Supershrinks - Learning from the Field's Most Effective Practitioners

Transcript of audio interview published by the International Centre for Clinical Excellence (ICCE), on Dec 22, 2014[1]. Scott D. Miller of ICCE is interview by Barbara Alexander.

Summary by Harry Norman (Transcript)
Compelling evidence (meta-analytic studies) show that the provider of counselling or psychotherapy services has a far greater impact on therapeutic outcomes than does the treatment model employed. Therapists whose outcomes are above average: (1) actively solicit negative feedback from clients/patients during the first and subsequent sessions (2) actively follow up on therapeutic progress with clients/patients between sessions or at the next session attended (3) work continuously on improving their therapeutic skills throughout their careers. Scott D. Miller of the International Centre for Clinical Excellence (ICCE) introduces the work of ICCE and gives direction for accessing free standardised resources[3] for therapists to monitor the therapeutic relationship, and progress towards therapeutic outcomes, on a session by session basis.

Introduction by Barbara Alexander (Interview)
Interview with Scott D. Miller, Ph.D. on research related to top performing therapists. In this lively exchange with Barbara Alexander from "On Good Authority," Miller summarizes three steps to improving one's effectiveness while simultaneously outlining practical strategies clinicians can begin using immediately in their work.

Interview

Barbara Alexander
Therapists differ in their ability to affect change we may not like to think it, but it is so. How many times have we heard someone referred to as a “gifted therapist” is this some inborn talent like musical talent, or artistic talent, or athletic ability, and if so are the rest of us ungifted folks doomed to mediocre performance? “Not so” says Dr. Scott Miller our first speaker and co-founder of the Centre for Clinical Excellence. Citing research going back to 1974, Miller tells us that the evidence is incontrovertible; who provides the therapy is a much more important determinant of success than what treatment method is provided. And the key to superior performance, simple as it may seem, involves constantly working harder, evaluating and improving one's performance. To do that, we first have to know our baseline performance and then engage in more “deliberate practice” to improve our work. This willingness to engage in deliberate practice is what makes some therapists super shrinks …and the rest well simply average. What's really scary is that we might not know which we are, because, in the words of Sherlock Holmes “Mediocrity knows nothing higher than itself”, but we'll let Dr. Miller tell you about it.

Scott D. Miller PhD is a co-founder of the Centre for Clinical Excellence, an international group of clinicians, researchers and educators dedicated to promoting excellence in behavioural health. Dr. Miller conducts workshops and training in the United States and abroad, helping hundreds of agencies and organisations both public and private to achieve superior results. He is one of a handful of invited faculty whose work, thinking and research is featured at the prestigious Evolution of Psychotherapy conference. His humorous and engaging presentation style, and command of the research literature, consistently inspires practitioners, administrators and policymakers to make effective changes in service delivery.

Dr. Miller is the author of numerous articles and books, among which are Psychotherapy with Impossible Cases, Efficient Treatment of Therapy Veterans, with Barry Duncan and Mark Hubble, The Heart And Soul of Change with Mark Hubbell Barry Duncan and Bruce Wampold, The Heroic Client - a Revolutionary Way to Improve Effectiveness Through Client Directed Outcome Informed Therapy with Barry Duncan and Jacqueline Sparks, and the forthcoming Achieving Clinical Excellence Lessons From the Fields Most Effective Practitioners.

www.solutionsology.co.uk
Tel (0117) 968 2417 Email support@solutionsology.co.uk
Harry Norman Partnerships Helios Medical Centre, 17 Stoke Hill, Stoke Bishop, Bristol, BS9 1JN

Dr. Miller you say that “Who provides the therapy is more important than what treatment is used”. And I wanted to go into that - If that's really true.

Scott D. Miller
Well, I think the evidence is actually fairly convincing that the provider of services has a greater impact on the outcome than a particular treatment model employed. When it comes to the provision of Psychological Services or Behavioural Health Care Services I'm certainly not against evidence. The question is what evidence we use to guide to the services that we offer. And right now there is a very particular, and I would even call peculiar view, of what constitutes evidence. Somewhere back in the eighties our field decided it was going to ape medicine. And medicine, in what is now recognized as a fairly limited model, decided that the randomized clinical trial where you pitched alternate treatments against one another, or even more often, you simply put a treatment against no treatment at all, or a sham treatment, was the best research design we could use to decide what would be the best treatment approaches.

