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Professional Development

From Oxymoron to Reality

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Nothing is so fatiguing as the eternal hanging on of an uncompleted task.

—William James

Psychotherapy works (Miller, Hubble, Chow, & Seidel, 2013). Across a large and diverse number of approaches and populations, the average treated person is better off than 80% of those receiving no treatment (Wampold & Imel, 2015). Not only is the overall efficacy firmly established, but so is its effectiveness in real-world clinical settings (American Psychological Association, 2012; Duncan, Miller, Wampold, & Hubble, 2010; Wampold, 2001). On average, more practicing clinicians achieve outcomes commensurate with results obtained in tightly controlled, randomized clinical trials (Barkham et al., 2006; Minami, Serlin, Wampold, Kircher, & Brown, 2008). Fifty years after Eysenck (1952) claimed that psychological treatments did nothing to facilitate recovery and actually hindered change, the scientific basis of psychological treatments is unassailable (Miller et al., 2013).

As encouraging as these general results are, other data provide the profession with little reason to be sanguine. For example, for close to four decades, the outcome of psychotherapy has remained flat. In their comprehensive review of the literature, Wampold and Imel (2015) noted, "From the various meta-analyses conducted over the years, the aggregate effect size related to absolute efficacy is remarkably consistent" (p. 94). Efforts to improve outcome by creating a psychological formulary—specific treatments for specific disorders—have done nothing to alter this fact. Indeed, studies in which one treatment is directly compared with another reveal few, if any, differences (Duncan et al., 2010; Hubble, Duncan, & Miller, 1999). Not surprisingly, neither clinicians' competence in conducting specific types of therapy nor their adherence to evidence-based protocols has been "found to be related to patient outcome and indeed . . . estimates of their effects [are] very close to zero" (Webb, DeRubeis, & Barber, 2010, p. 207).

Equally discouraging, additional findings show that the results obtained by individual clinicians are far from uniform (Crits-Christophe & Mintz, 1991; Garfield, 1997; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Miller, Duncan, Sorrell, & Brown, 200; Okiishi,

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Lambert, Egget, & Vermeersch, 2003). Simply put, some therapists are more (or less) helpful than others (Miller, Hubble, & Duncan, 2007). Moreover, instead of improving with experience, the effectiveness of the average practitioner plateaus early on and slowly deteriorates (Miller & Hubble, 2011). To illustrate, in the largest study of its kind, Goldberg, Rousmaniere, and colleagues (2016) documented an erosion in performance in a sample of 170 therapists working with more than 6,500 clients, tracked over a 5-year period. This decline was unrelated to initial client severity, number of sessions, early termination, caseload size, or various therapist factors (e.g., age, years of experience, theoretical orientation).

What does reliably improve is therapists' confidence in their abilities (Miller et al., 2007). Studies show that the least effective believe they are as good as the most effective and that average clinicians overestimate their outcomes on the order of 65% (Chow, 2014; Hiatt & Hargrave, 1995; Walfish, McAlister, O'Donnell, & Lambert, 2012). Ironically, it is as if practitioners have taken the advice of famed French psychiatrist Coué who, more than 100 years ago, instructed his patients to tell themselves repeatedly, morning and evening, "Every day, in every way, I'm getting better and better" (Clement, 1994).

Whatever outcome research shows, clearly therapists want to develop professionally. A large, 20-year, multinational investigation of 11,000 clinicians, conducted by researchers Orlinsky and Rønnestad together with members of the Society for Psychotherapy Research, confirms this deeply held desire (Orlinksy & Rønnestad, 2005; Rønnestad & Orlinsky, 2005). This same research revealed that improving clinicians' skills, deepening their understanding of therapeutic process, and overcoming past limitations are key to sustaining morale, reducing burnout, and maintaining enthusiasm for clinical work (Miller & Hubble, 2015). With respect to professional development, then, it is not a matter of a therapist's will; it is a matter of *way*.

Clinicians invest a great deal of time, energy, and money in professional growth. They undergo personal therapy, receive ongoing postgraduate supervision, and attend continuing education (CE) events (Rønnestad & Orlinsky, 2005). Nevertheless, one searches in vain for any evidence that such efforts help therapists accomplish their goal.

Taking each in order, although nearly 80% of practitioners cite a personal therapy as key to becoming a better therapist—second only to supervision (Orlinksy & Rønnestad, 2005)—the findings are at best "mixed and inconclusive" (Malikiosi-Loizos, 2013, p. 43; Geller, Norcross, & Orlinksy, 2005). Supervision fares no better. After reviewing a century of the literature and research on the practice, Watkins (2011) concluded, "We do not seem any more able to say now (as opposed to 30 years ago) that psychotherapy supervision contributes to patient outcome" (p. 235). More recently, Rousmaniere, Swift, Babins-Wagner, Whipple, and Berzins (2016) examined the impact of supervision on outcomes using hierarchical linear modeling (clients nested within therapists and therapists nested within supervisor). Data were gathered for more than 5 years on 23 supervisors working in a real-world setting. Supervision was not found to be a significant contributor to client outcome. Neither did the supervisors' experience level, profession (social work versus psychology), or qualifications predict differences between supervisors in client outcomes.

Finally, with regard to CE, although clinicians report being satisfied and believing these kinds of experiences lead to more effective and ethical practice, no proof of knowledge acquisition or growing clinical competency exists. In truth, although continuing education

is mandated by licensing and regulatory bodies worldwide, any connection between the quality and outcome of professional services and participation in CE has yet to be established (Neimeyer, Taylor, & Wear, 2009).

The question naturally arises: Where can a clinician go for instruction and guidance about becoming more effective? As seen, the field's traditions and methods have rendered "professional development" an oxymoron. Fortunately, research outside the field provides direction for making the growth clinicians seek a reality. These findings, drawn from the study of expertise, are less concerned with the particulars of a given performance domain than with how mastery of any human endeavor is achieved (Colvin, 2008; Ericsson, 2009; Ericsson, Charness, Feltovich, & Hoffman, 2006).

