Reflections on the Power to Define Psychotherapy Expertise

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Abstract

The field of psychology has struggled to define what it is that makes an expert therapist expert. Just as elusive has been the ability to know and articulate how one achieves expertise as a therapist. In their major contribution, Hill, Spiegel, Hoffman, Kivlighan, and Gelso identify a number of constructs that researchers interested in assessing expertise can consider and evaluate. In this reaction to their article, we share where we are in agreement with the authors and where our thoughts diverge. We conclude with what we deem to be missing from this discussion regarding therapist expertise—power and privilege as it relates to who decides what makes an expert.

Keywords

psychotherapy, professional issues, training

We would like to begin this reaction article with a question, one asked at one time or another of virtually every practicing therapist. Can you recommend a therapist for a friend/family member of mine? What names come to your mind? Put another way, who is on your list of therapists you believe have sufficient expertise that you would entrust them with your friends and family, and finally, how does

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one make that list? In constructing our response to Hill, Spiegel, Hoffman, Kivlighan, and Gelso's (2017 [this issue]) major contribution, we asked ourselves this same question. We considered our own internal constructions about what makes for an expert therapist and reviewed the list created by Hill et al., recognizing that our response is influenced by who we are and our lived experiences.

As part of our commitment to reflexive practice (Morrow, 2005) we would like to acknowledge our identities as they inform the response that follows. The first author identifies as a White bisexual cisgender woman who works as a counselor educator and supervisor, and as an integrative feminist, solution focused, and cognitive behavioral therapist in private practice. The second author identifies as a Chinese woman who grew up in China, received Western doctoral training in counseling psychology, and practices mostly in university counseling centers as an emotion-focused, interpersonal-process-oriented therapist. The third author identifies as an African American man who serves as a training director for social workers and psychologists in training. He identifies as a cognitive behavioral psychologist and has been in practice for approximately 20 years. None of the authors are fellows in the society, nor are we board certified.

We are appreciative and honored to have the opportunity to offer our perspectives on what we believe is a significant contribution to the ongoing debate within our field regarding how to define, measure, and develop expertise as a psychotherapist. We commend Hill et al. (2017) for their review of the literature and concomitant recommendations for future investigations of expertise. They provide a comprehensive review of empirical studies on factors that may explain the development of expertise in psychotherapy as well as highlight the dearth of adequate research on expertise. They accurately note that inadequate definitions of the construct have hampered this area of inquiry, take issue with definitions offered by others (e.g., Tracey, Wampold, Lichtenberg, & Goodyear, 2014; Weiss & Shanteau, 2014), and provide a new definition for the readers' consideration. The authors end their article with novel suggestions for future studies, including longitudinal designs, naturalistic studies, and qualitative research.

Hill et al. (2017) define expertise as "*the manifestation of the highest levels of ability, skill, professional competence, and effectiveness*" (p. 9). Moreover, they suggest eight criteria the field might consider in defining expertise: performance, cognitive functioning, client outcomes, experience, personal and relational qualities of the therapist, credentials, reputation, and therapist self-assessment. This definition is much broader than others have suggested (e.g., Tracey et al., 2014). We agree that some of these criteria are essential in any definition of expertise (e.g., client outcomes, personal and relational qualities of the therapist, and performance); however, in our assessment, the above

list is too broad to be helpful in refining this area of inquiry. Below we share the reasons that some of these criteria might even be inappropriate and suggest a more parsimonious list of criteria to identify what accounts for expertise in therapy—assuming expertise can adequately be defined.

Centrality of Client Outcomes in Defining Expertise

We concur with both Hill et al. (2017) and Tracey et al. (2014) that client outcome is a key consideration in establishing clinician expertise. We appreciate the attention given to the challenges that exist in adequately defining and capturing clinical outcomes, and we agree that we must do more in refining and enhancing our methods of assessing what, if any, meaningful differences are taking place in our clients' lives as a result of the work taking place in treatment. Furthermore, although there are challenges and practical constraints on collecting outcome data from collaterals (e.g., parents, partners), we support this recommendation and believe the more sources of outcome data the better.

We acknowledge that a challenge in utilizing clinical outcomes to determine expertise is the lack of control a therapist has over outcomes; we know that client extratherapeutic events and engagement in therapy predict outcomes more strongly than most of the therapist variables typically measured (Bohart & Tallman, 2010; Orlinsky, Rønnestad, & Willutzki, 2004). However, from our perspective, the therapist who is able to navigate this most effectively is most expert. That is, shouldn't our expert therapists be the ones who can collaboratively reach the best outcomes with their clients despite these external challenges?

