

# *The mystery of mastery: Breaking the code of superior performance*

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To meet the challenge of remaining competitive and relevant, psychotherapy practitioners are encouraged to aim for clinical excellence. Randomised clinical trials have established that excellence is not reserved for a select few, but is within the reach of all. Knowing your baseline, engaging in deliberate practice, and obtaining feedback as much as triples the effectiveness of individual practitioners, cuts dropout rates in half, reduces the rate of deterioration by one-third, speeds recovery by two-thirds, improves client satisfaction, and reduces the cost of care. SCOTT MILLER and MARK HUBBLE argue that individual achievement and the quest for excellence flourishes in supportive communities. Practitioners who connect, share, and learn from each other, demonstrate better outcomes for their clients. In order to establish and sustain a culture of excellence, we must relinquish our closed, risk-adverse service delivery system and embrace an open, transparent, and error-centric model of clinical practice. The International Center for Clinical Excellence (ICCE) has been established as a global, web-based community that aims to foster such excellence in behavioural health.

*'Talent is not the cause but the result of something.'* David Shenk.

Classical pianist Rachel Hsu enters the auditorium. Among the many pieces she will perform on this occasion is the Concert Etude No. 3 by Franz Liszt. *'Un Sospiro'* (Italian for 'sigh'), as the composition is known, is a famously challenging work that is also a pleasure to watch. The hands mirror the sound of the music, moving rapidly up and down the keyboard in an intricate, crisscrossing fashion that, when done correctly, evokes images of water tumbling over rocks in a small mountain brook. Most experts consider Liszt's Etude No. 3, with its third staff, abundance of notes, and complex finger work, exceptionally difficult—a 'twelve' on a scale from 'one to ten'.

Clad in a simple, yet elegant, black satin dress and red-sash, Rachel silently makes her way to the piano. A hush falls over the crowd as she sits and, with a practiced poise, effortlessly adjusts the bench, out of proportion to

her diminutive size. She straightens her back, takes a deep breath, and raises her hands, holding them momentarily above the keys. Then, magic.

To say the audience is stunned would be a gross understatement. Simply put, those in attendance are entirely unprepared for what they are witnessing. Six minutes of perfection, a combination of music and performance that brings many to tears—an experience made all the more compelling as the pianist is only eight years old.

Exceptionally talented children are nothing new of course. In a host of endeavours, individuals appear from time to time that seem touched by greatness, carriers of a 'divine spark'. Mozart who, like Rachel, was giving public performances as a pianist at the age of eight, immediately comes to mind. Incidentally, Rachel, like Mozart, also plays the violin,

following her performance on the piano with a flawless rendition of the Wieniawski Violin Concerto No. 2 in D Minor (excerpts of her playing both instruments can be seen online at [www.scottdmiller.com/?q=node/109](http://www.scottdmiller.com/?q=node/109)).

Contrary to what might be expected, this performance did not take place at Carnegie Hall or a similarly prestigious venue. Nor was it a recital convened by a teacher to showcase the quality of the instruction before a gathering of proud parents. Instead, Rachel was a presenter, along with a host of other internationally regarded researchers, clinicians, performers, and celebrities, at the first *Achieving Clinical Excellence* conference held in Kansas City, Missouri in October 2010—an event held exclusively for behavioural health professionals.

The purpose of the meeting was to lay out the path to achieving excellence

in psychotherapy—a series of steps that research has not only demonstrated result in superior treatment outcomes but lead to greatness in all fields, pursuits, or professions. Rachel and others—including David Helfgott

and prosperity of Western societies. Examples are legion—one only has to pick up a newspaper, turn on the TV, or search the internet. Iceland is bankrupt. The economies of Greece, Ireland, Spain, France, Italy, and

standard of living compared to prior generations, but also the country as a whole is falling behind other nations. China now possesses the world's fastest computer and is leading in green technology. And while the economies of most Western nations have been teetering, China's sprinted ahead by leaps and bounds. Finally, just before this article went to press, IHS Global Insight—the largest economic organisation in the world—announced that U.S. manufacturing fell for the first time in a century to second place, behind China.

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the classical pianist whose triumph against all odds, celebrated in the award winning film 'Shine', were invited to demonstrate how much can be accomplished by applying the steps, thereby, hopefully, inspiring the mental health professionals in attendance to commit to the hard work necessary for excellence.

