Therapist Expertise in Psychotherapy Revisited Ψ

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Abstract

The thesis of this article is that the lack of evidence related to the identification and development of therapist expertise is due to the inadequate definition and operationalization of the concept. We propose a definition of *expertise* that is restricted to performance in the conduct of psychotherapy: the manifestation of the highest levels of ability, skill, professional competence, and effectiveness. In addition, we offer several criteria that may be used to assess expertise: performance (including relational and technical expertise), cognitive processing, client outcomes, experience, personal and relational qualities, credentials, reputation, and self-assessment. We then review research related to the development of expertise, highlighting the role of experience with clients, personal therapy, supervision, deliberate practice, and feedback. Finally, we conclude with recommendations for conducting research on therapist expertise.

Keywords

psychotherapy, professional issues, training

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The fundamental assumptions that expertise exists for psychotherapists and that it develops as a result of training and experience have been the subject of considerable debate. These topics are of importance given questions of competence and credentialing, as well as the extensive training required to become a psychotherapist. 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.

In their provocative set of articles, Tracey, Wampold, Lichtenberg, and Goodyear (2014) and Tracey, Wampold, Goodyear, and Lichtenberg (2015) argued that psychotherapy is a profession without demonstrated expertise. Tracey et al. (2014) extensively cited Shanteau (1992), who stated that expertise is easier to develop in professions with more predictability of outcomes and greater availability of quality feedback (e.g., airline pilots) than in professions in which there is less predictability of outcomes and quality feedback available (e.g., psychiatry and clinical psychology).

Tracey et al. (2014) maintained that there is no evidence that experienced therapists achieve better client outcomes than do inexperienced therapists. They further proposed that therapists overestimate their clinical and diagnostic abilities, and an important reason that therapists do not improve in their clinical work is that they do not seek or receive adequate feedback about client outcomes. They recommended that therapists obtain better and more frequent feedback about client outcomes to improve these outcomes and enhance their expertise.

The overarching purpose of the present article is to advance the dialogue about the assessment and development of expertise. We suspect that the inability of investigators to provide evidence of developing expertise is due to serious flaws in the way expertise is conceptualized and operationalized. We thus focus on the definition, suggest criteria for assessing expertise, review the literature about therapist development, and highlight mechanisms by which expertise develops. We conclude with suggestions for research on expertise.

Our focus is on expertise with respect to the provision of psychotherapy. Although there are other important areas of expertise (e.g., assessment, diagnosis, evaluation, use of research evidence, ability to articulate theoretical approach), we agree with Shanteau and Weiss (2014) that it is preferable to restrict the focus so as to avoid confusion and to advance the discussion. In fact, much of the support for Tracey et al.'s (2014) conclusions that therapists do not develop expertise was based on studies of accuracy in clinical judgment rather than on studies of psychotherapy performance. Related to this, although expertise is undoubtedly similar for social workers, psychiatrists, psychiatric nurses, and other helping professionals, we have restricted our focus to counselors and psychotherapists.

Given that judgments about expertise often vary according to theoretical orientation (e.g., psychodynamic and cognitive-behavioral expert therapists might have different judgments about expertise), it is important to disclose our theoretical orientation. We (the five coauthors) primarily espouse psychodynamic, humanistic, interpersonal orientations within an integrationist context. Our comments should be taken in light of this broad theoretical perspective.

Although we argue in a subsequent section that experience is not equivalent to expertise, we acknowledge here that we cite literature that assesses experience (e.g., years of clinical experience, professional level) rather than expertise. Given the paucity of literature directly related to expertise, we incorporated literature on experience as a proxy for expertise but urge readers to remember that experience is not the same as expertise.

Defining Expertise

Shanteau (1992) defined expertise as "increased quality of performance gained with additional experience" (Tracey et al., 2014, p. 218). The fundamental problem with this definition (which was also adopted by Tracey et al., 2014) is that a therapist or therapists in general could increase in quality of performance but still be mediocre, or at least not possess what would generally be considered a high level of expertise.

Other definitions of expertise have been attempted. Jennings and Skovholt (1999) defined "master therapists" as "the best of the best." In a reaction to Tracey et al. (2014), Oddli, Halvorsen, and Ronnestad (2014) argued that expert therapists are those who organize their knowledge hierarchically, in ways that reflect a deep understanding of the phenomenon, focus on what is relevant and develop functional rather than merely descriptive accounts of the problem, and have the capacity to adjust to new situations and reflect on their knowledge and actions generally and in particular situations.

Given these considerations, we offer the following definition. Expertise in the practice of psychotherapy is defined as *the manifestation of the highest levels of ability, skill, professional competence, and effectiveness.* A few caveats are needed about this definition. A therapist might generally be considered an expert but nonetheless behave in a suboptimal manner in a specific session. This suboptimal behavior might be due to specific features of the client (e.g., personality dynamics, degree and type of psychopathology, strengths) or the therapist's own personal or experiential factors that are interfering with her or his performance in particular sessions.

There are two schools of thought in defining expertise. The "expert performance" school (Ericsson, Charness, Feltovich, & Hoffman, 2006)

focuses on superior performance, with experts being qualitatively differ than nonexperts. The performance-based school (Weiss & Shanteau, (2014), on the other hand, argues that there is a continuum of performance and that any distinction among people at the top of the continuum is arbitrary. We adopt the performance-based approach and suggest that therapist expertise exists on a continuum, ranging from highly inexpert to highly expert. To be considered an expert or judged as possessing high levels of expertise, one would need to function at a high point on this continuum across sessions and clients. The specific point on the continuum at which one may be judged as being expert or having a high degree of expertise is arbitrary and subjective (e.g., top 10% of sample). As with previous definitions, our definition is general, aspirational, and only partially evidence based. We offer it to guide theory and research but note that it needs to be operationalized in each individual study. We next turn to criteria against which expertise can be assessed.

Criteria for Assessing Expertise

We offer several criteria, presented in order of our view of their relative importance in assessing expertise. Performance (including technical and relational expertise), cognitive processing, and client outcomes are the most important criteria. Experience, personal and relational qualities of the therapist, credentials, reputation, and therapist self-assessment are all relatively less important criteria, although still worthy of inclusion. Thus, we assert that expertise can be evaluated against criteria such as a high level of therapist performance, personal qualities, credentials, professional reputation, and self-assessment, developing as a result of experience and resulting in improved client outcomes. We present these criteria as separate variables, but it is important to note that they are inextricably intertwined.

As a comparison, Tracey et al. (2015) offered the following four criteria for defining individual expertise in psychotherapy: (a) reputation, degree attainment, professional distinction, and experience; (b) skill, competence, or adherence to a prescribed standard of performance; (c) clinical accuracy; and (d) outcomes, or success with clients. We agree with Tracey et al. about the importance of a, b, and d, although we differ about the relative importance of these criteria (in Tracey et al. [2014], client outcomes appeared to be the ultimate criterion, but in their follow-up piece, Tracey et al. [2015], there did not appear to be any rank ordering of the criteria). In contrast to Tracey et al., we do not include clinical accuracy as a criterion because this construct pertains more to assessment and diagnostic accuracy than to psychotherapeutic treatment (as noted earlier). Although assessment and diagnostic accuracy may be

important elements, we believe at this point it is most useful, scientifically, to be specific and to not conflate treatment and diagnosis. We also separate experience from reputation because these two criteria are fundamentally different. Finally, we add therapist cognitive processing, the person of the therapist, credentials, and therapist self-assessment as criteria because all add value in defining expertise.

Performance as a Criterion of Expertise

Performance is difficult to define and assess (Tracey et al., 2014), but nonetheless we believe it is at the core of expertise. Hence, it is important to spend considerable time and effort defining and understanding performance and then figuring out how to assess it.

To understand performance, it is necessary to recognize that psychotherapy involves a complex therapeutic relationship that is both generalizable and unique to each case. Therapeutic relationships are by their very nature fluid and intricate, with interactions on both conscious and unconscious levels, and with influences from outside events and contexts. Because the requirements for establishing a relationship and intervening effectively differ somewhat for every client/therapist pairing, assessing expertise can be daunting. A fitting metaphor is that the practice of psychotherapy is more akin to improvisation than to acting in the role of a particular character in a play. Thus, rather than a clear, finite set of possibilities, there is great variability in how expert therapists behave. Often therapists' choices develop organically during sessions, as they might shift from a planned focus to respond flexibly according to the client's needs. Related to this, a therapist might be expert with one client but not another, which leads to the conclusion that expertise is at least partially contextually driven.

We conceptualize performance expertise as being both relational and technical, with the interaction of these two components acting in concert with client involvement to contribute to effective therapy. Similarly, Norcross (2002, 2011) summarized the extensive literature about therapist facilitative conditions (e.g., empathy) and interventions (e.g., collecting client feedback, self-disclosure, managing countertransference) that have been shown to be demonstrably effective or at least promising components of treatment. If called on to prioritize, we would say that relational expertise is more fundamental than technical expertise and certainly has more empirical support (see Norcross, 2002, 2011), but we stress that the two are intertwined. Sound interventions facilitate the development of the therapeutic relationship, and the strength of the relationship influences receptivity to the therapist's techniques (Gelso, 2014; Gelso & Hayes, 1998; Hill, 2005).

