

Shrink Rap Radio #66, December 14, 2006. What Really Works in Therapy

Dr. David Van Nuys, aka “Dr. Dave” interviews Dr. Scott Miller
(transcribed from www.ShrinkRapRadio.com by Jo Kelly)

Excerpt: *“There is great evidence that what clinicians do works. In fact the average treated client in most studies is better off than 80% of the untreated sample in those studies. And it gets obscured in this fight over which approach is best for this particular treatment condition, that has only intensified in the last 10 to 15 years. Therapists have fought for most of their history about which treatment approach is best. You can trace this all the way back to the fallout between Freud and Jung, and Jung and Adler; all the way forward to the battles between the cognitive people and the behavioral people; the brief therapy groups etc. So this is not something that just started, it’s something that continues.”*

Introduction: That was the voice of my guest, **Scott D. Miller, Ph.D.**, a noted author, psychologist, and workshop presenter. He's a therapist, lecturer and trainer on client-directed, outcome-informed clinical work and other time-sensitive therapeutic approaches. For three years, he co-directed Problems to Solutions, Inc. – a clinic specializing in the treatment of the homeless and other traditionally under served populations. Most recently, Dr. Miller co-founded the Institute for the Study of Therapeutic Change and works pro-bono at a clinic dedicated to serving the under served. He is the author of many papers and seven books including: *The Heroic Client* in 2000 and *The Heart & Soul of Change* in 1999.

Dr. Dave: Dr. Scott D. Miller; welcome to Shrink Rap Radio.

Miller: Thank you.

Dr. Dave: I've been reading your book, *The Heroic Client: Doing Client-Directed Outcome-Informed Therapy* and I'm really excited by it. You and your co-author Barry Duncan do a marvelous job of combining passion and scholarship and I love the in your face, take no prisoners style, in which you guys take on the medical model, psychiatric diagnosis the over reliance on psychotropic medications and the whole managed care industry. So let's step through some of that. Now the medical model supposedly frees us up from prior belief systems in which clients were seen in terms of either demon possession or moral flaws of some sort. It supposedly removed the moral stigma and moved us to a place of: well Joe just has a mental disease;

it's not his fault any more than coming down with diabetes would be. So what's your take on the plusses and the minuses of the medical model?

Miller: Well I think that the idea that we're talking about here is that the diagnosis a person has, and in our case in this context the American context, the DSM-IV diagnosis tells us which particular treatment approach we should use that will lead to the best treatment outcome. And that simply isn't the case. There is in fact very little or no evidence that the diagnosis a person receives is correlated with the outcome, much less that it tells us which treatment approach is best. And yet in the current Zeitgeist we've got this whole notion of evidence based practices, which is the idea that there are certain treatments that are best for certain kinds of diagnostic conditions. And yet we are arguing that the data just doesn't exist.

Dr. Dave: And that's based on a lot of research, right?

Miller: It's based on a ton of research actually. What's surprising is how easily the field has been caught up in this whole notion of evidence based practice, which we think are for reasons largely unrelated to the research, dating all the way back to the 1980s when psychiatry began to form consensus committees that said that for this particular condition these are the appropriate ethical treatments that you should be doing. APA was very upfront about it and said we are letting the other APA beat us to the punch, so we have to have something similar, they formed a task force on the promotion and dissemination of psychological procedures, which began to create and generate lists of treatment approaches for which there was evidence that they worked.

Now there's nothing wrong, per se in that, except to say that the evidence not only said that these treatment approaches work but there is not a hill of beans difference in terms of the outcomes. So it really doesn't address the question about whether or not these treatment approaches are best for a particular diagnosis. But that is exactly how the public has understood it and that is exactly how practitioners have understood it and that is exactly how continuing education activities run. That for this particular treatment condition this treatment approach is the best.

Dr. Dave: In your book though, you review 40 years of research and your findings suggest that people who are trained in using these diagnostic systems can't even agree on the diagnosis; that they have very low what we call reliability.

