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Identifying and Refining Your Individualized Learning Objective

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Truth, like gold, is to be obtained not by its growth, but by washing away from it all that is not gold.

—LEO TOLSTOY, *TOLSTOY'S DIARIES*

DECISION POINT

Begin here if you have read the book *Better Results* and

- are routinely measuring your performance *and*
- have collected sufficient data to establish a reliable, evidence-based profile of your therapeutic effectiveness *or*
- have created a map or blueprint of how you work sufficiently detailed another clinician could step into your shoes *and*
- need guidance using the Taxonomy of Deliberate Practice Activities in Psychotherapy to identify or refine an individualized learning objective with the greatest chance of improving your effectiveness.

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To begin, please rate your response to each of the following questions on a scale from 1 to 5, where 1 is *highly disagree* and 5 *highly agree*:

- You are someone who is often attuned to the feelings of others.
- You are someone who approaches life, work, and problems systematically and sequentially, often having clearly defined steps and procedures in mind (i.e., "If x, then y").

Not surprisingly, psychotherapists tend to assign a 4 or 5 to the first statement and lower scores to the second. Clearly, possessing an empathic disposition helps in fulfilling the desire to be of assistance to people in distress. Being in the moment, emphasizing understanding and acceptance, placing trust in feelings, and relying on intuition to guide decision making are often given priority in the daily conduct of therapy. Carefully constructing a treatment plan, following an established protocol, and being able to state clearly and explicitly the rationale for each and every action taken with clients is less common. On balance, therapists are more *empathizers* than *systemizers*.

As it is, being completely immersed in and sharply attuned to the client's experience has long been regarded as the sine qua non of expert clinical work. Indeed, a large multinational investigation by the University of Chicago's David Orlinsky and the University of Oslo's Michael Rønnestad (2005), involving more than 10,000 therapists, found the majority not only yearn for but also consider the experience of connecting deeply with clients the quintessence of what it means to be a therapist. For all that, *healing involvement*—the term used by researchers to characterize this belief and desire—has a curious relationship with results. The more it is valued, the *less* effective one is likely to be. In reality, the best clinicians rate it significantly less important to their work and identity than their more average counterparts (Chow, 2014). What holds their attention and gets them up and going in the morning? Outcome.

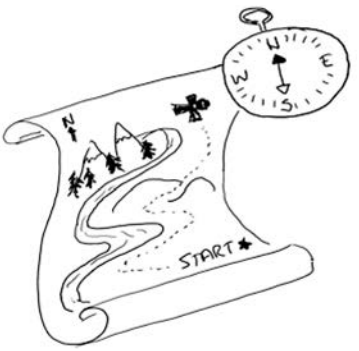
Enter the Taxonomy of Deliberate Practice Activities in Psychotherapy (TDPA; Chow & Miller, 2022; see Appendix A, this volume), the tool specifically designed to help practitioners develop a step-by-step professional development plan most likely to improve their results. Unfortunately, a cursory review of the document is likely to strike empathizers as, in a word, foreign. A spreadsheet of tables, ratings, and detailed instructions has replaced what they do best, know the most about, and hold in the highest esteem: connection, caring, intuition, and being in the moment. How can the seemingly detached, calculating, even antiseptic nature of the TDPA be experienced as anything other than off-putting?

Turns out, the answer—and the way forward—lies in redefining what healing involvement encompasses. Nowhere is the need to do so more apparent than in efforts to address the epidemic levels of burnout seen in the helping professions. The terms *vicarious trauma*, *secondary traumatic stress*, and especially *compassion fatigue* all point to the very real risks of deriving meaning and purpose primarily from the emotionally charged interactions during the therapy hour—especially with nonimproving clients. The pattern is as easy to see as the results

are predictable: In the face of continued suffering, deepening involvement feels like the right thing to do.

And yet, as Mathieu and colleagues (2015) pointed out, "Burnout doesn't begin with caring, or even caring too much, but continuing to care *ineffectively* [emphasis added], losing sight of what we're there to accomplish with our clients in the first place" (p. 22). Little wonder the panoply of recommendations offered by burnout experts—including cultivating mindfulness, going on walks, doing yoga, joining a service organization, turning off technology, capping client contact hours, and eliminating caffeine and alcohol intake—do not work. All miss that key protective factor—doing something that *actually helps*. Recall feeling effective is so crucial to the well-being of therapists, they routinely overestimate their actual results (see Chow et al., 2015; Lin et al., 2022; Walfish et al., 2012)!

Thus, it is essential for the definition of healing involvement to be extended beyond the immediate experience with the client to therapists' deeply felt desire to be of help. With this perspective in mind, "empathizers" can transform the TDPA from a mere chore to a deep and powerful act of caring. At this stage, it is recommended therapists work consciously and intentionally at developing a relationship, with achieving better results equal to the relationships one works so hard to establish and maintain with clients.



FIELD GUIDE TIP

Readers who scored a 4 or 5 on the second statement (i.e., systemizer) or who, after reading *Better Results* (Miller et al., 2020), are now looking for tips, suggestions, and practical guidance for maximizing the utility of the TDPA may feel free to skip ahead to the exercises at the end of this chapter.