Learning from Experts

> Few if any of the people around you are truly great at what they do . . . . Why—exactly why—aren't they?
>
> —*Geoff Colvin (2008)*

In 1993, researchers Ericsson, Krampe, and Tesch-Romer published the results of a groundbreaking study on the acquisition of expert performance. "The search for stable heritable characteristics that could predict or at least account for the superior performance of eminent individuals has been surprisingly unsuccessful," they observed (p. 365). "Neither," they continued, is "the maximal level of performance . . . in a given domain . . . attained automatically as a function of experience" (p. 366). In sum, expertise is not inherited nor does it directly follow from mere time spent in a given field or profession. Instead, top performers are made, a result of their "life-long . . . *deliberate* effort to improve" (p. 400, emphasis added).

Using violinists as the subjects for study, Ericsson and colleagues (1993) found that the best worked harder and smarter at improving their craft than the less capable players. Specifically, those at the top spent significantly more time—three times as much—than those at the bottom engaged in solitary activities specifically designed to better their performance. The best were more dedicated in every way. They devoted less time to leisure and more time to music-related activities. Additionally, they knew when they were slacking off, unlike the other subjects in the study who tended to underestimate time spent in recreation and relaxation.

Since the publication of this initial research, similar results have been found in sports, chess, business, computer programming, teaching, medicine, and surgery (Charness, Tuffiash, Krampe, Reingold, & Vasyukova, 2005; Duckworth, Kirby, Tsukayama, Berstein, & Ericsson, 2011; Ericsson et al., 1993; Keith & Ericsson, 2007; Krampe & Ericsson, 1996; Starkes, Deakin, Allard, Hodges, & Hayes, 1996). Ericsson et al. (1993) introduced the term *deliberate practice* (DP) to refer to the universal process associated with the development and maintenance of expertise across a variety of pursuits.

As the name implies, DP is purposeful and cognitively demanding, going beyond the execution of skills associated with routine work. The key attribute of DP is to "seek out challenges that go beyond their current level of reliable achievement—ideally in a safe and

optimal learning context that allows immediate feedback and gradual refinement by repetition" (Ericsson, 2009, p. 425). The process, as Ericsson et al. (1993) defined it, involves regular engagement in a set of tasks "rated high on relevance for performance, high on effort, and comparatively low on inherent enjoyment" (p. 373).

With regard to the specific nature of the activities, the deliberate practice framework contains four key elements:

1. A focused and systematic effort to improve performance pursued over an extended period
2. Involvement of and guidance from a coach/teacher/mentor
3. Immediate, ongoing feedback
4. Successive refinement and repetition via solo practice outside of performance (see Figure 2.1; Ericsson et al., 1993; Ericsson & Charness, 1994; Ericsson & Lehmann, 1996)

According to Ericsson (2006), the notion that superior performance required at least "10,000 hours" of practice—popularized in Malcolm Gladwell's book *Outliers* (2008)—is but a rough estimate.

Expert performance is believed to be mediated by "complex integrated systems of representations for the planning, analysis, execution, and monitoring of performance" (Ericsson, 2006, p. 698)—a mental map also called "domain-specific" knowledge (Ericsson & Staszewski, 1989). Bearing this in mind, engagement in DP is transformational. In pushing performers beyond their current abilities, DP gradually changes the physiologic and cognitive structures mediating performance (Ericsson, 1996, 2004). The data further suggest that the best purposefully and continuously work at acquiring higher levels of control over what they do (Ericsson, Nandagopal, & Roring, 2009). In the study of chess players, for example, improvements in performance have been found to follow an individual's development of more complex and selective mental representations of the game. In short, the best players approach the board

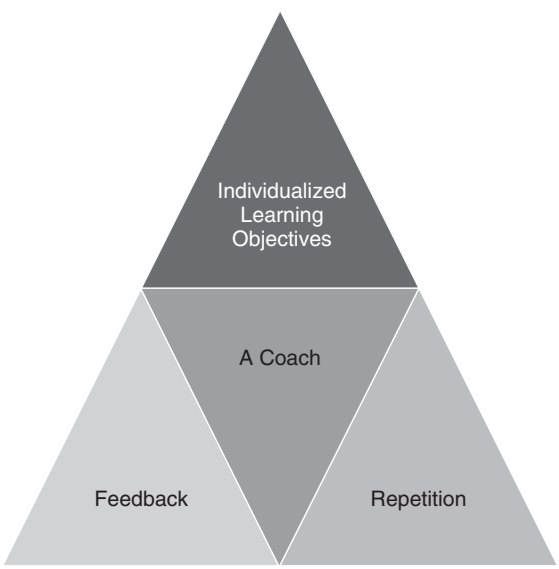

Figure 2.1 Four primary components of deliberate practice framework.

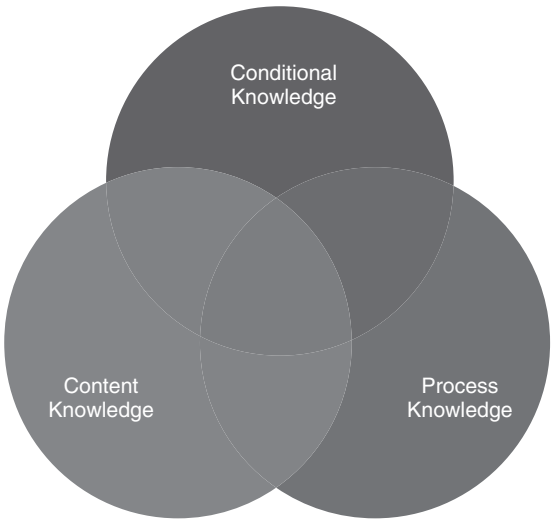

Figure 2.2 Three components of domain-specific knowledge.

very differently from novice players. Having developed higher-order units, or "chunks," for conceiving, understanding, and organizing their actions, chess masters store and retrieve relevant information with greater ease, speed, and effect (Feltovich, Prietula, & Ericsson, 2006).

