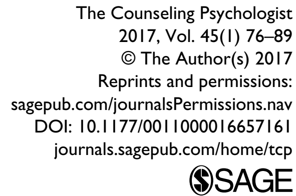
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The Promise and Challenge (and Reality) of Defining Therapist Expertise

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Abstract

This article is a commentary on Hill, Spiegel, Hoffman, Kivlighan, and Gelso's interesting and thought-provoking article focused on defining psychotherapy expertise. I address Hill et al.'s inclusion of other criteria to evaluate expertise that counters Tracey, Wampold, Goodyear, and Lichtenberg's conclusion that treatment outcome is the only criterion supported by the research to determine expertise. I also address Hill et al.'s discussion on the development of expertise with a focus on monitoring treatment outcome to promote therapist improvement. In sum, Hill et al. provide a way forward for psychotherapy researchers to address proposed dimensions of expertise that currently are based more on our clinical wisdom than empirical evidence and, in doing so, offer the promise of better understanding what makes an excellent psychotherapist.

Keywords

psychotherapy, professional issues, training

Let me begin by saying I am honored to provide commentary on Hill, Spiegel, Hoffman, Kivlighan, and Gelso's (2017 [this issue]) article that was written, in large part, in response to Tracey, Wampold, Goodyear, and Lichtenberg's

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(2015; Tracey, Wampold, Lichtenberg, & Goodyear, 2014) conclusions regarding therapist expertise. The authors from these articles are all leaders in counseling psychology and prolific psychotherapy researchers, dare I say experts, and reading their perspectives on this matter is a real treat. Their perspectives on psychotherapist expertise, however, are substantially different. Tracey et al. stay close to where the research is with regard to what we know about the therapist's role in treatment outcome. They conclude that there currently is no compelling evidence for expertise in psychotherapy, meaning there is no clear indication that there are demonstrable gains in skills accrued with experience that result in better treatment outcomes. Specifically, they dismiss commonly used markers that include reputation, experience, credentials, and performance skills based on these markers not being clearly connected to improved treatment outcomes. In the end, they believe that monitoring treatment outcome and using this feedback to promote reflective, responsive treatment is a necessary dimension for developing therapist expertise.

Hill et al. (2017), however, place some of the dismissed criteria back on the table for discussion as well as add others (cognitive processing, therapist as the person, self-reflection). Both groups interpret the psychotherapy literature similarly (with a couple of exceptions noted later) but come to different conclusions. The criteria of *coherence* (competence consistent with theory) and *correspondence* (competence in agreement with objective evidence, improved client outcome in this case) for establishing expertise (Shanteau & Weiss, 2014) are useful for framing their differences. Tracey et al. adhere to the more stringent criteria of correspondence, whereas Hill et al. seem willing to see coherence as the threshold for inclusion or at least further consideration. For example, Tracey et al. admit there are some studies that tie experience to outcome but conclude that their relatively small number, in comparison to several that find no relationship, do not provide clear evidence that experience is tied to better treatment outcomes. Hill et al. interpret these findings similarly but conclude that experience should be considered because the literature does not clearly dismiss it. Hill et al. admit that their criteria are "aspirational" and "only partially evidence based" (p. 10). They believe that skill and knowledge, experience, credentials, the therapist as person, and self-assessment continue to offer promise and are worthy of consideration, particularly with regard to therapist training and development.

There is much to appreciate in both positions. I appreciate Tracey et al. (2014) providing a summative, definitive response to where we are with regard to psychotherapy expertise that has expectedly generated responses from others (e.g., Hook, Watkins, Davis, & Owen, 2015; McMahan, 2014; Oddli, Halvorsen, & Rønnestad, 2014). I also appreciate Hill et al. (2017)

being willing to challenge and add to this discussion, particularly with providing clear ideas on training and future research. In reading their article, a quote by Harry Harlow came to mind: “Psychology of the future will catch up with, and eventually surpass common sense” (Harlow, 1953, p. 32). More rigorous research offers the opportunity to catch up with clinical wisdom and theory.

Hill et al. (2017) note that an important reason for defining expertise is for the purpose of training, and that how we provide training needs to be reexamined if we cannot demonstrate that therapists improve as a result of training. I agree wholeheartedly on both counts. In fact, perhaps the time is here to reexamine our training. The longer I train doctoral students, the more humble I have become about my role in producing excellent clinicians—I am not alone. Larry Beutler candidly admitted, “I don’t have a handle on teaching people at this point. I have little glimpses of how to teach people” (Tong, 2010). Beutler has authored or coauthored 350 publications and 20 books, is a fellow of multiple divisions of the American Psychological Association, and has held numerous leadership roles in the organization including serving as the president of the Society of Psychotherapy Research twice. And yet, he has only little “glimpses” of how to train psychotherapists. Indeed, we need to better understand how therapists are developed. However, before we get to the question of *how*, we must start with the question of *what*. What are the components of being an effective therapist, one with demonstrated expertise? Related to this, are these components learnable and trainable?

