Chapter 16
Feedback-Informed Treatment (FIT): Improving the Outcome of Psychotherapy One Person at a Time

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> It is the big choices we make that set our direction. It is the smallest choices we make that get us to the destination.
>
> Shad Helmstetter

In the field of psychotherapy a "great debate" is raging about how to improve quality and outcome (Wampold, 2001). On one side are those who hold that behavioral health interventions are similar to medical treatments (Barlow, 2004). Therapies work, they believe, because like penicillin they contain specific ingredients remedial to the disorder being treated. Consistent with this perspective, emphasis is placed on diagnosis, treatment plans, and adherence to so-called validated treatments (Chambless & Ollendick, 2001; Huppert, Fabbro, & Barlow, 2006; Siev, Huppert, & Chambless, 2009). The "medical model," as it is termed, is the dominate view of how psychotherapy works. It is arguably the view held by most people who seek behavioral health treatment.

On the other side of the debate are those who maintain that psychotherapy, while demonstrably effective, is incompatible with the medical view (Duncan, Miller, Wampold, & Hubble, 2010; Hubble, Duncan, & Miller, 1999; Wampold, 2001). Proponents of what has been termed the "contextual" perspective highlight the lack of evidence for differential effectiveness among the 250 competing psychological treatments, suggesting instead that the efficacy of psychotherapy is more parsimoniously accounted for by a handful of curative factors shared by all, chief among them being extratherapeutic phenomena, the therapeutic relationship, hope and expectancy, and model and structure (Hubble et al., 1999; Lambert, 1992).

The challenge for practitioners, given the sharply diverging points of view and dizzying array of treatments available, is knowing what to do, when to do it, and with whom? Thankfully, recent developments are on track to providing an empirically

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robust and clinically feasible answer to the question of "what works for whom?" Based on the pioneering work of Howard, Moras, Brill, Martinovich, and Lutz (1996) and others (c.f., Brown, Dreis, & Nace, 1999; Duncan et al., 2010; Lambert, 2010b; Miller, Duncan, Sorrell, & Brown, 2005), this approach transcends the "medical versus contextual" debate by focusing on routine, ongoing monitoring of engagement in and progress of therapy (Lambert, 2010a). Such data, in turn, are utilized to inform decisions about the kind of treatment offered, and improving quality by providing valid and reliable data about when to continue, modify, or even end services.

Multiple, independent randomized clinical trials now show that formally and routinely assessing and discussing clients' experience of the process and outcome of care effectively doubles the rate of reliable and clinically significant change, decreases dropout rates by as much as 50 %, and cuts deterioration rates by one-third (Miller & Schuckard, 2013). The process known as feedback-informed treatment (FIT) is a six sigma, quality improvement methodology specifically designed for application to behavioral health service delivery. In February 2013, the approach was listed on the Substance Abuse and Mental Health Service Administration's National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=249).

In the sections that follow, detailed instructions and examples are given for incorporating FIT into clinical practice. All practitioners, whether aligned primarily with the medical or contextual views of psychotherapy, can benefit, using the information generated by the process to improve service delivery, one client at a time.

Why Feedback Matters?

> The proof of the pudding is in the eating.
>
> Cervantes, *Don Quixote*

FIT is based on several well-established findings from the outcome literature. The first is psychotherapy works. Studies dating back over 30 years document that the average treated person is better off than 80 % of the untreated sample in most studies (Duncan et al., 2010; Smith & Glass, 1977; Wampold, 2001). Second, the general trajectory of change in successful treatment is predictable, with the majority of progress occurring earlier rather than later (Brown et al., 1999; Hansen, Lambert, & Forman, 2002). Third, despite the proven efficacy of psychotherapy, there is considerable variation in both the engagement in and outcome of individual episodes of care. With regard to the former, for example, available evidence indicates that as many as 50 % of those who initiate treatment drop out before achieving a reliable improvement in functioning (Garcia & Weisz, 2002; Kazdin, 1996; Swift & Greenberg, 2014; Wierzbicki & Pekarik, 1993). Of greater concern, Lambert (2010a), reviewing outcomes obtained in routine clinical settings, found that a mere 15 % of those treated met criteria for "recovered" status at termination of services. Fourth, significant differences in outcome exist between practitioners. Indeed, a large body of evidence shows that "*who*" provides a treatment contributes five to nine times more to outcome than "what"