BARRIERS TO BETTER RESULTS

To be clear, it is not that therapists do *not* want to improve. They do. The evidence reviewed in Chapter 12 of *Better Results* (*BR*; Miller et al., 2020) proves it. However, for empathizers and systemizers alike, three obstacles get in the way of deepening their relationship with better results:

- what therapists already believe works,
- not knowing what will work to improve their effectiveness, and
- what others insist works if only everyone would do it.

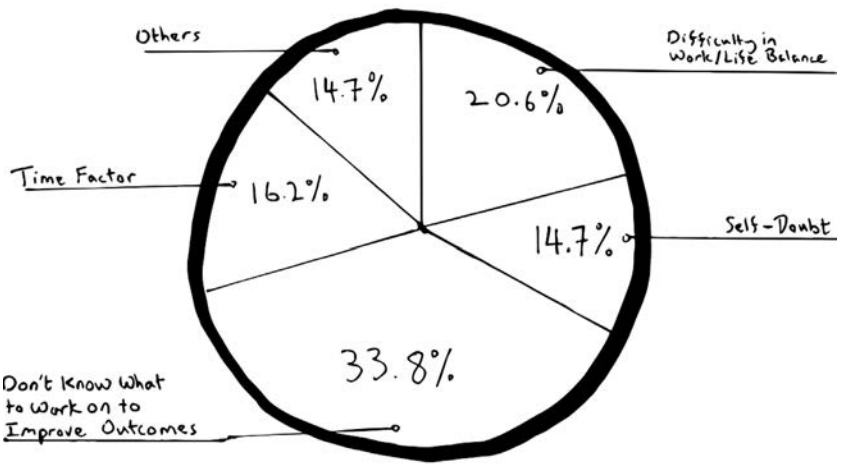
Regarding the last item on the list, nothing beyond the decades of research reviewed in Chapter 2 of *BR* and the first chapter of this volume need be repeated. The desire to help those in psychological pain is easily exploited by those promising a better way. In the busy, time-and-resource-limited world in which clinicians work, one of the major hooks is, "The heavy lifting has been done. All you need to do is follow directions." If this remains a temptation, complete the exercises on page 17 of Chapter 1 under Principle 1 (Avoid the Athenian Trap).

Turning to the first item, the evidence paints a rather bleak picture. Despite participating in continuing education throughout one's career, clinician confidence increases but their outcomes do not (Germer et al., 2022; Goldberg et al., 2016). Effective deliberate practice (DP) is predicated on developing an evidence-based profile of each therapist's effectiveness. The goal is to strengthen what one does well and target particular weaknesses for improvement. In either case, the expertise literature definitively shows intuition is not a reliable guide (Miller et al., 2018).

Finally, not knowing what to work on is a major obstacle—perhaps the biggest. It is also the reason for and purpose of this chapter. Consider the data presented in Figure 2.1. Displayed are the responses of hundreds of participants from an ongoing series of asynchronous, web-based trainings on DP conducted by the authors since the publication of *BR*. Asked at the outset of the course to identify the single biggest challenge attendees faced in their professional development, the majority (~38%) cited not knowing which goals or performance objectives to pursue.

The promise of the TDPA (as originally introduced in *BR*) was that completing the tool would help each therapist identify the specific DP activity exerting the greatest leverage on improving their results (McChesney et al., 2012). Experience showed clinicians needed more. Putting all the pieces together and arriving at a single professional development objective proved to be a

FIGURE 2.1. Responses From Deliberate Practice Web-Based Workshop



"bridge too far," at times eluding even the most dedicated. The sheer volume of information made it easy to get lost in the details, obscuring connections between the various inputs and, ultimately, the bigger picture.

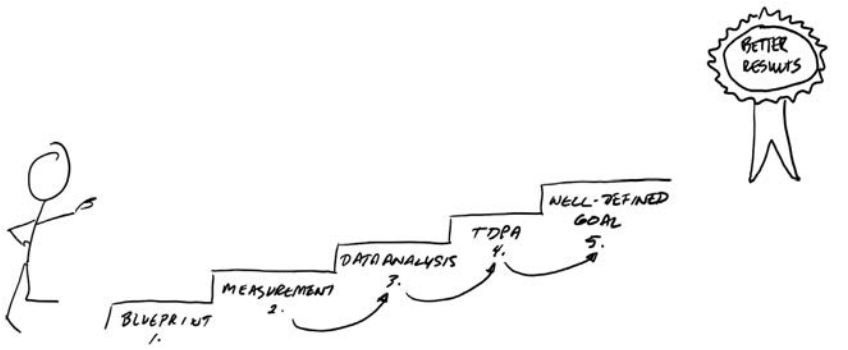
KEEPING THE BIGGER PICTURE IN MIND

Step back for a moment. The journey is a series of steps for deepening involvement with better results, beginning with creating a detailed blueprint of how one works (see Figure 2.2). Recall the blueprint is a guide on "how you do, what you do" in therapy. A useful way to think about this is to imagine explaining to someone what you do within the therapy hour. As introduced in *BR* and thoroughly described in Chapter 1 of this field guide (*FG*), the reason for doing so is to enable the clinician to pinpoint where in their work they can intervene once they have identified what needs to change. The next step is measurement, routinely assessing engagement and outcome. The purpose is to generate data sufficient for the therapist to identify any weaknesses or deficits in their clinical performance. Once known, completing the TDPA is supposed to, first, help the therapist link their specific shortcomings to the factor or factors (and associated clinical activities) having the greatest chance of improving their results and, second, to develop a single, well-defined, and achievable professional development goal.

