A Word From the Editor

Jeffery Smith

Whew! We are not alone. According to Tim Herrera of the New York Times, (April 23, How to Spot and Overcome Your Hidden Weaknesses) “Research has shown we humans are generally pretty awful at assessing our own competence and abilities, which in turn leads us to overestimate them — a phenomenon called the Dunning-Kruger Effect.” He cites a study showing that 80% of drivers think they are above average.” Sound familiar? And guess what: His remedies, “ask for feedback” and “keep learning,” sound like headlines for the ideas you will read here.

This month we present a rich and ample cross section of views on how to ensure continuing growth in excellence as a therapist. Alex and I have collaborated to gather sharp thinking from leaders in the field. You mustn’t miss Patricia Coughlin’s exhortation to go beyond psychology to realms like quantum physics and spirituality, Rønnestad’s extensive review and emphasis on personal sensitivity and the will to develop, Thomas M. Skovholt’s wonderful portrait of the paradoxical characteristics of the master therapist, David Burns’ highly developed formula, and Alexandre’s interview of Irvin Yalom. I could keep going with the nuances to be found in each contribution, but you’ll have to read them.

In addition, we gathered the best ideas from 33 respondents to our reader survey. You will soon find recurrent themes: Be systematic, get feedback from clients, show you work to others, keep learning, go outside your usual small world to other orientations and even to broader culture. In my view, two things stand out: First, there is no one answer for everyone. Different learning styles and personalities demand different approaches. And second, without investing a certain amount of time and vulnerability we stagnate. Please enjoy!

A Word from the Conference's Program Chair

Daniel B. Fishman

Dear SEPI Members,

We are excited about the upcoming SEPI conference in New York City on May 31-June 2, 2018. The location is the Marriott Downtown Hotel in Battery Park, a venue with many points of interest nearby and just a short subway ride to others in Manhattan. The conference theme is “Drawing on multiple theories and methods to enhance the integration of psychotherapy practice and research.” Thus, as in past conferences, presentations and discussions will focus on integrating across multiple theories to improve the effectiveness of psychotherapy. In addition, a particular emphasis this year will be on adding value to our psychotherapy knowledge by integrating across different methods, such as randomized clinical trials, nonexperimental group studies, systematic case studies, other types of qualitative research, and mixed methods designs that synthesize both quantitative and qualitative data.
Interview with Irvin Yalom

On Effective Therapists and Beyond

by Alexandre Vaz

Every generation has a cultural stereotype of what a psychotherapist is and does. From lying on the couch to encounter groups, TV series and popular books have probably had a greater impact on how our field is perceived by the public than just about anything else. In this sense, perhaps Irvin Yalom has been one of the most influential people in shaping this public perception. His best-selling books often present the therapist as a fellow traveler, someone equally vulnerable to life’s struggles and definitely not all-knowing. Here’s a brief exchange I had with Irv recently:

Alexandre Vaz: You strike me as someone who never really wanted to be associated with any theoretical model.

Irvin Yalom: No, I did not. I really did not want to be associated with any model. The main model to be exposed to in my time was psychoanalysis, and I did have a 700-hour immersion in personal analysis, and I realized this was not the model that I felt was effective or that I wanted to use. So, I deliberately did not get into any other institution, because I wanted to have the freedom of experimenting myself. I was very fortunate to have been at Stanford, with a chairman who really wanted me to use my own imagination, so I was free to try out all kinds of different approaches.

AV: And nowadays there are existential therapists, but I know you have some mixed feelings towards that idea.

IY: Well, I can’t understand quite how one can be an existential therapist when people come to you with marital problems, or other kinds of issues. I think there are some patients for which these existential factors are tremendously important, but there are others for whom it is not. So it takes a lot more than existential theory and practice to work, in general, with your general patients.

AV: If you had to select effective therapists, what are some of the defining characteristics you’d look for?

IY: I’d go back a very long way to Carl Rogers. He made a really tremendous contribution to our field, with this great emphasis on saying that the really crucial factors in therapy are the nature of the relationship between the patient and the therapist. And the therapist has got to be someone with genuine empathy and positive unconditional regard for the patient, and be able to be genuine in his relationship with him. I think those are the things I’ve come to see as most important. You know, we do a lot of talk about empirically validated research, but nothing is more empirically validated than those factors! There are hundreds and hundreds of dissertations written researching those factors. So if I had to select therapists, I would select someone who would really be willing and able to have an intimate relationship with his patient.

AV: How much do you feel that this is actually trainable?

IY: I think it is trainable, but I also think you’re off to a head start if you can start off with people who already have this ability. Carl Rogers at one point said, ‘you know, I think therapists probably should be more selected than trained’. But I know I’ve changed a great deal, through my own work, and I’ve seen many of my students who have done that as well. But that’s why I’m a great spokesman for continuous therapy. I think therapists need to have a lot of personal therapy, and I think it should be never-ending, continued from time to time. That’s a message I want to give out to therapists.

AV: Not only are many of your books for therapists, but a question comes up of how much of your books are also part of an ongoing self-analysis. At one point you’ve said that your character Julius, from The Schopenhauer Cure, “showed you the way”.

IY: Yes, that’s right. Are you raising the question “can you learn from your characters”? I think so. I created certain characters and I had no idea where they’d go. Your characters – and many others have said this, I’m not unusual in this regard – you set them out and watch what they do, and you report it.

AV: I’m now reminded of Karen Horney’s “Self-Analysis” book, and was wondering what are the limits of self-analysis.

IY: Oh yes, there are limits. You need other people. [laughs] You need some feedback, I learned that from my own work in group therapy.
Structured Interviews on Psychotherapy Expertise

The Integrative Therapist is proud to present a series of structured interviews on the topic of psychotherapy expertise. We asked a group of leaders in psychotherapy theory, practice and research to respond to five questions designed to bring out opinions, scholarly reflections and questions at the cutting edge of this exciting (yet elusive) topic.

Ten distinguished members of SEPI and beyond have kindly offered the contributions that follow. Enjoy!

Bruce Wampold
University of Wisconsin–Madison, USA

1. Please give us your personal definition of what constitutes an expert in psychotherapy practice (not as a researcher or academic).

An expert psychotherapy practice is one that consistently helps clients achieve their goals. It really is that simple: Expert therapists are those whose clients consistently benefit from therapy, regardless of the characteristics of the clients. Expert therapists also improve gradually over the course of their careers but focusing on improvement.

2. How might we go about evaluating such expertise?

Outcomes, outcomes, outcomes! We should evaluate therapists on what they achieve—and not much else.

3. What do you consider to be the main factors hindering the development of therapeutic expertise over time?

It is very difficult to improve as a therapist. We do our work in private, with little opportunity to practice particular skills. Experts in other fields have coaches, receive detailed feedback about particular components of performance, practice various components outside daily work or performance, and gradually improve. Unfortunately, given current practices in psychotherapy, it is very difficult to set up conditions to improve—but there are agencies and individuals who are using deliberate practice and they are succeeding! Therapists, in the right conditions, do improve their outcomes over time.

4. How might therapists counter these hindering factors and reliably grow their therapeutic expertise over time, to the best of their ability?

Practice, practice, practice… Outside of seeing clients. But it has to be the right type of practice and improvement efforts.

5. How has research (psychotherapy or otherwise) influenced your views on therapeutic expertise and its development? Please provide one or two examples.

We are beginning to identify the skills and actions of effective therapists. For example, Tim Anderson’s research on Facilitative Interpersonal Skills is fantastic—his and others’ work has shown us that effective therapists have a certain set of sophisticated interpersonal skills that are needed in challenging interpersonal situations (e.g., in working with challenging clients). There are also demonstrations that agencies that focus on therapist improvement by improving skills improve the quality of their services—additional clients benefit as a result (see Simon Goldberg’s study with the Calgary Counseling Center). We really have to stop arguing over whose therapy is best and realize that it is the therapist delivering the treatment that is important—the research on therapist effects have shown this time and time again.
“There are huge differences between individuals across the variables orientation and experience. The lesson was: the most interesting is actually the individual therapist.”