Relational expertise. Perhaps the most basic task of the therapist is to establish a sound relationship with each client. Skovholt, Ronnestad, and Jennings (1997) suggested that expertise in the alliance domain consists of "the ability to establish, maintain, and creatively use a positive working relationship with highly distressed—angry, depressed, rebellious, disturbed—individuals" (p. 363). They considered expertise in the alliance area to consist of cognitive (e.g., high intellectual and conceptual skills), relational (e.g., superb interpersonal skills), and emotional (emotional maturity and personal stability) components.

Much of the literature in this area 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. Although research does not support the assertion these qualities are sufficient to produce change, evidence does suggest that they are indeed necessary. Considerable meta-analytic support indicates that empathy, alliance, goal consensus and collaboration, positive regard and affirmation, and congruence and genuineness are robustly related to client outcomes (Elliott, Bohart, Watson, & Greenberg, 2011; Farber & Doolin, 2011; Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath, Del Re, Flückiger, & Symonds, 2011; Kolden, Klein, Wang, & Austin, 2011; Tryon & Winograd, 2011).

We suspect that some novice therapists are able to establish a "good enough" relationship with less disturbed or complicated clients based on their own early life experiences of being natural helpers, but are not able to work with more difficult or disturbed clients because natural talent is usually not sufficient. Although therapists vary in the ability to develop a relationship with clients from the beginning of training (Hill et al., 2016), training and experience facilitate both establishing and maintaining the therapeutic relationship while engaging in the many tasks that are required in successful psychotherapy, such as, setting boundaries, managing countertransference, understanding psychopathology, utilizing client strengths, clarifying theoretical orientation and therapeutic style, implementing the technical aspects of therapy, conceptualizing client problems, detecting and handling ruptures and mistakes with clients, and recognizing cultural and environmental factors that support or impede change (Hill, Charles, & Reed, 1981; Hill et al., 2016; Hill et al., 2015).

Some empirical support for the distinction between novice and experienced therapists in terms of establishing and maintaining a relationship with clients comes from two studies. Mallinckrodt and Nelson (1991) found no difference between novice and experienced therapist in the bond aspect of the working alliance, but experienced therapists established greater agreement

on the goals and tasks of the working alliance than did novice therapists. Thus, the goals and tasks of therapy rather than the bond might change more as a result of growing expertise. Furthermore, Kivlighan, Patton, and Foote (1998) found that greater therapist experience was unrelated to the strength of the working alliance with securely attached clients but was positively related to the strength of the working alliance within insecurely attached clients. These two studies suggest that experienced therapists are better at dealing with the more complex aspects of the therapeutic relationship.

There are some well-established methods for assessing relational expertise. Client postsession report of the working (or therapeutic) alliance is a typical way in which alliance is gauged, with evidence showing that client-rated alliance is a robust predictor of client outcome (see meta-analysis by Horvath et al., 2011). In addition, client-rated assessments of the real relationship might also be a good tool for assessing expertise given the association of real relationship with client outcomes (e.g., Gelso, 2011, 2014; Kivlighan, Hill, Baumann, & Gelso, 2016).

Technical expertise. Technical expertise involves the judicious and skillful use of specific interventions or techniques in sessions with clients. To maximize the impact of these skills, they must be used within the context of a strong therapeutic relationship.

A caveat when we consider technical expertise is that what is viewed as expertise varies dramatically across theoretical orientation, making it difficult to define technical expertise without considering the perspective from which expertise is being judged. Theoretical orientation directs the focus, intentions, and specific interventions and techniques that are used. In behavioral therapies, therapists might be considered expert if they use interventions (e.g., assertiveness training) to help clients overcome specific behavioral problems (e.g., social anxiety). In emotion-focused therapy, therapist expertise might involve the use of interventions (e.g., reflections of feelings, two-chair technique) to help clients identify and experience emotions. In psychodynamic therapy, therapist expertise might involve therapists using interventions (e.g., interpretations of defenses and transference) to help clients gain insight into unconscious processes so as to reduce inner conflict and live a more harmonious life. It is precisely because the desired therapist interventions vary so widely by orientation that it is difficult, if not impossible, to consider sound technique outside of the context of theoretical orientation. Indeed, judges must have a nuanced understanding of therapeutic models to judge the expertise of the interventions of therapists using these models.

Another caveat in reviewing this area is that we know of no studies directly assessing differences between experts and nonexperts in the use of

techniques. In lieu of specific studies of therapist expertise in this area, we describe related studies that will hopefully inform our thinking about expertise.

A number of coding systems have been developed that distinguish between theoretical orientations (e.g., Elliott et al., 1987). Stiles, Hill, and Elliott (2015) noted, however, that the codings have not been adequately linked with outcome. This lack of linkage between interventions and outcome is likely due to correlating frequency of interventions with session and treatment outcome without attending to issues of quality and timing. In addition, interventions might have immediate consequences or unfolding consequences that are dictated by complicated interactions between therapist interventions and client involvement. Stiles et al. suggested some ideas for new methods that may help us provide better assessments of the complex nature of the outcomes of interventions. For example, these researchers suggested that rather than trying to examine the overall effects of all interventions, researchers focus more specifically on discrete, well-defined interventions and examine them within the context of individual cases, as Hill, Gelso, et al. (2014) did in their examination of therapist immediacy. Stiles et al. further suggested that qualitative approaches, as well as more sophisticated quantitative approaches, be used to handle complex data.

One example of a research program assessing technical effectiveness is the study by Kuprian, Chui, and Barber (in press). They compared and contrasted three therapists who differed in terms of client outcomes (selected from a large randomized clinical trial of supportive-expressive treatment, SET). They coded the sessions for all three therapists using an observer-rated measure that included items from across several major theoretical orientations. The most effective therapist used more relationship-oriented interventions than did the other two therapists. Given that relationship-oriented interventions are theoretically appropriate for SET, these data provided some evidence for the use of this particular cluster of skills.

Another possibility for studying technical effectiveness is suggested by Ablon and Jones's (1998) research using the Psychotherapy Process Q-set (a 100-item measure that raters use to describe therapist-client interactions). These investigators had a panel of experts develop ideal prototypes of psychodynamic and cognitive-behavioral therapy. Results showed that the degree of similarity to the psychodynamic prototype was related to positive outcomes in both psychodynamic and cognitive-behavioral therapy, although the degree of similarity to the cognitive-behavioral prototype was not related to positive outcomes in either type of therapy. For example, a helpful psychodynamic technique was "Therapist points out patient's use of defensive maneuvers, e.g., undoing, denial."

It appears that therapist skill and theoretical expertise paired with appropriate adaptation to the client and the context might be more effective than strict adherence to a theoretical perspective or to a treatment protocol (see Owen & Hilsenroth, 2014). Thus, intentional flexibility might be an aspect of technical expertise.

Technical expertise includes competence. Not only do expert therapists use specific techniques, but they must use these techniques competently. The constructs of expertise and competence have often been used interchangeably in the literature, although competence indicates capable performance whereas expertise reflects performance at a higher level (Tracey et al., 2014). There are many competent therapists who would not qualify as expert. For example, trainees often demonstrate acceptable skill levels at the end of doctoral training, but still grow substantially in their performance before being viewed as experts by clients and peers.

Competence has also been defined as the quality or skill with which interventions and techniques are delivered, and thus involves the appropriateness of the interventions or techniques for the specific client and therapeutic situation (Dennhag, Gibbons, Barber, Gallop, & Crits-Christoph, 2012b). Definitions and judgments about competence also vary by theoretical orientation (e.g., Dobson, Shaw, & Vallis, 1985; Luborsky, McLellen, Woody, O'Brien, & Auerbach, 1985; Rounsaville et al., 1987), such that therapists are judged as competent if they are doing what is theoretically prescribed. The influence of theoretical orientation makes it difficult to derive an all-inclusive standard of competence.

In one study (Thompson & Hill, 1993), client ratings of therapist competence were positively related to some aspects of therapist style (e.g., being professional and caring) and interventions (e.g., validation of feelings, clarification) but negatively related to other aspects of style (e.g., being unprofessional and uncaring) and interventions (e.g., not being validating, lack of clarification). Furthermore, competence ratings were positively correlated with ratings of session depth, client changes in symptomatology as a result of treatment, and client ratings of satisfaction with treatment. These findings suggest that relationship and intervention expertise are confounded in the assessment of competence.

