It's not the right way: *How deliberate practice can improve performance – An interview with Scott Miller*

Alex Millham

I remember the first time I met a family under live supervision during my family therapy training. I felt terrified being observed by an experienced supervisor and by my peers. My supervisor was clear and direct in what he asked me to do and, at times, I struggled to do it. I both hated this and loved it. It wasn't comfortable but I knew it was stretching me and that I was learning. More recently, I have thought about how easily, once qualified, we can slide into our comfort zone. When I heard Scott Miller, an American psychologist, refer to the idea of deliberate practise, I wondered if this might help clinicians maintain good practise. So, I sought an interview with him.

Alex: How did you come across the idea of deliberate practise?
Scott: My career now spans over twenty years, I can't quite believe it. Like many clinicians, I began by learning a particular model. I had a fairly privileged experience because I was able to work with two leading people in the US, Insoo Kim Berg and Steve de Shazer, in the development, research and dissemination of solution-focused therapy. I was with them for about five years. We practised in an environment of observation and feedback, trying to refine a particular method and to research that method. The upshot of this experience was that I learnt a method extremely well – not only how to deliver it but also how to attend to a variety of nuances in content and delivery.

Interestingly enough, the research demonstrated that this model was no more effective than any other model. I initially thought I'd spent all this time learning this model and I might as well have been studying psychodynamic therapy or cognitive behavioural therapy. My curiosity has always been about what works in therapy and how can I learn it? Finding that my techniques or my preferred theoretical orientation wasn't responsible for the outcomes, given the equivalence of outcomes across all approaches, caused me a great deal of concern. At the same time, it opened up an opportunity to interact with colleagues from different orientations and we began investigating common factors. The basic idea was that, since it wasn't the specific ingredients in these models that made a difference, perhaps all models shared a similar underlying grammar or structure. There's a whole area of research that dates back 70 years now about the common factors. It's not the dominant way of thinking, and it's certainly not the most popular. Most clinicians believe it is their technology that makes a difference.

The most neglected variable in outcome is the therapist

After researching the common factors and spending six years writing about it together with my colleague Mark Hubble, people would ask us, *"How do you do the common factors?"* This made me immediately aware that the common factors were a dead end and couldn't do what most clinicians needed, which was to tell them what to do so that they could be the most effective. Moreover, logically, if the common factors were applicable across models, you might just as well pick any model. We were back at square one and that wasn't satisfactory. So, it seemed to me at the time that, perhaps because the common factors were an empirical and a theoretical dead end, what we could do was simply measure outcomes. After all, the research showed that treatment did work, regardless of model. This led us to discover, or rediscover, that the most neglected variable in outcome is the therapist. We've investigated methods, we've investigated clients and their pathology, but we haven't turned our attention to the clinicians. And yet, the amount of variability attributable to the individual provider trumps technical factors by eight or nine times. We began to measure outcome and found that some clinicians were better than others – consistently better. We struggled with this for a while, watching videos and trying to figure out if there was some theoretical orientation they all had that made them different and better; none of that panned out. I was about to give up when, truthfully, I was on an airplane and had nothing to do. I was stuck in a middle seat in economy class right at the back of the plane. There was a magazine in my seat pocket; the *Fortune* magazine, containing an article by Geoff Colvin. He was the author of the book *Talent is Overrated* (2008) and he talked about Anders Ericsson.

What do top performers do differently?

It's at this point that the pieces of the puzzle began falling into place. Number one, we are on the right track studying individual variability between performers. We are trying to understand what the top performers do differently. There's a whole literature about what it is that makes some people excel versus others: in sports, in chess, in medicine, in music, in a variety of fields. So, that's what led us to the concept of deliberate practise. Most of us go to work every day and, perhaps surprisingly, given that we spend so much time at our jobs – more time than we spend with our families – most of us are only average at what we do. That's pretty disturbing. So, what do top performers do? The truth is, they practise in a different way. You hear people, myself included, talk about how they practise but, unfortunately, that kind of practise doesn't make them any better. For a while, people like Ericsson *et al.* (1993) and, more recently, Colvin (2008) and Shenk (2010), have been talking about deliberate practise. Deliberate practise means there is a different order to, and level of investment by, top performing folk that lead them to amass a knowledge that is different. It is more nuanced and contextualised and it certainly has more breadth than the average practitioner's. So, that's where the whole idea came from: that's the long way around.

