Using an Outcome Specification Model

Recent research supports the fact that the demand for therapy has increased 400% in the last three decades (Meredith, 1986). Such demand translates into 80 million people and an annual cost of $4 billion. Psychotherapy is big business, and people have a vested interest in knowing that successful outcomes are a part of therapeutic treatment. Today’s health-care market is more outcome-oriented than ever before. Since nursing psychotherapy is a cost-effective method for exploring and achieving personal change (Durham, 1986), it can be argued that outcome-oriented nurse psychotherapists (NPTs) are in demand (Durham, 1983; Spunt, 1984; Durham, 1985).

The purpose of this article is to describe an outcome specification model that can be used by NPTs. Successful treatment and referrals depend on one’s skill in helping clients create and develop outcomes that are useful and relevant for them as they move forward in growth and development. The author believes that nursing psychotherapy can be enhanced by using some of the techniques of Neurolinguistic Programming (NLP) (Dilts, 1983c). Outcome specification is one such technique. The nature and process of outcome specification is discussed.

Problem is to Blame as Outcome is to Aim

Most psychotherapeutic models are derived from problem solving models, which are focused on the “why” of situations. Time and energy is spent gathering information about past history and discussing limitations involved with finding an acceptable solution to a specific problem. In some instances this discussion involves “blaming” others for one’s predicament, which influences and reinforces one’s perceptions of helplessness, lack of control, and personal responsibility for problem solutions.

Outcome specification is different from problem solving. Setting and achieving outcomes involves focusing on the “how to” aspects of achieving a desired result. For example, not long ago my son was learning to ride his bicycle. As a concerned parent, I found myself yelling to him, “Don’t fall!” as he wobble-wobbled down the street. Had I been more thoughtful, I could have yelled, “Keep your balance!” After all that was the outcome I wanted him to achieve.

Psychobase: Skepticism about Therapy

Concern about the effectiveness of psychotherapy began in the mid-1950s when Eysenck (1952) published a review of the literature that critically analyzed the effectiveness of therapy. He argued that two thirds of all neurotics who entered psychotherapy improved substantially within two years; and an equal proportion of neurotics who never

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entered therapy improved within the same period of time. Eysenck's conclusions created and continue to create a good bit of debate about the effectiveness of psychotherapy.

Although Bergin's (1971) critique of Eysenck's methods and meta-analytic studies (Landman, 1982; Shapiro, 1982; Smith, 1977) support the effectiveness of psychotherapy, there are still many consumers and critics who remain skeptical about the effectiveness of psychotherapeutic methods.

Consumer skepticism, coupled with recent changes in the health-care system, are two very important reasons to highlight the importance of focusing on outcomes in a therapeutic context. Psychotherapeutic outcomes are sometimes difficult for clients as well as therapists to specify. Since the quantity and quality of psychotechnologies is on the rise, consumers can easily become the victims of "psychabuse." "Psychabuse" is a term used by Zilbergeld (1986) to underscore the fact that psychotherapeutic techniques are used in inappropriate ways.

As a consumer advocate, he identifies four categories of psychabuse: 1) misleading promises about the scope and effects of therapy; 2) the use of one kind of therapy when another is more effective; 3) use of psychotherapy when alternative treatments are superior in results or costs; and 4) treatment that is too lengthy.

Zilbergeld (1986) argues that professionals do not necessarily possess superior clinical skills when compared with paraprofessionals, when one considers the development of measurable outcomes; and professional mental health education, training, and experience are not necessarily prerequisites for being an effective and helping person. Pondering these criticisms leads one to question whether or not nursing professionals engage in psychabuse. In addition, such criticisms serve as an impetus for nurse psychotherapists to question whether or not they are as outcome-oriented as they can be.

Are Nurse Psychotherapists Problem or Outcome Oriented?