Miller: Right. If there were interrater reliability that would be one thing; the major problem with the DSM is that it lacks validity however. That these groupings of symptoms actually mean anything; and that data is completely lacking. If people use very careful structured interviews you can increase interrater reliability, but if they are not related to outcome then what are we really doing? We are clustering symptoms together much the way medicine did in the medieval period: this is the way we treated people and thought about people when we talked about them being phlegmatic for example; or the humors that they had. Essentially they were categorizing illnesses based on clusters of symptoms.

Now at some point in the future there may actually be a diagnostic system that is similar to what happens in medicine, where the underlying pathogenesis or ideology of the problem is identified, and then the treatment would be tied to addressing that particular pathogenic process. But we are light years away from that as a field. Which is not to say, by the way and usually when I talk about this it generates alarm both the provider and the consumer side that somehow or other what therapists do doesn't work. In fact the data are equally clear here, and this is the part that we find so surprising and talk about in *The Heroic Client*, as well as in our book *The Heart & Soul of Change*; that there's great evidence that what clinicians do works. In fact the average treated client in most studies is better off than 80% of the untreated sample in those studies.

Dr. Dave: That's good news (laughing).

Miller: It's incredible news. And it gets obscured in this fight over which approach is best for this particular treatment condition, that has only intensified in the last 10 to 15 years. Therapists have fought for most of their history about which treatment approach is best. You can trace this all the way back to the fallout between Freud and Jung, and Jung and Adler; all the way forward to the battles between the cognitive people and the behavioral people; the brief therapy groups etc.

So this is not something that just started, it's something that continues.

Dr. Dave: Yes. You know it seems like psychology has really been co-opted by managed care and the medical model. I personally quit private practice in part because managed care so many hoops to jump through in terms of limiting the number of sessions, and having to assign diagnostic categories that I didn't believe in. And I know other clinicians who are in that situation of using these diagnostic codes just as a way to keep the treatment going. It's pretty widespread isn't it?

Miller: Well you know I'm of two opinions about all of this. I think that managed care frankly – and I'm no spokesperson for that particular industry – but in essence all they've done is enforce what clinicians have been saying matters. You know if you go to a staffing at any local agency and you listen to what is being said, when they talk about a case or a client, generally the first thing out of the clinician's mouth is: (a) what the diagnosis is, and (b) what the treatment approach is they're using.

So we can't have it both ways; we can't complain both about managed care's reliance on these things, and then use them in our day to day clinical work. They either matter or they don't. The data says those things really don't matter in terms of predicting outcome for the individual client seated in a clinician's office on that day. So it's a chicken and egg problem for me: who started this – I don't know. But everybody is paying the price for it. And the industry frankly knows that diagnostic groupings don't predict very much. Less than 1% of the variance is attributable to the diagnosis the clinician puts on their HCFA-1500 form. And yet there are other things that do predict, that we just seem to ignore.

Dr. Dave: When you say less than 1% predicts – predicts what? Predicts success of – ?

Miller: – of the outcome variants, yes; or in this case success, change in the client. And yet we spend huge amounts of time deciding what the diagnosis is; and managed care of course spends huge amounts of resources reviewing those files and treatment plans, to see do the goals fit with the stated diagnosis, and is that in any way related to what the expected course of treatment is.

Dr. Dave: One of the early chapters in the book is titled "Mental Health at the Crossroads", and you wrote that in 2000 and it's now seven years later. Are we still at the crossroads, or are we in some respects too late?

Miller: I don't think it's too late, we actually revised that book in 2004, but I think that much of what we predicted in the first edition of that book has in fact come to pass. In January the very influential and widely read journal called Psychotherapy Finances, which looks at what's it like to work in this field at the present time financially, talks about a turn downward in clinicians ability to maintain their lifestyle and their living, and in fact it's not good news.

