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NETWORKER

## CLINICAL GUIDE

# The Secrets of Supershrinks: Pathways to Clinical Excellence

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# The Secrets of Supershinks: Pathways to Clinical Excellence

BY SCOTT MILLER, MARK HUBLE, AND BARRY DUNCAN

**B**oisea trivittatus, better known as the boxelder bug, emerges from the recesses of homes and dwellings in early spring. While feared neither for its bite nor sting, most people consider the tiny insect a pest. The critter comes out by the thousands, resting in the sun and staining upholstery and draperies with its orange-colored wastes. Few find it endearing, with the exception perhaps of entomologists. It doesn't purr and won't fetch the morning paper. What's more, you'll be sorry if you step on it. When crushed, the diminutive creature emits a putrid odor worthy of an animal many times its size.

For as long as anyone could remember, *Boisea trivittatus* was an unwelcome yet familiar guest in the offices and waiting area of a large Midwestern, multicounty community mental health center. Professional exterminators did their best to keep the bugs at bay, but inevitably many eluded the efforts to eliminate them. Tissues were strategically placed throughout the center to assist staff and clients in dispatching the escapees. In time, the arrangement became routine. Out of necessity, everyone tolerated the annual annoyance—with one notable exception.

Dawn, a 12-year veteran of the center, led the resistance to what she considered “insecticide.” In a world turned against the bugs, she was their only ally. To save the tiny beasts, she collected and distributed old mason jars, imploring others to catch the little critters so that she could safely release them outdoors.

Few were surprised by Dawn’s regard for the bugs. Most people who knew her would have characterized her as a holdout from the Summer of Love. Her VW microbus, floor-length, tie-died skirts, and Birkenstock sandals—combined with the scent of patchouli and sandalwood that lingered after her passage—solidified everyone’s impression that she was a fugitive of Haight-Ashbury. Rumor had it that she’d been conceived at Esalen.

Despite these eccentricities, Dawn was hands-down the most effective therapist at the agency. This finding was established through a tightly controlled, research-to-practice study conducted at her agency. As part of this study of success rates in actual clinical settings, Dawn and her colleagues administered a standardized measure of progress to each client at every session. What made her performance all the more compelling was that Dawn was the top performer seven

years running. Moreover, factors widely believed to affect treatment outcome—the client’s age, gender, diagnosis, level of functional impairment, or prior treatment history—didn’t affect her results. Other factors that weren’t correlated to her outcomes either were her age, gender, training, professional discipline, licensure, or years of experience. Even her theoretical orientation proved inconsequential.

Contrast Dawn with Gordon, who couldn’t have been more different. Rigidly conservative and brimming with confidence bordering on arrogance, Gordon managed to build a thriving private practice in an area where most practitioners were struggling to stay afloat financially. Many in the professional community sought to emulate his success. In the hopes of learning his secrets or earning his acknowledgement, they competed hard to become part of his inner circle.

Whispered conversations at parties and local professional meetings made clear that others regarded Gordon with envy and enmity. “Profits talk, patients walk,” was one comment that captured the general feeling about him. But the critics couldn’t have been more wrong. The people Gordon saw in his practice regarded him as caring and deeply committed to their welfare. Furthermore, he achieved outcomes that were far superior to those of the clinicians who carped about him. In fact, the same measures that confirmed Dawn’s superior results placed Gordon in the top 25 percent of psychotherapists studied in the United States.

In 1974, researcher David F. Ricks coined the term *supershinks* to describe a class of exceptional therapists—practitioners who stood head and shoulders above the rest. His study examined the long-term outcomes of “highly disturbed” adolescents. When the research participants were later examined as adults, he found that a select group, treated by one particular provider, fared notably better. In the same study, boys treated by the “pseudoshrink” demonstrated alarmingly poor adjustment as adults.

That therapists differ in their ability to affect change is hardly a revelation. All of us have participated in hushed conversations about colleagues whose performance we feel falls short of the mark. We also recognize that some practitioners are a cut above the rest. With rare exceptions, whenever they take aim, they hit the bull’s-eye. Nevertheless, since Rick’s first description, little has been done to further the investigation of super- and pseudoshinks. Instead, professional time,

energy, and resources have been directed exclusively toward identifying effective *therapies*. Trying to identify specific interventions that could be reliably dispensed for specific problems has a strong common-sense appeal. No one would argue with the success of the idea of problem-specific interventions in the field of medicine. But the evidence is incontrovertible. *Who* provides the therapy treatment is a much more important determinant of success than *what* treatment approach is provided.