All well and good. Except . . .

Integrating data about one's performance deficits with the TDPA is where many end up feeling stuck. Consider the example of Liam.[1] First, he created a blueprint for his approach to clinical work. It took a while to fill in the details over time as he reflected on and conducted therapy. At the same time,

FIGURE 2.2. The Deliberate Practice Journey



Note. TDPA = Taxonomy of Deliberate Practice Activities in Psychotherapy.

[1]All case examples used in the *FG* are composites of real people whose identifying information has been altered to ensure anonymity.

he began administering standardized measures to his clients. Once sufficient data were gathered for a reliable assessment of his work, he learned his impact—as reflected in his effect size—was average. Wanting to improve nonetheless, he turned to the TDPA. Instead of leading him to a specific target for DP, variable scores within each of the five factors (i.e., structure, hope and expectancy, relationship, client, therapist) left him puzzled about where to start. Frustrated, he turned to colleagues in his consultation group: "What am I supposed to do to get better?"

Experience shows Liam's struggle is far from unusual. Recall most therapists are average. As such, an *initial* examination of one's overall results often fails to reveal the one truly transformative DP objective. Instead of returning to the data with different and more detailed questions, many place their trust in the TDPA, hoping it will provide direction. Occasionally, when completed together with a coach, potential targets for improvement are identified. However, more often than not—as in the case of Liam—nothing specific stands out. In either instance, disconnected from performance data, both risk investing significant effort for an unknown return.

Recalling the advice offered earlier, the key to success is to treat the process of arriving at a performance improvement objective the same way one approaches working with clients. Get involved. Dive in, care, be curious, make connections, think critically, test understandings, continuously adapt, and, when required, seek consultation. No therapist thinks of "getting to know" the client as an activity independent of treatment. Similarly, learning what one needs to learn (and learn next) is not a precursor to but an integral part of DP. Practically speaking, this means returning to earlier steps as often as needed with different questions in mind:

- Is my blueprint accurate? Does it reliably capture how I work?
- Have I created an atmosphere that supports and facilitates candid feedback from clients? How do I use client feedback to inform and improve my work?
- How well do I understand my performance-related data? What gives rise to the numbers in the report? What variations in my performance (e.g., types of clients, presenting concerns, times of day, days of the week, treatment delivery format) might be hidden in the aggregate statistics?
- How does the information from my map, ongoing measurement, performance data, and the TDPA tie together? What am I learning about myself, how I work, with whom, and under what circumstances I am most and least effective?

Liam sought out a coach who encouraged him to set aside the TDPA temporarily and revisit his performance data. Specifically, as suggested in Chapter 10 of *BR*, he was encouraged to begin parsing his outcomes, linking them to a variety of factors known to be associated with variations in therapist effectiveness (i.e., level of client distress, amount of improvement over time, culture, gender or sexual orientation, quality of the alliance, and presenting problem).

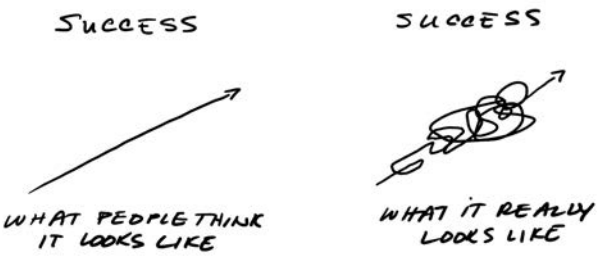
To this end, Liam created a spreadsheet. On the vertical axis, he listed his clients and, horizontally, the various factors. It took him the better part of a month to pull the specific data points for each client and place them in the appropriate column and row. Importantly, as he did so, he had no preconceived ideas about what he might find. Once complete, however, a pattern immediately jumped out. His poorest outcomes occurred with men. "Was this the answer?" he wondered. "Should I get some training on 'men's' issues? Supervision?" Feeling uncertain, he returned to the coach.

Together, they first examined the other dimensions in the spreadsheet, looking for connections and relationships. No other patterns stood out. The poor results weren't linked to the alliance, presenting problem, or differences in background or culture. Simply put, some men fared worse than others. "So, what is it I'm supposed to practice?" Liam asked, exasperated. The coach immediately replied, "Being curious. We're not done getting to know these men, what happens when you are with them, what it is about them." It was then the coach suggested Liam add a column to his spreadsheet. There, he was instructed to review his progress notes, tracking any recurring words used when documenting his work.

"I've figured it out!" Liam happily reported the following month: "I need to deliberately practice working with angry men—that's the word that showed up again and again in my notes: angry." Liam's experience highlights the need to modify the picture most people have of DP (see Figure 2.3). Rarely linear and sequential, more often than not, it is a matter of three steps forward and two back—and Liam had a couple more steps back ahead of him.

