

15

Speaking the
Language of
Medical Necessity

18

What Supershinks
Can Teach Us
about Keeping
Our Balance

24

Little and Often:
Micro-Practices
for Self-Care

32

Highlights
from the 2015
Symposium

\$6.00 US/\$6.00 CANADA

Psychotherapy

N E T W O R K E R

MAY
JUNE
2015

Burnout

*New Approaches
to Rekindling
the Flame*





Psychotherapy

NETWORKER

MAY/JUNE

2015

Vol. 39 ■ No. 3

Burnout: New Approaches to Rekindling the Flame

18 Burnout Reconsidered

BY SCOTT MILLER, MARK HUBBLE, AND FRANÇOISE MATHIEU

An entire industry has sprung up to address the problem of compassion fatigue, but research indicates that the most commonly proposed answer, improved self-care, doesn't work. In fact, the study of the most highly effective clinicians suggests that burnout isn't related to caring too much, but continuing to care ineffectively.

24 Little and Often BY ASHLEY DAVIS BUSH

The growing interest in micro self-care mirrors the developments in understanding self-directed neuroplasticity: small and frequent works better to create desirable neural pathways than big and seldom.

28 Don't Go It Alone BY JOAN KLAGSBRUN AND LYNN PRESTON

To emerge from the grip of feeling stale as a therapist and in danger of burning out, we need something to take us out of our isolation. Focusing partnerships can be a potent remedy for the circular thinking we tend to get mired in when we're by ourselves.

Extra Feature

32 The Colors of Tomorrow

In an increasingly complex world, we've become more and more aware of how hard it is to predict what lies around the corner, especially for the profession of psychotherapy. But at this year's Networker Symposium, a collection of clinical innovators and inspiring visionaries—including Jon Kabat-Zinn, Richard Schwartz, the Gottmans, Esther Perel, Diane Ackerman, and Daniel Siegel—gave it a try.



psychotherapynetworker.org



Burnout

RECONSIDERED

BY SCOTT MILLER,
MARK HUBBLE, AND
FRANÇOISE MATHIEU

What Supershrinks Can Teach Us

Jessica, a counselor in her mid-30's, works at a large, public mental health clinic in a major metropolitan area. Her workday begins early, the alarm sounding off at 5:30 a.m. Up she gets and down to the kitchen she goes. Thank goodness for Nespresso! Brewing her coffee has never been more efficient. Cup in hand, she rushes back upstairs, waking her daughter, Emily. Pausing briefly, she takes in the room. School clothes laid out. Check. Homework in backpack. Check. Off to the shower.

By 6:30 a.m., with breakfast finished, mother and daughter are out the door, headed across the street to the neighbors' house, where Emily will stay until the school bus arrives. Thank goodness for friends! After scraping the snow and ice off her 2001 Toyota Corolla, Jessica jumps into the driver's seat and turns the key. Following its familiar protest, the engine growls to life. Then the four-mile commute begins. It usually takes 45 minutes, but if there's an accident or road construction, all bets are off.

As she winds her way through traffic, her grip on the wheel tightens. She was hoping to arrive early enough to complete clinical notes left over from the day before. She's already on notice with her supervisor. In the past year, the entire agency adopted the practice of "concurrent documentation"—completing all paperwork together with the client during scheduled visits. The idea was easy enough to understand. It was supposed to save time, as well as foster a "culture of transparency," which would improve "client engagement."

Like many public behavioral health agencies, dropout rates at hers had been notoriously high, wreaking havoc with productivity statistics. Jessica and everyone else had been tasked with improving retention, but she knew she was resisting the new paperwork requirement. To her, it was just one more encroachment on the already scarce time she had available with clients. Recently, payers had begun offering a premium to agencies for 30-minute visits. And if that weren't enough, to maximize the number of face-to-face encounters, the administration decided that frequent "no-shows" would be double-booked. In that way, they hoped every clinical hour would be filled, thus eliminating expensive downtime.

