

On becoming a better therapist

BARRY DUNCAN

Most therapists aspire to become better at what they do. However, research has shown that personal therapy has nothing to do with outcome; there are no therapeutic approaches, strategies or interventions shown to be better than any other; professional training and discipline do not matter much to outcome; there is no evidence to show that continuing professional education will improve effectiveness; and, although it defies common sense, experience does not improve outcomes either. So what does 'professional development' mean and how do we accomplish it? In this edited extract from his recent book, *On Becoming a Better Therapist*, BARRY DUNCAN explores how we can remember our original aspirations, continue to develop as therapists, and achieve better results more often with a wider variety of clients.

As unsophisticated as it sounds, most of us got into this business because we wanted to help people, and most of us carry an inextinguishable passion to become better at what we do. Despite our good intentions, unfruitful encounters with clients, combined with the confusing cacophony of 'latest' developments, can weigh on us and steer us into ruts, making us forget why we became therapists in the first place. How can we remember our original aspirations, continue to develop as therapists, and achieve better results more often with a wider variety of clients?

Call me cynical, but the field is not really sure what professional development means or how we can accomplish it. We are often told that to develop ourselves as psychotherapists requires us to become more self-aware through personal therapy. This makes a lot of intuitive sense and to gain an appreciation of what it is like to sit in the client's chair seems invaluable. But a look at probably the best source, *The Psychotherapist's Own Psychotherapy* (Geller, Norcross & Orlinsky, 2005), reveals that the cold hard truth is that while therapists rave about its benefits,

personal therapy has nothing to do with outcome.

Our quest for the 'Holy Grail' does not help us either—our search for that special model or technique that will, once and for all, defeat the psychic dragons that terrorize our clients. The 'right approach', be it crafted by 'masters' of the field, or a meticulously researched evidence-based treatment, or the everyday garden variety, doesn't matter much to outcome. Not one approach has ever shown it is better than any other (Duncan, Miller, Wampold & Hubble, 2010).

The famous dodo bird verdict, "*All have won and all must have prizes*", invoked by Saul Rosenzweig in 1936 to illustrate the equivalence of outcome among approaches, is the most replicated finding in the psychological literature. A recent example is provided by treatments for the diagnosis *du jour*, Post Traumatic Stress Disorder (PTSD). Cognitive Behavioural Therapy (CBT) has been demonstrated to be effective and is widely believed to be the treatment of choice. Benish, Imel and Wampold (2007) have shown via meta-analysis that several approaches with diverse rationales

and methods are also effective—eye-movement desensitization and reprocessing, cognitive therapy without exposure, hypnotherapy, psychodynamic therapy, and present-centered therapy. What is remarkable here is the diversity of methods that achieve about the same results. Two of the treatments, cognitive therapy without exposure and present-centered therapy, were designed to exclude any therapeutic actions that might involve exposure (clients were not allowed to discuss their traumas because that invoked imaginal exposure). Despite the presumed extraordinary benefits of exposure for PTSD, the two treatments without it, or in which it was incidental (psychodynamic), were just as effective. This study only confirms that the competition among the more than 250 therapeutic schools remains little more than the competition among aspirin, Advil and Tylenol. All of them relieve pain and work better than no treatment at all.

Although the need and value of training seems obvious, it has long been known that professional training and discipline do not matter much to outcome (Beutler et al., 2004). A

just published study confirms this conclusion. Nyman, Nafziger and Smith (2010) reported that it did not matter to outcome if the client was seen by a licensed doctoral-level counsellor, a pre-doctoral intern, or a

growth (reported in their 2005 book, *How Psychotherapists Develop*). Over a 15-year period, they collected richly detailed reports from 5000 psychotherapists of all career levels, professions, and theoretical orientations

experience themselves as personally committed and affirming to patients, engaging at a high level of basic empathic and communication skills, conscious of flow-type feelings during sessions, having a sense of efficacy in general, and dealing constructively with difficulties if problems in treatment arise.

Healing Involvement represents us at our best—those times when our immersion into our client's story is so complete, our attunement so sharp, and the path required for change eminently accessible. So, what causes this and, more importantly, how can we make it happen more often?

Orlinsky and Rønnestad identified three sources of *Healing Involvement*. The first is the therapist's sense of *cumulative career development*—improvement in clinical skills,

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practicum student. As for continuing professional education, there is not one solitary study to support that it improves effectiveness in any way.

What about experience? Surely, years of clinical encounters make a difference. But are we getting better, or are we having the same experience year after year? More bad news here—experience just doesn't seem to matter much (Beutler et al., 2004). In large measure, experienced and inexperienced therapists achieve about the same outcomes. Although it defies commonsense, experience does not improve outcomes either.

Finally, regardless of our methods of getting better, we are quite self-delusional about our effectiveness. Consider a study reported by Sapyta, Riemer and Bickman (2005). One hundred and forty-three clinicians were asked to rate their job performance from A+ to F. Two-thirds considered themselves A or better, and 90% considered themselves in the top 25%! Not one therapist rated him or herself as below average. If you know anything about the Bell Curve, you know this cannot be true!

Does this mean that you should forget the whole thing? No. Contrary to my cynical portrayal of the state of the field's efforts to help you get better, an empirically-based method has arisen from the most extensive investigation of therapist development ever conducted.

How psychotherapists develop

In a remarkable study, David Orlinsky and Helge Rønnestad took an in-depth look at therapists' experience of their professional

from over a dozen countries. From this extensive analysis, *Healing Involvement*, the pinnacle of therapist development was identified.

Healing Involvement reflects a mode of participation in which therapists



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increased mastery, and gradual surpassing of past limitations. Therapists like to think of themselves as getting better, over time, at what they do. Eighty-six per cent of the therapists, regardless of career level, reported that they were 'highly motivated' to pursue professional development. There is no other profession more committed to getting better at what they do. At a personal level, it is important for the development of each therapist to know they have this commitment.

The second influence is the therapist's sense of *theoretical breadth*. The capacity to understand clients from a variety of conceptual contexts enhances the therapist's flexibility in responding to the challenges of clinical work. Possessing a range of understandings of client problems allows therapists to experience *Healing Involvement* more often with more clients.

The third, and by far most powerful, influence of *Healing Involvement* is the therapist's sense of *currently experienced growth*. Therapists like to think of themselves as developing *now*. Your ongoing experience of professional development is therefore critical to becoming a better therapist. Therapists with the highest levels of current growth showed the highest levels of *Healing Involvement*. The experience of current growth translates to positive work morale and energizes you to continue professional reflection—so that you keep the 'pedal down' on the developmental process. Your sense of current growth keeps you vitally involved in the work itself.

Now the astute reader might be thinking: "*Wait a minute... Isn't Healing Involvement just more therapist self-delusions about how effective they are?*" Yes, it would be if it were not for the other person who is critical to psychotherapy outcome—the client. We need their help to ensure our *Healing Involvement* translates to their benefit.

We need our client's help

While I often don't remember where I leave my glasses, I still vividly recall my first client, Tina. I was in my initial clinical placement in graduate school at the Dayton Mental Health and

Developmental Center, a euphemism for the state hospital. Tina was like a lot of the clients—young, poor, disenfranchised, heavily medicated, and on the merry-go-round of hospitalizations—and, at the ripe old age of 22, a 'chronic schizophrenic'.

I gathered up the battery of tests I was attempting to gain competence with, and was on my merry but nervous way to the assessment office, a stark, run-down room in a long-past-its-prime, barrack-style building that reeked of cleaning fluids over-used to cover up some other worse smell, the 'institutional stench'. On the way, I couldn't help but notice the looks I was getting—a smirk from an orderly, a wink from a nurse, and funny-looking smiles from nearly everyone else. My curiosity piqued, I was just about to ask what was going on when the chief psychologist, a kindly old guy, put his hand on my shoulder and said, "*Barry, you might want to leave the door open*". And I did.

I greeted Tina, a young, extremely pale woman with short brown, cropped hair, who might have looked a bit like Mia Farrow in the *Rosemary's Baby* era had Tina lived in friendlier circumstances. To begin, I introduced myself in my most professional voice. Before I could sit down and open up my test kit, Tina started to take off her clothes, mumbling something indiscernible. I just stared in disbelief. Tina was undaunted by my dismay and quickly was down to her bra and underwear when I finally broke my silence and said, "*Tina, what are you doing?*". Tina responded not with words but actions, and removed her bra as if it had suddenly become made of wool and very uncomfortable. So there we were, a graduate student, speechless, in his first professional encounter, and a client sitting nearly naked. Tina was mumbling loudly and incoherently, contemplating whether to stand up to take her underwear off or simply continue her mission while sitting.

In desperation I pleaded, "*Tina, would you please do me a big favor?*". She looked at me for the first time, and said, "*What?*". I replied, "*I would really be grateful if you could put your clothes back on and help me get through this assessment. I've done them before,*

but never with a client, and I am kinda freaked out about it." Tina whispered, "*Sure,*" and put her clothes back on. Although Tina struggled with the testing and clearly was not enjoying herself, she completed it. I was so appreciative of Tina's help that I told her she really pulled me through my first real assessment. She smiled proudly, and from then on smiled every time she saw me.

Tina started my psychotherapy journey and offered up my first lessons for consideration—authenticity matters and when in doubt or in need of help, ask the client. Asking clients for help, soliciting their feedback about the benefit of therapy allows you to use the empirical evidence about therapist growth without falling prey to the pitfalls of a therapist-centric view of outcome.

Feedback can, by itself, improve your outcomes substantially. Consider a recent investigation of client feedback I conducted with colleagues in Norway (Anker, Duncan & Sparks, 2009). This study, the largest randomized clinical trial (RCT) of couple therapy, found that clients who gave their therapists feedback about the benefit and 'fit' of services on two brief, four item forms, the *Outcome Rating Scale* (ORS) and the *Session Rating Scale* (SRS), reached clinically significant change nearly four times more than non-feedback couples (both measures available free for individual use at www.heartandsoulofchange.com). Moreover, the feedback condition maintained its advantage at the six-month follow-up and achieved a 46% lower separation/divorce rate, leading to the national adoption of the ORS and SRS in Norway.

And this study is not a fluke! The findings with the ORS and SRS have been replicated in two independent RCTs (Reese, Norsworthy & Rowlands, 2009; Reese, Toland, Slone & Norsworthy, in press). Moreover, our feedback system builds on the extensive pioneering research of Michael Lambert who has conducted five RCTs using the Outcome Questionnaire 45.2 (OQ) as the feedback tool. Lambert and colleagues, time and time again, have shown that systematic feedback significantly improves outcomes, and doubles treatment effectiveness for

clients who would otherwise be headed for treatment disaster (Lambert, 2010).

Continuous feedback individualizes psychotherapy based on treatment response, and provides an early warning system to identify 'at-risk' clients thereby preventing drop-outs and negative outcomes. Systematic client feedback also provides the means to accelerate your development.

Track your cumulative career development—getting better all the time?

Therapists like to think of themselves as getting better over time, but the only way to know is to collect outcome data. Routine collection of client feedback about the benefits of therapy that they experience allows you to plot your cumulative career development, so you know about your effectiveness, and importantly, so you can implement and evaluate strategies designed to improve your outcomes.

Finding out how effective, or not, you really are can be risky business. You might learn something you might not want to learn. But the only way to get better is through feedback about where you are now versus where you would like to be—to aspire for the best results, and proactively get them. It does take courage, but so did walking into a room for the first time with someone in distress—and so does doing it day in and day out.

Need some encouragement to consider this? In our Norway Feedback Study (Anker et al., 2009), we found that tailoring therapy based on client feedback improved the outcomes of nine of the ten therapists. Feedback seems to act as a 'leveler' among therapists, raising the effectiveness of lower or average therapists to that of their more successful colleagues. In fact, a therapist in the low effectiveness group without feedback became the therapist with the best results with feedback. This heartening finding suggests that regardless of where you start in terms of your effectiveness, you too can be among the most successful therapists if you take charge of your development.