As it turns out, the conference could not have been more timely, occurring at the very moment attention has become riveted on the deteriorating strength

Portugal are in freefall. In the United States, no less than two recent issues of 'Time' magazine have chronicled a pattern of decline that includes, but is not limited to, poor student test scores (once number 1 in the world, now 17th in science and 25th in maths), crumbling infrastructure and public works (23rd), decreasing overall life satisfaction (28th), and deterioration in the quality of, and access to, healthcare (37th).

Not only are children in the U.S. faced with the prospect of a lower

### Psychotherapy's track record

The field of mental health has not escaped the erosion so evident in larger society. Consider the following. What was the last truly revolutionary discovery in the field of psychotherapy? Why is it that no psychotherapist has won a noble prize or even been nominated? What 'treatment' (analogous to penicillin in medicine) has ever successfully eradicated a mental or emotional disorder? In fact, while we have been on post, provisioning and parading



Illustration: Savina Hopkins

an army of techniques and methods, rates of depression and anxiety have soared. Other countries ride a wave of productivity. We are sinking in a quagmire of psychiatric disability. A recent international survey conducted by Kings College, London (2010), revealed that Australians ranked mental health as one of the greatest challenges facing their country, exceeding poverty, war, terrorism, and pollution (cited in Wilson, 2010).

Even if one disagrees with this pessimistic assessment of the field's contributions and influence, it is hard to be sanguine about our status. In the U.S., incomes of mental health professionals have stagnated or declined over the last decade. In the same period, workloads have increased, professional autonomy has been subverted, and funding for public behavioural health has all but been gutted completely. Costs have also been on the rise: for graduate and professional training and for operating a practice. At present, as much as a third of the average practitioner's time and income is spent completing mindless paperwork required for insurance companies and state regulatory bodies! Recent decisions by the Australian Federal Department of Health and Ageing to cut the number of subsidised sessions for Medicare recipients by nearly 50 percent suggest that Australian practitioners will not escape a similar fate.

Meanwhile, the very relevance of psychotherapy is an open question in the minds of many current and prospective consumers. Despite overwhelming evidence that psychotherapy works, and that more than 90 percent of people would prefer to talk about, rather than take psychopharmacological drugs for their problems, most—males and females, young and old, rich and poor—doubt the efficacy of treatment. Perhaps this accounts for the fact that use of psychiatric drugs has steadily increased, while visits to a psychotherapist have been decreasing. Worse still, nearly 50 percent of those who begin therapy quit—a number that has remained conspicuously and, dare we say, egregiously robust year after year.

That we must do better, individually

and collectively, is clear. That we are each individually capable of improving our performance is now well established. In *'Supershrinks: What is the Secret of their Success?'* (Miller, Hubble & Duncan, 2008), we described our research into top performing therapists. We concluded that, *'The key to superior performance', in psychotherapy is, 'the best of the best simply work harder at improving their performance than others do'* (p. 16).

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Working harder is not about filling the week with additional hours on the job, as findings from other realms of expertise affirm. To illustrate, the number of hours devoted to playing chess is correlated negatively with performance. Similarly, time spent conducting therapy has never been a robust predictor of outcome. Instead, reaching the top requires 'hard work' of an entirely different order: consistently and consciously pushing to reach objectives just beyond one's level of proficiency.

Rachel Hsu is a perfect example. When interviewed in front of the audience following her performance, she readily admitted making, *"all sorts of mistakes"*. The audience laughed and were incredulous. Rachel continued undeterred, *"Hardly anyone notices, of course, but I do—and I remember."* More laughter. These mistakes, she went on to explain, become the focus of her efforts the next time she practices. Confident of the standard she's trying to reach, she slows down such passages, playing and replaying them until they are mastered, all the while subject to the scrutiny and approval of her mother or teacher.

Rachel's narrative, in fact, neatly captures and conveys the three steps we reviewed in our article, which research has shown are necessary to achieve excellence. First, know your

baseline. Rachel is able to accurately assess what she does, mindful of what she is capable. Second, engage in deliberate practice—a systematic and critical review during which time problematic aspects of the performance are isolated and rehearsed or, failing that, alternatives considered, implemented, and evaluated. Third and final: obtain formal, ongoing feedback. Exemplifying this last step, we noticed that, following the performance,

Rachel and her mother returned to the piano in the empty hall. In what amounted to no more than a minute, mother directed Rachel's attention to a short section of the composition, providing succinct suggestions for improvement.

