Structured Interviews on Research, continued

Scott D. Miller

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1. Psychotherapy research seems to point towards a greater variability in outcomes between therapists than therapies. How can this research on "therapist effects" inform clinicians and their real-world practice?

For me, at least in two ways. The first is that, given the variability of performance, we need to be monitoring our work on an ongoing basis, both in our ability to connect with the individual client but also our outcomes. The second one is how we determine whether or not we are developing professionally. There's overwhelming evidence that therapists value professional development activities, as well as an identity consistent with the idea that they are getting better with time and experience. The data indicates that they *don't* get better with time and experience. And so, the variability of individual performance gives us a window to look through to understand why some are better than others, consistently so. And, it turns out, some evidence exists that the differences are attributable to the amount of time spent in an activity called "deliberate practice." In 2007, our team introduced this concept to the broader psychotherapy audience, and began looking at how therapists who were better spent their time. On average, top performers spend two to four times as much time engaging in activities related to improving their outcomes, outside of performing psychotherapy—meaning, they're engaging in deliberate practice. I think those are really the two areas.

2. How can the field of *psychotherapy integration*, specifically, benefit from recognition of the importance of therapist effects?

Well, I think one of the chief integrative variables is the therapist. Sol Garfield was pointing this out nearly two decades ago, suggesting the field look into the contribution made by the clinician to outcome. Instead, our profession, in my opinion, took a detour developing treatment models and approaches, believing that training therapists in those approaches would lead to superior outcomes and superior performing therapists. I think the outcome of that choice has proven unhelpful, the opposite direction of what was predicted. So, one chief integrative variable should be the professional development of clinicians. To me, the variability between providers gives us evidence on what we might focus on.

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3. Funding for psychotherapy research has generally gone for the study of particular models applied to the treatment of specific disorders. Meanwhile, much of the research suggests that *who* provides the treatment is more important than *which* treatment is provided. Going forward, what can research programs do to deal with this tension?

I think there are so many things that could be done. Whether or not they will happen is an open question. The current way research is thought about and funded has been mastered and driven by those in university settings. Changing the dominant approach to thinking and researching is likely, as is true of change in general, to prove difficult. So, I'm not particularly sanguine about the prospects of researchers changing their view and adopting a different way of thinking about the field and how we do research. I also think that much of the research continues to be funded by organizations led by physicians and the medical model. Sorry to be pessimistic, but I think it's very unlikely that those organizations (e.g., NIMH, NICE) are going to foster change in a new direction. What's more likely to happen is what's been happening for the last 30 years: psychology will try to emulate medicine, and if it wants money to do research it will have to treat psychotherapy as an analogue to prescription drugs.

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4. Speaking of funding, would you rather be doing psychotherapy research in Europe or in the US, and why?

If the question is where I'd rather be practicing psychotherapy, I would say in Europe six ways 'til Sunday. The reason is I think Europe has a much larger social consciousness and safety net. The US has a distinctly different culture. More, much of the practice is driven by reimbursement economics. I don't know enough about how psychotherapy research in funded in Europe to comment about research there to argue convincingly one way or the other. For the reasons I stated in the previous questions, research funding is very difficult for someone coming from a contextual rather than medical paradigm.

5. In your opinion, of relatively recent research findings, what are the most important for clinicians?

In terms of effectiveness and professional development, I think some of the most intriguing results are about individual therapist's differences. It is also, at present, the "Wild West." We don't really have a good definition of what therapists need to practice in order to get better. Even those of us hailing from a contextual paradigm are unclear at this moment about what might be the best protocol for professional development. At the same time, I think there is emerging evidence that deliberate practice includes a number of essential elements. The first is, monitoring the outcome as well as engagement level of clients in your therapy practice. Doing so will aid in identifying performance improvement opportunities—where we show deficits in our outcomes, for example.

The Integrative Therapist: Call for Content

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Submission Deadlines and Publication Dates
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Specifications

- The preferred length of submissions is 1,250 words or less
- Block style, single spaced with an extra space between paragraphs
- No paragraph indentations, page numbering, headers or footers
- Use subheadings and bullet points freely
- Bare Minimum references should be single spaced, in approved APA-style format
- lease include a photo of the author or authors, minimum 50K file size each.
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