Tracking your career development need not be complicated or expensive. You can begin by simply entering scores from the *Outcome Rating*

Scale (or any other reliable and valid measure) into an Excel file. Then, track outcome over time with calculations available in Excel: average intake and final session scores; number of sessions; dropout rates; average change score (the difference between average intake and final session scores); and, ultimately, the percent of your clients

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who reach a reliable or clinically significant change—a statistical metric defined by your chosen measure (on the ORS, a reliable change is 5 points and a clinically significant change is a 5 point change that also crosses the clinical cutoff of 25). The percent of your clients who benefit is your benchmark—the number you are trying to increase by taking action about your development.

Simply plot your effectiveness by each block of 30 or more clients. These calculations provide a detailed snapshot of your growth over time. You will see whether your efforts are paying off, and if your chosen methods to increase your benefit to clients needs to be tweaked or changed outright. Excel does most of the calculations for you and there is also software (ASIST; visit <http://www.clientvoiceinnovations.com/>) and web options (<http://www.MyOutcomes.com>) available that make it easy. They do involve some cost (and ethically I am bound to inform you that I benefit financially from both of these options).

Once you know your baseline effectiveness level, you are 'ready to rock'. It is fine to put time into learning models and techniques, but it may make sense to invest your efforts in areas that will bring you the biggest return. What are those areas? One way to understand this is to look at the variation among therapists—we all know that some therapists are better than others. Who the therapist is exerts a powerful influence on outcome, second only to client factors—therapist effects account for six to nine times more impact on

therapeutic change than model and technique. A recent investigation of the therapists in the famous *Treatment of Depression Collaborative Research Program* highlights this point (Kim, Wampold & Bolt, 2006). Clients who received sugar pills from the top third most effective psychiatrists achieved better outcomes than clients prescribed

antidepressants from the bottom third, least effective psychiatrists. Who delivered the treatment mattered more than what they were delivering, even with drugs!

What accounts for the variability among therapists? There is one good possibility and one no-brainer that separate the best from the rest. In a clever investigation that conducted minute-by-minute analysis of therapist-client interactions, Gassman and Grawe (2006) found that unsuccessful therapists focused on problems and neglected client strengths, while successful therapists focused on their clients' resources from the start. As for the no-brainer, research consistently shows that the alliance accounts for the lion share of therapist variability. Therapists who form better alliances across clients, not just the 'easy ones', have better outcomes. These two areas, what Gassman and Grawe called '*resource activation*', and securing strong alliances with more clients represent the best ways to accelerate your development. Remember, though, whatever recipe you chose to improve your outcomes, 'the proof of the pudding is in the eating'.

Heroic stories

Resource activation does not mean ignoring pain, being a cheerleader, or glossing over tough issues. Rather, it requires that you listen to the whole story—what I like to call the 'heroic' story. Human beings are complex and have multiple sides, depending on who is recounting them and what sides are emphasized. The folklore of our field has drawn us toward the more

pathological account as the only or best version. It is neither.

Consider these comments from Sam, a very distressed young man:

"I've been in a lot more physical pain lately...No one wants to be around me because of my mental illness...My desire to self-injure has been higher... My financial situation is out of control...My dreams have been increasingly violent toward my stepfather, his mental torture is constant, telling me that I am never going to amount to anything...and that I am worthless and do everything wrong. It's hard to argue with him because here I am, I amounted to nothing, he's right...And I fantasize about it every day, different ways of just crushing him...And I feel just hopeless...and half the time I am fighting to survive and half the time I am wondering if I should just stop fighting... Part of me hopes that the whole system will collapse, that society itself will just fold. I am depressed now and the rest of the world is normal. Take an event that would depress anyone. And then being depressed would be normal so in a way the whole world would come to my level of depression so I wouldn't be abnormal."

There are stories of self harm and suicidal ideation, of homicidal ideation, and apocalyptic fantasies. Are these accounts the only or truest ones of Sam's identity as a human being? As you read the excerpts below, consider the following questions:

- what are the obvious and hidden strengths, resources and resiliencies?
- what are the competing stories of Sam's identity?
- what is present that can be recruited to solve the problems?

Sam: *"I am one of those leeches on society. I am a negative person. I take away. I think that is one of the reasons why I want to see it all come apart."*

Barry: *"Well, no wonder. It would be like a new beginning if everything came apart—you would have a fighting chance to have a different kind of life. Right now you don't see any hope for a different kind of life to be possible."*

Sam: *"Right, I feel I could contribute to a society that had decayed to the point where it would need my contribution. I just feel I would be really good in a situation like that. I could lead a small rag tag band of warriors to lead attacks on the machines or bad guys."*

Barry: *"So it's like there is this inner warrior that wants to come out, you'd be able to take charge of that situation, to contribute in that situation."*

Sam: *"I feel like I would be a good leader."*

Barry: *"What keeps you from killing your stepfather?"*

Sam: *"The only things keeping him alive are my fear of getting caught and my own personal realization that I am not sure killing him would make me feel any better...I am so full of rage when it comes to him. He screwed up all our lives. Everything he touches is destroyed. I almost feel like it's my responsibility to take him out of the world so he can't do any more harm. But then I would have to do harm to do that and I can't do that because it's against my religion."*

Barry: *"A couple of things occur to me. One is that it's really not surprising that you are struggling now, there are a lot of low spots in your life, a lot of shit has happened in the past, a lot of animosity directed at your stepfather, a lot of bad things have happened to you, to wake up every day and feel like you are a leech on society, your identity, this inner warrior never able to be expressed, all this stigma that goes along with the mental disability, the physical pain, being in a financial hole, there is a lot of stuff conspiring to make you feel very bad about yourself. On the other hand, while I believe that's true, simultaneously not only do you have this inner warrior aspect of you, that leadership, knowing that there is a lot more to you than this society at this time allows you to express, there are also all these other things about you that are very impressive. You are really a savvy guy, you're smart, you have a dry sense of humor, we didn't laugh much but you said a lot of things that were funny. And you have a little bit of a twisted way of looking at things and that's very funny and I think that's a real strength you have. You know a lot of stuff about a lot of things—you're bringing a lot to the table, not the least of which is your insight about your stepfather and your ability to control yourself."*

Many stories have emerged. While the story of Sam's problems—suicidal/homicidal ideation, depression and self-loathing—was real, this story was not the only one and not the most representative of his identity. There was another tale of a remarkably reflective man who wants to contribute to

society, a leader, an inner warrior who controls his impulses. Clients' heroic stories pave the way for change by showcasing abilities and making them available for use.

Consider Sam's concluding statements:

Sam: *"Somehow I'll find a way to give back to society. It may not be today or tomorrow but someday, because I am pretty young and have a lot of time to figure out how I can make society better and it doesn't have to be the end of the world."*

Several therapies that focus on resource activation or are 'strength based' offer a plethora of ways to inquire about, recruit, harvest and enlist client competencies; solution focused, narrative, client-directed, positive psychology, to mention a few. Find ways that fit your own therapeutic style to help you 'activate' client resources. For example, a question that comes from a narrative tradition and is a good fit for me is, *"Who in your life wouldn't be surprised to see you overcome the problem before you now?"*

Consider Yolanda, a young woman I saw the day after child protective services (CPS) removed her children because Yolanda started using 'crack' again. CPS was not the bad guy here—there was a contract and Yolanda violated it when she started using again. One story about Yolanda was that she was the crack-addicted mother who had her kids removed by CPS. A strength-based approach suggests this is not the only story that can be told, and is not the one that best reflects who Yolanda really is and what she brings to the table.

At our first meeting, Yolanda was devastated—teary, lethargic and she had an understandable 'edge'. Far worse was that she barely said anything and didn't even look at me. Here were two people who couldn't have been more different from one another—Yolanda was an impoverished 21 year-old African American woman whose world was just split wide open, and me, an old middle class white guy without a care in the world, relatively speaking. So I asked a question to see if I could get to Yolanda's resources.

Barry: *"Yolanda, who in your life wouldn't be surprised to see you stand up to this situation, stop using crack and do*

what CPS wants so you can get visitation of your kids back?"

Yolanda: (Long pause). "Well, my Uncle Charlie wouldn't be surprised."

Barry: "If Uncle Charlie was here, what story would he tell that would inspire in me the same confidence he has in you?"

Yolanda: "Uncle Charlie liked to tell the story of when I used to visit him over the summer with all my other cousins. One summer when I was six or seven, my cousins and I ran further into the forest than we had ever gone before. We were running full blast over a ravine and I stepped in quicksand and pretty quickly sank to my waist and was slowly sinking. We were way out in the woods and my cousins ran all the way back to get my uncle who rushed to get me, which seemed to me to be about forever later. Thinking that I would already be dead, Uncle Charlie was so relieved to see me that he cried for joy—by that time I had sunk up to my neck. He never stopped talking about when he found me. I was calm and collected and just as still as I could be—somehow I instinctively knew not to struggle or make a move. He always told me and everybody else what a trooper I was. Uncle Charlie would not be surprised by my ability to deal with this stuff. He always told me if I could deal with that situation as a kid, I would be able to deal with anything in my life."

Uncle Charlie was right. There were many other stories about Yolanda that could better capture her humanity and showcase her resources. For instance, when she stood up, under great peril, to her crack-dealing, abusive partner, and left him and the crack house behind. Despite his continued stalking and threat of violence, Yolanda acted to protect her children. In addition, under all this duress, she chose to quit crack—and did so for 17 months until a combination of events persuaded Yolanda to relapse. So there was a crack-addicted mother who lost her kids, and there was the heroic mother who stood up to abuse to protect her children, and had made good choices for 17 months regarding her crack use. With these resources and resiliencies to work with, and Yolanda now engaged in the beautiful thing we call therapy, my job was easy. Yolanda started going to NA again, worked with CPS and me to complete their requirements, and started supervised visitation that

ultimately led to regained custody of her children.

Reliance on the alliance

Although much ignored, it is a fact that the alliance is our most powerful ally and represents the most influence we can have over outcome—and is also the quickest way to accelerate

...your client's perception of empathy is more powerful than any technique you can ever wield.

our development. Do not give the alliance short shrift! I know this is challenging—the alliance is not sexy in comparison to 'the miracle cure'. But the alliance is not the anesthesia before surgery—it's not the stuff you do until you get to the real therapy. We do not offer Rogerian reflections to lull clients into complacency so we can stick the real intervention to them!

The alliance is probably best conceptualized as an all-encompassing framework for psychotherapy—it transcends any specific therapist behaviour and is a property of all aspects of providing services (Hatcher & Barends, 2006). The alliance is evident in anything and everything you do to engage the client in purposive work, from offering an explanation or technique to scheduling the next appointment.

You have to *earn* the alliance—it's not given to you, you have to put yourself out there with every person, every interaction, and every session. It is a daunting task—don't underestimate it.

Let's put the alliance in perspective. The alliance accounts for five to seven times the amount of variance of outcome attributed to model and technique. Although there is a lot of talk about what distinguishes therapists, the most definitive thing we know about what makes some therapists better than others is their ability to secure a good alliance across a variety of client presentations and personalities (Baldwin, Wampold & Imel, 2009). There are over 1000 process-outcome findings that support the association between a strong alliance and positive outcome

(Orlinsky, Rønnestad & Willutzki, 2004). Despite this, however, naysayers will dismiss the alliance by saying the research is only correlational. Even more damning, they say we don't know which comes first, client experience of a strong alliance or client report of change or benefit—the classic chicken

or the egg question. Our recent alliance study of 500 clients (Anker, Owen, Duncan & Sparks, 2010) directly addressed this question. The alliance significantly predicted outcome over and above early benefit, demonstrating that the alliance is not merely an artifact of client improvement, but rather a force for change in itself.

Embrace it and put it high on your developmental priority list. Monitor your alliance with clients, expand your repertoire of relational skills, and track your cumulative career development to see if it matters. I think it will. The alliance is your craft. Practice well the skills of your craft. At some point, your craftsmanship elevates to art. Investigate multiple ways to practice your alliance skills and consider your growth as a therapist to be parallel to the development of your relational repertoire.