It's not the right way

Alex: My next question is about how this applies to therapy. I once took singing lessons. I started at the most basic level and the teacher

would continually tell me it's about my breathing and about my posture. She would tell stories of her husband's friends. They were famous opera singers who would come for help and she would always say the same thing; "It's your breathing darling" or "You're not standing right". She was always clear about what they could do, but I'm not clear about what we can do about therapy?

Scott: Let me give you an example. I've been very close to therapy for some time. I've been doing it for twenty years. As a result, my memory of what has transpired in my professional life is clouded by what I think now as opposed to what probably happened. I picked up two hobbies to try to apply the principles I described earlier, to try and master an activity I have had no experience with. One of them is close-up magic and the other is the guitar. Let me talk first of the guitar. I found a teacher. He comes to my house once a week. At the very first lesson, he tells me, *"Here's how I want you to hold your hand on the neck of the guitar, this is the way I want you to hold it, whether you are at the top end of it or the bottom end"*. I say *"okay"* and then he adds, *"It's not the right way, it's my way. But if we establish a baseline way to perform, we can vary more effectively in the future when you begin to approach more difficult pieces of music"*.

Just think about this in therapy. You go to school and learn a particular model. It's not the right way; it's your starting point. You have to know that starting point well because, soon, you're going to have to depart from that starting point to accommodate different styles, different people. It's not the right way but, if we can agree on a baseline, then we can vary from the baseline and we can see if that variation leads to improvements in performance.

Find a model that you believe in

It's the same thing in psychotherapy; you have to start somewhere. Find a model that you believe in, that you have an affinity with, and start there. Get coaching, learn the standard protocol and do not do the nuances until you know that basic protocol inside out and in your sleep. On the guitar, for example, I've spent literally two months doing finger studies holding my hand in a very specific way. Not because it's the right way. Soon, I'll have to vary, depending on the music I want to play. Having a solid baseline ensures that the impact of any variation I introduce is easy to track and measure. In psychotherapy, you have to start somewhere. You have to start with a model. What you need to do is help clinicians make that first selection. Which models do you have an affinity with? Try a couple of them, first. But then, instead of continuing to survey, you should dive in to one of them. If you want to become great – although you don't have to become great, most people are satisfied with being good enough – but if you want to become a great clinician, learn it well. And then you'll need to get a coach who can help you to pay attention to nuances in the different environments in which you practise. You stick to that standard and then you vary from that standard, and then you need feedback and measurement. We need to see, did that variation you chose to introduce make a difference? So, I talk to therapists all the time and I hear, *"I went to that workshop and I tried that EMDR or that TFT thing, and it worked with one client and then not another"*. So they add it like spices on a spice rack but, mostly, what they do is never use that spice particularly well.

They continue to use salt and pepper, like everybody else, because they don't know when to use the other spices reliably.

Alex: My concern about becoming too eclectic is precisely what you spoke about just now; how do you choose what to do at what point. I often have a respect for people who are totally devoted to one

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model. Sometimes, they tend to be the leaders, the people that go out and teach, that are evangelical about a model. Most people in normal clinical practise are quite eclectic.

Scott: Yeah, that's right.

Alex: But, I wonder about people becoming too eclectic because of what you were saying before. They have the spice rack but they either throw spices in randomly or they try something for two months after going to a workshop, and then give up on it. So, I guess I'm thinking of two things: how do you stay great, and how do you choose what to use, when?

Get feedback, reflect on it, and make planned alterations

Scott: Well, the second one, lets start with that one first. How do you know what to do, when? The answer is time, practise and feedback. The longer you do that and push your realm of reliable performance, the broader your knowledge base becomes and the more aware of contextual clues you become. That allows you to access these experiences in working memory and to apply them appropriately. With most clinicians, they don't remember and they adhere to a particular approach or model. Now, adhering to a particular approach or model, we have learned from the research, doesn't make for good therapists, it makes for average therapists. Second, its not surprising to me that certain people are evangelical. Many leaders of the field promote a single model, but what we don't have any evidence for is that those people are any better at anything other that evangelising.

Alex: Yes, or presenting.

Scott: And you know, when I'm presenting, I'm very upfront. I say I've been tracking my outcomes for 10 years. I'm an average therapist. I can tell you my effect size. I know exactly what it is. But I consider

myself a good, a better than average presenter. And the reason for that is I spend huge amounts of time doing deliberate practise, getting feedback and reflecting on it, making strategies for how to improve my performance as a presenter. So, I have a very different approach to my work from which I actually make my living than I do to my clinical practise. Over time, you gain increasing knowledge because you are practicing deliberately and you are reflecting on it and you are making planned alterations from a known baseline.