In this paper I follow the questions formulated by Jeffery Smith and Alexandre Vaz, and, having recently published a more comprehensive article on the development of expertise in psychotherapy (Caspar, 2017), I will be rather brief. The position I'm going to outline will be better understood with some insight into my history of dealing with therapist expertise, to which I therefore dedicate this preface.

For a long time, I was not particularly interested in psychotherapists. I remember several small conferences in the early 80's at which most colleagues focused on patients, some on therapists. I did not really understand why those dealing with therapists found them particularly interesting. For me it was obvious that the center of interest should be the patient. So I definitely missed an early chance of getting a better understanding of therapists.

While I was working on the development of the Plan Analysis concept for case conceptualizations (Caspar, 2007), I got increasingly aware that when developing and conveying a prescriptive approach, that is, an approach giving advice for how one might observe patients and develop hypotheses about their functioning, one should have a good understanding of therapists' current functioning. A prescriptive approach means to try to move therapists from an untrained (as far as this form of case conceptualization is concerned) state A to a trained state B. It seems obvious that such a process is the more promising the better one understands functioning in state A.

So I began with research on psychotherapists' hypothesis generation processes in the late 80's. I submitted a project with the Swiss National Science foundation on this topic that allowed me to invest three intense postdoc years between 1987 and 1991 to the study of psychotherapists. One year I spent at the Institute of Cognitive Science at the University of Colorado in Boulder, one at the Clarke Institute of Psychiatry in Toronto, developing the computer and video supported technology to record intake interviews and to reconstruct their hypothesis generation with cognitive-behaviorally and analytically oriented, experienced and inexperienced psychotherapists. Methodology and findings of this naturalistic study on intake interviews – conducted by the therapists independent of the study - are reported in Caspar (1997). It has been found that the therapeutic orientation has some but not an overwhelming impact on the way in which the therapists in the study processed information and generated hypotheses, and the same applied to experience: some differences that made sense. The dominating impression, however, was that there are huge differences between individuals across the variables orientation and experience.

The lesson was: the most interesting is actually the individual therapist. My interest was anyway not primarily focused on finding differences, but on developing a better understanding of the involved processes. For example, we found evidence that in these therapists’ information processing, the extent to which they processed intuitively vs. rational-analytically was independent. This means that intuitive and rational-analytic were not the opposing extremes on one dimension, but each varied on its own independent dimension (Caspar, 1997). This finding is a lasting pillar for my understanding of master therapist's performance.

At the Institute of Cognitive Science in Boulder I met Anders Ericsson and – referring to his early work with Herbert Simon on protocol analysis – discussed also my methodology with him. One impact of him was the change for what I did from “introspective reports” to “retrospective reports” based, I guess, on his skeptical stance towards psychodynamic approaches.

While working on other topics too (such as the therapeutic relationship) I kept dealing with the therapist, primarily working on tools for the training of specific skills and abilities. All this was nourished by experiences as practicing therapist and supervisor, and a deep disbelief that the prevailing emphasis on approaches and techniques was justified.

In 1996 I used the “deliberate practice” model by Ericsson for the first time in a grant proposal for a computer supported training tool of which procedure and findings were published in Caspar, Berger & Hautle (2004). While my interest was not primarily on expert performance, I believed and keep believing that one can learn from them and from general research on expertise, also for therapists striving for very good performance even if they do not consider to ever becoming “top athletes”.

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I have also started a study on variables predictive of psychotherapy training success: It is common to select candidates for psychotherapy training based on rather arbitrary criteria, as there is not much empirical evidence what trainees have to bring in as they start training, to ultimately deliver good psychotherapy. We have assessed a number of pre-training variables, put them on ice for about five years until training is completed, and are about to see what turns out to be predictive.

In Fall/Winter 2010 and 2013 I spent sabbaticals with Anders Ericsson at Florida State in Tallahassee, discussing our research and deepening my understanding of research on expertise in general and deliberate practice in particular. Based on this good understanding (I believe) of many facets of this approach, I congratulate Tony Rousmaniere for his excellent contribution to disseminating it amongst clinicians. As far as I’m concerned, a major research project following principles of deliberate practice is planned but will have to wait for the time after my retirement in Summer 2018 which will disburden me of many current duties.

The Questions

Expert and expertise are terms showing up in every question. There are a number of definitions in the literature (Caspar, 2017), which all have their advantages and disadvantages. For now, let me use a quick and dirty definition: An expert in psychotherapy is a therapist who is able to conduct therapies with outcomes that are consistently and clearly beyond what one could expect for the patients he or she is treating, and this includes particularly difficult patients.

1. Please give us your personal definition of what constitutes an expert in psychotherapy practice (not as a researcher or aca-demic)

An expert is, first of all, able to engage a patient in therapy by offering an approach to therapy that makes sense to the patient, does not raise unnecessary fears or other negative feelings, and gives hope that the problems making the patient seek help, can be solved or improved to a satisfactory extent. The expert is also able to offer a therapeutic relationship in which the patient feels safe, supported, and also seen in his or her healthy motives and abilities.

This – appropriate approach and appropriate relationship – requires the therapist to be responsive. Responsiveness means to take into account many aspects beyond a diagnosis, to be able to derive an individualized procedure and to set it into action. According to the model of professional development by Dreyfus & Dreyfus (2005) it is an achievement in the last phases of the development of expertise that professionals become able to fully include “contextual” information, changing the simple rules that novices seem to need to an “it all depends on …”

As no single approach to psychotherapy has all the answers and advantages, to be responsive means also to be integrative and to see, acknowledge and use concepts and interventions from outside the fence around the approach one has learned first. Another requirement is interactional flexibility on the therapist’s side.

Ultimately an expert therapist will reliably contribute to good outcomes. This means that he or she will with no or only very few exceptions use the potential of patients for change to the fullest. An expert therapist will also learn from the course of therapies (including failures!) to ever improve his or her performance. He or she will not develop any bad habits in behavior and information processing that could affect performance negatively.

An expert knows his or her limits. This could mean to stay away from therapies with patients with whom one expects difficulties. If these expected difficulties are idiosyncratic, so that there is a fair possibility that the patient will find a therapist who will not experience or mind these difficulties: fine! If it is a patient who will probably have difficulties with any therapist, it becomes more of an ethical question whether being an exceptionally good therapist also obliges to some extent. The question is analogous to the question whether wealth implicates philanthropic obligations, at least if qualification as a therapist were as objectively assessable as wealth. For both questions I have no definite answer.

A related but somewhat different issue is to what extent excellent therapists compose their workload with most difficult patients. As far as the mixture of patients is concerned an expert would ideally also know what mixture allows him or her to maintain excellent performance over many years. As far as treatability is concerned, he or she would also acknowledge that some patients are –for whatever concrete reason- so difficult that the chances of success are minimal. If a therapist has a chance at all, it must be the best possible therapist, but still the a priori chances are so minimal that an expert therapist would consider and admit this. He or she would not run into a situation of having a list of therapies that are never ending (because of lack of progress), resulting in mediocre overall success. Here meet the observations

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by late Ken Howard (personal communication), that there is a tendency of very good therapists to run into such a situation, with the notion by Rob DeRubeis, that in the spectrum of patient difficulty there is an easy end (where a good therapy outcome can be expected even from suboptimal therapy quality), and a difficult end (where patients will remain without success no matter what).

2. How might we go about evaluating such expertise?

This question is, of course, closely related to the question of how to define expertise. Again, there are several definitions of value which all have their advantage and disadvantages. The value of a criterion depends also on the phase of research on expertise. A first access is certainly peer nomination. This is evidently vulnerable to effects of charisma and impression management. One would then, as it has been done in research, look for properties of these peer nominated experts.

An obvious and ultimately the most important criterion are measurable therapeutic changes. It does not need to be explained here how this can be done and obviously there are all the challenges that are usually related to outcome research. Two particular challenges worth mentioning:

1. When comparing different conditions, it is common to randomize patients to isolate the influence of one factor. When this factor is expertise vs. non-expertise in daily work, this paradigm does not work, as the patients with which our experts work are different in terms of how malleable they are. We therefore need a procedure to make effects comparable across institutions and patients.