To date, more than a dozen randomised clinical trials, involving thousands of clients and numerous therapists, establish that excellence is not reserved for a select few. Far from it, it is within the reach of all. The studies show that applying the steps—knowing your baseline, engaging in deliberate practice, and obtaining feedback—as much as triples the effectiveness of individual practitioners, cuts dropout rates in half, reduces the rate of deterioration by one-third, speeds recovery by two-thirds, and all this while simultaneously improving client satisfaction and reducing the cost of care!

Changing course is hardly a matter of not knowing what to do. If we learned anything in the years following the publication of the *'Supershrinks'* article it is this: knowing the facts and putting them into practice are two altogether different matters. Despite keen interest and obvious enthusiasm for the ideas—including participating in systematic training and coaching—the number of clinicians who put the steps to use in daily practice remains

stubbornly small. Additionally, many start to lose steam quickly. Finally, agencies and larger behavioural health systems who have devoted significant resources to implementation efforts struggle and, all too often, fail. Reflecting on these facts, we could not help but be reminded of the words of Confucius, *"The way out is through the door. Why is it that no one will use this method?"*

### The culture of excellence

In reality, no hard data exists to explain why some individuals devote the time, energy, and resources necessary to achieve greatness. Clearly, therapist motivation is not the deciding factor because, with few exceptions, we work with dedicated, hardworking professionals. Neither can the dearth of follow-through be attributed easily to personality or developmental differences, or the bureaucratic overload of contemporary clinical practice. And yet, above it all, two practitioners, two agencies, each labouring under the same conditions, one does it and one does not.

Top performers, we realised eventually, did not exist in a vacuum, bursting suddenly on the scene following years of private toil. To the casual observer, it can certainly appear that way. In truth, hearing performers like Rachel Hsu matter-of-factly report that she practices four hours a day, every day of the week, including weekends and holidays, amassing more than 4,000 hours, or the equivalent of almost 170 straight days at the piano had distracted us from a larger reality. It was as though looking into the bright light of greatness had blinded us to the surrounding context, rendering invisible a complex and interlocking network of people, places, resources, and circumstances without which excellence remains out of reach for all but a few. This supporting social structure, we have come to call the 'culture of excellence'.

Case in point: Rachel Hsu is not an island. Without the familial, social, economic, and cultural context to encourage and nurture her, Rachel most likely would never have acquired the skill and presence she now exhibits. She has parents, for example, both of whom devote a massive amount of



time, energy, and resources to nurture and advance her abilities. Moreover, Rachel happens to live in one of the largest cities in the U.S.—a location that affords her opportunities to attend world class concerts, participate in high level competitions, and have access to unsurpassed professional instruction.

To most, it makes intuitive sense that individual achievement and the quest for excellence flourish in supportive communities. The practice of psychotherapy is no different. Unfortunately, however, the environment surrounding clinical practice is not designed to advance excellence—if anything, it fosters mediocrity and inertia. Public agencies, for example, operate under the yoke of such economic instability and regulatory whim that the driving goal is solvency and survival—thus the intense focus on billable hours, productivity, and paperwork. In such circumstances, predictability and the appearance of competence easily trump superior performance.

Private practice is even more inhospitable to the pursuit of excellence. Isolated from view, insulated from supervision or ongoing peer review, and lacking any true measure of effectiveness, private practitioners can operate for years without improving their outcomes.

Real world clinical samples provide evidence that documents the impact such isolation has on performance. The outcome of treatment delivered in solo practice settings, for example, consistently lags behind larger, group practices—as much as 25 percent.

### And now for something completely different...

Identifying a culture of excellence and justifying the need for its existence is far easier to do than constructing one. Rachel had the good fortune of being born into privileged circumstances. For most practicing therapists, entering, establishing, and maintaining the same kind and quality of experience will require far reaching, if not drastic, changes in the customary ways most have come or been taught to think and behave—beginning with the core values and institutions that historically have informed the field. Topping the list, we will once and for all need to overcome our longstanding, crippling ambivalence regarding comparison and competition. Monitoring and measurement is commonplace among top performers, as are comparisons to externally established benchmarks and norms (e.g., efficiency, effectiveness, value).

