The Counseling Psychologist
2017, Vol. 45(1) 54–65

DOI: 10.1177/0011000016652691
journals.sagepub.com/home/tcp
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Psychotherapy Expertise Should Mean Superior Outcomes and Demonstrable Improvement Over Time

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Abstract

How the field understands psychotherapy expertise is important. It affects how we practice and how we prepare others for practice. As in our other work, we argue that the most meaningful definition of expertise must involve steady improvement over time to achieve superior performance on some meaningful measure, which typically is client outcome. We also argue that the best means by which a therapist can achieve this is through ongoing deliberate practice. We contrast our position with not only Hill, Spiegel, Hoffman, Kivlighan, and Gelso's preferred definition, in which they anchor expertise in therapist performance, but also with the various other possible definitions of expertise (e.g., therapist experience, therapist self-assessment of expertise) that they proffer as options.

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Keywords
psychotherapy, professional issues, training

Imagine a visit to the distant planet of Hecate (named for the Greek goddess of magic). Its inhabitants are avid players of Archarios, a game with few rules other than that it is played solitarily in 50-minute sets. Players keep score using whatever systems they choose, and although everyone discusses how they play Archarios, it is unusual to be able to watch others actually play. Visitors to Hecate notice the following:

- The Archarios Board of Elders certifies some players to be instructors of younger players; the elders must certify younger players before they can officially play Archarios.
- The players often argue among themselves about how to keep score.
- Archarios players spend hours discussing the intricacies of the game and, as they gain experience, grow increasingly articulate in describing their play.
- Players get no better as they play more games by any criterion, although most indicate that they do.
- The average player estimates himself or herself to be above the 80th percentile of all players in terms of skill level.
- Some Hecatians are recognized as exceptionally good players.
- Some few players are awarded a special status by the Archarios Board of Professional Players, which is composed of all who have that special status.

Given these circumstances, is it possible to be an expert Archarios player? Hill, Spiegel, Hoffman, Kivlighan, and Gelso (2017 [this issue]) apparently would answer in the affirmative. Consistent with the wide array of scoring systems that the Archarios players employ, Hill et al. present multiple (eight) ways to demonstrate expertise, including simple experience and therapist self-assessments. Hill et al. also suggest that "expertise exists on a continuum, ranging from highly inexpert to highly expert" (p. 10), with perhaps the "top 10% of all therapists" (p. 34) composing the experts. By this standard, 10 out of 100 players always will be experts, regardless of whether any of them are actually effective.

By contrast, our position (Tracey, Wampold, Goodyear, & Lichtenberg, 2015; Tracey, Wampold, Lichtenberg, & Goodyear, 2014; Wampold, Lichtenberg, Goodyear, & Tracey, in press) is that expertise requires an individual to have improved over time, to demonstrate superior performance as

measured by something that is both agreed on and important, and that outcome assessment is the crucial component of this. This would be an exceptionally difficult criterion for Archarios players to meet under the rules and conditions described above. Should the Hecate elders heed our suggestions about necessary rule changes, our next step then would be to advise the Archarios players that experience alone will be insufficient to take them to expert-level performance; it would be important that they engage in the hard, sustained work of deliberate practice (see, e.g., Chow et al., 2015; Duckworth, Kirby, Tsukayama, Berstein, & Ericsson, 2011) that is informed by clear and ongoing performance feedback. By this means, expertise would not simply be limited to some particular portion of the distribution of players but would be firmly connected to outstanding performance.

Hill et al. (2017), in their major contribution, have challenged our position on the nature of psychotherapy expertise. We welcome this opportunity to respond to their challenge and have organized our response by addressing, in turn, the construct of psychotherapy expertise and then how psychotherapists can develop expertise.

The Construct of Psychotherapy Expertise

In speaking to Charles Darwin's (1994) statement on the significance of theory, Shermer (2001) observed "The facts never just speak for themselves. They must be interpreted through the colored lenses of ideas: percepts need concepts" (p. 38). That important statement pertains here in that one's concept of psychotherapy expertise will influence which facts are attended to and how they are interpreted. This is clearly evident in comparisons of our work (Tracey et al., 2015; Tracey et al., 2014) to the Hill et al. (2017) article. And despite Rønnestad's (2016) question about whether this topic even matters, we are convinced that the concept of psychotherapy expertise that prevails within the discipline has consequences. It will affect how we practice, how we prepare others for practice, and even the quality of care our clients receive.

