followed this advice.

Then she visited the Marillac clinic. She was seen first by a doctor, who conducted a sophisticated assessment of her biomedical, psychological, social and even spiritual life. At the end of the interview, the doctor told her that while she might have gastroesophageal reflux disease (GERD), psychosocial factors, such as high stress, relationship difficulties, and perhaps depression, exacerbated her illness. He asked if Kathy would be willing to meet with “a behavioral care specialist” for some additional input and Kathy gave a tentative “maybe.” So Mahan joined the interview and, in the course of an amiable chat, was able to demystify psychotherapy and explain the relevance of Kathy's emotional state to her physical complaints. By the end of the session, Kathy had agreed to meet with him to work on managing her “stress.”

They met for three sessions. Kathy liked Mahan and felt she was finally making progress. While she responded positively to the treatment for GERD, which included medication and dietary changes, as well as an antidepressant prescribed by the intake physician, she also began examining the psychosocial stressors in her life. Kathy talked about her dead-end job as a retail clerk, her frequent arguments with her boyfriend, and her wish to move out of her parents' home. With Mahan's coaching and support, Kathy became more assertive in managing her own health: She learned more about GERD, formulated questions for her physicians, and transformed from docile observer to active, informed consumer.

Her newfound confidence manifested itself in other areas of her life as well. She became more assertive in her relationship with her boyfriend and her family, as well as in her job. She moved away from home, started a walking regimen, and finally got the wire-haired fox terrier she always wanted. In short, Kathy learned to speak up for herself and to act more decisively in her own interests. During a follow-up interview, she told Tom she was in better health and was paying more attention to her own needs. Kathy's new confidence also helped land her a more responsible position at work.

Integrated care was a godsend for Kathy. Aided by medical and behavioral professionals working in concert, she made changes in every facet of her life. Had Kathy not entered an integrated system, she might have continued to show up in the emergency room or the cardiologist's office, receiving costly, ineffective services. If she had encountered integrated health care from the beginning, she might have gotten the help she needed earlier and avoided the frustration of repeated but futile visits to doctors.

This is the beauty of an integrated system, its supporters say. Patients get a reliable diagnosis from a properly trained professional and no longer need to diagnose themselves. They get the medical and therapeutic care they need quickly and cost effectively. The system becomes more coherent—with mental health services easily available but only through the primary care physician. The bottom line: Carve-ins—done right—increase collaboration, improve care, and make psychotherapy more central to health care. And save insurance companies a lot of money.

### **The Nightmare of Integrated Care**

So if carving in offers all this, why do many therapists fear it could undermine our relationship with clients, rob us of our creativity, and challenge the fundamental values that underlie good psychotherapy? While the case of Kathy and the Marillac Clinic represents integrated care at its best, such success stories

can lull us into underestimating the insidious and deeply ingrained mindset of the traditional medical model—the idea that proper diagnosis plus prescriptive intervention equals effective treatment. What is obscured is the very real danger that in the name of “integration,” psychotherapy will become ever more dominated by the assumptions of the medical model. At issue here is not the theoretical advantages of greater collaboration among health care professionals or bringing more of a therapeutic perspective to bear on medical conditions, but whether we will lose our bearings—and our autonomy—as a profession by becoming immersed in the powerful professional culture of biomedicine today.

To understand the potential danger of carving behavioral care into an integrated system, consider the case of a 15-year-old girl we’ll call Carrie. Each morning, she would say goodbye to her mom and walk toward the bus stop near her home in one of the pleasantly named, planned communities that form the suburbs of a large southeastern city. But instead of getting on the bus, she’d walk to a friend’s house, where she would spend the day, returning home just as the afternoon bus drove down the street. If not for the notices the school eventually mailed home, her family might never have learned what was going on.