In the popular TV sitcom *Big Bang Theory*, the socially awkward theoretical physicist Sheldon Cooper develops an algorithm for how to make friends that he places into the format of a step-by-step flowchart. To Sheldon’s surprise, but to no one else’s, it flops. It makes for a funny scene; everyone recognizes that the components to building a friendship are hard to reduce to a series of linear steps. As applied psychologists, we often wish psychotherapy were less murky, more knowable and predictable. Our students also long for it, even though many of us would ultimately be bored with therapy that is akin to a cookbook.

Our efforts toward this are seen in our research. The psychotherapy research literature has become more voluminous and sophisticated in both our theoretical approaches and research methodology, yet treatment outcome effect sizes have remained stubbornly stable (Lambert, 2013). Small advances have been very, very hard won. Psychotherapy research, for example, has advanced by simply acknowledging that the therapist influences outcome, that who is providing treatment is more important than the type of treatment provided (Scheel & Conoley, 2012; Wampold & Imel, 2015). Yet, we have great difficulty identifying what is special or unique about the best therapists

beyond a few descriptive ideas that do not seem to reside easily within measured attributes or behaviors. We know good therapists build good relationships, but we rely on clinical wisdom to understand how that happens for any individual therapist—research in the aggregate has failed to distill the essential attributes, skills, or behaviors. A question remains whether we can *know* and verify such things within a positivist science paradigm; one's response lies within one's epistemic stance regarding psychotherapy (Shean, 2013). Hill et al. express hope that, in the spirit of Dr. Harlow, an empirical approach can catch up with our clinical wisdom. In the following sections, I address portions of each of the dimensions of therapist expertise the authors believe should be considered.

Performance and Cognitive Processing

Hill et al. (2017) note the difficult task of measuring performance but offer that both relational and technical expertise are criteria indicative of expertise. Common sense would seemingly dictate that therapists with expertise demonstrate more skill than novices—analogous to a concert pianist's capacity to play more difficult pieces than the average piano player. The challenge, however, is identifying a solid literature base to support the contention that such skills can develop as a result of training and experience, and that such skills translate into better outcomes with clients. With regard to relational expertise, Hill et al. mention a couple of studies (Kivlighan, Patton, & Foote, 1998; Mallinckrodt & Nelson, 1991) that find therapists improve in developing alliances with clients, noting that Mallinckrodt and Nelson found greater agreement on the task and goal dimensions, which suggests an increase in skill/performance. There are other studies (e.g., Dunkle & Friedlander, 1996; Tschuschke et al., 2015), however, that do not find a relationship between experience and/or training and improved relationship building, including the task and goal dimensions. It seems likely that if a meta-analytic strategy were used, no effect or only a small effect would be found. Also, if experience ultimately has not been found to predict better treatment outcomes, then does the experience-relational connection even matter?

Although the research to support this dimension is presently mixed, their inclusion of relational criteria does not concern me as much as the differential treatment regarding the measurement of relational expertise. Alliance measures are given a free pass in comparison to outcome measures. A problem with alliance measures is the lack of variability they yield, with most clients rating the alliance high (Tryon, Blackwell, & Hammel, 2007). My experience as a supervisor who requires students to provide outcome and alliance data is that most (but not all) beginning students are rated highly on the alliance,

including the task and goal dimensions, and do not differ much from more experienced students. This issue (whether it is a function of social desirability, the measures, or that clients generally feel positive about relationships) creates a problem of being able to differentiate those at the upper ends of the expertise continuum. More work is needed in this area. Alliance measures have been developed that have attempted to redress the measurement issues by focusing more on alliance behaviors, which are intended to create more variability and provide more instructive feedback for the therapist, such as Alliance in Action (Owen, Reese, Quirk, & Rodolfa, 2013).