particular treatment is offered (Miller, Hubble, Chow, & Seidel, 2013; Miller, Hubble, & Duncan, 2007; Wampold, 2005). Such findings indicate that people seeking treatment would do well to choose their provider carefully as it is the therapist—*not* the treatment approach—that matters most in terms of results. Fifth, and finally, a hefty portion of the variability in outcome among clinicians is attributable to the therapeutic alliance. In a study involving 80 clinicians and 331 clients, for example, Baldwin, Wampold, and Imel (2007) found that differences in the alliance accounted for a staggering 97 % of the variability in outcomes among therapists. By contrast, client variability in the alliance was found to be "unrelated to outcome" (p. 842).

Taken together, the foregoing results indicate that real-time monitoring and utilization of outcome and alliance data can improve quality and outcome by maximizing the "fit" between client, therapist, and treatment. Simply put, with so many factors at play influencing outcome at the time of service delivery, it is simply impossible to know a priori what treatment or treatments delivered by a particular therapist will reliably work with a specific client. Regardless of discipline or theoretical orientation, clinicians must determine if the services being offered are working and adjust accordingly.

Two simple scales that have proven useful for monitoring the status of the relationship and progress in care are the *Session Rating Scale* (SRS [Miller, Duncan, & Johnson, 2000]), and the *Outcome Rating Scale* (ORS, [Miller & Duncan, 2000]). The SRS and ORS measure alliance and outcome, respectively. Both scales are short, four-item, self-report instruments that have been tested in numerous studies and shown to have solid reliability and validity (Miller & Schuckard, 2013). Most importantly perhaps, the brevity of the two measures insures that they are *feasible* for use in everyday clinical practice. After having experimented with other tools, the developers, along with others (i.e., Brown et al., 1999), found that "any measure or combination of measures taking more than five minutes to complete, score, and interpret are less likely to be used by clinicians and increase the likelihood of complaints by consumers" (Bargmann & Robinson, 2012, p. 18). Indeed, available evidence indicates that routine use of the ORS and SRS is high compared to other, longer measures (99 % versus 25 % at 1 year [Miller, Duncan, Brown, Sparks, & Claud, 2003]).

Administering and scoring the measures is simple and straightforward. The ORS is administered at the beginning of the session. The scale asks consumers of therapeutic services to think back over the prior week (or since the last visit) and place a hash mark (or "x") on four different lines, each representing a different area of functioning (e.g., individual, interpersonal, social, and overall well-being). The SRS, by contrast, is completed at the end of each visit. Here again, the consumer places a hash mark on four different lines, each corresponding to a different and important quality of the therapeutic alliance (e.g., relationship, goals and tasks, approach and method, and overall). On both measures, the lines are 10 cm in length. Scoring is a simple matter of determining the distance in centimeters (to the nearest millimeter) between the left pole and the client's hash mark on each individual item and then adding the four numbers together to obtain the total score.

Versions of the scales are available for adults, adolescents, and children, in a number of different languages at no cost to individual practitioners at http://www.centerforclinicalexcellence.com/measures/. Additionally, a growing number of computer-based

applications are available which can simplify and expedite the process of administering, scoring, interpreting, and aggregating data from the scales. Such programs include Web-based outcome management systems (e.g., fit-outcomes.com, myoutcomes.com, pragmatictracker.com), smartphone apps (TOMS: Therapeutic Outcomes Management System, M2FIT), and Web services designed for integration into electronic health records (e.g., OpenFIT). Detailed descriptions of the other applications can be found online at www.scottdmiller.com.

Creating a "Culture of Feedback"

> My priority is to encourage openness and a culture that is willing to acknowledge when things have gone wrong.
>
> John F. Kennedy

Of course, soliciting clinically meaningful feedback from consumers of therapeutic services requires more than administering two scales. Clinicians must work at creating an atmosphere where clients feel free to rate their experience of the process and outcome of services: (1) without fear of retribution, and (2) with a hope of having an impact on the nature and quality of services delivered.

Interestingly, empirical evidence from both business and healthcare demonstrates that consumers who are happy with the way *failures* in service delivery are handled are generally *more* satisfied at the end of the process than those who experience no problems along the way (Fleming & Asplund, 2007). In one study of the ORS and SRS involving several thousand "at-risk" adolescents, for example, effectiveness rates at termination were 50 % higher in treatments where alliances "improved" rather than were rated consistently "good" over time. The most effective clinicians, it turns out, consistently achieve *lower* scores on standardized alliance measures at the outset of therapy, thereby providing an opportunity to discuss and address problems early in the working relationship—a finding that has now been confirmed in numerous independent samples of real-world clinical samples (Miller et al., 2007).