Perplexed about her aversion to school, weary of her rebelliousness and her contentious attitude, and frightened by her profound sadness, Carrie’s mom took her to the family’s HMO. A doctor there noted Carrie’s depression, prescribed an antidepressant and recommended psychotherapy. During her visit the next week to the therapist to whom she had been referred, Carrie revealed that she’d been going into the kitchen late at night and making scratches on her arms and legs with a knife. The alarmed therapist admitted Carrie to the hospital. After three nights, she was diagnosed with depression and sent home with orders to take her meds, see the therapist regularly, and come back to the hospital psychiatrist on a monthly basis.

In this case, the early referral for psychotherapy was no panacea. Carrie’s therapist saw a collection of symptoms rather than a person and focused on alleviating those symptoms with the most efficient intervention at hand—medication. What happened next reflects the pitfalls of applying the medical model to complex interactional problems—when people don’t respond to prescribed treatment, they are seen as “resistors” and, when in doubt, a hierarchical, medical system is likely to escalate its “treatment” in ways that compound, rather than resolve, problems.

Carrie didn’t want to take the antidepressant prescribed—she said it “made her skin crawl.” But in the face of the authority of the medical system, and at the insistence of her mother and the therapist, she took it anyway, and continued to feel bad and cut herself. Once, she even ran into traffic in an attempt to still the tumult inside her. Her friends ran after her, calmed her down, and made sure she took her next dose of medication. But when her mother saw the scratches and the continued despair, she called the therapist and, in the next in the escalation of her treatment, Carrie again found herself in the hospital. At the hospital the doctor diagnosed a bipolar disorder and added an anticonvulsant to her medication regimen.

But Carrie didn’t want more medication—she hated the way she felt when she took the pills, and she wanted to “rule” her feelings without drugs. She just wished she didn’t feel so bad. But the therapist and other health care professionals involved with her believed they knew the root of Carrie’s problem—Bipolar Disorder—and were emphatic about the importance of the medication, reminding Carrie’s mother that it was her *legal* responsibility to ensure that her daughter never missed a dose. Responding to the therapist’s warning, Carrie’s mom continued encouraging her daughter to take her pills and Carrie persisted in cutting herself to relieve her distress. All told, she was admitted three times to hospital, was variously diagnosed with depression, Bipolar Disorder, and Borderline Personality Disorder and was prescribed several antidepressants, lithium, and an anticonvulsant.

Fortunately for her, Carrie's story doesn't end here, but let's pause to contemplate the mental health care she received in a system insidiously dominated by diagnostic thinking and a hierarchical treatment model. Even in an HMO in which therapists were closely involved early on in treatment, just as is proposed in the integrated care model of the future, Carrie was first required to be a patient; second, to see her problems as medical, and third, to listen and follow orders—her own capabilities and perspective on her problems were never enlisted in her treatment. No one ever really asked her what she wanted, or formed a personal connection with her.

Integrated care, in and of itself, does not provide safeguards that would prevent the kind of treatment Carrie received. In fact, the monolithic power of such a consolidated system, becoming, in effect, a court of last resort for health care, should alert us to its possible dangers. Of particular concern should be an element that its proponents consider a cornerstone of the health care of tomorrow—the integrated data base. With such a comprehensive, computerized record-keeping system of a patient's entire medical and psychiatric history, Carrie's treatment would permanently follow her, available to anyone with access to the system. Ten years from now, she might be unable to get insurance or join the military. And her history of suicide attempts and diagnosis of Bipolar and Borderline Personality disorders could easily affect her career prospects and even her personal relationships. Employers and colleges routinely question applicants about medical history. *DSM* disorders hardly qualify as preferred credentials on such applications, nor is a history of mental treatment usually included on a resume. In fact, background checks for any reason would take on ominous overtones in a system that would document “mental illness” as part of the medical record.