I am attracted to the idea of technical expertise, which includes multicultural competence, as a criterion. Hill et al. (2017) propose several possibilities, eliciting concerns and pitfalls along the way (e.g., treatment adherence does not result in better outcomes), but this criterion seems premature and one that falls more on the aspirational side of things. My concerns for this moving beyond an aspirational dimension rest on the challenge of establishing an agreed upon operationalization of technical expertise and our ability to measure process constructs in a way that honors the complexity of such interpersonal exchanges. Regarding operationalization, it seems that perhaps a place to start would be with basic counseling skills rather than specific theoretical orientations or interventions. Tschuschke et al. (2015) found that therapists spend much more time providing nonspecific, common factor interventions than interventions that align with their identified theory. Rønnestad and Skovholt's (2003) reformulation of their cross-sectional and longitudinal qualitative data with 100 therapists found that more experienced therapists commonly indicated being more flexible and utilitarian with approaches and were skeptical of new approaches offering anything new or unique. Today's technical expertise can be tomorrow's fad (Norcross, Pfund, & Prochaska, 2013).

Regarding measurement, currently our description of the psychotherapy process is just that, descriptive rather than prescriptive and more general than behavioral (e.g., How do you build a good therapeutic relationship? What does a culturally responsive intervention look like?). That is part of the beauty (and frustration) of psychotherapy that is perhaps not likely to bend easily to a reductionist approach. Much like with dismantling studies (Ahn & Wampold, 2001; Bell, Marcus, & Goodlad, 2013), the magic is found not within one intervention or task—effective psychotherapy resides within the gestalt of the process, a mixture of the therapist, the client, the therapist–client interaction, and the exchanges that occur between the two. The same therapist using the same approach across clients who have similar problems will not be identical and may not yield the same result. From a training perspective, the literature has little support for supervision promoting better

therapy outcomes (Bambling, King, Raue, Schweitzer, & Lambert, 2006; Watkins, 2011). As stated earlier, this seems to be a case of neither knowing the *what* or *how* of technical expertise. If we can't provide specifics, then how can we train it? If we can't train it, we can't call it expertise. Yet, the researcher in me wishes to persist and continue to identify those markers that are essential to effective therapy.

Cognitive processing ability seems to also fall into a promising category, yet the research thus far has focused on process and satisfaction outcomes. Certainly more research should be done in this area. Through my experience as a supervisor, I have found that students tend to become more nuanced, sophisticated, and flexible in how they conceptualize clients and consider contextual factors in deciding how to intervene with a client. However, again, the lack of a connection with treatment outcome also places this dimension on the premature list.

Client Outcome

Utilizing treatment outcome as a marker of expertise is an area of agreement with Tracey et al. (2014). Hill et al. (2017) argue, however, that client outcome should not have such prominence for establishing expertise because of current limitations with measuring outcome. They do a nice job of noting the concerns and weaknesses that come with the use and reliance on treatment outcome to determine expertise. These concerns include not having access to networks with standardized data for comparison, the fact that therapists have differences in effectiveness with different clients, the recognition that change in therapy resides more with the client than the therapist, and that outcome rated measures tend to be nomothetic and focus only on general distress symptomatology. They also recommend the inclusion of others (e.g., objective raters, family member) in the outcome rating process, a broadening of outcomes considered, and the use of qualitative assessments.

The use of client outcome as presented in Hill et al. (2017) reflects the challenges of measuring outcome thoughtfully. My concern is that more time was devoted to the pitfalls of outcome rather than the virtues. Client outcome is currently the closest thing we have to a definitive measure of success akin to winning or losing in chess or another seemingly objective outcome. I find treatment outcome especially appealing because there is no consensus on the path to client benefit.

And, I agree, we need to be thoughtful in both the pragmatics of access to measures, having enough clients to have reliable data for comparison, as well as how we go about defining success via treatment outcome. Yet defining success via outcomes in any area inherently has these limitations. Baseball is

a nice example. There are statistics galore to describe a player's performance, including batting average, on-base percentage, earned run average, slugging percentage, wins above replacement, and on and on. Sabermetricians (i.e., baseball stats nerds) have wielded great influence and changed the ways in which a player's performance is understood. In fact, they have improved the measure of outcomes. They have determined that on-base percentage and slugging percentage better predict a player's offensive worth in relation to other players. And yet as objective as these measures are, they also all take place within a context. The outcome of a player's "at bat" is dependent on who bats in front of or behind the player, the pitcher, the size of the ballpark, the weather, the speed of the players on defense, and so on. These metrics, although not perfect (see your local sports bar for debates), are still good markers of whether I would want a certain player on my team. Measurement of psychological constructs, including the accurate measure of the multiple reasons people seek psychological services, is also imperfect. Yet, at the end of the day, outcome measurement still seems our best bet for figuring out who we want on our team, as client benefit is the purpose of psychotherapy.