So, our field took that up and we've been running randomized clinical trials and claiming that certain models are more effective than others, when in fact the evidence doesn't say this. We've run very cutting-edge scientifically sound meta-analytic studies comparing treatments for a variety of conditions in children and adults, from depression to post-traumatic stress disorder to alcohol abuse and dependence, and we find no difference in outcome between treatment approaches that are intended to be helpful. You find a dramatic difference of course when you compare a treatment approach against no treatment and some difference when you compare it against a sham treatment. This leaves open the question; then well if there's no difference between treatment approaches then what treatment approach do you use? And if I'm talking to consumers what I say is “Choose your provider carefully because the amount of variability and outcomes directly attributable to the provider of services is eight to nine times greater, than the variability attributable to the particular approach that provider happens to use”. And so yes it's absolutely true!

Barbara Alexander
That's amazing, because when you think of all the time that's spent in conferences seminars, workshops talking about this treatment method or that treatment method. It's very wonderful to hear something different, that it doesn't matter whether you make an interpretation here, or there, it's more like who's doing it

Scott D. Miller
Yes I think that's part of it! More specifically it doesn't matter so much if you apply a particular approach for a given diagnostic condition. It may matter a great deal to an individual client but, in general, when we compare treatments for very specific diagnoses we don't see any difference at all. And it really comes down to the abilities of that individual therapist to connect with the client, and I think this is the very good news! When you look at the factors that do predict outcome the particular treatment approach predicts very little if any. Neither really does the diagnosis that a client gets predict the outcome, but rather who's providing that particular service and the kind of engagement that they are able to gain while working with that particular client, or what's often referred to as “the alliance”. That relationship and that particular therapist’s ability to relate to, and as I said, engage that client, and alternate kinds of behaviour, and alternate thinking and alternate ways of dealing with and handling their emotions.

Barbara Alexander
What makes one therapist better than another? What makes one person be the best, rather than mediocre?

Scott D. Miller
That's the million dollar question and if that were the question our field were debating you know I would be a happy camper. Unfortunately very little research has been done for reasons that you could probably imagine if you let your thoughts run wild for a minute. The first study about this was done back in 1974 by a person named David F. Ricks, who was looking at adults who had been treated while adolescents in a state health care system. I believe it was in the state of New York but don't hold me to that. His article is interesting and fascinating reading, and virtually no one has even heard of David F. Ricks! It was in a book

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called the History of Research in Psychopathology. And in essence what he did, again, was he looked at these adults who'd been treated as kids. And he found that some of them were living very productive lives, they had gone on with jobs and relationships, careers, kids and families and stayed out of the legal and the mental health care system. Other kids had struggled their entire life ended up in prison settings, or in mental health settings, and never seemed to thrive. He wanted to look at what accounted for the difference and he was very careful in this initial research to make sure that he was comparing apples to apples. He was looking at kids that were matched for their family background, their history, the severity of their problems etc, and he found that none of those things really mattered that much. What mattered mostly was who treated the particular kid, and some of the kids had been treated by a particular therapist, in his study, who had far superior outcomes than other therapists. In the study he called that person "a super shrink", that's his language not mine, and he called the other therapist in the samples they had very poor outcomes "a pseudo shrink". It was just a preliminary investigation; we're now just beginning to turn our attention, and our sights, to what leads some clinicians to be more effective than others. Of course, the first step in the process is to find out who's effective, and we can't wait like David F. Rick's did for twenty five years and measure these young children as adults because it's going to take too long. So what we've done, as a group, has been promoting the use of outcome measures. Clinicians pick up a scale, their clients fill that out, and they aggregate the data and they can get an idea about just how effective they are. This is very new done within the last …really the last ten years that people are being encouraged to measure their outcomes, and that's the first step. If you want to be a better golfer, or if you want to find out who the best golfer is, you should find out their score for example, and so we've done that and we've identified people who consistently score in the top quartile of outcomes with regard to their peer group, or in their geographic location, or just in the world. And we're trying to understand what is it that these people do that's different.

Barbara Alexander
Any preliminary understandings? The article that was in the Psychotherapy Networker[2] a year or so ago was stupendous in describing this.

Scott D. Miller
Well there are a couple of findings that we, and I would say that this is very much, Barbara, the sort of wet edge of the paint for us. We're learning, what I'm saying now shouldn't be cast in stone, it's an exciting area of research simply because it's completely open - it's the Wild West! One of the key things that these therapists do that is different from average therapist, and that's who we're comparing it to, we're comparing it to the best to the rest not the best to the worst here. And these therapists in general seek, obtain, and maintain more consumer engagement than the average clinician does. And you may ask "Well how do they do that, how do they seek, maintain and obtain more consumer engagement?" We've noticed a very interesting pattern by using measures in following, and tracking the outcomes of therapists; and one of the interesting patterns we've noticed is that the superior performing therapists often score lower in the beginning stages of providing a service to their clients as compared to average therapists on measures of the therapeutic alliance.

