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The Road to Maste

by
SCOTT MILLER
and
MARK HUBBLE

CLASSICAL PIANIST RACHEL HSU ENTERS THE AUDITORIUM. Among the many pieces she'll perform on this occasion is the Concert Étude no. 3 by Franz Liszt. "Un Sospiro" (Italian for sigh), as the composition is known, is a famously challenging work to play, and a pleasure to watch. The hands mirror the sound of the music, moving rapidly up and down the keyboard in an intricate, crisscrossing fashion, which when done correctly, evokes images of water tumbling over rocks in a small mountain brook. Most experts consider Liszt's Étude no. 3, with its third staff, abundance of notes, and complex fingerwork, exceptionally difficult—a 12 on a scale from 1 to 10. ■ Clad in a simple, black-satin dress and red sash, Rachel silently makes her way to the piano. A hush falls over the crowd as she sits and, with a practiced poise, effortlessly adjusts the bench, which offsets her diminutive size. She straightens her back, takes a deep breath, and raises her hands, holding them momentarily above the keys. Then, magic! ■ To say the audience is stunned would be a gross understatement. Simply put, those in attendance are entirely unprepared for what they're witnessing. It's six minutes of

WHAT'S MISSING FROM THIS PICTURE?

PHOTO : CORBIS

perfection; a combination of music and performance that brings many to tears—an experience made all the more compelling by the fact that the pianist is only 8 years old.

Exceptionally talented children are nothing new, of course. In a host of fields, individuals who seem touched by greatness, like carriers of a "divine spark," appear from time to time. Mozart immediately comes to mind, who, like Rachel, was giving public performances as a pianist at the age of 8. Rachel, who also plays the violin, follows her piano performance with a flawless rendition of the Violin Concerto no. 2 in D Minor by Henryk Wieniawski.

Contrary to what might be expected, this performance didn't take place at Carnegie Hall or a similarly prestigious venue. It wasn't a musical recital for a gathering of proud parents. Instead, Rachel was a presenter, along with a host of other internationally regarded researchers, clinicians, performers, and celebrities, at the first Achieving Clinical Excellence conference. Held in Kansas City, Missouri, last fall, it was organized for behavioral health professionals.

The purpose of the meeting was to lay out a series of steps for achieving excellence in psychotherapy that research has shown result in superior treatment outcomes. In fact, they lead to greatness in *all* fields, pursuits, or professions. Rachel and others—including David Helfgott, the classical pianist whose triumph against all odds was celebrated in the award-winning film *Shine*—were invited to demonstrate how much can be accomplished by applying the steps, thereby, hopefully, inspiring the mental health professionals in attendance to commit to the hard work necessary for excellence.

The conference couldn't have been timelier. One only has to pick up a newspaper, turn on the TV, or search the Internet to hear news of America's declining global performance. Two recent issues of *Time* magazine have chronicled an across-the-board pattern of decline in America's standing worldwide that encompasses student test scores (once number 1, now 17th in science and 25th in math), infrastructure and public works (23rd), overall life satisfaction (28th), and quality of and access to healthcare (37th).

Not only are our children faced with the prospect of a lower standard of living compared to prior generations, but the country as a whole is falling behind other nations. China now possesses the world's fastest computer and is leading in green technology. While our economy has been in a virtual freefall, China's has sprinted ahead by leaps and bounds. IHS Global Insight—the largest economic organization in the world—recently announced that U.S. manufacturing fell, for the first time in a century, to second place, behind you-know-who.

Psychotherapy's Track Record

Turning to the field of mental health, what accomplishments can it boast of in recent years? What was the last truly revolutionary discovery in the field of psychotherapy? What "treatment" (analogous to penicillin in medicine) has *ever* successfully eradicated a mental or emotional disorder? In fact, while we've been at our posts, provisioning and parading an army of techniques and methods, rates of depression and anxiety have soared.

Even if one disagrees with this grim assessment of the field's contributions and influence, it's hard to be sanguine about our status. Over the last decade, median incomes for psychologists, both applied and academic, have dropped by thousands of dollars. In the same period, workloads have increased, professional autonomy has been subverted, and funding for public behavioral healthcare has all but disappeared. At the same time, costs have risen for graduate and professional training and for operating a practice. With regard to the latter, if medicine is any example, as much as a third of the average practitioner's time and income is spent completing the mindless paperwork required for third-party payers and federal and state regulatory bodies.