One concern raised was clinicians having access to networks that permit comparison. Access is possible with commercial feedback systems that monitor treatment outcome every session (e.g., OQ Analyst, Better Outcomes Now). Using such a system also permits the ability to track outcome every session, which provides a better understanding of client change trajectories and more information for both clinicians and researchers about session-to-session variations that occur. Another strategy noted by Tracey et al. (2015) is the use of benchmarking methodology (Minami, Serlin, Wampold, Kircher, & Brown, 2008) to compare naturalistic data against established benchmarks from clinical trials. A second concern raised was that therapists may be more expert with some clients and not others. It confused me as to why this is problematic. An elaboration would perhaps help. I assumed that knowing whether a therapist is more or less effective with a given group or issue is a good and important thing and will result in better information in multiple ways, the least of which is trying to decipher if Dr. X is an expert generally or demonstrates expertise with certain groups of clients and/or issues. For example, finding that a therapist is less successful with clients from a certain racial or cultural background highlights a possible need to address multicultural competence.

Hill et al. (2017) spend a significant amount of time advocating for different types of outcomes offered from different "stakeholders" in the client's treatment. In reading this section, I find myself torn between the ideal and the practical. On one hand, we should definitely establish that treatment outcome measures should be tethered to real external outcomes. As a simple example,

I had an adolescent client who showed remarkable progress on his outcome measure. I was internally self-congratulating myself (e.g., "You still got it!") when I asked how his self-esteem had improved, which was his reason for coming to therapy. He said his self-esteem had not improved, and that there were no questions regarding self-esteem on the measure (he was right, sort of). Indeed, this measure did not capture my client's reality well. The use of an idiosyncratic measure or the addition of such items to a standardized, nomothetic measure may have better captured my client's concerns and needs more completely. Of course, the other measurement approaches mentioned by Hill et al. also suffer from the same concerns they noted in terms of determining standards for success/expertise and their representativeness of client progress. Addressing these issues is an important area for outcome research that needs to be done. On the other hand, from a practice standpoint, simply getting clients and therapists to carve out time to complete brief outcome measures is a challenge. To go beyond this stretches feasibility. Robust research that can make the case for expanding outcome measures must first be done and then packaged in such a way that makes it feasible for clinicians and clients.

Experience, Attributes of the Therapist, Credentials, and Reputation

All of these criteria seem to also fall under the aspirational category. Hill et al. (2017) acknowledge that the literature on experience is currently lacking and that attributes of the therapist offer some promising possibilities. As in other professions, experience, credentials, and reputation are often indicators of expertise. Unfortunately, as Hill et al. note, the psychotherapy literature does not provide much support for these seemingly obvious criteria. Perhaps the research is accurate or perhaps we are not measuring these dimensions correctly. This could be a case where research has not caught up with common sense. I certainly have a hard time letting go of this paradigm. Recently, I was asked by a friend for a referral to a psychotherapist for her partner who is also a friend. These are people I deeply care about, and I want my friend to get the best care possible. She asked, "Who is best to work with Jack [name changed] for his anxiety [concern changed]?" Of the psychologists I know in my area, a few rose to the top. Of the several criteria I have, many represent the professional expert archetype. This includes experience, credentials, and reputation—even though I know what the psychotherapy research literature says about these criteria. For some reason, referring my friend to the university's local training clinic composed of psychotherapy

trainees was not my first thought. So I recognize why these are included for consideration. I was unclear, however, by Hill et al.'s conclusion that the American Board of Professional Psychology (ABPP) credential is a "good indicator of expertness" (p. 29) simply because there is a panel of judges who evaluate a number of areas. I know of multiple academics who possess the ABPP credential but do not engage in clinical practice. To say that the ABPP is pursued only by the most "highly motivated clinicians" (p. 29) seems both to overestimate this credentialing process and underestimate the majority of clinicians who see little benefit in pursuing it.

Development of Expertise

My commentary ends where it began—with training. The question "Does training matter?" (Stein & Lambert, 1995; Watkins, 2011) has persisted for some time. Hill et al. (2017) summarize evidence that trainees do demonstrate growth in self-efficacy, basic counseling skills, and other potentially important markers that suggest training helps propel students to be on the expertise continuum. They also acknowledge there is much work to be done in that we don't know what happens with these trainees postdegree. They provide summative evidence that we, as Beutler noted, have "glimpses" of how we should best train people (Tong, 2010). Evidence of supervision's contribution to developing therapists is slim (Callahan, Almstrom, Swift, Borja, & Heath, 2009; Watkins, 2011). We do not know if supervision works, much less how or what works best in developing competent therapists, especially expert ones. Much work is needed, particularly with better-designed studies that evaluate the contributions of supervision to client outcome and process.