Barbara Alexander
I don't understand - how could that be?

Scott D. Miller
That's what puzzles most people because most people of course would associate better outcomes with higher scores on the measure that we use - the session rating scale. It's a very simple alliance tool, in essence what it does is it gives a snapshot of the engagement level and activity, that bond between the client and their therapist. And the superior performing therapists tend, on balance, to get lower scores in the beginning than their more average peers! Average peers tend to get higher scores in the beginning, and when we've looked more carefully at this we've noticed that the super shrinks, not only get lower scores in the beginning, but those scores tend to improve over time. Where average therapist scores tend to either start high and stay high or start high and decrease over time. What could account for this? What we've come up with is that these therapists, in the work that they do with their clients, somehow manage to get more negative feedback about what they're providing to their client early in the treatment process

Barbara Alexander
By negative feedback what do you mean?

Scott D. Miller
I mean that the therapist creates a culture, an environment, in the session where the clients can say “We're not doing what I'd hoped to do here, you haven't understood me in a way that I believe I am, and the methods that we're using don't seem to fit me exactly”. And they do this because they feel able to, they don't feel like there's going to be criticism, that the therapist will take umbrage at this or punish them. And so it's truly a collaborative partnership between the two. The therapist try something, the client feels willing and able to say it needs to be tweaked in this way, the therapist doesn't take that as a sign of the client's pathology but instead takes that as a generous clue about how to work more productively together. And it creates a virtuous rather than a vicious cycle, these therapists are simply more inviting of that kind of negative feedback and they then adjust the services which lead to improvements. The average therapists, and remember we're comparing them to their peers and their more average peers, in terms of outcome tend to take, and I'll say this twice, they tend to take an absence of negative feedback as an endorsement of the status quo. Let me say it again they tend to take the absence of negative feedback as an endorsement of the status quo, in other words things must be okay because the client isn't complaining. And therefore they don't work very hard at getting that kind of information from their client that they could then use to improve the engagement levels of that particular client

Barbara Alexander
Well you would think then if the client keeps paying and keeps returning, that would lead the therapist to say okay this is going alright.

Scott D. Miller
Yeah you would think that unfortunately, and now you're pointing really at the second largest finding that we have, and that is the superior therapists are much more sensitive to the risk of drop out and deterioration, or lack of change, in the early phases of treatment. We think if the clients going to continue to come back that that must mean something, but the truth is a very large percentage of people don't come back after the first and second and third visits. They drop out and we have protected ourselves in some way and you can hear, I think, support here in what I was just arguing, by saying that these particular clients didn't come back because, A they got what they wanted, or B because they were too ill to appreciate what I was offering. In either case the therapist remains insulated and protected against this potentially negative feedback. Now I'm not suggesting that what the client is saying is correct, or accurate, because I have no idea or a way of judging that. What I am saying is that these therapists are able to solicit more of this information and their attention to it create stronger bonds which result in better outcomes overall.

Barbara Alexander
Well you know I could be flip, this is a little bit flip, but maybe the average therapist who gets the higher ratings at the start should just do very very brief treatment. And then let the other people who are more able to let things develop, and encourage things to develop, might be better at the longer term treatment is that at all available?

Scott D. Miller
I think in general what happens in our field is that a significant percentage, estimates range up to 47 %. Up to 47% of people in some studies drop out without experiencing a reliable improvement in their functioning and they don't tell their therapist, which is sort of even more troubling, because then the therapist is prevented from getting the feedback. But the second, and I think more troubling finding, is that a very small percentage of people both in psychological services and in healthcare in general account for the lion's share of the expenses. So you can have people who continue to come to therapy week after week after week, and estimates are between 10 and 20 percent of those people who start treatment end up accounting for 60 to 70 percent of the expenses by the end of it. So you've got people who go for a long period of time and who