No model of therapy is consistently associated with superior performance

Now, that's not sexy, that's the problem, and it's not romantic. It's much more sexy to think, I know the particular technique or wizardry I should use now; wave my fingers back and forward, tap on the clients face, reflect feelings, talk to an empty chair…. But the truth is, once again, we already know what those things lead to because we know that no model of therapy is consistently associated with superior performance. However, therapists are consistently associated – that is particular therapists – are consistently associated with superior performance.

We are a risk-averse error-phobic culture

Alex: Can you tell me more about what sets top therapists apart?

Scott: Well, this is an emerging area of research. What's amazing is that it is completely uncharted territory. I also believe that our field is fascinated with treatment models and being able to explain what they see in front of them rather than actually change what they see in front of them. I think, in general, life conspires against superior performance; it rewards average performance. The reason for that is we are a risk-averse, error-phobic culture. We would rather people not make mistakes than excel, so people consistently do that in their work environments, they take very few risks. One of the few studies right now that currently contribute to our understanding of the difference between top performers and average performers was done by Anderson *et al*. (2009), last summer. They looked at 25 therapists; they charted their outcomes. I don't remember how many clients. Of course, there was a range from low to high in terms of therapists' outcomes. The therapists' facilitative interpersonal skills (FIS) were measured by placing clinicians in a set situation where they saw a brief clinical vignette and had to type in, not what they thought was going on but, what they would do next. The quality of those responses were rated from low to high.

What they found is that social skills have no correlations with outcome; age has no correlation with outcome; experience doesn't have any correlation with outcome: what correlates with outcome is knowledge, meaning that the more situations the therapist was able to respond to, adequately, the better their outcomes were. Now, that just seems axiomatic; the problem is that most therapists think they respond adequately and, in many instances, they simply don't and they also don't know it. This leads them to continue to believe what they've always believed.

Alex: So there's something very important about stepping out of your comfort zone and moving all the time.

Scott: That's another reason why people, including me – I'm including me in this – just don't do it. I'm learning the guitar and, right now, when I think about going up there to practise, I don't really like it; you know, I'm not a rock star; I can't even play the children's song, hot-cross-bun.

Alex: You're reminding me of two things from my training. One was from my family therapy training where my supervisor would push me considerably out of my comfort zone, again and again. I knew he knew better than me, but it was tough. More recently, I did some training and work in multi-family therapy and, again, that shifted me right out of my comfort zone. In my career, I had that happen right at the outset and I had it happen again a bit with the multi-family therapy experience but, continuing to do it at other times has been very hard.

Scott: Now, you've mentioned one of the key things. I watch these young kids, 12 and 13 year olds, and the riffs they can do on their guitar, it's astonishing. An average person wouldn't be able to tell the difference between the 12-year old and Eddie Van Halen. So, how is that possible? Well, what kind of responsibilities does a 12 year old have? They can sit at home all day, in their room, practicing their guitar, hanging out. In the mean time, you, me and the rest of the world go to work every day, we're tired, we're fixing meals, we're worrying about the bills, and what we really want to do is, you know, have a beer, talk to our partner and "veg out" a bit.

Deliberate practise needs to be integrated into the daily workflow

I think the key in moving forward, is helping therapists improve, because it's not about necessarily being the best therapist on the planet; what it is about is consistently pushing you to do better. Now, that's something I want to do and something most people want to do. In order to make that happen, deliberate practise needs to be integrated into the daily workflow. If its not part of the daily workflow, people like you and me just won't be able to do it.

Alex: It's the same with exercise, isn't it?

Scott: It is the same idea, which, if you look at some businesses, like Compuware in Michigan, they have exercise facilities right on location. Their staff can go there any time they like for exercise. Plus, if they do go and exercise, they get some decrease in the amount they have to pay for their health insurance. What does management get for this? They get happier employees; employees that stay longer and are more productive, healthier and take less sick days. Most agencies and groups don't think like that. Again, it is an error-phobic rather than error-centric, and thinking that productivity comes about by measuring how long people are at their desk.