Jessica's thoughts turn to the last client who'd failed to appear: Cassandra, a single parent of three, with more problems than the DSM-V has diagnoses. She's well-known at the

agency, having worked with several of the staff over the years, participating in most of the programs at one time or another. Originally, she sought help for her daughter, who'd been sexually assaulted by the same relative who'd abused Cassandra herself when she'd been in her early teens. In time, it became apparent that these sad events were only the proverbial tip of the iceberg.

When Jessica explained the new no-show policy, Cassandra merely stared, saying nothing. It wasn't a matter of resistance or poor motivation. Jessica knew that. Life often conspired against her client. If it wasn't a problem with one of the kids, it was another family member, particularly the drug-addicted father of her oldest child. Lack of money was a constant threat, her food stamp allotment always running out long before the end of the month. When the agency began providing bus fare to help Cassandra make appointments, the city abruptly changed routes, adding an hour to the trip and forcing her to walk a fair distance through unsafe streets and often bad weather. Over the last week, Jessica couldn't stop herself from worrying about Cassandra. So far, all her calls have gone unanswered.

Up ahead, the traffic comes to a complete stop. A light snow starts to fall, with more in the forecast. Checking the dashboard clock, Jessica realizes the chance of arriving early is slipping away. That's when the feeling starts—first, a heaviness in the shoulders, quickly followed by a tightening around the heart. Jessica lets out an audible sigh and closes her eyes. She's no stranger to these sensations: they've become a near-constant companion on her way to and from work.

As the car ahead once again begins to move, she works at controlling her breathing, slowly inhaling and exhaling. Her mouth now dry, she reflexively reaches for the water bottle in the center console. It's made of cheap white plastic with her agency's name, address, and phone number printed in big black characters on the side. She takes a sip, recalling the day the bottles were passed out. Everyone who worked at the agency received one, following a day-long workshop on burnout. Proper hydration had been a top recommendation.

When the presenter had reeled off the signs of burnout, Jessica immediately recognized herself. In almost every way, the job she once loved had become unrewarding—a dreadful daily ordeal. Physically, she was worn out.

It was taking more and more effort just to get up and get going. In the year following her last performance evaluation, she'd taken more "personal days" than in all her previous years combined. Her usually hopeful and upbeat outlook had given way to discouragement, even cynicism. Increasingly, when working with clients—and even when meeting with coworkers—she found herself feeling either bored or detached, her heart no longer in it.

THE WALKING DEAD

Jessica's story is far from exceptional. Indeed, the world seems to be in the midst of a pandemic of burnout, spread across all age groups, genders, professions, and cultures. The lead article of this year's January/February *Scientific American Mind* boldly declares that job satisfaction worldwide is in "a surprisingly fragile state." Research specific to mental health providers finds that between 21 and 67 percent may be experiencing high levels of burnout. Since the 1970s, when the term first appeared, other related "conditions" have been identified, including compassion fatigue (CF), vicarious traumatization (VT), and secondary traumatic stress (STS), all aimed at describing the negative impact that working in human services can have on mental and physical health. The toll is severe. Growing rates of absenteeism, job turnover, and reports of depression, anxiety, exhaustion, and physical illness (e.g., insomnia, hypertension, high blood sugar, excess body fat, abnormal cholesterol levels, cardiovascular events, musculoskeletal disorders) are well documented.

In fact, an entire industry of authors, coaches, and trainers has

sprung up to address the problem, providing books, videos, presentations, retreats, and organizational consultation. Across such offerings, the advice given is remarkably similar. It falls into one or two categories, usually aimed at those considered at risk or already afflicted: (1) do more of this, and (2) do less of that.

On the "do more" side, Jessica and her coworkers were told to practice

avoiding stress-inducing people and experiences, and the ultimate "do less": quit.

