Therapist Expertise: The Debate Continues

The Counseling Psychologist
2017, Vol. 45(1) 99–112

DOI: 10.1177/0011000016671006
journals.sagepub.com/home/tcp
SAGE

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Abstract

In this rejoinder, we respond to comments raised by Goodyear, Wampold, Tracey, and Lichtenberg; Norcross and Karpiak; Reese; and O'Shaughnessy, Du, and Davis about the definition of expertise and methods for increasing expertise. The most consensus among these authors was found for client outcomes as a criterion of expertise and practice as a mechanism for increasing expertise. Until we have better empirical evidence, however, we suggest keeping the eight criteria that we originally proposed to measure expertise (performance, cognitive processing, client outcomes, experience, personal qualities, self-assessment, reputation, credentials), as well as the four mechanisms for increasing expertise (training, practice, feedback, and personal therapy). We challenge future researchers to hone the list and determine how to weight the various criteria and mechanisms based on empirical evidence.

Keywords

psychotherapy, professional issues, training

We deeply appreciate all of the comments made by Goodyear, Wampold, Tracey, and Lichtenberg (2017 [this issue]); Norcross and Karpiak (2017 [this issue]); Reese (2017 [this issue]); and O'Shaughnessy, Du, and Davis

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(2017 [this issue]). The arguments presented have given us much to ponder and help to advance thinking about expertise.

To clarify, in response to Norcross and Karpiak's query, our primary purpose in writing the Hill et al. (2017 [this issue]) article was to express our conviction that expertise does exist in psychotherapy. We asserted that, because of the complexity of human interactions in psychotherapy, expertise takes a different form in psychotherapy than it does in many other professions. As a result, we need to develop better clinically relevant definitions and measures to study it adequately. We believe that Tracey, Wampold, Lichtenberg, and Goodyear's (2014) conclusions were premature and that it is essential to express an opposing view informed by our cumulative experience with clinical practice, training, and research. Additional purposes were to inform therapist training and development, the practice of psychotherapy, and optimal referral of clients to therapists.

Reese (2017) accurately characterized the differences between our stance and that of Tracey et al. (2014): "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" (p. 77). We agree that our view is more aspirational, as we wanted to hold on to clinical wisdom that expertise does exist even if we have not yet been able to prove it with our current research methods. Our hope was that by putting forth our arguments, we could help to advance the field by suggesting where and how to look for expertise in a more multidimensional, clinically relevant approach.

We agree with Norcross and Karpiak (2017) that tackling expertise is a Herculean task, and we agree as well with Reese (2017) that we need to be humble about what we know. Although there is a rich literature on how to help clients, there is no cookbook that tells us how to be effective with each client, and indeed the process and outcome are different with each client. In this highly personalized, contextual endeavor, it is difficult to determine whether therapists are "good enough," let alone expert.

In this rejoinder, we consider a few of the major points raised in the reaction articles. We focus on definitions, criteria for assessing expertise, and mechanisms for achieving expertise. We close with some ideas for research on expertise.

Definition of Expertise

We defined therapist expertise as the manifestation of the highest levels of ability, skill, professional competence, and effectiveness. In response, Goodyear et al. (2017) reasserted Tracey et al.'s (2014) definition that expertise requires an individual to have (a) improved over time and to have

demonstrated superior performance (b) as measured by something that is both agreed on and important, and (c) as demonstrated primarily through client outcomes.

O'Shaughnessy et al. (2017) suggested that both our definition and Tracey et al.'s are problematic because they assume that expertise lies within the individual rather than being contextually bound. They preferred Tracey et al.'s emphasis on client outcome because they considered it more democratic, although they criticized both definitions for the unstated assumption that ranking individuals is a good practice.

Although we agree that expertise develops over time, we are not in favor of using the "improved over time" phrase in the definition because therapists could improve over time but only rise to the level of mediocrity. We strongly agree with the phrase about demonstrating superior performance, but we disagree that superior performance is measured primarily through client-rated outcome assessment. We argue that performance, cognitive processing, and client outcomes are separate and equally valid criteria for expertise, with some justification for the other five criteria (experience, personal qualities, self-assessment, reputation, credentials).