Meanwhile, the very relevance of psychotherapy is an open question in the minds of many current and prospective consumers. Despite overwhelming evidence that therapy works, and that more than 90 percent of people say they'd prefer to talk about their problems than take psychopharmacological drugs, most people doubt the efficacy of treatment. Perhaps this accounts for the fact that the use of medications has steadily increased, while visits to a psychotherapist have been decreasing. Worse still, 50 percent of those who begin therapy treatment quit prematurely—a number that's remained steady year after year. It's clear that we must do better, individually and collectively. As President Obama observed when addressing the nation's diminishing prospects, "This is our generation's Sputnik moment." Face it. Most efforts aimed at improving quality and outcome in behavioral health start with a

To date, more than a dozen randomized clinical **trials**, *involvin have established tha* **reserved**

call for higher professional standards: more schooling, more specialized training, and more stringent credentialing and rules for professional conduct. Regrettably, research shows this preferred, time-honored approach is an abysmal failure.

Nevertheless, it's now well established that clinicians are capable of improving their performances. At the end of 2007, we published two articles in the *Psychotherapy Networker*—"Supershinks: Learning from the Field's Most Effective Practitioners" and "How Being Bad Can Make You Good," with Barry Duncan—describing our research on top-performing therapists. In them we concluded: "The key to superior performance is . . . the best of the best simply work harder at improving their performance than others do."

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excellence *isn't*

for a select few.

Working harder is *not* about filling the week with additional hours on the job, as findings from other areas of endeavor affirm. In fact, the number of hours devoted to playing chess is negatively correlated with performance. Similarly, time spent doing therapy has never been a strong predictor of positive outcome. Instead, reaching the top requires hard work of an entirely different order: consistently and consciously pushing to reach objectives just beyond one's level of proficiency.

Rachel Hsu is a perfect example. When interviewed in front of the audience following her performance, she readily admitted making, "all sorts of mistakes." The audience laughed incredulously. Rachel continued undeterred, "Hardly anyone notices, of course, but I do—*and I remember.*" More laughter. These mistakes, she went on to explain, become the focus of her efforts the next time she practices. Confident of the standard she's trying to reach, she slows down such passages, playing and replaying them until they're mastered, all the while being subject to the scrutiny and approval of her mother or teacher.

Rachel's narrative neatly captures the three steps we reviewed in our two articles, which research has shown are necessary to achieve excellence. First, *know your baseline.* Rachel is able to accurately assess what she does, mindful of what she's capable of. Second, *engage in deliberate practice*—a systematic and critical review during which time problematic aspects of a performance are isolated and rehearsed or, failing that, alternatives are considered, implemented, and evaluated. Third, *obtain formal, ongoing feedback.* Illustrating this last step, we noticed that, following the performance, Rachel and her mother returned to the piano in the empty hall. Rachel's mother then directed her daughter's attention to a short section of the composition, providing suggestions on how to improve it.

To date, more than a dozen randomized clinical trials, involving thousands of clients and numerous therapists, have established that excellence isn't reserved for a select few. Far from it: it's within the reach of all. These studies show that applying the steps—know your baseline, engage in deliberate practice, and obtain ongoing feedback—increases the effectiveness of individual practitioners threefold, cuts dropout rates by 50 percent, reduces the rate of deterioration by 33 percent, and speeds recovery by 66 percent, while improving client satisfaction and reducing the cost of care.

However, if we learned anything in the years following the publication of the *Networker* articles, it's this: knowing the facts and putting them into practice are two altogether different matters. We didn't expect readers to beat a path to our door or be able to put the ideas into practice without additional help or training, but we were surprised that, even among the most interested and enthusiastic, the number of clinicians who put the steps to use in daily practice remained stubbornly small. We were also surprised that many who did follow the steps seemed to lose steam quickly. Moreover, agencies and group practices that devoted significant resources to implementation efforts struggled and all too often failed. Reflecting on this experience, we couldn't help but be reminded of words attributed to Confucius, "The way out is through the door. Why is it that no one will use this method?"