Domain-specific knowledge can be further understood and elaborated as being comprised of three interacting components. (See Figure 2.2.) The first, *content knowledge*, is the body of understandings comprising a particular field or performance domain. In fencing, for example, a riposte is defined as a quick return thrust following an opponent's parry. Such information is customarily conveyed in books, instructional media, and classrooms. If content knowledge is about the "what," *process* is the "how." Recognizing and describing a riposte is not the same as being able to execute the move. Finally, *conditional knowledge* involves knowing the right or opportune moment to apply "what" one knows "how" to do. By engaging in DP, performers are continuously pushing themselves to expand and refine the three types of knowledge with the goal of achieving a higher level of functioning.

In any given realm or field, no single activity, if practiced by all, invariably leads to expertise (Ericsson et al., 1993). What works for one will not necessarily work for another. For DP to be effective, it must be highly individualized, targeting personal objectives that lie just beyond an individual's current level of proficiency.

Successful DP also includes a continuous and conscious effort on the part of performers to monitor what they do. Specific attention is directed toward identifying errors and then taking steps to reduce those errors during their next round of DP (Ericsson, 1996, 2006). Top-performing stand-up comedians provide an excellent example of this "error-centric" approach (Coyle, 2008). Average comedians focus on telling jokes. In contrast, headliners are not invested in any particular gag or routine. Their purpose is to entertain. To that end, they watch, observe, and listen to the audience, using audience reactions to rework, change, and nuance their material until it elicits what they are there to evoke, laughter.

Although some performers reach a plateau and disengage from deliberate practice, evidence suggests the best purposefully work to counteract *automaticity* so as to acquire

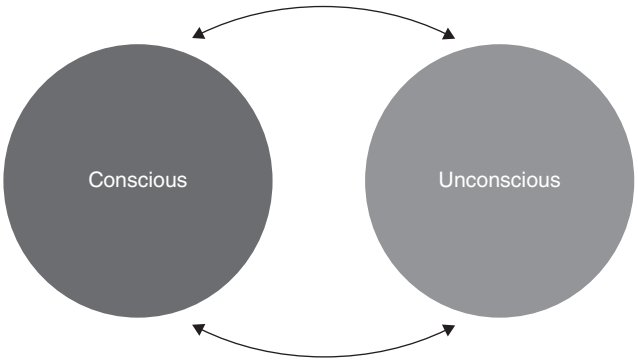

Figure 2.3 Cycle of overcoming automaticity.

higher levels of control over their performance (Ericsson, 2009). Through ongoing, deliberate reflection, superior performers consciously synthesize their knowledge and skills, ultimately enabling them to perform a particular task more efficiently and effectively (Feltovich et al., 2006). The cycle of making conscious what is unconscious and of making unconscious what is conscious is vital not only for the acquisition of superior performance but also for skill maintenance (see Figure 2.3; Ericsson et al., 2009; Krampe & Ericsson, 1996).

Although it may seem self-evident, what is practiced must lead to the acquisition of knowledge or skills causally related to a better outcome. As a case in point, consider the practice of astrology. Someone interested in interpreting the movements and positions of celestial objects for the purpose of divination could use and apply the principles of DP. Indeed, much has been written by scholars of the "esoteric arts" on the importance of practice (cf. Edmundson, 2004). In time, mastery of the extensive and complex knowledge base associated with this endeavor would result (Garner, 2010). Despite the effort expended and the confidence felt, however, one would be no better at predicting the future than anyone else.

Finally, DP requires a supportive social context—a frequently invisible, interlocking network of people, places, resources, and circumstances. Miller and Hubble (2011) termed this social scaffolding the "culture of excellence." DP is hard work. As Ericsson (1993) observed, "Unlike play, [it] is not inherently motivating; and unlike work, it does not lead to immediate social and monetary rewards . . . . . and [actually] generates costs" (p. 386). Not surprisingly, without strong, consistent validation, encouragement, and sponsorship (e.g., financial backing), top performance remains out of reach for all but a few.

Application of Deliberate Practice in Psychotherapy

> To practice isn't to declare that I am bad. To practice is to declare that I can be better.
> —*Dan Heath (2012)*

It is important to note that clinical practice and deliberate practice are not one and the same. Although necessary, clinical practice is insufficient for developing and refining the skills

associated with superior performance. Clinical practice is an "output"—the result of efforts to be helpful. Deliberate practice, in contrast, is an "input" aimed at improving skills. The returns are often not immediate, and rarely monetarily rewarding, but nonetheless they improve the quality of a practitioner's clinical work.

In 2015, Chow and associates published the first study on the impact of deliberate practice on therapist development. The research examined the relationship between outcome and a variety of practitioner variables, including demographics, work practices, participation in professional development activities, beliefs regarding learning and growth as a therapist, and personal appraisals of therapeutic effectiveness. As in previous studies, gender, qualifications, professional discipline, years of experience, time spent conducting therapy, and clinician self-assessment of effectiveness were not related to outcome (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Malouff, 2012; Walfish, McAlister, O'Donnell, & Lambert, 2012;Wampold & Brown, 2005). Consistent with findings reported in the expert performance literature, the amount of time therapists spent in activities intended to improve their ability was a significant predictor.

The cumulative impact deliberate practice exerted on clinician effectiveness can be seen in Figure 2.4. In the first 8 years of their professional work, the top quartile of practitioners spent, on average, nearly 2.8 times more time engaged in deliberate practice than those in the bottom three.