Consider a study reported by Bruce Wampold and Jeb Brown in the October 2005 *Journal of Consulting and Clinical Psychology*. It included 581 licensed providers—psychologists, psychiatrists, and master's-level therapists—who were treating a diverse sample of more than 6,000 clients. The therapists, the clientele, and the presenting complaints weren't different in any meaningful way from those in clinical settings nationwide. As was the case with Dawn and Gordon, the clients' age, gender, and diagnosis had no impact on the treatment success rate and neither did the experience, training, and theoretical orientation of the therapists. However, clients of the best therapists in the sample improved at a rate at least 50 percent higher and dropped out at a rate at least 50 percent lower than those assigned to the worst clinicians in the sample.

Another important finding emerged: in those cases in which psychotropic medication was combined with psychotherapy, the drugs didn't perform consistently. The effectiveness depended on the quality of the therapist—drugs used in combination with talk therapy were 10 times more effective with the best therapists than with the worst therapists. Among the latter group, the drugs virtually made no difference. So, in the chemistry of mental health treatment, orientations, techniques, and even medications are relatively inert. The catalyst is the clinician.

## The Making of a Supershrink

So how do the supershrinks—practitioners as dissimilar as Dawn and Gordon—do what they do? Are they made or born? Is it a matter of temperament or training? Have they discovered a secret unknown to other practicing clinicians or are their superior results simply a fluke, more measurement error than reality? Answering these questions is critical. If being the best is matter of birth, personal disposition, or chance, the phenomenon would hardly be worth further study. But should their talents prove transferable, the implications for training, certification, and service delivery are nothing short of staggering.

Enter the Institute for the Study of Therapeutic Change, an international group of researchers and clinicians dedicated to studying what works in psychotherapy. For the past eight years, the group, including ourselves, has been tracking the outcomes of thousands of therapists treating tens of thousands of clients in myriad clinical settings across the United States and abroad. Like David Ricks and other researchers, we found wide variations in effectiveness among practicing

clinicians. Intrigued, we decided to try to determine why.

We began our investigation by looking at the research literature. The institute has earned its reputation in part by reviewing research and publishing summaries and critical analyses on its website ([www.talkingcure.com](http://www.talkingcure.com)). We were well aware at the outset that little had been done since Rick's original paper to deepen the understanding of super- and pseudoshrinks. Nevertheless, a massive amount of research had been conducted on what makes therapists and therapy effective in general. When we attempted to determine the characteristics of the most effective practitioners using our national database, hypothesizing that therapists like Dawn and Gordon must simply do or embody more of "it," we smacked head first into a brick wall. Neither the person of the therapist nor technical prowess separated the best from the rest.

Frustrated, but undeterred, we retraced our steps. Maybe we'd missed something—a critical study, a nuance, a finding—that would steer us in the right direction. We returned to our own database to take a second look, reviewing the numbers and checking the analyses. We asked consultants outside the institute to verify our computations. We invited others to brainstorm possible explanations. Opinions varied from many of the factors we'd already considered and ruled out to "it's all a matter of chance, noise in the system, more statistical artifact than fact." Said another way, supershrinks weren't real, their emergence in any data analysis was entirely random. In the end, nothing we could point to explained why some clinicians achieved consistently superior results. Seeing no solution, we gave up and turned our attention elsewhere.

The project would have remained shelved indefinitely had one of us not stumbled on the work of Swedish psychologist K. Anders Ericsson. Nearly two years had passed since we had given up. Then Scott, returning to the U.S. after providing a week of training in Norway, stumbled on an article about Ericsson's findings published in *Fortune* magazine. Weary from the road and frankly bored, he'd taken the periodical from the passing flight attendant more for the glossy pictures and factoids than for intellectual stimulation. In short order, however, the magazine title seized his attention—in big bold letters, "WHAT IT TAKES TO BE GREAT." The subtitled cinched it, "Research now shows that the lack of natural TALENT IS IRRELEVANT to great success." Although the lead article itself was a mere four pages in length, the content kept him occupied for the remaining eight hours of the flight.