The results of one study are particularly startling. When a



representative sample of therapists (including psychologists, social workers, psychiatrists, and marriage and family therapists) were asked, '*compared to other mental health professionals (with similar credentials), how would you rate your overall clinical skills and effectiveness in terms of a percentile?*' respondents, on average, ranked themselves at the 80th percentile—a statistical impossibility. It gets worse: less than four percent considered themselves average and not a single person in the study rated their performance below average.

Cutting to the chase, how can we expect practitioners and the field to do the hard work necessary for attaining excellence when our perceptions are so wildly out of line with the facts? Our inflated self-assessments notwithstanding, in randomised clinical trials, where therapists are afforded numerous advantages absent in real world practice (i.e., carefully selected and screened clientele, small caseloads, access to ongoing, high quality training and supervision), reliable change—that is, improvement demonstrated to be greater than chance, maturation, and measurement error—is on average achieved with 50 percent of clients. Said another way, practitioners routinely overstate their skills and effectiveness by a staggering 60 percent.

To measure outcome routinely would certainly have a corrective effect. To solve the problem, however, requires that we also compare our work and results with others. As veteran psychotherapy outcome researchers Bruce Wampold and Jeb Brown (2005) point out, '*Therapists typically are not cognizant of the trajectory of change of patients seen by therapists in general...that is to say, they have no way of comparing their treatment outcomes with those obtained by other therapists.*' The good news is that making it possible for practitioners who work independently to connect, share, and learn from each other immediately results in better outcomes for clients. More on this later.

Moving forward, a second change required for establishing and sustaining a culture of excellence is relinquishing our closed, risk-adverse service delivery system and embracing an

open, transparent, and error-centric model of clinical practice. This means nothing is hidden, especially mistakes. Failure is not viewed as an indictment, but passionately embraced as a necessary and critical opportunity for learning and improvement. The literature on expert performance makes clear that a mindset, be it individual or organisational, which prizes proficiency, comfort, certainty, and a belief in 'innate talent', over development, progress, experimentation, and hard work invariably leads to mediocrity.

Effective therapists, it turns out, both report making more mistakes and are more self-critical than their less effective counterparts. Purposefully striving not to make mistakes, the latter group not only suffers poorer overall performance, but also seeks out fewer and less challenging tasks in the future. The result is a vicious cycle. The very behaviours that lead to high levels of achievement (e.g., identifying and working hard to exceed the limits of current performance, receiving negative feedback, and being inspired by the success of others) are avoided, in the process reinforcing an exaggerated perception of one's abilities.

Contrary to what might be expected, available evidence indicates that healthcare professionals are less likely to be sued when errors are acknowledged and disclosed. Unfortunately, whether intended or not, many managerial and regulatory policies put practitioners on the defensive, thereby inhibiting the admission and exploration of mistakes. In the United States, the recent passage of House Bill 2059 by the Oregon State Legislature mandating that all health care professionals report on one another for 'conduct unbecoming a licensee' is exemplary.<sup>1</sup> Leaders of local professional organisations report a chilling effect on professional collaboration.

Finally, and perhaps the most challenging of changes required for making possible a culture of excellence, is thinking differently about what constitutes competence. Throughout our history, therapeutic literacy has been treated as a distinct

body of knowledge and skills that can (and must) be mastered and then reliably applied in order to be effective. Diplomas, licensure, and other certifications serve as public confirmation of having 'arrived'. For this reason, most efforts aimed at improving the quality and outcome of behavioural healthcare start with a call for higher standards for practitioners: more schooling, more specialised training, and more stringent credentialing and rules for professional conduct.

Findings from a large, long-term, multi-national study confirm that clinicians desire to—and see themselves as—continually improving throughout their careers. Given the costs in time and money, one could not be faulted for expecting training and regulation (e.g., licensure) to confer an advantage in performance. Despite what most believe, they do not and never have. Put bluntly, the whole enterprise—current oversight strategies and the way professional preparation is structured—is an abysmal failure.

As just one example, Nyman, Nafziger and Smith (2010) compared licensed doctoral-level providers, pre-doctoral interns, and practicum students. They found that '*the extensive efforts involved in educating graduate students to become licensed professionals result in no observable differences in client outcome*'. Given these results, on what basis can the customary practice of restricting payment for services to one professional group (e.g., psychologists), versus another (e.g., counsellors), be defended? Or, for that matter, to any group that calls themselves 'professional'?