Inconsistent results have been reported in the relation between judge-rated competence (using the above Dennhag et al., 2012b, definition) and client outcome. In their meta-analysis, Webb, DeRubeis, and Barber (2010) found no relation between competence and outcome regardless of treatment modality. By contrast, in a meta-analysis of cognitive behavioral treatments, Zarafonitis-Müller, Kuhr, and Bechdolf (2014) found a small,

significant effect for therapist competence (r = .24) on client improvement across diverse disorders and a significant, moderate effect (r = .38) for therapist competence for clients with major depression. Similarly, Crits-Christoph, Gibbons, and Mukherjee (2013) found evidence that competence was associated with outcome in psychodynamic psychotherapy. These inconsistent findings may be due to the inherent difficulty in defining and assessing competence.

Research outside of psychotherapy shows that incompetent performers cannot accurately recognize their own or others' competence or incompetence (Dunning, Johnson, Ehrlinger, & Kruger, 2003). Perhaps one must have the knowledge base to judge whether one or others are acting competently or expertly. These findings highlight a paradox for research in therapist competence; it may be that only expert therapists can accurately recognize competence in other therapists. This difficulty in judging therapist competence may account for research findings that show that judges have a hard time distinguishing between adherence and competence (e.g., Weck et al., 2013) and that supervisors and independent judges have only small levels of agreement on therapist competence (e.g., Dennhag et al., 2012a).

Technical expertise includes multicultural competence. Being multiculturally competent has been defined as "having both the ability to work effectively across diverse cultural groups and the specific expertise to treat clients from certain culturally diverse groups, as well as minority and underrepresented groups" (Tao, Owen, Pace, & Imel, 2015, p. 337). Given that the provision of culturally competent services has been cited as an ethical imperative (Ridley, 1985), it stands to reason that expert psychotherapists must be culturally competent. Tao et al. conducted a meta-analysis of 18 studies of multicultural competence (generally assessed using the client-rated version of the Cross-Cultural Counseling Inventory–Revised; LaFromboise, Coleman, & Hernandez, 1991) and therapy process and outcome in actual psychotherapy. Client ratings of therapist multicultural competence accounted for about 52% of the variance in client-rated satisfaction, 38% of the variance in client-rated general counseling competence, 37% of the variance in client-rated working alliance, 34% of the variance in client-rated session depth, and 8% of the variance in client-rated symptom improvement. Given the overlap between general counseling competence and multicultural competence, we speculate that general competence needs to include cultural competence.

We should note that although the idea of being generally multiculturally competent sounds good, it well may be that therapists are not competent with all clients. As we review later under the section about client outcomes, some

evidence indeed shows that therapists may be competent with some types of clients but not others.

Distinguishing technical expertise from adherence to a treatment protocol. Technical expertise can be distinguished from adherence, which Dennhag et al. (2012b) defined as the extent to which a therapist succeeds in delivering the techniques or interventions prescribed in a treatment manual and restrains from using techniques or interventions from other approaches. Results of meta-analytic examinations of this literature are inconclusive. One meta-analysis (Webb et al., 2010) revealed no relation between adherence (accounting for less than 1% of therapy outcome using Dennhag et al.'s definition) and outcome regardless of treatment modality. Webb et al. (2010) concluded that greater adherence resulted in varied outcomes including being detrimental, beneficial, or having no association with client outcome. In contrast, Crits-Christoph et al. (2013) found a moderate association between adherence (using the above definition) and outcome in psychodynamic psychotherapy. In fact, Owen and Hilsenroth (2014) demonstrated that the flexible application of manualized techniques across treatments was associated with better client outcome, supporting the idea that knowing when and how to modify a technique is more important than rigid adherence to manual protocols. Interestingly, Owen and Hilsenroth (2014) found that within-case variability in adherence (flexibility) was associated with better therapy outcomes. These studies suggest that the relationship between adherence and outcome is not consistently linear and that this relationship might be better described as curvilinear (Owen & Hilsenroth, 2014). In other words, therapist skill in adapting treatment to the client and context might be more effective than close adherence to a treatment protocol.

Responsiveness as a mixture of technical and relational expertise. Another way of conceptualizing expertise is through of the concept of appropriate responsiveness, which involves a continuing adjustment of interventions based on the changing nature of the situation (Hatcher, 2015). In sessions, therapists' interventions are shaped by their perceptions of the client's needs in the moment, or knowing what to do, when, to help the client (Stiles, 2013). Likewise, how they develop the bond and therapeutic relationship with the client is shaped by their sense of the client's needs. For example, some clients want a more personal relationship whereas others want a more professional relationship (Bachelor, 1995). In terms of assessment, Elkin et al. (2014) recently developed an observer-rated process measure for assessing responsiveness during psychotherapy sessions. Another

means for evaluating both competence and responsiveness would be through supervisor evaluation.

Cognitive Processing as a Criterion of Expertise

Expert therapists must encode, process, organize, and retrieve vast amounts of information about their clients, therapeutic techniques, and therapeutic situations to establish strong therapeutic relationships and intervene in an effective manner. The general literature on expertise (e.g., Ericsson, 2009) has specifically focused on how experts organize their domain specific information. Thus, cognitive processing ability generally and knowledge structuring specifically seem to be a hallmark of expertise.

Across a number of fields, research has shown that experts (a) perceive comprehensive meaningful patterns in domain relevant information, (b) have excellent short- and long-term memory for information in their domain of expertise, (c) quickly and automatically execute basic skills in their domain, (d) spend considerable time developing ways to understand problems, (e) represent problems at a deep as opposed to a surface level, and (f) use self-monitoring skills effectively (Chi, Glaser, & Farr, 1988). Unlike psychotherapy research, expertise research in other fields usually relies on objective criteria for identifying experts (e.g., chess experts can be identified by number of tournaments won).

More specifically in psychotherapy, we contend that expert therapists are able to conceptualize clients, understand client dynamics, understand clinical situations, see their interactions with clients in a complex way, understand the relationships among therapeutic techniques, and develop treatment plans. This ability to process and organize information about clients, situations, and techniques is a necessary but not sufficient foundation for intervening effectively with clients. In other words, it is possible to have a brilliant formulation about a client but not be able to translate that formulation into an effective intervention.

Researchers studying the cognitions of experienced and expert psychotherapists have primarily focused on how expert (i.e., those who had obtained either or both fellowship or diplomate status) versus novice therapists make sense of different types of counseling-related information (e.g., client statements or descriptions of group situations). More expert therapists, as compared with novice therapists, perceive more comprehensive and meaningful patterns (a) in the statements that clients make in counseling sessions (Mayfield, Kardash, & Kivlighan, 1999, (b) in the diagnostic information about clients (Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989), (c) in terms of differences among group members (Kivlighan & Quigley, 1991), (d)

in terms of the interventions that leaders made in group treatment (Kivlighan & Kivlighan, 2009), and (e) in terms of group situations (Li, Kivlighan, & Gold, 2015). In addition, when therapists-in-training were more like experts in terms of seeing comprehensive and meaningful patterns in counseling data, their clients reported deeper and smoother sessions and greater therapist attractiveness, trustworthiness, and expertness (Kivlighan, 2008). Similarly, when group therapists-in-training increasingly became like experts in terms of seeing comprehensive and meaningful patterns in group counseling data, group members reported greater satisfaction with leadership (Kivlighan & Kivlighan, 2010). Furthermore, group therapy trainees who observed expert therapists, were observed by experts, and received feedback developed more complex, deeper, and more integrated knowledge structures about group members (Kivlighan, Markin, Stahl, & Salahuddin, 2007) and group leader interventions (Kivlighan & Kivlighan, 2009).

Closely related to cognitive processing specific to psychotherapy is the concept of *case formulation*, defined as "a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal and behavioral problems: It guides therapy by helping identify treatment goals, appropriate interventions, and potential problems that may arise" (Kendjalic & Eells, 2007, p. 66). Eells, Kendjelic, and Lucas (1998) developed a content coding manual to define the important elements in a case formulation. Using this coding system, Eells et al. (2011) found that expert therapists (10,000 or more hours of practice plus a national or international recognition in the area of case formulation) displayed more forward reasoning, description, inferences, and treatment planning in their case formulations than did experienced and novice therapists (Eells et al., 2011). Thus, possessing more complex, deeper, and more integrated knowledge structures and case formulation can be considered as criteria of psychotherapy expertise.

Client Outcomes as a Criterion of Expertise

Clients in treatment with expert therapists should have the best outcomes, whereas clients of novice or poor therapists should have the worst outcomes. Empirical support for this view comes from two sources: (a) analyses of client engagement and dropout and (b) analyses of therapist effects using standardized client self-report measures.

Client engagement and dropout. One way of assessing outcome is whether clients return following the initial session, a phenomenon that has been referred to as engagement (Tryon, 2002). Although some clients do not return after the initial session because they believe their needs have been met, not returning

more often reflects the failure to establish an initial working alliance. In her review of the engagement literature, Tryon found that engagement quotients (number of clients who returned for at least one session past intake divided by number of clients seen) ranged from 20% to 70% for counseling and clinical psychology doctoral trainees, suggesting a wide range of therapist ability to involve clients in psychotherapy. Given that professional counselors had higher average engagement quotients than did trainees (Tryon, 1985, 1989a, 1989b), Tryon (2002) speculated that ability to engage clients improves with experience but offered no longitudinal evidence to support this claim.