Beyond displaying an attitude of openness and receptivity, creating a "culture of feedback" involves taking time to introduce the measures in a thoughtful and thorough manner. Providing a rationale for using the tools is critical, as is including a description of how the feedback will be used to guide service delivery (e.g., enabling the therapist to catch and repair alliance breaches, prevent dropout, correct deviations from optimal treatment experiences). Additionally, it is important that clients who trust the therapist will not be offended or become defensive in response to feedback given. Instead, therapists must take client's concerns regarding the treatment process seriously and avoid the temptation to interpret feedback clinically. When introducing the measures at the beginning of a therapy, the therapist might say:

> (I/We) work a little differently at this (agency/practice). (My/Our) first priority is making sure that you get the results you want. For this reason, it is very important that you are involved in monitoring our progress throughout therapy. (I/We) like to do this formally by using a short paper and pencil measure called the Outcome Rating Scale. It takes about a

> minute. Basically, you fill it out at the beginning of each session and then we talk about the results. A fair amount of research shows that if we are going to be successful in our work together, we should see signs of improvement earlier rather than later. If what we're doing works, then we'll continue. If not, however, then I'll try to change or modify the treatment. If things still don't improve, then I'll work with you to find someone or someplace else for you to get the help you want. Does this make sense to you? (Bargmann & Robinson, 2012)

At the end of each session, the therapist administers the SRS, emphasizing the importance of the relationship in successful treatment *and* encouraging negative feedback:

> I'd like to ask you to fill out one additional form. This is called the Session Rating Scale. Basically, this is a tool that you and I will use at each session to adjust and improve the way we work together. A great deal of research shows that your experience of our work together—did you feel understood, did we focus on what was important to you, did the approach I'm taking make sense and feel right—is a good predictor of whether we'll be successful. I want to emphasize that I'm not aiming for a perfect score—a 10 out of 10. Life isn't perfect and neither am I. What I'm aiming for is your feedback about even the smallest things—even if it seems unimportant—so we can adjust our work and make sure we don't steer off course. Whatever it might be, I promise I won't take it personally. I'm always learning, and am curious about what I can learn from getting this feedback from you that will in time help me improve my skills. Does this make sense? (Bargmann & Robinson, 2012)

Integrating Feedback into Care

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

In 2009, Anker, Duncan, and Sparks published the results of the largest randomized clinical trial in the history of couple therapy research. The design of the study was simple. Using the ORS and SRS, the outcomes and alliance ratings of 200 couples in therapy were gathered during each treatment session. In half of the cases, clinicians received feedback about the couples' experience of the therapeutic relationship and progress in treatment; in the other half, none. At the conclusion of the study, couples whose therapist received feedback experienced twice the rate of reliable and clinically significant change as those in the non-feedback condition. Even more astonishing, at follow-up, couples treated by therapists not receiving feedback had nearly twice the rate of separation and divorce!

What constituted "feedback" in the study? As in most studies to date (c.f., Miller & Schuckard, 2013), the feedback was very basic in nature. Indeed, when surveyed, *none* of the clinicians in the study believed that it would make a difference as *all* stated that they already sought feedback from clients on a regular basis. That said, two kinds of information were made available to clinicians: (1) individual client's scores on the ORS and SRS compared to the clinical cutoff for each measure, and (2) clients' scores on the ORS from session-to-session compared to a computer-generated "expected treatment response" (ETR).

Integrating the Clinical Cutoff into Care

Beginning with the clinical cutoff on the SRS, scores that fall at or below 36 are considered "cause for concern" and should be discussed with clients *prior* to ending the session. Large normative studies to date indicate that fewer than 25 % of people score below the cutoff at any given point during treatment (Miller & Duncan, 2004). Single-point decreases in SRS scores from session to session have also been found to be associated with poorer outcomes at termination—even when the total score consistently falls above 36—and should therefore be addressed with clients (Miller et al., 2007). In sum, the SRS helps clinicians identify problems in the alliance (i.e., misunderstandings, disagreement about goals and methods) early in care, thereby preventing client dropout or deterioration.

