Beyond Critique: The Partners for Change Outcome Management System as an Alternative Paradigm to Psychiatric Diagnosis

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Abstract

Critics claim that current psychiatric diagnostic systems lack reliability, validity, and clinical utility; are incompatible with known evidence of how change occurs in psychotherapy; are compromised by bias; and risk harmful effects for clients. This article argues that the Partners for Change Outcome Management System (PCOMS), a transparent, egalitarian process that collects and utilizes client feedback at each session, convincingly addresses these concerns. Furthermore, it suggests that PCOMS offers a viable alternative to the reimbursement and administrative functions of the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Classification of Diseases*. The authors propose that PCOMS represents a radical realignment of the practitioner/client relationship via full, dialogical partnership at every level of psychotherapy practice and thus constitutes a step toward a new paradigm that reconnects psychotherapy and humanistic psychology with its core relational values.

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Keywords

For decades, concerned scientists and clinicians have called for a re-evaluation of the preeminent role of psychiatric diagnosis in psychotherapy. Protests continue, notably the Society for Humanistic Psychology's Global Summit on Diagnostic Alternatives, a multidisciplinary group of researchers and practitioners using an Internet-based platform for furthering critique and proposing change (http://dxsummit.org/). Critique alone, however, has done little to displace psychiatric diagnosis as the centerpiece of mental health practice. The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association [APA], 2013) and the *International Classification of Diseases* (*ICD*; World Health Organization, 1992) live on, more prominent and pervasive with each passing year.

Moreover, most if not all proposed diagnostic alternatives represent *first order change* or "one that occurs within a given system which itself remains unchanged" (Watzlawick, Weakland, & Fisch, 1974, p. 10), and therefore fail to address the fundamental problems of diagnosis. In essence, most proposed replacements offer professionally devised, expert-driven formulations, albeit often more benign, of client problems as alternatives to the existing professionally devised, expert-driven formations of client pathological states. Instead, this article proposes *second order change*, a reformation of the foundational principles of a psychotherapy influenced by psychiatric diagnosis. Specifically, we maintain that systematic client feedback represents a profound transformation of psychotherapy and constitutes a viable alternative to psychiatric diagnosis (Duncan, 2014). Feedback, here, refers to the continuous monitoring of client perceptions of progress throughout therapy and a real-time comparison with an expected treatment response to gauge client progress and signal when change is not occurring as predicted. With this alert, clinicians and clients have an opportunity to shift focus, revisit goals, or alter interventions before deterioration or dropout.

Several feedback systems have emerged (Castonguay, Barkham, Lutz, & McAleavey, 2013), but only one has randomized clinical trial support, is included in the Substance Abuse and Mental Health Administration's National Registry of Evidence-based Programs and Practices, and has positioned itself as an alternative to psychiatric diagnosis: the Partners for Change Outcome Management System (PCOMS; Duncan, 2014; Duncan & Reese, 2015). Derived from everyday clinical practice and specifically designed to

privilege the client, PCOMS employs two 4-item scales, one focusing on outcome (the Outcome Rating Scale; Miller, Duncan, Brown, Sparks, & Claud, 2003) and the other assessing the therapeutic alliance (the Session Rating Scale; Duncan et al., 2003). PCOMS directly involves clinicians and clients in a continuous process of measuring and discussing both progress and the alliance, the first system to do so. PCOMS is used in mental health and substance abuse programs across the United States, Canada, and in more than 20 other countries, with more than 1.5 million administrations in its database.

Germane to replacing diagnosis, unlike most outcome instruments, the PCOMS measure (the Outcome Rating Scale) is not a list of symptoms or problems checked by clients on a Likert-type scale. Rather, it is individualized with each client to represent his or her unique experience of life and reasons for service. Clients report their distress/well-being on four domains (personal, family, social, overall), and the clinical conversation evolves this general framework into a specific representation of the reason(s) for service. No intermediary label, therefore, is required to categorize client experience. Additionally, PCOMS, by design, is transparent and collaborative, involving clients in all decisions that affect their care (Duncan & Sparks, 2002). PCOMS moves the focus of clinical practice away from diagnosis-based, manualized treatments and toward a more relational, individualized therapeutic process.

To envision a future of psychotherapy no longer dominated by the *DSM* or any system that catalogues human challenges via pathological states, traits, presumed psychological dimensions, or experiences of trauma, we first briefly summarize critiques of psychiatric diagnosis. Next, we describe PCOMS (Duncan, 2012; Duncan & Reese, 2015), including its clinical application and collaborative, egalitarian process. Finally, we discuss how integrating PCOMS into everyday clinical practice addresses the most cogent critiques of psychiatric diagnosis, bringing psychotherapy in line with scientifically defensible and socially just practice and realigning both psychotherapy and humanistic psychology with its core relational values.