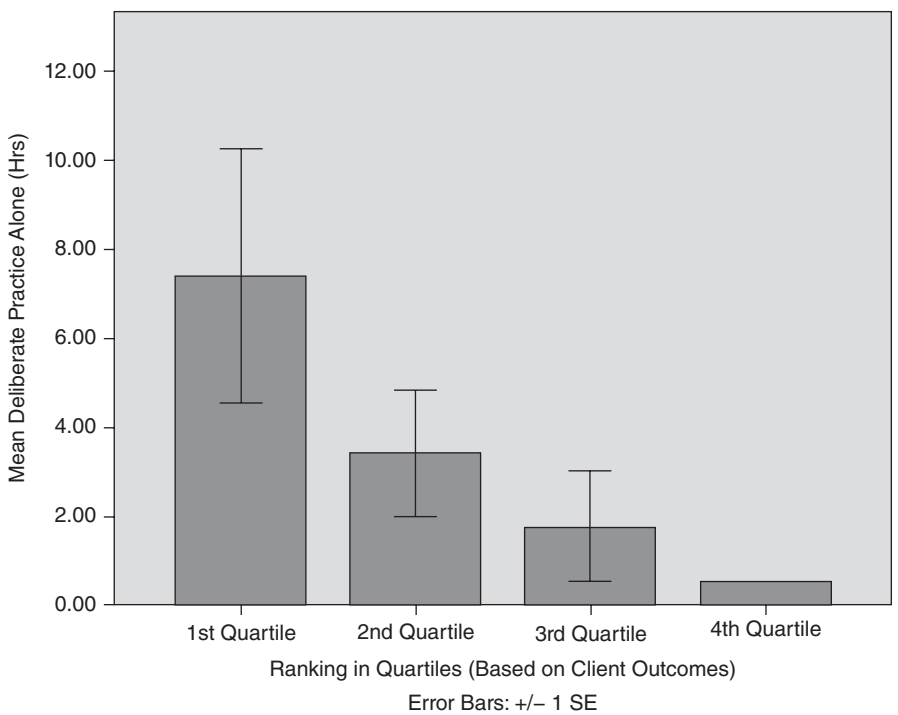

Figure 2.4 Therapists grouped in quartiles based on their adjusted client outcomes as a function of estimated time spent on "deliberate practice alone" per typical workweek.
Note. SE = standard error of mean; 4th quartile consists of only one therapist. Therefore, no error bar was included.

Chow et al.'s (2015) study further examined what therapists actually do when they engage in deliberate practice. Informed by prior research on expertise, the investigators designed a survey assessing the type of activities study subjects pursued, the amount of time spent in each, the perceived relevance to skill improvement, and the cognitive effort required to complete them (Chow & Miller, 2012). Consistent with the results reported by Ericsson et al. (1993) in their investigation of violinists, Chow and colleagues (2015) found that no one activity reliably produced better outcomes. In point of fact, what needs to be practiced will vary from one person to the next depending on where the individual "starts" and whatever is instrumental in either impeding or improving his or her specific performance.

Miller et al. (2007) identified three steps for constructing an individualized professional development plan. Working in tandem to create a "cycle of excellence," they include: (a) determining a baseline level of effectiveness; (b) obtaining systematic, ongoing, formal feedback; and (c) repeatedly engaging in activities specifically designed to refine and improve performance. Together, the steps integrate Ericsson's work with very recent innovations in psychotherapy outcome research that, when implemented, enable practitioners to achieve real gains in their effectiveness. Each step is discussed in turn.

Step 1: Determining a Baseline Level of Effectiveness

Improving performance and growing as a therapist begin with determining one's current level of effectiveness. It stands to reason. If one calls for directions to a particular destination, the first question likely to be heard is "Where are you *now*?" In truth, most practitioners have no hard data about how they are performing—their success rates (Boswell, Kraus, Miller, & Lambert, 2013). Not knowing where they are, they have no reference point for charting a course of professional development. As noted, therapists' personal appraisals are grossly inaccurate. They believe themselves to be more effective than they are, chronically underestimate the number of clients who deteriorate while in their care, and think they are improving when they are not (Chow et al., 2015; Miller et al., 2007; Walfish et al., 2012). More, such bias is not self-correcting, despite time and experience. Taking all these findings into consideration, it is easy to understand why professional development has remained so elusive (Hannan et al., 2005; Kahneman, 2011; Kruger, 1999).

Across a wide variety of endeavors, performers who rise to the top are constantly comparing what they do with existing standards or norms (Ericsson, 2006). Fortunately, owing to advances in measurement and technology, psychotherapists can do the same. Over the last two decades, numerous, well-established scales for assessing outcome have become available (cf. Corcoran & Fischer, 2013; Froyd & Lambert, 1989; Ogles, Lambert, & Masters, 1996). Additionally, computerized systems exist that automate calculations of individual clinician effect sizes, thus facilitating comparisons with national and international norms (cf. Lambert, 2012; PCOMS, 2013). Any of these tools or systems can be used to establish a personal benchmark against which efforts aimed at improving can be assessed.

Two systems—the Partners for Change Outcome Management System (PCOMS) and the Outcome Questionnaire Psychotherapy Quality Management System (OQ-Analyst)—have been reviewed independently and listed on the National Registry of Evidence-based Programs and Practices of the Substance Abuse and Mental Health Services Administration (2012). The registry identifies mental health and substance abuse interventions that have

met national criteria for evidence of positive outcomes and readiness for implementation. Both systems were purposely designed to be used across treatment modalities, diagnoses, and professional discipline. They are simple, require little time to administer and score, and yield valid and reliable measures of client progress. PCOMS includes a scale for assessing the quality of the therapeutic relationship, a robust predictor of client engagement and outcome (Norcross, 2010; Orlinsky, Rønnestad, & Willutzki, 2004; Wampold & Imel, 2015). OQ-Analyst provides additional information about the alliance, patient motivation, social supports, and negative life events.

Lead versus Lag Measures

Although the measurement of outcomes is essential for determining one's effectiveness level, it is not enough to aid in professional development or improved performance. Indeed, focusing exclusively on outcomes cannot lead to better results as doing so does not inform the performer about *how* or *what* to improve. On this score, distinguishing between lead and lag measures is helpful (McChesney, Covey, & Huling, 2012). Briefly, *lag measures* are defined as penultimate or distal outcomes; in psychotherapy, for example, the ideal lag measure is improved client outcomes. *Lead measures* are those that predict, lead to, or impact lag measures. Using the simple example of losing weight, the lag outcome is pounds lost. Caloric intake and time spent exercising, both items within the performer's control, would be considered lead measures.