Of course, given her recent feelings, Jessica had been looking forward to the workshop. She agreed with the presenter's assertion that self-care wasn't merely a personal matter, but an ethical duty, key to maintaining one's ability to help others and avoid harm. But at the same time, the shared feeling in

the group was that none of these strategies had any real chance of solving the core problems they all faced: too much paperwork, too many clients, deteriorating and inadequately maintained clinic facilities, ongoing financial uncertainty, and administrative indifference.

"How is any of this going to help?" Jessica overheard one of the other counselors later say. "I feel like one of the zombies in *The Walking Dead*. Why don't they just put us out of our misery?"

The image neatly captured Jessica's experience of late.

"Yeah," added another, laughing sarcastically. "We're zombies all right, but don't forget: we have an 'ethical duty' to take care of ourselves."

"So we're *guilty* zombies," Jessica chimed in. Everyone laughed.

“Indeed, the world seems to be in the midst of a pandemic of burnout, spread across all age groups, genders, professions, and cultures.”

mindfulness meditation, eat healthy snacks, go for short walks, exercise regularly, get enough sleep, join a service organization, take up a hobby, attend a continuing education event, learn to say no, see a therapist, and take time out to value oneself. On the "do less" side, recommendations included leaving work at work, turning off technology, limiting the number of client contact hours per week, cutting back on or eliminating caffeine and alcohol,

THE MONKEY ON OUR BACK

Although it's of little solace to Jessica, the subject of stress in the workplace is hardly new and has been a topic of interest among researchers for decades. One of the first studies, published in 1958, in *Scientific American*, was conducted by behavioral neuroscientist Joseph Brady. In brief, he restrained a pair of Rhesus monkeys in chairs and then administered electric shocks at 20-second intervals. One of the ani-

mals—called the executive—could avert the shock for both by pressing a lever; the other—the control—lacked an effective means to escape the noxious stimulus. Consistent with Brady's hypothesis, the executive monkey experienced greater levels of stress-related illness as measured by gastric ulceration. The results were widely reported, quickly entering popular culture and giving rise to the belief that reducing stress is the key to workplace health. Decision makers, especially those whose actions affected the welfare of others, were thought to be especially vulnerable.

While it seemed the cause of workplace stress had been settled once and for all, a major problem soon emerged. Brady's contemporaries couldn't replicate his findings. In fact, in the decades that followed, hundreds of studies found exactly the opposite. So-called executives—be they primates, rodents, or human beings—always fared better than controls. Put another way, being in charge wasn't the issue. Instead, circumventing stress was a matter of possessing the ability to act effectively in any given circumstance. Convincing evidence for this conclusion can be found in a massive study of government employees in the United Kingdom, ongoing since the 1960s, showing that the more control workers have, the less stress-related illness they experience.

Such data make clear that the field's approach to healing the healer's heart must change. Contrary to conventional wisdom, what matters most isn't how demanding a particular job is, or the level of responsibility it comes with, but how much personal agency one has in performing the work. In essence, we put the monkey on our own back whenever the solution to burnout is tied to controlling our response to circumstances over which we have no actual control. Instead of offering liberation, any strategy based on this premise ends up trapping us in a classic double-bind. It's this crazy:

those most stressed by the circumstances of their work, which they can't control, are expected to reduce their own stress, which they can't do because of their lack of control, and in the end, are held responsible by those in control when they ultimately fail to reduce their stress, which they can't help but do. The result is a kind of tertiary traumatization. In effect, the message is "We gave you what you needed. If you're not improving, it's your fault."

Little wonder Jessica feels guilty! Her gallows humor underscores the futility of currently fashionable approaches to burnout. Put bluntly, workplace initiatives focused on individual self-care and work-life balance aren't only doomed to fail, but may make us worse. This isn't mere speculation or a conclusion extrapolated from animal analogue studies. It's a fact. Even when clinicians wholeheartedly believe such activities will help and work hard to apply them in their lives, the empirical evidence shows it makes no difference. As Toronto-based researchers Ted Bober and Cheryl Regehr conclude, "It does not appear that engaging in any coping strategy recommended for reducing distress, . . . including effective use of leisure, self-care, supervision, [or] . . . augmenting individual coping responses, . . . has an impact."