Ericsson, Scott learned, was widely considered "the expert on experts." For the better part of two decades, he'd been studying the world's best athletes, authors, chess players, dart throwers, mathematicians, pianists, teachers, pilots, physicians, and others. He was also a bit of a maverick. In a world prone to attribute greatness to genetic endowment, Ericsson didn't mince words, "The search for stable heritable characteristics that could predict or at least account for superior performance of eminent individuals [in sports, chess, music, medicine, etc.] has been surprisingly unsuccessful. . .

. Systematic laboratory research . . . provides *no* evidence for giftedness or innate talent.”

Should Ericsson’s bold and sweeping claims prove difficult to believe, take the example of Michael Jordan, widely regarded as the greatest basketball player of all time. When asked, most would cite natural advantages in height, reach, and leap as key to his success. Notwithstanding, few know that “His Airness” was cut from his high school varsity basketball team! So much for the idea of being born great. It simply doesn’t work that way.

The key to superior performance? As absurd as it sounds, the best of the best simply work harder at improving their performance than others do. Jordan, for example, didn’t give up when thrown off the team. Instead, his failure drove him to the courts, where he practiced hour after hour. As he put it, “Whenever I was working out and got tired and figured I ought to stop, I’d close my eyes and see that list in the locker room without my name on it, and that usually got me going again.”

Such *deliberate practice*, as Ericsson goes to great lengths to point out, isn’t the same as the number of hours spent on the job, but rather the amount of time specifically devoted to reaching for objectives *just beyond one’s level of proficiency*. He chides anyone who believes that experience creates expertise, saying, “Just because you’ve been walking for 50 years doesn’t mean you’re getting better at it.” Interestingly, he and his group have found that elite performers across many different domains engage in the same amount of such practice, on average, every day, including weekends. In a study of 20-year-old musicians, for example, Ericsson and colleagues found that the top violinists spent 2 times as much time (10,000 hours on average) working to meet specific performance targets as the next best players and 10 times as much time as the average musician.

As time consuming as this level of practicing sounds—and it is—it isn’t enough. According to Ericsson, to reach the top level, attentiveness to feedback is crucial. Studies of physicians with an uncanny knack for diagnosing baffling medical problems, for example, prove that they act differently than their less capable, but equally well-trained, colleagues. In addition to visiting with, examining, taking careful notes about, and reflecting on their assessment of a particular patient, they take one additional critical step. *They follow up.* Unlike their “proficient” peers, they don’t settle. Call it professional compulsiveness or pride, these physicians need to know whether they were right, even though finding out is neither required nor reimbursable. “This extra step,” Ericsson says, gives the superdiagnostician, “a significant advantage over his peers. It lets him better understand how and when he’s improving.”

Within days of touching down, Scott had shared Ericsson’s findings with Mark and Barry. An intellectual frenzy followed. Articles were pulled, secondary references tracked down, and Ericsson’s 918-page *Cambridge Handbook of Expertise and Expert Performance* purchased and read cover to cover. In the process, our earlier confusion gave way to understanding. With con-

siderable chagrin, we realized that what therapists per se do is irrelevant to greatness. The path to excellence would never be found by limiting our explorations to the world of psychotherapy, with its attendant theories, tools, and techniques. Instead, we needed to redirect our attention to superior performance, regardless of calling or career.

## Knowing What You Don’t Know

Informed by this new perspective, the team moved into high gear. Suddenly, several studies we’d come across during our review of the literature took on new meaning, illuminated by Ericsson’s finding that direct feedback made a big difference in creating people who excelled. The first focused on private practitioners working in a managed behavioral health care network. Veteran researchers Deirdre Hiatt and George Hargrave used peer and provider ratings, as well as a standardized outcome measures, to assess the success rates of therapists in their sample. Once again, providers were found to vary significantly in their effectiveness. What was disturbing, though, is that the *least* effective therapists in the sample thought they were on par with the *most* effective! As the brilliant detective Sherlock Holmes once observed, “Mediocrity knows nothing higher than itself.” Like diagnosticians who don’t follow up and merely assume that their analysis is correct, without direct feedback, the ineffective therapists in the Hiatt and Hargrave study assumed that they were performing adequately.