The measurement of expertise in therapy has significant implications for the training of therapists. If we are able to identify the critical components of what expert therapists do (or fail to do), we are in a position to pass that wisdom on to the next generation of therapists. To that end, we believe there is an opportunity to enhance this area of research by building on the relatively recent shift to a culture of competence (Fouad et al., 2009; Roberts, Borden, Christiansen, & Lopez, 2005). In their exploration of what differentiates "supershrinks" from "pseudo-shrinks," Miller, Duncan, and Hubble (2008) hypothesized that the former engage in a cycle of excellence that includes (a) determining one's baseline, (b) engaging in deliberate practice, and (c) seeking feedback. This is akin to what we ask of the students we teach and supervise. To improve any skill and demonstrate competence, therapists need to identify their strengths and areas for growth. Once these areas for growth are identified, it is critical that therapists practice said skill(s) and receive reliable and consistent feedback on their performance. Thus, for us, any definition of expertise and competence begins with the use of outcome data.

A Case For and Against Performance/Competence as a Criterion

It is clear that certain aspects of performance as outlined by Hill et al. (2017) are essential aspects of expertise. Certainly, the working alliance as rated by clients has arisen as one of the primary contributors to client outcome that involves the psychotherapist (Baldwin, Wampold, & Imel, 2007). There is a growing body of work (e.g., Flückiger et al., 2012) suggesting that when therapists receive feedback on the quality of their working alliance, they are able to improve the alliance, and thus appear to be developing increased skills, which is likely a path toward expertise. We are less confident in the utility of other aspects of performance, such as observer-rated responsiveness, observer-rated theoretically appropriate interventions, and even client-rated multicultural competence for establishing expertise. We see the allure in these constructs; however, we can envision cases where an observer may give poor ratings on responsiveness and yet the client improves dramatically. In some ways, adding in these additional layers to a definition of expertise may introduce more noise that obscures the signal we are trying to measure. One may perform beautifully as a clinician in the eyes of observers; however, if our clients and communities are not becoming better, stronger, and more well adjusted as a result of our work, then, we ask, what is the point?

An additional challenge in relying on competency assessment is that the voices that have been privileged to contribute to the definition of competence have been largely those of dominant cultural group members. For example, prior to 1973 and the removal of homosexuality from the list of mental disorders by the American Psychiatric Association (Garnets, 2007), provision of therapy that affirmed a lesbian, gay, or bisexual identity would have received low observer competence ratings. We cannot decontextualize our performance ratings from the time and place in which we practice. Professionals who are in power set the criteria for competence, which may or may not be related to enhanced well-being in our clients. Thus, although performance is likely an important area of expertise, we caution that it must not supersede client outcomes grounded in enhanced client welfare.

Conflating Expertise With Experience, Credentials, and Reputation

Experience

At present, the extant research (e.g., Goldberg et al., 2016) does not support the concept that factors as simple as years of experience, number of client hours, variety of clients, amount of training, amount of supervision, or

amount of reading, in and of themselves, cause expertise to develop. Although at times there may be statistically significant correlations between some of these variables and expertise, it is through deliberate practice, or an intentional engagement, that clinicians improve. The outcome is not simply related to time passed or number of clients seen. In addition, working long term in the mental health field serves as a potential risk factor for psychotherapist burnout, especially when therapists perceive their caseload to be excessive (Maslach, 1978; Raquepaw & Miller, 1989). Thus, with the passage of time, all experts will have experience, but not all therapists who have extensive experience are, or will become, experts.

Credentials

Credentials such as licensure do seem important to set a base standard for what we would consider minimal competence to practice, but we fail to see how a credential could predict expertise. In our experience, few of the therapists we would consider experts pursue board certification, largely due to time constraints, limited funds, or limited desire for additional recognition. Similarly, as Prilleltensky (1989) notes, "Every ruling group of an organized community requires the existence of cultural mechanisms designed to ensure or at least facilitate the perpetuation of its position" (p. 796). Additional credentials feel in some ways like a cultural mechanism developed within our field to strengthen our own sense of importance. Virtually all physicians are board certified in some specialty (e.g., family medicine, dermatology), and few would suggest that all, or even the majority, are experts. There would be little reason to seek second opinions if that were true. Many of us know the experience of feeling disappointed when we call our primary care office for a same-day appointment and get assigned to the less stellar, although still board certified, member of the practice. Thus, it seems that although there could be some correlation between credentials and expertise, it is unlikely to be a causal relationship in a direction that is useful for this area of research.