The Culture of Excellence

Once again, we found ourselves with a question and no ready answer. Available research was no help, because no hard data exist to explain *why* some individuals devote the time, energy, and resources necessary to achieve greatness. Clearly, therapists' motivation, personality, and developmental history weren't the deciding factors, since, with few exceptions, we were working with dedicated, hard-working professionals. Neither could the lack of follow-through be attributed to the bureaucratic overload of contemporary clinical practice.

Top performers, we eventually realized, didn't exist in a vacuum, bursting suddenly on the scene following years of private toil. To a casual observer, it can certainly appear that way. In truth, hearing performers like Rachel Hsu matter-of-factly report that she practices four hours a day, every day of the week, including weekends and holi-

days, amassing more than 4,000 hours, or the equivalent of almost 170 straight days at the piano had distracted us from a larger reality. It was as though looking into the bright light of greatness had blinded us to the surrounding context, rendering invisible a complex and interlocking network of people, places, resources, and circumstances without which excellence remains out of reach for all but a few. We've come to call this social scaffolding the "culture of excellence."

Without the familial, social, economic, and cultural context to nurture and encourage her, Rachel most likely would never have acquired the skill and presence she now exhibits. She has two parents who devote a massive amount of time, energy, and resources to nurture and advance her abilities. Moreover, she happens to live in a location that affords her opportunities to attend world-class concerts, participate in high-level competitions, and take advantage of unsurpassed professional instruction, all of which her family can afford to provide.

It makes intuitive sense that individual achievement and excellence flourish in supportive communities. The practice of psychotherapy is no different. For clinicians, rising to the top depends largely on the professional community that directly surrounds them. Unfortunately, however, the current culture of psychotherapy isn't designed to foster clinical excellence—if anything, it fosters mediocrity and inertia. Agencies frequently experience such economic instability that their driving goal is solvency and survival—thus the intense focus on billable hours and productivity. Regulation, institutionalized habits, management policies, and cost-effectiveness measures all tend to reward predictability and the *appearance* of competency.

The private practice model is even more antithetical to achieving excellence. Isolated from view, insulated from supervision or peer review, and lacking any true measure of effectiveness, private clinicians can operate for years without improving their outcomes. Evidence from real-world clinical samples documents that the outcomes of treatment delivered in solo practice settings lag behind those of larger, group practices by as much as 25 percent. The reason is simple. As veteran psychotherapy outcome researchers Bruce Wampold and Jeb Brown point out, "Therapists typically . . . have no way of comparing their treatment outcomes with those obtained by other therapists."

Furthermore, and without casting aspersions, the current system of reimbursement rewards practitioners for continuing to see clients who keep their appointments, regardless of outcome. The problem extends to how agencies measure productivity. For example, it doesn't take a genius to calculate the impact of a policy that reduces productivity to a simple ratio of the number of clients seen, divided by the therapist's available hours.

Compounding the problem of isolation is the well-documented tendency of clinicians to overestimate their level of skill and effectiveness. In one study, a representative sample of psychologists, social workers, psychiatrists, and marriage and family therapists from all 50 states were asked to rank their clinical skills and effectiveness compared with other mental health professionals with similar credentials. Respondents, on average, ranked themselves at the 80th percentile—a statistical impossibility. It gets worse: fewer than 4 percent considered themselves average, and *not a single person* in the study rated their performance below average.

Our inflated self-assessments notwithstanding, in randomized clinical trials, where clinicians are dealing with carefully selected and screened clientele, small caseloads, and access to high-quality training and supervision, reliable change (improvement *demonstrated* to be greater than chance, maturation, and measurement error) was achieved with only 50 percent of clients, on average.

So, the therapy profession faces some big challenges in the quest for excellence. Generally speaking, the culture of psychotherapy—in agencies or private practice—tends to punish risk and reward mediocrity. Given these facts, how can the field retool and rebuild itself so that we have a better shot at becoming the kind of therapists we genuinely want to be?