As it was, Carrie's treatment took an unexpected and fortuitous turn. Her truancy triggered involvement by juvenile authorities, who ordered her to receive treatment from a home-based therapist. Now outside the domain of the medical system, the focus of treatment shifted from Carrie's individual symptoms to understanding the fuller context of her life. The new therapist's first move was to include all Carrie's family members, not just her mother, in treatment. With their help she began to develop a more complete picture of Carrie—that she was everyone's pet, and every one's headache. The therapist learned about her karate class, about her love for the horses she cared for on the weekend, and about her passion for Egyptian archaeology. The family began a home schooling program and Carrie's mother took on responsibility for helping her daughter with her daily schoolwork. The therapist also learned, for the first time, that Carrie had been sexually abused by a friend's father.

After three months, and many intense family meetings, Carrie argued less, had stopped cutting herself and had decided to go back to school. At one point, after Carrie broke up with her boyfriend, the therapist worried that the scratching might go deeper and enlisted Carrie's family and friends in a 24-hour support network. They scheduled “check-in” points throughout the day, and Carrie and her family weathered the crisis. After six months of gradually less frequent visits with her therapist, Carrie experienced fewer periods of depression and returned to school.

In short, Carrie was finally helped by good old-fashioned therapy—the kind that entails listening to clients, meeting them in their own worlds and on their own terms, and supporting them as they construct a life based on renewed confidence in their own capacities. But how would one translate this kind of treatment into medical terms? A health care system organized by traditional diagnostic thinking that addressed Carrie's symptoms had trouble grasping the larger context of her life.

Clearly, the initial involvement of a therapist in this case was no guarantee of the engagement of Carrie and her family that proved to be pivotal in the work with her. But it would be a mistake to simply write off the treatment Carrie initially received as simply bad therapy. In fact, it may closely resemble the kind of experience patients will receive within many integrated care systems. Why? Because this initial

approach is far more consistent with the traditional medical-model thinking that permeates our health care system at all levels—match the right clinical method with the correct diagnosis. And, in what is perhaps the most disturbing development that may determine the nature of “integrated” care in the future, the major professional associations have begun to position themselves as champions and adjudicators of a distinct set of “approved” interventions for targeted diagnostic groups that, in fact, ignore much of what we have learned makes therapy work in the first place. It is this fundamental misconception within the discipline itself about what constitutes effective psychotherapy that poses the gravest danger for our field.

### **The Myth of Empirically Supported Practice**

In spite of the call to provide a bridge between therapeutic methods and scientific findings, the growing ascendancy of evidence-based practice may also be understood as the product of increasing competition among mental health professions. Since the 1980s the number of mental health practitioners has jumped by some 275 percent. Consumers can currently choose among psychiatrists, psychologists, social workers, counselors, marriage and family therapists, psychiatric nurses, pastoral counselors, addiction counselors, and many others advertising their services under a variety of job titles and descriptions. In response, the various professional groups have felt an urgent need to document the scientific efficacy of their preferred approaches. In the early 1990s, members of American Psychiatric Association (APA) decided that they should take the lead in determining the best treatments for the various diagnostic subgroups. So in 1993, the APA established the Steering Committee for Practice Guidelines to prepare guidelines designating specific treatments for specific disorders.

Beginning in 1993 with guidelines for Major Depression and Eating Disorders, the committee has produced guidelines for 10 disorders ranging from Bipolar Disorder to Alzheimer’s disease to Nicotine Dependence. Practice guidelines cover everything from treatment planning to psychiatric management and treatment selection for each of the disorders. Most recent guidelines, issued since 1997, also include “practice parameters,” ranging from “standards” (should be followed with few exceptions), to “guidelines” (exceptions are not rare but require justification) to, finally, “options” (where there is no preference between choices). Yet, despite the committee’s claim to strong empirical support for its recommendations and reliance on overwhelming clinical consensus, these guidelines have been criticized for treating open therapeutic questions about treatment effectiveness as though they have been definitively settled. For example, the guidelines for the treatment of depression are heavily skewed towards pharmacological intervention, despite the questionable evidence of the efficacy of drug therapy and the fact that studies show that psychotherapy with depressed people provides at least as much—and perhaps longer-lasting—symptom relief. However, the APA’s imprimatur has given an aura of scientific legitimacy to what was primarily an agreement among psychiatrists about their preferred practices, with an emphasis on biological treatment.