Consider the following example from a recent, first session of couples therapy where using the SRS helped prevent one member of the dyad from dropping out of treatment. At the conclusion of the visit, the man and woman both completed the measure. The scores of two diverged significantly, however, with the husband's falling below the clinical cutoff. When the therapist inquired, the man replied, "I know my wife has certain ideas about sex, including that I just want sex on a regular basis to serve my physical needs. But the way we discussed this today leaves me feeling like some kind of 'monster' driven by primitive needs." When the therapist asked how the session would have been different had the man felt understood, he indicated that both his wife and the therapist would know that the sex had nothing to do with satisfying primitive urges but rather was a place for him to feel a close, deep connection with his wife as well as a time he felt truly loved by her. The woman expressed surprise and happiness at her partner's comments. All agreed to continue the discussion at the next visit. As the man stood to leave, he said, "I actually don't think I would have agreed to come back again had we not talked about this—I would have left here feeling that neither of you understood how I felt. Now, I'm looking forward to next time."

Whatever the circumstance, openness and transparency are central to successfully eliciting meaningful feedback on the SRS. When the total score falls below 36, for example, the therapist can encourage discussion by saying:

> Thanks for the time and care you took in filling out the SRS. Your experience here is important to me. Looking at the SRS gives me a chance to check in, one last time, before we end today to make sure we are on the same page—that this is working for you. Most of the time, about 75 % actually, people score 37 or higher. And today, your score falls at (a number 36 or lower), which can mean we need to consider making some changes in the way we are working together. What thoughts do you have about this?

When scores have decreased a single point compared to the prior visit, the clinician can begin exploring the possible reasons by stating:

> Thanks so much for being willing to give me this feedback. As I've told you before, this form is about how the session went; and last week (using the graph to display the results), your marks totaled (X). This week, as you can see, the total is (X – 1). As small as that may seem, research has actually shown that a decrease of a single point can be important. Any ideas about how today was different from prior visits and what, if anything, we may need to change?

Finally, when a particular item on the SRS is rated lower compared to the other items, the therapist can inquire directly about that item regardless of whether the total score falls below the cutoff:

> Thanks for taking this form so seriously. It really helps. I really want to make sure we are on the same page. Looking at the SRS gives me a chance to make sure I'm not missing something big or going in the wrong direction for you. In looking over the scale, I've noticed here (showing the completed form to the client), that your mark on the question about "approach and method" is lower compared to the others. What can you tell me about that?

When seeking feedback via the SRS, it is important to frame questions in a "task-specific" manner. Research shows, for example, that people are more likely to provide feedback when it is not perceived as a criticism of the *person* but rather about specific behaviors (Coyle, 2009; Ericsson, Charness, Feltovich, & Hoffman, 2006). In addition, instead of inquiring generally about how the session went or how the client felt about the visit, the therapist should frame questions in a way that elicits concrete, specific suggestions for altering the type, course, and delivery of services:

- "Did we talk about the right topics today?"
- "What was the least helpful thing that happened today?"
- "Did my questions make sense to you?"
- "Did I fail to ask you about something you consider important or wanted to talk about but didn't?"
- "Was the session too (short/long/just right) for you?"
- "Did my response to your story make you feel like I understood what you were telling me, or do you need me to respond differently?"
- "Is there anything that happened (or did not happen) today that would cause you not to return next time?

On the ORS, the clinical cutoff is 25 and represents the dividing line between clinical (above) and scores considered nonclinical (below) (Bargmann & Robinson, 2012). Importantly, clients who score below 25 are likely to show measured benefit from treatment while those falling above 25 at intake are *less* likely to show improvement and are, in fact, at higher risk of deterioration in care. With regard to the latter, available evidence indicates that between 25 and 33 % of people presenting for treatment score *above* the clinical cutoff at intake (Bargmann & Robinson, 2012; Miller & Duncan, 2004; Miller et al., 2005).

The most common reason given by clients for scoring above the clinical cutoff at the first visit is that someone else sent them to or believes they need treatment (e.g., justice system, employer, family member, partner). In such instances, the client can be asked to complete the ORS *as if* they were the person who sent them. Time in the session can then be usefully spent on working to improve the scores of the "concerned other." A recent session with a man referred for "counseling" by his physician illustrates how this process can work to build an alliance with people who are mandated into care.