Retrieving the TDPA, the coach wondered how best to understand the anger reported in Liam's notes. Was a description of the men, their nature, and how they presented a client factor? Or was it a result of something taking place in the therapeutic interaction (i.e., relationship factor)? There is one more

FIGURE 2.3. Deliberate Practice: What People Think and What It Really Looks Like



possibility: Was it a therapist factor? Did Liam somehow evoke an angry response from certain men? If so, what was it about him?

With these questions in mind, Liam returned to his notes. In short order, he discovered the problem was not "angry men." Rather, those with the poorest results *became* angry when they were not getting what they wanted: advice and direction, two activities conspicuously missing in Liam's blueprint.

"I'm not comfortable telling people what to do," he observed at the next session with his coach, adding, "In fact, I was trained *not* to do that." At this point, and after months of work, a DP objective likely to have leverage on Liam's outcomes started to emerge. Along the way, several shifts in perspective had occurred. What began abstractly as "men's issues" (TDPA Dimension 4) turned into "relating to angry men" (Dimension 3, Di, ii) but eventually landed on the necessity of being aware of and accommodating the expectations of certain men (Dimension 4b, c). With the correct focus sorted, Liam was finally able to act, devoting attention to learning when, with whom, and under what circumstances being more direct and offering specific guidance were indicated. In time, he modified his therapeutic map to reflect his new understandings.

PRINCIPLES FOR IDENTIFYING AND REFINING YOUR INDIVIDUALIZED LEARNING OBJECTIVE

Three principles essential to developing a learning objective with the greatest chance of improving your effectiveness are suggested. Derived from experiences working with clinicians like Liam since the publication of *BR*, they include

- approaching finding your performance improvement objective with the same interest and dedication you devote to understanding your clients,
- treating the process of arriving at your performance improvement objective as an ongoing learning project, and
- focusing on the "what," and the "know-how" will follow.

Up to this point, the aim of the entire chapter has been operationalizing the first two principles—what identifying your specific performance objective *actually* entails and the perspective required to sustain your efforts along the way. What more can be said? Like getting to know your clients, no shortcuts exist. Hopefully, it is clear DP is not an event (or even a series of discrete events). It is an ongoing, *iterative* process. Arrival is not possible without the journey—and in the case of working to achieve better results, it is best to think of the two as one and the same. You are here now. What are you learning? What is next?

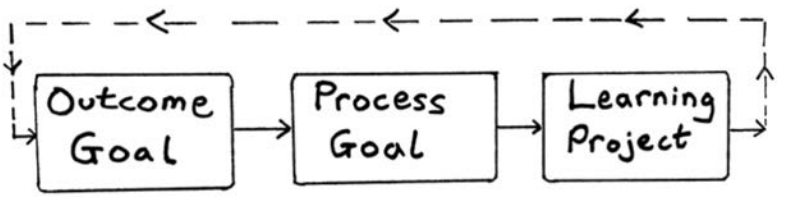
Whereas the first two principles direct attention to the importance of attitude, Principle 3 is less about one's point of view than how the task is best

approached. Toward this end, a specific framework for conceptualizing and organizing your efforts to identify the "what" and "how" to DP has proven useful. Known by the acronym OPL, it contains three elements: outcome goal, process goal, and learning project (see Figure 2.4).

Of the three, the learning project has already been introduced and illustrated with an example. Its purpose is to fill in gaps in knowledge. Its nature is dynamic, flexible, and exploratory. That said, effective learning projects share three qualities. First, the environment is conducive to learning and relearning, retrieving and reflecting on prior knowledge, and ultimately transferring what is being learned into clinical practice (Ahrens, 2017; Chow, 2019a; Haskell, 2001). As recommended in *BR*, one important strategy is actively working to protect the time one sets aside for DP (e.g., turning off the phone, social media, and email notifications, including other interruptions). Second, effective learning projects are open to a wide variety of inputs. That means looking beyond the world of therapy for inspiration and guidance. For example, if creating more effective structure in sessions is the objective, "know-how" might come from a colleague or therapy book but also from watching a documentary on how filmmakers craft the narrative arch of a story to create emotional impact. Third, and last, mindful of "Parkinson's Law"—the danger that when left open-ended, work will expand to fill the time allotted—the most productive learning projects are time bound. As simplistic as it may seem, Liam was given specific tasks to complete within a given period, allowing him and his coach to monitor progress easily, make needed "just-in-time" adjustments, and plan the next steps.

It goes without saying that learning projects are goal directed. Goals both inform and determine the learning project. Returning to Figure 2.4, the first, or outcome goal, is "what" one aims to achieve in the learning project. Recall that Liam's initial objective was to improve his results. When his attention shifted to the "how," or process goal, the initial outcome goal evolved—first, from improving results with men to becoming eventually more comfortable and skilled in working with men who wanted and expected direction and advice. Once clear, the items listed in the TDPA provide numerous evidence-based suggestions for effective action. As portrayed in the graphic, think of the process goal as a lever. Its purpose is to provide the structure (i.e., lift) to reach the desired outcome.