A group of researcher at the other APA, the American Psychological Association, was quick to follow psychiatry’s lead, arguing that clients have a right to proven treatments. In 1993, a special task force, acting under the auspices of the APA’s Division of Clinical Psychology derided psychiatry’s approved treatment list as medically biased and unrepresentative of the clinical literature and set forth its conclusions about what constituted scientifically valid psychological treatments. Instead of clinical consensus and comprehensive guidelines, the task force concentrated its efforts on research demonstrations that a particular treatment has proven to be beneficial for clients in well-controlled studies. To be considered well established, a treatment must have demonstrated that its benefits exceed those of an alternative treatment or a placebo condition that controls for attention and expectancy. Additionally, this efficacy must be demonstrated by at least two independent research teams.

Since then, the task force has cited 71 empirically supported approaches for an ever-expanding list of disorders. Perhaps believing more is better, the list not only covers conditions like depression and anxiety,

but also addresses marital discord, health problems, and sexual dysfunction, to mention a few. While the psychiatry association's guidelines focus on a thorough delineation of psychiatric treatment for a few disorders, relying extensively on clinical consensus among experts, the APA task forces' list emphasizes specific treatment with replicated empirical support.

There is a certain seductive appeal to the idea of having a specific psychological intervention for any given type of problem—the psychological equivalent of a pill for emotional distress. But, in fact, a closer look at the research literature on therapy clearly reveals that the whole idea of empirically supported treatments (ESTs) is critically flawed, especially as any kind of mandate for what should be done in therapy.

To start with, the criteria for the clinical procedures used to validate a treatment contain a fatal bias. Standard research design requires that the treatments being assessed not contain the inevitable improvisations of therapy as practiced in the real world. Instead, the approaches studied are all required to follow a script so that the “variable” presumably being examined—a precisely defined and structured form to treatment—can be strictly controlled.

But while certain kinds of therapy can be scripted—cognitive-behavioral therapy (CBT) being the most prominent—most cannot. So it should come as no surprise that CBT and other behavioral approaches dominate the list of treatments that have received the imprimatur of the task force, amounting to about 80 percent of the list. Is this because these treatments are more effective? No, it is really because they are the easiest to duplicate and, therefore, have been the ones chosen to be researched. This privilege does not extend to some 250 other approaches around today.

Besides the issue of what determines whether a treatment is chosen for study in the first place, questions have also been raised about whether the specific methods associated with an EST really constitute its “active ingredient.”

One of the most provocative of the studies that raise doubts about this assumption was conducted by Louis Castonguay and Marvin Goldfried, prominent cognitive-behaviorally oriented researchers who set out to compare the effects of the therapeutic alliance with the effectiveness of a highly structured cognitive approach with depression. Surprising for many who carry the banner for ESTs, their study concluded that the more emphasis a therapist placed on cognitive behavioral techniques, the worse the treatment outcomes for clients. In their study of 30 depressed clients, Castonguay and Goldfried compared the impact of a treatment technique specific to cognitive therapy—the focus on correcting distorted cognitions—with two other, presumably, non-specific, treatment variables: the therapeutic alliance (agreement between therapist and client on treatment goals and methods) and the client's emotional involvement with the therapist. Results revealed that while the two so-called common variables were highly related to therapeutic progress, the technique unique to cognitive-behavioral therapy—eliminating negative emotions by changing distorted cognitions—was negatively related to successful outcome!

Although the APA task force's intention in proposing ESTs was to demonstrate that psychiatrists have not cornered the market on empirically verifiable treatments, in effect, it has responded to the myth of the magic pill by propagating the myth of the magic method. In fact, the uncomfortable truth for advocates of these verified treatments is that there is no solid evidence demonstrating that specific treatment models have unique effects, or that any single therapeutic approach is superior to another. Of course, there have been studies that purport to show that a particular therapy is especially effective. CBT is an example of this. But studies have yet to show consistent differences in effectiveness among therapies developed to address a particular problem despite the Herculean efforts of legions of researchers to do just that.