Briefly, the man's score on the ORS at the initial session was 28, placing him above the cutoff and in the nonclinical or "functional" range of scores. The therapist plotted the scores on a graph saying, "As you can see, your score falls above this dotted line, called the clinical cut-off. People who score above that line are scoring

more like people who are not in treatment and saying life is generally pretty good." The man nodded his head in agreement. "That's great," the therapist said without hesitation, "Can you help me understand why you have come to see me today then?"

"Well," the man said, "I'm OK, but *my family*—and my wife in particular—have been complaining a lot, about, well, saying that I drink too much."

"OK, I get it," the therapist responded, "*they* see things differently than you." Again, the man nodded in agreement. The therapist quickly responded with a request, "Would you mind filling this in one more time then, as if you were your wife and family?" When the items on the ORS were added up, the total had dropped to 15—well below the clinical cutoff.

Using a different colored pen, the therapist plotted the "collateral score" on the graph. Pointing to the man's score, the therapist said, "You're up here, at 28," and then continued, "but your family, they have a different point of view."

"Exactly," the man said, nodding his head and signaling agreement. When the therapist then asked what it would take for the score of his wife and family to go up, the first words out of the man's mouth were, "I'd definitely have to cut down the drinking …," followed by a lengthy and engaged conversation regarding the family's concern about driving while intoxicated and the man's frequent inability to recall events after a night of heavy alcohol consumption.

Another common reason for scores falling above the clinical cutoff at intake is that the client wants help with a very specific problem—one that does not impact the overall quality of life or functioning but is troubling nonetheless. Given the heightened risk of deterioration for people entering treatment above the clinical cutoff, clinicians are advised against "exploratory" and "depth-oriented" work. The best approach, in such instances, is a cautious one, using the least invasive and intensive methods needed to resolve the problem at hand (Miller & Bargmann, 2011; Tilsen, Maeschalck, Seidel, Robinson, & Miller, 2012).

Finally, less frequent, although certainly not unheard-of, causes for high initial ORS scores include (1) high-functioning people who want therapy for growth, self-actualization, and optimizing performance, and (2) people who may have difficulties reading and writing or who have not understood the meaning or purpose of the measure. In the latter instance, time can be taken to explain the measure and build a "culture of feedback" or, in the case of reading or language difficulties, a standardized, oral version is available. For high-functioning people, a strength-based, coaching-type approach focused on achieving specific, targeted, and measurable goals is likely to be most helpful while simultaneously minimizing risks of deterioration (Bargmann & Robinson, 2012).

Integrating the Expected Treatment Response (ETR) into Care

In addition to the clinical cutoff, clinicians in the couple study, as indicated above, received feedback comparing a client's score on the ORS to a computer-generated "expected treatment response" (ETR). As researchers Wampold and Brown (2005) have observed, "Therapists are not cognizant of the trajectory of change of patients

(sic) seen by therapists in general … that is to say, they have no way of comparing their treatment outcomes with those obtained by other therapists" (p. 9). Using the largest normative sample to date, including 427,744 administrations of the ORS, 95,478 episodes of care delivered by 2354 providers, a set of algorithms were developed for plotting progress in successful and unsuccessful treatment episodes using ORS scores (Miller, 2011; Owen et al., in press). Comparing an individual client's scores to the ETR enables clinicians to identify those at risk for a null or negative outcome at a time when altering, augmenting, or even referring to other services (or providers) can improve the chances of success (see Fig. 16.1).

In the study by Anker, Duncan, and Sparks (2009) reviewed earlier, participating clinicians used a simple table to determine the ETR for each client. Computer-generated ETRs are available in electronic format in the computer-based applications mentioned above.

So how can clinicians integrate the ETR into their day-today practice with clients? Progress falling short of the ETR should prompt discussion focused on identifying barriers and developing a plan for altering or augmenting services in order to bring about the desired change. Consider the following discussion between a clinician and a 20-year-old female being treated for depression. Two years prior to their first meeting, the client's mother died unexpectedly from a brain hemorrhage. At the initial session, the woman scored 15.4 on the ORS—well below the clinical cutoff. For the first three sessions, the therapist focused on grief, assuming that it