The Critique

The judges of normality are present everywhere. (Michel Foucault)

Scientific and ethical critiques of psychiatric categorization have a long history. A principal theme asserts that the *DSM* lacks reliability, validity, and clinical utility. The ability of clinicians to agree on a diagnosis for a given client based on independent evaluations (i.e., reliability) has been a target of

critics for decades (e.g., Kirk & Kutchins, 1992). While authors of the *DSM-5* claim that the "DSM is the cornerstone of substantial progress in reliability" (APA, 2013, p. 5), others have pointed out that the *DSM-5* field trials' reliability estimates are based on relaxed norms for kappa coefficients and, for all practical purposes, have not improved since those observed in 1974 (Frances, 2012; Vanheule et al., 2014). Critics have also long established that *DSM* diagnoses contain significant overlap with one another, are often indistinguishable from everyday human behavior, do not identify discreet conditions, and thus fail the crucial test of validity, that is, the ability to represent and delineate conditions that actually exist in the natural world (e.g., Caplan, 1995; Kendell &Jablensky, 2003; Kirk & Kutchins, 1992; Timimi, 2014). A 2002 *DSM* white paper (Kupfer, First, & Regier, 2002), for example, states that "the goal of validating these syndromes and discovering common etiologies has remained elusive . . . not one laboratory marker has been found to be specific in identifying any of the DSM-defined syndromes" (p. xviii).

Without the ability to reliably identify syndromes of established validity, the *DSM*'s clinical utility falls decidedly flat as a tool for understanding client dilemmas or choosing an approach (Duncan, 2014). Selecting a treatment based on diagnosis is moot anyway, given that the preponderance of evidence demonstrates that no one approach is reliably superior to another (Duncan, Miller, Wampold, & Hubble, 2010; Wampold & Imel, 2015). Moreover, studies repeatedly demonstrate that diagnoses neither predict outcome nor length of stay. For example, a large benchmarking study of more than 5,000 clients diagnosed with a full range of "disorders" who received services in a public behavioral health setting found no differential outcome or length of stay by diagnostic category (Reese, Duncan, Bohanske, Owen, & Minami, 2014).

A second theme of critiques of current diagnostic systems points to robust data underscoring the empirical chasm between *medical* and *relational* models in psychotherapy (e.g., Duncan, 2014; Elkins, 2015; Wampold & Imel, 2015). While the medical model, simplified to diagnosis plus prescriptive treatment equals cure or symptom amelioration, is a valid approach to physical problems, its assumptions do not hold up in psychotherapy. Decades of comparative trials and meta-analyses have found that specific treatments are minimally related to psychotherapy outcome compared with other factors, especially client, therapist, and relationship effects, common to all legitimate approaches (Duncan et al., 2010). Thus, a medical view of therapy is empirically vacuous because diagnosis yields little that is helpful and model/technique accounts for so little of outcome variance, while the client and the therapist—and their relationship—account for so much more. Clinically, it reduces clients to diagnoses and therapists to treatment technologies while failing to acknowledge the importance of relationship or the idiosyncrasies of

the human condition (Duncan & Reese, 2015). Instead, the extensive common factors literature makes abundantly clear that psychotherapy, in fact, is a relational, not medical endeavor (Duncan, 2014), one that is wholly dependent on the participants and the quality of their interpersonal connection. In other words, diagnostic templates and the accompanying matching treatments do not tap the evidence for factors most strongly associated with outcome.

A third critical theme claims that the *DSM* is a socially constructed text, suffused with and sustaining social norms (e.g., Caplan & Cosgrove, 2004; Gergen, 1990; Hare-Mustin & Marecek, 1997; Timimi, 2014). For example, Kirk and Kutchins (1992) point out that psychiatric classification reflects consensus among invested parties, not real entities. Thus, "normal" for White, privileged males becomes the fulcrum to which the subjects of diagnosis either conform or deviate. An assumed validity masks the *DSM*'s social origins and justifies not only classification but judging, monitoring, and regulating those diagnosed, deterring scrutiny and opposition (Foucault, 1963/1973; Goffman, 1961; Scheff, 1966).

Particular interests of professional guilds and pharmaceutical industries capitalize on the *DSM*'s presumed objectivity (Caplan, 1995). The APA, for example, relies on the cash windfall from *DSM* sales, a conflict of interest, according to critics, that compromises the integrity of the project. To illustrate, Allen Frances, former chair of the *DSM-IV* (APA, 1994) taskforce, accused the APA of curtailing adequate *DSM-5* field trials to speed the manual's publication (Frances, 2012). Others have pointed to drug company screening tools and "manufactured diseases" that expand markets for their products (e.g., Kutchins & Kirk, 1997; Whitaker, 2010). Findings that 61% of *DSM-5* Task-Force members report affiliations with drug companies (Cosgrove et al., 2014) justify such concerns. The stakes are high for aligning psychiatry and the *DSM*, and psychiatric diagnosis provides the vital link.

