

A growing number of psychology practitioners are embracing feedback-informed therapy and deliberate practice, and research is beginning to show it improves outcomes.

CE Corner

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CONTINUING EDUCATION PRACTICE MAKES PERFECT: STRATEGIES THAT HONE PRACTITIONERS' SKILLS

BY TORI DEANGELIS

Watching a basketball pro finesse a long shot, a chess master outwit a seasoned opponent or an Olympic diver execute a flawless backflip are the moments that bring audiences back for more. But such performances aren't magic: Among other factors, they're the result of skillful coaching, specific and sometimes grueling practice routines, and an ongoing commitment to avoiding the status quo and choosing excellence instead.

While such performance-boosting strategies have been used for decades in music, athletics, dance and other fields, they've only found their way into the therapy world in the last several years.

A driver of this adaptation is psychologist Scott D. Miller, PhD, who heads the International Center for Clinical Excellence, a consortium of clinicians and

educators devoted to training fellow clinicians. The work incorporates two main areas of intervention. The first is "feedback-informed treatment," or FIT, which uses data from clients and videos of therapy interactions to understand where treatment might be flagging. With this methodology, clients fill out forms at the beginning and end of each therapy session, and the resulting feedback highlights progress or potential trouble spots.

The second area is "deliberate practice," a methodology for addressing the problems highlighted by the feedback.

Integral to this work is a coach or consultant, which for therapists is a mental health colleague or trainer who is expert in this kind of analysis or in the type of therapy the practitioner is providing. Together, the clinician and coach assess the feedback, and the coach provides exercises aimed at helping the clinician overcome deficits identified by the data. The therapist then practices those exercises independently of therapy until he or she has mastered them.

Miller used such a process to help psychologist Susanne Bargmann, PhD, reduce dropout rates at her clinic near Copenhagen, Denmark. When she first contacted him, her data showed that about a quarter of her clients were leaving after the first few sessions. To help Bargmann determine why, Miller asked her to gather files on 60 patients who had dropped out.

When the two scoured the material, a pattern emerged: The dropouts' therapy-alliance scores—measures of how connected they felt with Bargmann—had declined almost imperceptibly over the course of the sessions, dropping about one point on a 40-point scale compared with the scores of those who stayed.

When Miller asked Bargmann why that might be happening, she explained that her standard approach was to let the process unfold for a while. Her training had taught her that alliance scores that took a temporary dive might actually indicate progress—a sign that people were getting closer to their real issues and were growing more uncomfortable as a result.

Miller suggested that instead, Bargmann try intervening with clients by explicitly talking with them about their scores, asking why they might feel more distant from her and explaining a bit about how therapy typically proceeds. After six months of practicing this strategy, Bargmann's dropout rate fell from 25 percent to 8.7 percent.

"I've become more attentive to the cases where there is a risk that they're giving up on me," she says, "and I follow up more often than I did before."

Bargmann's experience illustrates another key feature of this work: It's not always easy to see your weaknesses, says psychologist Tony Rousmaniere, PsyD, who conducts trainings with Miller and uses FIT and deliberate practice

CE credits: 1

Learning objectives: After reading this article, CE candidates will be able to:

1. Define feedback-informed treatment and deliberate practice.
2. Discuss the benefits of these approaches to improving psychology practice.
3. Describe the steps to conduct self-training in deliberate practice.

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to improve his own clinical work. That's true in any domain, he says, but maybe particularly in therapy, where clients may not be willing to say what they really think, at least for a while.

While the field tends to focus on success stories, "deliberate practice is more about looking at the things that aren't going as right," says Rousmaniere, "and then deliberately working on areas that need improvement."

In the view of Bruce Wampold, PhD, a therapy researcher at the University of Wisconsin-Madison, the methods of FIT and deliberate practice are a fresh opportunity for clinicians to share in advances that have clearly benefited other fields.

"In psychology, we're essentially still training people the way we did 50 years ago," with supervision that is more general than specific, Wampold comments. "With standard training, practitioners do improve, but their days are so full that they rarely have a chance to practice particular skills that would improve their performance."

