

Interview

Improving our effectiveness: An interview with
Scott D. Miller

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Scott D. Miller, Ph.D. is the founder of the International Center for Clinical Excellence, an international consortium of clinicians, researchers, and educators dedicated to promoting excellence in behavioural health services. He is the co-author of classic books including Escape from Babel, The Heroic Client and The Heart & Soul of Change. Scott was a member of the Brief Family Therapy Center team with Steve de Shazer and Insoo Kim Berg for several years in the late 1980s and early 1990s, and has gone on expanding research into what makes for effective practice.

What are some of the most exciting things in your work at the moment?

Studying what it takes to improve one's effectiveness as a therapist.

And how are you going about doing that?

For me, this topic has been a driving ambition most of my career, although the pathway it has taken has changed over time. Like many beginning therapists I first aligned with a particular model, I sought out some people whose work I admired, and I went to work at their agency. I helped develop that particular model, and during that time I truly believed we were getting better results, that I was getting better results. We had some researchers come in and look at our results, and we were achieving good results, but they were not better than anybody else's, which threw me into a dilemma: how were we

supposed to get better? My training and certainly my cultural background had a medical point of view: you had to learn a method, apply it to the right problem, and then the best results should follow. And so the team split up in 1993, and I went in search of an alternative explanation and way of improving my outcomes. This turned into the work on the common factors.

The idea for me at the time was that, maybe all methods shared a common core group of ingredients that could be operationalised in different ways depending on the therapist, the client and the context or culture. We wrote about the common factors extensively, worked on this perspective as a team. Then, at one point, we began to recognise that what we were saying made no sense; that it was paradoxical, even illogical. Specifically, since all of the models seemed to work equally well and the common factors were based on those models, how could learning those common factors make you more effective? And why would anybody be motivated to leave behind their approach to learn about the common factors—after all, according to us, their model already worked because of the factors anyway!

So we abandoned the common factors and instead began advocating that everybody should just measure their results. At least then each of us would know when we were and were not effective. We knew there was variability in our performance: sometimes we were effective, sometimes we weren't. And maybe, if we could find the times when we weren't effective, we could do something different that would enhance our effectiveness.

So this would be about measuring your own results?

Yes, the practitioner's own results using some standardised scale.

Irrespective of their allegiance to any model?

That's right. Earlier, when we were looking at the common factors we had pretty much decided that the model wasn't

important – that the ingredients in that model probably contributed nothing. Consistent with that view, we decided we didn't care how therapists worked as long as they were measuring their outcomes, identified when they weren't effective and, in those cases, did something different. We developed a couple of simple tools that could be used. However, when we began aggregating outcomes for very large groups, we discovered something that, once again, had stared the profession in the face for decades: the issue of therapist effects, therapist variability. Some therapists were consistently better at it than others. And I have to tell you, initially I thought, and I argued with one of my former supervisors for a long time, that this variation in effectiveness was chance, random variation, that therapists who had superior results one year would, given the clientele they saw the next year, return to the average. But it turned out that wasn't the case. Some therapists were consistently better, and with nearly anybody that walked through their door.

For me, that presented another puzzle. How do we account for this? Frankly, I didn't have any way to explain it. So I went back to what we always did, looking at the variables where the “light shone the brightest”: what kind of therapist and client qualities might account for this? And what methods did these top performers use? Despite our efforts, there was nothing there! It wasn't age, it wasn't experience, it wasn't the treatment model. Neither was it some personal quality of either the client or therapist that accounted for the superior effect.

As it so happened, I was on a flight coming back from Europe and stumbled on a magazine that featured the work of Anders Ericsson, a Swedish psychologist. The magazine was not one that I would ever have picked up or read on my own. It was a business magazine called *Fortune*. The issue included a review of Ericsson's work by Geoff Colvin, the editor of *Fortune* magazine, and author of a fabulous book, “Talent is overrated”. Colvin was intrigued by the very same phenomenon we were interested in, but in the fields of sports and finance. The typical answer is: “Well, there are simply some

who are genetically or some other way endowed with superior abilities". For him, like us, this was a very unsatisfactory answer. It is like: "There is no way any of us could do it, because we weren't born that way!" Anders Ericsson said that he did not see any evidence for that position, especially given that, in certain fields, improvements in performance had occurred at a rate that significantly outpaced what could have occurred by evolution.