In the absence of proven methods for ameliorating this suffering, what are Jessica and the many others who find themselves in similar straits to do?

DON'T STOP BELIEVIN', HOLD ON TO THAT FEELIN'

Over the last decade, we've published a series of articles in the *Networker* on the subject of top-performing clinicians. The first, titled "Supershrinks" (November/December 2007), described the practices of this highly effective group. Clients of these therapists, compared to those treated by average clinicians, experience 50 percent more improvement and 50 percent less dropout, have short-

er lengths of stay, and are significantly less likely to deteriorate while in care. In "The Road to Mastery" (May/June 2011), we identified factors in the work environment or culture necessary for the emergence of superior practitioners and their continued development.

And we've continued to accumulate data, much of it awaiting further analysis and explanation. One finding, however, stood out immediately, as it contradicted what's often cited by therapists as the core of their professional identity and what most say is essential for their being effective. Later, we'd learn it had a direct bearing on the question of burnout. Here's the rundown.

Being completely immersed in and sharply attuned to the client's experience has long been the *sine qua non* of "good" clinical practice. Research confirms as much. For example, a large multinational investigation by University of Chicago's David Orlinsky and the University of Oslo's Michael Rønnestad involving more than 10,000 therapists found the majority not only yearn for but consider a deep connection with their clients the pinnacle of professional development. Not long ago, this subject was addressed in the Q&A department of the *Networker*, called *In Consultation*. "Something is missing from my work," a clinician wrote plaintively, "some level of deep connection." The advice given was remarkably consistent with what studies say therapists want: love your client. "Not the personal love we feel for a spouse or our children," the author explained, "but love as a heart energy within all of us that's far more spacious, selfless, and unqualified."

Curiously, our own research showed that Healing Involvement (HI)—the construct used by researchers to capture clinicians' felt sense of being deeply connected to their clients—varied by success rate, with top performers rating it significantly *less* important to their work and identity than their

more average counterparts. At the same time, this group of therapists evinced little interest in traditional self-care practices. Most importantly, they reported far less burnout.

Determined to make sense of the discontinuity between the best and the rest, we reached out to top performers. How, we wondered, could caring *less*—at least as our field might view such findings—yield better results for clients and, simultaneously, protect clinicians from burnout?

One of the first practitioners we spoke with was Paulina Bloch, a highly effective therapist identified in our research, who works for the National Health Service in Staffordshire, England. When asked about the role *caring* played in her work, she thought for a moment and replied, “I guess I have a funny relationship with that word. It’s not me liking or worrying so much about my clients, or even being deeply invested in their lives or stories really. It’s a question of whether or not I’m helping.” Paulina paused, wondering out loud whether she should say what was on her mind, then continued, “The first thing I think when I meet a new client is *When can I stop seeing this person? And I know I can do that if I get results.*”

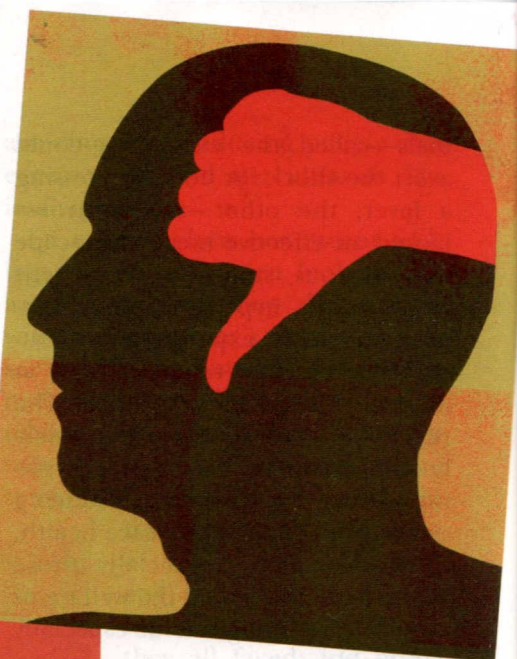
In interview after interview, the field’s most effective clinicians placed the outcome of treatment above involvement with clients as their chief consideration, the focus of their work and professional identity. This isn’t to say they don’t care about their clients. They do. Yet, as Bloch suggests, they don’t see caring, or connection, as the point. For them, involvement is a means to an end, not an end in itself.