Criteria for Assessing Expertise

O'Shaughnessy et al. (2017) raised the valid point that we need people from different perspectives weighing in on how to define and measure expertise, but we note that it is important to be specific about how to operationalize these different perspectives. They went on to argue that expertise is not a destination but something that must be earned each day. We readily admit that there are situations in which a professional who was once considered high in expertise may lose that status due to changes over time, and that expertise varies by the situation to some extent. However, we do not agree with their extreme position that expertise has to be earned every day. Furthermore, they argued that we should be focusing on competence rather than expertise, because the latter reinforces linear and hierarchical thinking rather than being open, humble, holistic, and curious. We also cherish the values of being open, humble, holistic, and curious, and believe they are compatible with the pursuit of excellence, and emphasize the need to distinguish competence and expertise empirically.

Goodyear et al. (2017) also disagreed with our suggestion of assigning expertise by looking at the top 10% of therapists. We hold to the idea that expertise has to be measured relative to some norm, although we readily admit that 10% is an arbitrary figure and it could just as easily be the top 5% or 15% who qualify as the best of the best.

O'Shaughnessy et al. (2017) thought that our list of criteria was too broad to be helpful. Similarly, Goodyear et al. (2017) suggested that our list of eight criteria with 32 ways of assessing expertise makes the construct so broad that "virtually everyone who works long enough in the field might claim psychotherapy expertise. As a result, the concept loses any practical meaning" (p. 57). We argue that if only approximately 10% can attain the designation of expert based on some integration of the multiple criteria, it is hardly the case that anyone who works hard enough over time will attain expertise.

We admit to being less certain about the specific criteria that should be used to assess expertise and the weight that should be allotted to each of the criteria. At this point in history, however, we think it is best to include many potential criteria that can be tested empirically before we make final judgments. Furthermore, given that expertise is complex and hard to define, it is especially important to have multiple indicators of expertise, each with different sources of error. Indeed, the best practice in research design favors using multiple indicators for a construct rather than relying on a single indicator (Heppner, Wampold, Owen, Thompson, & Wang, 2016). Thus, we focus in the next sections on our eight criteria (recall that we presented the criteria in a specific order, with performance being the most important and credential the least important in operationalizing expertise) and how we might modify these criteria given the reactions to our article.

Performance as a Criterion of Expertise

Norcross and Karpiak (2017) agreed that performance is key, but they specifically valued relational expertise (e.g., multicultural competence, responsiveness, and empathy) above other indicators of performance. They stressed the importance of the therapeutic relationship in particular, and wanted more inclusion of empathy, congruence, collaboration, support/affirmation, requesting feedback, and repairing alliance ruptures (see reviews in Norcross, 2011). Although we agree that these variables are important, they are precisely the variables for which it is difficult to separate out therapist and client influences, as they depend on the recursive and reciprocal nature of the relationship. We do particularly like their points about responsiveness and that expert therapists must be able to adapt to different types of clients. We suggest that with experience, expert therapists veer toward working with those types of clients that they are most likely to help.

We agree with Reese (2017) that there is nothing problematic about being more effective with some types of clients than others. We also concur with Reese that we gave alliance measures a free pass despite some limitations

that have been identified with these measures. Indeed, we need better alliance measures that focus on what exactly it is that therapists *do* to establish and maintain relationships.

Cognitive Processing as a Criterion of Expertise

Although Norcross and Karpiak (2017) and Reese (2017) thought that the criterion of cognitive processing was promising, they were concerned about the lack of evidence for an association with client outcomes, which we would assert is due to a lack of empirical effort in this area. Our experience as supervisors mirrors that of Reese, who has 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" (p. 81). Given the many studies of cognitive processing in psychotherapy and the findings in cognitive psychology (reviewed in Hill et al., 2017), we argue that this is a promising criterion.

Client Outcomes as a Criterion of Expertise

All the reactors concurred that client outcome (our third criterion) is a key criterion for assessing therapist expertise, and that the expert therapist is one who helps clients improve in terms of mental, emotional, and relational functioning. Where we disagree is in how to assess client outcomes. Reese (2017) thought that although we were accurate in criticizing the flaws of current outcome measurement, we did not recognize their virtues. Goodyear et al. (2017) and O'Shaughnessy et al. (2017) similarly agreed with us that the current measures are flawed but gave them a "free pass" as the best we have. Our reaction is that we can and should do better. In our article (Hill et al., 2017), we suggested a number of ways that we could improve outcome measurement including placing these outcome measures within a context, which was also advocated by Reese (2017) and Norcross and Karpiak (2017).