Finally, the effects on the recipients of diagnosis have rightfully been at the heart of many critiques. For example, it has been noted that diagnoses rarely represent clients' presenting complaints (Duncan, Solovey, & Rusk, 1992); instead of meeting clients where they are, diagnoses force clients to meet clinicians where they are, potentially compromising client motivations and interfering with the alliance. Additionally, despite calls to de-stigmatize "mental illness," critics have pointed out that diagnoses have real world consequences such as denied entry into schools, employment, or political positions (Kutchins & Kirk, 1997) and adverse influences in child-custody and health-insurance decisions (Caplan & Cosgrove, 2004). Diagnoses can further single out persons at the margins of society (e.g., Breggin, 1991; Samson, 1995). On interpersonal levels, friends and family of those diagnosed may defer, protect,

patronize, or distance from someone designated as sick, reinforcing an illness identity (Kleinman, 1988); thus, diagnosed persons and their helpers are less likely to examine and protest societal causes of distress and the labeling process itself (Foucault, 1982). Finally, as gateways to prescription, diagnoses open the floodgates to psychiatric drugs, many of which entail significant adverse effects, especially for youth and older adults (Moncrieff, 2007).

Despite these longstanding, convincing critiques, psychiatric diagnosis is central to psychotherapy—from initial assessment to treatment planning and supervisory oversight to billing. It remains a fixed part of graduate training, a prominent feature of evidence-based treatments, and a prerequisite for research funding and service reimbursement—all of which engenders an illusion of scientific aura and clinical utility that overreaches its flawed infrastructure. The inseparability of diagnosis and service delivery in most settings, including agencies, schools, community-based services, and hospitals means that millions of individuals have been diagnosed and more are added to the rosters each day. This presents an ongoing dilemma for clinicians, researchers, and academics whose motives stem from the desire to ground their work in the best available science and to be of help to those they serve. To function side by side with the *DSM*, many clinicians have learned to tell "the little white lie" when entering a diagnostic code. Even staunch critics advise on how to "play the system." For example, Caplan and Cosgrove (2004) recommend that clinicians

> select a label that seems to represent accurately as many of the patient's [*sic*] difficulties as possible . . . [and] be aware that diagnoses frequently have negative effects on patients' rights to child custody, employment, health insurance, or the right to make decisions about their lives. (p. xxix)

The game is to have it both ways, but in the end, clinicians must capitulate. This routine disingenuousness speaks to a fundamental incompatibility of the *DSM* system with psychotherapy and is contradictory to the authenticity required for a real therapeutic relationship.

The Partners for Change Outcome Management System

We are continually faced by great opportunities brilliantly disguised as insoluble problems. (Mark Twain)

A potential solution to the significant drawbacks of psychiatric classification may be found in systematic client feedback. PCOMS, in particular,

represents a departure from expert-driven formulations that attempt to classify client distress and problems of living. Instead, clients are empowered to "self-diagnose," refocusing psychotherapy toward individualized treatment selection and away from manualized options based on diagnosis.

PCOMS provides a methodology to partner with clients to identify those who are not responding and address the lack of progress in a proactive way that keeps clients engaged while new directions are collaboratively sought. It is a light-touch, checking-in process that usually takes about 5 minutes to administer, score, and integrate into the psychotherapy. Aside from the brevity of its measures—and therefore its feasibility for everyday use in the demanding schedules of clinicians, PCOMS is distinguished by its routine involvement of clients; client scores on the progress and alliance instruments are openly shared and discussed at each administration. Client views of progress serve as a basis for beginning conversations, and their assessments of the alliance mark an endpoint to the same. With this transparency, the measures provide a client-defined, mutually understood reference point for reasons for seeking service, progress, and engagement.

PCOMS[1] and the session start with the Outcome Rating Scale (ORS; Miller et al., 2003). The ORS (see Figure 1) is a visual analog scale consisting of four 10 cm lines, corresponding to four domains (individual, interpersonal, social, and overall). Clients place a mark (or mouse click or touch) on each line to represent their perception of their functioning in each domain. Therapists use a 10 cm ruler (or a web system) to sum the client's total score, with a maximum score of 40. Lower scores reflect more distress.

Clients most often mark the scale the lowest that they are there to talk about, bringing an understanding of the client's experience to the opening minutes of a session. Given that the ORS is individually tailored by design, the practitioner ensures that the ORS represents both the client's experience and the reasons for service. At the moment clients connect the marks on the ORS with the situations that prompt their seeking help, the ORS becomes a meaningful measure of progress and a potent clinical tool calibrated to their idiosyncratic circumstances—leading to the next question: "What do you think it will take to move your mark just one cm to the right; what needs to happen out there and in here?"