The results of any attempt to rate the effectiveness of clinical methods—as opposed to the individual effectiveness of practitioners—is best summed up by the dodo bird in *Alice’s Adventures in Wonderland*. “Everybody has won and all must have prizes.” In 1936, Saul Rosenzweig invoked the dodo’s words to describe the equivalent success of diverse psychotherapies. It has since been called the “dodo bird verdict” and has proven to be one of the most replicated findings in the psychotherapy literature—no approach can reliably make a greater claim to effectiveness than any other.

Perhaps the best publicized study to confirm this idea that all techniques are created equal is the landmark 1989 Treatment of Depression Collaborative Research Project, widely viewed as the most ambitious and methodologically sophisticated outcome study ever undertaken. This NIMH-funded project, which involved both psychiatrists and psychologists at multiple sites around the country, randomly assigned 250 depressed participants to four different treatments: Aaron Beck’s cognitive therapy—an approach that seeks to reduce depressive symptoms by challenging irrational and distorted attitudes; Gerald Klerman and Myrna Weissman’s interpersonal therapy—which focuses on developing more effective strategies for dealing with “here and now” interpersonal problems; treatment with antidepressant medication; and, finally, a placebo approach called “clinical management,” which included a pill placebo plus support and encouragement. After all the effort that went into designing a study that represented the state-of-the-art in outcome research, the investigators were stunned by their own findings. Overall, the four treatments—including placebo—worked with about the same effectiveness.

Recent advancements in statistical methodology, particularly metanalytic studies, which allow researchers to comb through the vast clinical literature and draw conclusions from huge collections of data, lend even further credence to the dodo bird verdict. In psychotherapy researcher Bruce Wampold’s comprehensive 1996 review of the therapy-outcome literature, some 277 studies conducted from 1970 to 1995 were analyzed—with particular attention given to the presumably more methodologically sophisticated research of recent years—to determine which therapeutic models have yielded the most robust results. This comprehensive review once again verified that no approach has reliably demonstrated superiority over any other. “Why,” Wampold asks, “[do] researchers persist in attempts to find treatment differences, when they know that these effects are small?”

### **The Client as Partner**

So, if empirically supported treatments aren’t what makes psychotherapy beneficial to clients, what is? Even though Rosenzweig addressed this question 65 years ago, his conclusion still applies today. Writing in the *American Journal of Orthopsychiatry*, he argued that all approaches appear to be equally effective, so there must be some larger common factors in operation that overshadow any presumed differences between techniques. What are these factors? The answer isn’t really a mystery. The real key to the success or failure of therapy, as Rosenzweig and many other therapists over the years have argued, is the resources a client brings into the room.

Why should it be a surprise that the very factors that were operating in a client’s life before counseling also have a crucial effect on therapy? Clients who are, for example, persistent, open and optimistic, who, for that matter, have a supportive grandmother or are members of a religious community are more likely to make gains in therapy.

What else is important to therapeutic success? Researchers Alexandra Batchelor and Adam Horvath argue in their comprehensive 1999 review article that the client’s perception of the therapeutic connection is the second most important ingredient of successful therapy, accounting for 30 percent of the outcome. In other words, therapy is much less about method than about the quality of the bond established between therapist and client. To many clinicians, this may seem obvious, but partisans of models and manuals too

easily ignore this basic truth: The nature of a client's relationship with a therapist is more important than our cherished theoretical schools, our favorite techniques, or our most worshipped gurus.