FIGURE 2.4. The OPL Framework



PRINCIPLE-BASED EXERCISES

Before considering the following exercises, ensure you have taken all the steps outlined in the decision tree presented at the start of this chapter. It is assumed you (a) are routinely measuring your performance; (b) have collected sufficient data to establish a reliable, evidence-based profile of your therapeutic effectiveness; (c) have created a map or blueprint sufficiently detailed so that another clinician could replicate your work; and (d) have tried to complete the TDPA but want additional help to develop the learning objective with the greatest chance of improving your effectiveness.

Have your outcome data, blueprint, and TDPA in front of you while determining which ones will work best for you. If, after considering the suggested exercises, you still find yourself struggling with outcome goals, process goals, and a learning project, consult the suggestions and detailed case example at the end of the chapter.

Exercise 1: Connecting With Your Authentic Self

Principle: 1
Applicability: TDPA Items 3Aiv, 3Biv, 5Avi
Purpose
People routinely equate authenticity with acting in a manner consistent with their *actual* selves. For all that, research indicates the experience most often arises when we think and act in ways consistent with our *ideal* self (Gan & Chen, 2017). As already stated, for many psychotherapists—especially those who principally see themselves as empathizers—data, statistics, and performance metrics evoke strong feelings of "not me." This exercise is designed to honor and reconnect you with the ideals that brought you to the field—being of service to others.

Task
Part 1. Set aside 20 minutes once or twice a week for 1 month to think about a person you hold in high esteem because of who they are and what they do. It could be anyone from any domain of human performance—an athlete, scientist, musician, philanthropist, a person from the present, or perhaps a historical figure. "Spend time with them" by looking up their accomplishments, listening to interviews, watching videos online, reading a biography, or imagining a conversation with them. Complete this part of the exercise before reading further.

Part 2. After a month, devote the same amount of time over several weeks to imagining how others would know that data-driven DP is part of your ideal self. Using paper and pencil or your favorite note-keeping app, maintain a record of your thoughts and reflections. Be as specific as possible about what you would be doing; how others would know your work with statistics, metrics, and data is critical to being the most helpful you can be. Last, make engaging in this exercise routine.

Exercise 2: Recovering Your "University Days" Mindset

Principle: 2
Applicability: Potentially All Items on the TDPA
Purpose

Going to college is more than earning a degree and getting a job. It's about exploration, self-discovery, learning to tolerate boredom, being exposed to diverse peoples and ideas, making friends, falling in love, and having fun. It is noteworthy that most who start end up studying a subject entirely different from what they originally planned—around 80%, actually (The University of Tulsa, 2020). Such shifts in interest and focus are both difficult to anticipate and far from an indication of failure, given their dependence on chance and experience. Of course, graduation is the ultimate objective (i.e., outcome goal). And yet, relishing the journey—its fits and starts, ups and downs, twists and turns—makes earning a degree rewarding and transformational. The same may be said of DP.

Task

Part 1. Set aside 20 minutes once or twice a week for 1 month to think about a person, class, relationship, book, time of life, or event that unexpectedly but positively impacted the direction of your career and life. Keep a log of your reflections, noting the circumstances, any challenges arising from the change in direction, and what was required of you to step off your then-current path and make it so (see Exercise 7). Consider how the change both confirmed or disrupted your sense of self up to that time.

Part 2. When it comes to your DP learning project, suspend the desire for an immediate result (i.e., being given a degree before the education). Cultivate a "university mindset." For the following month, be open to chance change-producing events, people, and experiences related to your desire to improve your therapeutic effectiveness. Keep a log using index cards or a note-keeping app. Return to this exercise whenever you embark on a new learning project.

Exercise 3: Specifying the Outcome Goal

Principle: 2, 3
Applicability: Potentially All Items on the TDPA
Purpose

The purpose of DP is different from attempting to resolve a difficult or "stuck" case. The latter is typically focused on anomalies or outliers, one-off experiences from which little can be learned or applied to other clients and contexts (in *BR,* referred to as random errors). The former is about identifying and addressing recurring patterns in one's behavior that consistently undermine effective performance (i.e., nonrandom errors). Doing so requires gathering data via routine outcome monitoring sufficient to offer a reliable and valid profile of one's strengths and weaknesses. Once done, patterns can be extracted and effectively targeted for performance improvement.

Task

Part 1. Solve for patterns. After you have collected outcome and relationship data on 40 to 60 cases:

1. Using "closed" cases only, partition your outcome data into "successful" versus "unsuccessful" groups.
2. Study the two groups, looking for differences (gender, age, presenting problem, strength of the relationship, amount and trajectory of change, consistencies in your thinking and feeling about the clients).
3. Spend no more than 20 minutes at any one sitting, allowing time in between for the information to "percolate." Jot down any observations, thoughts, or "aha's" that occur to you during the time away.

Part 2. The next step is separating committed from aspirational outcome goals. To do so,

1. List all potential targets for DP (i.e., outcome goals) based on the analysis completed in Part 1.
2. Compare your results with the performance benchmarks (*BR*, pages 74–75).
3. Get as specific as possible. For example,
   - Reduce my youth population dropout rates from 47% to below 20%.
   - Reduce deterioration rates for men from 12% to 6%.
   - Reduce the rates of clients who make an unplanned termination after the first session from 35% to 20%.
   - Improve the rate of reliable change improvement for clients who have not experienced improvement after being seen for more than six sessions from 50% to 60%.
4. Commit to one outcome goal, temporarily designating all others aspirational (Doerr, 2018). The one committed outcome goal is the single target to which you will devote your efforts. (The next exercises will help identify and refine the process goal and learning project.) A good rule to follow is picking "low hanging fruit"—something that has high leverage on improving your overall effectiveness while also being easy to reach.