The Session Rating Scale (SRS; Duncan et al., 2003), also a four-item visual analog scale, covers the classic elements of the alliance (Bordin, 1979) and is given toward the end of a session. Similar to the ORS, each line on the SRS is 10 cm and can be scored manually or electronically. Use of the SRS encourages all client feedback, positive and negative, creating a safe space for clients to voice their honest opinions about their connection to their therapist and to psychotherapy. The SRS provides a structure to address the

Outcome Rating Scale (ORS)

Name _____ Age (Yrs):___   Gender: M / F / Other
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____   Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

|--|

Interpersonally
(Family, close relationships)

|--|

Socially
(Work, school, friendships)

|--|

Overall
(General sense of well-being)

|--|

The Heart and Soul of Change Project

https://heartandsoulofchange.com; www.pcoms.com

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Figure 1. The Outcome Rating Scale.
Note. For examination only. Download a free working copy at https://www.heartandsoulofchange.com/.

alliance, allows an opportunity to fix any problems, and demonstrates that the therapist does more than give lip service to forming good relationships.

After the first session, PCOMS simply asks: Are things better or not? ORS scores are used to engage the client in a discussion about progress, and more important, what should be done differently if there is not any. When ORS scores increase, a crucial step to empower the change is to help clients see any gains as a consequence of their own efforts. Reliable and clinically significant change provide helpful metrics to gauge noted gains. When clients

reach a plateau or what may be the maximum benefit they will derive from service, planning for continued recovery outside of therapy starts.

A more important discussion occurs when ORS scores are not increasing. The longer psychotherapy continues without measurable change, the greater the likelihood of dropout and/or poor outcome. PCOMS is intended to stimulate both interested parties to reflect on the implications of continuing a process that is yielding little or no benefit. Although addressed in each meeting in which it is apparent no change is occurring, later sessions gain increasing significance and warrant additional action—what we have called *checkpoint conversations* and *last chance discussions* (Duncan & Sparks, 2002).

Checkpoint conversations are conducted at the third to sixth session and last-chance discussions are initiated in the sixth to ninth meeting. The trajectories observed in outpatient settings suggest that most clients who benefit usually show it in 3 to 6 sessions (Duncan, 2014); and if change is not noted by then, then the client is at a risk for a negative outcome. The same goes for Sessions 6 to 9 except that the urgency is increased, hence the term "last chance." A more nuanced identification of clients at risk is accomplished by comparing the client's progress to the expected treatment response of clients with the same intake score. The progression of the conversation with clients who are not benefiting goes from talking about whether something different should be done to identifying what can be done differently, then to considering other options or approaches including transferring the client to a different provider. PCOMS spotlights the lack of change, making it impossible to ignore, and often ignites both therapist and client into action—to consider other options and evaluate whether another provider may offer a better match with client preferences, culture, and frame of reference.

PCOMS increases in value exponentially when it extends beyond the client-therapist dyad to proactively address those who are not responding at an organizational level. Successful implementation of PCOMS requires data collection and the timely dissemination of data to the supervisory process. The method of collecting PCOMS data can range from Excel to an electronic health records' existing data collection and analysis functions, to commercial web-based services. All enable therapists and supervisors to review first and most recent ORS scores and number of sessions to identify clients who are not benefitting. This process is intended to be the antidote for blaming clients or therapists. Not all clients benefit from services. No clinician serves all clients. If those facts are accepted, the more productive conversation of what needs to happen next to enable the consumer to benefit can occur. The percentage of clients who achieve reliable or clinically significant change or reach the expected treatment response provides an easily understood metric of effectiveness and a way to track therapist development and agency improvement over time.

Beyond Critique

No real social change has ever been brought about without a revolution . . . revolution is but thought carried into action. (Emma Goldman)

Those who have opposed the centrality of psychiatric diagnosis to mental health training, practice, and research primarily contend that the *DSM* and other similar systems lack reliability, validity, and clinical utility, are incompatible with known evidence of how change occurs in psychotherapy, are compromised by bias, and risk harmful effects for clients. The flaws of current diagnostic systems provide an opportunity to evaluate other alternatives. Any proposed candidate must convincingly counter these criticisms. In addition, a replacement must address the business of therapy, including a way for practitioners and administrators to monitor outcomes, to improve services both at individual and agency levels, and to justifiably anchor third party reimbursement.

Reliability, Validity, and Clinical Utility

Any system seeking to replace psychiatric diagnosis should have convincing psychometrics and empirically demonstrated clinical utility. Multiple validation studies of the PCOMS' outcome measure, the ORS (Bringhurst, Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Miller et al., 2003), as well as five efficacy studies (Anker, Duncan, & Sparks, 2009; Reese, Norsworthy, & Rowlands, 2009; Reese, Toland, Slone, & Norsworthy, 2010; Schuman, Slone, Reese, & Duncan, 2015; Slone, Reese, Mathews-Duvall, & Kodet, 2015), have found that it generates reliable scores. Coefficient alphas (internal consistency) have ranged from .87 to .91 in psychometric validation studies and from .82 (Reese et al., 2009; individual therapy) to .92 (Slone et al., 2015; group therapy) in clinical studies.