“The tendency to conflate involvement with effectiveness is easy to

understand,” observes psychologist Daryl Chow. His research is the most in-depth examination of supershrinks to date. “In the face of suffering, even if we’re not helping, deepening our involvement feels like the right thing to do. Add this together with findings showing that therapists aren’t particularly skilled at detecting a lack of progress or deterioration in care, and the stage is set.”

“Put bluntly, workplace initiatives focused on individual self-care and work-life balance are not only doomed to fail, but may make us worse.”

Here, it might be tempting to conclude that caring is wrongheaded, as though clinicians must choose between caring about their clients—and risking burnout—or being effective. No such choice is being proposed: to care or not to care is not the question. If there’s one thing we can learn from highly effective therapists, it’s that burnout doesn’t begin with caring, or even caring too much, but continuing to care ineffectively, losing sight of what we’re there to



accomplish with our clients in the first place.

Proving this point, a new study of mental health professionals by Michelle Salyers and colleagues at Indiana University–Purdue University Indianapolis found that emotionally exhausted clinicians are blind to the effect burnout has on their performance. While most readily agree that it negatively affects the quality of services and productivity in general, they strangely convince themselves it has no effect on the outcomes of their own work.

Such findings indicate that the real challenge for practitioners is knowing when to let go, “when to stop believin’ and to let go of that feelin’.” In the same way that we don’t marry everyone we date, therapists can’t help everyone who comes through their doors. Research shows that therapists, on average, fail to help as many as 50 percent of their clients achieve a measurable improvement. So sometimes we have to let go, relinquishing both the belief that we have something to offer and the duty we feel to help. Of course, the arguments against doing so are legion and, unfortunately, powerfully per-

suasive: "My client needs me." "It's my job to hang in there." "We just need a little more time; then it'll work." "At least they're not getting worse." And finally, "There's no one else." Mix in a generous portion of guilt and a dash of professional pride and burnout is all but guaranteed.

"I think we've been approaching the problem of burnout wrong," Chow speculates. "It's not about reducing or managing our stress, or how to take care of ourselves. It's about choice and having effective options." In short, it's not the burden of our responsibilities that matters so much as it is improving our "response-abilities."

HOW JOE GOT HIS MOJO BACK

"We're never so defenseless against suffering," Freud wrote in 1930, "as when we love." These words perfectly describe Joe, a clinical social worker and 20-year veteran of service in rural community mental health. Joe had been raised on an ethic of service. In the small, Southern town where he'd grown up, everyone knew his father, a minister. The area was economically depressed, and members of the congregation did what they could to help each other. They collected and distributed food and clothing, and pitched in whenever something needed to be done. Throughout his childhood, his family home was always open—people coming in and out, being fed, and even staying the night.

Joe's upbringing complicated the guilt he felt when he lost his heart for clinical work. He'd always been the go-to person at the agency, the one others trusted to work with the most troubled clients, the person they consulted when needing to discuss a case, get personal advice, decompress, or just share a laugh. Many weekends, he volunteered at the local food pantry and Red Cross, and helped coach a Little League Baseball team.

"I can't think of a date, or put my finger on any one thing that happened," he recalls. "But it's like my

flame slowly went out." What he does remember is his mood changing. Normally positive and optimistic, he found himself increasingly irritable and impatient. Whereas before, the door to his office was always open, colleagues increasingly found it closed. He felt burdened by the clients, secretly glad when they didn't show up.