Engagement is not limited to the initial encounter with the client; rather it is a process that continues throughout the course of therapy. Premature discontinuation (i.e., dropout) is often indicative of the lack of engagement during later stages of treatment. In their review, Swift and Greenberg (2012) found considerable variability between therapists in dropout rates, with experienced therapists having a significantly lower dropout rate than therapists-in-training (17% vs. 27%). Similarly, in a recent longitudinal study, practicing therapists had fewer clients terminate early over time as they gained experience (i.e., were in practice longer or saw more clients; S. B. Goldberg et al., 2016).

Client report of outcome. Considerable evidence now exists that therapist effects explain 5% to 10% of the variance in client outcomes across different types of treatment (see Baldwin & Imel, 2013, for a review). Thus, some therapists are better able than others to form working alliances (Baldwin, Wampold, & Imel, 2007; Kivlighan et al., in press), form real relationships (Kivlighan, Gelso, Ain, Hummel, & Markin, 2014, 2015), and yield better client outcomes (Baldwin, & Imel, 2013; Kim, Wampold, & Bolt, 2006; Okiishi et al., 2006; Okiishi, Lambert, Nielson, & Ogles, 2003). We might consider those at the top of the statistical distribution to be experts.

Producing substantially greater client change as compared to other therapists is an intuitively appealing criterion for evaluating therapeutic expertise. However, one problem with using this criterion for the typical therapist is that many therapists are not part of the huge networks that collect data about client outcomes, and so no standardized data are available for them. A second and related problem is that to obtain reliable differences in client outcome between therapists, each therapist must treat at least four to 14 clients (Dennhag et al., 2012a).

Third, a therapist may not be expert with all clients, but rather may have expertise with a specific subset of clients, although the evidence here is mixed. Some research shows therapists are more effective with some clients than others based on client variables such as racial/ethnic status, gender, and problem

type (Hayes, Owen, & Bieschke, 2015; Imel et al., 2011; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Owen, Wong, & Rodolfa, 2009), whereas others show consistency of effects across client types (Green, Barkham, Kellett, & Saxon; 2014; Huppert et al., 2001; Wampold & Brown, 2005).

A fourth consideration is that client-rated outcome is influenced by a whole host of factors other than therapist expertise. For example, Lambert (1986, 1992) suggested that approximately 40% of the variance in treatment outcome is attributable to client factors and events outside of therapy. So unless clients are randomly assigned to therapists, average differences in outcome across therapists may actually reflect differences among clients. Some research has shown, in fact, that between-client differences in alliance are more related to client outcome than are between-therapist differences (e.g., Marcus, Kashy, Wintersteen, & Diamond, 2011). Therapists do differ in average client outcome, but it is unclear if these differences are related to therapists, clients, or a combination of the two.

In addition to sorting out the variance due to therapists in client-rated outcome measures, there are problems with the way that client outcomes have typically been assessed. Most researchers have taken a narrow view of client outcome, typically assessing only symptomatology. Connolly and Strupp (1996), however, found that successfully treated clients improved in self-understanding, self-confidence, and greater self-definition in addition to reduced symptoms and interpersonal distress. Other studies have found positive changes in quality of life over the course of a variety of types of therapies and client concerns (e.g., Crits-Christoph et al., 2008). Related to this, Hill, Chui, and Baumann (2013) argued that change assessments need to be tailored to the individual (given that all change is individual), using measures such as Goal Attainment Scaling (Kiresuk, Smith, & Cardillo, 1994) and Target Complaints (Battle et al., 1965). It appears that clients seek treatment for a number of different reasons and treatment results in diverse and often individual outcomes. Therefore, to be a meaningful criterion of therapist expertise, client outcome assessment needs to be broad, multifaceted, and individualized.

Furthermore, the evaluations of client outcome are most often assessed only through client self-report measures. Clients often complete these self-report measures quickly by checking responses rather than reflecting deeply about their inner experiences as they would be more likely to do in an interview format. Similarly, these instruments assess only conscious experiences and often do not detect defensive responding. For example, Shedler, Mayman, and Manis (1993) found that many clients defensively report normal functioning when in fact they are not functioning well. Similarly, in the "hello-goodbye effect," clients 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.

Strupp and Hadley (1977) recommended that change be assessed from the perspectives of clients, therapists, and significant others, as all are important stakeholders in the change process. Clients are the consumers and clearly have the greatest say in terms of staying or leaving therapy. Therapists have considerable training and have seen a wide range of clients, and so can offer an important perspective on client outcome. For example, in randomized controlled trials (e.g., Barber, Barrett, Gallop, Rynn, & Rickels, 2012), therapists or trained clinical assessors often judge client functioning using standardized interview assessments (e.g., Hamilton Rating Scale for Depression; Hamilton, 1967). However, the evidence about the accuracy of clinicians' judgments is mixed. For example, clinicians' ratings of distress were better predictors of physiological measures of distress than were client ratings of distress (Shedler et al., 1993). On the other hand, clinicians did not accurately predict who would not benefit from psychotherapy (Hannan et al., 2005). Therefore, in some situations, clinicians might offer an important perspective on client outcome that can supplement clients' perspectives.

Obtaining reports from significant others offers an important perspective on change, one that is often quite different from the client's perspective. Friends and family often see things that clients and therapists do not, although of course they may have a vested interest in the client changing or staying the same. For example, significant others can rate whether or not clients have made changes on the problems that they discuss in therapy (e.g., Flowers & Booarem, 1989). We would add that trained judges observing in-session behavior can provide another valuable perspective on therapist expertise. All perspectives are likely to be different (Hill & Lambert, 2004), reflecting the complexity of the change process.

We also argue for including qualitative assessments as part of outcome batteries. McLeod (2011) suggested asking clients to provide a narrative about their goals during intake and then having them reassess their progress on these specific goals in the same manner after treatment.

Finally, behavioral measures such as missed days of work and doctor visits are also relevant measures. When people in psychotherapy use fewer medical resources, this is a big advantage given the relatively lower costs for psychotherapy. For example, Davidson, Gidron, Mostofsky, and Trudeau (2007) assigned patients with myocardial infarction or unstable angina to either cognitive-behavioral group therapy or information sessions. Group therapy patients had shorter hospital stays and consequently lower hospitalization costs. Davidson et al. derived the cost-offset ratio by dividing hospitalization

savings by the cost of group therapy, finding that every dollar spent on group therapy resulted in a savings of almost two dollars in hospitalization costs.

In sum, we agree with Tracey et al. (2014) that client-rated outcome is an important criterion of therapist expertise, but we argue that it should not be used as the sole criterion for establishing expertise, given that it is influenced by many other factors and is limited in terms of measurement. Furthermore, we argue that client outcome needs to be assessed more broadly and that complex interactions between aspects of the therapist and client and different types of outcomes need to be addressed. More specifically, although we recognize that not all of these can be measured in any given study, we suggest that client outcomes be measured by (a) engagement quotients and drop-out rates; (b) reports by clients, therapists, significant others, and trained observers about symptomatology, interpersonal functioning, quality of life or well-being, self-awareness, self-understanding, self-acceptance, satisfaction with work, and meaning in life; and (c) behavioral measures such as missed days of work and doctor visits. Researchers will probably have to develop measures to assess some of the more complex constructs.

Experience as a Criterion of Expertise

Much of the literature on therapist effects has used years of clinical experience to characterize therapist expertise. In addition, researchers have often used years of experience in hopes of explaining variance in client outcome. In narrative reviews of this literature, support was found for a small association between therapist experience and client outcome (Beutler et al., 2004; Stein & Lambert, 1995).

When age was used instead of years of experience, mixed results were found. Beutler et al. (2004) concluded that age did not play a role in treatment outcome, whereas Anderson, Ogles, Patterson, Lambert, and Vermeersch (2009) concluded that older therapists had better outcomes and noted that "age serves as an indicator of the accumulation of clinical experiences needed to master the interpersonal qualities inherent in facilitative interpersonal skills" (p. 764).

Two cross-sectional studies with very large samples provide no evidence for years of experience and client-rated outcome. Wampold and Brown (2005) found no effects for years of practice in their analysis of the outcomes of 6,146 clients seen by 581 postdegree managed care therapists. Similarly, Okiishi et al. (2006) found no effects for three levels of therapist experience (preinternship, internship, postinternship) on improvement of about 5,000 clients seen by 71 therapists at a university counseling center.