There are many ways to understand alliance skills as well as many available systems to improve your relational abilities, from classic Rogerian to addressing alliance ruptures, to specific models that are attentive to relational aspects, such as motivational interviewing. One way to think of your relational responses, as an overall backdrop, is the concept of *validation*. Validation reflects a genuine acceptance of the client at 'face value' and includes an empathic search for justification of the client's experience in the context of trying circumstances—that they have good reason to feel, think and behave the way they do. Validation helps them breathe a sigh of relief and know that blame is not a part of our game—we are on their team.

Validation combines two robustly empirically demonstrated aspects of the relationship—empathy and unconditional positive regard. A review of the research (Norcross, 2010) in the second edition of *The Heart and Soul of Change* (Duncan et al., 2010) confirms what you already know. Regarding empathy, a meta-analysis of 47 studies found an effect size (ES) of .32. To put this in perspective, the ES of model and technique differences is only .20. So your client's perception of empathy is more powerful than any technique you can ever wield. With respect to positive regard, when clients rate outcome, 88% of studies find a significant relationship between client experience of positive regard and a successful conclusion of therapy. Carl Rogers was on to something!

Consider Sam again. After hearing all the things troubling him and his desire to see the end of world, these were my first comments:

"Makes a lot of sense. Another way of saying that would be that anyone experiencing what you are—if they were in pain, just came out of surgery, were in a financial hole they couldn't get out of, and didn't have anything going socially, anybody on the planet would be depressed, anybody walking in your shoes would be depressed, and anybody would be struggling with whether or not they wanted to live." That's a long way to say, "No wonder you are depressed".

These comments replaced the self-invalidations ("I'm a leech, a negative person, etc"), and the invalidations of others (bizarre thinking, etc). When clients feel validation, different conclusions can be reached and alternative actions can emerge. Sam sighed and relaxed, knowing I was in his corner and the next exchange further clarified why he wanted an apocalypse as well as his recognition of his leadership ability.

Securing a good alliance also entails agreement about the goals and the tasks of therapy—what you are going to work on and how you are going to do it. In an important way, the alliance is dependent on the delivery of some particular treatment—a framework for understanding and solving the problem. There can be no alliance without treatment. On the other hand, technique is only as effective as its

delivery system—the client-therapist relationship. If technique fails to engage the client in purposive work, it is not working properly and a change is needed.

Here is where the variety of models and techniques pays off. While there is no differential efficacy among approaches in general, there is differential efficacy among approaches with the client in your office *now*. The question is: does the approach resonate or not? Does its application help or hinder the alliance? Is it something that both you and the client can get behind?

Your alliance skills are truly at play here—your interpersonal ability to explore the client's ideas, discuss options, collaboratively form a plan, and negotiate any changes when benefit to the client is not forthcoming. Technique, its selection and application, in other words, are instances of the alliance in action. This process of exploration can also help you expand your theoretical breadth.

Theoretical breadth—what the eclectic/integrationists have been telling us all along

Another important influence on *Healing Involvement* is your *theoretical breadth*. Therapist allegiance to any particular theoretical content involves a trade-off that enables and restricts options. Theoretical loyalty provides a clear direction but is inherently limiting—'cookie cutter therapy' is safer to do, but is only useful for a portion of the people you see.

We probably, at most, can hold only two or three systems of therapy in our heads at one time. However, we can use far more successfully if we open ourselves to Jerome Frank's classic observation that what is important about a model is not their inherent truth across clients, but rather a rationale for the client's problem and a ritual to solve it. Knowing all models can be 'boiled down to' an explanation and remedy makes them easier to get a handle on and try out. This is in contrast to the arduous requirement of two years of intensive supervision often portrayed as necessary in order to understand or implement an 'approach' (but you might want to keep that to yourself).

So how do we broaden our theoretical horizons? First, pay attention to those theories that make sense to you—that fit your own views of human nature, problems and solutions. Expand what you already know. Add explanations and methods from approaches that are similar to the one you already practice e.g., if you are solution-focused then it is likely narrative ideas would be an easy stretch of your skills.

Next, listen to your client's ideas and throw your self-consciousness to the side—let the client's theory be your theory with *that* client (Duncan, Solovey & Rusk, 1992). Tailoring your approach to your client's ideas provides opportunities to expand your theoretical breadth. This may not be easy to do if the client's ideas rub you up the wrong way. For example, at one time, I was biased against any historical expedition into client's lives. I was rigid in my thinking and, while I didn't know it, I'm sure I lost plenty of clients as a result. Until one day a young woman, Claire, told me that she had been sexually abused as a child and that she wanted to pursue therapy based on a *Courage to Heal* framework, a popular approach back in the eighties. I bristled immediately and offered to refer her to therapists who I knew did 'that kind of work'.

But Claire didn't take my refusal. She told me that a close friend of hers had seen me, and she was convinced I was the person for the job. Claire asked, "Couldn't you at least look at the book and give it a try?". Essentially, she shamed me into stepping outside of my comfort zone, and it was incredibly rewarding. We followed the workbook, I shared my concerns along the way, and Claire benefited greatly from the work—her own idea of how she could be helped. Her toughest task was to get me on board. The '*Courage to Heal*' approach provided a rationale for Claire's experience of problems, and a remedy to address them. Claire helped me to learn that theory only has value in the particular assumptive world of the participants—the client and therapist—and that theory need not be 'true' across clients; rather, any theory needs only to be valid with *this* client in my office *now*.

Finally, be proactive in adding theoretical dimensions to your work. Become familiar with many ways of understanding problems and solutions. Play ‘on the other hand’ games with your colleagues in supervision and client conferences. When someone presents an explanation about a client difficulty, encourage everyone to present alternative myths and rituals. You can then turn the discussion toward the description that represents the better fit with the client. Talking with your colleagues about varied rationales and remedies will benefit everyone’s work. It is also fun and allows an appreciation that models offer only metaphorical accounts of how people can change, not the truth with a capital ‘T’ or what clients must do to change.

Currently experienced growth—what have you done for me lately?

Critical to therapists’ perceptions of their development is their currently experienced growth. Therapists like to think of themselves as developing now, but where does this sense of growth come from? According to Orlinsky and Rønnestad, the most widely endorsed influence was practical learning through therapists’ experiences with clients. Not workshops and books trumpeting the latest and greatest. Rather, almost 97% of therapists reported that learning from clients was a significant influence on their development. In truth, beyond cliché, therapists do believe that clients are the best teachers.

How do we put those hard earned lessons to work for us and our outcomes? It starts with separating your current clients into two piles—those who are benefiting and those who are not. Reflect on your clients who are changing and how you are contributing; also consider your clients who are not improving and how you are therapeutically handling these tough circumstances—we can do our best work in these challenging situations. The idea is to proactively consider the lessons clients are teaching us, and to reflect on their importance to our development as well as our identity as therapists. Your reflections and discussions with colleagues and supervisors, as well as clients, will

permit you to squeeze all the learning out of each situation.

Note any changes or new behaviours with clients, then put a magnifying glass on them, and strive to understand how you were able to ‘pull it off’. Recognize that these instances depict a new chapter in your development as a therapist. Perhaps you did something for the first time with a client, or a light went on and you now understand something in a different way. When you articulate what is different about your work, you make it more real, and are more likely to continue it in the future and have it impact your outcomes. The Norwegian therapist who became the most effective in our study noted several things that feedback brought to her work, as well as what she had learned from her experiences with clients—the value of clarity and focus, of shared responsibility, purpose and true collaboration, and importantly, she gained a sense of security and the courage to take risks.

Don’t take it lightly when you do something different. Talk to your colleagues and reflect upon your actions in terms of your development and identity.

You do what?

I used to avoid the question of what I did for a living like the plague. I didn’t like saying I was a psychologist or a therapist and hearing remarks like, “*Are you going to psychoanalyse me?*”, or other harmless looks or comments people give or say ‘off the cuff’. I didn’t like it because I didn’t have an authentic way to describe what I did that captured what being a therapist meant to me. I knew the medical model didn’t do it for me—I never saw clients as patients with illnesses who require treatment from an expert administering powerful interventions. I wasn’t sure until I tried to articulate answers to these questions: What is your identity as a therapist? How do you describe what you do? At your very best, what role do you play with your clients? What recent work with a client represents the essence of your identity, illustrating what you embrace most about what you do (Duncan & Sparks, 2010)?

As we develop as therapists, it is useful to contemplate both our identity and how we describe what we do—to define, edit, refine, expand, or outright change it altogether. This helps to keep our growth clearly in focus and enables us to compare our current descriptions to earlier accounts. Our belief in what we do, or what researchers call our ‘*allegiance*’ to our chosen ideas and practices, is a powerful mediator of positive outcome. Given the impact of our expectations and beliefs, it makes sense to describe our work in ways we can believe in and that do not restrict our flexibility. Anything that keeps our development on the front burner will help us stay vitally involved in the work—which is what it takes to get better.

The treasure chest

The ‘*Treasure Chest*’ started out as a file into which I put clients’ unsolicited communications about the work I did with them—their feedback, usually well after therapy had ended. Over time, the Treasure Chest offered a way to buffer burn out, a momentary sanctuary from the downsides of the work, when the requirements of the system bring you down, or when you see several clients in a row that aren’t benefiting much, or when a client story hits home in a particularly painful way. It’s the place to escape tough times and reconnect to the work, to why you became a therapist in the first place.

Consider Adam, a young man who spent his eighteenth birthday in prison for gang violence, but was released soon after as part of an early parole program. He was mandated to therapy and I saw him as a favour to the probation officer who had been a student of mine. Adam was a long time member of the skinheads. I wasn’t sure I could work with Adam, not because of his record or gang status or because he was a scary looking dude, but rather because he was openly racist and regularly spewed hate-filled comments. In amazing ways I had never heard, Adam strung together obscenities and slurs with an alarming passion—about me (I was a lackey for the other side), the probation officer (an African American woman), and about everyone else who wasn’t dedicated to white supremacy. But somehow,

therapy worked its magic with Adam and me. Over time, Adam's intellect and compassion pulled him out of the indoctrination of hate that had dominated his life. He became curious about my attitudes about African Americans, Jews and Hispanics when he learned that I grew up not far from where he did—a serendipitous shot in the arm for our work. Our conversations deepened and ultimately challenged the lies embedded in hate and prejudice. Adam, an introspective man, took these discussions to heart, and began to let go of his racist background and understand how poverty and despair set the context for his beliefs. He moved out of the neighborhood where the spectre of gang life was inescapable, and moved on in other ways as well.

About six months after I had written a letter in support of Adam's enlistment in the Army, I received this:

*"Hi Barry,
I wanted to write you and let you know what was happening and to say thanks. As you know I fulfilled the obligations of my parole and joined the Army (Thanks for the letter!). I just made corporal and things are going well for me. I am told that I am sergeant material and I intend to take college courses when I get stationed after infantry training. But what I really wanted to tell you about was my barracks.*

The Army has lots of different kinds of people. In fact, I am the minority here. Most of the guys in my unit are black or Hispanic. And that's the thing I wanted to tell you. I see their uniform first before I notice whether they are white or not. I see them as my team and I will watch their backs like I know they will watch mine. My best friend in my unit is a Mexican-American guy from Texas. We have had some great discussions about racism and he came from a real poor background, probably even worse than me. He has gone through some real hard times with white people.

So, thanks Barry. Thanks for not giving up on me, for putting up with my bullshit, and for seeing that I was capable of something different."

These unsolicited notes, letters, and cards have sustained me in tough moments as a therapist. Over the years, I added another dimension to my Treasure Chest file, my reflections about the clients who taught me the

most about being a psychotherapist, a narrative account of my development as a therapist told through my experiences with clients. Tina was one of those stories. Some have appeared in previous issues of *Psychotherapy in Australia*.