Experience as a Criterion of Expertise

Therapist experience as a criterion of expertise raised some negative reactions and disagreement among the reactors. We agree that therapist experience is problematic, particularly because it has been so poorly defined (and we reassert that it needs to be defined in a more multidimensional manner). But we do argue that experience is necessary to achieve expertise, even though it is not sufficient. Therapists need experience to have time to improve

(recall that was part of Goodyear et al.'s [2017] definition), practice, and receive feedback. The major issue here is that some therapists profit from experience, whereas others do not.

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

Norcross and Karpiak (2017) suggested that the person of the therapist is the most important indicator of expertise. They suggested that the best therapists are those who have weathered adversities, confronted life, struggled with its vicissitudes, and benefitted from personal therapy and personal development. They also suggested that we could develop the best therapists through better selection and training. Although we wholeheartedly agree with Norcross and Karpiak about the importance of the person of the therapist, we are more disheartened about our accuracy in knowing how to select them. In a recent study, we tried a multitude of predictors and had minimal success in predicting who would do well in undergraduate helping skills training (Hill, Anderson, et al., 2016). Furthermore, Reese noted that as he has become more experienced in training clinicians, he has become more humble about his role. In contrast, we are more sanguine about the effects of training, as reviewed in Hill et al. (2017).

Credentials as a Criterion of Expertise

O'Shaughnessy et al. (2017) suggested that credentials are important as a basis for minimal competence but not for expertise (although they did not define either term, so it is not clear what they thought the differences were). They suggested that therapists often do not seek board certification due to time, funds, and a lack of desire. They also suggested that there is a "ruling group" who legislates the credentialing process and that it is just a cultural mechanism for therapists to inflate their own sense of self-importance. In fact, they noted that none of them are fellows in any professional societies, nor have they pursued board certification.

O'Shaughnessy et al. (2017) further argued that board certification is meaningless since "virtually all physicians are board certified." However, we argue that board certification in medicine is not equivalent to board certification for psychologists. Certification by the American Board of Professional Psychology involves a rigorous, performance-based examination. Only a small percentage of psychologists seek out and attain this esteemed credential, lending greater meaning to this certification than board certification for physicians. We agree that credentials should not be the only criterion for

expertise (note that it is last on our list), although we argue that it would be a mistake to dismiss it without the benefit of empirical evidence. Indeed, we suggest that a similar performance-based examination could be considered for licensure.

Reputation as a Criterion of Expertise

We are glad that we were able to give Norcross and Karpiak (2017) a reason to chuckle with our discussion about therapist reputation. Despite its limitations, however, we are not willing to give up on reputation as a criterion (although we note that it is low on the list). Reputation is used to identify experts across all fields, ranging from auto mechanics to physicians, and we all use reputation in terms of referrals for psychotherapy. The question really becomes what the reputation is based on. We often have information about therapists based on our experiences with them as supervisors, friends, and colleagues, but we have no empirical evidence about the similarity in their behavior across personal and clinical interactions.

Self-Appraisal as a Criterion of Expertise

Self-assessment received minimal support from the reactors as a criterion of expertise. We agree with Norcross and Karpiak (2017) and the considerable literature that suggests that when viewed as a group, therapists have inflated estimates about their global ability, with most viewing themselves as "better than average." However, we suggest that experts may have more accurate assessments and probably have even better estimates about their performance when it comes to specific clients or client types. Furthermore, we trust therapists' self-assessments at least as much as or more than we would trust client assessments. We can all attest to how some clients, especially those with personality disorders, might not be "accurate" about their assessments of therapy and outcomes. Indeed, we argue that therapist self-awareness, deep reflection on performance, and attention to remediation of deficiencies may be associated with expertise.

Consideration of Context as Defining and Measuring Expertise

Norcross and Karpiak (2017) and O'Shaughnessy et al. (2017) indicated that we were acontextual in that we did not consider other factors (e.g., client variables, setting variables) that likely interact to contribute to expertise. Similarly, Reese (2017) noted the role that context plays in how we interact with clients and in how they respond to therapy, and suggested that

researchers should include context in assessing therapy outcomes. O'Shaughnessy et al. went on to emphasize the importance of considering power and privilege in determinations of expertise, noting that those who get to define expertise have power and that we must acknowledge the positions from which constructs arose. We agree wholeheartedly that context is important and hope that future theoreticians and researchers think about how to include it in the equation. We agree that therapy is complex, and that it is not just therapist skills that are important, but rather how therapists and clients interact within the context in which therapy is occurring as well as the environment in which the client is living.