Scholars have defined expertise in a number of ways. Most of these definitions, however, have important empirical and conceptual limitations when applied to psychotherapy (see Tracey et al., 2015; Tracey et al., 2014). Therefore, we adopted a definition that has the virtues of parsimony, logic, and practicality: Experts are those for whom there is evidence of improvement over time and who demonstrate superior performance as measured by something that is both agreed on and important, specifically client outcomes.

By contrast, Hill et al. (2017) begin by defining psychotherapy expertise as "*the manifestation of the highest levels of ability, skill, professional competence, and effectiveness*" (p. 9) but then later assert that "we believe it is

preferable to specify multiple criteria rather than to be excessively restrictive in our criteria, especially if this stimulates research about correlates of these variables" (p. 31). To this end, they proposed eight criteria (e.g., performance, cognitive function, client functioning) and a total of 32 ways of assessing these eight criteria. This perspective is so inclusive that it is not a stretch to imagine that virtually everyone who works long enough in the field might claim psychotherapy expertise. As a result, the concept loses any practical meaning.

We do not have the space to address each of the criteria for expertise that Hill et al. (2017) offer, although we see no value in such criteria as therapist self-assessment and experience, two criteria that older therapists would most likely universally possess, regardless of whether they are effective therapists or not. Moreover, and perhaps reflecting their own ambivalence about these criteria, some of the arguments they made were difficult to follow. For example, much of their section on self-assessment was critical of therapists' ability to do this accurately, and yet their concluding sentences to that section implied that maybe these self-estimates actually reflected self-efficacy, which was not then linked to expertise. Indeed, the literature demonstrates that the degree of self-assessed specialized knowledge is related to overconfidence in those domains (Atir, Rosenzweig, & Dunning, 2015). But because Hill et al. (2017) declare performance as the most important of their eight suggested criteria for psychotherapy expertise, it warrants particular attention.

Performance as a Criterion for Expertise

Hill et al. (2017) explain that performance expertise is of two types: relational and technical. They note that much of the literature on relational expertise is "based on Rogers's (1957) bold hypothesis that therapist facilitative conditions (empathy, positive regard, and genuineness) are necessary and sufficient conditions for therapeutic change" (p. 12). Although there is no evidence that these relationship qualities are sufficient, they do have robust effect sizes in predicting client outcomes (see Norcross, 2011; Wampold & Imel, 2015). But rather than declaring these to be criteria of expertise, we propose that these are qualities that the therapist should continually strive to improve using outcome feedback, and that it is the outcome that needs to be seen as the performance criterion.

Hill et al. (2017) clarified that technical expertise has several components including competence and its more specific version, multicultural competence. To understand the limitations of competence as a criterion, consider the example of Emil Zatopek, a triple gold medalist at the 1952 Olympics.

> [He] was not a graceful runner. With every step, his body rolled and heaved, his head lurched back and forth, and his tongue lolled out. . . . He was well aware of his less-than-perfect style, saying "I shall learn to have a better style once they start judging races according to their beauty. So long as it's a question of speed, my attention will be directed to seeing how fast I can cover ground." (Sears, 2015, p. 196)

The analogy to psychotherapy seems clear: If a therapist has developed an individualized style that results in superior outcomes with clients, how do we profit from criticizing the "beauty" of his or her performance? Competence ratings are, of course, ratings of beauty or aesthetics as judged by particular groups of "experts." It is important to note that the field has no broad consensus about which standards of beauty should be adopted. Therefore, a psychodynamic therapist is likely to judge the work of psychodynamic therapist who has fully mastered the craft to be aesthetically pleasing, but could have a very different judgment of therapy by a therapist who demonstrates excellent CBT skills.

Hill et al. (2017) acknowledge that this is true when they assert that "Definitions and judgments about competence also vary by theoretical orientation . . . such that therapists are judged as competent if they are doing what is theoretically prescribed . . . [which] makes it difficult to derive an all-inclusive standard of competence" (p. 15). We wonder then about the usefulness of this criterion.

In short, there are at least two problems in embracing competence ratings as a criterion for expertise. The first is that to do so is to invoke a criterion of aesthetics that will be judged differently across theoretical orientations. The second is that these aesthetic judgments (i.e., competency ratings) are poorly related to actual outcomes (Boswell et al., 2013; Wampold & Imel, 2015; Webb, DeRubeis, & Barber, 2010).