As we approach a far-reaching transformation in the way mental health services are delivered, it is more important than ever that we recognize that the very foundation of our work is the tailoring of our approaches to the unique needs and circumstances of each client. When you try to do therapy by a book, research tells us that things may not go according to plan. For example, researcher Hans Strupp's classic studies, collectively known as the Vanderbilt II Psychotherapy Training Project, conducted in the early 1990s, demonstrated the dangers of overprogramming therapy. Strupp compared the works of therapists before and after they were trained with a manual on psychodynamic therapy. The results: Those who followed the manual were less approving and supportive of their clients, less optimistic and more authoritarian and defensive. Before health care systems organize themselves according to recommendations of the APAs about what constitutes effective treatment, we need to heed such findings, as well as the previously mentioned study by Castonguay and Goldfried—practitioners of standardized therapy are in danger of developing better relationships with their treatment manuals than with their clients.

Nevertheless, within the medical world, the concept of empirically supported standardized treatments has tremendous appeal. Today, we may stand on the brink of a misguided system of "integrated care" in which manualized therapy will reduce clinicians to mere technicians. And, to make matters worse, integrated data bases will make it easier than ever for managed care organizations to keep track of whether our clients are adhering to the standardized regimens prescribed for them. Lists of approved treatments will give health care bureaucrats a potent weapon to use against those of us who don't order off the menu. This could even leave us in the ethically dubious position of enforcing compliance with treatments we don't endorse, and reporting our clients' lapses to the HMOs.

When our services are provided without a partnership with those receiving them, the client can easily become a cardboard cutout. Moreover, as the trend toward evidence-based practice picks up steam, therapists and clients uncomfortable with this market-driven standardization will find themselves under enormous pressure to conform. So before carved-in care becomes the only game in town, those of us who envision a different future of psychotherapy must step forward to make the case for therapeutic multiplicity.

No matter how invested we are in our own particular clinical methods, we first need to acknowledge that there are many ways to respect our clients' values and perceptions, many ways to be effective, and many ways to maintain our clinical integrity. This isn't as easy as it sounds. We have all worked hard to establish our own distinct identity as therapists. We have invested heavily in our own methods. But if we do not unite behind methodological pluralism, we will be easy targets for medical-model ideologues, the proponents of empirically supported treatment, and the bean counters of the HMOs.

Clinicians today must take stock of both the values that underlie our practices and our responsibility for professional accountability. Each of us must do his own soul searching about these issues. So what follows is not meant as a blueprint for how therapy should be practiced, just my own conclusions (along with my colleagues Scott Miller and Jacqueline Sparks) about how to extend to clients the same therapeutic freedom we must defend for ourselves and some alternative ideas about what the empirical literature can teach us regarding accountable practice.

Not long ago, I worked with Erica, a woman in her mid thirties who came into therapy searching for an identity that she believed that she had lost. All her life, Erica had wanted to be a police officer. As a

teenager, she rode with state troopers, and as a young woman, she became the first female to graduate from the police academy.

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

How might a medical system of care address Erica's concerns? Although her quest for a new identity does not neatly fit into DSM categories or empirically supported treatments, there is a good possibility that Erica would be reduced to a collection of symptoms and interventions. She might well be diagnosed as depressed and prescribed cognitive-behavioral therapy and an SSRI, along with additional skills training for deficits left by her brain injury. In the process, the fullness of Erica as a person could easily be lost and she could be reduced to a description of "illness."

My first contact with Erica, as with all my clients, was founded not in just giving lip service to being respectful of clients and collaborative with them, but in using the set of empirically supported findings that I have found most useful in making my therapy as effective as possible. In all the research literature, perhaps the most clinically relevant finding I've discovered is that client's improvement early in treatment is one of the best predictors of successful outcome. So, instead of regarding the first few therapy sessions as a "warm up" period or a chance to try out the latest brief therapy technique, I believe it is crucial to be accountable in the very first contact with clients. And given all we know about the importance of the therapeutic alliance, I approach such initial sessions as a chance to discover how to make the best possible match between myself and my prospective client. Our burgeoning alliance is monitored by clients' session-by-session evaluations of their satisfaction with and progress in treatment. In other words, the guiding principle behind my work with clients is recognizing that all my decisions as a therapist must be guided by my clients' engagement in the treatment process, their view of the quality of the therapeutic relationship, their expectation for change, and—the gold standard—their assessment of whether change occurs.