Ericsson's idea was simple: top performers, regardless of the particular domain of expertise, are very focused in their efforts and put in much more time and effort practising at their "edge", where their usual effectiveness begins to break down. When I read that article, and later the book, it was like a light went. I couldn't believe we hadn't thought of it before. In psychotherapy, you diagnose, and then apply the techniques remedial to that diagnosis. Ericsson was arguing that the difference in effectiveness between therapists was in how they spent their time when they were not doing treatment.

This was the critical juncture. As a team, we had been looking in the wrong place. We were looking at what went on in therapy when we needed to look at what therapists did before therapy and after therapy. Finally, our long search bore fruit: more effective therapists spend a lot more time reflecting on their performance, identifying small errors, developing a plan for improving their performance, rehearsing it, executing it and then reviewing it once more. Over time, our research shows, this continuous process leads to small and incremental improvements. Right now, fleshing out the particulars is where my head is at.

That's really fascinating! I've been following your blog – one of your latest posts was about how “negative feedback” helps people improve even more than praise or “positive” feedback.

Yes – such findings have been well known in other areas of psychology, but not within the therapy realm. "Negative" feedback does have a profound, positive impact on perform-

ance. Unfortunately, negative sounds so negative! But really what is meant is simply “critical” feedback. “Critical” in the dictionary definition of the word means coming at the right moment and pointing out what could be or needs to be done differently. That’s critical, or negative, and contrasts sharply with praise for what one has done well. Don’t get me wrong, praise is important, especially when someone is first adopting a skill. Unfortunately, it quickly loses its ability to transform behaviour as expertise grows. In fact, what it tends to do is reinforce what Ericsson and other people might call “System 1-thinking” or “automaticity”. It reinforces our current way of doing things rather than causing us to pause, reflect, plan and try something different.

Ericsson’s starting point seems to have been the world of sport and other more physical skills, where you can see the outcome of what you have been doing rather quickly, where you have almost instant feedback about how you did. That seems to be very different in therapy – how do you know that something you did in therapy was actually something that helped the client to get a better outcome or not?

I would say, first, that your question, if it’s the first question that someone has, is the right question to have: “What would be the sign that we are doing something right?” Because right now what the field seems to say is: “Am I using the right technique for that problem, for this client?” And it is all about fidelity to an approach as opposed to trying to figure out: “What do I need to do to generate an appropriate outcome?” Which, of course, begs the question: “What outcome are we thinking about?” In the case of therapy we have offered some answers based on some of our earlier work with the common factors.

The single most important threat to outcome is lack of engagement. Clients tend to drop out physically or emotionally from the therapeutic process at a fairly alarming rate before they have achieved an improvement in their well-being of functioning. So one thing we could look at is client engage-

ment levels. And a good indicator of that is the client's experience of the working alliance or relationship. So we can ask the client to complete a simple scale right at the end of the visit to give instant feedback about their experience, about their engagement levels, about a couple of core topics which –as research has indicated for decades – have large effect-sizes, for example, empathy. If you look at the client experience of empathy, it has an effect-size of 0.6. By contrast, adherence to treatment model has less than 0.1.

So we've spent all of our time teaching therapists how to diagnose and to apply methods instead of learning how to develop empathetic responses that engage their clients. So that could be one area. And we would recommend that most therapists start there, because it's the largest contributor to engagement that research has established. Secondly, it is also an area where therapists get virtually no training after their initial introduction to a counselling course. And therapists vastly overestimate their ability to respond empathetically to people. If it weren't so sad, it would be funny to watch experienced therapists, when you present them with scenarios that most consider challenging, for example: dealing with a hostile or angry client; dealing with a threatening client; dealing with a client who is psychotic; therapists' abilities shrink from empathic abilities to untrained folks very quickly. But yet, when you give therapists the opportunity to learn relationship skills, most of them won't sign up for such a workshop. It is considered too basic, beneath them, in some way.

Coming from the Solution Focused coaching side, I was wondering about how we teach. We don't usually teach empathy. We somehow presume that empathy just happens when you take an SF stance: not assuming anything about the client and stressing their resources. What you think about that?