To aid in the identification of lead measures most likely to aid in individual practitioner development, Chow and Miller (2015) developed the Taxonomy of Deliberate Practice Activities Worksheets (TDPA).[1] Using the worksheets, clinicians and their supervisors routinely rate key aspects of the supervisee's work. The TDPA isolates multiple aspects of practice that are known to exert a high degree of influence on the lag measure of therapy: client outcomes. As the clinician progresses, developing mastery in a particular therapeutic domain, the target of deliberate practice efforts can shift.

Step 2: Feedback

The second step in fostering professional development is obtaining systematic, ongoing feedback. Therapists need to know when they are on the right track and be given direction when they are not. Lambert et al. (2001) were the first to document what happens when therapists are provided with ongoing feedback about the effectiveness of their work. In their study, alerting therapists to cases most at risk of failure resulted in better outcomes and reduced rates of dropout and deterioration.

Since that pioneering work, research on feedback has continued and accelerated. Positive findings have been reported in outpatient and inpatient settings, counseling and university training centers, individual and group therapies, and specialized treatment programs (Anker, Duncan, & Sparks, 2009; Berking, Orth, & Lutz, 2006; Bickman, Kelley, Breda, Andrade, & Riemer, 2011; Brodey et al., 2005; Byrne, Hooke, Newnham, & Page, 2012; Crits-Cristoph et al., 2012; De Jong et al., 2014; Hansson, Rundberg, Österling, Öjehagen, & Berglund, 2013; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004;

1 To request a copy of the taxonomy, contact daryl@darylchow.com.

Murphy, Rashleigh, & Timulak, 2012; Probst et al., 2013; Probst, Lambert, Dahlbender, Loew, & Tritt, 2014; Reese, Norsworthy, & Rowlands, 2009; Reese, Toland, Slone, & Norsworthy, 2010; Reese, Usher et al., 2009; Schuman, Slone, Reese, & Duncan, 2015; Simon, Lambert, Harris, Busath, & Vazquez, 2012; Simon et al., 2013; Slade, Lambert, Harmon, Smart, & Bailey, 2008; Sorrell, 2007). To date, five meta-analyses demonstrate the consistently favorable impact of providing progress feedback to therapists: Lambert et al. (2003); Knaup, Koesters, Schoefer, and Puschner (2009); Shimokawa, Lambert, and Smart (2010); Lambert and Shimokawa (2011); and Davidson, Perry, and Bell (2015).

Consistent with studies on expert performance in other professions, research specific to psychotherapy underscores the importance of the availability, frequency, and immediacy of whatever feedback is provided. Without access to a formal system for assessing progress, therapists fail to predict or identify deterioration in their clients (Hannan et al., 2005; Hatfield, McCullough, Frantz, & Krieger, 2010). Making outcome data available to both clients and therapists enhances outcome (Hawkins et al., 2004). Pertaining to immediacy, Slade and colleagues (2008) found that feedback delivered at the time of service had a considerably larger impact than when delayed by 2 weeks. Even the mere anticipation of more immediate feedback, as opposed to delayed results, improves performance (Kettle & Haubl, 2010).

At present, both of the systems approved by the Substance Abuse and Mental Health Services Administration, PCOMS and OQ-Analyst, meet the requirements for the type and quality of feedback most likely to impact the course of treatment. The measures are administered when service is delivered. Client scores are immediately plotted against empirically established norms for progress and made available to the client and therapist. (See Figure 2.5.) If needed, treatment can be altered in real time whenever deviations from the expected trajectory are found.

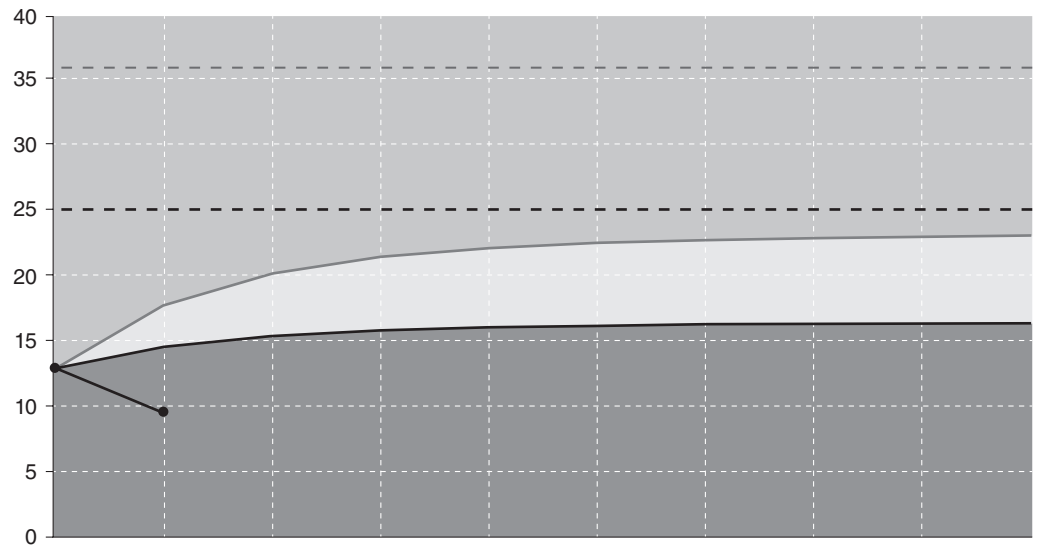

Figure 2.5 Normed progress trajectory for PCOMS.
Note. Client scores for two sessions are plotted as a thick black line against a normed trajectory. Scores falling in the light gray zone are predictive of eventual success; in the dark gray, an indeterminate result; and in the black, a negative or null outcome.