Hill et al. (2017) give examples of trainees improving over time, but it would be unusual to claim, under any criterion, that a trainee or someone who very recently completed her or his training was an expert. So what we know is that there are changes in performance on some rated skills while people are trainees (Hill et al., 2015), and even modest increases in client outcomes (Owen, Wampold, Kopta, Rousmaniere, & Miller, 2016). But this is scant evidence of trainee expertise.

Deliberate Practice as the Mechanism for Developing Expertise

Hill et al. (2017) suggested personal therapy, experience with clients, and supervision as mechanisms for developing expertise. They acknowledge that

the "empirical support for these is minimal . . . [but that] they seem to make conceptual sense" (p. 35). We agree, of course, that the evidence is lacking. The evidence to support personal therapy's effects on practice is equivocal at best (Geller, Norcross, & Orlinsky, 2005; Malikiosi-Loizos, 2013), and experience with clients is essential but not sufficient (see our discussion of deliberate practice [DP] next). Indeed, there is evidence that the outcomes of therapists do not improve over the course of their careers and that there might be a small deterioration (Goldberg, Rousmaniere, et al., 2016). And whereas there is a great deal of literature to support the effects of supervision on the personal attitudes, beliefs, and skills of therapists (Bernard & Goodyear, 2014), the evidence of its effects on client outcome unfortunately remains mixed at best (Watkins, 2011).

The fourth mechanism that Hill et al. (2017) suggest for developing expertise is DP. We also argued for the merits of DP as essential for this purpose. Ericsson's work (e.g., Ericsson, 2006) certainly illustrates the importance of DP across many performance domains. Lee (2016) provided a wonderful case example, noting "World-renowned cellist Pablo Casals continued to practice 5 hours to 6 hours a day well into his 80s because as he once stated: 'I think I am making progress'" (p. 895).

Because any meaningful conversation about DP needs to be grounded in a common definition, we adopt that of Miller, Hubble, and Chow (in press), who maintain that DP comprises four elements:

1. A focused and systematic effort to improve performance pursued over an extended period.
2. Involvement of and guidance from a coach/teacher/mentor.
3. Immediate, ongoing feedback relative to particular important skills.
4. Successive refinement and repetition via solo practice outside of performance.

All four of these elements need to be present for an activity to qualify as DP practice: DP is not occurring if one is missing. This means, for example, that whereas reflective practice can be important, it is not in itself DP, as Hill et al. (2017) suggest it might be. To require these elements also explains why their suggested mechanism of experience with clients is in itself insufficient.

Feedback

In our earlier work (Tracey et al., 2015; Tracey et al., 2014) we made the case that the general unavailability of systematic and immediate performance feedback to therapists is an important barrier to developing expertise (see

also Dawes, 1995). Consequently, we want to single out feedback, the third of the Miller et al. DP elements, for specific attention.

Feedback that is clear, anchored against some criterion, and relatively immediate is essential for the development of expertise. It also is an important means of reducing practitioners' overestimates of effectiveness (see Walfish, McAlister, O'Donnell, & Lambert, 2012). Therapists can obtain that feedback from various sources, including their supervisor, coach, or consultant and their clients.

Hill et al. (2017) share our belief that clients are an important source of feedback. We differ, however, in the extent to which we would rely on observing client changes and behaviors and on eliciting information from the use of immediacy for that information. Because our concern is with obtaining accurate, unbiased feedback, we believe that therapists are wise to use routine outcome monitoring (ROM) measures to obtain client feedback. The development of ROM systems during the past couple of decades has been an especially important contribution to the field, improving practice, training, and research, and the systems now have become sufficiently widespread that Wampold (2015) declared them to have come of age. Although ROM-derived feedback does not provide guidance about specific behaviors or interventions for the therapist to use, it can provide an important signal to carefully examine therapy processes and, in so doing, help therapists develop greater expertise.

But Hill et al. (2017) offer concerns about ROM feedback that we do not share. They assert, for example, that ROM systems focus too narrowly on client symptomatology, when this actually is true for only some of the systems. For example, the Partners for Change Outcome Management System obtains client ratings both of client functioning and the therapy session (Duncan & Reese, 2015). Lambert's Outcome Questionnaire measures interpersonal relationships and social role difficulties, two very important domains for clients, as well as symptom distress.