The ORS also generates valid scores as a measure of general distress. Three studies found evidence of concurrent validity for the ORS by comparing ORS scores to the OQ (Bringhurst et al., 2006; Campbell & Hemsley, 2009; Miller et al., 2003). Average bivariate correlations were .62 (range .53-.74; Gillaspy & Murphy, 2011). Two studies have also demonstrated that scores reflect real-world outcomes. Anker et al. (2009) found that couples with higher post treatment ORS scores were more likely to be together at 6-month follow-up. Schuman et al. (2015) found that active-duty soldiers who had higher post ORS scores received higher behavioral ratings from their commander.

The SRS also generates reliable and valid scores. Gillaspy and Murphy (2011) reported the average internal consistency of SRS scores across five

studies equaled .92 (range .88-.96). SRS scores also exhibit moderate concurrent validity with longer alliance measures; r = .48 with the Helping Alliance Questionnaire-II (Duncan et al., 2003), r = .63 with the Working Alliance Inventory (Campbell & Hemsley, 2009), and r = .65 with the Working Alliance Inventory–Short Revised (Reese et al., 2013). The predictive validity of SRS scores has been supported by two studies. Duncan et al. (2003) found a correlation of r = .29 between early SRS scores and outcome, which is consistent with previous alliance-outcome research (Horvath, Del Re, Flückiger, & Symonds, 2011). More recently, Anker et al. (2009) reported third session SRS scores predicted outcome beyond early symptom change (d = 0.25).

Regarding clinical utility, there are currently five randomized clinical trials conducted by the Heart and Soul of Change Project[2] that support the efficacy of PCOMS in individual (Reese et al., 2009), couple (Anker et al., 2009; Reese et al., 2010), and group therapy (Schuman et al., 2015; Slone et al., 2015), with overall effect sizes ranging from d = 0.28 (group therapy) to 0.54 (individual therapy). Clients in feedback conditions achieved more pre- post-treatment gains, higher percentages of reliable and clinically significant change, faster rates of change, and were less likely to drop out. An independent meta-analytic review (Lambert & Shimokawa, 2011) evaluated three PCOMS studies (n = 558) and reported clients in the feedback group had 3.5 times higher odds of experiencing reliable change and less than half the chance of deterioration than clients in the treatment as usual condition.

These findings suggest that systematic feedback could offer a more cost effective and practical alternative as a quality improvement strategy compared with the transporting of evidence-based treatments (Laska, Gurman, & Wampold, 2014). To evaluate this proposition, Reese et al. (2014) employed benchmarking (Minami, Serlin, Wampold, Kircher, & Brown, 2008) to investigate outcomes of 5,168 racially diverse, impoverished (all below the federal poverty level) adults who received therapy in a public behavioral health setting. The overall effect size (d = 1.34) for those diagnosed with a "depressive disorder" (N = 1,589) was comparable to treatment efficacy benchmarks from clinical trials of those diagnosed with major depression (d = 0.89). Effect sizes for the entire sample (d = 0.71) were also comparable to benchmarks derived from nine client feedback RCT studies (d = 0.56) that used the OQ System and PCOMS (Lambert & Shimokawa, 2011).

Clinical utility is also reflected in the ability to predict outcome. As noted, diagnosis neither predicts outcome nor length of stay (Reese et al., 2014). PCOMS incorporates two known predictors of ultimate treatment outcome, the client's subjective experience of early change (e.g., Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009; Howard, Moras, Brill, Martinovich, & Lutz,

1996) and the alliance (e.g., Horvath et al., 2011). In addition, given the mass data collection that everyday clinical use permits, trajectories based on client intake scores (level of distress) offer robust accounts of what can be expected in any given occurrence of psychotherapy (Duncan, 2014), providing information for transparent conversations with clients.

Medical and Relational Models, and the Common Factors

As noted, the medical model, specifically diagnoses and matched treatments, do not align well with what is known about change in psychotherapy, with the common factors (Duncan et al., 2010). PCOMS arose from everyday clinical practice seeking to privilege clients and their views of the therapeutic process. It provided a way to operationalize what Duncan and Moynihan (1994) called "client directed" clinical services. Applying the extensive empirical support for the common factors and especially the relationship/alliance, Duncan and Moynihan proposed a more intentional use of the client's frame of reference to maximize common factor effects and client collaboration, including devotion to client views of how therapy can address the reasons for service and what constitutes success.

Systematic feedback is a natural extension of this argument and more importantly, offers a way to make it happen—a structured process to honor the client's frame of reference while encouraging clinicians to routinely and transparently discuss outcome and the alliance. PCOMS arose from a desire to make manifest what mattered most in psychotherapy outcomes and a set of values about client privilege and egalitarian services. PCOMS directly applies the research about what really matters in therapeutic change (Duncan et al., 2010). Collaborative monitoring of outcome engages the most potent source of change—namely, clients (Bohart & Tallman, 2010), thereby heightening hope for improvement; it also tailors services to client preferences, maximizing the alliance and participation (Duncan, 2014). Thus, PCOMS is grounded in a relational model of therapeutic change.