Ericsson’s work on practice and feedback also explained studies showing that most of us grow continually in confidence over the course of our careers, despite little or no improvement in our actual rates of success. Hard to believe, but true. On this score, the experience of psychologist Paul Clement is telling. Throughout his years of practice, he kept unusually thorough records of his work with clients, detailing hundreds of cases falling into 86 different diagnostic categories. “I had expected to find,” he said in a quantitative analysis, published in May 1994 in the peer-reviewed journal *Professional Psychology: Research and Practice*, “that I had gotten better and better over the years . . . but my data failed to suggest any . . . change in my therapeutic effectiveness across the 26 years in question.”

Contrary to conventional wisdom, the culprit behind such mistaken self-assessment isn’t incompetence but rather *proficiency*. Within weeks and months of first starting out, noticeable mistakes in everyday professional activities become increasingly rare, making intentional modifications seem irrelevant, increasingly difficult, and costly in terms of time and resources. Once more, this is human nature, a process that dogs every profession. Add to this, the custom in our profession of conflating success with a particular method or technique and the door to greatness for many therapists is slammed shut early on.

During the last few decades, for example, more than 10,000 “how-to” books on psychotherapy have been published. At the same time, the number of treatment approaches

has mushroomed, going from around 60 in the early days to more than 400. There are presently 145 officially approved, manualized, evidence-based treatments for 51 of the 397 possible *DSM* diagnostic groups. Based on these numbers alone, one would be hard pressed not to believe that real progress has been made by the field. More than ever before, we know what works for whom. Or do we?

Comparing today's success rates with those of 10, 20, or 30 years ago is one way of finding out. One would expect that the profession is progressing in a manner comparable to the Olympics. Fans know that during the last century, the best performance for every event has improved—in some cases, by as much as 50 percent. What's more, excellence at the top has had a trickle down effect, improving performance at every level. As an example, the fastest time clocked for the marathon in the 1896 Olympics was just one minute faster than the time currently required just to participate in the most competitive marathons like Boston and Chicago. By contrast, no measurable improvement in the effectiveness of psychotherapy has occurred in the last 30 years.

The time has come to confront the unpleasant truth: our tried-and-true strategies for improving what we do have failed. Instead of advancing as a field, we've stagnated, mistaking our feverish peddling on a stationary bicycle for progress in the *Tour de Therapy*. This isn't to say that therapy is ineffective. Quite to the contrary, the data are clear and unequivocal: psychotherapy works. Studies conducted over the last three decades show effects equal to or greater than those achieved by a host of well-accepted medical procedures, such as coronary artery bypass surgery, the pharmacological treatment of arthritis, and AZT for AIDS. At issue, however, is how we can learn from our experiences and *improve* our rate of success, both as a discipline and in our individual practices.

Incidentally, psychotherapists aren't alone in this struggle to increase our expertise. During our survey of the literature on greatness, we came across an engaging and provocative article published in the December 6, 2004, *New Yorker* magazine. Using the treatment of cystic fibrosis (CF) as an example, science writer Atul Gawande showed how the same processes undermining excellence in psychotherapy play out in medicine. Since 1964, medical researchers have been tracking the outcomes of patients with CF, a genetic disease striking 1,000 children yearly. The disease is progressive and, over time, mucus fills, hardens, and eventually destroys the lungs.

As is the case with psychotherapy, the evidence indicates that standard CF treatment works. With medical intervention, life expectancy is just over 30 years; without care, few patients survive infancy. The real story, though, as Gawande points out, isn't that patients with CF live longer when treated, but that, as with psychotherapy, treatment success rates vary significantly. At the best treatment centers, survival rates are 50 percent higher than the national average, meaning that patients live to be 46 on average.

Such differences, however, haven't been achieved through standardization of care and the top-down imposition of the "best" practices. Indeed, Cincinnati Children's Hospital (CCH), one of the nation's most respected treatment centers—which employs two of the physicians responsible for preparing the national CF treatment guidelines—produced only average to poor outcomes. In fact, on one of the most critical measures, lung functioning, this institution scored in the bottom 25 percent.

It's a small comfort to know that our counterparts in medicine, a field routinely celebrated for its scientific rigor, stumble and fall just as much as we "soft-headed" psychotherapists do. But Gawande's article, which is currently available for free from the *New Yorker* website archives ([www.newyorker.com](http://www.newyorker.com)), provides so much more than an opportunity to commiserate: it confirms what our own research revealed to be the essential first step in improving outcomes: knowing your baseline performance. It just stands to reason. If you call a friend for directions, her first question will be, "Where are you?" The same is true of RandMcNally, Yahoo! and every other online mapping service. To get where you want to go, you first have to know where you are—a fact the clinical staff at CCH put to good use.