In two recent longitudinal studies, some evidence was found for changes in trainees but not for experienced therapists. Owen, Wampold, Kopta, Rousmaniere, and Miller (2016) found that 114 trainees (practicum, predoctoral interns, and postdoctoral fellows) increased a small but significant amount in terms of client outcomes over the course of 12 months treating 2,991 clients. They changed, however, only with less distressed clients but not with more disturbed clients. In another study, S. B. Goldberg et al. (2016) found a small overall decline in client-rated outcomes for 170 therapists (ranging from trainees to licensed professional) treating 6,591 clients across the course of an average of 45.31 months (experience was assessed both as the cumulative number of clients and as years of experience). Interestingly, some therapists showed improvement whereas others declined. In contrast, early termination decreased overall across time.

Similar to S. B. Goldberg et al.'s (2016) finding about early termination, the authors in a meta-analysis of studies examining premature discontinuation in adult treatments indicated that one of their "most noteworthy findings" (p. 526) was that the discontinuation rate for experienced therapists was significantly lower than the rate for therapist-in-training (17% vs. 27%; Swift & Greenberg, 2012). These authors speculated that experienced therapists were more responsive and focused on the therapeutic relationship than were trainee therapists. It is interesting, however, that different results were found in this meta-analysis for client-rated outcomes and early termination.

Relying on years of experience as the criterion of expertise is problematic in view of the multitude of factors (e.g., different types of clients and supervision) and confounding variables (e.g., engagement in personal psychotherapy and postdoctoral training) that get incorporated into years of practice. As Hill and Knox (2013) noted, experience has rarely been defined. Most studies simply measure experience as number of years in graduate school, number of completed practica, number of clients, or number or years of postdegree experience. But it is apparent that quantitative measures of the passage of time do not reflect the nature and quality of professional development during that time. Some applicants go directly from college to graduate school, whereas others may have extensive work experience prior to beginning their graduate education. In some graduate programs, trainees get extensive individual supervision, whereas in others they get only minimal group supervision. In addition, some therapists see many clients per week, whereas others see just a few and client populations vary depending on setting.

Another problem with the research on experience is that, with the exception of two recent studies (S. B. Goldberg et al., 2016; Owen et al., 2016), the majority of studies are cross-sectional (between-therapist studies). However, the critical question that needs to be addressed is a within-therapist question.

Does a therapist have better outcomes with specific types of clients as she or he gains experience? These questions are best studied through longitudinal rather than cross-sectional methods to show changes over time. Especially problematic in the cross-sectional studies are when trainees are compared with experienced therapists. Trainees do not practice independently, but rather are given substantial support by their supervisors. We have no empirical studies during graduate training where trainees are randomly assigned to supervision or no supervision, given that it would be unethical to allow trainees to practice without supervision. Thus, we have no empirical evidence from graduate training about the effects of treatment where supervision is not provided.

A final problem is that experience is a multidimensional construct but it is usually assessed as a single dimension (e.g., years since obtaining the terminal degree). We agree with Skovholt et al.'s (1997) recommendation for expanding how experience is operationalized to include time (e.g., years of experience), intensity (e.g., number of client hours per year), variety (e.g., number of different types of clients), type of training, depth of training with specific types of clients and problems, and amount and type of supervision and independent reading.

The Personal and Relational Qualities of the Therapist as a Criterion of Expertise

Most clients will attest to the fact that therapists are not interchangeable. These differences go beyond specific education and skills to other factors that may be harder to quantify. We argue that these factors involve the personal and relational qualities of the therapist. Personal qualities include all aspects of mental health such as being grounded, nondefensive, comfortable in one's skin, and self-aware. Relational qualities refer to ease in developing a warm and caring connection with clients while maintaining appropriate boundaries. Thus, we hypothesize that exemplary (expert) therapists are high functioning in both the personal and relational areas, thus enabling them to interact effectively and also provide a positive role model for clients.

Supporting these assertions, effective therapists have been found to be sensitive, caring, self-controlled, sympathetic, positive about self and others, able to handle countertransference, satisfied with their jobs, able to establish warm and supportive relationships, dedicated to their own and clients' growth, and flexible (C. Goldberg, 1992; Hillerbrand, 1989; M. Jackson & Thompson, 1971; Luborsky et al., 1985; Ricks, 1974; Wicas & Mahan, 1966; Wiggins & Weslander, 1979). In addition, master therapists (as identified by peer nominations) were voracious learners, drew heavily on accumulated experiences,

valued cognitive complexity and ambiguity, were emotionally receptive, were mentally healthy, were aware of how their emotional health impacted their work, had strong interpersonal skills, believed in the working alliance, and were able to implement their exceptional relational skills in therapy (Jennings & Skovholt, 1999). Unfortunately, much of this research is limited in that these therapist characteristics were not linked to client outcomes.

Many personal and relational qualities are promising and in need of further research. In the next sections, however, we highlight only a few that seem most promising. Under personal qualities, we consider the related qualities of reflectivity, mindfulness, and flexibility. Under relational qualities, we consider the broad domain of an empathic personality.

Therapist personal qualities. One of the benchmarks for competency in professional psychology is "Professionalism." A foundational component of this benchmark is "Reflective Practice/Self-Assessment/Self-Care" (American Psychological Association, 2012). This benchmark is described as practice conducted with personal and professional self-awareness and reflection, including awareness of one's competencies and engaging in appropriate self-care. Graduate students are expected to demonstrate an increasing level of reflectivity as they progress through their graduate training, and those who are deemed ready for entry to practice must demonstrate reflectivity both during and after professional activities, be able to act on these reflections, and be able use the self as a therapeutic tool. In other words, evidence of increased expertise in reflectivity is expected to occur as graduate training progresses (see Kaslow et al., 2009, for tools for assessing reflectivity).

Skovholt et al. (1997) argued that a key quality of effective therapists is "a focused inquiry aimed toward attaining a comprehensive and nuanced understanding of the phenomena encountered in one's professional work" (p. 365). They noted that reflectivity involves an active exploratory stance and openness to the complexity of the client's reality. Skovholt et al. considered reflectivity to be similar to deliberate practice (Ericsson, Krampe, & Tesch-Romer, 1993). We consider reflectivity as a crucial personal characteristic because it is important for therapists to observe carefully and think intentionally (e.g., Fuller & Hill, 1985) about their interventions and to have a well-developed and internalized theoretical orientation. In other words, expert therapists think intentionally about their actions and interventions based on having a well-developed and empirically supported theoretical rationale.

One way to specifically reflect about practice is by doing an assessment of personal factors. Knapp, Youngren, Van de Creek, Harris, and Martin (2013) suggested that therapists conduct a personal skills inventory about their training, experiences, reading, study, consultation, supervision, and

risk management strategies. They further suggested that therapists evaluate the information they have in their personal database about diagnoses and areas of professional practice. Such activities could help therapists manage their risks and provide better services.

Closely related to reflectivity is the concept of mindfulness, which involves therapists' ability to (a) observe and attend to internal and external experiences as they occur in therapy, (b) describe these experiences nonjudgmentally, (c) give full attention to being present with the client, and (d) not label experiences as "good" or "bad." In situations in which there is danger of harm or self-harm, therapists must of course depart from the mindful nonjudgmental stance and adopt a more direct approach. Research by Ryan, Safran, Doran, and Moran (2012) showed that this type of mindfulness in therapists is related to both client- and therapist-rated working alliance and to client improvement in interpersonal problems. In addition, another aspect of mindfulness, nonreactivity, was related to supervisors' ratings of therapists' ability to manage their countertransference reactions (Fatter & Hayes, 2013). A number of good self-report measures now exist for mindfulness such as the Five Factor Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006).

Flexibility involves sensitivity to the context of the client and therapeutic situation, possessing a diverse repertoire of counseling responses, and being responsive to both verbal and nonverbal feedback from the client (e.g., Bonanno & Burton, 2013). Studies have shown that effective therapists had a flexible interpersonal style (Laska, Smith, Wislocki, Minami, & Wampold, 2013) and maintained a high level of facilitative conditions in the face of client resistance and hostility (Anderson et al., 2009).

Tracey, Hays, Malone, and Herman (1988) operationalized therapist flexibility as the intraindividual standard deviation of the therapists' responses. In this approach, flexibility is a meta-construct that could be used with any measure of therapist technical activity to derive an intraindividual standard deviation. For example, Kivlighan (2010) used Hill and O'Grady's (1985) Intentions List to derive a measure of therapist flexibility. Therapists who used a broader range of intentions were considered more flexible.

Therapist relational qualities. Some therapists naturally have an empathic personality, which is characterized by warmth, compassion, and caring (Stahl & Hill, 2008). We hypothesize that therapists who possess these natural abilities will develop high levels of relational expertise quickly and readily because they have an intuitive sense of how to connect with their clients (see also Hill et al., 2016).