The pre-requisite to accelerating your development is your understanding that you are a primary figure in each client's ultimate outcome—the client is certainly central, but as the old saying goes, 'it takes two to tango'. Your view of your growth impacts your ability to be involved deeply in the therapeutic process. The first step is to track your cumulative career development and take it on as a project. Proactively monitor your effectiveness in service of implementing strategies to improve your outcomes. Practice the skills of your craft and monitor your results. Next, deliberately expand your theoretical repertoire and loosen your grip on the inherent truth value of any given approach. Plurality of perspective serves you and your clients. Most importantly, pay close attention to your currently experienced growth. Take a step back, review your current clients and consider the lessons you are learning. Empower yourself, like you would your clients, to enable the lessons to take hold and add meaning to your development as a therapist. Articulate how client lessons have changed you and your work, and what it means both to your identity as a helper and to how you describe what it is that you do. Continuing that theme, reflect on your identity and construct a story of your work that captures what you do as a helper. Continue to edit and refine your identity and accounts of what constitutes the essence of your work—evolve a description you can have allegiance to but that doesn't lead to dead ends. Finally, to keep your development in the viewfinder, collect client notes, cards, and letters about your work with them as well as client stories that mark significant events in your growth as a psychotherapist—the *Treasure Chest*. Helping you re-remember why you became a therapist, opening this file enables an escape from the pressures and disappointments of the daily grind of being a therapist. Chronicle your development as a therapist through

narrative accounts of the clients who taught you the most.

If you got into this business, like me and the majority of therapists I meet, because you wanted to help people, you already have what it takes to become a better therapist. It boils down to two things. The first is your commitment to forming partnerships with clients to monitor the outcome of the services you provide. The second is your investment in yourself, your own growth and development. Systematic client feedback provides the method for both. Your love of the work provides the rest.

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AUTHOR NOTES

BARRY DUNCAN PsyD, is a therapist, trainer and researcher with over 17,000 hours of clinical experience. He is the director of the Heart and Soul of Change Project, a practice-driven training and research initiative that focuses on what works in therapy, and more important, on how to deliver it on the front lines via client-based outcome feedback. Dr. Duncan has over 100 publications as well as 15 books to his credit, including *The Heroic Client*, *Brief Intervention for School Problems*, and the second edition of *The Heart and Soul of Change*. He is the co-developer of the *Outcome Rating Scale (ORS)*, *Session Rating Scale (SRS)*, *Child ORS*, and *Child SRS*, measures designed to give clients the voice they deserve, as well as provide clients, clinicians, administrators, and payers with feedback about the client's response to services, thus enabling more effective care tailored to client preferences.

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'When I'm good, I'm very good, but when I'm bad I'm better': a new mantra for psychotherapists

BARRY DUNCAN and SCOTT D. MILLER

Current estimates suggest that nearly 50 per cent of therapy clients drop out and at least one-third, and up to two-thirds, do not benefit from our usual strategies. Following on from the 'Supershrinks' article in the previous issue, BARRY DUNCAN and SCOTT MILLER provide a comprehensive summary of the Outcome-Informed, Client-Directed approach and a detailed, practical overview of its application in clinical practice. Through case examples they demonstrate how most practitioners can increase their therapeutic effectiveness substantially through accurate identification of those clients who are not responding, and addressing the lack of change in a way that keeps clients engaged in treatment and forges new directions.

At first blush, Mae West's famous words *'When I'm good, I'm very good, but when I'm bad I'm better'* hardly seem like a guide for therapists to live by—but, as it turns out, they could be. Research demonstrates consistently that *who the therapist is* accounts for far more of the variance of change (6–9 per cent) than the *model or technique administered* (1 per cent). In fact, therapist effectiveness ranges from a paltry 20 per cent to an impressive 70 per cent. A small group of clinicians—sometimes called *'supershrinks'*—obtain demonstrably superior outcomes in most of their cases, while others fall predictably on the less exalted sections of the bell-shaped curve. However, most practitioners can join the ranks of supershrinks, or at least increase their therapeutic effectiveness substantially.

Consider Matt, a twenty-something software whiz who was on the road

frequently to trouble-shoot customer problems. Matt loved his job but travelling was an ordeal—not because of flying but because of another, far more embarrassing problem. Matt was long past feeling frustrated about standing and standing in public restrooms trying to 'go'. What started as a mild discomfort and inconvenience easily solved by repeated restroom visits had progressed to full blown anxiety attacks, an excruciating pressure, and an intense dread before each trip. Feeling hopeless and demoralized, Matt considered changing jobs but as a last resort decided instead to see a therapist.

Matt liked the therapist and it felt good finally to tell someone about the problem. The therapist worked with Matt to implement relaxation and self-talk strategies. Matt practiced in session and tried to use the ideas on his

next trip, but still no 'go'. The problem continued to get worse. Now three sessions in, Matt was at significant risk for a negative outcome—either dropping out or continuing in therapy without benefit.

We have all encountered clients unmoved by treatment. Therapists often blame themselves. The overwhelming majority of psychotherapists, as clichéd as it sounds, want to be helpful. Many of us answered *"I want to help people"* on graduate school applications as the reason we chose to be therapists. Often, some well-meaning person dissuaded us from that answer because it didn't sound sophisticated or appeared too 'co-dependent'. Such aspirations, we now believe, are not only noble but can provide just what is needed to improve clinical effectiveness. After all, there is not much financial incentive for doing

better therapy—we don't do this work because we thought we would acquire the lifestyles of the rich and famous.

Unfortunately, the altruistic desire to be helpful sometimes leads us to believe that if we were just smart enough or trained correctly, clients would not remain inured to our best efforts—if we found the Holy Grail, that special model or technique, we could once and for all defeat the psychic dragons that terrorize clients. Amid explanations and remedies aplenty, therapists search courageously for designer explanations and brand name miracles, but continue to observe that clients drop out, or even worse, continue without benefit. Current estimates suggest that nearly 50 per cent of our clients drop out and at least one-third, and up to two-thirds, do not benefit from our usual strategies.

So what can we do to channel our healthy desire to be helpful? If we listen to the lessons of the top performers, the first thing we should do is step outside of our comfort zones and push the limits of our current performance—to identify accurately those clients not responding to our therapeutic business as usual, and address the lack of change in a way that keeps clients engaged in treatment and forges new directions.

To recapture those clients who slip through the cracks, we need to

embrace what is known about change: Many studies reveal that the majority of clients experience change in the first six visits—clients reporting little or no change early on tend to show no improvement over the entire course

Next we need to measure those known predictors in a systematic way with reliable and valid instruments. So instead of regarding the first few therapy sessions as a 'warm-up' period or a chance to try out the latest

Amid explanations and remedies aplenty, therapists search courageously for designer explanations and brand name miracles, but continue to observe that clients drop out, or even worse, continue without benefit.

of therapy, or wind up dropping out. Early change, in other words, predicts engagement in therapy and ongoing benefit. This doesn't mean that a client is 'cured' or the problem is totally resolved, but rather that the client has a subjective sense that things are getting better. And second, a mountain of studies have long demonstrated another robust predictor—that reliable, tried and true but taken for granted old friend—the therapeutic alliance. Clients who highly rate the relationship with their therapist tend to be those clients who stick around in therapy and benefit from it.

technique, we engage the client in helping us judge whether therapy is providing benefit. Obtaining feedback on standardized measures about success or failure during those initial meetings provides invaluable information about the match between ourselves, our approach, and the client—enabling us to know when we are bad, so we can be even better. The only way we can improve our outcomes is to know, very early on, when the client is not benefiting—we need something akin to an early warning signal.

Using standardized measures to monitor outcome may make your skin



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crawl and bring to mind torture devices like the Rorschach or MMPI. But the forms for these measures are not used to pass judgment, diagnose or unravel the mysteries of the human psyche. Rather, these measures invite clients into the inner circle of mental health and substance abuse services—they involve clients collaboratively in monitoring progress toward their goals and the fit of the services they are receiving, and amplify their voices in any decisions about their care.

You might also think that the last thing you need is to add more paperwork to your practice. But finding out who is and isn't responding to therapy need not be cumbersome. In fact, it only takes a minute. Dissatisfied with the complexity, length, and user-unfriendliness of existing outcome measures, we developed the *Outcome Rating Scale* (ORS) as a brief clinical alternative. The ORS (child measures also available) and all the measures discussed here are available for free download at www.talkingcure.com.

The ORS assesses three dimensions:

1. personal or symptomatic distress (measuring individual well-being),
2. interpersonal well-being (measuring how well the client is getting along in intimate relationships), and
3. social role (measuring satisfaction with work/school and relationships outside of the home).

Changes in these three areas are considered widely to be valid indicators of successful outcome. The ORS simply translates these three areas and an overall rating into a visual analog format of four 10-cm lines, with instructions to place a mark on each line with low estimates to the left and high to the right. The four 10-cm lines add to a total score of 40. The score is simply the summation of the marks made by the client to the nearest millimeter on each of the four lines, measured by a centimeter ruler or available template. A score of 25, the clinical cutoff, differentiates those who are experiencing enough distress to be in a helping relationship from those who are not. Because of its simplicity, ORS feedback is available immediately for use at the time the service is

delivered. Rated at an eighth-grade reading level, the ORS is understood easily and clients have little difficulty connecting it their day-to-day lived experience.

Matt completed the ORS before each session. He entered therapy with a score of 18, about average for those attending outpatient settings, but continued to hover at that score. At the third session, when the ORS reflected no change, it was not front page news to Matt. But a different process ensued. In the same spirit of collaboration

'pissed off', and amused. And he started to go.

This process, the delightful creative energy that emerges from the wonderful interpersonal event we call therapy could have happened to any therapist working with Matt. The difference is that the use of the outcome measure spotlighted the lack of change and made it impossible to ignore. The ORS brought the risk of a negative outcome front and center and allowed the therapist to enact the second characteristic of supershrinks,

Research shows repeatedly that clients' ratings of the alliance are far more predictive of improvement than the type of intervention or the therapist's ratings of the alliance.

as the assessment process, Matt and his therapist brainstormed ideas, a free-for-all of unedited speculations and suggestions of alternatives, from changing nothing about the therapy to taking medication to shifting treatment approaches. During this open exchange Matt intimated that he was beginning to feel angry about the whole thing—real angry. The therapist noticed that when Matt worked himself up to a good anger—about how his problem interfered with his work and added a huge hassle in any extended situation away from his own bathroom—that he became quite animated, a stark contrast to the passively resigned person that had characterized their previous sessions. One of them, which one remains a mystery, mentioned the words 'pissed off' and both broke into a raucous laughter. Subsequently, the therapist suggested that instead of responding with hopelessness when the problem occurred, that Matt work himself up to a good anger—about how this problem made his life miserable. Matt added (he was a rock and roll buff) that he could also sing the Tom Petty song "Won't Back Down" during his tirade at the toilet. Matt allowed himself, when standing in front of the urinal to become incensed—downright

to be exceptionally alert to the risk of drop out and treatment failure. In the past, we might have continued with the same treatment for several more sessions unaware of its ineffectiveness or believing (hoping even praying) that our usual strategies would eventually take hold, but the reliable outcome data pushed us to explore different treatment options by the end of the third visit.

Pushing the limits of one's performance requires monitoring the fit of your service with the client's expectations about the alliance. The ongoing assessment of the alliance enables therapists to identify and correct areas of weakness in the delivery of services before they exert a negative effect on outcome.

Research shows repeatedly that clients' ratings of the alliance are far more predictive of improvement than the type of intervention or the therapist's ratings of the alliance. Recognizing these much replicated findings, we developed the *Session Rating Scale* (SRS) as a brief clinical alternative to longer research-based alliance measures to encourage routine conversations with clients about the alliance. The SRS also contains four items. First, a relationship scale rates

the meeting on a continuum from "I did not feel heard, understood, and respected" to "I felt heard, understood, and respected." Second is a goals and topics scale that rates the conversation on a continuum from "We did not work on or talk about what I wanted to work on or talk about" to "We worked on or talked about what I wanted to work on or talk about." Third is an approach or method scale (an indication of a match with the client's theory of change) requiring the client to rate the meeting on a continuum from "The approach is not a good fit for me" to "The approach is a good fit for me." Finally, the fourth scale looks at how the client perceives the encounter in total along the continuum: "There was something missing in the session today" to "Overall, today's session was right for me."