"I just got beat down," Joe says. "The paperwork, runaway caseloads, lack of support—my job was no longer about helping. It was about something else, crunching numbers, whatever. And with the clients, their lives, what happened to them—the trauma and suffering—it just seemed to get worse and worse. Somewhere along the way, I started being there, but not there."

Joe seriously contemplated quitting, yet felt trapped. "I have no real skills," he jokes, "hate computers, am only so-so with my hands. What could I do, really?" When asked to describe what eventually turned it all around for him, he leans forward and with mischief written all over his face, whispers, "Bunting."

In baseball, Joe explains, bunting is a technique where the batter pivots toward the pitcher, holds the bat loosely over home plate and, instead of swinging, gently taps the ball into play. The method forces opposing players to leave their positions and rush infield to retrieve the ball, which can dribble off in almost any direction. Confusion among the players over who's to field the ball and who's to cover the bases often allows runners to advance and even score.

A remarkable degree of controversy surrounds the technique. It's reviled among many fans and analysts. Players capable of knocking the ball out of the park still consider it weak, an affront to their pride. Yet a successful bunt has often proven to be the deciding factor in a game.

"In the right circumstances, it's amazingly effective," Joe says.

His excitement grows as he describes the types of bunts, when they're used, and for what purpose.

One is of particular relevance to his own comeback story. "The sacrifice," he explains. "Stepping up to the plate, the player knows he's probably going to get out. But you see, he's doing it for the good of the team. If he does it right, his sacrifice will help his teammates advance, and maybe even score a run."

With that, Joe leans back in his chair, puts his hands behind his head and waits, deliberately heightening the drama. "I can tell from your faces," he says, "that you're wondering what in the hell this has to do with me getting my mojo back. Well," he says, "two things. Since most players look down on bunting, they don't practice it. They just wing it, getting up there and doing it when they're forced to by the coach during a game. And since when did winging something in the heat of the moment ever make you better at it? The other thing is, sometimes you've gotta sacrifice. You're not going to be the one who helps *that* client score, so you bunt. You have to have that hard conversation about moving on, practice having those hard conversations. Think of it this way, I strike out so my client can advance, get where they need to be."

Joe's story about bunting, as home-spun as it seems, fits squarely with research from the studies of super-shrinks. First, compared to average therapists, top performers spend two-and-a-half to four times *more* hours per week outside of work in activities specifically designed to improve their outcomes. Practice, practice, practice! This group is constantly working at their craft, intolerant of mere proficiency, always pushing beyond what they're already capable of doing. Second, highly effective therapists always have their "eyes on the prize." Just as a good batter is willing to use a sacrifice bunt for the good of the team, these clinicians are willing to remove themselves from a therapy for the good of the client.

Joe readily admits that as a therapist, his newfound appreciation for

CONTINUED ON PAGE 42

the humble art of bunting was hard won: the change it required in his philosophical outlook was far more difficult and time consuming than his story about baseball techniques would suggest. The same could be said of the entire agency where he worked. The place was in big trouble. Funding was being cut. Staff morale was sinking. They had a backlog of clients. Many started; fewer finished. The result was long waiting lists of people in need of service. The county mental health board was hammered with complaints from clients and referral sources, which, in turn, were heaped on agency directors and the clinical staff.

"Anyway, we're talking a few years back now. Some board member goes to a workshop and the word comes down: the solution to our problems is to measure outcomes, at every session! I remember thinking to myself, *How's that supposed to help? It's just another harebrained scheme. We're headed to hell in a handbasket.* With everything else we had on our plates, we didn't have enough time as it was." Right then and there, Joe decided he wasn't going to participate.

"Then," Joe recalls, "my boss asked me to join the planning team, the group that was going to make it happen. In no uncertain terms, I told him, 'No thanks.' But on the day of the first meeting, he came and got me! He refused to accept my refusal," Joe laughs.