Additional Criteria for Expertise

Norcross and Karpiak (2017) suggested additional criteria that we agree could be considered in future investigations of expertise. Their additions were skill in repairing ruptured alliances, successfully treating difficult clients, effectively managing countertransference, reliably rallying when presented with data that treatment is not succeeding, and demonstrating devotion to the craft. They suggested that expertise is less about mastering a therapy method and more about the relationship, responsiveness to the process, and commitment to improvement. There are probably other criteria that could also be considered.

Mechanisms for Increasing Expertise

Training was the first mechanism we proposed for helping therapists become experts. We strongly believe that structured training and supervision help therapists develop, although the effects are especially pronounced at the beginning of training and level off, becoming harder to detect as individuals grow more individually toward the expertise level.

The reactors did not have much to say about training, although Reese (2017) liked the emerging evidence about training for beginning therapists, and Norcross and Karpiak (2017) suggested the importance of selecting and growing talented trainees without specifying exactly how to do so. We reiterate our position about the pathway to expertise being through training. We can see changes in beginning trainees when they learn basic helping skills (e.g., reflection of feelings, interpretation); these changes come primarily through practice and feedback. Once learned, these basic skills become automatic and are not later the focus of attention for advanced therapists. The effects of training and supervision for more advanced therapists are more individualistic and harder to measure, but we

feel confident that with better research methods we will begin to see more evidence of such growth. In terms of supervision, Reese was accurate in saying that the empirical literature supporting evidence of supervision's contribution to developing therapists is sparse, but we suggest that this is because of the difficulty of tracing the effects of supervision through the therapist and to the client (see Hill, Lent, et al., 2016). In addition, in our experience, supervision can be extremely helpful for some therapists with some clients, but the effects are often not straightforward. For example, therapists do not discuss all cases with their supervisors, they modify what they hear from supervisors to fit their own style, and expert therapists might seek supervision from highly selected supervisors only for specific troubling cases. Nonetheless, we agree with Reese that much work is needed with better-designed studies to evaluate the contributions of supervision to client outcomes.

Similarly, reactors did not have much to say about the influence of personal therapy on developing expertise, although Goodyear et al. (2017) suggested that the evidence for personal therapy is equivocal at best. In contrast, we hear repeatedly from our students, as well as from trainees and experienced therapists in our qualitative studies, that personal therapy was crucial in providing a model for how to be and not to be as a therapist, and in helping therapists resolve personal and countertransference issues that would have interfered with their ability to help clients. Hence, we are firm in our conviction of the value of personal therapy as a mechanism for developing expertise, especially when this personal therapy focuses on issues that arise in the therapist's work with clients. Again, we suggest that better research methods are needed for studying such complicated influences.

Enthusiasm was expressed by all reactors about practice as a mechanism of developing expertise, although exactly what form the practice (deliberate versus reflective) takes has yet to be determined. Great excitement has been expressed for deliberate practice (DP), which Ericsson and Lehmann (1996) 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" (pp. 278-279). Goodyear et al. (2017) cited Miller, Hubble, and Chow (in press) noting that DP consists of four elements: (a) an effort to improve performance over an extended period, (b) guidance from a mentor, (c) immediate feedback, and (d) refinement and repetition outside of performance. Only one study (Chow et al., 2015) has been conducted on DP in psychotherapy, and this study was not without problems (e.g., only 25% of recruited therapists participated, therapists completed a survey about how much they engaged in 20 activities in the past typical month rather than monitoring their actual

engagement in such activities, and the activities surveyed did not match the definition of DP). Our concern about DP is that it was developed in cognitive psychology and is not sufficiently tailored to the needs of experienced/expert therapists. The complexity and dyadic nature of psychotherapy makes it different from other types of practice where the actor has more control over the outcome. We agree with Reese's (2017) view that in psychotherapy DP might take the form of self-reflection rather than practice per se. We need to develop a specific set of suggestions based on what expert therapists actually do (after identifying who the expert therapists are, of course), rather than base suggestions on what cognitive psychologists think expert therapists do.