The SRS simply translates what is known about the alliance into four visual analog scales, with instructions to place a mark on a line with negative responses depicted on the left and positive responses indicated on the right. The SRS allows alliance feedback in real time so that problems may be addressed. Like the ORS, the instrument takes less than a minute to administer and score. The SRS is scored similarly to the ORS, by adding the total of the client's marks on the four 10-cm lines. The total score falls into three categories:

- SRS score between 0–34 reflects a poor alliance,
- SRS Score between 35–38 reflects a fair alliance,
- SRS Score between 39–40 reflects a good alliance.

The SRS allows the implementation of the final lesson of the supershrinks—*seek, obtain, and maintain more consumer engagement*. Clients drop out of therapy for two reasons: one is that therapy is not helping (hence monitoring outcome) and the other is alliance problems—they are not engaged or turned on by the process. The most direct way to improve your effectiveness is simply to keep people engaged in therapy.

An alliance problem that occurs frequently emerges when client's goals do not fit our own sensibilities about what they need. This may be particularly true if clients carry certain diagnoses or problem scenarios.

I'D LIKE YOU TO RATE ME AS A THERAPIST, USING ONLY THE WORDS "BRILLIANT", "INCISIVE" AND "EXTRAORDINARILY PERCEPTIVE" ...



J. WRIGHT

Consider nineteen-year-old Sarah, who lived in a group home and received social security disability for mental illness. Sarah was referred for counselling because others were concerned that she was socially withdrawn. Everyone was also worried about Sarah's health because she was overweight and spent much of her time watching TV and eating snack foods.

In therapy Sarah agreed that she was lonely, but expressed a desire to be a Miami Heat cheerleader. Perhaps understandably, that goal was not taken seriously. After all, Sarah had never been a cheerleader, was 'schizophrenic', and was not exactly in the best of shape. So no one listened, or even knew why Sarah had such an interesting goal. And the work with Sarah floundered. She spoke rarely and gave minimal answers to questions. In short, Sarah was not engaged and was at risk for drop out or a negative outcome.

The therapist routinely gave Sarah the SRS and she had reported that everything was going swimmingly, although the goals scale was a 8.7 out of 10 instead of a 9 or above out of 10 like the rest.

Sometimes it takes a bit more work to create the conditions that allow clients to be forthright with us, to

develop a culture of feedback in the room. The power disparity combined with any socioeconomic, ethnic, or racial differences make it difficult to tell authority figures that they are on the wrong track. Think about the last time you told your doctor that he or she was not performing well. Clients, however, will let us know subtly on alliance measures far before they will confront us directly.

At the end of the third session, the therapist and Sarah reviewed her responses on the SRS. Did she truly feel understood? Was the therapy focused on her goals? Did the approach make sense to her? Such reviews are helpful in fine tuning the therapy or addressing problems in the therapeutic relationship that have been missed or gone unreported. Sarah, when asked the question about goals, all the while avoiding eye contact and nearly whispering, repeated her desire to be a Miami Heat cheerleader.

The therapist looked at the SRS and the lights came on. The slight difference on the goals scale told the tale. When the therapist finally asked Sarah about her goal, she told the story of growing up watching Miami Heat basketball with her dad who delighted in Sarah's performance of the cheers. Sarah sparkled when she talked of

her father, who passed away several years previously, and the therapist noted that it was the most he had ever heard her speak. He took this experience to heart and often asked Sarah about her father. The therapist also put the brakes on his efforts to get Sarah to socialize or exercise (his goals), and instead leaned more toward Sarah's interest in cheerleading. Sarah watched cheerleading contests regularly on ESPN and enjoyed sharing her expertise. She also knew a lot about basketball.

Sarah's SRS score improved on the goal scale and her ORS score increased dramatically. After a while, Sarah organized a cheerleading squad for her agency's basketball team who played local civic organizations to raise money for the group home. Sarah's involvement with the team ultimately addressed the referral concerns about her social withdrawal and lack of activity. The SRS helps us take clients, and their engagement more seriously, like the supershrinks do. Walking the path cut by client goals often reveals alternative routes that would have never been discovered otherwise.

Providing feedback to clinicians on the clients' experience of the alliance and progress has been shown to result in significant improvements in both client retention and outcome. We found that clients of therapists who opted out of completing the SRS were twice as likely to drop out and three times more likely to have a negative outcome. In the same study of over 6000 clients, effectiveness rates doubled. As incredible as the results appear, they are consistent with findings from other researchers.

In a 2003 meta-analysis of three studies, Michael Lambert, a pioneer of using client feedback, reported that those helping relationships at risk for a negative outcome which received formal feedback were, at the conclusion of therapy, better off than 65% of those without information regarding progress. Think about this for a minute. Even if you are one of the most effective therapists, for every cycle of ten clients you see, three will go home without benefit. Over the course of a year, for a therapist with a full caseload, this amounts to a lot of unhappy clients. This research shows

that you can recover a substantial portion of those who don't benefit by first identifying who they are, keeping them engaged, and tailoring your services accordingly.

The nuts and bolts

Collecting data on standardized measures and using what we call 'practice based evidence' can improve your effectiveness substantially. "Wait a minute" you say, "this sounds a lot like research!" Given the legionary schism between research and practice, sometimes getting therapists to do the measures is indeed a tall order because it does sound a lot like the 'R' word.

A story illustrates the sentiments that many practitioners feel about research. Two researchers were attending an annual conference. Although enjoying the proceedings, they decided to find some diversion to combat the tedium of sitting all day and absorbing vast amounts of information. They settled on a hot air balloon ride and were quite enjoying themselves until a mysterious fog rolled in. Hopelessly lost, they drifted for hours until a clearing in the fog appeared finally and they saw a man standing in an open field. Joyfully, they yelled down at the man, "Where are we?" The man looked at them, and then down at the ground, before turning a full 360 degrees to survey his surroundings. Finally, after scratching his beard and what seemed to be several moments of facial contortions reflecting deep concentration, the man looked up and said, "You are above my farm."

The first researcher looked at the second researcher and said, "That man is a researcher—he is a scientist!" To which the second researcher replied, "Are you crazy, man? He is a simple farmer!" "No," answered the first researcher emphatically, "that man is a researcher and there are three facts that support my assertion: First, what he said was absolutely 100% accurate; second, he addressed our question systematically through an examination of all of the empirical evidence at his disposal, and then deliberated carefully on the data before delivering his conclusion; and finally, the third reason I know he is a researcher is that what he told us is absolutely useless to our predicament."

But unlike much of what is passed off as research, the systematic collection of outcome data in your practice is not worthless to your predicament. It allows you the luxury of being useful to clients who would otherwise not be helped. And it helps you to get out of the way of those clients you are not helping, and connecting them to more likely opportunities for change.

First, collaboration with clients to monitor outcome and fit actually starts before formal therapy. This means that they are informed when scheduling the first contact about the nature of the partnership and the creation of a 'culture of feedback' in which their voice is essential.

"I want to help you reach your goals. I have found it important to monitor progress from meeting to meeting using two very short forms. Your ongoing feedback will tell us if we are on track, or need to change something about our approach, or include other resources or referrals to help you get what you want. I want to know this sooner rather than later but because if I am not the person for you I want to move you on quickly and not be an obstacle to you getting what you want. Is that something you can help me with?"

We have never had anyone tell us that keeping track of progress is a bad idea. There are five steps to using practice based evidence to improve your effectiveness.

Step one: introducing the ORS in the first session

The ORS is administered prior to each meeting and the SRS toward the end. In the first meeting, the culture of feedback is continually reinforced. It is important to avoid technical jargon, and instead explain the purpose of the measures and their rationale in a natural commonsense way. Just make it part of a relaxed and ordinary way of having conversations and working. The specific words are not important—there is no protocol that must be followed. This is a clinical tool! Your interest in the client's desired outcome speaks volumes about your commitment to the client and the quality of service you provide.

"Remember our earlier conversation? During the course of our work together, I will be giving you two very short forms

that ask how you think things are going and whether you think things are on track. To make the most of our time together and get the best outcome, it is important to make sure we are on the same page with one another about how you are doing, how we are doing, and where we are going. We will be using your answers to keep us on track. Will that be okay with you?"

Step two: incorporating the ORS in the first session

The ORS pinpoints where the client is and allows a comparison for later sessions. Incorporating the ORS entails simply bringing the client's initial and subsequent results into the conversation for discussion, clarification and problem solving. The client's initial score on the ORS is either above or below the clinical cutoff. You need only to mention the client scores as it relates to the cutoff. Keep in mind that the use of the measures is 100% transparent. There is nothing that they tell you that you cannot share with the client. It is their interpretation that ultimately counts.

"From your ORS it looks like you're experiencing some real problems." Or: "From your score, it looks like you're feeling okay." "What brings you here today?" Or: "Your total score is 15—that's pretty low. A score under 25 indicates people who are in enough distress to seek help. Things must be pretty tough for you. Does that fit your experience? What's going on?"

"The way this ORS works is that scores under 25 indicate that things are hard for you now or you are hurting enough to bring you to see me. Your score on the individual scale indicates that you are really having a hard time. Would you like to tell me about it?"

Or if the ORS is above 25:
"Generally when people score above 25, it is an indication that things are going pretty well for them. Does that fit your experience? It would be really helpful for me to get an understanding of what it is that brought you here now?"

Because the ORS has face validity, clients usually mark the scale the lowest that represents the reason they are seeking therapy, and often connect that reason to the mark they've made without prompting from the therapist. For example, Matt marked the *Individual scale* the lowest with the *Social scale* coming in a close second. As

he was describing his problem in public restrooms, he pointed to the ORS and explained that this problem accounted for his mark. Other times, the therapist needs to clarify the connection between the client's descriptions of the reasons for services and the client's scores. The ORS makes no sense unless it is connected to the described

way of working. The use of the SRS continues the culture of client privilege and feedback, and opens space for the client's voice about the alliance. The SRS is given at the end of the meeting, but leaving enough time to discuss the client's responses.

"Let's take a minute and have you fill out the form that asks for your opinion

We found that clients of therapists who opted out of completing the SRS were twice as likely to drop out and three times more likely to have a negative outcome.

experience of the client's life. This is a critical point because clinician and client must know what the mark on the line represents to the client and what will need to happen for the client to both realize a change and indicate that change on the ORS.

At some point in the meeting, the therapist needs only to pick up on the client's comments and connect them to the ORS:

"Oh, okay, it sounds like dealing with the loss of your brother (or relationship with wife, sister's drinking, or anxiety attacks, etc.), is an important part of what we are doing here. Does the distress from that situation account for your mark here on the individual (or other) scale on the ORS? Okay, so what do you think will need to happen for that mark to move just one centimeter to the right?"

The ORS, by design, is a general outcome instrument and provides no specific content other than the three domains. The ORS offers only a bare skeleton to which clients must add the flesh and blood of their experiences, into which they breathe life with their ideas and perceptions. At the moment in which clients connect the marks on the ORS with the situations that are distressing, the ORS becomes a meaningful measure of their progress and potent clinical tool.

Step three: introducing the SRS

The SRS, like the ORS, is best presented in a relaxed way that is integrated seamlessly into your typical

about our work together. It's like taking the temperature of our relationship today. Are we too hot or too cold? Do I need to adjust the thermostat? This information helps me stay on track. The ultimate purpose of using these forms is to make every possible effort to make our work together beneficial. Is that okay with you?"