Exercise 4: Figuring out Your Process Goal

Principle: 2, 3
Applicability: Potentially All Items on the TDPA
Purpose

Once you know your "what," the TDPA is specifically designed to help you figure out the "how" (i.e., your process goal). On the basis of feedback from therapists since the publication of *BR* and the research reviewed in the *FG*, significant revisions have been made to the tool.

Task

With your outcome goal in mind, review the latest version of the TDPA, taking time to

1. Rate each item. Spending time reviewing case notes from active clients will ensure accuracy and representativeness.
2. Go through the document and identify the top three activities you believe will have the greatest impact on your results.
3. Select one to work on now, making sure it is *influenceable* and *predictive* of the outcome goal you've listed (see Figure 2.5).
4. Have a coach or expert—someone who knows your work—complete the Supervisor/Coach version of the TDPA and compare the ratings. Work together to identify and design a single process goal.

Exercise 5: Antigoals

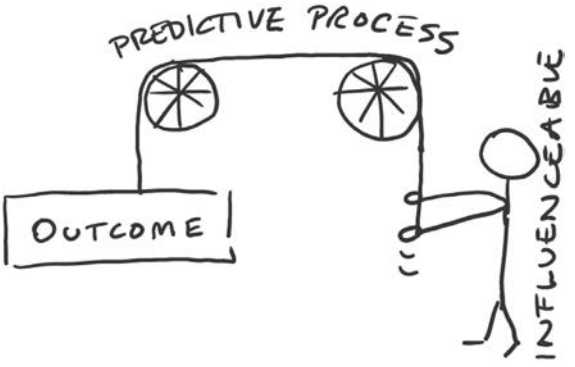
Principle: 2
Applicability: Potentially All Items on the TDPA
Purpose

Being clear about what is unimportant in our efforts to improve can be a powerful way to achieve clarity and maintain focus on our process goal.

Task

This exercise is simple yet effective. Review your completed TDPA, making a list of the items (and factors) that will *not* be a part of your primary process goal. Keep the list handy, reviewing it whenever you are tempted to pursue training or activities (outside of playful experimentations and just having fun) unrelated or tangential to your current process goal.

FIGURE 2.5. Influencing Outcome With a Process That Is Predictive and Influenceable



Exercise 6: Create a Centralized Note-Taking System

Principle: 1, 2, 3
Applicability: Potentially All Items on the TDPA
Purpose

Journaling and note taking, research indicates, has multiple benefits. A study in the *Journal of Experimental Psychology*, for example, found it reduced intrusive and avoidant thoughts about negative events while improving working memory (Klein & Boals, 2001). Such improvements, it is believed, free up precious (and limited) cognitive resources to focus on other mental activities (e.g., managing stress, maintaining focus, learning). While popular in the treatment and self-help literature, the benefits for anyone engaging in DP could not be clearer. Keeping a consistent and "centralized" (i.e., one fixed note-taking location) record helps in the recollection, organization, and consolidation of new learnings (Agarwal & Bain, 2019; Chow, 2019a; Miller et al., 2020). On the flip side, the lack of a centralized note-taking system is often a barrier to accelerated learning.

Task

Part 1. Determine how you will keep a record of your DP efforts (e.g., handwritten, using a note-taking app). In this record, document your experiences, including those that might strike you as irrelevant to your current learning project. Treat your record as a garden you must seed, nurture, nourish, and prune on an ongoing basis to bear fruit.

Here are some tips that others have found helpful:

- If you decide to keep handwritten notes:
  - Put them in a bound journal.
  - Number and date both the notebook and pages because doing so will help in recall.
  - Leave the first few pages blank to facilitate the later creation of a *map of content.* Unlike a traditional table of contents, the map of content is designed to both highlight where specific content can be found (e.g., "Learning Project 1 on improving structure in therapy; see pages, 4, 32, and 33") and also facilitate making connections between sections within and between notebooks.
  - Use sticky "flag tabs" to highlight themes (e.g., green for key learnings, yellow for points requiring further consideration, blue for interesting but less useful ideas and insights).
- If you choose to use an electronic medium:
  - It should be easy to use. Bells and whistles are less important than accessibility and simplicity.
  - It should be easy to search, retrieve, and, most important, create links between notes. Certain apps (e.g., Notion, Roam Research, Obsidian)

allow for linking one note to another as well as using links to reference and connect themes within the notes (i.e., bidirectional. For instructions on the use of Obsidian to link your notes, see https://darylchow.com/frontiers/rightforyou/).

  - Use tags, labeling each note to create relationships amid the content (e.g., #empathy, #dropout, #couplestherapy). Of course, storing the notes in themed folders can also help to organize content.