In truth, most practicing psychotherapists have no hard data on their success rates with clients. Fewer still have any idea how their outcomes compare to those of other clinicians or to national norms. Unlike therapists, though, the staff at CCH not only determined their overall rate of effectiveness, they were able to compare their success rates with other major CF treatment centers across the country. With such information in hand, the medical staff acted to push beyond their current standard of reliable performance. In time, their outcomes improved markedly.

## A Formula for Success

Within the last year, here in this country and abroad, we've started teaching this basic formula for success to therapists. Each of the formula's components—(1) determining your baseline of effectiveness, (2) engaging in deliberate practice, and (3) getting feedback—depends on and is informed by the others, working in tandem to create a "cycle of excellence."

Turning to specifics, the truth is we have yet to discover how supershrinks like Dawn and Gordon ascertain their baseline. Our experience leads us to believe that they don't know either. What's clear is that their appraisal, intuitive though it may be, is more accurate than that of average practitioners. It's likely, and our analysis thus far confirms, that the methods they employ will prove to be highly variable, defying any simple attempt at classification. Despite such differences in approach, the supershrinks without exception possess a keen "situational awareness": they're observant, alert, and attentive. They constantly compare new information with what they already know.

Thankfully, for the rest of us mere mortals, a shortcut to supershrinkdom exists. It entails using simple paper-and-pencil

scales and some basic statistics to compute your baseline, a process we discuss in detail in the article that follows. In the end, you may not become the Frank Sinatra, Tiger Woods, or Melissa Etheridge of the therapy world, but you'll be able to sing, swing, and strum along with the best.

The prospect of actually knowing one's true rate of success can provoke anxiety even in the best of us. For all that, studies of working clinicians provide little reason for concern. To illustrate, the outcomes reported in a recent study of 6,000 practitioners and 48,000 clients were as good as or better than those typically reported in tightly controlled studies. Findings like these are especially notable because clinicians, unlike researchers, don't have the luxury of handpicking the clients they treat. Most clinicians do good work most of the time, and do so while working with complex, difficult cases.

At the same, you shouldn't be surprised or disheartened when your results prove to be average. As with height, weight, and intelligence, success rates of therapists are normally distributed, resembling the all-too-familiar bell curve. It's a fact: in nearly all facets of life, most of us are tightly clustered around the mean. As the research by Hiatt and Hargrave shows, a much more serious problem is when therapists don't know how they're performing or, worse, think they know their effectiveness without outside confirmation. Unfortunately, our own work in tracking the outcomes of thousands of therapists working in diverse clinical settings has exposed a consistent and alarming pattern: those slowest to adopt a valid and reliable procedure for establishing their baseline performance typically have the poorest outcomes of the lot.

Should any doubt remain regarding the value and importance of determining one's overall rate of success, let us underscore that the mere act of measuring yields improved outcomes. In fact, it's the first and among the most potent forms of feedback available to clinicians seeking excellence. Several recent studies convincingly demonstrate that monitoring client progress on an ongoing basis improves effectiveness dramatically. Our own study, published last year in the *Journal of Brief Therapy*, found that providing therapists with real-time feedback improved outcome nearly 65 percent. So no downside exists to determining your baseline effectiveness: one either is proven effective or becomes more effective in the process.

There's more good news on this score. Share your baseline—good, bad, or average—with clients and the results are even more dramatic. Drop outs, the single greatest threat to therapeutic success, are cut in half. At the same time, outcomes improve yet again, in particular among those at greatest risk for treatment failure. Cincinnati Children's Hospital provides a case in point. Although surprised and understandably embarrassed about their overall poor national ranking, the medical staff nonetheless resolved to share the results with the patients and families. Contrary to what might have been predicted, not a single family chose to leave the program.

That everyone decided to remain committed rather than bolt should really come as no surprise. Across all types of

relationships—business, family and friendship, medicine—success depends less on a connection during the good times than on maintaining engagement through the inevitable hard times. The fact the CCH staff shared the information about their poor performance increased the connection their patients felt with them and enhanced their engagement. It's no different in psychotherapy. Where we as therapists have the most impact on securing and sustaining engagement is through the relationship with our clients, what is commonly referred to as the "alliance." When it works well, client and therapist reach and maintain agreement about where they're going and the means by which they'll get there. Equally important is the strength of the emotional connection, the bond.