Such findings are hardly anomalous and underscore the urgent need to revise traditional approaches aimed at creating and evaluating competence. In cultures of excellence, emphasis is placed on the here-and-now rather than the there-and-then, on the future versus the past. It is not what you know or have accomplished before that matters. Consistent with the principles and practices just discussed—measurement, comparison, transparency, and error-centricity—it is providing evidence of what you are achieving on this day, in this moment with this particular client. Even more,

<sup>1</sup> See <http://www.leg.state.or.us/09reg/measpdf/hb2000.dir/hb2059.en.pdf>

it is about continually identifying the limits of, and working to exceed, one's current level of performance.

### Connection and community: Next steps

Aware of the changes required in our core values and practices, and accepting that our clinical institutions do not encourage excellence, what then can a practitioner, and our field, do? Our investigation of elite agencies and therapists revealed that nearly all were not the beneficiaries of determined benefactors, fortunate circumstances, or sheer luck. On the contrary, the majority had gone to great lengths to either construct, or gain access to, a community that supported and nurtured professional growth.

Although the eventual achievement is remarkable, the beginnings are often strikingly ordinary. For instance, one well-known practitioner and writer, when asked to trace his path to superior performance, on reflection, remarked, *"It all goes back to ZIP codes"*. As a graduate student, feeling perennially shortchanged by classes in school, he was determined to find better teachers, mentors, and learning opportunities. Toward that end, he volunteered to mail out workshop brochures for a local professional organisation. Given this was the 'pre-computers' era, he had the exceedingly tedious and time-consuming task of sticking mailing labels on 15,000 brochures and organising them by ZIP code. He wasn't even paid, but he did get a priceless payoff: free admission to any of the trainings advertised in the brochures.

*"Fellow grad students thought I was nuts and told me I was being exploited",* he said, *"but over the three years, I met almost every major theorist and practitioner in the field. Typically, I'd review their publications before the event and come prepared with questions. Given my inexperience, a lot of what they said didn't make sense to me, so I sought them out on breaks. I always asked if I could call or write to them at some later point, if I had further questions. Very few declined, and I followed up with most. Eventually, these people became my support system, giving generously of their time, providing guidance, and opening doors that would otherwise have remained closed to me."*

In due course, 'Dr. Zip Code' went to work with one of the foremost groups of clinicians in the country. *"I wanted to be there—not read about it in a book or watch it on film. So, I wrote a letter and asked. True story. Six weeks later, I was packing up my meager belongings and moving across the country. Incidentally, the very same people who had earlier questioned my sanity now attributed the offer to good luck! Over the next five years, I spent literally thousands of hours watching top clinicians perform 'unplugged,' as well as having them watch, comment on, and critique my own work."* He continued, *"The job paid very little, and much to my mom's horror, I*

*sure practices that encourage excellence are standard throughout the agency."* As reported above, having practitioners consistently solicit feedback and measure clinical outcomes improves the quality of therapy.

*"We are and have from the outset been obsessed with measurement",* says Belinda Wells, the managing director of the 16 member, UK-based treatment agency known simply as, The Counseling Team. *"I expect staff to measure and, most importantly, to be interested in the results",* she emphasised and then went on to explain how their interest in assessing and comparing clinician outcomes developed and accelerated over time.

## *...the environment surrounding clinical practice is not designed to advance excellence—if anything, it fosters mediocrity and inertia.*

*had to live in a rooming house with some pretty unsavory types. I loved it. Now, whenever someone watches me work and then asks, 'How did you know to do or say that?' I think back to that time."*

*"I'm still working with a team, twenty-plus years later. Never seen a client or written a paper without others being involved."* When asked how that's financially viable in today's world, he tersely responds, *"Wrong question",* and then continues, *"The right question is, 'How can I make that happen?' I'll tell you what I did. First, I found other ways to make money. Second, I found a group of friends and colleagues who were willing to volunteer time along with me, observing and assessing each others' work."*

This is a nice story about an ambitious, determined self-starter, who ingeniously constructed his own first 'team' from the raw material of mailing labels. But what does excellence look like when embodied in a larger setting, like a clinic or public agency? What might be the recipe for actually building this way of relating from the inside out?