2. A particular aspect of this is – even within one institution, even within one therapist over the course of his or her career – patient difficulty. Expert therapists would generally take on more difficult patients. It could therefore turn out that they do not produce better effect sizes than novices, or better than at a time when they were much less experienced and far from an expert state themselves. Indeed we find such effects in comparison of experienced vs. inexperienced therapists at our outpatient clinic. So we would, here again, need procedures to compensate for such an effect.

It is obvious that we would not primarily base our assessment of effects on subjective reports by the therapists, but we may want to use therapist’s self-reports as part of the picture. Therapists are not necessarily just defensive in the case of less than ideal effects, they may be in the best position to validly contribute to an understanding of how the values in the assessment of a particular patient came about.

In our conversations, Anders Ericsson has been intrigued by the possibility of using an (letting aside the tricks of anorectic patients when it comes to assessing their weight) absolutely objective measure, weight gain, with these patients. While the appeal of such a criterion for a non-clinician is perfectly understandable, from a clinical point of view the use of weight gain as the sole or main criterion for treatment success is debatable, and it would exclude most experts: Only a small part of them is routinely treating patients with anorexia.

3. What do you consider to be the main factors hindering the development of therapeutic expertise over time?

Although not a sufficient condition, a lot of practice is definitely required for developing expertise, and this may be limited by various factors: academic and administrative duties, working part time due to family duties, etc. As we have developed some skills that are important for good therapists already before we began psychotherapy training and practice, we may not need full time therapy practice over 8 years. Clinical activities other than practicing psychotherapy, such as supervision and case seminars, may also help with training some aspects.

The main hindering factor as far as the nature of therapy is concerned is that we have little intrinsic feedback coming naturally with psychotherapies.
Even observable changes in the behavior may not have been caused the way the therapist thinks, and whether they ultimately contribute to a lasting better patient life, is open at the moment they occur. And: Unlike the surgeon, the psychotherapist normally does not have a team supporting, watching, and (in a not too authoritarian setting) giving immediate feedback and critique. In psychotherapy we definitely need much extrinsic feedback, be it from patient questionnaires, be it from colleagues watching and commenting on our video tapes.

It is in the nature of psychotherapy that it is difficult to learn from practice. If we want to have a chance, it is crucial that we understand as much as possible of the patient’s functioning and the ongoing process: Learning in a process that one does not understand is clearly impaired. The weight given to individual case conceptualizations varies widely – in principle and well as in real everyday practice. In my view, beyond the therapist motive of delivering a maximally effective therapy to a current patient, the motive of learning in the process, based on tracing the factors contributing to the process in every moment, should be another strong argument for investing in case formulations. They allow us to come as far as we can in an understanding of the patient, and based on this, of the process.

Another hindering factor as far as responsiveness and including all aspects of potential relevance are concerned are certainly blinders related to schools of therapy. While it is to some extent understandable that professionals in a field as complex as psychotherapy seek orientation and reduction of complexity, an a priori neglect of relevant factors is a hindering factor for the development of true expertise. The opposite would be a “General Psychotherapy” (Grawe, 1999; Caspar, 2010) which is open to all that might be relevant for a particular topic or patient, even if it contradicts something we have originally learned.

Last but not least: The extent to which we feel secure does not increase with increasing expertise in a linear way. Dreyfus (2004) has pointed out, that an increase of mastering the simple, context free rules by which novices are guided leads to an initial increase of security. But as expertise develops further, professionals (here: therapists) recognize that (here) psychotherapy is more complex than that, that they are, among others, also responsible for choosing the right models for understanding their patients. This increase of acknowledged complexity leads to a temporary increase of insecurity. Dreyfus argues that the insecurity needs to be admitted and worked on, and that those who do have the best chance of developing further. From this perspective, psychotherapy trainers and supervisors pretending they work always without major problems are bad role models and can by this be a hindering factor.

4. How might therapists counter these hindering factors and reliably grow their therapeutic expertise over time, to the best of their ability?

We have to take advantage of the information processing capacity liberated by the automatisation of much that we have to consider, decide, plan, and formulate, and use it for a deeper analysis of what is going on with a patient in the concrete process. While automatisation is an asset, we need to de-automatize to recognize problems requiring deliberate attention.

We have to remain critical with our therapeutic actions, not to hassle with all that we could have done better, based on a high, not low self-esteem, but with awareness that there are always different views and potential ways of action. While what we have done may have been the best we could have done when we did, but this does not mean that we should not reflect on it (and in particular shortcomings), motivated to do even better when similar tasks come up in the future.

We should look for possibilities of practicing, in the sense of deliberate practice (Ericsson, 2009), which does not need further explanation here, but further development of concrete training possibilities. An ideal would in many ways be a therapy simulator, much like a flight simulator.

It is obvious to me that a view that one learns automatically “in real practice” is about as naive as a view that an Olympic athlete does not need artificial practice, arguing he or she learns best on the Olympic games. How many planes would have crashed without pilot training in simulators, how many therapies would have gone better had their therapists had a simulator training?

While this is something for the future, we can read what smart colleagues have written about problems we are dealing with, we can talk to colleagues, be it informally or in regular intervision, we can play through interactions with patients in our phantasies. Master therapists are described as “voracious learners” (Sperry & Carlson, 2014). It is unrealistic to assume that every psychotherapist is motivated and able (in terms of external factors such as family life) to walk these extra miles, and nobody who makes explicit or implicit decisions to remain a good enough “only” therapist should feel...
“We should capitalize on the differences between therapists and offer individualized training.”

bad about this as long as he or she does a solid, well informed, and motivated job. Not every person doing sports seriously has to feel bad when motivation, circumstances, or current level of performance do not allow a participation at the Olympics. As DeRubeis, Cohen, Forand, Fournier, Gelfand, et al. (2014) have argued, not every patient needs a supershrink for a good outcome. But we should do what we can to be able to offer good, empirically based advice and programs to those who do want and can walk the extra mile.

5. How has research (psychotherapy or otherwise) influenced your views on therapeutic expertise and its development? Please provide one or two examples.

Generally speaking, there is little research on expertise within psychotherapy research. In this situation it makes sense to look into research on expertise in other domains. If I should mention just one such source, it would be Anders Ericsson’s work not only but particularly on deliberate practice. Other influential non-psychotherapeutic authors are Dreyfus & Dreyfus (1986; Dreyfus 2004): They explained how expert intuition is different from naïve lay intuition and how it develops through repeated deliberate information processing. In addition, they have contributed the observation that the increase of feeling secure with increasing expertise is not linear (see above).

Another influential person for me has been the Cognitive Scientist Juan Pascual Leone, father of our dear psychotherapy researcher colleague Antonio Pascual Leone. His work on the collaboration of intuitive and rational-analytic information processing has been influential on me, and in our research we found that the switching between the two modes described by him seem to be typical for experienced therapists.

In the realm of psychotherapy research, there are many authors who have pointed out that there is huge variation between patients and therapists, and that in this variation the secret of how good therapy works, is buried. This is also what we have repeatedly found in our own research. Of course this means not to force therapists on one track that has turned out to bring about good training and therapy outcomes. We should rather acknowledge that several ways of conducting therapies as well as training can be good. We should therefore rather capitalize on the differences between therapists and offer individualized training. An utopia for this I have described in my 1997 paper.

References:

These observations have led me to identify a set of Core Therapeutic Tasks.

Having a sense of "humility" also correlates with being a more effective psychotherapist.

1. What constitutes an “expert” in the field of psychotherapy?

This is a question that I have been preoccupied with for some time. I have been involved in training psychotherapists for over 30 years and have noted that some therapists are significantly more effective than others. Therapists vary both in their ability to achieve lasting changes in their patients and in their ability to engage patients in the therapeutic process. The more effective therapists have the ability to establish, maintain and monitor on a regular session-by-session basis the quality of the therapeutic alliance and adjust treatment accordingly. They have a set of interpersonal skills that engenders hope in their patients and they can individualize and tailor their treatment approach in response to the patient’s needs and to the collaboratively generated patient treatment goals. They are not tied to a specific treatment manualized approach. They meet the patient where he/she is at. These observations have led me to identify a set of Core Psychotherapeutic Tasks that characterize more effective psychotherapists.