Supershrinks, our own research shows, are exquisitely attuned to the vicissitudes of client engagement. In what amounts to a quantum difference between themselves and average therapists, they're much more likely to ask for and receive negative feedback about the quality of the work and their contribution to the alliance. We have now confirmed this finding in numerous independent samples of practitioners working in diverse settings with a wide range of presenting problems. The best clinicians, those falling in the top 25 percent of treatment outcomes, consistently achieve lower scores on standardized alliance measures at the outset of therapy—perhaps because they're more persistent or are more believable when assuring clients that they want honest answers—enabling them to address potential problems in the working relationship. Median therapists, by contrast, commonly receive negative feedback later in treatment, at a time when clients have already disengaged and are at heightened risk for dropping out.

How do the supershrinks continually use feedback regarding the alliance to maintain engagement? A session conducted by Dawn, rescuer of the boxelder bugs, is representative of the work done by the field's most effective practitioners. At the time of the visit, we were working as consultants to her agency, teaching the staff to use the standardized outcome and alliance scales, and observing selected clinical interviews from behind a one-way mirror. She'd been meeting with an elderly man for the better part of an hour. Although this first therapy session had lurches along to begin with, an easy give and take soon developed between the two. Everyone watching agreed that, overall, the session had gone remarkably well.

At this point, Dawn gave the alliance measure to the client, saying "This is the scale I told you about at the beginning of our visit. It's something new we're doing here. It's a way for me to check in, to get your feedback or input about what we did here today."

Without comment, the man took the form, and after quickly completing it, handed it back to Dawn.

"Oh wow," she remarked, after rapidly scoring the measure, "you've given me, or the session at least, the highest marks possible."

With that, everyone behind the one-way mirror began to

stir in their chairs. Each of us was expecting Dawn to wrap up the session—even, it appeared, the client, who was inching forward on his chair. Instead, she leaned toward him.

“I’m glad you came today,” she said.

“It was a good idea,” he responded, “um, my, uh, doctor told me to come, in, and . . . I did, and, um . . . it’s been a nice visit.”

“So, will you be coming back?”

Without missing a beat, the man replied, “You know, I’m going to be alright. A person doesn’t get over a thing like this overnight. It’s going to take me a while. But don’t you worry.”

Behind the mirror, we and the staff were surprised again. The session had gone well. He’d been engaged. A follow-up appointment had been made. Now we heard ambivalence in his voice.

For her part, Dawn wasn’t about to let him off the hook, “I’m hoping you *will* come back.”

“You know, I miss her terribly,” he said, “it’s awfully lonely at night. But, I’ll be alright. As I said, don’t worry about me.”

“I appreciate that, appreciate what you just said, but actually what I worry about is that I missed something. Come to think about it, if we were to change places, if I were in your shoes, I’d be wondering, ‘What really can she know or understand about this, and more, what can she possibly do?’”

A long silence followed. Eventually, the man looked up, and with tears in his eyes, caught her gaze.

Softly, Dawn continued, “I’d like you to come back. I’m not sure what this might mean to you right now, but you don’t have to do this alone.”

Nodding affirmatively, the man stood, took Dawn’s hand, and gave it a squeeze. “See you, then.”

Several sessions followed. During that period his scores on the standardized outcome measure improved considerably. At the time, the team was impressed with Dawn. Her sensitivity and persistence paid off, keeping the elderly man engaged, and preventing his dropping out. The real import of her actions, however, didn’t occur to any of us until much later.

All therapists experience similar incisive moments in their work with clients—times when they’re acutely insightful, discerning, even wise. Such experiences are actually of little consequence in separating the good from the great, however. Instead, superior performance is found in the margins—the small but consistent difference in the number of times corrective feedback is sought, successfully obtained, and then acted on.

## Systematically Seeking Feedback

Most therapists, when asked, report checking in routinely with their clients and knowing when to do so. But our own research found this to be far from the case. In early 1998,

we initiated a study to investigate the impact on treatment outcome of seeking client feedback. Several formats were included. In one, therapists were supposed to seek client input informally, on their own. In another, standardized, client-completed outcome and alliance measures were administered and the results shared with fellow therapists. Treatment-as-usual served as a third, control group.

Initial results pointed to an advantage for the feedback conditions. Ultimately, however, the entire project had to be scraped as a review of the videotapes showed that the therapists in the informal group routinely failed to ask clients for their input—even though, when later queried, the clinicians maintained they *had* sought feedback.