I have to tell you when we wrote the book in 2000 and we would go out and talk about this, generally we were poo-pooed you know. The people would listen to us and say: ah the sky is in fact not falling; well now it is. And of course in 2000 people were saying: well I'm just shifting more of my practice towards self pay clients. We predicted in the book in 2000, the first edition, that this was not sustainable as a source of income. And as a matter of fact Psychotherapy Finances comes out in January of this year 2006 and says: it's not sustainable. There is a huge downturn, probably close to 60 to 70% fewer clients willing to pay for treatment services out of pocket.

Dr. Dave: So it sounds like it's hard times for psychotherapists in private practice.

Miller: I think it's incredibly hard, and it's not just for therapists in practice. If you work in an agency you are now inundated with an increasing amount of paperwork and regulation which in some instances eats up to 60% of clinical time. So 60% more than is actually spent helping the consumers of mental health services is spent with clinicians sitting at their desk dealing with payers and funding forms and paperwork.

Dr. Dave: Exactly. That's what drove me out.

Miller: Let me give you an idea about why I think that is, and this is the argument we make in *Heroic Client*. We are using as criteria for success things that have no bearing on success of the case. So for example diagnosis, and treatment approach, and treatment plan; these things are largely unrelated to outcome and yet clinicians' time is being spent doing that. We all act like it matters. The result is that the paperwork gets turned in, the funders review it and they tighten the controls and that doesn't seem to lead to more efficient utilization of resources, so what do they do? They are left to believe that obviously they haven't tightened the controls enough; and the result is more paperwork, oversight and regulations. This spiraling pattern is the tyranny of escalating sameness that we are all operating under right now.

Dr. Dave: Yes. I think your book makes really important points about what's broken in the so-called mental health system, but I'm wondering if it's preaching to the choir, or if you have been able to have any impact on the policy makers, for example in the American Psychological Association?

Miller: Well here again I'm going to put the burden of responsibility on the people who have it. Policy makers are listening – they are politicians, in

essence, and they are listening to their membership, who in strange ways talk about therapy in one way and do it in a very different way.

So as I said earlier about the staff meeting if you go: what do they talk about at a staff meeting when they bring up consumer material – the diagnosis, and the treatment approach, and they argue over which particular treatment approach or drug etc should be given to this particular client – when those things matter very little if anything at all, in terms of treatment outcomes. So my sense is in fact that clinicians need to do something different, they need to have an alternate language and then talk to these politicians about changing the policies, and changing the language of mental health practice.

Dr. Dave: And what would that alternate language sound like?

Miller: Well in terms of accountability, which everybody is asking about, that would be ongoing measurement of outcome and factors that do matter in treatment. Let me give you an example of one of those. We have known for years, at least 40, that the relationship between the client, the consumer, and the provider of care is predictive of outcome. We also now know that if consumers are asked, and able to provide feedback about the nature of the alliance, positive and negative, that those consumers are much more likely to stay until they achieve a good outcome in treatment and we have better outcomes as a result.

If the consumer is able to feed back information to the system about their progress, whether or not progress is being made, those two things together can improve outcomes by as much as 65%. Clinicians in that case are free to use whatever treatment approach or techniques best fit them and that they feel, and the client feels best fit the client. All they are asked to do is expose themselves to ongoing client feedback about the nature, the scope, the amount and the success of the procedures being used in the treatment process.

This is the alternate language. Outcome and alliance language versus diagnosis and treatment approach, and all driven from the client's point of view: involving the consumer in reviewing the types of services offered.

Dr. Dave: That really does seem to be a language that could speak to policy makers and so on, since they are very concerned about outcome; or at least they talk like they are.

Miller: Well you know the consumers are also quite interested in outcome. Three recent surveys, one by the American Psychological Association, one

by CAMFT (California Association of Marriage and Family Therapists) which is the largest mental health provider organization in the state of California, and one done last year by Psychology Today, all said the following, which is quite disturbing if you consider what I said at the beginning of the interview about how successful we actually are, which we are. And that is, second to cost, lack of confidence in the outcome of treatment is the primary reason that potential consumers give for not going to seek the help of a therapist; even though they think they could use it.