FROM FEEDBACK TO PRACTICE

Psychology's entry into using these methods began around the mid-1990s, when Brigham Young University psychologist Michael Lambert, PhD, developed a client self-report measure to track patient progress. The current version of this outcome questionnaire, called the OQ®-45.2, is widely used. It contains 45 items that assess client symptoms and problems in relationships and social roles. Lambert and his team also developed related algorithms that predict whether a patient is

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at high risk for dropout, deterioration or insufficient progress, using a color-coded alert system.

Miller, who studied under Lambert, was intrigued by the potential benefits of using such measures on a broad scale. He decided to develop his own shorter measures and algorithms, called the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS), with the aim of making them quick to administer. The ORS, given at the start of each session, asks four questions about client symptoms; the SRS, given at the end, asks four questions about the quality of the therapy relationship. (The client-feedback programs that support Lambert's and Miller's measures are the only ones to be listed on the Substance Abuse and Mental Health Services Administration's National Registry

of Evidence-based Programs and Practices.)

While FIT measures generally helped to improve outcomes, they yielded inconsistent results: User feedback showed that while some clients improved under the regimen, others didn't. What's more, the measures did not help practitioners learn. "Getting feedback was like using a GPS," says Miller. "It got you where you needed to be, but it didn't help you understand the geography."

In 2007, Miller found his missing link in the work of K. Anders Ericsson, PhD, a cognitive psychologist at Florida State University who studies how expert musicians, athletes, chess masters and others improve their crafts. Dubbing the methodology "deliberate practice," Ericsson codified a coaching and self-practice methodology that helps

performers hone their skills. The basic strategy sets a baseline of effectiveness, provides ongoing and systematic feedback on performers' weak or blind spots, and prescribes homework accordingly. Once performers have drilled and mastered one area, they can move on to others.

Despite the specificity of its recommendations, a key element of deliberate practice is helping therapists to improve core therapy skills such as the ability to

create and maintain the therapy relationship, foster hope and expectancy in clients, and practice therapy using a structure, which in general terms means a format that includes an overall assessment of why the patient is troubled and a pathway to solving his or her dilemmas, says Miller. The specificity comes in helping people work on weak spots within those larger skill sets. This could include adding more hopeful statements in your work with clients with

serious depression, or working on specific verbal or facial expressions that help clients know that you are on their side.

A growing number of psychology practitioners are embracing FIT and deliberate practice, and research is beginning to show it improves outcomes. A 2015 study in *Psychotherapy* (Vol. 52, No. 3) by Daryl L. Chow, PhD, Miller and colleagues, for example, found that therapists who facilitated better clinical outcomes in their

HOW TO GET TRAINING IN DELIBERATE PRACTICE

ONGOING TRAINING

Deliberate practice leader **Scott D. Miller, PhD**, and trainers at his **International Center for Clinical Excellence** hold regular experiential intensives in feedback-informed treatment (FIT) and deliberate practice, as well as webinars and an annual conference. Visit www.centerforclinicalexcellence.com.

Seattle-based FIT and deliberate practice trainer **Tony Rousmaniere, PsyD**, leads workshops and webinars on deliberate practice: Visit www.dpfortherapists.com/calendar.

DIY TRAINING

Psychology practitioners can create their own deliberate practice routines. In his new book, "Deliberate Practice for Psychotherapists: A Guide to Improving Clinical Effectiveness," Rousmaniere recommends that practitioners:

■ **Continuously assess your performance** via client-outcome reports Choose cases that are stalled, deteriorating or at risk for deterioration.

Download Miller's Outcome Rating Scale and Session Rating Scale for free at <https://scott-d-miller-ph-d.myshopify.com/collections/performance-metrics/products/performance-metrics-licenses-for-the-ors-and-srs>.

■ **Observe these cases via videotape** with the client's permission.

■ **Seek feedback** from a respected mental health colleague or expert.

■ **Rehearse specific skills that arise from your data.** If FIT data show that you lose most of your highly anxious clients after a few sessions, for instance, observe on video what might be happening. You may see, for example, that you are unwittingly projecting discomfort with these clients. To work on this issue, you could establish a regular practice of deliberately relaxing your body and facial muscles with this discomfort in mind, so that when you are in session, you respond more openly and calmly.