To what degree do we as nurse psychotherapists say to our patients, "Don't fall?" How often do we encourage our clients to "Keep your balance?" Having been a nurse for 13 years with experience as a staff nurse, clinical specialist, nursing administrator, and nurse educator, my experiences tell me it is relatively easy for nurses to focus on problems. Indeed, the nursing process is, in essence, a problem solving model. As I review treatment records I am often concerned about the lack of well-specified, measurable, patient-centered outcomes on patients' records. I am surprised by the fact that many clinical specialists have difficulty transforming problems into specific treatment outcomes.

So, in my treatment record feedback notes I often write, "What will the results or consequences of this therapeutic intervention be? How, specifically, will you know when these results are achieved?" Sometimes I pose the question, "Is this your outcome or the client's outcome?"

Perhaps one of the reasons nurses may find it difficult to articulate specified outcomes is the ritualistic use of the nursing process (Henderson, 1982; Tanner, 1986). As the profession learns more about diagnostic reasoning, perhaps ritual will be replaced with reflection-in-action (Schon, 1983). Ritualistic use of the nursing process is not useful for outcome specification and the advanced practice of psychiatric mental health nursing. In fact, McHugh (1986) suggests the nursing process may be suitable for beginners, but leaves expert nurses frustrated.

Could it be that the nursing process is the best model for technical nursing, but not the most useful model for nursing psychotherapy and other types of advanced nursing practice? The author believes that ritualistic application of the nursing process limits nurse psychotherapists' diagnostic reasoning abilities and outcome specification skills.

The nursing process model is not the only therapeutic model that is problem oriented. Few therapeutic models deal specifically with outcome specification. Most models focus on past history, working through, and remediation of identified problems. By the very nature of these models the nurse and other therapists must deal with "problems." Problems bring people into therapy; achieving identified outcomes often results in people discontinuing therapy.

It is interesting to note that there may be a bias among certain psychotherapeutic schools that targeting results is not appropriate. Lego (1985), for example, argues that in psychoanalytically oriented therapy it is generally not helpful to set specific goals, because clients may distort or be unaware of their reasons for entering therapy, as well as have conflicting conscious and unconscious goals that are unobtainable due to unconscious factors. Lego believes that goal setting implies a mechanical problem solving approach that impedes the process of exploring human experiences, and is antithetical to the natural process of developing ongoing intimate relationships as well as implies a kind of closure in life that is limiting in itself.

Lego does agree that overall goals for all therapy clients are to remove, modify or retard existing symptoms, mediate disturbed patterns of behavior, and promote positive personality growth and development. Indeed Hardin (1985) found that the majority of nurse psychotherapists do set treatment goals as a mutual endeavor with patients. Goals are something one moves toward; outcomes are something one achieves.

Therapeutic outcomes are the results or consequences of a therapeutic experience. Therapists and clients may have different outcomes in mind. However, if a client has no idea of what he/she wants to achieve as a result of therapy, the
client will be in therapy for a long time. In order to specify an outcome, the patient and nurse psychotherapist have to create an image of what is desired and a procedure detailing how to achieve a desired state. Again, it represents the differences between telling someone “Don’t fall,” and reminding them to “Keep your balance.”

Clinically, many clients enter therapy because they experience anxiety. Anxiety is the problem and the nurse psychotherapist might spend a good deal of time talking about the why, where, when, and with whom of the anxiety state. But consider what would happen if the nurse psychotherapist asked the clients what they would like to feel instead of anxiety.

It takes some work to get the client to the point where he/she agrees that the specified outcome would be, “I want to be resourceful, satisfied, or appreciated.” Since nursing is still in a state of transition from medical to nursing models (Durham, 1986) it may be easier to talk about problems than to specify outcomes.

In spite of the fact that NPTs and other therapists use problem-solving models, the current health-care environment supports practitioners who are outcome-oriented. A therapist’s success and survival depends on his/her abilities to be effective and efficient at translating client concerns into behaviorally specific outcomes. This type of outcome specification serves as a yardstick for success, satisfaction, achievement, and reimbursement (Durham, 1985). Learning specific strategies that help one refine outcome specification skills is one of several ways to enhance the effectiveness of nursing psychotherapy.