Hang with me because, of course, that's where I started. In 1988, I left my comfortable digs in Palm Springs, California and moved to Milwaukee, Wisconsin to work at the Brief

Family Therapy Center. I was there, full time, until 1993. Our own research showed that what we did contributed very little to the outcome and it did not result in more efficient or more effective care. What's more, I know the outcomes of every therapist who was working at the clinic at the time I was there because we tracked them, and the outcomes were very variable. Some were consistently more effective than others – and not the ones you might think, the ones that got attention. In fact, the most effective practitioner there was a student, and she was more effective than any of us.

How was effectiveness measured at that point?

At that particular time we were using the same questionnaire MRI had developed and used. It's a fairly soft metric, but even with such a gross measure, administered the way it was, it confirmed what the research says about the contribution of the treatment model to outcome. If we ask: "Which model works best?", the answer is: "They all work equally well in the main and there is significant variability among therapists in terms of their effectiveness". Simply put, model and technique are the smallest contributors to change. So for me, if I wanted to improve my effectiveness, I wouldn't start by learning a new model. I would start with the factor that decades of research shows contributes the most to improved outcomes: relationships.

I think that our readers will be very interested in your point of view!

Now, just to be clear, sometimes when I talk about this, people think I'm saying therapists do not need a model. But actually, I am saying exactly the opposite. Of course you need a model, treatment needs structure. But what makes a model effective is who is using it and with whom. The real key to improving your effectiveness is noticing when what you usually do that you think works doesn't, and then doing something different.

And how are you then going to develop alternatives?

Yeah! That's the important question. And sadly, there are no shortcuts in that regard. Improving one's performances requires measurement, reflection and analysis, and input from a coach or an expert. Multiple studies have come out in the last year looking at therapists, and have found that the best—that is those with higher effect sizes – devote about 4 1/2 times more hours per week to this process – known in the literature as “deliberate practice” – than average therapists, and 14 times more time than the least effective therapists. The latest study was prospective in nature. It found ongoing measurement of results, identification of errors and failing cases, giving specific feedback and helping in the development of a plan for improvement leads to slow, modest, incremental changes in effectiveness at the individual provider level. Believe it or not, it's the first study of its kind. By contrast, there is no evidence that traditional professional development activities, such as supervision or continuing education workshops, improve effectiveness. Again, the key is reflecting on one's practice, using some standardised measure of outcome to identify areas for improvement, and engaging in a process of planning and reflection.

So when you look at how therapists can improve, do you think that is also somehow applicable to how coaches can improve? What's your take on whether your results are also applicable to other forms of helping conversations?

If we are really strict and we say: “Is there evidence?”, the answer has to be: “No”. However, my sense is that coaches are employing the very same basic core skills as therapists, meaning you're trying to engage people in a process of improving their performance. So, unless there is some evidence that the processes by which change is accomplished in coaching and psychotherapy are dramatically different – and I don't see any evidence of that – I think the answer is, “Yes!”

If coaches would measure their outcomes, establish a baseline, identify the edge of their performance – errors and failures-, develop a plan and rehearse that plan, execute and reassess, then over time their outcomes, however defined, would likely improve. Now, sometimes when I talk about this stuff, the next question that comes up: “What specifically am I supposed to practise?”

Yeah, exactly. I was going to ask that.

OK, initially this may sound evasive, so hang with me as I try to explain. The mentality that leads to this question is the very same mentality that has limited our profession for decades. It's a medical mentality: “Tell me what to do, and I'll do it”. It's like if we all practised the same thing, we all would improve! The problem is that your errors, your growth edge, is going to be different from my errors and growth edge. That's why it requires a community and a coach, somebody to really help you look at your data and figure out what you need to work on. The best pianists, the best violinists, the best chess players don't all practise the same things. They practise what they need to practise.

There is this idea in the coaching field that coaching at a master level shouldn't be demonstrating adherence to a model in the coaching conversation. Your coaching is not supposed to show that you are using a specific model, you're supposed to tailor and customise whatever you do exactly to the client in front of you. From what you said it seems like that this is not the way to go. Could you share some of your thinking around that?