2. What are the core tasks of psychotherapy that you have identified?

1. First, and most importantly, is the ability to establish, maintain and monitor the quality of the therapeutic alliance on a regular basis. The “expert” therapist has to be culturally, gender and developmentally sensitive.

2. The ongoing assessment process and the ongoing psychoeducational processes have to be collaborative and strength-based. The most valuable tool for effective psychotherapists is the “art of questioning”. I focus in on HOW and WHAT questions, rather than on WHY questions.

3. Any skills training programs that are conducted need to incorporate generalization guidelines in order to increase the likelihood of achieving lasting changes. Psychotherapists cannot merely “train and hope” for transfer and maintenance. I have enumerated elsewhere what therapists need to do before, during and after training to be most effective.

4. Expert therapists provide integrative treatment in order to address the impact of co-occurring disorders and a history of victimization and trauma, if these are present.

3. What other features characterize “expert” psychotherapists?

Another key factor that I have recently written about is that experts have the ability to spot HYPE in the field of psychotherapy. In fact, with my co-author Scott Lilienfeld, we have generated a 19-item checklist on how to spot hype in the field of psychotherapy, including exaggerated claims of efficacy and the use of psycho-babble and neuro-babble. Having a sense of “humility” also correlates with being a more effective psychotherapist. “Expert” therapists never tell their patients that they are experts. Instead, they continually seek feedback on how they can improve their effectiveness as therapists. They engage in deliberate practice with feedback to constantly improve.

One other observation is that “expert” therapists have the ability and commitment to help their patients to build upon the strengths that they bring into treatment. They bolster their patients’ resilience. Please see my recent book Roadmap to Resilience to see ways therapists can bolster resilience in six domains (physical, interpersonal, emotional, cognitive, behavioral and spiritual). (www.roadmaptoreislience.com).

4. How did you come to highlight resilience as central to your psychotherapeutic approach?

My recent work with trauma survivors highlighted that most individuals (some 75%) who experience traumatic and...
and victimizing events, whether as a result of natural disasters or due to intentional human design, are impacted but go onto evidence resilience and, in some instances, post-traumatic growth. On the other hand, 25% get stuck and develop PTSD and related behavioral challenges. What distinguishes these two groups are the stories they tell themselves and that they tell others. Our patients are “storytellers” or “homo narrans”. This has led me to adopt a Constructive Narrative Perspective of psychotherapy. I believe that “expert” therapists are able to help their patients develop redemptive stories and help them embed their traumatic experiences into a larger autobiographical account -- develop a Resilient Mindset. Moreover, “expert” therapists challenge, cajole and encourage their patients to develop and implement their accompanying coping skills.

I encourage the interested reader to visit a Website that I oversee for the Melissa Institute (www.melissainstitute.org), that has had two million hits worldwide this year, to find the papers on: ways to spot hype in the field of psychotherapy; how to implement the Core Tasks of Psychotherapy; how to implement generalization guidelines, and the like.

Thank you for the opportunity to share my story.

Recommeded reading:
www.melissainstitute.org/documents/Meichenbaum-Coretasks.pdf

“Expert therapists are able to help their patients develop redemptive stories and help them embed their traumatic experiences into a larger autobiographical account.”

“Perhaps a great therapist helps increase client discomfort on the way to a longer client road to greater maturity and well-being.”

Thomas M. Skovholt
University of Minnesota, USA

1. Please give us your personal definition of what constitutes an expert in psychotherapy practice (not as a researcher or academic).

A psychotherapy practitioner who has human depth as reflected in the following Paradoxical Characteristics and is high in the integration of three Central Characteristics of Cognitive, Emotional and Relational. ¹ See the two Figures.

<table>
<thead>
<tr>
<th>Portrait of the Master Therapist</th>
<th>Paradoxical Characteristics</th>
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<tbody>
<tr>
<td>Drive to mastery</td>
<td>AND Never a sense of having fully arrived</td>
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<tr>
<td>Able to deeply enter another’s world</td>
<td>AND Often prefers solitude world</td>
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<tr>
<td>Can create very safe client environment</td>
<td>AND Can create very challenging client environment</td>
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<tr>
<td>Highly skilled at harnessing the power of therapy</td>
<td>AND Quite humble about self</td>
</tr>
<tr>
<td>Integration of the professional / personal self</td>
<td>AND Clear boundaries between the professional / personal self</td>
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<tr>
<td>Voracious broad learner</td>
<td>AND Focused narrow student</td>
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<tr>
<td>Excellent at giving of self</td>
<td>AND Great at nurturing self</td>
</tr>
<tr>
<td>Very open to feedback about self</td>
<td>AND Not destabilized by feedback about self</td>
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Figure 1. Paradoxical Characteristics

Continued on page 11
"There are three main data sources for the practitioner’s work: Theories/research, Practitioner Data and One’s Personal Life."

"Start with three preconditions on the way to expertise: being relationship oriented; drawn to uncertainty and the intrigue of ambiguity; being affectively attuned to others."

2. How might we go about evaluating such expertise?

We did it by the use of peer nominations to find experts and then interviewed them. There are strengths with this method and weaknesses too. Some researchers use post-therapy symptom checklists to compare practitioners as a way to search for expertise defined by symptom reduction. However, a reduction in symptoms can be a seduction into a vortex of measuring with numbers and defining psychotherapy as a reduction of one of the major arenas of distress—anxiety, depression or anger. Of course, usually less distress is a wonderful therapy outcome. However, perhaps a great therapist helps increase client discomfort on the way to a longer client road to greater maturity and well-being. The Master Therapist in our sample with the greatest number of peer nomination stated this when we interviewed him. An analogy is that of a great athletic coach increasing the challenge for the athlete on the way to optimal development. Here is another unintended consequence with too soon measurement after performance: Grade inflation in college has occurred in part because of student evaluations. It is difficult for a 19-year old college student to give a high teacher evaluation when the student is doing poorly; even though these are separate domains.

3. What do you consider to be the main factors hindering the development of therapeutic expertise over time?

- An ongoing continual intense quest to improve is important. When this ebbs, hindering sludge enters the scene. Development is a process, there is no end point.
- Not taking in feedback and using it productively to improve one’s work. There are so many ways to get feedback e.g. the client’s subtle reactions, feedback forms, one’s own internal reflections, and a consultation group. Therapist narcissism is dangerous for many reasons including the blocking of challenging feedback that can, if accepted, be instructive for the practitioner’s own development.
- A reduction in the sources of great vitality in the therapist’s own personal life. Therapy takes enormous positive energy from the therapist to combat the client’s demoralization and despair.
- Boredom, which can result from reduced challenges in the practitioner’s life. While exploring new areas of human experience can bring on renewed performance anxiety, working in the same small domain over and over can be mind numbing.
- There are three main data sources for the practitioner’s work: Theories/Research, Practitioner Data and One’s Personal Life. All are important. Each of these can greatly help the practitioner improve, together they produce the

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“With diminished anxiety, I became less and less afraid of my clients and with that came an ease for me in using my own wide repertoire of skills and procedures.”

“Therapy and counselling in one of the great inventions of the last half of the 20th century because it is an effective method” for reducing human distress.”

4. How might therapists counter these hindering factors and reliably grow their therapeutic expertise over time, to the best of their ability?

Here is one view using a road to expertise metaphor.2 Start with three Preconditions on the way to expertise: Being Relationship Oriented; Drawn to Uncertainty and The Intrigue of Ambiguity; Being Affectively Attuned to Others. Important Markers on the Road: Marker #1: Rage to Master—Intense Will to Develop. Marker #2: Deliberate Practice Over Many Years. Marker #3: Open to Feedback but Not Derailed by It. Marker #4: Humility. Marker #5: Having Deep Coaching Attachments and Marker #6: Boundaried Generosity. Here is a favorite quote from an expert: At age 68, she described the pleasure and effectiveness of the work at the expert level.

"With diminished anxiety, I became less and less afraid of my clients and with that came an ease for me in using my own wide repertoire of skills and procedures. They became more available to me when I needed them. And during those moments it became remarkable to me that someone would have the willingness to share their private world with me and that my work with them would bring very positive results for them. This brought a sense of immense pleasure to me." 4

Here is another answer to Question #4. In the Skovholt Professional Resiliency and Self-Care Inventory 5. there are four dimensions of Professional Vitality, Personal Vitality, Professional Stress and Personal Stress. All of these areas must be actively addressed by the practitioner to stop the hindering of practitioner development.