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Dr. ZIP Code

Because our clinical institutions don't encourage excellence, how do leaders in the field become the masters they are? Investigating some of the best agencies and most eminent and successful therapists in the world, we found that if they weren't already in a *community of excellence*, they went to great lengths themselves to construct, find, or gain access to one. For instance, one well-known practitioner and writer, when asked to trace his path to superior performance, immediately remarked, "It all goes back to ZIP codes." As a graduate student, feeling perennially shortchanged by classes in school, he

nurture *and encourage her,*

have acquired the

she now **exhibits.**

was determined to find better teachers, mentors, and learning opportunities. Since this was pre-computers, he volunteered to mail out workshop brochures for a local professional organization. Sticking labels on 15,000 brochures and organizing them by ZIP code was exceedingly tedious, he recalled, consuming hours of time. He wasn't even paid, but he did get a priceless payoff: free admission to any of the trainings advertised in the brochures.

"Fellow grad students thought I was nuts and told me I was being exploited," he said, "but over the three years, I met almost every major theorist and practitioner in the field. Typically, I'd review their publications before the event and come prepared with questions. Given my inexperience, a lot of what they said didn't make sense to me, so I sought them out on breaks. I always asked if I could call or write to them at some later point, if I had further questions. Very few declined, and I followed up with most. Eventually, these people became my support system, giving generously of their time, providing guidance, and opening doors that would otherwise have remained closed to me."

What kind of opportunities? In due course, "Dr. Zip Code" went to work with one of the foremost groups of clinicians in the country. "I wanted to be there—not read about it in a book or watch it on film. So, I wrote a letter and asked. True story. Six weeks later, I was packing up my meager belongings and moving across the country. Over the next five years, I spent literally thousands of hours watching these, as well as many other top clinicians, perform 'unplugged,' as well as having them watch, comment on, and critique my own work." He continued, "The job paid very little, and much to my mom's horror, I had to live in a rooming house with some pretty unsavory types. I loved it. Now, whenever someone watches me work and then asks, 'How did you know to do or say *that*?' I think back to that time.

"I'm *still* working with a team. Twenty-plus years later. Never seen a client or written a paper *without* others being involved." When asked how that's financially viable in today's world, he tersely responds, "Wrong question," and then continues, "The right question is, 'How can I make that happen?' I'll tell you what I did. First, I found other ways to make money. Second, I found a group of friends and colleagues who were willing to volunteer time along with me, observing and assessing each others' work."

This is a nice story about an ambitious, determined self-starter, who ingeniously constructed his own first "team" from the raw material of mailing labels. But what does excellence look like when embodied in a larger clinical setting, like an agency? What might be the recipe for actually building this way of relating from the inside out?

The Role of Leadership

"Cultures of excellence don't just happen—leadership is essential," says Cynthia Maeschalck, a Vancouver-based training consultant specializing in improving clinical performance. "Leaders need to take charge and make sure practices that encourage excellence are standard throughout the agency." It's now well-known that having clinicians consistently get client feedback and measure their outcomes improves the quality of therapy. Measurement and feedback are vital for any clinical culture of excellence, because of the human tendency to underplay our shortcomings and overplay our successes.

"But most people still don't want

PHOTO © MARCO BARONCINI CORBIS

to measure outcomes," continues Maeschalck, "because it's laborious—just because it's a good idea and improves results doesn't make it more appealing. Somebody has to take the lead and have the passion to insist on and maintain high standards, so that excellence becomes a habit." However, the leader can't merely act as an enforcer, ordering staff members to use the measurement tools they're given; he or she needs to "make it come alive for people," help them understand and believe in these tools.

Leadership may be the first principle in creating a culture of excellence, but success remains unlikely unless a culture of trust is established at the same time. This is because the most important building blocks of excellence are failure and the willingness to admit it. Failure and error, if not accompanied by shame, can provide compelling motivation to learn. However, people won't admit to error—making a mistake—if they fear it'll be held against them or that they'll be viewed as incompetent.

It's an open secret in the world of great achievement—from art to literature to sports to business to science—that the road to success inevitably passes through the dark terrain of failure. Psychotherapy studies similarly reveal that effective therapists report making more mistakes and being more self-critical than their less effective counterparts. Other evidence documents that healthcare professionals who acknowledge errors and disclose mistakes are less likely to be sued. Additionally, research conducted by Stanford psychologist Carol Dweck and colleagues points out that purposefully striving to be mistake-free is characteristic of an approach to life and learning that leads not only to poorer overall performance, but also to seeking out fewer, less challenging tasks.