Reputation

The recent findings of the Hoffman Report (Hoffman et al., 2015) have helped to clarify in our minds why reliance on a construct as susceptible to bias as reputation is not a useful measure to include in an evidence-based definition of expertise. Many individuals deemed experts based on "advancement to positions of honor within organizations," "invitations to demonstrate methods in videos, workshops, or books," and even "lack of ethical complaints" (Hill et al., 2017, p. 32) were not performing at an expert level on multiple occasions. Although it is true that even experts make mistakes and

perform at less than expert levels on occasion (i.e., no one is perfect), we see the Hoffman Report as a cautionary tale to not rely on reputation as a proxy for competence or expertise. Similarly, fellow status was noted as a potential indicator of psychotherapy expertise; however, in our observations of who has recently been awarded fellow status within the Society of Counseling Psychology, it seems clear that advancement to this pinnacle of the field is more related to being an academician and prolific researcher and not necessarily to being an expert therapist providing psychotherapy on a day-to-day basis. We caution against conflating the networking ability, extraversion, desire to join organizations, availability of discretionary income or reimbursement, and ability to garner release time to attend national conventions with expertise in psychotherapy.

Examining Power and Privilege in Expertise

There is an intimate connection between power and knowledge. Those individuals who have the opportunity to define the "knowledge" required to be expert in our field have tremendous power. Too often in our field, constructs like expertise and competence are put forth without acknowledging the contexts from which these constructs arise. Rossiter, Prilleltensky, and Walsh-Bowers (2000) spoke of the problem of our fields constructing "ethics as properly emerging from an internal, private, cognitive function of the individual" (p. 86), ignoring the structural and political contexts from which they emerged. We argue that the same is true for the definition of expertise put forth in this major contribution. In their present form, the proposals in both Hill et al. (2017) and Tracey et al. (2014) are highly individualistic; expertise exists primarily within a professional. Tracey et al.'s version perhaps democratizes it a bit more by centering practice outcomes, that is, utilizing clients' improvement as the ultimate criterion of expertise. However, even here there is the unstated assumption that ranking individuals is a worthwhile approach to our work and essential to improving the practice of psychotherapy.

We are concerned that by placing the emphasis on expertise over competence, psychologists run the risk of reinforcing a primarily linear and hierarchical thinking style (Jun, 2010) as opposed to a more humble, curious, holistic, and open style that we attempt to foster in both our clinical work and our social justice focused education. From our perspective, expertise is not a destination that one reaches (e.g., "top 10% of all therapists"; Hill et al., 2017, p. 34). Rather, expertise, similar to sobriety or being antiracist, is an aspect of our identity that expires when we go to sleep and must be earned back every day and in each interaction with our infinitely complex and unique clients. Hill et al. accurately note, "expertise is at least partially contextually driven" (p. 11); however, we struggle to see how expertise can be decontextualized

from a specific clinical interaction or setting and individualized into the characteristics of a single clinician. Said differently, we suggest that there are just as many ways of being an expert therapist as there are ways of knowing and being in the world. We recognize that, if this is true, it likely makes efforts to measure or quantify expertise more challenging. However, given the continued disparities in dropout rates as well as (dis)satisfaction with therapy among clients of color (Owen, Imel, Adelson, & Rodolfa, 2012), it appears that our current methods of measurement and focus are still falling far from the mark for the majority of the world population.

We acknowledge that the use of outcome data as the path to improvement (and developing expertise) is not apolitical, as the design of assessment measures as well as the identification of what is considered healthy or progressive are still determined by *expert* researchers, funders, and those in positions of power. However, at present, it is the best step we see toward a more democratic process of evaluating our work and ensuring that what we do is improving our clients' lives and communities. From our perspective, it seems logical that experts would be those who are capable of helping to facilitate the best outcomes over time. We appreciate the push in both the trauma informed care (Substance Abuse and Mental Health Services Administration, 2014) and recovery model (Sheedy & Whitter, 2009) movements that emphasize bringing consumers of our services in on the decision making and design of our work. We believe prioritizing client perspectives on therapeutic outcomes aligns well with this push to further empower clients and democratize our work.

Closing Thoughts

Returning to our initial referral question, we believe, and here we agree with Hill et al. (2017), that we would want the most expert therapist to provide services to our friend or family member. We want this therapist to demonstrate cultural humility (and competence), have positive outcomes with previous clients, a be open to feedback. Thus, even with our questions about the construct of expertise, we recognize the importance of deepening our understanding of how one builds expertise. To that end, we believe Hill et al. accomplished their primary goal—"to further the debate on therapist expertise" (p. 40). We are grateful for the opportunity to contribute to the dialogue and hope that as this dialogue continues, a deeper look at issues of power and positionality is integrated into the development of measures to assess outcomes.

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