Putting research tools in the hands of everyday clinicians via systematic data collection could usher out the medical model and open a new vista of understanding treatment from the consumer's perspective. Large-scale collection of outcome data could help reevaluate funding parameters and the medical model assumptions that support them. As more evidence shows the lack of relationship between diagnoses, evidence-based treatments, length of stay, and improvement, the real predictors of progress, like alliance, hope, and individually tailored services can finally inform and enhance psychotherapy.

Bias and the Harmful Effects of Labeling

Putting clients in the forefront of their own change process and honoring their preferences and goals, hallmarks of PCOMS, are powerful antidotes to diagnostic bias and to the harmful effects of labeling (Foucault, 1982; Kutchins & Kirk, 1997; Link & Phelan, 2014). First, use of client perspectives for clinical decisions supplants manual-derived assessments that can harbor class bias. When client views form the core of psychotherapy process, diagnosis based on subjective benchmarks is no longer part of the equation. Similarly, influence from either professional or corporate entities becomes moot.

Psychiatric diagnosis forms the connecting grid for the infrastructure of psychotherapy, including paperwork, policies, procedures, professional language, and payment. It is difficult to think of any other aspect that so thoroughly dictates how mental health professionals discuss, write about, and document clients' lives and concerns. The *DSM* and *ICD* funnel client stories through the confines of diagnostic descriptors, diminishing their human animation and connection to their source, the client. The content-free dimensions of the PCOMS measures allow for personal and idiosyncratic renderings, told without preconceived theoretical or symptom-based constraints. Thus, client accounts retain the richness of real life, including the unique back-stories that contextualize client dilemmas. Such methods center client views, not diagnostic manuals, and do not entail the untoward effects of psychiatric labeling.

Where diagnoses have been accused of imbedding identities of illness and deficiency, sapping confidence in personal resources, and fostering dependency, PCOMS implicitly and explicitly communicates to clients that their opinions not only are important, they also trump those of manuals and professional helpers. The conversations that are generated by client scores on the measures are openings for therapists to inquire about clients' reasons for service, views on precipitating and contextual factors, and impact of the problem in clients' lives and general directions for resolving it. These conversations alone revitalize clients' hope and belief in their capacity to effect meaningful change, energizing them to become activists rather than passive patients and bringing to bear potent client factors in the resolution of difficulties.

Diagnosing is an act of power, one in which a privileged professional dispenses an identity from a preselected list, all of which are negative. By declaring an individual ill, key aspects of that person's life, including discrimination, poverty, or abuse, become tangential to the label itself. In the PCOMS process, client and therapist both engage in a mutual struggle to identify and resolve client-defined concerns. Even though socially defined roles and the nature of the helping relationship grant greater authority to

therapists, PCOMS stretches the limits of these constraints by utilizing client feedback at every meeting, particularly attending to client goals and preferred methods.

Routinely requesting, documenting, and responding to client feedback transforms power relations by privileging client beliefs and goals over potentially culturally biased and insensitive practices. Valuing clients as credible sources of their own experiences of progress and relationship allows consumers to teach us how we can be the most effective with them and reverse the hierarchy of expert delivered services. PCOMS provides a ready-made structure for collaboration with consumers and promotes a more egalitarian psychotherapeutic process. It ensures therapy's match with a client's preferred future via monitoring progress on the ORS. And it provides a way to calibrate therapy to a client's goals and preferred way of achieving goals via monitoring the alliance with the SRS. Thus, PCOMS promotes the values of social justice by privileging consumer voice over manuals and theories enabling idiosyncratic and culturally responsive practice with diverse clientele.

Outside the therapy dyad, client-generated data help overcome inequities built into everyday service delivery by redefining whose voice counts. Without such data, client views do not stand a chance to be part of the real record—that is, critical information that guides decisions or evaluates eventual outcomes at larger programmatic or organizational levels. Client-generated data, as concrete representations of client perspectives, offer a direct way to describe benefit at both clinician and agency levels and keep client voice primary to how services are delivered and funded.