- For the purposes of your learning project, consider keeping a record of the following:
  - Each week, recall the people you worked with, recording one mistake and one success. Limit each entry to 140 characters to ensure consistency and efficiency (see https://darylchow.com/frontiers/weeklytherapylearnings/ for an example).
  - Note thoughts, reflections, and summaries of readings, movies, books, and podcasts you have encountered, whether or not they seem relevant to your current learning project.
  - Record client feedback. Although you likely record this in your case notes, keeping a record in a central location will help in making connections between the various sources of information related to your learning project.

Part 2. After creating and starting a note-taking system, the next step is engaging in what experts in the learning sciences call *retrieval practice* (Agarwal & Bain, 2019). In practical terms, this means revisiting your notes on a routine basis, first looking at the heading or tags and trying to recall the specifics, and then refreshing your memory by reading the entire entry. Turns out that "testing yourself to learn" as opposed to "teaching to the test" is a powerful way of deepening your knowledge and understanding. Researchers believe it disrupts the false sense of fluency that can develop when details and nuance are forgotten in the learning process (Bjork, 2011). As you do so, resist early temptations to come to a conclusion, instead allowing the information to percolate in the hopes of making "higher order units, or 'chunks,' for conceiving, understanding, and organizing" (Miller et al., 2020, p. 27).

JANICE AND THE GIANT OUTCOME GOAL

As an example of applying the preceding exercises, consider Janice, a therapist with about 7 years of clinical experience who worked in both inpatient and outpatient mental health clinics. Once she had enough cases for a reliable, evidence-based analysis of her clinical performance, she took up Exercise 3 (i.e., specifying the outcome goal). In an effort to identify the outcome goal with the most leverage on improving her results, she created a spreadsheet listing each client's data (i.e., outcome and relationship scores) and other details. In a separate column, a distinction was drawn between those she treated

successfully (reliable improvement) and unsuccessfully (lack of reliable change, deteriorated, or dropped out after the first session). Next, with the spreadsheet open on her computer, she started reviewing the progress notes of her closed cases, "sorting for patterns."

Four were immediately apparent. First, many of the clients Janice treated unsuccessfully were originally seen in an inpatient context. Second, client progress and the quality of the relationship as measured by the Session Rating Scale (SRS) covaried. Specifically, SRS scores generally improved over time for those in the successful group while remaining stable (whether beginning high or low) among the unsuccessful. Third, no difference in initial SRS scores was found between clients who made progress over the course of care and dropped out, deteriorated, or did not improve. Janice knew this was a potential target for DP, given evidence showing lower initial relationship ratings are associated with better results at the end of treatment (Miller et al., 2020). Fourth and finally, the modal number of sessions Janice had with clients was 1, with 32% attending only a single visit.

As a professional whose identity was closely tied to her commitment to excellence, Janice's performance data evoked both anxiety and a strong sense of inadequacy. On the recommendation of her supervisor/coach, she chose to spend the next month engaging in Exercise 2 (i.e., recovering your "university days" mindset). While she was typically focused on achievement and performance, she worked at being open to growth instead of just competence (Chow, 2019b). Although the change in mindset did not come easily, spending time with her performance data was what did the trick. She marveled at how the routine administration of simple measures could reveal patterns that had, despite her best intentions, eluded detection.

Eager to begin actively taking steps to address the problems identified, she returned to Exercise 3, determined to choose a single, committed outcome goal on which to work. Once again, Janice found herself struggling. Turns out, consultation with her supervisor/coach revealed the issue. It is a common one: focusing on the "how" before being clear about and committed to the "what." For example, given the various patterns her SRS data revealed, she decided to work on developing skills related to eliciting more detailed, critical feedback (TDPA Dimension 1A). She further concluded that adding more organization and focus to her sessions (TDPA Dimension 1J) would improve results with clients she initially met in an inpatient setting and treated for longer periods.

Returning to her spreadsheet to revisit the patterns and choose a single, committed outcome proved to be the solution. After recording the four patterns in her journal, Janice spent a week thinking about the clients with whom she had been unsuccessful, reviewing the case notes for each:

- Clients starting in an inpatient context (~65%) routinely failed to follow through with scheduled outpatient appointments.
- Clients whose SRS scores did not improve over the course of care were significantly more likely to end treatment with little or no improvement in Outcome Rating Scale scores.

- Clients with high initial SRS scores were equally likely to end treatment unsuccessfully as successfully.
- Nearly a third of Janice's clients did not return following their first session.

With help from her supervisor/coach, Janice chose what she believed would be the easiest to address. In this instance, that "low-hanging fruit" was the high number of unplanned terminations by clients first seen in an inpatient setting. Stated specifically, her outcome goal was to reduce dropouts for clients transitioning from inpatient to outpatient from 65% to 40%. The remaining three performance concerns were labeled "aspirational" and set aside for possible DP in the future.

Exercise 4 came next—figuring out the process goal that would decrease the dropout rate of inpatient clients. After watching video recordings of several representative sessions together with her supervisor/coach, both agreed the conversations conducted with hospitalized clients were more unfocused than typical outpatient visits. Consistent with Janice's lower rating on TDPA Dimension 3Ai (3/10), this led to the formulation of a process goal and learning project organized around establishing and checking goal consensus in first and later sessions. However, when Janice subsequently interviewed several former clients, a different angle emerged. A number mentioned being surprised by her questions about and characterization of not continuing with sessions on an outpatient basis as "dropping out."