There are at least five additional reasons to focus on outcomes in a therapeutic context: 1) Outcomes increase efficiency and effectiveness; 2) Outcomes help define means; 3) Outcomes detail procedures; 4) Outcomes provide standards for evaluation; 5) Outcomes are generative (creative) rather than remedial (Bergin, 1971). Outcomes create excitement, focus energy, and preserve resources. With an outcome in mind the NPT can accomplish more with less effort.

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Frustration can turn into action and satisfaction. Outcome specification can move both the NPT and client from a “stuck” to creative place where alternatives are generated and specified. Instead of dealing with what is wrong, client and therapist engage in dialogue about how they want things to be.

Think about one of your clients who has a problem-oriented thinking pattern. In my experience, people who focus on problems are generally defensive, inflexible, fear risks, project blame or responsibility, and lack imagination. These clients drain my energy quickly. By helping these clients learn to set outcomes I preserve their right to be problem-oriented, but also give them choices for behaving differently.

The Neurolinguistic Programming Outcome Specification Model

Neurolinguistic Programming (NLP) is a model of human behavior and communication that specifies outcomes and is therefore particularly useful and compatible with nurse psychotherapy. The model is a unique synthesis of a variety of therapeutic techniques (Einspruch, 1985). NLP is conceptually challenging and a detailed discussion of the complexities of NLP is beyond the scope of this article. Interested readers can find many resources available to explore this model in depth (Bandler, 1985; Bradley, 1985; Brockopp, 1983; Dilts, 1983c; Hartman, 1984; Knowles, 1983; Laborde, 1981). The following presuppositions highlight some of the assumptions and values of the model:

1. The meaning of communication is the response one receives, regardless of one’s intention. When one does not get the desired response, do something else.
2. Since a person cannot not respond, everything one does can influence another person.
3. An individual’s reality is based on his/her subjective, not objective experience. The map is not the territory.
4. All behavior is useful in some context. It is better to have a choice than no choice.
5. People make the best choice they can for themselves at any given moment.
6. The person with the most flexibility in a system will be the most controlling element.
7. Each person has within him/her self all of the psychological resources needed to resolve any difficulty.
8. There are no mistakes, only outcomes.
9. Anything one can pretend, one can master.
10. There are no limitations, only opportunities.

These are powerful values and beliefs. How might NPTs act if they integrated these beliefs into their practices? If clients incorporated some of these ideas, how might they behave differently?

Dilts (1983a) convincingly writes that 70%-90% of the impact of any therapeutic process is the establishment of the outcome. He explains that if one does not know where he is going, any road will get him there. Thus, it is important, after establishing rapport in a therapeutic context, to help clients clarify what they want, instead of dwelling on their problems.

How Are Outcomes Different From Problems?

As mentioned in the beginning of the article, one of the first steps in outcome specification is awareness and recognition of the differences between prob-
lems and outcomes. Fundamentally, it is the difference between blaming and aiming. The questions listed in the table help contrast the differences between problems and outcomes.

The first set of questions focus on the "why" of a situation, generally eliciting information about limitations and past history. These questions may or may not be useful for arriving at a well-specified outcome. The second set of questions move the client beyond the problem state to consider possible creative future alternatives or desired states.

Think of a situation in your own life, or identify a client with whom you are working who consistently gets into the "blame" mode. That is, everyone else is responsible for their situation. Ask yourself the first set of questions, and reflect on your reactions to the questions.

After going through the first set of questions, change your physical state by standing up or thinking about something entirely different. Problem thinking has a way of lingering in mind and body, so often it is useful to change position or thoughts before beginning to develop outcomes. These may be very useful techniques to employ during the course of therapy. If, for example, your clients continue to bring up problems that have been discussed in previous sessions and your goal is to move them to an outcome orientation, spend the first 15 minutes of a session discussing the problem.