5. How has research (psychotherapy or otherwise) influenced your views on therapeutic expertise and its development? Please provide one or two examples.

My answer has a personal history. In the 1970’s Helge Ronnestad (now Professor at the University of Oslo) and I were classmates in the counseling psychology program at the University of Missouri. My advisor Joe Johnston and Helge’s—Norm Gysburs—were experts in career development and career psychology. We tolerate this area as Helge and I headed to work, for us, in the more interesting area of counseling and psychotherapy. However, a decade later, in April 1985, he visited me in Minnesota after attending a hypnosis conference in Canada. Together we decide ‘Let’s study the career development of therapists and counselors.’ And so we did for the next decades! And produced many books on the way. 4,6,7 Recently, when our advisors retired at age 80 and 82, Helge and I returned and gave a talk on career development of therapists and counselors. It was a great honor for us to be invited for this complete the circle--from care development to career development--event.

Professional development is a multi-year process of internal development (being oneself) followed by the external development of professional training followed by a new long internal development process. As an analogy, artists start painting then go to art school to learn to paint then go our on their own (internal-external-internal). My view is that expert practitioners become science informed artists in their work. Second, professional development is a long evolving process depending on the therapist’s intense will to grow. Remember when we learned in training that Freud’s last stage Genital lasted from Puberty to Death? As if ages 15 to 85 was all the same. In contrast, professional development it is a long, slow, uneven, cyclical at times, process.

Thank you for asking me these questions. Therapy and counseling is one of the great invention of the last half of the 20th century because it is an effective method for reducing human distress. I have been fortunate to be part of this profession!~

References


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“Expertise in psychotherapy is primarily operationalized as the ability to help a wide range of patients, especially challenging clients.”

My definition of an expert in psychotherapy practice relies on successful performance in the provision of psychotherapy, including a demonstration of therapeutic effectiveness - that is, superior client outcomes over time. However, client outcomes are strongly influenced by client factors and other circumstances outside the realm of the therapist's expertise; hence a definition solely based on client outcome is limited. A demonstration of high performance in providing psychotherapy and engaging the client in a fruitful collaboration, is needed too. A true expert or high performing therapist should exhibit excellent use of technical and relational skills and associated interventions, some of which would depend on the treatment model(s) used. These interventions, as well as the therapist's interpersonal behaviors, are adapted to suit the particular and unique needs of every client.

In essence, a definition of expertise in psychotherapy is primarily operationalized as the ability to help a wide range of patients, especially challenging clients, change and improve their quality of life, not how much training or experience one has, nor one’s reputation as a therapist in the field of professionals. That said, a definition of expertise based on positive patient change requires a more comprehensive assessment of outcome than what is usually applied in psychotherapy research, which often is limited to measuring change in symptoms from before to after treatment. Even if symptom distress is important for a person's wellbeing, measures of psychosocial or work-related functioning are central too. We know that a moderate or even high level of symptoms may impact two people differently, depending on several other factors. Improvement in psychological resources, coping, work functioning and relational capacities should hence be included when defining a good outcome. A low level of drop out and client maintenance of treatment gains over time (i.e. less relapse) would also be part of my understanding of good outcomes. Secondly, as mentioned, a definition of expertise would also involve a demonstrated capacity to use therapeutic competence to benefit client change, involving the capacity for a nuanced and rich conceptualization of the client and therapy process, and the ability to create sustainable relationships over time, especially with challenging or “difficult to treat” clients (see Rønnestad, 2016). At the level of the therapists’ self-assessment, somewhat paradoxically, not seeing oneself as an expert but as a continuous learner, always willing to develop and evolve as a human being and professional, engaging in deliberate practice - remaining open to experience and feedback, seems a vital if not a necessary, component of expertise.

1. How might we go about evaluating such expertise?

A more comprehensive assessment of client outcome is crucial, in my view. One should assess patient outcome in different areas of functioning, include measures of patient resources, and combine quantitative and qualitative analyses.

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of the therapists’ actions (what they do in sessions). Evaluating therapist competence through interviewing clients on their experiences and not just rely on questionnaires could be useful too. It is important to study therapists’ outcomes over time in a longitudinal design, and include enough patients per therapists to account for the large individual differences in patients’ response to treatment, which do not necessarily result from varieties of therapeutic expertise or clinical performance of the therapist. Also, observer ratings of therapists’ performance in using technical and relational skills and degree of responsiveness to the individual client, would further inform us about the degree of therapeutic expertise.

3. What do you consider to be the main factors hindering the development of therapeutic expertise over time?

Factors that may hinder development of expertise over time are both structural or systemic or more individual. Among the structural impediments are difficulties to obtain information on one’s treatment, expectations for seeing too many clients in too little time, among others. We need to cultivate an atmosphere of openness and curiosity and continuous learning; one in which one can get help and supervision when working with complex cases in which clients stagnate or even deteriorate or present with particularly challenging material, as well as a supportive environment where one can be open and honest and provide and get constructive feedback about one’s work without risking a loss of status and opportunities.

The individual ones may be therapists’ lack of humility, lack of creativity, and lack of openness to feedback and development; in fact, the tendency to view oneself as an ‘expert’ because of extensive experience or training in psychotherapy and a ‘good reputation’. Of course, extensive training, readings and clinical experience may contribute to therapeutic expertise but they are not sufficient.

4. How might therapists counter these hindering factors and reliably grow their therapeutic expertise over time, to the best of their ability?

The crucial point here is the willingness to learn throughout one’s whole career, to seek feedback from clients and from colleagues, to show video material from sessions and practice. As part of this is learning different ways of formulating and understanding a client’s problems, and developing treatment plans that are based on a rationale of change and change mechanisms - but which are open to modification at all times. Flexibility is central. To apply some form of systematic feedback informed treatment using routine outcome measurement, as well as regularly seeking ‘individualized feedback’ in treatment sessions from any individual client, is recommended. Reading, evaluating and taking in research findings, including findings that seem to go against one’s convictions, is a marker of an attitude that can foster therapist development and eventually expertise.

5. How has research (psychotherapy or otherwise) influenced your views on therapeutic expertise and its development? Please provide one or two examples.

My own experience and training as well as teaching and supervision of psychotherapy have been influential in determining my view on therapeutic expertise, but reading the research literature has been vital. There are many important research findings, but I will limit my list to only a few, as well as mentioning some influential conceptual contributions and discussions in the field. Tim Anderson’s studies (e.g. 2009; 2015), using the creative and ingenious FIS (Facilitative Interpersonal skills) paradigm, are a good example of research that has linked therapist characteristics to client outcome, if not expertise per se. Using a fixed stimulus of interpersonally challenging client behaviors (performed by actors), therapists’ improvised therapeutic responses are coded against a set of criteria resulting in scores on different facilitative interpersonal skills, such as verbal fluency and sensitivity. The associations between one’s FIS score and client outcome is to my knowledge the strongest in the literature. The fact that the presented material represents interpersonally challenging client behaviors seems essential to bring out the superior qualities of high performing therapists. The intriguing findings of Goldberg et al. (2016) indicating that therapists on average do not necessarily improve with time and experience, including when taking the number of clients seen into account, are well noticed in the field and for good reason. In addition, the studies of Chow et al. (2015), which suggest that deliberate practice (i.e. goal-directed and intensive practice informed by systematic feedback about one’s work), operationalized for example as time and effort spent on improving one’s therapeutic skills, is linked to superior outcomes, are also important, in my view. Helge Rønnestad’s and David Orlinsky’s work (2005) on concomitants of the development of psychotherapists through one’s career, and Rønnestad’s and Oddli’s research on highly experienced or expert therapists and what they
“The associations between one’s FIS score and client outcome is to my knowledge the strongest in the literature.”

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1. Please give us your personal definition of what constitutes an expert in psychotherapy practice (not as a researcher or academic).