Clinical Supervision

Few supervisors use outcome monitoring as a tool (Swift et al., 2015). Working without information about the progress of a supervisee's clients is like the coach of a football team working without knowledge of the scoreboard. Worthen and Lambert (2007) suggested that to maximize improvement in those clients who are not responding to treatment, both therapists and supervisors need to monitor progress. To date, only one study has examined the use of such monitoring in supervision (Reese, Usher et al., 2009). Doing so resulted in statistically significant benefits in terms of client outcomes.

As the Goldberg, Rousmaniere et al. (2016) study cited earlier makes clear, receiving feedback about performance does not necessarily mean one is learning (Bjork & Bjork, 2011; see Figure 2.6). At the same time, learning may not necessarily result in improved performance in the short term. Thus, while systematic, session-by-session feedback about client progress is vital, feedback about how one is developing is also critical to success. The former may be called performance feedback (PF); the latter, learning feedback (LF).

As the name implies, PF is focused on outcomes as assessed by the lead and lag measures discussed earlier. LF, by contrast, refers to individualized performance objectives, the achievement of which can be assessed by the gradual acquisition of a well-defined skill set identified by the performer in collaboration with a supervisor/coach. For LF to be effective, the coach/supervisor focuses on the objective at hand, avoids criticizing the learner, and breaks the feedback provided into portions that are manageable and enable clinicians to reach beyond their current comfort zones (Shute, 2008). A basketball player, for example, receives immediate PF when shooting the ball. It either goes in the basket or does not. To improve, LF must take place. Before and after the game, the coach reviews video recordings and works with the player to identify small errors and develop specific skills. Similarly, a psychotherapist receives immediate PF about the quality of the relationship when a standardized alliance measure is administered at the end of a session. By reviewing audio or video recordings with a supervisor, therapists have the opportunity to receive LF about their performance.

Step 3: Successive Refinement

The accumulation of experience does not necessarily translate into increased expertise. Indeed, clinical experience is not and has never been a predictor of good outcomes (Beutler et al., 2004; Chow et al., 2015; Wampold & Brown, 2005). Similarly, as powerful an effect as

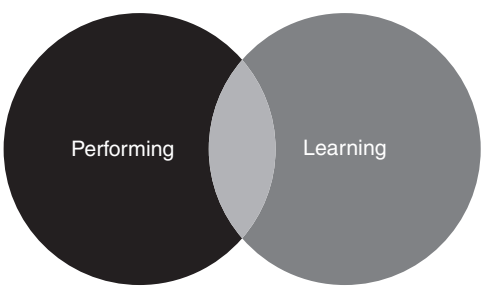

Figure 2.6 Differentiation between performance and learning.

measurement and feedback have on outcome, they are not enough to ensure professional development. Together, they function much like a global positioning system. Measurement pinpoints an operator's location and indicates progress toward the desired location. Feedback alerts drivers when they are off track, providing directions for resuming progress and even suggesting alternate routes. What the global positioning system does *not* do, however, is improve overall navigational skills or knowledge of the territory (Miller et al., 2007; Miller & Hubble, 2011).

More than a decade ago, Lambert pointed out practitioners did not improve in their ability to detect when cases were off track or at risk for dropout or deterioration, despite measuring and receiving feedback about their outcomes on a daily basis for 3 years (Miller, Duncan, & Hubble, 2004). De Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) later confirmed these findings. Clearly, to learn from the information that measurement and feedback provide, the third step of "successive refinement" is necessary. Going beyond mere "course correction," it entails setting aside time for self-reflection, identification of errors or deficiencies in one's performance, obtaining guidance, and then developing, rehearsing, executing, and continuously evaluating a plan for improvement, based on PT and LF.

With regard to specifics, individual therapists can use the data generated by whatever measures they employ to identify opportunities for professional development. Indeed, computerized outcome management systems provide an unprecedented wealth of data for profiling a particular practitioner's strengths and weaknesses. Therapists can, for example, examine their dropout, no-show, and deterioration rates. They can also determine whether these rates and their overall effectiveness vary depending on the presenting problem or client population.

Of the steps discussed thus far, step 3 is the most labor-intensive. Disciplined concentration and focus are required as performers push themselves to the limits of their abilities. Without planning ahead and dedicating time to the process—whether reflecting on and planning for a challenging case, reviewing a recording of a recent session, or becoming acquainted with a new area of clinical practice—the path of least resistance will be followed (Newport, 2016).

One fundamental element known to be highly predictive of therapeutic success is a clinician's ability to establish a working alliance (Norcross, 2010; Wampold & Imel, 2015). In the largest meta-analysis to date, involving 190 studies and more than 14,000 cases, Horvath, Del Re, Flückiger, and Symonds (2011) showed the alliance accounted for 8% of outcome variance. As noted in the discussion of the three components of domain-specific knowledge, knowing "what" is important—*content* knowledge—does not necessarily result into knowing "how"—*process* knowledge. (See Figure 2.2.) For example, despite awareness of the key role the alliance plays in a course of treatment, major differences obtain in therapists' ability to form and sustain helpful relationships (Baldwin, Wampold, & Imel, 2007). There is more. Research by Anderson and colleagues (2009) found that differences among therapists in the depth of their *conditional* knowledge—the "when" to do "what" one knows "how" to do—explained this variability. In that study, the more effective the clinicians, the more they were able to interact empathically and collaboratively when faced with a broader and more diverse group of clients and presenting complaints. Additionally, their interactions were

much less likely to create interpersonal distance. More recently, Anderson, Crowley, Himanwan, Holmberg, and Uhlin (2015) found that therapists who scored higher in these relational skills obtained higher client-rated alliance scores than their colleagues from the outset of treatment.

Investigators have established that "healing involvement"—a practitioner's experience of an empathic, engaging, flexible, and constructive interpersonal interaction—tops therapists' aspirations (Orlinsky & Rønnestad, 2005). However, evidence suggests that therapists' self-perceived healing involvement is inversely related to their outcomes (Chow, 2014). That is, therapists who rate themselves higher on healing involvement tend to perform more poorly than their peers. Moreover, neither training nor time spent doing therapy has proven effective in enhancing clinician abilities in this area (Anderson et al., 2009, 2015; Horvath, 2001). A recent study by Chow, Lu, Owen, and Miller (2015) is an exception.