For their part, supershrinks consistently seek client feedback about how the client feels about them and their work together; they don’t just say they do. Dawn perhaps said it best, “I always ask. Ninety-nine percent of the time, it doesn’t go anywhere—at least at the moment. Sometimes I’ll get a call, but rarely. More likely, I’ll call, and every so often my nosiness uncovers something, some, I don’t know quite how to say it, some barrier or break, something in the way of our working together.” Such persistence in the face of infrequent payoff is a defining characteristic of those destined for greatness.

Whereas birds can fly, the rest of us need an airplane. When a simple measure of the alliance is used in conjunction with a standardized outcome scale, available evidence shows clients are less likely to deteriorate, more likely to stay longer, and *twice* as likely to achieve a clinically significant change. What’s more, when applied on an agency-wide basis, tracking client progress and experience of the therapeutic relationship has an effect similar to the one noted earlier in the Olympics: performance improves across the board; everyone gets better. As John F. Kennedy was fond of saying, “A rising tide lifts all boats.”

While it’s true that the tide raises everyone, we’ve observed that supershrinks continue to beat others out of the dock. Two factors account for this. As noted earlier, superior performers engage in significantly more deliberate practice. That is, as Ericsson, the expert on experts says, “effortful activity designed to improve individual target performance.” Specific methods of deliberate practice have been developed and employed in the training of pilots, surgeons, and others in highly demanding occupations. Our most recent work has focused on adapting these procedures for use in psychotherapy.

In practical terms, the process involves three steps: think, act, and, finally, reflect. This approach can be remembered by the acronym, T.A.R. To prepare for moving beyond the realm of reliable performance, the best of the best engage in forethought. This means they set specific goals and identify the particular ways they’ll use to reach their goals. It’s important to note that superior performance depends on attending to both the ends and the means, simultaneously.

To illustrate, suppose a therapist wanted to improve the engagement level of clients mandated into treatment for substance abuse. She'd first need to define in measurable terms how she'd know that the client was actively engaged in the treatment (e.g., attendance, increased dialogue, eye contact, posture, etc.). Following this, the therapist would develop a step-by-step plan for achieving the specific objectives. Because therapies that focus on client goals result in greater participation, she might, for example, create a list of questions designed to elicit and confirm what the client wanted out of therapy. She might also spend time anticipating what the client might enumerate and planning a strategy for each response.

In the act phase, successful experts track their performance: they monitor on an ongoing basis whether they used each of the steps or strategies outlined in the thinking phase and the quality with which each step was executed. The sheer volume of detail gathered in assessing their performance distinguishes the exceptional from their more average counterparts.

During the reflection phase, top performers review the details of their performance, identifying specific actions and alternate strategies for reaching their goals. Where unsuccessful learners paint with broad strokes, attributing failure to external and uncontrollable factors (e.g., "I had a bad day," "I wasn't with it"), the experts know exactly what *they* do, more often citing controllable factors (e.g., "I should have done x instead of y," or "I forgot to do x and will do x plus y next time"). In our work with psychotherapists, for example, we've found that average practitioners are far more likely to spend time hypothesizing about failed strategies—believing perhaps that understanding the reasons why an approach didn't work will lead to better outcomes—and less time thinking about strategies that might be more effective.

Returning to the example above, an average therapist would be significantly more likely to attribute failure to engage the mandated substance abuser to denial, resistance, or lack of motivation. The expert, in contrast, would say, "Instead of organizing the session around 'drug use,' I should have emphasized what the client wanted—getting his driver's license back. Next time, I will explore in detail what the two of us need to do right now to get him back in the driver's seat."

The penchant for seeking explanations for treatment failures can have life-and-death consequences. In the 1960s, the average lifespan of children with cystic fibrosis treated by "proficient" pediatricians was three years. The field as a whole routinely attributed the high mortality rate to the illness itself—a belief which, in retrospect, can only be viewed as a self-fulfilling prophecy. After all, why search for alternative methods if the disease invariably kills? Although certainly less dramatic, psychologist William Miller makes a similar point about psychotherapy, noting that most models don't account for how people change,

but rather why they stay the same. In our experience, diagnostic classifications often serve a similar function by attributing the cause of a failing or failed therapy to the disorder.