One of the unfortunate developments has been the separation between research/academics and clinical practice. With a proliferation of literally hundreds of different “therapies” — most of them not based on empirical evidence — psychotherapy practice is often an uncertainty for prospective consumers. I view an expert in psychotherapy practice as someone who is grounded in some familiarity with the research in psychopathology, a good general background in psychology, expert knowledge about empirically supported treatment and the ability to coordinate this into effective treatment. Thus, in my field of CBT this would involve the ability to conceptualize the patient’s problem, identify problematic perspectives and coping strategies, assist clients in developing competent independence, and establish a compassionate but also effective therapeutic alliance. Being an expert is not reducible to caring or knowing psychology — but rather to understanding and helping people change. But we also have to care and know psychology to help people change.

2. How might we go about evaluating such expertise?

Expertise needs to be understood in terms of the specific therapeutic modality. For example, we have standards for conducting Beckian cognitive therapy and the DBT community is now implementing a credentialing program. With the Beckian model we can evaluate the individual’s ability to conceptualize the patient’s cognitive predispositions and biases,

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“Some CBT people approach therapy with a minimal focus on case conceptualization and an over-reliance on techniques”

“I realized the limits of a strict cognitive model in coping with losses and disappointments in my life.”
The study of expertise in psychotherapy should be designed to enable careful and in-depth study of the performances of therapists who obtain exceptionally good client outcomes."

“I have four recommendations for how to evaluate expertise.”

The Integrative Therapist

Society for the Exploration of Psychotherapy Integration

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Structured Interviews on Expertise, continued

It is commendable that SEPI continues to address the topic of expertise in psychotherapy. It is indeed an important topic. To be presented with five questions to address provides an opportunity to clarify my position on this important topic. I am grateful for that.

1. Please give us your personal definition of what constitutes an expert in psychotherapy practice (not as a researcher or academic).

For some years now, there has been an intense debate on how to define expertise within psychotherapy. Some have argued for a definition of expertise that focuses on the practice and performances of psychotherapists (e.g. Hill, Spiegel, Hoffman, Kivlighan, Jr., Gelso, 2017) while others have argued that expertise is defined by client outcome (e.g. Tracey, Wampold, Lichtenberg, & Goodyear, 2014). I think this distinction is an artificial one, and as the discussion evolves, I think there will be a consensus that expertise cannot be defined without taking client outcome into account. On the other hand, to limit the definition to outcome only, i.e. not taking into account what therapists do (their performance) is not wise and is heuristically and pragmatically limited. To focus only on outcome without studying what therapists do provides no knowledge of the practice that leads to exceptionally good outcome, knowledge that can be transformed to the training of psychotherapists. So, as I have argued before, the study of expertise in psychotherapy should be designed to enable careful and in-depth study of the performances of therapists who obtain exceptionally good client outcomes (Rønnestad, 2016). So to repeat, I suggest that expertness is constituted by two elements, a performative element as well as an outcome element.

However, I think that outcome defined only by client functioning measured at the end of psychotherapy is insufficient, and suggest that outcome is expanded in two ways: 1) to include outcomes that are maintained beyond the end of therapy, i.e. good follow-up results, and 2) the assessment of client drop-out. An assumption is that compared to psychotherapists in general, expert psychotherapists are better able to effectuate change that are maintained beyond the end of the therapy. Dropout can be seen as an expression of negative outcome (but need not be as clients may drop out because their goals are met). An assumption is that compared to psychotherapists in general, expert psychotherapists are better able to establish good working alliances also with clients who are more likely than others to drop out of psychotherapy.

Furthermore, my suggestion is that expert psychotherapists obtain exceptionally good results with clients with some variety in client problems and diagnoses, including clients that are assumed to be difficult to treat. Focusing specifically on alliance, it has been suggested that expertise involve “the ability to establish, maintain, and creatively use a positive working relationship with highly distressed - angry, depressed, rebellious, disturbed - individuals” (Skovholt, Rønnestad, & Jennings, 1997, p. 363). Note that the formulation “some variety in clients’ problems and diagnoses” implies that expert therapists may not be equally effective with all clients. There are indications that it may be a global construct (e.g. Nissen-Lie, Goldberg, Hoyt, Falkenström, Holmqvist, Nielsen, & Wampold, 2016). We need more research on this topic.

2. How might we go about evaluating such expertise?

As I have implied above, two features of expertise should be evaluated, i.e. client outcome and the performance of therapists who have demonstrated exceptionally good client outcome. A discussion on the evaluation of the outcome of expert therapists is embedded within the general discussion on psychotherapy outcome. This discussion has a long
history in psychotherapy research. For more than 40 years ago Strupp and Hadley (1977) wrote a seminal article on the topic. They suggested that it was only by considering multiple perspectives that it would be possible to define mental health comprehensively and also evaluate psychotherapy outcome in a meaningful way. They suggested three major parties that were invested in the definition and measurement of mental health (1) society (including significant persons in the patient’s life), (2) the individual patient, and (3) the mental health professional” (p. 188).

In their conceptualization of expertise, Goodyear, Wampold, Tracey and Lichtenberg (2017) have proposed a call for agreement on what is important to measure. They wrote: “Experts are those for whom there is evidence of improvement over time and who demonstrate superior performance as measured by something that is both agreed on and important, specifically client outcomes’ (p. 56). It is a commendable proposal. I fully agree with their emphasis on “improvement over time” and “specifically client outcomes” in their definition of expertise, but I doubt that it will be possible to arrive at a consensus on what is important and how to measure what one might agree on as being important. The reason for my scepticism is that psychotherapy researchers, as are practitioners, infinitely diverse in terms of characteristics such as world views, epistemologies, training and practice ideologies, theoretical and methodological preference, nationalities and cultures. Although this diversity may be a limitation if the aim is consensus on how to research expertise, the diversity is also an expression of the richness that characterizes the conceptions and practices of psychotherapists.

I have four recommendations for how to evaluate expertise. First, choice of how to assess/evaluate outcome should always reflect the needs of the client expressed as psychotherapy goals that the client and psychotherapist have agreed on. Second, the choice should include clients’ perceptions of any change that may have taken place and their perception of how this change came about. Thus, I give priority to the needs of the client. It may be difficult to differentiate the needs of the client from the needs of the profession. I mention this nevertheless, as it seems as if choice of assessment/evaluation method in psychotherapy research often solely reflects the needs of the profession. Third, I recommend that when choosing assessment/evaluation methods, the choice should reflect procedures that are both inherent to and different from the theoretical orientation of the researcher. By doing so, the influence of researcher allegiance is reduced and generalization to other studies is facilitated. Fourth, to ensure that the needs of the profession are met (which may or may not meet the needs of the client), I suggest that a minimum of including symptomatic measures, measures of interpersonal functioning, self-perceptions, and work/study and daily functioning measures (these are measured by various instruments, including the OQ-45).

The question of how to define the time frame for assessing superior follow-up results is a difficult one, and I understand that it may be hard for the field to come to an agreement on this question. In order for a decision to be made, we need to consider types of client problems, types and duration of therapy, and consider stability and turmoil in clients’ life situations. Also preferences for research strategies will influence the decision on what is a sensible time frame for follow-up assessments. In a process-outcome study conducted at the Department of Psychology, University of Oslo, a study with many long-term psychotherapies, we have chosen to assess client outcomes also 3.5 years after the end of psychotherapy. If more researchers would assess follow-up results beyond 12 to 18 months after treatment termination (which is an upper limit in much psychotherapy research), we would be better able to identify and study the expertise as I have defined it above.

Given the diversity among psychotherapy researchers, it will be hard to come to an agreement on what aspects of performance should be studied. It is not only a theoretical question, but ultimately an empirical one. I suggest that an approach searching for summaries of research that focus on process-outcome (e.g. Orlinsky, Rønnestad & Willutzki, 2004), therapeutic change principles (Goldfried, 1980), or reviews that assess effect sizes for therapy elements/factors (e.g. Wampold & Imel, 2016) may be efficient heuristics to locate and describe expert therapist performance.

3. What do you consider to be the main factors hindering the development of therapeutic expertise over time?

I will present some characteristics of the practice environment and individual characteristics that hinder the development of expertise.