"Error-centric" thinking—looking for what isn't quite right, where there's a shortcoming, where improvements can be made—is characteristic of work environments that are committed to enhancing therapeutic performance, according to experts on the subject. In fact, leaders of excellence cultures sometimes seem as focused on failure as the rest of us are on success. "I purposefully recruit staff that are flawed, have tripped up, made mistakes—and recovered," says Belinda Wells, the managing director of the 16-member, United Kingdom–based treatment agency known simply as The Counseling Team. "Don't get me wrong," she adds, "They're top performers. It would be hell if they weren't, since the standards are so high." But, she says, "I avoid those who, being young or having little real-life experience, are always trying to 'do the right thing,' so to speak." In cultures of excellence, such people can feel deeply threatened; their investment in seeing themselves as smart, competent, and capable at all times clashes with the very behaviors that promote high levels of achievement—recognizing and being unashamed to share failure, and using it as a springboard for improvement.

Unfortunately, many managerial and regulatory policies undermine the willingness of professionals to reveal their own failings to colleagues. An example is the recent passage of Oregon State Statute HB 2059, which *mandates* all healthcare professionals to report on one another for any "conduct unbecoming a licensee." Under such a censorious shadow, with potentially serious legal penalties hanging over their heads, it isn't likely that a doctor, nurse, or psychotherapist will go to colleagues to admit making a mistake. Rather than encouraging the admission and exploration of errors, this kind of policy shuts down conversation. In fact, leaders of local professional organizations are already reporting that the statute is having a chilling effect on professional collaboration.

The third element in building a culture of excellence is creating a common ethic about performance and measurement. Whether working as a private practitioner, in a group practice, or an agency, a key feature of cultures of excellence is being able to easily share and compare results. Among top-performing therapists and agencies, measurement is as commonplace as the more established benchmarks, such as efficiency and return on investment.

Many therapists experience misgivings about measuring their impact—how can the subjective quality of the therapist–client relationship possibly be reflected by crude metrics? Yet, at agencies committed to excellence, measurement is central to the way staff members think about what they do. Far from being a source of discouragement, numbers that assess the outcome at every visit focus attention on the session-to-session progress. No matter how refractory the depression, how paralyzing the anxiety, tracking outcomes can help to reveal some—possibly small, but *concrete*—improvement. By contrast, if there's no progress, or the scores deteriorate, the therapist is learning that changes in the service are necessary—useful informa-

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tion that can be shared and discussed with colleagues.

As noted earlier, when therapists track progress, dropouts decrease and overall outcomes improve—a great motivator for any clinician. "We are and have been from the outset obsessed with measurement," says the Counseling Team's Belinda Wells. "I expect staff to measure and to *be interested in the results.*" The impact of such a "measurement obsession" has been astonishing. "One day, the consultant whose scales we were using to measure our results called me. After exchanging the usual pleasantries, he asked, 'What exactly is your team doing up there in Kent?' And when I said, 'What on earth are you referring to?' he replied, 'Your team is exceptional: first, the quality and comprehensiveness of the data you send for analysis, and second, the astonishing rate of recovery among the people your group treats.' It was a pivotal moment." Wells paused. "But it's not the numbers, *really.* It's about being curious," she notes. "Trying to figure out what's not working and how we can do better."

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Darkness before the Light

Wonderful as all this sounds, the time and effort of launching and sustaining a focus on performance is daunting. "It's not easy to establish a culture of excellence—staff buy-in isn't automatic," says Robbie Babins-Wagner, CEO of the Calgary Counseling Centre (CCC), which has a staff of 62 and sees 8,000 new clients a year. Babins-Wagner began the process of establishing a culture of excellence at her agency 11 years ago, and it's still a work in progress.

"At first, many staff members didn't believe in it and didn't even want to be held accountable for their work—they were afraid they'd fail or look bad," she says. "Even when we told them that their salary and advancement wouldn't be based on these performance measures, a large percentage of staff didn't turn in their measures, or did them in a superficial way." In fact, during the early years of the effort, the agency saw a 40-percent staff turnover. She adds that transforming the work habits of an entire agency can't be done without a certain amount of negativity, resentment, and staff loss. "Sometimes substantial change is possible only with the hiring of new staff. They know what they're coming into, and accept it, when they agree to take the job."