When Erica first called our clinic, she was given the opportunity to structure her therapy, including a choice about whether to meet with an individual therapist or a team. She chose to see me individually, and I first met with her outside the consultation room and told her that I wanted her perceptions to be the light that guided us through the coming process. At my request, she filled out a brief form about how she felt she was progressing individually and socially. Only then did we walk to the consultation room.

She then explained that she felt at a dead end in her life. Having recovered enough to go back to work of some kind, she could not even imagine a back-up dream now that her career in police work seemed over. To complicate matters, Erica was also wrestling with the idea of being "disabled," a word she despised.

She recognized that she had some limitations and could not perform the strenuous duties she had once dispatched with ease. Still, the word stuck in her craw. As we explored her experience on the path to recovery, I found myself amazed by her courage, resilience and wisdom. Here was a woman who had it all and lost it—who defied others' expectations of what she could and could not do many times—early on, when she became the first female police officer, later, when she unexpectedly came out of a coma, and now, once again. Despite her problems with seizures, vision, and balance, she was fighting the expectations of her "disabled" label. She knew there was much more to her than any description of her disability could begin to capture. I knew it, too, as would anyone who spent any time getting to know her. I told Erica that one of the things I liked most about her was her refusal to accept her disability.

A few minutes before the end of our meeting, I asked Erica to fill out another short form, evaluating the progress of therapy to that point. Here, the key clinical information for me was that she felt that I took her problems and ideas seriously, and that she felt hopeful about her situation. Reflecting on how impressed I had been by her, I jokingly asked her if she had ever thought about pursuing a career as a motivational speaker. It was an offhand tribute to the power of her story, but, as I learned later, it struck a deep chord. As we discussed our meeting, Erica told me that she enjoyed the process we had begun—she liked telling her life story and fielding questions about her experiences. Just as the conversation was about to end, she declared that it had occurred to her that she might pursue a career teaching police officers.

That pronouncement was a key step in Erica’s journey toward reclaiming her life. She did not end up as a training officer, but was able to reestablish her relationship with the work she loved by becoming a dispatcher. This satisfied Erica’s itch for reconnecting with police work, which, for her, was a key to a meaningful life. It allowed her to move on and to address other issues, such as her loneliness and her current living arrangements. Erica reported improvement on the outcome measure, and therapy ended a few sessions later.

I don’t mention my experience with Erica as an example of a one session therapeutic miracle, just the reverse. In fact, it is the ordinariness of this kind of interaction that addresses the core of what we have to offer as therapists—the forming of partnerships with clients that makes therapy effective and accountable. I offered Erica no irresistibly powerful interventions, just a relationship structured around her goals and values, that showcased her talents and fortitude. And my repeated requests of Erica to tell me whether the therapy was serving her needs involved a kind of accountability that is very different from the accountability that HMOs increasingly demand from therapists, and that we may expect even more of under integrated care. It stands in sharp contrast to a decision making process predicated on psychiatric diagnoses, “approved” therapeutic modalities, or treatment plans.

As is true of most therapeutic interventions, standardized treatments can be helpful with many clients. But we need a health care system that recognizes that many clients are unlikely to be helped by a medical model of treatment.

And that means that if the emerging system of integrated care adopts evidence-based practice as its standard, they may not be helped at all. It is our responsibility as therapists to lift our voices and to advocate on behalf of our clients and our profession. We must make sure that the integrated care system is truly integrated and that it draws from the best of the vast range of approaches that therapists currently tailor to their clients’ needs, not the limited number of techniques that are most easily studied. As we are about to enter the next stage of evolution of our health care system, we need to draw from the accumulated wisdom in our field that teaches us that not all of our clients’ struggles fit within diagnostic categories and that therapy can never be reduced to a set of prescribed interventions, no matter how “empirically” supported they may seem to be.