The practice environment. I think many psychotherapists will agree that in many work environments, work pressure is so hard, that there simply is not enough time to engage in the activities needed to develop expertise. Resources to engage in activities such as continuing education, supervision, collegial discussion and time for reflection on one’s
A perspective of optimal challenge to facilitate learning reflects a well-established pedagogical principle.

In my own summary of psychotherapy research, I see psychotherapists' interpersonal sensitivity as a superordinate meta competence.

practice are simply speaking not available. Work-settings which do not provide support, autonomy, stimulation and do not provide feedback to its members in some form are unlikely to facilitate the development of expertise. Furthermore, practice cultures which do not continually scrutinize their own practice and which are closed to new ideas are unlike to facilitate the development of expertise. It seems that we can now safely say that continued monitoring of client progress and providing feedback is one of many ways to improve outcome. An influential feedback strategy was initiated by Mike Lambert (see for example Lambert, 2010) and thereafter adapted and extended to deliberate practice (e.g. Chow, Miller, Seidel, Kane, Thornton, & Andrews, 2015; Rousmaniere, Goodyear, Miller, & Wampold, 2017).

Throughout psychotherapists’ career, but especially important in the early phases of the career, a poor match between the professional challenges encountered and skillfulness of the psychotherapist can lead to erosion of skillfulness and mastery. A perspective of optimal challenge to facilitate learning reflects a well-established pedagogical principle formulated by many prominent scholars. Particularly important in this regard are Vygotsky’s (1999) concepts of zone of proximal development, the Vygotsky inspired concept of scaffolding by Wood, Bruner & Ross (1976), and also Csikzentmihalyi’s (2008) concept of flow, an emotional state which is facilitated by being optimally challenged.

If psychotherapists are not resolving the difficulties they encounter in their work, they are over time at risk of losing their enthusiasm for work, be exhausted, disillusioned with themselves and/or the profession and potentially also disengage themselves from clients as well as from work (Rønnestad & Skovholt, 2013). Therapists who in their practice experience much difficulty, anxiety or boredom in sessions, and who avoid therapeutic engagement (i.e. are Stressfully Involved with their clients) are likely to experience a dulling and erosion of responsiveness, a disillusionment about therapy, a lacking capacity to respond with empathy (i.e. are experiencing Currently Experienced Depletion) (Orlinsky & Rønnestad, 2005). Over time, this may lead to unsolved limitations as a therapist, minimal skill change, and a scant sense of therapeutic mastery (i.e. Limited Overall Career Development). For those interested, see Orlinsky and Rønnestad, (2005) for how these concepts are operationalized. To repeat, the argument is that a poor match between the competence of the psychotherapist and the challenges that clients represent constitutes a factor that hinders the development of expertise.

Individual psychotherapist characteristics. Given what we know from research on psychotherapy process-outcome, it seems more than likely that therapists who lack interpersonal sensitivity, warmth, respect, genuineness, humility and the capacity to establish growth promoting working alliances are limited in their capacity to develop expertise within the field of psychotherapy. In my own summary of psychotherapy research, I see psychotherapists’ interpersonal sensitivity as a superordinate meta competence that allows psychotherapists to pick up subtle nuances in how clients’ respond to psychotherapists’ communication, thus continually providing psychotherapists with valuable feedback. An assumption is that it is therapists’ interpersonal sensitivity that accounts for the findings that some [sic] “experienced psychotherapists are more flexible, and that they cope better with more complex conditions and severe problems”, and thereby are capable of forming “more complex, nuanced and succinct conceptualizations than their less experienced colleagues” (Oddli, Halvorsen & Rønnestad, 2014; http://societyforpsychotherapy.org/expertise-demonstrated/). However, some therapists, regardless of experience level, may simply not have the interpersonal sensitivity needed to recognize the feedback that clients are giving them (Rønnestad & Skovholt, 2013). To repeat, lack of interpersonal sensitivity appears to be a crucial factor than hinders the development of expertise.

Some therapists are already engaging in expert practice, but do so without having engaged in deliberate practice with feedback from experts as a central learning component. My assumption is that these therapists may have an interpersonal sensitivity that has enabled them to pick up the feedback that clients have been giving them, a sensitivity that has enabled them to continually adjust their behavior in a responsive fashion. (For elaboration of therapist responsiveness, see Stiles, Honos-Webb, and Surko, (1998) and for appropriate responsiveness, see Hatcher, 2015). Another assumption is that these psychotherapists have throughout their professional lives been engaged in a reflective practice (Rodolfa, Bent, Eisman, Nelson, Rehm, & Ritchie, 2005). To the degree that psychotherapists have sufficient interpersonal sensitivity, this perspective is in agreement with clients as primary teachers (Skovholt & Rønnestad, 1995), a finding at least partly replicated across psychotherapists’ professions, nationalities, theoretical orientations and gender (Orlinsky, Botermans & Rønnestad, 2001).

Studies on the professional development of psychotherapists have suggested that psychotherapists lacking in desire to develop professionally, lacking in curiosity and zest for learning, and psychotherapists who are rejecting the potential wisdom that may reside in theological orientation outside of their primary interest, are likely not developing optimally and thus not developing expertise. In a related vein, psychotherapists who for some reason do not

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continuously engage in reflective activity are likely not developing expertise. I feel this is an important but also delicate point as it raises the question of suitability for being a psychotherapist and also of screening of students.

In this brief description of factors hindering the development of therapeutic expertise over time, I will end with a note on the role of what we, for the lack of a better term, may call "the person of the psychotherapist". Carl Rogers explicitly addressed psychotherapists' personhood, by more than 60 years ago proposing therapist congruence as one of the necessary and sufficient conditions for therapeutic personality change. Since then, researchers have off and on addressed the topic of "the person of the therapist", expressed also in the concept of the real relationship (Gelso, 2009). It seems that researchers are increasingly addressing the topic, which has direct implication for the development of expertise.

A line of research at the Department of Psychology at the University of Oslo, has addressed the relationship between psychotherapists' life quality, aspects of the psychotherapists' personality, attitude to psychotherapeutic work and psychotherapy processes and outcome. This research has documented associations between psychotherapists' being personally burdened (an aspect of life quality) and working alliance development as rated by clients (Nissen-Lie, Havik, Høglend, Monsen, & Rønnestad, 2013). A significant association was also found between psychotherapists introject quality in combination with experiencing self-doubt about their professional competence and client rated processes and outcomes of psychotherapy (Nissen-Lie, Rønnestad, Høglend, Havik, Solbakken Stiles & Monsen, 2015). The latter result resonates with Jennings and Skovholt (2016) who highlighted humility as meta-category in their description of master therapists. Results like these combine to suggest that not recognizing and attending to the personal aspects of being a psychotherapist limits the probability that psychotherapists will attain a level of competence that we may define as expert behavior.

4. How might therapists counter these hindering factors and reliably grow their therapeutic expertise over time, to the best of their ability?

Based on many years as a practitioner, teacher, supervisor and researcher, I will point to some perspective and strategies that might counter the barriers that hinders the growth of expertise. But, although there may be some common elements that optimally facilitate growth, I have become convinced that there are many different routes to the development of expertise.

I want to emphasize that psychotherapists 'will to develop' is a prerequisite for psychotherapists overcoming hindering factors and thereby developing expertise.”

“I have become convinced that there are many different routes to the development of expertise.”
A small minority of psychotherapists seem not to be highly motivated to develop professionally.

It seems clear that the clinic directors have an enormous impact on qualities of the practice milieu.

more extensive than merely the formulation “client preferences” by Sackett et al., (2000). This, in addition to the APA formulation “in the context of”, may mean that knowledge of clients is awarded a higher priority. The formulation “in the context of” is a strong one, and may suggest that knowledge of clients is a foundation for which aspects of clinical expertise is most relevant and also for deciding what is “the best research evidence”. We know for example that for low-frequency conditions, RCT-designs are not possible.