Dr. Dave: And where do you think that lack of confidence in outcome comes from?

Miller: I think that it comes from our lack of interest in the outcome, and our obsession with the process of treatment. We are overly focused on how we work, and consumers don't care; much the same way you don't really care how your DVD player works, what you want is it to play DVDs, that's the outcome you are looking for. This is something by the way that the drug companies know very well about. They know from if you watch their commercials on TV, they are marketing the outcomes: they are not spending tons of time talking about how the drugs work, they are showing you pictures of happy people with hard erections.

Dr. Dave: (laughing) Yes.

Miller: And that's what the consumer wants, they don't really care about the vasodilation involved, they don't care about that. They want to get to the end game: what is in it for me? And we as a profession continue to fight with each other, and fight with consumers about how we are going to work, and whether or not they have a particular diagnostic.

Let me give you another example: every year, a study, usually done by the American Psychiatric Association because they have the biggest investment in the Diagnostic and Statistical Manual; it's the best selling volume ever in the history of psychology and psychiatry. They will publish a study somewhere, an epidemiological study that says we have surveyed Americans and 20 to 25% of Americans suffer from a condition listed in the DSM; and then of course the lament is, but only 5% of that group ever get any help. And then they offer the solution, which is always the same: we need to educate people about the benefits of treatment.

So my sense is that we don't need to educate people, we need to highlight what the benefits are, and they are many, but instead what to do we keep doing? Marketing diagnostic groupings: if you go to the self-help section

it's all listed by which diagnosis you have or by the treatment approach. And what consumers want is better, happier, more fulfilling lives.

Dr. Dave: Yes. Scott in your book you really take to task the over reliance on medications for depression, and for other sorts of conditions. Can you talk about that some?

Miller: Sure. And before I do this let me make a point. We are not suggesting that medication isn't helpful to some people. What we question is what is and when. What is it about medication that may be helpful, and when does it generally help?

Because let me tell you about a study that's going to be coming out in the flagship journal of the American Psychological Association, called the Journal of Consulting and Clinical Psychology. Two researchers, Bruce Wampold and Jeb Brown, both members of our Institute, which can be found on the net, www.talkingcure.com have taken a look at real world cases. So we are not talking about the highly selected population usually seen in a randomized clinical trial.

Let me take a second to talk about that because everybody is talking about the RCT, the so-called gold standard of identifying which treatment approaches are best for which kinds of conditions and clients. When you do one of these studies, typically the people included in the sample are so highly selected that they never ever look like anybody a real clinician would see in their clinical practice. For example they may take people who have only been depressed for one episode in their life, and have no other comorbidity. Now at workshops I usually ask: now how many therapists – and I have them show by raising their hands – have seen a client who has only one diagnosis? And generally no-one raises their hand. And I say, that's right, these kinds of studies simply don't apply to the people you see whose modal number of diagnosis is around 3 or 4.

So with that, the question is what do we do with regard to medication because everybody believes, and certainly the TV commercials seem to promise lots of wonderful benefits if you take the medications. These two researchers, Wampold and Brown go and they look at real world clients as I say, they poll the data and they look at a variety of factors that seem to affect treatment outcome. And this really ties back to what I'm saying about needing feedback from consumers. What they find is that prescribing clients a drug – and this was for clients who had anxiety and depression, post traumatic stress disorder, and bipolar disorder – really made not much appreciable difference in the outcome. Unless the provider of that care, in

other words the prescriber, was already an effective therapist. Are you with me here?

Dr. Dave: Yes.

Miller: In other words, the medication, the effect of the medication was in who prescribed it; not in what was prescribed.

Dr. Dave: Are you saying that the medication worked because the person was also receiving effective psychotherapy at the same time?