Step four: incorporating the SRS

Because the SRS is easy to score and interpret, you can do a quick visual check and integrate it into the conversation. If the SRS looks good (score more than 9 cm on any scale), you need only comment on that fact and invite any other comments or suggestions. If the client marks any scales lower than 9 cm, you should definitely follow up. Clients tend to score all alliance measures highly, so the practitioner should address any hint of a problem. Anything less than a total score of 36 might signal a concern, and therefore it is prudent to invite clients to comment. Keep in mind that a high rating is a good thing, but it doesn't tell you very much. Always thank the client for the feedback and continue to encourage their open feedback. Remember that unless you convey you really want it, you are unlikely to get it.

And know for sure that there is no 'bad news' on these forms. Your appreciation of any negative feedback is a powerful alliance builder. In fact, alliances that start off negatively but result in your flexibility to client input

tend to be very predictive of a positive outcome. When you are bad, you are even better! In general, a score:

- that is poor and remains poor predicts a negative outcome,
- that is good and remains good predicts a positive outcome,
- that is poor or fair and improves predicts a positive outcome even more,
- that is good and decreases is predictive of a negative outcome.

The SRS allows the opportunity to fix any alliance problems that are developing and shows that you do more

SRS, therefore, are good news and should be celebrated. Practitioners who elicit negative feedback tend to be those with the best effectiveness rates. Think about it—it makes sense that if clients are comfortable enough with you to express that something isn't right, then you are doing something very right in creating the conditions for therapeutic change.

Step five: checking for change in subsequent sessions

With the feedback culture set, the business of practice based evidence can begin, with the client's view of

that off? Where do you think we should go from here?"

If no change has occurred, the scores invite an even more important conversation.

"Okay, so things haven't changed since the last time we talked. How do you make sense of that? Should we be doing something different here, or should we continue on course steady as we go? If we are going to stay on the same track, how long should we go before getting worried? When will we know when to say 'when?'"

The idea is to involve the client in monitoring progress and the decision about what to do next. The discussion prompted by the ORS is repeated in all meetings, but later ones gain increasing significance and warrant additional action. We call these later interactions either checkpoint conversations or last-chance discussions. In a typical outpatient setting, checkpoint conversations are conducted usually at the third meeting and last-chance discussions are initiated in the sixth session. This is simply saying that based in over 300,000 administrations of the measures, that by the third encounter, most clients who do receive benefit from services usually show some benefit on the ORS; and if change is not noted by meeting three, then the client is at a risk for a negative outcome. Ditto for session six except that everything just mentioned has an exclamation mark. Different settings could have different checkpoints and last-chance numbers. Determining these highlighted points of conversation requires only that you collect the data. The calculations are simple and directions can be found in our book, *The Heroic Client*. Establishing these two points helps evaluate whether a client needs a referral or other change based on a typical successful client in your specific setting. The same thing can be accomplished more precisely by available software or web-based systems that calculate the expected trajectory or pattern of change based on our data base of ORS administrations. These programs compare a graph of the client's session-by-session ORS results to the expected amount of change for clients in the data base with the same intake score, serving as a catalyst for conversation about the next step in therapy.

Where in the past we might have felt like failures when we weren't being effective with a client, we now view such times as opportunities to stop being an impediment to the client and their change process.

than give lip service to honoring the client's perspectives.

"Let me just take a look at this SRS—it's like a thermometer that takes the temperature of our meeting here today. Great, looks like we are on the same page, that we are talking about what you think is important and you believe today's meeting was right for you. Please let me know if I get off track, because letting me know would be the biggest favor you could do for me."

"Let me quickly look at this other form here that lets me know how you think we are doing. Okay, seems like I am missing the boat here. Thanks very much for your honesty and giving me a chance to address what I can do differently. Was there something else I should have asked you about or should have done to make this meeting work better for you? What was missing here?"

Graceful acceptance of any problems and responding with flexibility usually turns things around. Again, clients reporting alliance problems that are addressed are far more likely to achieve a successful outcome, up to seven times more likely! Negative scores on the

progress and fit really influencing what happens. Each subsequent meeting compares the current ORS with the previous one and looks for any changes. The ORS can be made available in the waiting room or via electronic software (ASIST) and web systems (MyOutcomes.com). Many clients will complete the ORS (some will even plot their scores on provided graphs) and greet the therapist already discussing the implications. Using a scale that is simple to score and interpret increases client engagement in the evaluation of the services. Anything that increases participation is likely to have a beneficial impact on outcome.

The therapist discusses if there is an improvement (an increase in score), a slide (a decrease in score), or no change at all. The scores are used to engage the client in a discussion about progress, and more importantly, what should be done differently if there isn't any.

"Your marks on the personal well-being and overall lines really moved—about 4 cm to the right each! Your total increased by 8 points to 29 points. That's quite a jump! What happened? How did you pull

If change has not occurred by the checkpoint conversation, the therapist responds by going through the SRS item by item. Alliance problems are a significant contributor to a lack of progress. Sometimes it is useful to say something like, *“It doesn’t seem like we are getting anywhere. Let me go over the items on this SRS to make sure you are getting exactly what you are looking for from me and our time together.”* Going through the SRS and eliciting client responses in detail can help the practitioner and client get a better sense of what may not be working. Sarah, the woman who aspired to be a Miami Heat cheerleader, exemplifies this process.

Next, a lack of progress at this stage may indicate that the therapist needs to try something different. This can take as many forms as there are clients: inviting others from the client’s support system, using a team or another professional, a different approach; referring to another therapist, religious advisor, or self-help group—whatever seems to be of value to the client. Any ideas that surface are then implemented, and progress is monitored via the ORS. Matt and the idea of encouraging his anger illustrate this kind of discussion.

If the therapist and client have implemented different possibilities and the client is still without benefit, it is time for the last-chance discussion. As the name implies, there is some urgency for something different because most clients who benefit have already achieved change by this point, and the client is at significant risk for a negative conclusion. A metaphor we like is that of the therapist and client driving into a vast desert and running on empty, when a sign appears on the road that says ‘last chance for gas’. The metaphor depicts the necessity of stopping and discussing the implications of continuing without the client reaching a desired change.

This is the time for a frank discussion about referral and other available resources. If the therapist has created a feedback culture from the beginning, then this conversation will not be a surprise to the client. There is rarely justification for continuing work with clients who have not achieved change in a period typical for the

majority of clients seen by a particular practitioner or setting.

Why? Because research shows no correlation between a therapy with a poor outcome and the likelihood of success in the next encounter. Although we’ve found that talking about a lack of progress turns most cases around, we are not always able to find a helpful alternative.

Where in the past we might have felt like failures when we weren’t being effective with a client, we now view such times as opportunities to stop being an impediment to the client and their change process. Now our work is successful when the client achieves change and when, in the absence of change, we get out of their way. We reiterate our commitment to help them achieve the outcome they desire, whether by us or by someone else. When we discuss the lack of progress with clients, we stress that failure says nothing about them personally or their potential for change. Some clients terminate and others ask for a referral to another therapist or treatment setting. If the client chooses, we will meet with

or no improvement is forthcoming, however, this same data indicates that therapy should, indeed, be as brief as possible. Over time, we have learned that explaining our way of working and our beliefs about therapy outcomes to clients avoids problems if therapy is unsuccessful and needs to be terminated.

Barry Duncan writes: But it can be hard to believe that stopping a great relationship is the right thing to do.

Alina sought services because she was devastated and felt like everything important to her had been savagely ripped apart—because it had. She worked her whole life for but one goal, to earn a scholarship to a prestigious ivy-league university. She was captain of the volley team, commanded the first position on the debating team, and was valedictorian of her class. Alina was the pride of her Guatemalan community—proof positive of the possibilities her parents always envisioned in the land of opportunity. Alina was awarded a full ride in minority studies at Yale University. But this Hollywood caliber story hit

...findings of virtually every study of change in therapy over the last 40 years provide substantial evidence that more therapy is better than less therapy for those clients who make progress early in treatment.

her or him in a supportive fashion until other arrangements are made. Rarely do we continue with clients whose ORS scores show little or no improvement by the sixth or seventh visit.

Ending with clients who are not making progress does not mean that all therapy should be brief. On the contrary, our research and the findings of virtually every study of change in therapy over the last 40 years provide substantial evidence that more therapy is better than less therapy for those clients who make progress early in treatment and are interested in continuing. When little

a glitch. Attending her first semester away from home and the insulated environment in which she excelled, Alina began hearing voices.

She told a therapist at the university counseling center and before she knew it she was whisked away to a psychiatric unit and given antipsychotic medications. Despondent about the implications of this turn of events, Alina threw herself down a stairwell, prompting her parents to bring her home. Alina returned home in utter confusion, still hearing voices, and with a belief that she was an unequivocal failure to herself, her

family, and everyone else in her tightly-knit community whose aspirations rode on her shoulders.

Serendipity landed Alina in my office. I was the 20th therapist the family called and the first who agreed to see Alina without medication. Alina's parents were committed to honor her preference to not take medication. We were made for each other and hit it off famously. I loved this kid. I admired her intelligence and spunk in standing up to psychiatric discourse and the broken record of medication. I couldn't wait to be useful to Alina and get her back on track. When I administered the ORS, Alina scored a 4, the lowest score I ever had.

We discussed her total demoralization and how her episodes of hearing voices and confusion led to the events that took everything she had always dreamed of from her—the life she had worked so hard to prepare for. I did what I usually did that is helpful—I listened, I commiserated, I validated, and I worked hard to recruit Alina's resilience to begin anew. But nothing happened.

By session three, Alina remained unchanged in the face of my best efforts. Therapy was going nowhere and I knew it because the ORS makes it hard to ignore—that score of 4 was a rude reminder of just how badly things were going.

At the checkpoint session, I went over the SRS with her, and unlike many clients, Alina was specific about what was missing and revealed that she wanted me to be more active, so I was. She wanted ideas about what to do about the voices, so I provided them—thought stopping, guided imagery, content analysis. But, no change ensued and she was increasingly at risk for a negative outcome. Alina told me she had read about hypnosis on the internet and thought that might help. Since I had been around in the 80's and couldn't escape that time without hypnosis training, I approached Alina from a couple of different hypnotic angles—offering both embedded suggestions as well as stories intended to build her immunity to the voices. She responded with deep trances and gave high ratings on the SRS. But the ORS remained a paltry 4.

At the last chance conversation, I

brought up the topic of referral but we settled instead on a consult from a team (led by Jacqueline Sparks). Alina, again, responded well, and seemed more engaged than I had noticed with me—she rated the session the highest possible on the SRS. The team addressed topics I hadn't including differentiation from her family, as well as gender and ethnic issues. Alina and I pursued the ideas from the team for a couple more sessions. But her ORS score was still a 4.

Now what? We were in session nine, well beyond how clients typically change in my practice. After collecting data for several years, I know that 75 per cent of clients who benefit from their work with me show it by the third session; a full 98 per cent of my clients who benefit do it by the sixth session. So is it right that I continue with Alina? Is it even ethical?

Despite our mutual admiration society, it wasn't right to continue. A good relationship in the absence of benefit is a good definition of dependence. So I shared my concern that her dream would be in jeopardy if she continued seeing me. I emphasized that the lack of change had nothing to do with either of us, that we had both tried our best, and for whatever reason, it just wasn't the right mix for change. We discussed the possibility that Alina see someone else. If you watch the video, you would be struck, as many are, by the decided lack of fun Alina and I have during this discussion.

Finally, after what seemed like an

eternity, including Alina's assertion that she wanted to keep seeing me, we started to talk about who she might see. She mentioned she liked someone from the team, and began seeing our colleague Jacqueline Sparks.

By session four, Alina had an ORS score of 19 and enrolled to take a class at a local university. Moreover, she continued those changes and re-enrolled at Yale the following year with her scholarship intact! When I wrote a required recommendation letter for the Dean, I administered the ORS to Alina and she scored a 29. By getting out of her way and allowing her and I to 'fail successfully', Alina was given another opportunity to get her life back on track—and she did. Alina and Jacqueline, for reasons that escape us even after pouring over the video, just had the right chemistry for change.