His account of how his boss had to drag him to the planning session parallels Martin Seligman's report of what transpired in his famous experiments on learned helplessness. In that research, dogs that had previously learned they could do nothing to avoid a painful stimulus didn't try to flee when later given the opportunity. Instead, they gave up, refusing to move, merely whining in response. Recovery of their ability to act on their own behalf occurred only when the experimenters picked

the dogs up and physically moved their legs to simulate the actions necessary for escape.

"Truth is," Joe admits, his tone more serious, "I don't think I'd be here today if that hadn't happened, if my boss had let me be and not come and gotten me." When asked to describe this experience in greater detail, he continues, "I can't speak for everybody. You know, there was a lot of discouragement. Being involved, though, is what got me started, got us all going."

As early as 1996, researcher Laurie Anne Pearlman argued that any successful approach to burnout would need to address simultaneously causative factors operating at every level: individual, agency, and system. Such advice appeared more sophisticated than the traditional homilies about individual self-care, but it failed to yield practical solutions, much less effective ones. The basic message was simply that the problem was complex. And, as often happens when the definition of a problem is too broad and ambiguous, the all-too-human response was finger-pointing—finding someone or something specific to blame. Clinicians attributed the problem to their clients and work setting, administrators pointed back at clinicians and inadequate funding, and both groups griped about the system that set standards of care all agreed were absurd.

"From the beginning, it was a team effort," Joe says emphatically. He and his colleagues began using two simple measures at every visit: one to assess the quality of the work and the other the outcome of the service. Ample evidence indicates that this practice as much as doubles the probability of improvement by identifying clients at risk of dropout, deterioration, or a lack of progress. (Practitioners can review the empirical support, watch how-to videos, and access free copies of the evidence-based measures at whatispcoms.com.) "By measuring our outcomes," Joe opines, "we could see who we were helping and who we weren't."

Time was set aside to discuss clients not making progress or dissatisfied with the treatment approach or therapeutic relationship. Every aspect of the services offered was organized around outcome, including paperwork, supervision, flow of information within the organization, up to and including funders and the board. Of major importance is that it wasn't considered a problem when the measures showed, despite everyone's best efforts, that therapy wasn't working. There was no need for guilt or shame, no need to fix blame, or shift the burden of failure to the client. Instead, such occurrences were seen as an opportunity, a time to make a choice, to take action in the service of a larger objective, a higher order of caring.

"We all learned to do the sacrifice bunt!" Joe chuckled. "We'd trade cases or refer them out. And occasionally, we just plain stopped seeing them. Surprisingly, nothing bad happened. Actually, consumer complaints to our county mental health board declined dramatically. But the first time I did this, my oh my, was it painful. I'd seen this young woman 10 times. She'd gone away to a church camp for the summer and had a psychotic break. She ended up coming home early, couldn't tie two thoughts together, didn't want to leave the house, wasn't eating or sleeping much. She was so scared, and so was her family. Nothing like this had ever happened to them. I was the only one she'd talk to. She and her family knew me from church."

Leaning forward, he places his hands on his knees, "Believe me when I say, I tried. And I wanted to keep on trying, and I would have, but the measures showed, even though we had a good relationship, I wasn't helping. She knows this, because we look at the results every time we meet. Whenever I point it out though, she begs me not to stop. When I suggest changing therapists, she starts crying. I don't know how I did it, but I held my ground and stood by the need for a change, offering to sit in on the first appointment with the new thera-

pist.” Joe did, and the young women improved. Within a handful of visits, she was back at church. Eventually, she was her old self again.

Improving Joe’s “response-ability” with clients he wasn’t helping proved the turning point in recovering his heart for clinical work. Still, he emphasizes, it was only the start. “What’s kept me going since, every day, is working at getting better at what I do.”

Joe’s observation is echoed by the thousands of therapists around the world who participated in the multinational study by Orlinsky and Rønnestad cited earlier, the majority of whom cite professional development as both a key motivation for their work and a buffer against burnout.