Feedback as a mechanism of change also generated considerable enthusiasm from the reactors. We agree with the reactors that feedback is important, but disagree with Goodyear et al. (2017) that feedback must come *only* from standardized client-reported measures. Although such feedback is valuable, it is limited for all the reasons we cited in our initial article. Similarly, Reese (2017) noted that standardized feedback does not always include individualized client concerns and contextual factors.

Goodyear et al. (2017) appear to be contradicting themselves in saying that relationship skills and technical skills cannot be used to define expertise, and then saying that expertise is achieved by feedback "relative to particular important skills." Furthermore, we have two additional concerns about Goodyear et al.'s desire for accurate, unbiased ongoing feedback *relative to particular important skills*. First, all feedback is biased in some way, and it depends on what form of bias researchers are willing to accept. Second, feedback on standardized client outcomes does not provide information relevant to particular therapist skills or even to the specific goals of the client. For example, feedback from routine outcomes monitoring may show that a client's symptoms are not improving, but it does not link this lack of improvement to something that the therapist did or did not do (let alone to whether the client is changing in something other than symptomatology). A general principle from behavior therapy is that feedback focused on specific behaviors is more effective than global feedback. Just as people who are on a diet are told to look at their dieting behaviors rather than just at their weight for feedback, therapists need to look at what they do and how well they do it in sessions rather than just at how the client changes, given that client change is influenced by so many other factors. In addition, research shows that feedback alone does not lead to improvements in performance (Gabelica, Van den Bossche, De Maeyer, Segers, & Gijselaers, 2014). Rather, feedback must be combined with prompts to reflect on one's performance, and reflection in turn enhances performance.

Implications for Future Research

We believe that this set of articles has highlighted much about the state of the therapist expertise literature, and at the same time has illustrated how little we know empirically about the development of expertise in psychotherapy. We also hope, however, that we have provided some ideas for future theorizing and research. Reese (2017) appreciated our willingness "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" (p. 85-86). This was our intention in writing this article. We agree with the comments of some reactants that we took on a daunting task (Norcross & Karpiak, 2017), but we did so with the optimistic outlook that better research methodologies might match our clinical wisdom (Reese, 2017).

This debate about expertise has been energizing, but now it is time for all of us to start working to better define and measure expertise! Researchers need to continue to identify multiple criteria of expertise and to assess expertise using the different criteria recommended in the literature and in our article.

Although it is beyond the scope of this rejoinder to go into depth, we suggest one idea for how researchers might move forward in examining expertise. Within a circumscribed sample of therapists in a large managed care data bank, a set of master therapists could be identified using Jennings and Skovholt's (1999) criteria for reputation, and another set could be identified according to client outcomes on standardized measures. Clients of these therapists could be interviewed about their experiences in therapy, and therapist behaviors could be coded in sessions. It would then be possible to compare reputation and client outcomes as criteria (other criteria could similarly be tested).

In terms of effectively training both predoctoral and postdoctoral psychotherapists, we need to continue studying the mechanisms that increase expertise, such as demonstrating how supervision and outcome feedback influence therapist skills and client outcomes. Reese (2017) noted that there are several commercial feedback systems that monitor client outcome every session (e.g., OQ Analyst, Better Outcomes Now) and provide therapists with the ability to track outcome, examine outcome trajectories, and assess session-to-session changes on a continuous basis. Goodyear et al. (2017) have also advocated the value of client outcome feedback systems. We agree that feedback is important but believe it needs to be augmented with (a) continuous feedback about what the therapist is or is not doing, and (b) a system to measure how much therapists reflect on and analyze the feedback received. Other areas greatly in need of more and better research are (a) the

cognitive processes that differentiate expert and novice performance (and how these cognitive processes can be enhanced) and (b) how to operationalize practice in therapy.

Finally, it is clear that some therapists are better than others in promoting client outcomes (Baldwin & Imel, 2013), forming working alliances (Baldwin, Wampold, & Imel, 2007), and establishing real relationships (Kivlighan, Gelso, Ain, Hummel, & Markin, 2015), *but* we have only hints about what characterizes these therapists. We agree with Norcross and Karpiak (2017) that these therapist characteristics are important to consider in understanding therapist expertise and thus deserve further empirical attention.

Declaration of Conflicting Interests

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

Funding

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

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