Then encourage them to stand up and change positions. Perhaps you can ask them to sit in another chair in your office that henceforth can be "anchored" as the "outcome" chair. This "pattern interruption technique" is useful if clients ruminate about problems without focusing on the outcomes that they want. Changing position alerts the body and mind that something different is about to happen.

Based on your reaction to the questions in the table, do you have a better understanding of the difference between a problem and an outcome? In addition to the specific outcome questions, there are other criteria that are important in the development of a well-formed outcome in the NLP model.

#### TABLE

**Problem Versus Outcome-Oriented Questions for Nurse Psychotherapists**

<table>
<thead>
<tr>
<th>Problem-oriented questions:</th>
<th>Outcome-oriented questions:</th>
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<tbody>
<tr>
<td>What is wrong?</td>
<td>What do you want? (Defining the outcome)</td>
</tr>
<tr>
<td>Why do you have this problem?</td>
<td>How will you know when you have it? (Evidence)</td>
</tr>
<tr>
<td>How does this limit you?</td>
<td>What will you expect to see, hear, and feel? (Evidence)</td>
</tr>
<tr>
<td>What does this problem prevent you from doing?</td>
<td>When/where do you want it? (Context)</td>
</tr>
<tr>
<td>Whose fault is it that you have this problem?</td>
<td>When you get what you want what else in your life will change? (Ecology)</td>
</tr>
<tr>
<td>When is the worst time you have experienced this problem?</td>
<td>What resources do you have available to help you with this?</td>
</tr>
<tr>
<td>How long have you had it?</td>
<td>How can you utilize the resources you have?</td>
</tr>
<tr>
<td></td>
<td>What are you going to do to get what you want?</td>
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</table>

The first criterion for formulating a well-specified outcome is that it be stated in positive behavioral terms and be within the individual's control. A client outcome such as, "I want my son to stop sucking his thumb," is negatively worded and not within the client's control. Thus it is not a well-formulated outcome. For example, a client's concern about anxiety, "I don't want to be anxious," can be transformed into something desired such as "I want to be satisfied in this situation."

A second criterion for a well-formulated outcome is behavioral specificity. That is, the outcome evidence is detailed. For example, how will the therapist or the client know when he/she is satisfied? What would both see, hear, and/or feel? For example, the following questions help specify the desired state of satisfaction. What would satisfaction feel like? How would you know when you had it? What would you be telling yourself? Would you have any specific internal images or pictures that help you realize when you are satisfied? What would you see, hear, and feel from those around you? Such questions build a vivid representation of the desired state of satisfaction.

The third criterion for a well-formed outcome is that it be appropriately contextualized. This means the who, what, where, when, and with whom of the outcome needs to be detailed. Does your client want to be satisfied all the time or only with certain individuals and at certain times and in certain places?

Finally, a well-formed outcome preserves system ecology. A well-formed outcome will preserve the positive intention or useful byproducts of a problem state when necessary. If the outcome is consistent with other aspects of a client's life, it is likely to be accomplished. If, however, some part of the individual does not agree with the outcome, it may not be ecological for the client's system. Another way to think about this is to ask the client to evaluate any possible price or consequences that would result from achieving the outcome. For example, is there a price or consequences for being too satisfied in certain contexts? If the client raises any objections, these
objections can become grist for future therapeutic intervention.

Nurse psychotherapists who use both the outcome questions listed in the table and the criteria for well-formed outcomes will increase the probability of transforming problems into outcomes. For those developing skills as a therapist, the questions outlined in the table help define the differences between blame and aim. It is likely that certain skilled NPTs already use this model to help clients define the differences between where they are and where they want to be. It is likely that systematic use of the outcome specification model described in this article will contribute to changes in nurse psychotherapists’ approaches to practice.

Neurolinguistic programming has been described as a cutting edge technology in the field of communication. This article described an example of one NLP technique—outcome specification. Nurse psychotherapists who explore NLP technology as an adjunct to their current repertoire of therapeutic skills will discover many techniques to enhance their efficiency and effectiveness.

References