Discussing her findings with her supervisor/coach, the two agreed hope and expectancy factors were implicated, one element of which (TDPA Dimension 2A & D regarding role induction, setting and monitoring client expectations, and adapting the treatment rationale to foster engagement and hope) Janice had also rated low (3/10) on her initial completion of the tool.

Janice immediately went to work creating a learning project, taking time to brainstorm, talk with colleagues, and research ideas related to operationalizing her process goal. Because she found clients frequently struggled to parlay improvements made while in the hospital to their lives following discharge, she created what she later termed her "safety-net" system. Introduced early in care, it emphasized the critical role she would play and resources she could bring to bear in supporting lasting change for the client. Appointment reminders and help with arranging transportation to and from sessions were two among the many aspects of the system specifically designed to reduce dropouts.

Together with her supervisor/coach, Janice continued to monitor her performance data as she put her plans into action. Six months later, she was disappointed when improvement in the percentage of clients failing to follow through with posthospitalization outpatient sessions stalled at 50%. At one point, she began actively considering replacing her committed outcome goals with one of her remaining (three) aspirational goals. "Actually," she said, "nearly all of the items on the TDPA are things I could work on and do better at. How can I *not* try to improve on more of these?"

Completing the "antigoal" exercise (5) persuaded Janice to maintain her current objective but reconsider her process goal. Addressing TDPA Factor 2 (hopes, expectations, and role) had resulted in a decline in dropouts, but she was looking for more. Returning to recordings of her sessions and consulting the therapy blueprint she had created at the outset of her foray into DP, she noted the significant amount of time spent in initial visits conducting a thorough psychosocial history. It was an activity that had been ingrained in her clinical routine from her university days—and yet, she realized, the information gathered only rarely informed her work, delayed actively intervening to help clients, and often resulted in lower levels of engagement.

At this time, she ran across the book *The First Kiss* (Chow, 2018), which focused on the importance of the initial therapeutic encounters. In place of "taking" (paperwork, information gathering, long diagnostic workups), it encouraged therapists "giving" to clients, taking full advantage of the change research shows occurs early in treatment (Lutz et al., 2009, 2014). The same body of evidence reviewed in the book showed traditional "intake" practices resulted in higher dropout rates, slower progress, and more expensive care. It also identified an alternative: *resource activation* (Gassmann & Grawe, 2006). Instead of asking about the presenting problem, symptoms, and struggles, it involves actively soliciting information about client capabilities, motivations, and existing social support network.

At this point, Janice made a conscious choice to change her process goal from Items A and D on Dimension 2 (relationship factors) of the TDPA to Dimension 4 (client factors), specifically, Item D, "incorporating your client's strengths, abilities, and resources into care." In support of this new objective, she sought out research, training materials, and consultation. After several months, Janice's hard work began to pay off. Interestingly, her discontinuation rates among those clients beginning care in an inpatient setting declined (from 50% to 18%), and the modal number of sessions she met with clients tripled (from 1 to 3). As often happens, such improvements influenced other performance metrics, including a rise in Janice's overall effectiveness (i.e., effect size).

FINAL CONSIDERATIONS

Our empathic disposition primes us to zoom in on one person rather than many. In so doing, developmental psychologist Paul Bloom (2016) argued, we become biased by the spotlight effect, missing bigger patterns, the so-called forest for the trees. The purpose of this chapter has been to marry our empathic ability with the systematic approach needed for successful DP. Whatever one's primary disposition, the process is hard work. Some suggestions born of experience follow:

- Unless your data indicate deficits in the structural domain of the TDPA, limiting your process goals and learning project to mastering a specific theoretical orientation is a mistake. Instead of aiming at "doing things right,"

focus on finding the "right thing" to improve your results. In other words, keep your eyes on the outcome goal.

- If the TDPA and OPL framework took you an hour or so to complete, it probably isn't going to serve you well. More time—much more time—is required.
- If your process goal feels easy, it's unlikely to stretch you sufficiently to improve your performance.
- If you are struggling with your process goal and learning project, your outcome goal may be too vaguely defined or ambitious.
- If your outcome goal is proving too difficult to achieve, designate it as "aspirational" and move on.
- If you find yourself losing track of what you were working on, consider reviewing your journal (i.e., notes) more often and making your learning project more visible.
- If your learning project and process goal are not leading to improvement in your outcome goal, consider the following:
  - whether your process goal is clearly linked to your outcome goal
  - allowing more time to pass before assessing results
  - whether adequate effort has been devoted to your process goal and learning project
  - consulting a coach
- Keep in mind that outcome goals do not always equate with improving or learning therapy skills. A high "no-show" rate, for example, might best be addressed by adopting an automated email or message reminder system rather than new engagement techniques or abilities (Martin et al., 2015).

DECISION POINT

What to do next:

- If you have completed the TDPA and OPL framework and need guidance developing an exercise for your specific objective, turn to
  - Chapter 3 for client factors
  - Chapter 4 for therapist factors
  - Chapter 5 for relationship factors
  - Chapter 6 for hope and expectancy factors
  - Chapter 7 for structure
- If you have used the TDPA to establish a specific, individualized learning objective but are struggling to stay focused or motivated, turn to Chapter 8.

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