don't get well, you've got people who go for a short period of time and don't get well! Now, let me just say in defence of therapists and therapy, average therapist outcomes are very good. But we're not here to talk about average therapists - we're talking about these superior therapists. When you look at the average outcomes of psychological services in the U.S. dating back now 30 years; you go back all the way 30 years, the outcomes have remained largely the same. The outcomes of psychological treatments are on par with coronary artery bypass surgery, and treatments known for acute stroke, and myocardial infarction. So our outcomes are really quite good, but that said - that's the given, that's where we're starting! The question really is "Why does that physician doing a coronary artery bypass graft do so much better than average?" And we're saying the same thing about psychotherapists here - some of them do slightly better. And it's in those small differences where we achieve gold records …or gold medals, so to speak. So what is it that those people are doing? They're more attentive to that one out ten or two out of ten clients who is not making progress. How do they do it? We can go into that in a minute. And they are much more sensitive to drop out they don't say this to themselves "That it's ok that clients drop out", they don't defend themselves. In fact, in a very non-scientific finding that we published in the super shrink article, we found at two locations that the superior performing therapists also had the highest outgoing call logs of the therapists in the entire clinic. Meaning that these therapists didn't settle after a first, second, and third visit; they would sometimes pick up the phone, or at least more significantly more often than their average peers, and call the client. Again, this isn't scientific, but we talked to some of these people and asked them "Why are you calling? "And the general gist of feedback we got from our superior performing therapists was "I was dying to know". "I was dying to know, did what I say help, did it make a difference? Was I right about my diagnosis? Was this homework I gave engaging and interesting?" So it wasn't about checking in on the client in a sort of some dependent fashion, but rather about refining their skills, and that feedback loop is really a huge part of what separates the good from the great

Barbara Alexander
Well, I want to talk about how the feedback enhances the therapeutic relationship, and what kind of feedback are we talking about?

Scott D. Miller
We don't really understand, or know, how the super shrinks do this naturally. We're in a bit of an empirical bind as you may well imagine. There have always been, and people do believe, that there are superior therapists. The only way we could find them, since most methods for identifying them like peer nomination are unreliable …what we did, is we asked all therapists in various agencies around the world to fill out outcome tools. And then we've looked at therapists again, as I said at the beginning, who've consistently scored very high in terms of their outcomes. And so that's how we've been measuring the outcomes. And with regard to the feedback piece, we've watched how these therapists deal differently when they get information about their work. Now, how the individual therapists do this, before we measure them, we don't know, but we do know that the superior performing therapists, for example, get lower SRS scores. Which has led us to assume, once again, and consistent with other research on expertise, that these people won't settle, they're interested in knowing they create an environment where people feel free to complain, and I mean complain, in the most non pejorative whiney way. I mean it's simply that they say that it wasn't up to what I had hoped for which allows for process improvement.

Barbara Alexander
SRS score is what please?

Scott D. Miller
The session rating scale is our SRS score, it's a very brief alliance tool and if you go to my personal website that's Scott D. Miller dot com, Scott D for David Miller dot com. Go down to the tab that says performance metrics, individual clinicians can download and use those scales for free[3]. We have two, one is the outcome rating scale which is a very brief way of measuring your outcomes. You can take that data you can aggregate it and determine your effectiveness, and then the SRS is, again, that alliance measure tells us about the bond, the engagement level, with the client

Barbara Alexander
What about the idea of the match, or the fit, between the therapist and the patient and their attachment styles, and how everything blends together' does this matter to the super shrink?

Scott D. Miller
It matters to some and not to others. I haven't met any except, unless they're perhaps of a dynamic leaning, that would potentially bring that up. But what these therapists do is that they're dynamic in interaction with the client, they are seeking and obtaining feedback, that feedback allows them to alter their style to a better accommodate whatever it is the clients presenting with. The funny thing about the way we do research in our field is we hold variables constant, and then we try to treat. So if you give a dose of antibiotics, well then you give it the same dose. You know everybody doesn't get their own dose even though they may need a very specific dose, and the superior therapists use very careful observation, interaction, and engagement with the client to alter the dose type level and intensity of services they offer.

Barbara Alexander
So, let's go to an example of the feedback. I mean I know that there's no standard rubber-stamp kind of feedback questions to ask, but in the article you gave the example of Dawn and how she responded to the person, the older person who…