*"Cultures of excellence don't just happen—leadership is essential",* says Cynthia Maeschalck, a Vancouver-based training consultant specialising in improving clinical performance. *"Leaders need to take charge and make*

*"One day",* as Belinda tells it, *"the consultant whose scales we were using to measure our results called me on the phone. After exchanging the usual pleasantries, he inquired, 'what exactly is your team doing up there in Kent?' And when I asked him, 'what on earth are you referring to?' he replied, 'Your team is exceptional: first, the quality and comprehensiveness of the data you send for analysis; and second, the astonishing rate of recovery among the people your group treats.' It was a pivotal moment that."*

Interestingly enough, 'being noticed'—identified as a person with the potential for reaching the highest levels of performance—is not an uncommon occurrence among those who go on to become the best in their field. Whether the appraisal is accurate or not, the recognition often results in access to resources and experiences unavailable to others. The improvement in performance that follows opens additional doors that, in turn, further accelerate development. As the saying goes, one good thing leads to another—a process, writers on expertise have termed the 'dynamic multiplier' effect. Along the way, the community supportive of excellence expands in scope and influence.

*"It's not the numbers, really",* Belinda adds as if suddenly recognising that

a word of caution is warranted. *"It's about being curious", she says, "Trying to figure out what's not working and how we can do better."* Cynthia Maeschalck agrees, adding *"It's just human nature to underplay our shortcomings and overplay our successes"*. That said, just because it is a good idea and improves results does not make the prospect of opening our work to strict and thorough scrutiny particularly appealing. *"Somebody has to take the lead",* Maeschalck affirms, and then continues, *"have the passion to insist on and maintain high standards, so that excellence becomes a habit"*. For all

*them in daily conversation and action. For us, that means trust, transparency, respect, and a willingness to do things differently. Unfortunately, short-term productivity often wins out over long-term growth."*

Remember the one-way mirror? For most, it is the relic of a bygone era. At CCC, clinicians schedule time to watch each other work live from behind the mirror, providing needed peer consultation as well as opportunities for coaching by senior clinicians and a safe place to experiment for all. Clinical supervision is ongoing and organised around clients

*staff members didn't believe it",* Babbins-Wagner reports, *"they were afraid they'd fail or look bad. Even when we told them that their salary and advancement wouldn't be based on these performance measures."* As a result, during the early years of the project, CCC saw a 40 percent turnover in staff. She adds that transforming the culture of an entire agency cannot be done without a certain amount of emotional distress and 'push back'. In time, the trust required for open, demanding examination of self and one's clinical work was established.

In sum, at CCC, management demonstrated its commitment to reforming the culture by creating 'mindful' infrastructures, planned opportunities for discussion, brainstorming, strategising, execution and evaluation. Such deliberate, conscious reflection is, in fact, a requirement for the development of true competence. And the evidence is unequivocal. Top performers not only end up knowing more than their average counterparts, but are vastly better at recognising when, where, how, and with whom to use what they know. Researchers have termed this highly contextualised, situational awareness 'deep, domain-specific knowledge'.

On this score, master chess players actually see more than amateurs, recognising up to 100,000 distinct patterns on the board. A select group of nurses working in neonatal intensive care units develop an uncanny ability to spot infections before symptoms are visible, and despite negative diagnostic testing. Tennis champions correctly perceive where the ball will land and move to intercept it before their opponent serves. Owing to the many hours spent planning, practicing, and reflecting, the most effective therapists sense many more interpersonal patterns and possibilities for relating to clients than average clinicians.

Weigh a recent, groundbreaking study on the therapeutic relationship conducted by researchers Anderson, Ogles, Lambert and Vermeersch (2009). Clinicians were asked to respond to a series of video simulations. Each presented a difficult clinical situation, complicated by a client's anger, dependency, passivity,

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that, the leader can not merely act as a taskmaster and enforcer, ordering staff members to use the measurement tools they are given; he or she needs to 'make it come alive for people', create a vision and structure for nurturing excellence.

*"There are so many challenges",* says Robbie Babbins-Wagner, the CEO of Calgary Counseling Center (CCC). *"But the absolute key is integrating learning into daily workflow."* Management and staff at CCC have been working together to create a 'culture of excellence' since 2004. *"Measurement and feedback are not enough",* Wagner says, *"If you want therapists to grow and develop, they must have time to process and reflect while they work"*.