“If you want to get better at anything, or any skill,” Joe says, “you’ve got to practice. These outcome measures enable me to see when I’m helping and when I’m not, which clients I connect with and the ones I don’t. Sometimes, the reasons remain a mystery, and I can’t tell what wasn’t working or what went wrong. Like that young woman, I’m still trying to figure that one out. But when the same problem creeps up again and again, then you know what it is, and you can work on it.”

A cultural shift is well under way at Joe’s agency. The committee he serves continues to explore ways to empower practitioners, to enhance choice and effectiveness. What’s happening in Joe’s setting is also taking place in others. “Our doors are open nearly 12 hours a day,” says Robbie Babins-Wagner, the director of the Calgary Counseling Center. “Apart from using outcome measures, our staff has the flexibility to schedule their work within a range of days and hours. They set their own schedules. If someone wants to see his child in the school play, he can! He should. It’s good for him, and it’s good for the agency.” She adds, “We’ve capped the number of hours our therapists can spend conducting therapy beyond which our out-


come data show a decline in effectiveness.” The results speak for themselves. Burnout is a thing of the past. Indicators such as staff turnover and number of sick days have declined dramatically. At the same time, the percentage of clients improved or recovered has increased 21 percent, deterioration rates have declined by a third, and the percentage of clients in therapy who experience no benefit has dropped.

In other words, being effective and improving over time are the best medicine for what ails the healer’s heart.

FULFILLMENT OF PURPOSE

In the February 2014 issue of the *Atlantic Monthly*, medical professor Richard Gunderman, writing on the causes of burnout, warned against seizing on obvious stressors to explain the problem. He was writing to medical students who, in a recent study, were found to be at significantly greater risk of emotional exhaustion, depersonalization, and diminished sense of personal accomplishment than age-matched peers. Students enter medicine, he observes, “Because they care, because people matter to them, and because they want to make a difference.” Long hours, financial uncertainty, rapidly changing and demanding practice environments aren’t the problem, he argues. Instead, the cause of burnout is “the sum total of hundreds and thousands of tiny betrayals of purpose, each one so minute that it hardly attracts notice.”

It’s equally true of therapists. We care. People matter to us. We want to make a difference. We’re dedicated to helping people overcome the problems that bring them to treatment, to make it possible for them to enjoy healthier, happier, more productive lives. In this effort, we place ourselves at risk whenever the boundary between what we’re there to accomplish becomes conflated with what we bring to the work. In the end, we don’t fulfill our purpose by providing caring, empathy, and compassion,

no matter how lovingly extended. We do fulfill our purpose, however, when we consistently engage in the kinds of therapeutic practices that objectively promote the client’s improvement. Further, genuinely and demonstrably helping people improve is the entire point of therapy and, in the end, the best of all ways to show that we really, deeply care. 

Scott Miller, PhD, is the founder of the International Center for Clinical Excellence, an international, web-based consortium of clinicians, researchers, and educators dedicated to promoting excellence in behavioral health services. He’s the coauthor or coeditor of eight books and numerous chapters, research studies, and popular articles. Contact: info@scottdmiller.com

Mark Hubble, PhD, is a national consultant and graduate of the postdoctoral fellowship in clinical psychology at the Menninger Clinic. He’s coauthored and coedited six books and is a senior advisor and founding member of the International Center of Clinical Excellence. Contact: raptor7@comcast.net.

Françoise Mathieu, MEd, CCC, is a certified mental health counsellor and compassion fatigue specialist with more than 20 years of experience in trauma and crisis intervention. She’s the director of Compassion Fatigue Solutions, Inc., and author of The Compassion Fatigue Workbook.

Tell us what you think about this article by emailing letters@psychnetworker.org. Want to earn CE credits for reading it? Visit our website and take the Networker CE Quiz.

BOOKLINK

A listing of the latest books of interest to *Networker* readers. Check online for direct link to book ordering information at

psychotherapynetworker.org/booklink