Scott D. Miller
Yes, it was an elderly gentleman whose wife had passed away, and she just had a sense that she hadn't engaged him completely. It's in the session, and when you watch this kind of thing happen as a clinician and the client then confirms. And all of us have had that experience where we say to the client something that nobody else would have potentially said, and the client is shocked and they're helped because of it - or they agree! But these superior therapists do it better and more often. So the questions is "How to help average therapists be able to emulate the behaviour of super shrinks?" Because super shrinks, as I said, none of them before we did the project we're using our measurement tools. And so here's what I usually say "Where birds can fly the rest of us need an airplane", me and the rest of the average therapist in the world, we can listen to people who extol the virtues of listening carefully and reflecting feelings and attending to and trying to create a culture of feedback. You can hear all that kind of stuff. The problem is we don't have the scaffolding, and the structure, to make that happen. So, in other words, we need an aeroplane. The super shrinks do it in diverse ways. There are million different species of birds and they all fly in slightly different ways, their bone structure is slightly different. But we can copy that structure, and one thing therapists could do right now, average therapists, if they wanted to improve their outcomes, was to begin to measure the outcomes on a regular basis at every single session. Now let me just say if a therapist listening to this rolls their eyes, and think "Oh my God I'm not going to do that". Well you know there's good news and bad news. Either they're a super shrink already, or they're average and they're not likely to improve. So, if you want to improve your outcomes, there's a very simple way to do it. Measure the outcomes and then talk about them with the client at every single visit. You would expect the same dialogue with your physician, if you were trying to get your blood pressure, or blood sugar levels, blood glucose levels in balance. You'd want them to measure every single time and if they weren't coming into balance, in spite of the physician's treatment, you would want either a different kind of service, or a different physician at some point. And it's the same thing here, measure and monitor your outcomes, and then at the end of each visit measure and monitor the status of the alliance and discuss it with your client.

Barbara Alexander
So you would say, what for example?

Scott D. Miller
In the beginning I would say the following: I'd say "You know I work a little differently than you may be accustomed to, and I know from the research literature that if I'm going to be of help. and service to you, you should start to see signs of improvement sooner rather than later - generally within five or six weeks. That may not mean that you're finished, or done, but you should not have to wait months and months before you experience an effect of our work together. If you're not experiencing some kind of benefit, then

you and I need to talk about what I can do differently, where else you can go. And, ultimately if I don't help you I will help you get in touch with someone else, who may be able to be of more help. And the way we'll notice this is, I'm going to ask you to fill out this simple scale, and you and I will talk about it every single time." At the end of my visit I'm doing a similar repeat, I say again "Here's the last piece and I'd like to hand out this brief tool, and it's like taking the temperature of our work together. Is it too hot? Is it too cold? Is it just right?" And I then add, "You know high scores mean very little to me here, I'm not going to take what you say personally, I will take it seriously. And, what I want to know is how I can improve the service I'm providing to you, and secretly, to everybody else who sits in your chair from hour to hour here. So, really go through here, it doesn't have to be something egregious, large, it can be something that may even in your mind seem inconsequential, as you fill out this measure about what happened over the last hour" and then I hand out the form!

Barbara Alexander
Dr. Miller let's say that you're in a session with someone who's been talking about some very upsetting material, they're crying, they're very emotional. Or, another example, perhaps the person is very angry, or it's a couple and they're very upset and emotional or it's a person with borderline personality disorder, and you know it's not going to be easy to end the session, either for the person or for you. So then how do you give that person outcome questions to answer? It would seem to me that it would be sort of out of nowhere, or not empathic.

Scott D. Miller
l let's take a look The first thing is as we talked about, that you're going to start the conversation you have with clients by reintroducing at each visit, and trying to create a culture of feedback. That culture of feedback states, that I work a little differently, that I'm interested in hearing how you're doing between sessions, and how you experience this particular visit. And so, at the end of each visit, each time that we meet, I'm going to be asking you for feedback, because I don't know if the session was, too hot, too cold, or just right. That involves filling out a very brief survey it takes, usually about a minute and then I look at it and see if we should talk about it. A lot of these kinds of questions can be dealt with by ensuring that you've created the culture of feedback in the beginning. That's the first answer. The second answer is the clients are very upset and it's going to be hard to end the session anyway. I think the use of the SRS, the session rating scale, or any alliance tool that you want to use - that's the perfect time to do it! When, actually, you may end up with some feedback that says the you that the way you did the session today that led to whatever emotions are being experienced was too much, or in fact, if it's just right. If you're concerned about that, then, and people express concerns about this both at the beginning in the end of the visit frankly Barbara. And, what they'll say sometimes "I'll have a client coming in a crisis and they are so upset and then I'm supposed to hand them this form to fill out that seems kind of rude." And I always use an example of a television show, and this will show you just how kitschy I am, from the 1980s it was called Rescue 911 with William Shatner. And, you know, whether you like the show or not, what was always impressive to me about these 911 operators, and you think about that, there there's probably no more stressful job than fielding phone calls from people who were in an automobile accident, whose child is just drowned, who've cut off their arm with a with a band saw out in their yard. And here's this 911 operator, now what is that 911 operator do? They don't say "Well let's not talk about it", in fact they get an incredible amount of detailed information from people at the moment of crisis; their name, their age, the description of the situation, their address. My sense is that, if therapists are committed to getting feedback, that this will be exactly the time that you either, A. want to measure the clients baseline, or B. get feedback about what they've just experienced the last hour.