At CCC, leadership has worked to create "mindful infrastructures." These include opportunities for staff to brainstorm about the agency's purpose and goals, and evaluate the work each and all are doing. Remember the one-way mirror? A relic of a bygone era for most therapists, at CCC, clinicians regularly schedule time to watch each other work, providing continuing peer consultation and coaching. Clinical supervision is ongoing and organized around clients whose feedback indicates lack of progress or problems in the therapeutic relationship. Twice a month, the entire staff spends two hours together with an external consultant, reviewing the outcomes of the agency, individual clients, and therapists. Clearly, CCC's staff is doing something right: the dropout rate after the first session is half that of the worldwide norm, while outcomes have been steadily improving, with success rates almost tripling since the project began.

At CCC, clinicians are free to use whatever treatment approach is congenial to them and their clients, and employ a variety of different models, including CBT, structural-strategic, and psychodynamic. "We're not interested in controlling *how* therapists work. Like our clients, our team isn't homogenous. But we *are* interested in each therapist being good and getting better." That means regularly seeking feedback regarding the fit and effect of services offered. Babins-Wagner understands the lack of enthusiasm many clinicians feel about using measurement tools. "As a graduate student, I did everything possible to avoid statistics," she says. But since then, she's seen the light. "Here, data are front and center. At every turn, the therapeutic process is linked to outcomes, which allows a dialogue to begin—'Is what we're doing working? If not, what else can we do?'" For Babins-Wagner, as for other excellence-driven therapists, measurement keeps practitioners moving forward: good, bad, or indifferent, the numbers tell a tale every therapist needs to heed in order to grow.

All committed therapists want to increase their expertise and effectiveness. They earn advanced degrees, spend years honing their craft, and attend meetings and workshops—and not just to add credentials to their names. The majority hope that they'll become expert practitioners through the acquisition of knowledge and experience. Findings from a large, long-term, multinational study of behavioral health practitioners confirm that therapists desire to—and see themselves—continually improving throughout their careers.

When researchers examine the evidence, however, they find little proof of increasing expertise. As just one example, in a comparative study of licensed doctoral-level providers, pre-

doctoral interns, and practicum students that appeared in last spring's *Journal of Counseling & Development*, Scott Nyman, Mark Nafziger, and Timothy Smith found "the extensive efforts involved in educating graduate students to become licensed professionals result in *no observable differences* in client outcome."

The problem isn't that professionals are failing to acquire new knowledge or skills: the problem is that what's learned is unrelated to improved outcomes. Over time, and through training, clinicians compile a grammar for clinical practice, which heightens their self-confidence and increases their sense of mastery. However, as anyone who's attempted to learn a second language recognizes, even an extensive vocabulary, ability to conjugate verbs, and knowledge of syntax doesn't necessarily translate into a capacity to communicate effectively with different people in different settings. Without context, even the simplest of exchanges becomes impossible

And herein lies the crucial difference between the best and the rest: what researchers refer to as "deep, domain-specific knowledge." Top performers not only *know* more than their average counterparts, but are vastly better at recognizing when, where, how, and with whom to use what they know.

For instance, master chess players actually see more than amateurs, recognizing up to 100,000 distinct patterns on the board. A select group of nurses working in neonatal intensive care units develop an uncanny ability to spot infections before symptoms are visible, and despite negative diagnostic testing. Tennis champions correctly perceive where the ball will land and move to intercept it before their opponent serves. The most effective therapists sense many more interpersonal patterns and possibilities for relating to clients than average clinicians.

Consider a recent, groundbreaking study on the therapeutic relationship conducted by researchers Timothy Anderson, Benjamin Ogles, Michael Lambert, and David Vermeersch. Clinicians were asked to respond to a series of video simulations. Each presented a difficult clinical situation, complicated by a client's anger, dependency, passivity, confusion, or need to control the situation. Their findings: therapist gender, theoretical orientation, professional experience, and overall social skills were found to be unrelated to outcome; the best results were obtained by clinicians who exhibited deeper, broader, more accessible, interpersonally nuanced knowledge. No matter the client's presenting problem or style of relating, the top-performing practitioners were more collaborative and empathic, and far less likely to make remarks or comments that distanced or offended a client.