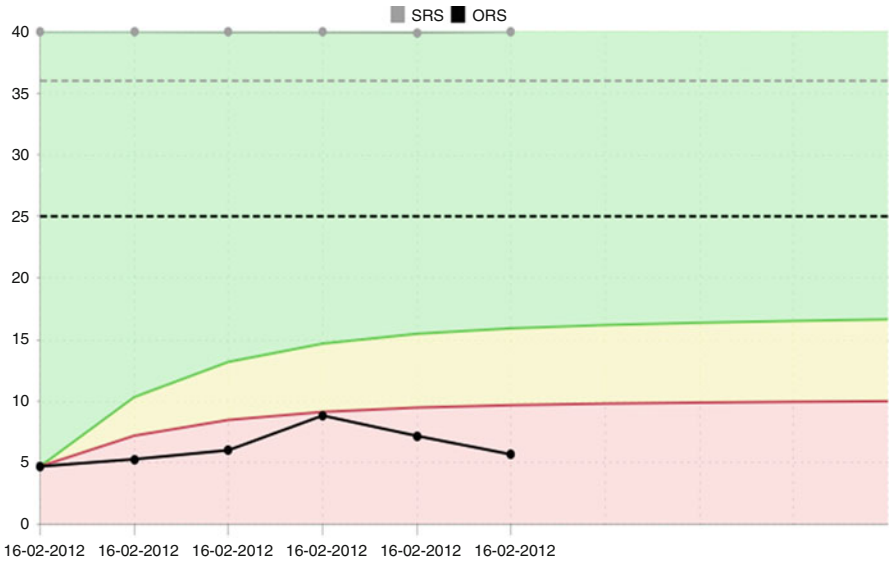

Fig. 16.1 The *green area* represents successful outcomes; the *red area* represents unsuccessful outcomes. The *solid black line* represents actual session-by-session ORS scores (screenshot courtesy of www.fit-outcomes.com) (Color figure online)

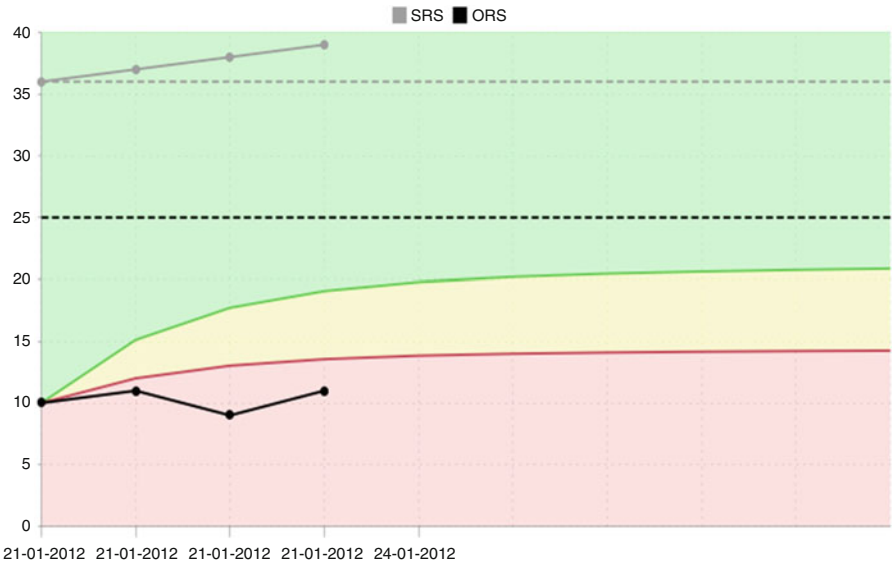

Fig. 16.2 The *dotted lines* on the graph (on 25 and 36) represent the clinical cutoff for the ORS and the alliance cutoff for the SRS. The *green area* represents the expected treatment response (ETR) for a successful treatment episode. The *solid black line* represents the client's actual ORS scores. The *solid gray line* denotes SRS scores from session to session (screenshot courtesy of: www.fit-outcomes.com) (Color figure online)

was at the core of the woman's depression. As can be seen in Fig. 16.2, SRS scores improved with each visit, leading the clinician to believe that the therapeutic alliance was strong. Despite this, ORS scores remained unchanged. Using the ETR as a guide, the therapist initiated a conversation with the client near the beginning of the fourth visit.