Barbara Alexander
Do you think it's okay to let patients leave their sessions angry or upset, or do they always have to feel kind of resolved in some way?

Scott D. Miller
Do I think it's okay? I think it's going to happen and that we need to be able to deal with that eventuality. Clients will be upset and giving the ORS gives me a critical opportunity to discuss that, and to perhaps ensure

that the client doesn't take whatever they felt during the session and, because I didn't address it, not come back an additional time. Drop out, remember, following the first visit is the single largest threat to outcome that we know about. Studies indicate nearly half of the people who start treatment in the United States drop out after a single visit and it's high at the second. So that's the key, I want to be able to ask for feedback and make sure. Now, what happens if the client gives me low marks? Well, we kind of talked about this, but in essence it says that that either that I didn't understand et cetera… I usually do one of two or three things, I usually say "Well if I'm right up against the end of the hour and the client doesn't seem too upset about this", but they do say "Yes I didn't feel like you heard, or we didn't really talk about what I wanted to talk about, or your approach, I'm not sure about a good fit." I say one of two things. Number one "Would it be okay if we talked about this at the beginning of your very next session, because this is exactly what I should have been on top of, and I'm sorry we missed it." If I get any hesitation at all, and I've got somebody else in the waiting room, I say "Would it be okay if I called you at the end of the day and followed up and heard more about what you had to say?" You would expect this in a restaurant, in a hotel, why wouldn't you expect this from the person treating you - a mental health professional? If the client is not too upset and they say "Yes I'd be okay if we take this up at the beginning the next visit", and then I always ask at the end then "Is there anything in what we've talked about today that would prevent you from attending the next appointment?" If they say "No", I say "If something comes up will you call me and let me know?" All I'm doing is trying to use that measure as a shoehorn to slip that client back into the seat, to give me one more chance to engage them.

Barbara Alexander
That's very helpful - very helpful!

Scott D. Miller
Thanks, my sense is that therapist reticence about using the scales has more to do with their with their lack of familiarity with it. And all of us need some sort of hooks to hang - some language hooks - to sort of be able to approach clients when these situations come up. But I've been watching therapists do this now for close to nine years, and I'm amazed at how therapists can ask for feedback, especially at those particular times where they seem to most need it.

Barbara Alexander
You're right about language hooks especially for a new skill, or introducing a new procedure, you really do need to have some language hooks. That's a great way of putting it. What if the person you're seeing has a big need to please you, or to not show anger, and not be critical, and what if, simultaneously you as a therapist, want to be seen as very helpful and very good? So you don't want to hear anything much negative. You got a person who can't express anything too negative, and the person who can't listen to anything too negative - so then where are you?

Scott D. Miller
There's a couple of things, lets start with the latter instance. First start talking about the therapist, the best way to get better outcomes is in fact to be open to negative feedback. So the best way to ensure mediocrity and average outcomes is, to get no feedback about your performance, which is exactly what the research literature says happens to most therapists. Their outcomes improve for about six to eight weeks of starting, and then they and then they level off and they don't get any better, at the same time confidence levels go up. Think about that, you have therapists feeling more and more confident despite the fact that their outcomes are remaining relatively average. So, the first thing you can do, if you want to improve, is to is to get some feedback about areas where you could change something. Now, let's go back to the first example with regard to the client, the client who has a need to… I'm always puzzled by this comment, although I hear it fairly often. First off, who gets to decide whether the client is that way or not - that is shy, or prone not to not to disclose. Who gets to decide that? Well usually the therapist who's sitting opposite that client, who may have engendered that very behaviour! And this idea is supported by our research which shows that variability in the alliance, and feedback, is not attributable to the client - it's attributable to the therapist! In other words some therapists create a culture in which clients, regardless of how they present, are more likely to disclose. Other therapists, more average therapists, create environment in which clients are less

likely. So I would say the fickle finger of responsibility points back at us! Now that can create monumental amounts of frustration, because the truth is most of us average clinicians, me included, have no idea about how to language things. The scaffolding and the structure, in order to get that kind of negative feedback. In fact we do things and we scaffold and we talk and we create an environment in which it's virtually guaranteed that the client won't. So let me give you an example, I've already said that the superior performing therapists are much more likely to have contact with their clients between visits. Whenever I make this statement, at a workshop, somebody invariably raises their hand and says “Won't that create dependency?” and another one raises their hand and says “What about boundary issues?” We are well defended against this idea! All I'm recommending is when you give an assignment, maybe you should follow up and find out between visits. These people, the superior performing clinicians, and in fact physicians, radiologists, chess players and pianists, they share the same quality they are dying to know “Did it work?”