I suppose it's similar to someone from the outside saying that: “Jazz is the best kind of music because it doesn't follow any structure, so that's the best kind!” Really? Who decided that? The best kind of music depends on the person listening. I can listen to someone playing Mozart and be uninspired and unmoved. Then I listen to another person and it makes my hair

stand on end! So when you're learning something, when musicians learn something, they start with scales and they gradually build skills from there. Most expert musicians continue to do scales. Therapists need to do the same. It's wrong to think the most advanced performers within a domain don't have to do the basics anymore. That's not true at all. It's certainly not true of the most accomplished performers. The mindset behind the question – the assumption – is that process is more important than outcome.

Honestly, for me, I don't care how the good results are achieved. I just care about "are the results achieved?" And the bottom line is, you'd better do everything in your power to achieve the best results. More importantly, if you want to improve, then you have to find out when you're not producing the best outcomes and then plan to do better. Having a solid standard from which to vary is essential and it's also what differentiates work from chaos: "I'm just going to go in and do whatever fits the client!" Really? I don't even know what that means. What's the measurable standard of that? How would you know that you have done it? It's ridiculous, I think. You have to have a standard. If you are going to get better, you have to be able to vary from a known standard or, what I earlier called, a baseline. So, most jazz musicians don't start out playing jazz. They are classically trained and then they move onto jazz.

So can you say that you cannot assess the quality of the coaching session from just one coaching session, but you can identify what this coach might explore in order to get better?

I would say that most clinicians, at least in the therapy world, have no idea how effective they are. When I'm teaching this stuff, I often tell a joke. Let's say you're having a party at your house, and somebody calls you and asks you: "How do I get to your house?" What is the first question that you will ask them?

Where are you?

In our field, nobody asks: “Where are you?” and they are still assuming that they can teach you how to get to where they are. Again, it is this wildly crazy disconnect. So, I would say that the first thing that people have to do is measure their results – establish a baseline against which any attempts to improve performance can be judged. What to measure? Two things: (1) the working relationship – and I don’t see any reason why the working relationship wouldn’t be important coaching; and (2) outcome. In psychotherapy, we propose measuring well-being because it is a fairly good predictor of a number of other important variables (e.g. how often a person accesses the doctor, whether they work and can go to work, whether they are present at work when they are there, etc.). In other words, before you can improve, you need to know where you are. Once the baseline has been established, you can start to identify moments when you’re not living up to that baseline.

For example, maybe you are a coach that does well with men but for some reason your outcomes with female clients are slightly poorer. Maybe there is a difference in your ability to engage and retain people in your services? What does that mean exactly? Is that good or bad? Reflection follows. “What might account for the difference in outcome and retention?” Looking closely at our data can help us identify potential areas for improvement we can both reflect on and make plans to improve. Very often, the burden of responsibility when our services don’t work is shifted to the client or failure to implement the method correctly. And there, we remain stuck: “Well, if you had asked the ‘miracle question’ the right way, it would have worked”. To this, I ask, “Really? That’s what caused the problem?” I don’t think so.

Yeah, it really seems to fly in the face of the emergence of the conversation. I have a couple of more questions that were sparked by your story of BFTC and measuring differences in effectiveness there. When you look at the development of brief therapy – it seems to me that you have a good overview of the field – to what extent has brief therapy arrived on the therapy stage?

I had this experience when we did a Festschrift for John Weakland back in 1992 in New Orleans. Jay Haley was there, Paul Watzlawick, Richard Fisch, and of course Steve de Shazer. I can remember Jay Haley getting up and going on and on about how bad psychoanalysis was, and how problems could be solved much more efficiently with brief therapy. Even then – 24 years ago, sitting in the back of the room, I was thinking: “Jay, what are you on about. Don’t you know, the war has been won!” Why are we still fighting this battle of brief therapy? Virtually all therapy was, by that time, short term – at least, in the United States. But, it seemed to me, he/they couldn’t let it go. The battle between long and short term therapy was what defined *their* era – and I believe they served an important role, sparking the transition from “Everybody needs long-term, insight-oriented analysis to resolve their problematic childhood”, to “Hey, we might be able to help people more quickly!”

Nowadays, I think the distinction has lost its usefulness. For example, can you imagine needing, say, heart surgery, and the physician asking, “Would you like the long or short surgery?” Surely, you’d think the question ridiculous. My thought would be, “I want the *effective* one”.