## **The Value of Practice, Practice, Practice**

By comparison with explanations that blame the client or excuse the therapist, deliberate practice bestows clear advantages. In place of static stories and summary conclusions, practice enhances options. Take chess, for example. The unimaginable speed with which master players intuit the board and make their moves gives them the appearance of wizards, especially to dabblers. Research proves this to be far from case. In point of fact, they possess no unique or innate ability or advantage in memory. Far from it. Their command of the game is simply a function of numbers: they've played this game and a thousand others before. As a result, they have more means at their disposal.

The difference between average and world-class players becomes especially apparent when stress becomes a factor. Confronted by novel, complex, or challenging situations, the focus of the merely proficient performers narrows to the point of tunnel vision. In chess, these people are easy to spot. They're the ones sitting hunched over the board, their fingers glued to a piece, contemplating the *next* move. But studies of pilots, air traffic controllers, emergency room staff, and others in demanding situations and pursuits show that superior performers expand their awareness when events are stressful, availing themselves of all the options they've identified, rehearsed, and perfected over time.

Deliberate practice, to be sure, isn't for the harried or hassled. Neither is it for slackers. Yet, the willingness to engage in deliberate practice is what separates the wheat from the chaff. The reason is simple: doing it is unrewarding in almost every way. As Ericsson notes, "Unlike play, deliberate practice is not inherently motivating; and unlike work, it does not lead to immediate social and monetary rewards. In addition, engaging in [it] generates costs." No third party (e.g., client, insurance company, or government body) will pay for the time spent tracking client progress and alliance, identifying at-risk cases, developing alternate strategies, seeking permission to record treatment sessions, insuring HIPPA compliance and confidentiality, systematically reviewing the recordings, evaluating and refining the execution of the strategies, and soliciting outside consultation, training, or coaching specific to particular skill sets. And let's face it, few of us are willing pay for it out of pocket. But this, and all we've just described, is exactly what the supershrinks do. In a word, they're self-motivated.

What leads people, both children and adults, to devote the time, energy, and resources necessary to achieve greatness is poorly understood. Even when the path to improved

performance is clear and requires little effort, most don't follow through. As reported in the December 14, 2006, *New England Journal of Medicine*, a study of 12 highly experienced gastroenterologists found that some doctors were 10 times better at finding precancerous polyps than others. An extremely simple solution, one involving no technical skill or diagnostic prowess—spending more time and being more thorough during the procedure—was found to increase the polyp-detection rate by up to 50 percent. Sadly, according to a December 19, 2006, *New York Times* article on the study, despite this dramatic improvement, many doctors spend relatively little time—considerably less than 30 minutes—doing the procedure.

Ericsson and colleagues believe that future studies of elite performers will give us a better idea of how motivation is promoted and sustained. Until then, we know that deliberate practice works best when done multiple times each day, including weekends, for short periods, interrupted by brief rest breaks. “Cramming” or “crash courses” don't work and increase the likelihood of exhaustion and burnout.

To assist busy behavioral-health professionals, the Institute for the Study of Therapeutic Change is developing a web-based system for facilitating deliberate practice. The system is patterned after similar programs in use with pilots, surgeons, and other professionals. The advantage here is that the steps to excellence are automated. At [www.myoutcomes.com](http://www.myoutcomes.com), clinicians are already able to track their outcomes, establish their baseline, and compare their performance to national norms. The system also provides feedback to therapists when clients are at risk for deteriorating or dropping out.

We're currently testing algorithms that identify patterns in the data associated with superior outcomes. Such formulas, based on thousands of clients and therapists, will enable us to identify when an individual's performance is at variance with the pattern of excellence. When this happens, the clinician will be notified by e-mail of an online deliberate-practice opportunity. Such training will differ from traditional continuing education in two critical ways. First, it'll be targeted to the development of skill sets specific to the needs of the individual clinician. Second, and of greater consequence in the pursuit of excellence, the impact on outcome will be immediately measurable. It's our hope that such a system will make the process of deliberate practice more accessible, less onerous, and much more efficient.

The present era in psychotherapy has been referred to by many leading thinkers as the “age of accountability.” Everyone wants to know what they're getting for their money. But it's no longer a simple matter of cost and the bottom line. People are looking for value. As a field, we have the means at our disposal to demonstrate the worth of psychotherapy in eyes of consumers and payers, and markedly increase its value. The question is, will we?

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