Barbara Alexander
Years back I saw a patient who said to me that I was a B+ therapist. “You're a B+, but I want an A+!” And I asked what would make me be an A+ and she really didn't know. She really couldn't say, but she kept coming back, and she kept complaining about me. I just couldn't get at what she wanted me to be, what she wanted me to be doing differently. So I tried, maybe I didn't try hard enough, or I didn't pursue…

Scott D. Miller
Well there's two things, and this kind of points to the last, and the third item, that is on our list of things that the superior performing therapists do. So the person says you're a B+ therapist, and what they've given you, is really no useful information. As you're pointing out - about how you can change your behaviour! We find that, for the most part, clients are often unable to give you specific direct instructions for how to change the treatment in order to improve their experience of it. So what can you do? The first thing you can do is, you could use its alliance tool I'm telling you about, because it's going to give you four very specific pieces of feedback at the end of each visit - just like that! So you can go in and you'll be able to see where the client is saying that things are not just right. That's the first step, the second step relates to the third point and the difference that we've noticed about superior performing clinicians, which is they're constantly pushing their realm of reliable performance. The problem in our field, and in every field where average is in fact “the average”, is that people's outcomes level off at an average level and they stop getting feedback. And, in fact, they begin to explain and understand their average outcomes, at the same time as their confidence level increases. What happens to make that happen researchers call “automaticity”. We stop thinking about our work. We say things like “I've seen this before”. Now automaticity isn't bad in and of itself. You have to you have automaticity in order to walk, otherwise you'd never you never get up from a crawling position. Some things have to become automatic! At the same time, most of us are no better at walking than we were when we were three, because we're not thinking about it anymore. And the way to think about it is to engage in a process called “deliberate practice”. Deliberate practice is not a concept I invented, it's really owes its entire existence to a phenomenal psychologist and researcher by the name of K. Anders Ericsson. And K. Anders Ericsson is the one whose research has really opened my eyes, at least in terms of understanding the difference between average and superior, by noting that these people engage in deliberate efforts to improve target performance. So here's the key, first you have to know that your performance is either average or less than average. That can help you engage in and develop a plan of deliberate practice, for improving those outcomes. Then you have to set some very specific target behaviours that you want to change, and you have to develop a very detailed plan about how you're going to approach that. In your example, your client says you're a B+ therapist. What would I be doing after the session? What superior performers do, is videotape or audio that session. Sit down and think about what's going on in the session that may be contributing to an okay performance, not a great, not perfect but okay. You then develop a plan, with very specific targets in terms of process - what you're going to say and what you're going to do. Because the truth is, most of us do this on the fly, or when we're not doing on the fly it's become automatic. This means you're deliberately sitting down hammering out a step-by-step plan. And in your step-by-step plan, you don't just have one direction, you consider permutations. So you might say to a client, who says you did really good today. You might say something like “I'm very happy to hear that, what would have made it better?” If the client says “nothing could have made it better”; you would need to consider two or three alternate ways to ask that same question to get information. You'd have a very deliberate plan, you then go

back the next time, and you try out your plan. At the end of that visit, you look back at did your plan work to achieve the target process objective. Did you miss any steps in the plan? If it didn't work, you're thinking again. This seems to be what leads to superior performance, say in chess. In contrast to popular myth chess players do not have superior memories, they don't have a superior IQ! What they have are more lateral moves at every point along the chessboard, unlike me! I have two or three ways I play chess. For them each move on the chess board there are multiple permutations from that particular point. They've gotten this by rehearsing and practicing those steps one by one before and after they play. That's the process of "deliberate practice" and it is very intense - and it is why most people settle for average.

Barbara Alexander
There's a lot in the theory that kind of makes it, well in the psychodynamic theory, that makes that not so easy to do - because of the multi-layered aspects of it perhaps. But also because, for instance, Winnicott the developmental child psychiatrist had the concept of the good enough mother. And so, you think well I've done a good enough job with this person. It's a good enough job, it's not the greatest, it's not the best, but it's good enough …and so you don't grow then.