Making time for clinicians to learn from, rather than simply administer, the measures has been the primary objective of most changes in daily business operations at CCC over the last six years. *"Only now are we beginning to 'shift the culture,'"* says Ms. Babbins-Wagner, *"Doors are open. Dialogue is constant."* When asked how such changes have come about, she chuckles, then answers, *"If you are looking for some earth-shaking revelation here or 'secret' for bringing such a shift about, you are going to be disappointed."* She adds, *"It's about deliberate choices and actions; in particular, keeping your core values front and center, revisiting*

whose feedback indicates a lack of progress or problems in the therapeutic relationship. Twice a month the entire staff spends two hours, together with an external consultant, reviewing the outcomes of the agency, individual clients and therapists.

*"The process is quite deliberate",* says Ms. Babbins-Wagner, *"data is front and center. At every turn, therapeutic process is linked to outcomes and a dialogue begins. 'Is it working?' 'If not, what else can we do?' 'If yes, how can we do better as individual practitioners and as an agency?'"* No one is exempt. Top to bottom, supervisor to student, all are encouraged to move beyond their comfort zone, to question habitual assumptions and therapeutic practices, and to identify the edge of their professional knowledge and ability. *"None of this is antithetical to instruction",* Robbie states in a matter-of-fact tone, *"but we're not interested in controlling or dictating how therapists work. Like our clients, our team is not homogenous. We are interested in each being good and getting better at what they do: 'Struggling with a client?' 'Are your outcomes not what they could be?' 'Hit a developmental plateau?' That's good, I say, because we can help."*

Of course, as is true of change in general, challenges emerge. *"It's not easy to establish a culture of excellence—staff buy-in isn't automatic. At first, many*

confusion, or need to control the situation. Their findings: therapist gender, theoretical orientation, professional experience, and overall social skills were found to be unrelated to outcome; the best results were obtained by clinicians who exhibited deeper, broader, more accessible, interpersonally-nuanced knowledge. No matter the client's presenting problem or style of relating, the top-performing practitioners were more collaborative and empathic, and far less likely to make remarks or comments that distanced or offended a client.

To acquire such understanding, perception, and sensitivity is a common goal among helping professionals. Researchers have found that *'healing involvement'*—a clinician's experience of feeling engaged, affirming, highly empathic, flexible, and capable of dealing constructively with difficulties encountered in the therapeutic interaction—is the pinnacle of therapists' aspirations. Spending more time engaged in deliberate, ongoing and systematic reflection and practice is why some end up having such knowledge while others, of equal experience and social ability, do not. In the words of the old proverb, 'the proof of the pudding is in the eating'. Babbins-Wagner reports that outcomes at CCC have been improving steadily from year to year, almost tripling, since the project began.

### Virtual communities

So where and how can private practitioners find a trustworthy community of peers that will challenge them to keep growing as therapists and people? After all, many therapists who begin their careers in agencies eventually move on to private practice. At that point, they are truly on their own—directly accountable to nobody except their clients, the law, and their own consciences.

In December 2009, the *International Center for Clinical Excellence* (ICCE) was launched ([www.centerforclinicalexcellence.com](http://www.centerforclinicalexcellence.com)), and since then, it has grown into the largest, global, web-based community of clinicians, researchers, administrators, and policymakers dedicated to excellence in behavioural health. Clinicians can choose to

participate in any of the 100-plus forums, create their own discussion group, immerse themselves in a library of documents and how-to videos, and consult directly with peers. Membership costs nothing and the site is free of the advertising, solicitations, and the endless e-mail so typical of the web, list-serves, and other online venues. With just a few clicks, practitioners are able to plug into a group of like-minded clinicians whose sole reason for being on the site is to raise everyone's performance level.

*"Being a solo practitioner can be very isolating",* says Australian psychologist and ICCE member Vanessa Spiller. *"Having a supportive, like-minded community in which I can ask questions and present ideas and thoughts, and have people critically review these—which I've done several times—has been very helpful. It's been great to be able to access this 'oasis' of international expertise, providing me with a community of peers willing to critically review my work, identify some of my unquestioned assumptions, and make specific suggestions for changes I can implement and then objectively evaluate the effectiveness of."* Similar sentiments are expressed by Dutch psychologist Peter Breukers. *"As a solo practitioner, the ICCE gives me a safe ground to fall back on while I practice sticking my neck out, implementing new ideas, and thus continually and deliberately refining my ideas and methods."*

What seems so striking about ICCE is that it transcends its online limitations—which often reinforce anonymity and invisibility—to provide members with the same complex norms of personal connection, openness and honesty, mutual trust and support, challenge and accountability that any 'land-based' community of excellence offers. There is, for example, the same emphasis on taking risks and sharing one's mistakes, admitting when you are having difficulty, do not know what to do, or suspect you are not helping a client get better.