Acquiring such understanding, perception, and sensitivity is a common goal for clinicians. Researchers have found that "healing involvement"—a clinician's experience of feeling engaged, affirming, highly emphatic, flexible, and capable of dealing constructively with difficulties encountered in the therapeutic interaction—is the pinnacle of therapists' aspirations. However, the study by Anderson, Ogles, Lambert, and Vermeersch proves that *some* end up having such knowledge while others, of equal experience and social ability, don't. So the question is how to go beyond believing in your own

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PHOTO - TED HOROWITZ/CORBIS

expertise and actually achieving it. The professional literature on expert performance is clear: no shortcuts exist. The best spend more time engaged in deliberate, ongoing, and systematic practice to improve.

Consider Robbie Babbins-Wagner, who focused exclusively on particular kinds of cases until she'd mapped every possible feature of the territory in her mind. "I'd pick a specific clinical population and see case after case of just that, with the idea that you can't see a potpourri of different problems if you want to gain genuine mastery over any particular problem. I saw 50 or 100 or 200 cases of depression or domestic violence, and by seeing these cases over and over again, I picked up the patterns common to all of them that I might otherwise have missed." She learned, for example, while treating violent couples, that even after the violence has ended and the couple is doing better, there'll almost always be a relapse. Because she knows the pattern, she's ready for this—it's not a therapy failure, nor the end of treatment, simply a predictable pothole in the road that needs to be negotiated.

In a way, Babbins-Wagner is like surgical specialists who've performed one kind of operation so many times that they've achieved a degree of mastery and success unmatched by any other colleague. Even so, this ability to specialize your way to excellence is a luxury not available to most therapists in most agencies, where "potpourri" or "mishmash" is the only kind of case load most can expect, and if agencies have their own problems in creating the kind of conditions that promote a culture of excellence, individual therapists face even more of a challenge.

Virtual Communities

Most therapists who begin their careers in agencies move on to private practice as soon as they can. At that point, they're truly on their own—directly accountable to nobody except their clients, the law, and their own consciences. So where and how can private practitioners find a trustworthy community of their peers that will challenge them to keep growing as therapists and people?

In December 2009, the International Center for Clinical Excellence (ICCE) was launched (*www.centerforclinicalexcellence.com*), and since then, it has grown into the largest, global, web-based community of clinicians, researchers, administrators, and policymakers dedicated to excellence in behavioral health. Clinicians can choose to participate in any of the 100-plus forums, create their own discussion group, immerse themselves in a library of documents and how-to videos, and consult directly with peers. Membership costs nothing, and the site is free of the advertising, solicitations, and endless e-mail so typical of the web, list-serves, and other online venues. With just a few clicks, practitioners can plug into a group of like-minded clinicians whose sole reason for being on the site is to raise everyone's performance level.

"Being a solo practitioner can be very isolating," says Australian psychologist and ICCE member Vanessa Spiller. "Having a supportive, like-minded community in which I can ask questions and present ideas and thoughts, and have people critically review these—which I've done several times—has been very helpful. It's been great to be able to access this 'oasis' of international expertise, providing me with a community of peers willing to critically review my work, identify some of my unquestioned assumptions, and make specific suggestions for changes I can implement and objectively evaluate the effectiveness of." Similar sentiments are expressed by Dutch psychologist Peter Breukers. "As a solo practitioner, the ICCE gives me a safe ground to fall back on while I practice sticking my neck out, implementing new ideas, and thus continually and deliberately refining my ideas and methods."

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What seems so striking about ICCE is that it transcends its online limitations—which often reinforce anonymity and invisibility—to provide members with the same complex norms of personal connection, openness and honesty, mutual trust and support, challenge and accountability that any "land-based" community of excellence offers. There is, for example, the same emphasis on taking risks and sharing one's mistakes, admitting when you're having difficulty, don't know what to do, or suspect you aren't helping a client get better.

"Risk is the key to growth," says Danish psychologist and ICCE Community Manager Susanne Bargmann, "Without taking a chance, venturing beyond the tried and true, nothing happens. It's only through difficulty that you learn. It's precisely for this reason that the members and associates continue working very hard at making the ICCE a safe place for clinicians to share openly, and be pushed and stretched."