Scott D. Miller
Right, and you know what, good is good! We're talking about average versus superior, the question is whether or not you want to be a superior performer or not. And you know what's amazing about this, and this isn't my idea. This is an author whose work I also admire, his name's Geoff Colvin, he's written a phenomenal book called 'Talent is Overrated'. He says, think about the people around you, and the work that they do, and most of us and this includes me. Most of us go to work every day and we work at the same thing every day and we're good at what we do. But isn't it interesting, how few of us are actually great at what we do. And why is that "Yes why is it?" and he says, there are two primary reasons. Number One, people believe that greatness is due to an innate inborn talent, for which Erickson says, there is absolutely no proof. And secondly, he says even if there is such a thing as native inborn genetic talent, it doesn't seem to matter. Because, for example, there are chess grandmasters who have below average IQs. So I agree with you. From most of us it's okay to be good, and there's nothing wrong with that. But if you want to improve your performance there are some very specific steps you can take, but it is hard work.

Barbara Alexander
Well the hard work would reflect in an improvement in the relationship wouldn't it? Because the patient or the client would see that "Gee this person is really trying hard and really wants me to be better, really wants me to grow, or that this person really wants to help me".

Scott D. Miller
I'm not sure the clients are going to notice that. No primary research has been done on the subject. But I wish, instead, therapists had that idea that "I really want to grow", "I really want to get better", but what happens typically is our confidence grows and our outcomes remain flat - and I mean flat. I mean average. The best physics, instructors and professors and thinkers, they may experience decline in virtually every other aspect of their functioning, but they don't experience it in the realm in which they deliberately practice. And so for me it's very good news you can not only maintain your skill level, but you can improve your skills and your outcomes, virtually until your death. But, it does require …it does require effort. I think it's important to note that, again, we're just learning about this. And bringing these ideas to the field of therapy, they've been in operation in sports and in music and other areas – business - for a long time, but they're just now coming to the field of therapy. So I think it's critical Number One that that you've given exposure to them in general. And I hope that, when I present the ideas that my commentary about where the field is at, and where we need to go, isn't discouraging. But instead gives as you say - which i think is the best feedback you could give me - some very specific concrete steps people can take in order to improve their performance. Otherwise we just feel like it's all futile and it is definitely not futile. Download and use the scales[3], talk about them with your client. Begin to record some of your sessions, that you feel like you're struggling with, develop a plan and deliberate practice. And get a coach whose work you admire, to learn a very specific skill, and have them listen and comment about your plan. These are all things you can do to improve your performance and they will pay off in terms of outcomes.

Barbara Alexander
Dr.Miller thank you. I want to say again that your article in Psychotherapy Networker[2] is a feast, and it should be read by every therapist. People don't realise, how, what's the word for it ...sanguine they get about how they're doing, how complacent. And it's so important. I loved the article, and I'm very happy that you gave us the time today to speak with you.

Scott D. Miller
My pleasure! You know you can download that article[2] and all the scales[3] and everything else from my website. Again, it's Scott D. Miller dot com. There is a link there. It's a scholarly publications and handouts and you can you can download it there. And Barbara, I respond to all of my email. Sometimes it takes me a day or two but everybody gets a response. And if you don't get a response within three days it means I haven't gotten your email. So you should send it again. And I love, I love, the subject and I love talking to clinicians, I'm very hopeful about us, as a group, we are resourceful, and I think once the information is available we'll suck it up!

Barbara Alexander
Okay Dr. Miller thank you very much,

Scott D. Miller
You're welcome.

Barbara Alexander
This concludes our interview with Dr. Scott Miller. We hope you learned from this interview and that you enjoyed it. To order Dr. Miller's publications view his workshop calendar, download his evaluation forms, and to contact him visit his website www.scottdmiller.com. I need to say here, that the views expressed by our speakers are theirs alone ,and do not necessarily reflect the views of On Good Authority. On behalf of On Good Authority this is Barbara Alexander thank you for listening.

1. Supershrinks - Learning from the Field's Most Effective Practitioners
https://www.youtube.com/watch?v=WGgPvpNHzbY

2. The Secrets of Supershrinks: Pathways to Clinical Excellence
by Scott Miller, Mark Hubble, and Barry Dun
https://www.scottdmiller.com/wp-content/uploads/2014/06/Supershrinks-Free-Report-1.pdf
First published by Psychotherapy Networker November/December 2007

3. Performance Metrics - Licenses for the ORS and SRS
A license to use the ORS (Outcome Rating Scale) and SRS in paper and pencil format is available for free to individual practitioners.
https://scott-d-miller-ph-d.myshopify.com/collections/performance-metrics/products/performance-metrics-licenses-for-the-ors-and-srs

Transcribed by Harry Norman
12/3/19
support@solutionsology.co.uk