I think Steve de Shazer said once: “Therapy should take as many sessions as necessary and not one session more”. It seems that you’re agreeing with that.

Yeah, sort of, but my sense is that this idea of just doing a short term intervention, if that’s all that’s necessary, has aligned, once again, with medicine: treating disorders or

problems, the goal of which is that those things go away. We become psychological surgeons. We cut out the problem. And I think that this puts us at a distinct disadvantage, economically. I prefer, and this is what I tell people in workshops, them to think much more like dentists. The dentist is a professional you go to every so often. They clean your teeth, they give you a report, and every once in a while you need a bit more work. But no dentist says: “We’re done now, never come back.” And no dentist would say: “Oh, no! You have another cavity. I’m a failure! What’s wrong with my model?” To me it’s a rather bankrupt idea. And instead we should be able to provide care for people throughout their lifecycle.

This seems much more like a coaching model.

And this is what Nick Cummings was arguing back in the 1980s: that we should function a bit more like dentists than surgeons. I get this question in workshops about whether I have done follow-ups to find how long the effects last. And when people ask that question, I don’t think they realise how absurd it is. If somebody comes back with a cold year after they were treated for a cold by their physician, the physician doesn’t say: “Oh, the treatment didn’t work!” or “You’ve had a relapse into colds.” It is a logic that makes no sense, but we continue to apply this mentality to psychotherapy: if you’re depressed, a good outcome is that it never happens again.

It seems to me that this medical model is far less prevalent in the coaching community. We have brief coaching. However, for example, BRIEF in London try to be as fast as possible and, of course, that puts you at an economic disadvantage as a coach. So if I hear you correctly, there is a lot of hope for solution focused brief – or not brief – coaches to accompany people like dentists.

Yes. And here’s something that we have known for decades, and that the data at BFTC also showed: outcomes improve with every additional session. So, having a goal to be “brief”,

to me, is more a preoccupation of therapists than clients. Again, my goal is not about long or short. It's about effect. And now, thankfully, we have some empirically established norms about how and when people should change in therapy. In general this evidence indicates that most people respond relatively quickly.

Now, that doesn't mean everybody should be better within a handful of visits, but it can serve as a benchmark, or norm-reference against which a therapist may compare the progress of an individual client and make an informed decision about when a change of approach may be warranted.

So can we think out-of-the-box and think about coaching? We are “The Association for the Quality Development of Solution Focused Consulting and Training” publishing this journal. What would be your recommendation for us in supporting the quality development of solution focused coaches, what should we require them to do, what would be a good way to support the development of solution focused coaching quality?

The most challenging aspect of the research we've been talking about is that it – deliberate practice, that is – is no fun. In other words, it's hard work. It's not something that is pleasant, and it requires a great deal of investment of time and effort just to improve a little bit. So, to answer your question, what organisations can do is provide a standard, a criterion, a norm reference, and then secondly a community to support people in deliberately practising.

Give me some practical examples.

Let's talk about the standard first. It would, first of all, be interesting to me to have people decide what good coaching accomplishes and have a clear definition of that, and then an organisation that supports measurement of that on a routine basis, and then provide a norm reference. So, the first discussion that needs to happen is about how practitioners know that

what they are doing works. What are you shooting for? Then, a set of measures or access to measures of those outcomes needs to be provided. Once practitioners gather outcome data, the organisation can say: “Members of our organisation cannot only talk the talk but they can also walk the walk!” They can not only say what coaching is, but they’re actually measuring their results to make sure that they are helping.

After a baseline level of performance is established for the field of coaching in general, the organisation could say: “Members of our organisation meet the standard”. Now, I can tell you that people’s response to this idea initially is fear. They fear they won’t be good. What most will find out is perhaps more frightening: they are average! And as an organisation, you can provide a community that will support people in doing the hard work required to improve from there. Such a focus, it seems to me, really changes the nature of how we train people at a postgraduate level. In truth, most practitioners are pretty good at what they do. The challenge is that getting better requires even more effort than it took to get pretty good.

This is very interesting! Thank you for your thoughts!

I am grateful to be called. Solution Focused Brief Therapy is where my roots are – I have moved on but I haven’t abandoned these roots.

Thank you very much.