This was a watershed client for me. Although I believed in practice based evidence, especially how it puts clients center stage and pushes me to do something different when clients didn't benefit, I always struggled with those clients who did not benefit, but who wanted to continue with me nevertheless. This was more difficult when I really liked the client and had become personally invested in them benefiting. Alina awakened me to the pitfalls of such situations and showed a true value added dimension to monitoring outcome—namely the ability to fail successfully with our clients. Alina was the kind of client I would have seen forever. I cared

AUTHOR NOTES

BARRY L. DUNCAN, Psy.D. and SCOTT D. MILLER, Ph.D. are co-founders of the *Institute for the Study of Therapeutic Change*. Together, they have authored and edited numerous professional articles and books, including *The Heart and Soul of Change: What Works in Therapy, Escape from Babel, Psychotherapy with Impossible Cases*, and *The Heroic Client*. Recently, they released self-help books, *Staying on Top and Keeping the Sand Out of Your Pants: A Surfer's Guide to the Good Life*, written by Scott and Barry published, *What's Right with You: Debunking Dysfunction and Changing Your Life*.

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deeply about her and believed that surely I could figure out something eventually.

But such is the thinking that makes 'chronic' clients—an inattention to the iatrogenic effects of the continuation of therapy in the absence of benefit. Therapists, no matter how competent or trained or experienced, cannot be effective with everyone, and other relational fits may work out better for the client. Although some clients want to continue in the absence of change, far more do not want to continue when given a graceful way to exit. The ORS allows us to ask ourselves the hard questions when clients are not, by their own ratings, seeing benefit from services. The benefits of increased effectiveness of my work, and feeling better about the clients that I am not helping, has allowed me to leave any squeamishness about forms far behind.

Practice based evidence will not help you with the clients you are already effective with; rather, it will help you with those who are not benefiting by enabling an open discussion of other options and, in the absence of change, the ability to honorably end and move the client on to a more productive relationship. The basic principle behind this way of working is that our day-to-day clinical actions are guided by reliable, valid feedback about the factors that account for how people change in therapy. These factors are the client's engagement and view of the therapeutic relationship, and—*the gold standard*—the client's report of whether change occurs. Monitoring the outcome and the fit of our services helps us know that when we are good, we are very good, and when we are bad, we can be even better.

Duncan, B. (2011). What therapists want: It's certainly not money or fame. *Psychotherapy Networker*, May/June, 40-43, 47, 62.

Duncan, B. (2011). Opening a path: From what is to what can be. *Psychotherapy Networker*, May/June, 46-47.

What Therapists Want

It's certainly not money or fame!

By Barry Duncan

It's no secret to anybody in our field that this is a tough time to be a therapist. In public agencies, we're underpaid, overworked, and held to unattainable "productivity standards" (24 to 28 client hours a week; 30 to 34 scheduled appointment hours to make up for cancellations and no-shows). We're subjected to a continual onslaught of paperwork to secure payments, and frequently face cutbacks and layoff threats. While some of us still thrive in private practice, most of us make far less than we did during the "golden age" of fee-for-service insurance reimbursement. Furthermore, the nature of clinical work often is frustrating, even anxiety-provoking, exposing us to high levels of human suffering.

Adding insult to injury, the culture at large doesn't seem to admire therapists particularly, or understand what we do. This point is clear if you take a moment to think about the portrayals of therapists by Dr. Marvin Monroe of *The Simpsons* or Jack Nicholson in *Anger Management* or Barbra Streisand in *Meet the Fockers*. Sure, good examples of competent clinicians exist, but they're far outweighed by those that cast us as self-indulgent crackpots endlessly mouthing psychobabble. So, why *would* anybody choose to enter such a field? To be sure, most of us didn't choose this work because we thought we'd acquire the lifestyles of the rich and famous—we knew at the outset that devoting our lives to trying to assuage human misery wouldn't be a walk in the park. Still, given the increasing hardships of the profession, many of us do grow battle weary and begin to wonder why we enlisted in the first place. So what keeps us from succumbing to burnout or getting a job that's more fun—like tarring roofs in Miami in August or draining septic tanks?

A massive, 20-year, multinational study of 11,000 therapists conducted by researchers David Orlinsky of the University of Chicago and Michael Helge Rønnestad of the University of Oslo (both contributors to the venerable *Handbook of Psychotherapy and Behavior Change*) not only has the answer, but captures the heart of our aspirations and perhaps the soul of our professional identity. For their book published in 2005, *How Psychotherapists Develop*, they collected and analyzed detailed reports from nearly 5,000 psychotherapists about the way they experienced their work and professional development. Since then, 6,000 more therapists have participated in the study as a collaborative project with

members of the Society for Psychotherapy Research. What's fascinating about the results of this longitudinal study is the consistency of response across therapist training, nationality, gender, and theoretical orientation. The study portrays psychotherapy as a unified field, despite what our warring professional organizations and theories often tell us.

The specific findings reaffirm some characteristics therapists already know about themselves, and includes new, illuminating details. Therapists stay in the profession, not because of material rewards or the prospect of professional advancement, but because—above all—they value connecting deeply with clients and helping them to improve. On top of that, the clinicians interviewed consistently reported a strong desire to continue learning about their profession, regardless of how long they'd been practicing. Professional growth was cited as a strong incentive and a major buffer for burnout across the board.

Orlinsky and Rønnestad termed both what therapists seek in their professional careers and the satisfaction they receive from the work they do *healing involvement*. This concept describes therapists' reported experiences of being personally engaged, communicating a high level of empathy, and feeling effective and able to deal constructively with difficulties. Healing involvement represents us at our best—those times when we're attuned to our clients and the path required for positive change becomes clearly visible; those times when we can almost feel the "texture" of our therapeutic connection and know that something powerful is happening. But what causes this, and more important, how can we make it happen more often?

We all know that healing involvement isn't simply an inevitable outcome of sitting in an office with troubled and unhappy people for many years. According to Orlinsky and Rønnestad, it emerges from therapists' *cumulative career development*, as they improve their clinical skills, increase their mastery, gradually surpass limitations, and gain a positive sense of their clinical development through the course of their careers. Therapists have a deep need to think of themselves as learning more and getting better at what they do over time. As they accrue the hard-earned lessons offered by different settings, modalities, orientations, and populations, they want to come out on the positive end of any reappraisal of their experience. It's a feeling common to people in many professions and walks of life: the better you think you are at something, the more invested you are in doing it.

But an even more powerful factor promoting healing involvement is what the authors call therapists' sense of *currently experienced growth*—the feeling that we're learning from our day-to-day clinical work, deepening and enhancing our understanding in every session. Orlinsky and Rønnestad suggest that this enlivening experience of current growth is fundamental to maintaining our positive work morale and clinical passion.

According to their study, the path to currently experienced growth is clear. It's intimately connected to therapists' experiences with clients and what they learn from them, and is unrelated to workshops and books trumpeting the latest and greatest advances in our field. Almost 97 percent of the therapists studied reported that learning from clients was a significant influence on their sense of development, with 84 percent rating the influence as

“high.” It appears therapists genuinely believe that clients are the best teachers. But the finding that most impressed Orlinsky and Rønnestad was therapists’ inextinguishable passion to get better at what they do. Some 86 percent of the therapists in the study reported they were “highly motivated” to pursue professional development. It appears that no matter how long they’ve been in the business, therapists still want to learn more and get better.

To the question, “Why is our growth so important to us?” Orlinsky and Rønnestad posited a close link between healing involvement and currently experienced growth. The ongoing sense that we’re learning and developing in every session gives a sense of engagement, optimism, and openness to the daily grind of seeing clients. It fosters continual professional reflection, which, in turn, motivates us to seek out training, supervision, personal therapy, or whatever it takes to be able to feel that the developmental process is continuing. Borrowing a term from the late Johns Hopkins psychiatrist and common-factors theorist Jerome Frank, having a sense of currently experienced growth “remoralizes” therapists, repairing the abrasions and stressors of the work and minimizing the danger of falling into a routine and becoming disillusioned. “[It] is the balm that keeps our psychological skin permeable,” said Orlinsky. “Many believe that constantly hearing problems makes one emotionally callused and causes one to develop a ‘thick skin.’ But not therapists. We need ‘thin skin’—open, sensitive, and responsive—to connect with clients.” Currently experienced growth, then, is our greatest ally for sending the grim reaper of burnout packing—we *need* to feel we’re growing to fend off disenchantment.

The Importance of Measuring Outcomes

Achieving a sense of healing involvement requires a continual evaluation of where we are compared to where we’ve been. We must keep examining our clinical experiences, looking for evidence of our therapeutic mastery and mining our sessions for the golden moments that replenish us. But if our sense of healing involvement with clients is tied to our ongoing sense of making a difference, how do we *know* we’re truly helping? You know when a roof is tarred or a tank drained, but how do you know when psychotherapy is beneficial? Therapeutic outcomes are hard to define and harder to measure.

The research literature offers strong evidence that therapists aren’t good judges of their own performance. Consider a study by Vanderbilt University researcher Leonard Bickman and associates reported in 2005 in the *Journal of Clinical Psychology: In Session* in which clinicians of all types were asked to rate their job performance from A+ to F. About 66 *percent* ranked themselves A or better. Not one therapist rated him- or herself as being below average! If you remember how the Bell Curve works, you know that this isn’t logically possible.

Further evidence of therapists’ self-assessment difficulties is found in a study by Brigham Young University’s Corinne Hannan, Michael Lambert, and colleagues, reported in the same issue of the *Journal of Clinical Psychology: In Session*. They compared therapist judgments of client deterioration with actuarial predictions for 550 clients (algorithms based on a large database of clients who completed the Outcome Questionnaire 45.2). The

average deterioration rate for psychotherapy clients is about 8 percent, so about 40 clients in this study of 550 would likely worsen with treatment. Therapists accurately predicted deterioration in only 1 out of 550 cases. Thus, of the 40 clients who deteriorated, psychotherapists missed 39. In contrast, the actuarial method only missed 4.

It's not that we're naïve or stupid; it's simply hard, if not impossible, to accurately assess your effectiveness on a client-by-client basis. For this, you need some quantitative standard as a reference point—you need to measure outcomes. I can hear you groan, but I'm not talking about outcome measurement for the sake of bureaucratic "accountability" to funding sources or for justifying your existence by demonstrating your "proof of value" or "return on investment." Rather, measuring outcomes allows you to cut through the ambiguity of therapy, using objective evidence from your practice to help you discern your clinical development without falling prey to that perennial bugaboo of the therapeutic endeavor: wishful thinking. Taking the time to measure outcomes relates directly to both having an awareness of our mastery over time and experiencing a sense of current growth.

How does outcome measurement further cumulative career development and currently experienced growth—the two keys to greater healing involvement with clients? First, cumulative career development is another way of saying that we're "getting better all the time." The routine collection of outcome data allows you to determine your effectiveness over time, and gives you a base for trying out and accurately evaluating new strategies. Begin simply by entering your outcome scores into a database, and keeping track of them on an ongoing basis: intake and final session scores, average change score (the difference between average intake and final session scores), and, ultimately, the percent of your clients who benefit. If you can review and assess your clinical work through the years, you can actually *learn* from your experience, rather than simply repeating it and hoping for the best.

Of course, finding out how effective you really are can be risky business. What if you find out that you're not so good? What if you discover that you're—say it isn't so!—just average? Measuring outcomes takes courage, but so did walking into a consulting room for the first time to counsel someone in distress—and so does doing it day in and day out.

There are some good reasons to take the risk, however. Consider the results of a 2009 investigation of client-outcome feedback that I conducted in Norway with psychologist Morten Anker and family therapy professor Jacqueline Sparks and published in the *Journal of Consulting and Clinical Psychology*. The largest randomized clinical trial of couples therapy ever done, it found that clients who gave their therapists feedback about the benefit and fit of services on two brief, four-item forms reached clinically significant change nearly four times more than non-feedback couples did. (Both measures are available to download for free at www.heartandsoulofchange.com.)