With respect to measuring this construct, several self-report measures of empathy have been developed (e.g., Davis, 1983), although these instruments

have the same problems as described above of self-report measures (e.g., can individuals really judge their own empathic qualities?). Also promising are performance measures of interpersonal ability. For example, the Facilitative Interpersonal Skills task (FIS; Anderson et al., 2009) assesses a therapist's ability to provide facilitative conditions (e.g., warmth, empathy) and to be actively engaged (e.g., persuasive) in response to filmed stimuli of difficult clients. Clients of therapists with higher FIS scores had greater reduction in symptoms over treatment than did clients of therapists with lower FIS scores (Anderson et al., 2009; Anderson, McClintock, Himawan, Song, & Patterson, 2016); they also fared better with respect to alliance development and outcome (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2015). Similarly, Schöttke, Flückiger, Goldberg, Eversmann, and Lange (2016) found that ratings of therapists' communication ability (e.g., clarity of communication, empathy, respect and warmth, management of criticism, and willingness to cooperate) based on their behavior in group discussions after viewing a provocative film predicted client outcomes.

Also promising are nonverbal measures of emotion recognition (i.e., the ability to interpret emotional expressions in the face, voice, or body posture), which seem related to an empathic personality. The ability to read nonverbal cues of emotion is particularly relevant because of the link between nonverbal emotion recognition and interpersonal competency, empathy, emotional intelligence, and social skills (Austin, 2004; Cook & Saucier, 2010; Lawrence, Shaw, Baker, Baron-Cohen, & David, 2004; Padykula & Horwitz, 2012). One such measure is the Reading of Mind in Eyes Test (Baron-Cohen, Wheelwright, Hill, Raste, & Plumb, 2001), which assesses ability to identify emotional states based on identifying emotions from photographs of a person's eyes.

To summarize, to assess personal and relational qualities, we suggest that researchers draw from both the personal and relational areas to assess expertise. First, they could assess personal qualities to determine how well the therapist is functioning, perhaps using measures such as reflectivity, mindfulness, and flexibility. Second, they could examine relational functioning by assessing levels of empathy from the perspective of self-report, observer ratings, and nonverbal measures. A caution about these measures is that although therapists may generally have a personal and relational quality (trait), they may not exhibit this quality with a specific client (state). Further research is needed to definitively link these variables to client outcomes.

Credentials as a Criterion of Expertise

A starting point on the journey to expertness is graduation from an accredited doctoral-level psychotherapy training program. This credential guarantees at

least a minimum level of competence given the ethical imperative that students should not be allowed to graduate unless they fulfill specific benchmarks. Trainers in doctoral psychology programs are required to verify readiness for predoctoral internship by attesting to trainee skills, maturity, and professional and ethical conduct, and predoctoral internship sites must attest that the student has satisfactorily completed training and is competent to practice.

Following graduation, students must pass licensure requirements prior to practicing independently. We would not, however, consider licensure as evidence of clinical expertise because the licensure tests do not assess performance in a therapeutic setting.

A more important indicator of expertise is board certification. An increasing number of licensed psychologists now seek board certification through the American Board of Professional Psychology (ABPP). Board certification by ABPP is a very rigorous and time-consuming process that is pursued by highly motivated clinicians. A major aspect of such certification is evidence that applicants engage in self-reflection and in routine assessment of practice outcomes and provide evidence of effectiveness to the evaluators through written materials and videotapes followed by an oral examination. A panel of judges evaluates each applicant to determine expertness in a given area. Thus, certification by this group is a good indicator of expertness.

Reputation as a Criterion of Expertise

Experts have been described "as those who have been recognized within their profession as having the necessary skills and abilities to perform at the highest level" (Shanteau, 1992, p. 255), which is a good working definition of reputation. For example, peer nominations of expert therapists are frequently based on (a) professional interactions with therapists in which they have been observed to be knowledgeable, helpful, and trustworthy (i.e., the person to whom you would refer a family member); (b) advancement to positions of honor within an organization (e.g., fellowship status with the American Psychological Association or awards based on clinical expertise); (c) positive feedback from clients about the therapist's skills and referral of friends and family members to therapist; (d) reports from colleagues, friends, or other sources about their interactions with the therapists (although this category may be empirically problematic because it is likely to be influenced by factors other than actual performance); (e) invitations to demonstrate methods in workshops, videos, or books; and (f) a professional record free from ethical violations.

Tracey et al. (2014) suggested that reputation (e.g., peer nomination, degree attainment, diplomate status, amount of experience) is not a useful

criterion of expertise because of its tenuous connection with performance and client outcomes. Although it certainly has limitations, we argue that reputation can be used as one index of expertise and that many professional fields use reputation as an index of expertise.

Indirect evidence for the importance of reputation as an indicator of expertise comes from three sources. First, most of the studies examining the cognitive processing of therapist use reputation to identify the "expert" therapists studied. In these studies the expert therapists consistently have higher quality cognitive processes than the nonexpert group. Therefore, it appears that reputation is associated with cognitive processing expertise. Second, Jennings and Skovholt (1999, 2016) used nominations for identifying master therapists in their studies and found a great deal of consistency across countries in characteristics of master therapists. Third, in two surveys conducted 20 years apart, Norcross and his colleagues (Norcross, Bike, & Evans, 2009; Norcross, Strausser, & Faltus, 1988) asked mental health professionals what criteria they would use in selecting their personal therapists. In the 1988 study, professional reputation was ranked third out of 16 criteria, with only competence and clinical experience being ranked higher. In the 2009 study, professional reputation was ranked fifth out of 20 criteria with only competence, warmth and caring, clinical experience, and openness being ranked higher. These studies suggest that at least in other therapists' minds, reputation is an important aspect of therapeutic expertise.

Self-Appraisal as a Criterion of Expertise

A final criterion of expertise is therapist self-assessment. In psychotherapy, self-assessment of competence has been defined as "a form of appraisal that makes a comparison between one's behavioral outcomes and an internal or external standard" (Boekaerts, 1991, p. 11). Elks and Kirkhart (1993) argued that clinicians continually evaluate their own skills, form global appraisals of their work based on intuition and experience, monitor their reactions, and make judgments in comparison to guidelines for good practice.

Research has consistently found that people engaged in a variety of tasks, from driving to engineering and medicine, report an overly positive self-assessment, rating themselves as above average (e.g., Dunning, Health, & Suls, 2004; Meyer, 1980). Similarly, psychologists, psychiatrists, and other mental health professionals have rated themselves as being above average in terms of their clinical skills and performance in comparison to other clinicians with similar credentials (Parker & Waller, 2015; Walfish, McAlister, O'Donnell, & Lambert, 2012). Parker and Waller (2015) also found that higher levels of conscientiousness, emotional stability, and openness (traits

that are viewed as positive attributes in clinicians) were associated with higher self-appraisals and higher ratings of client recovery. In addition, older, more experienced clinicians rated themselves as more skilled than did younger, less experienced therapists.

In general, people have a tendency to overrate their abilities and performances (Kruger & Dunning, 1999). This tendency can be explained by the inaccuracy of low performing individuals who tend to grossly overestimate their abilities and performance, whereas the best performers (i.e., experts) are accurate in their self-assessments (Schlösser, Dunning, Johnson, & Kruger, 2013). In addition, research shows that experience can improve people's ability to accurately self-assess (Miller & Geraci, 2014). Researchers have not examined if expert therapists are also accurate in their self-assessments or if therapists improve with experience in their ability to accurately self-assess.

In a comparison of therapists' self-assessments with supervisor assessments and judges' ratings, Mathieson, Barnfield, and Beaumont (2010) found positive but nonsignificant correlations (ranging from .10 to .32). The authors concluded that self-assessments are not particularly reliable measures of competence, although they may reflect confidence (i.e., self-efficacy). It is interesting to note here that social psychologists (e.g., Taylor, 2003) have found that self-assessment is positively associated with multiple measures and judgments of mental health and a favorable impact on others. Hence, it may be that a positive self-assessment is an indicator of self-efficacy and a lack of depression.

Determining Expertise Based on the Proposed Criteria

Therapist expertise appears to be a multidetermined and multifaceted construct derived from complex human interactions. At this point in our understanding and in the interest of advancing research and practice, 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. Hence, we have included in Table 1 criteria that we propose could be used to measure expertise, along with specific methods for assessing each criterion. Much research will be needed to determine the relative importance of the various criteria.

The Development of Expertise

In this section, we first briefly cover what we know about therapist development, extracting the implications for expertise. We then cover several specific mechanisms of change that have been identified as helping therapists develop expertise.