Miller: No. I'm saying this is a therapist effect. Some therapists, we know from tracking outcomes, are better at their work than other therapists. And if you put the medications in the hands of an effective clinician, then they got outcomes that were in some instances ten times that of other prescribers whose work was not effective. So the ability to prescribe – and this is a very controversial idea – did not make an appreciable difference. What made an appreciable difference was the ability to prescribe in the hands of somebody who was a good clinician; who was an effective clinician.

Now as radical as that sounds, it's the same in other branches of medicine. Not all surgeons are created alike, what you want is an effective surgeon because them doing a new procedure are much more likely to do it in an effective way.

Dr. Dave: Now are you saying it's because they are prescribing the right drug and that's what makes them effective, or are you saying that they are a better shaman.

Miller: No. I'm saying that there is something about these people that makes them better at their work overall, whether they are prescribing or not. We think that there are a couple of characteristics of what we are actually calling the super shrinks.

These are people who seem to get reliably better outcomes, and here's what they are: they are open to feedback, in other words they listen to what the consumer is saying, as opposed to rely on their ideology or treatment technology, or training. So they are open to feedback, they are constantly saying try this, did it work? What do you think? How can we nuance that in some way? Open to feedback. Number 2, and it's related to number 1, they are flexible in terms of their strategy; that is they are not committed to any one thing. And the third thing is they are doggedly committed to the outcome.

So these are people who are going to flexibly accommodate the consumer until they get it right. And if they don't within a certain period of time, they know their limitations, and they are trying to make sure that the person gets to somebody else, or someplace else on the continuum of care.

Dr. Dave: This again sounds like relationship factors and therapist client alliance.

Miller: I think that it has tons to do with that. And with regard to medications we think that the issue here is that everybody believes one thing, when in fact something else is true. The thing I think we continue to act like is that: if you are depressed then of course antidepressants are the cure, or CBT.

The reason that is believed is that we are addressing the underlying pathogenesis of the problem, when in fact people who are depressed for example, they have no more or less serotonin at their synapses than other people. They don't. Plus the drugs take three weeks to work, and yet the serotonin at a person's synapses 20 to 30 minutes after taking an SSRI is the same as it will be 3 weeks later. So the drugs are not working simply because they improve serotonin at the synapses, it just doesn't work like that.

Dr. Dave: Boy we could go on and on about this, it raises some very interesting issues.

Miller: Are you hearing me say that medication isn't effective?

Dr. Dave: No I'm not hearing you say that, but I am hearing you say that whether or not it's effective depends upon who is prescribing it, in terms that the relationship can somehow amplify or potentiate it.

Miller: Absolutely, and that is the key variable. So I say to people, choose your therapist carefully. Find someone who has good rumors and who does a lot of work with people who are dealing with the same kind of situation that you are dealing with; and best of all if they happen to be using the outcome tools that we make available for free to clinicians on our website.

I should also say in relationship to that there is very good news that there are agencies all over the US and abroad, and there are seven managed behavioral health care organizations that have either completely adopted this way of thinking about clinical work or are in the process of doing that.

Dr. Dave: Very good, I'm glad to hear that.

One of the things that caught my interest in the book, was you do this breakdown of what really works in psychotherapy; you've got a pie chart with I think four sectors, and you have already indicated the importance of relationship but could you take us through that pie chart?

Miller: Sure. This is data that goes back again close to 30 years, and sometimes people say – in fact I heard it at this conference I was just at from some members in the audience – well we don't really know what makes treatment work, the science really isn't there. When in fact the science is there, it just doesn't fit with this notion that we currently have that somehow or other we are fixing a diagnosis; we are fixing an underlying pathology with our treatments.

There are four basic common elements that seem to account for effectiveness and get this across treatment approach. So whether you are doing CBT, or EMDR, or solutions focused, or psychodynamic treatment – some of the variants of various psychodynamic treatment approaches – these four factors are involved.

One of them is the alliance: it generally accounts for between 30 and 60% of the variance, the variability in the treatment effects.