The Business of Psychotherapy

PCOMS offers a coherent response to major concerns regarding psychiatric diagnosis. While a strong case can be made for replacing an empirically and ethically compromised system with a more humanistic and scientific one, jettisoning the *DSM* or the *ICD* would leave a vacuum in how psychotherapy practice operates administratively. No replacement can be taken seriously without consideration of certain practical aspects of psychotherapy services. PCOMS rises to this challenge, offering a framework for service accountability and reimbursement that stands to improve any diagnostic system. First, session summaries and treatment plans under PCOMS would take the form of client accounts, descriptions, perceptions, and goals, in clients' languages. These would be elicited from systematically checking in with clients via the ORS and SRS. Second, the numbers clients enter on the ORS and SRS reflecting their views of progress and the alliance, typically electronically graphed and analyzed, offer hard data.
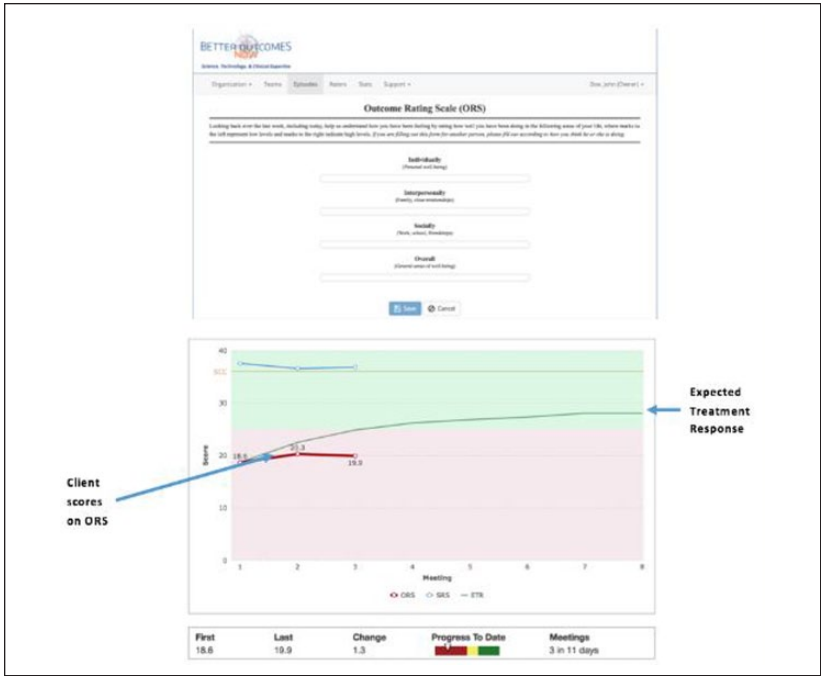
Figure 2. The web-based Outcome Rating Scale (ORS) (top) and graph with ORS scores and expected treatment response (ETR) (bottom).
Note. Progress meter shows client to be less than 50% of ETR, suggesting a conversation about changing therapeutic directions (https://www.betteroutcomesnow.com/#/).

Hundreds of thousands of administrations of the instruments translate client perceptions into expected response trajectories, status of treatment, and off-track warnings (see Figure 2); these allow data-informed decisions about staying or revising a therapy course and provide administrators and payors with valid information about individual cases and program/agency efficacy. No diagnostic system comes close to delivering this degree of administrative utility.

PCOMS provides an empirical basis for discussion in the therapy room, supervision hour, and client staffings. Given that ORS and SRS scores are client-generated, they represent a shift in whose voice counts, extending the client's influence beyond the confines of the therapy hour into all levels of service delivery. Importantly, practitioners no longer need to "hold their noses" while they enter a diagnostic code or feel compelled to use the language and treatment protocols required by those who pay the bill.

Use of PCOMS for funding decisions is the final hurdle in envisioning it as a viable replacement, and in fact this is already occurring in both public and private arenas (Duncan, 2014). Although it might be tempting to *pay for performance*, this practice constitutes a significant departure from PCOMS' underlying intentions and values. For example, rewarding ORS scores improving along an expected response trajectory and withholding reimbursement when responses fall outside statistical norms creates oppressive conditions for client and therapist alike. In addition, forcing termination of services based on ORS scores sabotages a collaborative decision-making process designed to be informed by ORS scores, not dictated by them. These scenarios undermine PCOMS' primary value of honoring client preferences and disregard unique variations in clients' challenges and the contingencies of diverse practice settings.

The more frequent suggestion regarding pay for performance is rewarding those clinicians who achieve the best results or meet arbitrarily set outcome benchmarks with increased pay, referrals, or inclusion on provider panels. Such practices distort PCOMS' primary intention of improving the quality of provided services, alienate therapists from considering outcome management, and likely foster cheating. No licenses for PCOMS are issued if pay for performance is the intended purpose. Instead, Duncan (2014) recommends *pay for participation*. This initiative rewards providers who use their data to identify nonresponding clients and participate in a proactive process to recapture those consumers and improve outcomes. This too is already happening.

Over a dozen randomized clinical trials now support improvements in overall efficacy for clinicians using feedback systems. The evidence is so compelling that the American Psychological Association Task Force on Evidence-based Practice has called for all clinicians to routinely collect and utilize client feedback (Ackerman et al., 2001; American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). Pay for participation, then, simply rewards a practice already deemed critical for good therapy. Importantly, neither clinicians nor clients are penalized for the spectrum of variations likely to occur in any clinical endeavor or setting. Instead, clinicians are allowed the freedom to integrate the "best available research with clinical expertise in the context of patient [*sic*] characteristics, culture, and preferences," the American Psychological Association's definition of evidence-based practice; in other words, therapists use their best judgment while partnering fully with clients (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 273).