*"Risk is the key to growth",* says Danish psychologist and ICCE Community Manager, Susanne Bargmann, *"Without taking a chance, venturing beyond the tried and true, nothing happens. It's only through difficulty that you learn. It's precisely for this reason that the members and associates*

*continue working very hard at making the ICCE a safe place for clinicians to share openly, and be pushed and stretched."*

The ICCE community is not merely a resource aimed at preventing ethical and professional lapses. It is a genuine source of friendship, support, and encouragement to those practicing a profession that is not only lonely, but frequently characterised by real self-doubt and anxiety. *"I don't feel alone—I never feel it's just me and the client",* says Bargmann. *"I have this whole team—a network, a community of colleagues that I can access whenever I need them."* As in any other excellence-driven community of practice, the freedom the ICCE provides to openly and freely admit failure, embrace error, and make mistakes is 'enormously empowering', says Bargmann.

With thousands of practitioners using the website, including some of the world's best-known therapists, it may be surprising to learn that the self-promotion and ego stroking that often colours professional gatherings is almost entirely lacking. Also absent is the contentiousness that supplants civil conversation on so many online listservs and forums. No 'my way is the best way' is tolerated. *"While the various forums are monitored by ICCE trainers and associates for compliance",* says Ms. Bargmann, *"the need for intervention by management has been minimal. In fact, the staff spends more time participating than policing! And there's an ecumenical spirit and degree of curiosity, humility, and camaraderie in the interactions that's quite inspiring and, frankly, seems organic in origin."*

### Meeting the challenge

The field as a whole, and practitioners in particular, face a number of stark challenges in the future, not the least of which is remaining competitive, if not relevant. As the people we work with and the culture in which we all live is constantly changing, so must we. The time is now. Complacency is the enemy.

Although the prospect of pursuing excellence may seem daunting, even at times insurmountable, it does not require that we be superhuman. *"I can't be a perfect therapist",* says clinician Wendy Amey. *"No matter one's*



experience or training, it's an imperfect practice." Amey was one of the first top-performing clinicians we met at the outset of our research into excellence. Based on her impressive outcomes working with the victims of the most severe types of trauma, we expected more—more confidence, more certainty, a presence commensurate with her results. Instead, in our conversations with her, we often came away feeling underwhelmed and strangely disquieted.

"I don't see myself as a brilliant therapist", she said when asked to account for her effectiveness. "My brain doesn't work that fast, and my memory is really quite limited. Other people always seem to have better ability than me. I have to struggle to keep up." And then, as though to prove the fact, she shared a story of being sent as a student therapist for an evaluation to determine whether she had a learning disorder! (She did not and, in fact, tested well above average).

It was not until Wendy began describing how she works that our feelings of unease gave way to inspiration. "Being limited means that I have to try harder, to work harder than

most do. You see, what comes easily to others, takes time for me. If I had their ability, I probably wouldn't need to work as hard at it as I do." Somehow, hearing this top-performing clinician speak was immensely humbling. She continued, her words identifying the scope of her ambition, as well as the concrete steps she takes every day to realise it, "Even if you always do your best, it won't always be good enough for this client, at this time and place. So what I do, because I'm passionate about helping my clients the best way I can, is get the help I need, and be very open to all of the experiences out there—very, very open to it. And I constantly engage with people that I can learn from."

There is nothing accidental about the community Wendy chooses to surround her. "Always wanting to be more capable than I am, I recognise people with great ability, and I reach out." She reported being "blessed with outstanding colleagues, six or seven of them", whom she regularly contacts, and always on the lookout for others.

At the conclusion of our last conversation, she mentioned having met a psychologist the preceding week who, in her estimation, would

undoubtedly become a resource in the future. When we asked how, Wendy responded, "Hey, I'll say, I've got a problem, what ideas do you have for me? If you aren't invested in being superior, then why not just admit that you don't know, and ask?"

Exactly! Let's get started.

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