So it's clear that clients benefit from the use of feedback forms, but so do we. Tracking outcomes improved the results of 9 out of 10 therapists in this study. In fact, Anne, a therapist in the low-effectiveness group without feedback became the therapist with the

best results with feedback. This heartening finding suggests that, regardless of where you start in terms of your effectiveness, you, too, can be among the most successful therapists if you're proactive about tracking your development.

As for the relationship of measuring outcomes to currently experienced growth, as Orlinsky and Rønnestad have shown, the old therapeutic cliché is true: therapists really do believe that clients are their best teachers. Clients provide the opportunity for constant learning about the human condition, different cultures, and worldviews, as well as the myriad ways that people transcend adversity and cope with the unthinkable. But while we learn a great deal almost by osmosis from our clients, tracking outcomes takes the notion that “the client is the best teacher” to a different, higher, and more immediately practical level. Tracking outcomes with clients not only focuses us more precisely on the here-and-now of sessions, it takes us beyond mere intuition and subjective impressions to quantifiable feedback about how the client is doing. We get unambiguous data about whether clients are benefiting and whether our services are a good fit for them. From their reactions and reflections, we receive information that we can use in figuring out the next step to take in therapy. In short, tracking outcomes enables your clients—especially those who aren't responding well to your therapeutic business-as-usual—to teach you how to work better. In fact, clients who *aren't* benefiting offer us the most opportunity for learning by helping us to step outside our comfort zones.

Recall Anne, one of the lowest-scoring Norwegian therapists, who became the best therapist when she collected client outcome and alliance feedback. Here are her reflections about the relationship between her clients' feedback and her sense of currently experienced growth:

Discussing when clients were not benefiting helped me be more straightforward, more courageous. I inquired more directly about what we could do together. . . . Clients taught me how to handle it when I was not useful. Clients and I reflected more on their changes and on the sessions. We got more concrete regarding change, how it started, and what else would be helpful.

In all, collecting outcome data with clients helped me take risks and invite negative feedback. So I asked for it, showed I could handle it, validated it, and then incorporated it in the work. That's what therapy's all about—real collaboration.

The Orlinsky and Rønnestad study contains important information about who we are and what we have to do to remain a vital force in our clients' lives. It shows that our professional growth is a necessary part of our identity, as is our need to harvest the experiences that replenish us. It's not enough to be soft-hearted and empathetic. Therapists need to have a keen sense of reality-testing to keep their heads above water in this field and make sure their work continues to be fulfilling.

Attaining healing involvement requires two things: your investment in yourself and a recognition of your own growth and development. This, in turn, necessitates a commitment to tracking your outcomes.

Tracking outcomes enables a big-picture view of your cumulative career development and a microscopic view of your currently experienced growth. Both perspectives allow you to continually assess your development, challenge your assumptions, adjust to client preferences, and master new tools. Monitoring outcomes can help you survive—indeed thrive—in a profession under siege, yet still compelling; a profession that offers a lifetime training ground for human connection and growth, and frequently yields small victories that matter in the lives of those we see.

Download free outcome and alliance measures at: www.heartandsoulofchange.com, and learn about the Partners for Change Outcome Management System.

Resources

Anker, Morten, Barry Duncan, and Jacqueline Sparks. "Using Client Feedback to Improve Couples Therapy Outcomes: A Randomized Clinical Trial in a Naturalistic Setting." *Journal of Consulting and Clinical Psychology* 77, no. 4 (2009): 693-704.

Duncan, Barry. *On Becoming a Better Therapist*. Washington, D.C.: American Psychological Association, 2010. Details about tracking your development with outcome data and enhancing your clinical effectiveness.

Duncan, Barry, Scott Miller, Bruce Wampold, and Mark Hubble. *The Heart and Soul of Change: Delivering What Works in Therapy, 2nd Edition*. Washington, D.C.: American Psychological Association, 2010. Find out how to improve your outcomes from leading researchers.

Hannan, Corinne, Michael J. Lambert, Cory Harmon, et al. "A Lab Test and Algorithms for Identifying Clients at Risk for Treatment Failure." *Journal of Clinical Psychology: In Session* 61, no. 2 (2005): 155-63.

Lambert, Michael J. "Yes, It Is Time for Clinicians to Routinely Monitor Treatment Outcome." In *The Heart and Soul of Change: Delivering What Works*. Washington, D.C.: American Psychological Association, 2010. Find systems for tracking outcomes here.

Orlinsky, David E., and Michael H. Rønnestad. *How Psychotherapists Develop: A Study of Therapeutic Work and Professional Growth*. Washington, D.C.: American Psychological Association, 2005. Learn about the groundbreaking study and see how you compare to the therapists involved.

Sapyta, Jeffrey, Manuel Riemer, and Leonard Bickman. "Feedback to Clinicians: Theory, Research, and Practice." *Journal of Clinical Psychology: In Session* 61, no. 2 (2005): 145-53.

Opening the Path

From what is to what can be

By Barry Duncan

A recent consult I did illustrates the intrinsic rewards of healing involvement and intimate connection. Rosa, who was 7, had gone to live with her foster parents—her aunt and uncle, Margarita and Enrique—because the parental rights of her birth parents had been terminated. Both her father and mother were addicts with long criminal records; the father was in jail, and the mother was still using drugs. The new situation wasn't going well, however. Rosa's mom had ingested crack and other drugs during the pregnancy and the child, as young as she was, already had received a handful of diagnoses (pediatric bipolar disorder, AD/HD, oppositional defiant disorder). She clearly had been born with two strikes against her: parents missing in action and her development impaired by drugs.

Rosa was a "difficult" child, to say the least—prone to tantrums that included kicking, biting, and throwing anything she could find. The family's previous therapist was stymied and had referred the family to me for a consult. I began the session by asking Rosa if she could help me out by answering some questions. She immediately yelled, "NO!" leaning back, with her arms folded across her chest. As I turned to speak with Enrique and Margarita, Rosa began having a tantrum in earnest—screaming at the top of her lungs and flailing around, kicking me in the process.

With Rosa's tantrum escalating, Margarita, who'd first tried to soothe her, dropped a bombshell. In a disarmingly quiet voice, she announced that she didn't think she could continue foster-parenting Rosa. The tension in the room immediately escalated; the only sound was Rosa's yelling, which had become more or less rote at that point. I felt as if I'd been kicked in the gut. I'd expected to be helping foster parents contain and nurture a tough child. Now it felt like I was participating in a tragedy in the making. Here was a couple, trying their best to do the right thing by taking in a troubled kid with nowhere else to go, but who seemed ready to give up.

The situation was obviously wrenching for Margarita and Enrique, but it was potentially catastrophic for Rosa. In this rural setting, they were her last hope, not only of living with family, but of living nearby at all, since the closest foster-care placement was at least 100 miles away. I contemplated Rosa's life unfolding in foster care with strangers who'd encounter the same difficulties and likely come to the same impasse—resulting in a nightmare of ongoing home placements.

Margarita continued explaining why she couldn't go on, speaking softly while tears rolled down her cheeks. Not only did she feel she couldn't handle Rosa, she also worried about

the child's attachment to her. She said Rosa's mother still engaged in behind-the-scenes sabotage, trashing Margarita and Enrique to relatives and sending messages undermining the two of them to Rosa whenever she could. Margarita said that her arguments with Enrique about how to deal with the child were taking a toll on their relationship.

As Margarita expressed her doubts in a near whisper, Enrique's eyes began to tear up and a feeling of despair permeated the room. At that moment, I felt helpless to prevent a terrible ending to an already bad story. Meanwhile, Margarita began gently caressing Rosa's head and speaking softly to her—the Spanish equivalent of “there, there, little one”—until the little girl started to calm down. With her tantrum at an end, Rosa turned to face Margarita, and then reached up and wiped the tears from her aunt's face. “Don't cry, Auntie,” she said warmly, “don't cry.”

Witnessing these actions was yet another reminder to me of how new possibilities can emerge at any moment in a seemingly hopeless session. “It's tough to parent a child who's been through as much as Rosa has,” I said. “I respect your need to really think through the long-term consequences here. But I'm also impressed with how gently you handled Rosa when she was so upset, and with how Rosa comforted you, Margarita, when she saw you crying. Clearly there's something special about the connection between you two.”

Margarita replied that Rosa definitely had a “sweet side.” When she saw that she'd upset either Margarita or Enrique, she quickly became soft, responsive, and tender. I began to talk with Margarita and Enrique about what seemed to work with Rosa and what didn't. While Rosa snuggled with Margarita, we talked about how to bring out Rosa's sweet side more often. As ideas emerged, I was in awe, as I often am, of the fortitude clients show when facing formidable challenges. Here was a couple in their late forties who'd already raised their own two children, considering taking on the responsibility of raising another one who had such a difficult history.

By now, the tension and despair present a few moments before had evaporated. The decision to discontinue foster parenting, born of hopelessness, had lost its stranglehold, though nothing had been said explicitly about that. As we were wrapping up, I gave all of them the alliance tool—the Session Rating Scale that solicits client feedback about how the meeting went for them. Rosa wrote “good” at the far right of each item. I'd obviously won her over—a real coup from my perspective. As an old family therapist, I thought she was a good barometer for the overall affect in the room. Now all smiles and bubbly, she was bouncing up and down in her chair.

Somewhat out of the blue, Margarita announced that she was going to stick with Rosa. “Great,” I said quietly. Then as the full meaning of what she'd said washed over me, I repeated it a bit louder, and then a third time with enthusiasm—“Great!” I asked Margarita if anything in particular had helped her come to this decision. She answered that, although she'd always known it, she'd realized in our session even more than before that there was a wonderful, loving child inside Rosa, and that she, Margarita, just had to be patient and take things one day at a time. The session had helped her really see the attachment that

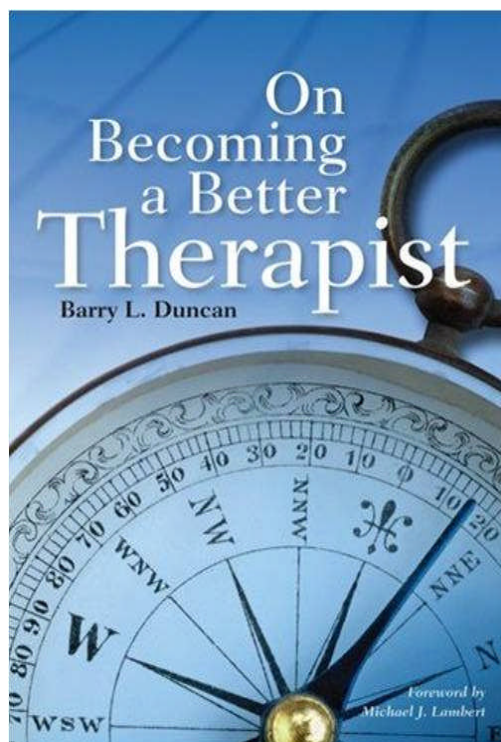
was already there. I felt the joy of that moment then, and I still do.

Follow-up revealed that this family stayed together. Margarita never again lost her resolve to stick with Rosa. In addition, many of Rosa's more troubling behaviors fell away, perhaps as a result of having stability in her life for the first time. Confirming this picture were the family's perceptions of their own change on the outcome measures.

In my view, the session included a lot of healing involvement—that intimate space in which we connect with people and their pain in a way that somehow opens the path from what is to what can be. My heartfelt appreciation of both the despair of the circumstance and their sincere desire to help this child, combined with the fortuitous “attachment” experience, generated new resolve for Margarita and Enrique.

Regarding currently experienced growth, this session taught me, once again, that anything is possible—that even the bleakest sessions can have a positive outcome if you stay with the process. Just when things seemed the most hopeless, when both the family and I were surely down for the count and needed only to accept the inevitable, something meaningful and positive emerged that changed everything—including me.

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Feedback pioneer Michael Lambert says, “The possibility and novelty of Duncan’s ideas makes this an important and provocative contribution to the field.”