T: Looking at your graph, it seems that despite talking about your mother, you're not feeling any better than when we started. Is that right?
C: Yeah, these feelings … they won't go away.
T: (Pointing to the ETR) You can see that your scores fall below this red line here …
C: (Nodding) Mmm huh.
T: The green line shows where we should be …. any thoughts about that?
C: Well, actually, yes.
T: Can you share them with me?
C: Well … I'm just not sure this is all about my mom.
T: Really? The problem may lie elsewhere?
C: (Nodding affirmatively). I mean, of course, I'm very sad about my mom …
T: Sure …
C: (Nodding) … but …

T: … you're thinking there's something else, something we haven't addressed here or talked about?
C: (Nodding) … I'm sad about my Mom, and I think I'm going to be sad for a long time … but I think the real problem, what I really need to work on … is stuff that's going on right now … not the past (long pause).
T: Wow. I'm grateful you're telling me this … so, what is it? Can you tell me?
C: Well … I just really unhappy about living at home … with my Dad.
T: Uh huh …
C: He doesn't seem to really care about me. It's like there's nobody who cares about me now, and that hurts (crying).

The client went on to explain how her father had changed following the death of her mother. Once warm and loving, he had become distant and cold. By the end of the visit, an agreement was made to invite the client's father into the sessions. Scores on the SRS were slightly higher than in previous visits. Over the next few sessions together with the father, the woman's scores on the ORS began moving up, approaching and then slightly exceeding the green line. In sum, the ETR prompted an open and transparent dialogue about the lack of progress and exploration of alternatives. In this instance, altering the focus of services—a component of the therapeutic relationship—resulted in progress in subsequent sessions.

From Feedback to Continuous Practitioner Improvement

> Experts are always made not born.
>
> K. Anders Ericsson

As effective as feedback has proven to be for improving the outcome of individual episodes of care, available evidence indicates that it is not sufficient for generating continuous practitioner improvement. de Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) found, for instance, that not all therapists benefit from feedback. In addition, Lambert reports that practitioners do not get better at detecting when they are off track or their cases are at risk for dropout or deterioration, despite being exposed to "feedback on half their cases for over three years" (Miller, Duncan, & Hubble, 2004, p. 16). In sum, it appears that feedback functions like a GPS, pointing out when the driver is off track and even suggesting alternate routes while not necessarily improving overall navigation skills or knowledge of the territory and, at times, being completely ignored.

True quality improvement will only occur when practitioners continuously learn from the feedback they receive. Such learning requires an additional step: engaging in deliberate practice (Ericsson, 1996, 2009; Ericsson et al., 2006; Ericsson, Krampe, & Tesch-Romer, 1993). Deliberate practice means setting aside time for reflecting on feedback received, identifying where one's performance falls short, seeking guidance from recognized experts, and then developing, rehearsing, executing, and evaluating a plan for improvement. In addition to helping refine and extend specific skills, engaging

in prolonged periods of reflection, planning, and practice engenders the development of mechanisms enabling performers to use their knowledge in more efficient, nuanced, and novel ways than their more average counterparts (Ericsson & Staszewski, 1989).

Results from numerous studies across a variety of professional domains (e.g., sports, chess, business, computer programming, teaching, medicine and surgery) document the effect of deliberate practice on improving performance (Charness, Tuffiash, Krampe, Reingold, & Vasyukova, 2005; Duckworth, Kirby, Tsukayama, Berstein, & Ericsson, 2011; Ericsson et al., 1993; Keith & Ericsson, 2007; Krampe & Ericsson, 1996; Starkes, Deakin, Allard, Hodges, & Hayes, 1996). Chow et al. (2015) conducted the only study on the subject to date in the field of behavioral health. Using a sample of practitioners working in real-world settings, the researchers found, consistent with other studies, that therapist age, gender, years of experience, professional degree or certification, caseload, and theoretical approach were not significant predictors of effectiveness (Beutler et al., 2004). By contrast, the average number of hours clinicians spent in solitary practice outside of work targeted at improving therapeutic skills was a significant predictor of clinician effectiveness. As seen in Fig. 16.3, the top quartile of