You've got allegiance effects: which is the therapists' belief in what they do, that contributes between 20 and 30% to the outcome; the therapists have to believe in their approach.

Then you've got structure, model and technique effects: so the treatment does have to have some structure – a start and an end and something in between that the client likes – that it makes sense to the client; and you are talking about between 5 and 10% of the treatment effects.

Then you've got this whole other area that researchers usually refer to that is the largest percentage; that I'll refer to as extra therapeutic factors, that impact outcome greatly. And that is what the client walks in the door with; their pre-morbid functioning, their environment that they live in, the chance events that weave in and out of their lives.

Dr. Dave: You touched earlier on this next topic I think; but maybe you could say just a little bit more about it. And that's the move within APA to

“manualize” therapy. Maybe you can explain to our audience what’s meant by that and what the current status of it is.

Miller: Well you know it’s not exactly the official policy of the APA, but it is everything but that. This is the notion again, and it starts with the notion that there are certain diagnoses and that they are related to outcome. And that for those diagnoses we need to have a treatment approach for which there’s evidence that it works. And since the assumption is that it’s something in the treatment approach, we have to manualize, we have to make a cookbook of that approach so that people know how to follow it.

The problem with this is on a larger scale this makes imminent sense to most people; it makes sense to me; it feels right culturally. If you are going to manufacture an automobile you have to have a plan, so that you can gather the raw materials etc and make the car to specification so that it drives at the end. What we are saying is that metaphor just simply doesn’t apply; that analogy does not apply in psychological treatment approaches.

But they have, there are between 100 and 125 different manualized treatment approaches and in some states actually the legislatures have gotten together with the various professional organizations. The legislatures of course demanding accountability and the professional organizations say, here’s how we are going to give it to you. We will specify which treatment approaches work, and then we will provide a manual for that, and then what you can do is measure our adherence to that manual.

And the result of course is that clinicians’ hands are increasingly tied about what they can say in their room with consumers. All of which sounds very good, sounds like we are finally going to get some quality in the service, and all of which has little or nothing to do with the outcome of the treatment service.

Dr. Dave: So for example: somebody comes in, they’ve got depression, it may be kind of dictated to them that they will use cognitive behavioral therapy and say, not hypnotherapy.

Miller: That’s exactly right, or psychodynamic. And regardless of what the client says they really want to do. Now here’s what good clinicians do. We are talking at two levels here, we are talking at the policy level and the accountability level, and then we are talking at the actual practice level; because clinicians for the most part pay attention to the consumer seated in the room in front of them. And it turns most clinicians – and maybe I’m

telling tales out of school here and somebody will call and get me in trouble – but the truth is most clinicians are turned into liars this way.

Dr. Dave: Yes.

Miller: What they do is they do one thing in their room with their consumer, that they think is best, and the consumer is demanding; and then they do another thing on the paperwork.

Dr. Dave: Right.

In the subtitle of your book you advocate for client directed therapy and you have talked about the importance of relationship factors and so on. How is this different than the client-centered therapy that Carl Rogers championed in the late 60s and 70s?

Miller: Well in many ways we are standing on the shoulders of great thinkers and practitioners like Carl Rogers that place the alliance or the relationship between clients and therapists at the center of the work. We mean something a bit different from client-directed; we mean literally putting the client in the driver's seat evaluating the outcome and the relationship, rather than the therapist, because the outcome is truly in the eyes of the beholder. Interestingly enough, when we integrate the client's feedback into the service, not only did I reflect feelings and address your negative thinking, but I asked the client did it help you and is this what you wanted to do?

That feedback is what leads to better retention and outcome in the treatment services; which again, is what most therapists do in their offices behind closed doors. They don't do therapy by the book; no therapist I know does therapy by the book. Instead what they do is they accommodate their knowledges to the individual in their room, based on their generally informal assessment of the client's response.