Chow et al. (2015) applied the three steps of deliberate practice to enhancing empathic attunement, a critical component of the therapeutic relationship. Empathy is not only one of the most consistent predictors of psychotherapy outcome; it is among the largest, having an effect size exceeding .6 (Wampold & Imel, 2015). In this study, participants watched a video depicting a difficult moment in a therapy session. The subjects were given a brief description of the client and instructed to respond as if the person were seated in front of them. The baseline performance of each subject was established by rating their responses to the video on a standardized scale of relational abilities (subscales of the Facilitative Interpersonal Skills; Anderson, Patterson, & Weis, 2007). In a second trial, no feedback was provided, but participants were given time and instructed to self-reflect in an attempt to improve their responses. In the third and fourth trials, participants watched the same video, followed by individualized LF derived from their scores. Again, LF was provided and time set aside for therapists to reflect on how they might improve their responses. In a fifth, and final trial, a new video was introduced involving a different client and presenting problem. Once more, participants responded and were rated, this time to determine whether any learning had generalized to the new scenario.

As illustrated in Figure 2.7, the provision of immediate, individualized LF, with time to reflect and plan for improvement, enhanced the subjects' ability to respond warmly, empathically, and collaboratively. More, these gains generalized to the new vignette.

Making Professional Development a Reality

> If we don't change direction, we'll end up where we're going.
>
> *—Professor Irwin Corey*

When it comes to professional development, two facts are apparent. The first, to the credit of practicing psychotherapists worldwide, is that they want to get better at what they do. This is not only a shared goal; it is a core value. The second is that the traditions and practices informing and comprising professional development do not work. When it comes to improving outcomes, the time, money, and effort expended—even mandated by licensing

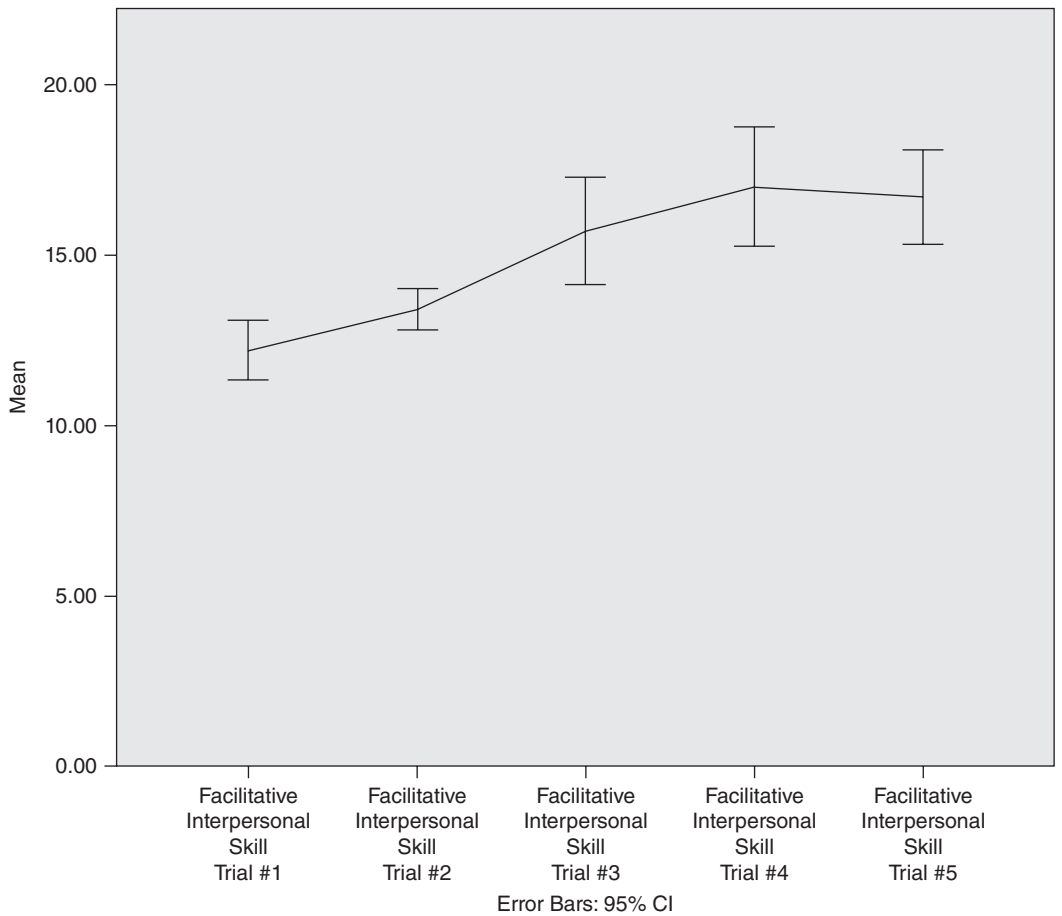

Figure 2.7 Mean scores based on subscales of the Facilitative Interpersonal Skills ratings across the five trials in difficult conversations in therapy.
Note. CI = confidence interval.

and certification bodies—are largely wasted. The overall effectiveness of psychotherapy has remained stagnant, and the results of individual clinicians do not improve with time, training, and experience.

Research from the field of expertise and expert performance provides an evidence-based alternative for making professional development a reality. Although its application to the field of psychotherapy is in its infancy, research to date is quite promising. Studies by Chow and colleagues (2015), for example, established the role deliberate practice plays in the development of highly effective therapists and its potential usefulness in fostering improvement in core therapeutic skills among individual practitioners. To date, one study has documented the results of consciously and planfully implementing the three steps of the "cycle of excellence" (Goldberg Babbins-Wagner et al., 2016). Specifically, routine outcome monitoring, combined with systematic feedback and deliberate practice, incrementally improved the outcomes of individual therapists and overall agency results. Notably, therapists

continued improving every year over 7 years, highlighting the potentially large cumulative effect of small changes accrued over time (Ericsson et al., 1993; Imel, Sheng, Baldwin, & Atkins, 2015). The study further highlights the importance of establishing a social context—including policies, procedures, administrative approval, and funding—supportive of a culture of excellence (Ferlie & Shortell, 2001; Miller & Hubble, 2011). In the chapters that follow, the promise and possibilities of deliberate practice are presented and explored.