The inclusion of deliberate practice to promote development is intriguing to me. Chow et al.'s (2015) finding that therapists who reported spending more time on activities designed to assist and improve their work with clients predicted better treatment outcomes reflects seemingly good common sense. Related to this, Tracey et al. (2014) strongly advocated for using feedback as a means to engage in reflective and deliberate practice. Client feedback systems were initially developed for the purpose of identifying clients who are at risk for dropping out of treatment prematurely or having a poor treatment outcome (Lambert et al., 2001). Client feedback does this well, leading to improvement for clients at risk for poor outcome (Lambert & Shimokawa, 2011) and even clients who are on track (Reese, Norsworthy, & Rowlands, 2009). This identification allows a therapist to gain an understanding for the lack of improvement and to adapt or modify treatment that fits the client.

My enthusiasm for client feedback is twofold: It provides accountability in a profession that has offered little with regard to quality assurance and offers possibilities for training. Feedback on outcome and other therapy processes provides the therapist an opportunity to identify if he or she is being effective with the client and, in following up with clients and within supervision, perhaps the reason(s) why therapy is being helpful or not (Sparks, Kisler, Adams, & Blumen, 2011; Worthen & Lambert, 2007). I view client feedback as a form of deliberate practice and an opportunity to promote self-reflection. Chow et al. also advocated for monitoring treatment outcome as a deliberate practice strategy. The accompanying measures of a feedback system do not make therapy more effective with one client or all clients; it is what a therapist does with the measures that matters. Going back to my example of a measure not assessing self-esteem, the measure was inadequate but the data and process permitted me to follow up and learn that things were, indeed, not going well. This does not remove the measurement problem, but the feedback process permitted us to correct it clinically. This is somewhat echoed by Hill et al.'s mentioning the use of immediacy, processing the relationship, and seeking out feedback to gain additional information other than what is gleaned from outcome measures. In fact, two feedback systems—the OQ Analyst (Lambert et al., 2004) and the Partners for Change Outcome Management System (Duncan, 2012)—include measures of the alliance, albeit used differently, to process the relationship.

The question was posed by Hill et al. (2017) whether feedback promotes expertise when feedback is removed. I think it is the wrong question, perhaps because I am biased and believe that feedback, if useful for a clinician, should simply be used. Why would you not want to use something that is helpful? It seems analogous to asking if an expert golfer would still have expertise if she could not use a driver. Perhaps, but it would limit her ability to demonstrate her expertise (or in the case of novice golfers, such as myself, further demonstrate my lack of expertise).

Conclusion

I am in agreement that we need better research on expertise to identify the building blocks of what makes an excellent clinician—from looking at the therapist as a person to the skills and knowledge that should be part of our training curriculum. I appreciate the willingness of Hill et al. (2017) to operationalize expertise more broadly, to not foreclose on variables that may hold promise for promoting expertise but are currently more consistent with clinical wisdom or simply have not been rigorously

evaluated enough. Their article is important and has engaged and challenged me to think hard about how we go about training and measuring psychotherapy. Their ideas will challenge me long beyond the scope of this commentary.

Both Hill et al. (2017) and Tracey et al. (2014) not only highlight where the therapist expertise literature is, but also offer the promise and insight of where we could and should go. However, their work also illustrates just how little we do know and affirms that, as a teacher, clinician, and researcher, I should be humble in how I approach psychotherapy (Hook et al., 2015). Psychotherapy is a wonderful worthwhile endeavor, and it is clear that psychotherapy is beneficial for most people who seek treatment. It seems the differences between the definitions and positions posed by Tracey et al. (2014) and Hill et al. are that Tracey et al. are focused on where the literature as a whole is currently (the reality) whereas Hill et al. look at the literature as to where it could be (the promise). Hill et al. have a seemingly more optimistic outlook (although acknowledging the challenges) that psychotherapy expertise is indeed identifiable and verifiable, being comprised of multiple dimensions that we rely on in our current training and professional practice models. I do hope the criteria proposed (or some semblance of them), go from contenders to evidentiary criteria comprising psychotherapy expertise. As a trainer and a clinician, I will, however, continue to rely on treatment outcome as my best marker of a good clinician (recognizing the caveats), not as an absolute, but as my best piece of information based on the research. I also believe the use of client feedback offers potential for promoting therapist expertise. As a researcher, I hope we move the literature forward on therapist expertise to a place where we can place more tools at our disposal that will develop expertise within students and clinicians who are committed to better serving their clients.

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