What we've advocated is a formal assessment of the client's response; we're literally asking the client for feedback and integrating that into the treatment. And that's where the research I think is so interesting and fascinating; just doing that encourages changes in that relationship that lead to better retention rates. In other words the clients don't drop out; and by the way I should say drop outs are in fact the scandal of mental health and substance abuse treatment in the US. Not our outcomes, our outcomes are great for the people who stay. But about half of the people who go

terminate unilaterally, that is without informing their therapist very early in the treatment process.

And then again the second piece is improving the outcomes by as much as 65%.

Dr. Dave: I think you also refer to your work as solution-focused therapy. I recently had Bill O'Hanlon on as a guest. I assume you know him – to what extent has your work been influenced by him if at all.

Miller: We don't refer to our work as solution-focused. I spent my youth as a therapist working in Milwaukie with people who really started solution-focused therapy: Steve De Shazer and Insoo Berg; I was there between 1988 and 1993. And the difference between what we were doing then and what we are doing now – and I think what Bill is talking about and many others – is that they are very much interested in how to do therapy. And I am not interested in that; I am interested in whether or not consumers think the therapy is working and how to let therapists know when it is not.

So we are offering a much more meta model to treatment rather than a model of therapy. Frankly it does not matter if the therapist has been solution-focused, cognitive or psychodynamic; what matters is: does the client like it, and are they getting better? That is what matters.

Dr. Dave: Yes, that's really interesting.

Miller: Now sometimes people hear this and say: well it obviously doesn't matter what treatment approach; I don't need to learn anything.

Which I would say is a mistake in the opposite direction; I think therapists need to be exposed to a wide variety of ideas because the clientele that we're seeing nowadays is diverse, and their ways of thinking about their problems and how to solve them are equally diverse.

Dr. Dave: Yes. We've also had a couple of recent interviews with people in the positive psychology movement and you emphasize enhancing client resources and client strengths. So it sounds like your approach would fit into their rubric or their rubric would fit into yours. What's your take on the positive psychology movement?

Miller: Well I have a couple of feelings. We have a chapter on client directed work, in I think it's the Handbook of Positive Psychology that just came out.

Dr. Dave: Oh really?

Miller: Yes. You know my sense about all of this is that whether it's positive or negative is not the issue; whether we are focused on client's resources or their deficits is not the issue. This takes us back down to a very low level of abstraction to the how to pragmatics of to do therapy, where you are going to highlight strengths and resources or not. Now again from the average clinician's point of view, I don't find any clinicians that are entirely deficit based, or entirely solution or positive based.

I find therapists are mixing those things because that is what day to day clinical work requires; figuring out what works for the individual, not what the appropriate ideology is for the field as a whole. So whether, again positive or negative doesn't matter to me, what matters to me is if you are approaching the client from a position of strength and resources, which have in many ways been ignored by the field of psychology and psychotherapy in general; does the client like that, and are they getting better?

Dr. Dave: OK.

Miller: The bottom line message to all this is relatively simple, and let me just say one other thing about that. This is an idea that when I present it to business people, people with a business background, they kind of nod their head and say: aha, and?

This isn't a surprise to them, because they are dependent on consumer feedback. If you call Dell customer service line, you are going to get a survey at the end. They are interested in this because they know that clients who are dissatisfied, not satisfied but dissatisfied, are much less likely to call Dell back again and buy another Dell product. They would like to have a better customer service mentality and this is all we are trying to bring to the field of psychological treatment.

Dr. Dave: Interesting. Are there ways in which your involvement with psychology and psychotherapy have impacted or helped you in your own personal life?

Miller: No, I don't...

Dr. Dave: I know I've kind of sprung this on you without any preparation.

Miller: No, well I'm just trying to think. I mean I love what I do, and I feel passionate: I hope that comes across in writing about and talking about these ideas.

Dr. Dave: It definitely comes across.

Miller: I suppose within my own work the idea of feedback is critical because I spend about 100 or more days on the road every year, doing training and workshops and consultation. The feedback of the people in the audience is critical to fine tuning and making what I hope are presentations superior to any other presentations they might go to. So in that way I think this has affected me.