Alex: Yes, and I was thinking about the conventional ways of remaining good at your practise. These are to continue to do training and to have supervision. Both of which could be useful but they may have a limited effect.

Scott: Well, you know, I challenge you to find any research supporting supervision and I'm a fan of supervision. I just think the people promoting it just haven't done their job, and the supportive empirical literature is just so weak. So, yes, I think that it could be part of it, but supervision, as an exercise, is more of a tradition than it is a practise and one that we know from the evidence actually does little to improve much of anything.

Alex: But you were also saying that, if you have somebody who is an expert and knows these things, they could help you continue to challenge yourself.

Scott: They can. With most supervision that I see, the clinician gets to choose a case and they go and they talk about it, either in a group or with a supervisor. To me, this has none of the qualities of deliberate practise or helpful feedback. Feedback has to be delivered in a timely fashion. It has to be task specific, and it actually has to be tied to behaviour. We're so far removed from that in a traditional supervision. So, I'll give you an example. I'll go in with my laptop to an agency that is using our outcome tools (I hope this doesn't sound

dire). I'll ask, *"Which clients are you struggling with right now?"* And they'll list a group they want to talk about that day. However, when I look at the outcome data, very seldom is there a single person the staff are struggling with that is listed in the data set as problematic. In other words, the client is making progress but the therapist has some other difficulty with them and vice versa. There are lots of clients in the data set that are in big trouble outcome-wise – and the therapist is missing them.

Alex: Right, so we are poor judges of who to bring to supervision first off?

Scott: Which is going to defeat the whole purpose. Now, in most situations, not all but most, supervision has been ideologically driven. As I said earlier, I'm not against people owning a model, but ideology means that I bring the cases and I discuss them within the framework of the particular treatment approach. Now, that's very different from my experience of being observed by Steve de Shazer in 1988 and him calling in on the phone to me and saying, *"Scott, lean back in your chair when you ask questions"*. It's task specific. He rings in ten minutes later and he says, *"LEAN BACK IN THE GOD DAMN CHAIR"*. He calls back a third time and he says, *"If you don't lean back in the chair, I'm going to duct-tape you to the chair"*. It was very specific feedback and I think it really made a difference in my own practise. That is just a minor example; most clinicians have had a similar experience with a supervisor. The point is that it was timely, it was deliberate, it was task-focused, and we can measure the immediate outcome of it in the presence of a much more skilled supervisor.

Psychotherapy is living in the Stone Age

Alex: Which begs the question for me about family therapy. Family therapy is therefore maybe on a better footing because it tends to promote live supervision or use of video feedback.

Scott: In terms of learning a model well, I think they are light years ahead. Probably, the best example of supervision I have ever seen is the motivational interviewing group. I think the network Bill Miller and his colleagues (Miller & Rollnick, 2002) have set up is light years ahead of where any other model is in terms of training. They routinely evaluate; they have a very well developed and task specific feedback system; their trainings are a short amount of content followed by a great deal of practise in an environment where feedback is delivered. It's very different from most experiences. You know, I blogged, and you probably saw this as well if you saw the others, about the state of the art in terms of continuing education. The current head of continuing education in the American Psychological Association has now written three articles, or maybe even more, where he basically shows there is no evidence that the current way we require continuing education of professionals, professional development, has any impact what-so-ever. Medicine has gone in a different direction; music and education have gone in a different direction; psychotherapy is still living in the Stone Age.

Alex: Maybe that's a good place to finish, that's quite a catchy note to end on. [Scott laughs]

Alex: Is there anything else you think it might be important to say on this?

Scott: I guess the only other thing to say is that I am very hopeful. You know, some of my comments may seem very derisive, but only of the status quo. The important thing is that clinicians, in general, do very good work. But they could do better, and the way we've set up most of our training programs just doesn't capture or utilise the most current data. It is so exciting to be part of something different.

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Alex: Yes, that contrasts to what's happening in the British context: we are continually being told to use particular models with particular problems, which is the opposite of what you're talking about, isn't it?

Scott: Yes.

Alex: The NICE guidelines. I'm sure you are familiar with these.

Scott: Yes, and if you look on my blog, I blogged about NICE last night and, to me, these guidelines are driven by allegiances. There is nothing wrong with CBT. What is wrong is assuming that it's what is responsible for the outcome. We now know it's not.

Alex: The other thing that resonated for me in what you just said is that the whole process is risk-averse.

Scott: Yeah, that's exactly right. Yeah.

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