Table 1. Criteria and Related Measures for Assessing Expertise

Criteria	Possible ways of assessing criteria
1. Performance	A. Client-rated working alliance B. Client-rated real relationship C. Observer-rated responsiveness D. Use of observer-rated theoretically appropriate interventions E. Observer-rated competence F. Client-rated multicultural competence G. Observer-rated responsiveness H. Supervisor-rated competence or responsiveness
2. Cognitive functioning	A. Observer-rated assessment of cognitive processing B. Observer-rated assessment of case conceptualization ability
3. Client outcomes	A. Engagement in therapy (percentage of clients who return after intake)/dropout rates B. Clinically significant change on reports by clients, therapists, significant others, or observers using measures of symptomatology, interpersonal functioning, quality of life/well-being, self-awareness/understanding/acceptance, satisfaction with work C. Behavioral assessments (e.g., fewer missed days of work, fewer doctor visits)
4. Experience	A. Years of experience B. Number of client hours C. Variety of clients D. Amount of training E. Amount of supervision F. Amount of reading
5. Personal and relational qualities of the therapist	A. Self-rated self-actualization, well-being, quality of life, lack of symptomatology, reflectivity, mindfulness, flexibility B. Empathy ability (self-rated, nonverbal assessments, observer ratings) C. Nonverbal assessments of empathy
6. Credentials	A. Graduation from an accredited training program B. Board certification
7. Reputation	A. Professional interactions B. Advancement to positions of honor within organizations based on recognition of clinical expertise C. Positive feedback and referrals from clients D. Reports from colleagues/friends E. Invitations to demonstrate methods in videos, workshops, or books F. Lack of ethical complaints
8. Therapist self-assessment	A. Evaluation of own skills

Note. The criteria are listed in the order of perceived relevance to assessing expertise, from 1 (*most relevant*) to 8 (*least relevant*).

Evidence of Changes Over Time

We know of no direct empirical evidence about the development of expertise per se. We do, however, have evidence for the development of some of the components identified above as criteria of expertise.

In their review of the empirical literature on training and supervision, Hill and Knox (2013) cited evidence that beginning trainees learn to give less unsolicited advice, talk less, interrupt less, use more exploratory interventions and ask fewer closed questions. They also reported evidence for the effectiveness of helping skills training programs that was popular in the 1960s and 1970s. More recently, Hill et al. (Hill et al., 2016; Hill et al., 2008) found that undergraduate students become more proficient in using helping skills (e.g., reflections of feelings, interpretations) over the course of a semester of helping skills training. Hill and Knox suggested that it might be easier to show changes with novice trainees than more experienced therapists, given that novice trainees tend to make dramatic changes early in training as they shift into a more professional role.

Similarly, a fair amount of research now shows that student increase in their abilities across a semester of graduate training. Williams, Judge, Hill, and Hoffman (1997) found decreases in trainee anxiety as well as increases in self-efficacy, therapeutic skills, and countertransference management over the course of a semester. Lent, Hill, and Hoffman (2003) found that self-efficacy for using helping skills, managing sessions, and working with difficult client situations increased over the course of a semester-long practicum and that self-efficacy was higher for more advanced students.

Several longitudinal studies have investigated changes across at least a year of doctoral training. Hilsenroth, Kivlighan, and Slavin-Mulford (2015) found that client-rated alliance and use of psychodynamic techniques increased linearly across training cases. Hill et al. (2015) found that trainees increased in client-rated working alliance and real relationship; therapist-rated working alliance; client-rated interpersonal functioning; ability to use helping skills (e.g., challenges, immediacy); higher-order functioning (e.g., conceptualization ability, countertransference management); feelings about themselves as therapists (e.g., more authentic, more self-aware); and understanding about being a therapist (e.g., theoretical orientation, curiosity about client dynamics). In contrast, trainees did not change in engaging clients (return after intake or for at least eight sessions), judge-rated psychodynamic techniques, or changes in client-rated symptomatology. Finally, as cited earlier, Owen et al. (2016) found increases for trainees over the course of a year in terms of client outcome, although these changes were only observed among the less disturbed clients and not the more disturbed clients.

From these investigations, we conclude that there is evidence of growing expertise from undergraduate- through doctoral-level training. We would not assert that these student therapists were yet experts (i.e., at the top 10% of all therapists), but it does seem convincing that, on average, students were progressing along the continuum of expertise.

It may be that the various components of therapist expertise develop at different rates. For example, therapists seem to more rapidly develop expertise in the task of formulating specific verbal response modes, as reported in Hill and Knox (2013). It may also be that therapists become more flexible or intentional over time in their use of verbal response modes, although this has not yet been studied. There also seems to be rapid changes in areas such as decreased anxiety, talking less, interrupting less, and general professional demeanor (e.g., Hill et al., 1981; Matarazzo & Patterson, 1986; Williams et al., 1997). We expect that changes in self-awareness, ability to maintain boundaries, countertransference management, and the development of a theoretical orientation that is consistently integrated into the clinical work are slower to develop and require more intensive practice and supervision. Finally, we propose that therapists learn how to work with clients "in general" in a few years, but that it takes more time and training to learn how to work with individual clients with specific issues, and probably even more time and training to learn to work with very difficult clients.

Less is known about the development of postdegree therapists. As cited earlier, no changes were found over time in client-rated outcome (S. B. Goldberg et al., 2016), although therapists had lower rates of early termination as they gained experience (S. B. Goldberg et al., 2016; Swift & Greenberg, 2012). In a study examining how earning continuing education credits contributed to licensed psychologists' perceptions of their own competence in practice, a moderate effect was found for activities such as taking courses, attending workshops and psychology conferences, and reading professional books and articles (Bradley, Drapeau, & DeStefano, 2012). The transfer of such training to client outcomes has not, however, been demonstrated (see Neimeyer, Taylor, & Phillip, 2010).

In addition, a study on the career development and growth of psychotherapists is also relevant to components of expertise. The Collaborative Research Network project (Orlinsky & Ronnestad, 2005) was a 15-year study of nearly 5,000 psychotherapists at all career levels, theoretical orientations, and from a dozen different countries. Data were collected based on therapist self-report summing across all current patients. Orlinsky and Ronnestad reported that levels of effective practice were higher whereas incidences of disengaged and distressed practice were lower for more senior clinicians. Therapists in this study were grouped in terms of their "experienced growth" and "depletion"

with about half reporting much growth and little depletion (effective practice) in contrast to 10% of therapists reporting more depletion and little growth (distressed practice). Depletion and disengagement were related to higher routinization in therapeutic work, disillusionment regarding its effectiveness, and declining empathy for patients. In contrast, therapist perceptions of "experienced growth" and "healing environment" were related to career development.

Mechanisms of Change

In their review, Hill and Knox (2013) reported that therapists perceived that hands-on experiences with clients, personal therapy, and supervision were the most helpful factors in their growth. Although the empirical support for these is minimal, we highlight them because they seem to make conceptual sense. We also focus on two additional mechanisms, as they too seem important and promising: deliberate practice and feedback about clients.

Hands-on experiences with clients. In a series of studies based on Bandura's (1969) framework, Chui et al. (2014), J. Jackson et al. (2014), and Spangler et al. (2014) studied the effectiveness of instruction, modeling, practice, and feedback for training undergraduate students in insight skills (challenges, interpretation, immediacy). They found evidence for the effectiveness of all four components, but by far they found that practice was cited as the most helpful component. Similarly, psychology externs and interns reported learning a lot from their experiences seeing clients (Hill et al. 2014; Stahl et al., 2009).

Personal therapy. Although personal therapy is not generally a requirement of graduate training (nor would we advocate to make it a requirement), there is substantial reason to believe it is an important aspect of a therapist's development (see also Hill & Knox, 2013). Sitting in the client's chair and understanding the vulnerability and impact of that perspective are essential components of building empathy with clients. Being in the role of the client enables the therapist to understand in a very experiential manner the importance of both technique and the therapeutic relationship. In addition, psychotherapy can help the therapist trainee gain greater self-awareness and self-insight, resolve personal problems, and recognize and manage countertransference, all of which can help the trainees be a better therapist.

Supervision. Supervision has been shown to have major effects on aspects of trainee development such as enhanced self-efficacy and awareness, and skill acquisition (e.g., Ladany & Inman, 2012). However, it has been more

challenging to ascertain the contribution of supervisors to client outcomes, also important in establishing expertise. In his review of the extant literature on this topic over a time period of 20 years, Freitas (2002) concluded that supervisors do appear to have an impact on client outcome, but he also noted that methodological problems made this finding difficult to interpret. In a more recent study of clients being seen in a doctoral training clinic, clients were divided into one of four outcome categories: recovered, reliably improved, no change, and deteriorated (Callahan, Almstrom, Swift, Borja, & Heath, 2009). Although client's level of initial distress was most predictive of treatment outcome, results suggested that supervisors (but not counselors) had a significant moderate impact on client outcomes. The authors concluded that supervisors account for about 16% of the variance in client outcome when controlling for therapist attributes and the client's initial severity level. Thus, supervision seems to be helpful in developing expertise both in terms of trainee development and client outcomes.

Deliberate practice. There is a growing body of research across a variety of fields on the relationship between deliberate practice and expertise. Deliberate practice has been defined as "individualized training activities especially designed by a coach or a teacher to improve specific aspects of an individual's performance through repetition and successive refinement (Ericsson & Lehmann, 1996, pp. 278-279). According to Ericsson and Lehmann (1996), research suggests that deliberate practice leads to expertise after a sustained and extended period of practice over about 10 years. This sustained and deliberate practice leads to cognitive and emotional adaptations to domain tasks that enhance expertise.