I think as a young person being interested in psychology, if that's what the question is aiming at, when I went to university I started as an accounting major. I was raised in a family that didn't have much money, but my mother thought that maybe if I could count other people's money I could at least be close to it at some point in my life.

But then I did like many people do, I took an undergraduate course, a GE course in psychology, and I met a guy named Hal Miller, who was one of Skinner's students. I don't know whether it was psychology that I became so much interested in as it was Hal Miller. I wanted to be like him, I wanted to think like him, I wanted to have the depth and breadth that he conveyed in his lectures. And that literally was a tipping point for me; I changed my major within one semester and began to work much more closely in my undergraduate career with Hal Miller. It had a profound impact on me personally.

Dr. Dave: Well thank you for sharing those personal insights. We do have some students who follow this series and I think they are always interested in how people get into psychology and wind up in the careers in which they do wind up.

And it's interesting that you started out with that focus on accounting, and in some ways it seems like the work that you are doing now is still kind of this meta level that you are working at; seems like it has some resonance with that to me.

Miller: (laughing) Yes. I think it does, interestingly enough.

Dr. Dave: To wrap things up, what is your advice to our listeners in terms of finding a good therapist or a counselor? I know that's one of the ending chapters that you had in your book.

Miller: Well a couple of things. The first one is, don't think about finding a therapist. Look for a variety of therapists and call them, and talk to them, interview them with some very specific questions over the phone. Let me give you some examples of that. And if the therapist will not spend 10 minutes with you on the phone, then this is not somebody that you want to see. For whatever reason, they may be the greatest therapist in town but if they don't have 10 minutes to talk with you about what they are going to do, then my rule is you don't go see that person; because they are not going to have 10 minutes between visits to talk to you if the therapy is not going the right way.

The second thing I would do, is when talking with them I'd want to describe the situation in clear, concise terms that you want help with and ask them how many cases like this do you see a year? And I want to see somebody who does this a lot. I want to see somebody who has a lot of experience working with my kinds of cases.

And number two, I want to know how do they know whether or not their treatment is working? Do they have some formal assessment they use for making sure that it works or not.

The third thing is to look for referrals from friends and family that have had successful experiences with therapists in the past; but here again I'd be cautious and careful. You've got to find a therapist that fits for you; and that may mean you have to go through 3 or 4 people unfortunately at the present time before you find somebody that really works for you.

Fourth item is to know that if a particular therapist working in their way is going to be of help to you, you should begin to experience some resolution of your problem, or feelings, or whatever, within weeks rather than years. So you should see some light at the end of the tunnel.

Now I'm not saying that you should feel completely better necessarily, but you should start to feel something within the first 4 to 6 weeks. If you don't, then it's probably an indication that you need to talk to that therapist about adjusting what they are doing. When I say adjusting I mean adjusting either the type, or the focus of the treatment, or involving additional resources: going to see the psychiatrist perhaps, going to a group, augmenting with reading material, homework assignments etc. If you don't

see any change by the 8th to 12th week then chances are that this relationship between you and this provider is not likely to lead to change over the long haul, and you'll want to get to see somebody else.

Dr. Dave: OK that's great. Finally I want to mention that you have upcoming workshops in Los Angeles on Friday January 5th and in San Francisco on January 6th 2006. Who should attend those workshops, and what will they learn?

Miller: I would say psychologists, social workers, marriage and family therapists; anybody who is doing direct clinical services, that's the group we are going to be focusing on. And we are going to be talking about how to improve the outcome of the clinical work you do with your most challenging cases. And the contact person is a guy named Bob Cassidy, whose email address is bob@rcassidy.com

Dr. Dave: OK and I will also put a link to the registration website in the shownotes on my own website.

Miller: That would be great.

Dr. Dave: Scott thanks for being a guest today on Shrink Rap Radio.

Miller: My pleasure.