Hill et al. (2017) also express the concern that "clients often complete these self-report measures quickly by checking responses rather than reflecting deeply" (p. 21). And they note that "many clients defensively report normal functioning when in fact they are not functioning well . . . [and can] report functioning poorly initially to look like they need treatment, and then report functioning well at the end of treatment because they want to stop treatment" (p. 21-22). Both of these are possible, of course. No measure is perfect. But what is the better alternative? Therapists, for example, are poor judges of how well their clients are doing in therapy. Hannan et al. (2005) found that in their sample, psychotherapists identified only one in 40 (2.5%) clients who eventually left therapy worse than when they began and

estimated that 91% of their clients obtained positive outcomes whereas the actual value was 40%. Hatfield, McCullough, Frantz, and Krieger (2010) examined case notes of patients who deteriorated to see if therapists noted worsening at the session it occurred and found that they were not at all good at doing so. Finally, Samuel (2015), in a meta-analysis of clinician diagnostic skills relative to patient self-ratings, found that although clinicians agreed more with other clinicians as they increased in experience, their accuracy was not better; client self-ratings were much better than those of their therapists, and Samuel (2015) found only modest agreement (median *r* of .23) between therapists' personality disorder diagnoses and diagnoses derived from other measures (e.g., self-report).

In summary, ROM data are a helpful source of feedback to therapists who wish to develop expertise. ROM is not without its problems in implementation, but those problems are offset by their value. For feedback to be effective, it needs to be obtained relatively immediately, and few other measures that Hill et al. (2017) suggest can be obtained so readily and consistently.

Concluding Comments

As we noted early in our response, the way the construct of psychotherapy expertise is understood has important implications for the field in terms of training and practice. We see no advantage to the field in having (a) multiple ways of understanding expertise so that nearly all therapists might claim expertise by some criterion, (b) criteria that do not converge (i.e., one criterion would identify X as an expert and another Y but not X), and (c) a guarantee that X% of therapists are experts regardless of actual performance. Hill et al. (2017) do express a preference for therapist performance (which subsumes competence) as a criterion, and we would agree that to achieve competence (from whatever perspective) is an important training goal when working with novices. But we see it as one step in what is a process of DP through which therapists become increasingly individualized in their personal models as they obtain and use meaningful performance feedback. And it is important that experts gradually increase their performance, as measured by outcomes achieved by clients. We cannot emphasize sufficiently that the goal is to help clients improve their mental health, and all other criteria must be subservient to the pursuit of client improvement.

In short, our concern has been with how to help therapists improve. This was not always the focus of Hill et al. (2017), who seemed to shift their focus to research on what makes therapy effective often in their article. To illustrate, they observe that "Sound interventions facilitate the development of the therapeutic relationship, and the strength of the relationship influences

receptivity to the therapist's techniques" (p. 11). Although we do not disagree with such observations (nor would many), our focus is on how therapists could improve their effectiveness over the course of their careers.

Hill et al. (2017) began their article by asserting "If we cannot show that therapists become more expert as a result of training and practice, our current models of graduate training, as well as continuing postdoctoral education, need to be reexamined" (p. 8). We agree completely! Indeed, models of graduate training and continuing education do need to be examined. In this brief response we have mentioned where that reexamination might lead, and there are efforts to systematically incorporate DP into training, supervision, and practice (e.g., Rousmaniere, Goodyear, Miller, & Wampold, in press). Agencies that have adopted models of DP have seen increases in client outcomes over time (Goldberg, Babins-Wagner, et al., 2016), demonstrating that we can, indeed, get better at what we do.

We conclude, then, by returning to Hecate and the game of Archarios, which we intended as a thinly disguised characterization of the practice of psychotherapy. Where the parable breaks down is that the game is not simply for the pleasure of its players: There are clients who receive services. The good news is that even if the "game" of psychotherapy were not changed, psychotherapy would continue to be very effective (Wampold & Imel, 2015). What Hill et al. (2017) offer would leave it at that. Our proposal is for a more hopeful understanding of psychotherapy expertise and how it develops—one that strives for the opportunity to achieve even better client outcomes.

Acknowledgments

The authors would like to express appreciations to the Otsego Group and to Conroy Reynolds for suggesting the example of Emil Zatopek.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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