Ericsson et al. (1993) argued that expert performance is more strongly related to engagement in deliberate practice rather than to hours of experience. They defined deliberate practice as participating in structured activities designed to improve performance. For example, an accomplished pianist might spend hours practicing a particular passage before performing that passage as a part of a larger piece. In their meta-analysis of studies examining the relationship between deliberate practice and performance, Macnamara, Hambrick, and Oswald (2014) found that deliberate practice explained 26% of the variance in performance for games, 21% for music, and 18% for sports, but only 4% of the variance in performance for education, and less than 1% for professions. Macnamara et al. argued that the effect sizes for education and professional training were so much smaller than for games, music, and sports because deliberate practice is less well defined in education and professions.

An important challenge for research in the development of therapist expertise is to describe what deliberate practice looks like in therapy. For example Molyn Leszcz, who has published with Irving Yalom (Yalom & Leszcz, 2005), has, for 25 years, led an open-ended therapy group that is observed by trainees. After each group session, Dr. Leszcz meets with the trainees to discuss the session. Observing an expert group of therapist is of course a valuable experience for the trainees, but being observed, reflecting on the group, explaining actions and inactions, hearing different points of view about group processes, and receiving feedback are also invaluable experiences and are examples of deliberate practice for Dr. Leszcz. We believe that the processes involved in this observation and reflection experience have contributed to Dr. Leszcz's expertise in group therapy and that the processes of reflection, explanation, considering alternatives, and feedback may constitute deliberate practice in psychotherapy.

Only one study has examined deliberate practice in therapy. Chow et al. (2015) used the Retrospective Analysis of Psychotherapists' Involvement in Deliberate Practice Scale, which assesses "the amount of time therapists spend in practice outside of work aimed at improving their therapy skills" (p. 339), to study deliberate practice. Specifically, the authors assessed

> (a) the frequency with which therapists engaged in 25 activities (the amount of time spent in the last typical work month), (b) the confidence therapists had in their frequency rating from 0 (*not at all confident in my time estimate*) to 10 (*highly confident in my time estimate*), (c) the relevance of the particular activity to improving clinical skills from 0 (*not at all relevant*) to 10 (*highly relevant*), and (d) the cognitive effort required for engaging in the activity from 0 (*no effort exerted at all*) to 10 (*highest possible effort exerted*). (p. 339)

Chow et al. found the amount of time that therapists spent in deliberate practice (e.g., mentally running through and reflecting on past and future sessions) was significantly related to client outcome. We believe that this study has the potential to transform how expertise researchers think about and operationalize therapist experience.

We suggest that expert therapists spend considerable amounts of time in deliberate practice through such activities as peer and professional supervision, reflecting about clients between sessions, and planning specific interventions. Future research could build on the Chow et al. (2015) study to investigate more about the types of deliberate practice or reflectivity engaged in by expert therapists. It might be interesting to compare expert therapists with the 10% to 26% of therapists identified by Orlinsky and Ronnestad (2005) who are depleted or disillusioned or static to see what they do in terms of deliberate practice or whether they are simply in more difficult clinical settings.

Feedback about client outcome. In their meta-analyses of randomized controlled studies that evaluated the effectiveness of providing therapists with feedback on client outcome using client self-report measures, Lambert and Shimokawa (2011) tentatively concluded that feedback improves outcomes, and this effect is more pronounced for clients who are at risk for deterioration or dropout. However, it is not clear if therapists who use feedback to become more "expert" in treating a specific set of clients can generalize this "expertise" to other clients when a feedback system is not in use. Similarly, Leon, Martinovich, Lutz, and Lyons (2005) found that therapists learned from working with clients, but could apply the learning only to new clients with similar presenting problems and pathology. Such results suggest that we cannot just look at change across clients, but must examine therapist changes with similar clusters of clients. In addition, even if a feedback system can improve therapist effectiveness specifically or generally, it is not clear what level of improvement would constitute the attainment of expertise.

Tracey et al. (2014) suggested that therapists ought to rely on feedback from standardized measures of client outcome to increase their expertise. For all the reasons cited above in the section on client outcomes as a criterion of expertise, we argue that such feedback is limited. We do, however, believe that feedback from a number of sources is an essential component of therapist growth. This feedback can be derived from the perspective of trained observers, clinical supervisors, clients, and the therapists themselves. We contend that expert therapists rely on careful observations of clients, carefully noting changes in behavior (e.g., subtle withdrawals). In addition, they use immediacy (Hill et al., 2014; Hill & Knox, 2009) to ask clients about their reactions. Such in-session behaviors could be studied using state-of-the-art process research (e.g., Safran, Muran, & Eubanks-Carter, 2011).

In addition to feedback from standardized measures of client outcome, we suggest that therapists be trained specifically to seek feedback from clients via immediacy and processing the therapeutic relationship (see Hill et al., 2015; Hill & Knox, 2009; Yalom, 2002). Asking the client directly about problems in the relationship or the focus of the therapy would seem to be the most likely method for learning about specific, individualized problems. Of course, it is not enough to simply ask. Trainers need to help therapists learn to be genuinely curious about their client and to manage their own reactions to clients (Gelso & Hayes, 2007). Even though the feedback from clients may contain varying degrees of client transference material, we theorize, as have many others (see Gelso, 2011), that therapists contribute to transferences, and it is important for the therapist to understand his or her contribution.

Self-feedback necessitates valuing and taking the time for self-reflection and self-assessment. This basic value is often stressed in graduate training as

essential in enhancing therapist behavior. Toward that goal, we recommend that therapists be encouraged to get training in mindfulness and self-awareness (see Hill, 2014, chap. 4). By learning to pay attention to bodily signals of discomfort and distress, therapists can better manage countertransference. Self-reflection and self-assessment may help therapists become aware not only of how they react to clients in sessions, but how they view social and cultural factors that influence their clients and that may differ from their own experience.

In addition, a primary way of gaining feedback is through supervision. During their graduate training, student therapists receive feedback on a regular basis from their supervisors who observe their sessions by means of audio or videotaped recordings. Furthermore, after completing the doctoral program, many therapists avail themselves of opportunities for feedback by joining peer supervision groups or pursuing postdoctoral training to refine and improve their clinical skills (refer back to the earlier description of the study by Callahan et al., 2009, about the effectiveness of supervision).

Conclusions

In this article, we have argued that some therapists do indeed develop high levels of expertise, and that the relative lack of empirical support for this development is due to limitations in the definitions of expertise and the methods that have been used to assess this construct. Thus, we hope that the definition, criteria, and assessment ideas provided above will help to further the study of expertise.

We need better research on expertise. Most of the studies of expertise (as defined by years of experience) have used cross-sectional designs to compare experienced and inexperienced therapists with respect to client outcome. As noted above, many confounding variables limit the contribution of these studies. Two longitudinal examinations of early training (Hill et al., 2015; Hilsenroth et al., 2015) show positive effects of increasing trainee expertise during supervised experiences, and two recent longitudinal studies of trainees and practicing therapists (S. B. Goldberg et al., 2016; Owen et al., 2016) demonstrate how elegantly change can be assessed. What is needed are more longitudinal studies so that we can see changes over longer periods (e.g., changes over the course of graduate training, changes over the course of postdoctoral practice).

Naturalistic studies provide the best method for examining therapist expertise. Naturalistic studies have tended to find greater therapist effects than controlled studies (see Elkin, Falconnier, Martinovich, & Mahoney, 2006), perhaps because therapists are less constrained in what they do

in sessions and because there is often greater statistical power with more therapists and more clients per therapist. Furthermore, because meta-analyses have found great variability in therapist effects on psychotherapy outcomes ranging from 0% to 50% (Crits-Christoph & Mintz, 1991), research is needed to examine therapist expertise using an array of measures of client outcomes across multiple clients. Such research would allow us to assess various aspects of therapist expertise.

Using therapists as participants, qualitative research might examine some of the most relevant characteristics of experts based on cognitive research summarized by Chi et al. (1988). For example, they concluded that experts compared to nonexperts perceive large meaningful patterns, see and represent a problem in a deeper (more principled) level, spend much time analyzing a problem qualitatively, and have strong self-monitoring skills.

In addition, researchers need to carefully consider perspective in any assessment of expertise. Strupp and Hadley (1977) eloquently argued that clients, therapists, and significant others are important stakeholders in the outcome of psychotherapy and should be included in such evaluations. We would add that trained judges can offer an invaluable perspective about expertise. Clearly, these four perspectives offer different ideas about expertise and all can add to the complex picture of which therapists are deemed to be expert and why.

In conclusion, we hope that we have helped to further the debate on therapist expertise. We look forward to reinvigorated theoretical and empirical work on this topic.

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