We are not suggesting that PCOMS can single-handedly replace the *DSM* or create more humane and effective services. Moving from an expert-controlled to a collaborative model of practice involves an ongoing struggle. For

example, practitioners and clients can come to view the instruments as tick boxes, devoid of clinical relevance. Using the ORS and SRS exposes clinicians to conversations that may challenge tightly held beliefs, provoking anxiety and avoidance. In addition, services can implement PCOMS in a mechanical manner without affecting the therapeutic culture and histories of oppression that revolve around diagnosis. PCOMS does not offer a panacea. However, proper application of PCOMS has been demonstrated to be an important piece of an initiative to replace diagnosis with more client-directed, just, and evidence-informed practices.

Imagine

You may say that I am a dreamer, but I'm not the only one. (John Lennon)

Ethical considerations and empirical evidence suggest that psychiatric diagnostic systems like the *ICD* and *DSM* should no longer be used for research, clinical practice, or reimbursement. PCOMS provides an alternative. It incorporates the overall evidence on what influences outcomes and has an existing evidence base demonstrating its effectiveness in both research and real-world settings. PCOMS is not only an evidence-based approach; it also has an ethical stance that challenges the potential of diagnostic systems to disempower consumers and overlook cultural diversity. By all accounts, the scientific validity underpinning PCOMS is superior to the empirical pitfalls of psychiatric diagnosis.

Moving to a PCOMS-driven psychotherapy represents a step toward a new paradigm. It shifts the conversation from a discourse dominated by the medical model, empirically and ethically ill-suited to psychotherapy, to a more scientific, relational one characterized by dialogical, collaborative process. This transformation is best understood as a realignment of the relationship between practitioner and client. The ideal of full partnerships with clients embodied in the new paradigm described in this paper is lacking in other proposed alternatives.

For example, Insel's (2013) call for abandoning symptom nosology in favor of neuro-biomarkers, presumably to be uncovered and understood with increased funding from the NIMH, merely substitutes one label for another and reinforces the power differential between medical professional and patient (Research Domain Criteria, n.d.). Moreover, the designation of brain abnormality, already strongly positioned in the psychiatric literature for some *DSM*-defined disorders, likely would incur far greater social consequences than labels associated with "psychological" deficit. Additionally, such newly defined disorders inevitably would require matching biological solutions,

spawning a surge of psychiatric drug prescription and expansion of the pharmaceutical market. Meanwhile, the real struggles of clients that expose unjust social conditions further recede into the shadows—or disappear altogether.

Efforts like the Global Summit on Diagnostic Alternatives are heartening, and the mobilization of psychotherapy professionals from around the world in this effort represents the extent of distaste for the *DSM* and, through collective action, a bona fide threat to its continued dominance. However, alternatives proposed so far in this initiative struggle with envisioning how psychotherapy could exist without some diagnostic framework to provide a "common language" and means to select intervention, evaluate outcomes, and justify funding. For example, some proposals attempt to replace negative labels with ones that empower. However well-intended, labeling in any form maintains an impenetrable wall between the proprietor of specialized knowledge with power to name and those subject to being named. Marginalized in this process is the client's local knowledge—his or her own self-narrative and experience of a particular family, neighborhood, and culture—essential, from the premise of this article, to devising a meaningful definition of the presenting concern and to fashioning a compatible solution.

Second order change, a radical overturn in the underlying rules and structure of a system (Watzlawick et al., 1974), requires stepping outside the fundamental premises of diagnosis as it relates to psychotherapy, including the myriad ways it undergirds mental health's daily procedures, paperwork, and policies. Imagine, for example, no code required to describe/define a client, no conversations steered by that code, either in therapy, supervision, or staff meetings, and no need for a code to dictate payment and thus whether therapeutic services can even exist. Imagine that the accounts clients tell us are not contorted to fit the Procrustean bed of the *DSM* or *ICD* but are listened to and honored as authentic portrayals of each client's unique world—his or her perceptions, understandings, and dreams, as well as invaluable descriptions of significant interpersonal and societal relationships. Imagine that these are recognized as holding keys to best practice, including goals for therapy and measures of success. Imagine listening for, witnessing, and inquiring about changes in clients' stories, realigning therapy directions accordingly. Imagine all of this encouraged and validated by brief, respectful, and content-less assessments in which *clients* inform therapists about what they know best—the status of their lives and perceptions of the usefulness of therapy.

PCOMS holds promise to take us from imagining to reality. Beginning as a clinical, relational, and value-driven project, this system has evolved into an empirically validated methodology for improving outcomes and a viable quality improvement strategy. We propose that this system offers a way to reprioritize what matters to psychotherapy outcome and reclaim our

empirically validated core values and identity from the stranglehold of psychiatric diagnosis.

Declaration of Conflicting Interests

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Notes

1. The PCOMS family of instruments are free for individual use at heartandsoulofchange.com.
2. The Heart and Soul of Change Project (https://heartandsoulofchange.com) is a training and research consortium committed to consumer privilege, a relational model of psychotherapy, outcome accountability, and demonstrating that social justice makes empirical sense.

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