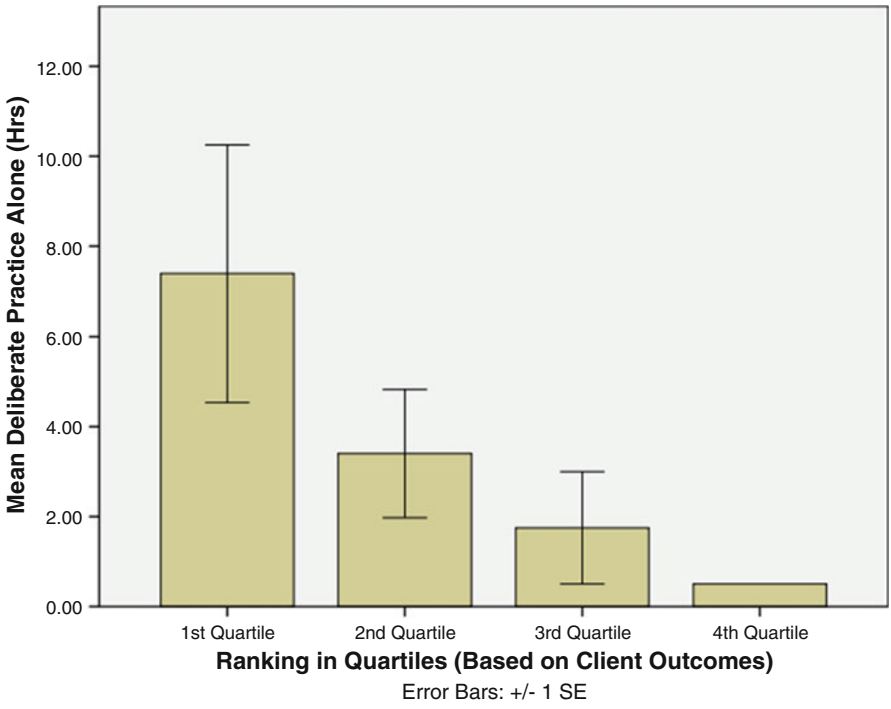

Fig. 16.3 Therapists grouped in quartiles based on their adjusted client outcomes as a function of estimated time spent on "deliberate practice alone" per typical work week. *Note*. Groupings of therapists were based on the ranking of the complete cohort from an initial study. Two out of the 17 therapists in Study II did not complete this part of the questionnaire. Number of therapists in quartile grouping: first quartile = 7; second quartile = 5; third quartile = 2; fourth quartile = 1. There is no error bar for the fourth quartile, as it consists of only one therapist. *SE* standard error of mean

practitioners invested twice as much time as the second engaged in deliberate practice, and four times more than the third. Indeed, across groups, the less time a clinician spent "practicing outside of practice," the less effective they were overall.

Clearly, given the widely varying rates of deliberate practice among practitioners, the important question is how to increase the amount of dedicated time each spends in activities specifically aimed at improving specific aspects of their therapeutic skills. On this subject, available evidence suggests that a focus on intrinsic motivators (i.e., recognition, attention, enhanced competence, and professional identity) is superior to an emphasis on extrinsic drivers (e.g., financial incentives, punishment, external controls [Colvin, 2009]). That said, as Boswell, Kraus, Miller, and Lambert (2013) point out, ample opportunities need to be provided at work for receiving, reviewing, and reflecting on feedback about performance. Left to the individual provider, those most in need are likely to be the least inclined to invest the time and effort required (Maeschalck, Bargmann, Miller, & Bertolino, 2012).

Improving the Outcome of Therapy One Practitioner and One Client at a Time

> It is better to take many small steps in the right direction than to make a great leap forward only to stumble backward.
>
> Chinese Proverb

The research evidence is clear: psychotherapy is an effective treatment for a wide range of presenting concerns and problems. Despite these positive results, too many clients deteriorate while in care and even larger number drop out before experiencing a reliable improvement in functioning. At the same time, outcomes vary widely and consistently among clinicians.

FIT uses routine, ongoing feedback regarding the client's experience of the therapeutic experience and progress to guide behavioral health service delivery. A significant and growing body of research documents that, regardless of theoretical orientation or preferred treatment approach, FIT improves retention and outcome while simultaneously reducing rates of deterioration. In February 2013, the approach was listed on the Substance Abuse and Mental Health Service Administration's National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=249).

While feedback has been shown to result in documented improvements in the quality and outcome of individual treatment episodes, it has not proven sufficient for generating continuous practitioner improvement. For feedback to engender learning, practitioners must engage in deliberate practice. Results from numerous studies across a variety of professional domains, including psychotherapy, indicate that the number of hours spent receiving, reviewing, and reflecting on feedback received is a significant predictor of performance.

In sum, FIT and deliberate practice improve the quality and effectiveness of psychotherapy one client and one therapist at a time.

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