The ICCE community isn't merely a resource aimed at preventing ethical and professional lapses. It's a genuine source of friendship, support, and encouragement to those practicing a profession that's not only lonely, but frequently characterized by real self-

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MILLER/HUBBLE *from page 31*
doubt and anxiety. "I don't feel alone—I never feel it's just me and the client," says Bargmann. "I have this whole team—a network, a community of colleagues that I can access whenever I need them." As in any other excellence-driven community of practice, the freedom the ICCE provides to openly and freely admit failure, embrace error, and make mistakes is "enormously empowering," says Bargmann.

With thousands of practitioners using the website, including some of the world's best-known therapists, it may be surprising to learn that the self-promotion and ego stroking that often color professional gatherings is almost entirely lacking. Also absent is the contentiousness that supplants civil conversation on so many online listservs and forums. No "my way is the best way" is tolerated. "While the various forums are monitored by ICCE trainers and associates for compliance," says Ms. Bargmann, "the need for intervention by management has been minimal. In fact, the staff spends more time participating than policing! And there's an ecumenical spirit and degree of curiosity, humility, and camaraderie in the interactions that's quite inspiring and, frankly, seems organic in origin."

Meeting the Challenge

Coming full circle, our investigation of top-performing agencies and clinicians shows that excellence requires that we look forward and have a process in place that enables continuous renewal, growth, and expansion. Complacency is the enemy. The field as a whole and practitioners in particular face a number of stark challenges in the future, not the least of which is remaining competitive, if not relevant. As the people we work with and the culture in which we all live are constantly changing, so must we. The time is now.

Evoking Sputnik brings to mind an era of unqualified achievements, beginning with primitive satellites and ending with lunar landings. Spaceflight is now so commonplace as to barely register with many people. Generally forgotten is the extraordinary amount of time and sacrifice expended in the pursuit of these historical objectives.

Fortunately, we don't, as individuals or as a field, need to prepare and plan for the equivalent of the next conquest in space. But we can each begin by treating every encounter with a client and colleague as a "Sputnik moment"—waking up to the fact that we almost always fall short of our potential, and making a decision to do better. Thankfully, this doesn't require that we be superhuman.

"I can't be a perfect therapist," says clinician Wendy Amey. "No matter one's experience or training, it's an imperfect practice." Amey was one of the top-performing clinicians we met at the outset of our research into excellence. Given her impressive outcomes working with the victims of the most severe types of trauma, we'd expected *more*—more confidence, more certainty, a presence commensurate with her results. Instead, as the interview unfolds, we feel underwhelmed and strangely disquieted.

"I don't see myself as a brilliant therapist," Amey insists when we ask her to account for her effectiveness. "My brain doesn't work that fast, and my memory is really quite limited. Other people always seem to have better ability than me. I have to struggle to keep up." As if to prove the fact, she then tells of being sent as a student therapist for an evaluation to determine whether she had a learning disorder! (She did not and in fact tested well above average).

It isn't until she begins to describe how she works that our feelings of unease give way to inspiration. "Being limited means that I *have* to try harder, to work harder than most do. You see, what comes easily to others, takes time for me. If I had their ability, I probably wouldn't need to work as hard at it as I do." Somehow, hearing this top-performing clinician speak is immensely humbling. She continues, her words identifying the scope of her ambition, as well as the concrete steps she takes every day to realize it. "Even if you always do your best, it won't always be good enough for this client, at this time and place. So what I do, because I'm passionate about helping my clients the best way I can, is get the help I need, and be very open to all of the experiences out there—very, very open to it. And I constantly engage with people that I can learn from."

There's nothing frivolous about the community Amey chooses to surround her. "Always wanting to be more capable than I am, I recognize people with great ability, and I reach out." She reports being "blessed with outstanding colleagues, six or seven of them" whom she regularly contacts, and always being on the lookout for others.

At the conclusion of the interview, she mentions having met a psychologist the last week, who'll undoubtedly be a resource in the future. What will she ask? "'Hey,' I say, 'I've got a problem, what ideas do you have for me?' If you aren't invested in looking superior, then why not just admit that you don't know, *and* ask?"

Exactly, we think. Let's get started!

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RESOURCES:

Excerpts of Rachel Hsu playing the violin and piano can be seen online at: http://www.scottdmiller.com/?q=node/109.

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