Questions from the Editors

Question #1. You mention that no one specific training activity reliably produces better outcomes and that what works for one therapist may not work for another. What advice do you have for therapists who want to experiment with deliberate practice and discover which training activities help them most?

Answer from Authors: One of the biggest challenges of deliberate practice (DP) is sustaining it. Therefore, a framework to aid experimentation and leveraging on key activities are important pillars to support such efforts. We use the acronym *ARPS* to stand for *a*utomated structure, *r*eference point, *p*layful experimentations, and *s*upport (Chow, in press).

1. Automated Structure
   - Block out 1 hour a week for deliberate practice. Avoid bingeing, and stick to a time limit.
   - Plan on how you will spend your time for the week ahead (e.g., reflection, reviewing segments of a therapy recording).
   - Set up automated reminders for DP on your digital devices.
   - Set up a simple system to audio-video/audio-record your sessions. Make sure to obtain consent from clients. Explain that the aim of the recordings is to improve your work with clients. Do not record when clients express discomfort. Automate this decision making with recording as a default mode.
2. Reference Point
   - Keep one eye on your outcome data (individual cases and aggregated performance indices) and the other eye on systematically monitoring your learning objectives. The TDPA can greatly assist in tracking your professional development based on defined learning objectives that you have specified with the help of a clinical supervisor/coach. With continuous use of the TDPA, key learning objectives are likely to change and evolve.
   - At the end of each workweek, utilize a note-taking app (e.g., simplenote.com or evernote.com) to jot down your weekly learnings. Borrowing from Twitter's philosophy of constraint, limit yourself to 140 words. Just ask yourself: Based on my week's worth of clinical engagement, what is the one thing that stands out, that WE want to remember?
   - As mentioned in the chapter, we highly encourage recording your sessions. As you start out in your DP efforts, pick a session that stands out as representative of you at your best. Analyze the session and tease out what makes it stand out. Then get your supervisor/coach to review it, and elicit feedback from him or her.

3. Playful Experimentation
   - Watch a 5- to 10-minute segment of your therapy recording. Pause and consider how you might carry on the session more constructively.
   - Highly effective therapists report being more surprised by clients' feedback than their average cohorts (Chow, 2014). Seek to be disconfirmed by your clients' feedback rather than to be confirmed. Without looking at client scores, fill out the alliance measure at the same time as your client. Compare and contrast the ratings. Ask what surprises you about how your client scored the alliance.
4. Support
   - Seek out a supervisor/coach who is willing to do three key things:
     1. He or she must be willing to analyze your therapy recording segments rather than just talk about the sessions.
     2. He or she incorporates the outcome and alliance information into the discussion.
     3. Your supervisor/coach should not only discuss cases with you; rather, he or she should help you develop key learning objectives to guide your professional development.
   - Form a small community of practitioners as dedicated as you are to reaching for excellence. When no one is available locally, reach out globally. The technology available today can help to facilitate these connections.

Question #2. Please describe an example of a therapist who has used deliberate practice and the Cycle of Excellence to improve their clinical effectiveness.

Answer from Authors: Using the ARPS framework mentioned in the last question, here's an example of a therapist working in a mental health institution who employs the key principles of DP.

1. Automated Structure

   Jean, who is trained as a psychologist with 8 years of experience, sets aside two batches of periods for DP in her Google calendar (set to repeat). Once a week is devoted to solitary deliberate practice (e.g., reviewing of cases that are at risk of poor outcomes, watching 5- to10-minute segments of such cases, and inquiry learning on specific content that she lacks knowledge in when needed).

   The other period is set aside for fortnightly supervision. Jean brings in the at-risk cases for discussion. She brings into the supervision session outcomes and alliance information, along with the video recording segments.

   Jean uses her laptop as a straightforward video-recording system. She learns from experience and discussion with her colleagues that opting out of recording is due more to the therapist's discomfort than to the client's.
2. Reference Point

   Jean routinely reviews her outcomes on her outcome management system, coupled with the TDPA that she has established with her supervisor, which reminds her of her key learning objective at that point in time.

   She also writes down her weekly learnings on Fridays in her iPhone Notes app, indicating the date for each "therapy learning." By the end of a year, she will have approximately 40 to 45 individualized learnings that she can review and reflect on.

3. Playful Experimentation

   During her weekly DP, Jean watches a 10-minute segment of her therapy recording that is not going well. She pauses it and reflects on how she can better engage the client. She writes out longhand how she will deal with this situation differently.

   During her clinical practice, she would score the Session Rating Scale, attempting to predict how the client would rate it. Jean would then compare and contrast, and use any discrepancy to guide her questions in eliciting feedback.

4. Support

   Jean has the support of her supervisor. Unfortunately, she is rather a lone voice in her efforts in DP. Her supervisor is not on staff at her agency. Jean struggles to form a small community of practitioners for support and is now seeking connections outside of her workplace.

Question #3. You mention that deliberate practice is "hard work" that takes time, energy, and money, three resources that therapists at all career stages may have in limited supply. What advice do you have for busy therapists who want to try to fit deliberate practice into their schedule?

Answer from Authors: The key is not to try to "fit" in deliberate practice. Build it into the workweek (see "1. Automated Structure" in our response to Question #1). Protect it like sacred ground.

Let's face it: We are all busy. If we leave it to our ongoing week-by-week decision making, we will not have the time to do something that is not immediately rewarding. What is more, it is cognitively taxing always trying to fit in time for hard work. We would rather attend to what is knocking on doors right now.

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