■ **Set incremental learning goals just beyond your ability.** Work on general skills, too, like improving your

emotional attunement with clients, Rousmaniere suggests. One effective way to do this is to watch videos of your therapy interactions with the sound turned off. If your impression of a client is different from your impression with the sound turned on, consider what the person might be trying to express nonverbally.

■ **Schedule a set time** for practice in a quiet place. Start with 20 minutes three times a week and build up from there.

■ **Repeat these steps regularly** and often throughout your career.

In addition, you can network with colleagues interested in these activities by visiting the International Center for Clinical Excellence at www.centerforclinicalexcellence.com. The site provides an online forum for discussions, resources and networking with practitioners, health care managers, educators and researchers who want to foster excellence in behavioral health services. The rewards are worth it, Rousmaniere says. "If it doesn't feel hard, then you're not advancing your skills." —*Tori DeAngelis*

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patients said they spent two to three times more hours working on targeted therapy skills than those with less successful outcomes. Conversely, their research showed, factors such as years of experience, profession and highest level of qualification made little difference. Meanwhile, a prospective study by Simon B. Goldberg, Rousmaniere, Wampold and colleagues conducted at the Calgary Counselling Centre in Calgary, Alberta, over seven years (*Psychotherapy*, Vol. 53, No. 3, 2016) found small but gradual improvements in patient outcomes since the center began implementing aspects of FIT and deliberate practice in 2004. Specifically, overall client outcomes improved by about 3.8 percent per year across the agency, while individual therapists' caseloads improved by about 3.7 percent per year. And a 2017 study by Andrew S. McClintock, PhD, and colleagues in the *Journal of Counseling Psychology* (Vol. 64, No. 3) found that clients who received treatment that included feedback to therapists and clients on three main treatment

processes—outcome expectations, empathy and the therapy alliance—reported a 56 percent increase in alliance scores and a 91 percent increase in therapist empathy compared with those who received treatment as usual.

GAINING MOMENTUM

These methods are starting to percolate into graduate schools and into training opportunities for clinicians (see sidebar on page 39). In addition, mental health agencies are taking an interest. Robbie Babins-Wagner, PhD, chief executive officer of the Calgary Counselling Centre, has found that when therapists use these tools, clients show small but steady improvements in symptoms and life satisfaction. Wampold and Miller are now working with Babins-Wagner to train supervisors in deliberate practice methods and to study the results. And at Prairie Ridge Integrated Behavioral Healthcare, which provides mental health, substance use and primary care treatment to some 4,000 patients in north central Iowa, clinicians regularly use FIT and

FURTHER READING

Feedback-Informed Treatment in Clinical Practice: Reaching for Excellence
Prescott, D.S., Maeschalck, C.L., & Miller, S.D. (Eds.), 2017

The Cycle of Excellence: Using Deliberate Practice to Improve Supervision and Training
Rousmaniere, T., Goodyear, R.K., Miller, S.D., & Wampold, B.E. (Eds.), 2017

Deliberate Practice for Psychotherapists: A Guide to Improving Clinical Effectiveness
Rousmaniere, T., 2016

What Your Therapist Doesn't Know
Rousmaniere, T.
The Atlantic
(April, 2017)

deliberate practice methods to measure patient engagement and outcomes and improve clinical supervision.

"FIT has allowed us to better understand patients' needs and wants, so we can respond with interventions that meet their goals and improve outcomes," says Prairie Ridge's executive director Jay Hansen.

That said, the area is new and plenty of questions remain. For example, can you really equate the subtleties of therapy with performance in other domains?

Also, will deliberate practice prove to be more powerful than traditional supervision in helping clinicians to achieve good treatment outcomes? In other performance domains, for example, critics of Ericsson's work have argued that practice isn't everything. They cite research showing that IQ, motivation and other factors matter just as much as practice. A 2014 meta-analysis in *Psychological Science* (Vol. 25, No. 8), by Brooke M. Macnamara, PhD, and colleagues, for instance, found that deliberate practice explained 26 percent of the variance in performance for games, 21 percent for music, 18 percent for sports and 4 percent for education.

More research will help address such questions, but in the meantime, many psychologists say practice can only help.

"There is always something more we can do to get better," says Penn State psychologist Louis G. Castonguay, PhD, whose research focuses on the process and outcome of different forms of psychotherapy. The message? "Work on it!" ■

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