APA’s statement on EBP can be interpreted as a programmatic call for clinicians to strive towards acquiring and developing more in-depth and comprehensive conceptions of clients. APA statement suggests that in forming and maintaining a treatment, a therapeutic relationship and in implementing specific interventions, a wide range of relevant research literature can inform practice. Examples mentioned specifically are ethnography, cross cultural psychology, cultural psychiatry, cultural anthropology and cultural psychotherapy. This literature will not only provide knowledge of the varieties of normality but also of the vicissitudes of human behavior and being. In my view, an implication of APA’s definition is that sources of knowledge that can make psychotherapists better able to understand clients in their varieties and depths are important developmental resources. To me, it seems logical to extend the EBP paradigm to include knowledge, not only specifically from the social sciences as recommended by the APA, but also from the humanistic sciences, as for example prose, poetry, drama and film. Thus the contributions by for example Fjodor Dostojevsky, Doris Lessing, William Butler Yeats, Henrik Ibsen, August Strindberg, and Ingmar Bergman are important resources for the psychotherapist to develop expertise in assisting people in improving their lives.

Will to develop. I want emphasize that psychotherapists’ “will to develop” is a prerequisite for psychotherapists overcoming hindering factors and thereby developing expertise. “Will to develop is an individual characteristic but is nourished and maintained by a practice milieu that is developmentally oriented, one that provides the resources that are needed to grow professionally, one that provides opportunities for new learning, which provides support, which allows for autonomy in the sense that therapists’ have control over intake of clients and how to work, one which is characterized by a culture that is appreciative of new ideas. “Will to develop” can indirectly be studied by asking psychotherapists “How important to you is your further development as a psychotherapist?” This is exactly what was done in a study within the SPR/Collaborative Research Network (Orlinsky & Rennestad, 2005). With data from more than 4700 psychotherapists, results showed that 65% of the therapist gave it the highest rating (i.e. a rating of 5 on a 0-5 scale), while another 21% gave it the next highest rating. In other words, it seems that 86% of this sample seems to be highly motivated for further professional development. Additional analysis showed that between 80% and 90% of therapists across professional background, theoretical orientation, career level, gender, and nationality, suggesting that motivation to develop may be a shared characteristic of psychotherapists. But, as we warned, these proportions may be overestimates of motivation to develop, as those provided with the opportunity to take part in the survey, but did not participate, may not be as motivated to develop professionally as the results above indicate.

Even though the results above may seem impressive from one perspective, a more negative view is that more than a small minority of psychotherapists seem not to be highly motivated to develop professionally. Given what we know of the relationship between psychotherapists’ attitude to professional development, sense of growth/decline and perception of therapeutic work, the results above are disconcerting. It seems plausible that psychotherapists, regardless of experience level, who are not obtaining good results with their clients, can be found in this group. If lack of motivation to develop to some extent can be attributed to qualities of the work environment as described above, it seems logical to ask how the quality of the work environment can be improved. If lack of motivation to develop professionally can largely be attributed to personal characteristics of the psychotherapists, personal psychotherapy and also ‘personal practice’ (Bennett-Levy, & Finlay-Jones, 2018) are recommended. These issues will briefly be addressed below.

More focus on qualities of the work-environment. From teaching psychotherapist development to colleagues, it is striking how differently participants describe their work environments. Some report an individual private practice in which no or only minimal initiative is taken to interact with other colleagues. It is my impression that if these therapists do not take steps to use the many developmental resources that are available to them, they are at risk for stagnating professionally, possibly also deteriorating in skillfulness. Fortunately, many professional organizations and bodies of certification require a minimum of continuing education in order for practitioner to maintain and improve their competence. Others, working in a work setting with colleagues, will nevertheless describe their work environment similar to the solo-practice described above, with interactions limited to client-intake meetings, and brief and superficial staff-meetings. Fortunately, some will talk of a stimulating work environment with numerous opportunities for interactions with colleagues in the form of established procedures to give and receive feedback, internal seminars, formal or informal supervision and/or

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“Deliberate practice comes in many forms. In its most comprehensive form it incorporates client feedback with repetitive practicing of targeted skills and feedback from experts.”

consultation, opportunities and funding to take part in external events such as professional conferences and workshops. Psychotherapists working in this kind of work environment may develop expertise if they make continued and committed use of the developmental resources available to them.

From my teaching and consultation with colleagues and clinic directors, it seems clear that the clinic directors have an enormous impact on qualities of the practice milieu. Their job is a difficult one, and many need to balance the demands from higher up in the organizations to reach institutional treatment goals (typically defined as number of treated patients) with the wishes of the staff to provide quality treatment to clients and also to develop professionally.

**Feedback and deliberate practice.** I want to highlight the role of feedback for the development of expert performance. Feedback provided to psychotherapists either from clients after client-outcome assessments, and/or from competent colleagues after observing psychotherapists’ work constitutes an important resource for developing expertise. I recommend that psychotherapists continually enlist feedback in a form that gives meaning to them and which facilitates constructive psychotherapy processes. The important role played by feedback for learning is of course not a new perspective. From the earliest supervision literature it has been discussed. Contemporary supervision literature addresses the topic. See for example Bernhard and Goodyear (2009) for useful recommendations for how to give formative feedback in clinical supervision.

One of the most substantial contributions within psychotherapy for decades is the establishment of procedures for monitoring therapeutic work by assessing client outcome and providing feedback to psychotherapists on outcome, i.e. Routine Outcome Monitoring (Lambert, 2010). There are many issues and challenges that need further investigation such as “identifying the efficacious components, implementation, utilization, scientific inquiry…” (Wampold, 2015, p. 458). However, the general positive effect of research informed feedback is well established (Lambert, 2010; Wampold, 2015). However, a note of caution is warranted, as outcome monitoring may serve many masters (Sundet, 2012)

Deliberate practice comes in many forms. In its most comprehensive form it incorporates client feedback with repetitive practicing of targeted skills and feedback from experts, which enhance the quality of the psychotherapists’ deliberations. There is an increasing body of knowledge on the topic (e.g. Chow, Miller, Seidel, Kane, Thornton, & Andrews, 2015; Rousmaniere, Goodyear, Miller, & Wampold, 2017). It is an open question if deliberate practice is an equally effective learning strategy throughout psychotherapists’ career and under all circumstance. Hopefully research will inform us.

**Personal therapy.** I recommend that all psychotherapists should engage in personal therapy or in other experiential activities which may increase self-knowledge, self-insight, quality of relatedness, procedural competence and more generally, understanding of human variability. Psychotherapists know best when to engage in this practice. Although there is little empirical evidence to suggest that psychotherapists’ personal therapy has a direct effect on client outcome, (e.g. Norcross, Geller & Orlinsky, 2005). I nevertheless encourage psychotherapists to engage in personal therapy. I do so, as I trust the evaluations that psychotherapists have provided for how important personal therapy has been for them. From a survey of approximately 5000 psychotherapists from many countries (Orlinsky, Botermans, & Rennestad, 2001), personal therapy was ranked 2nd or 3rd among fourteen sources of influence for overall professional development. (With one exception—i.e. beginning therapists—formal supervision was ranked first). In other words, personal therapy has a strong standing as a developmental resource among psychotherapists.

Another rationale for my recommendation that therapist should engage in personal therapy (or related experiential practices, see below) is found in recent research. Based on a review of the research literature on psychotherapists’ personal therapy (Rennestad, Orlinsky & Wiseman, 2016), participating in personal therapy was reported to influence therapist role performance, therapist role identity and also their perception of themselves in the personal domain (as people, i.e. not just in their role as therapists). Role performance was influenced in two interrelated ways. First: “The therapist’s own therapy provides an experiential understanding of the client role and empathy for clients’ feelings in the therapeutic situation…This enables the therapist to view their clients not as others (i.e. as objects of the therapists’ treatment procedures), but as another self with whom they can engage intersubjectively in an empathic way, yet with a clear sense of differentiation between their own and their clients’ feelings…” (p. 229). Second: Personal therapy also increased therapists’ awareness of how important it was to be committed and reliable and also to protect the client. Personal therapy also provided an opportunity for developing procedural competence and therapeutic skillfulness. The above review also provided another argument for recommending personal therapy as a way to develop expertise. Several studies reported changes in therapist role identity, specifically how important the therapist’s therapist became as a role models with whom they could identify. Furthermore, Taubner, Zimmermann, Kachele, Miller, and Sell (2013) reported the following: “Given a positive experience in their personal therapy, therapists clearly gained confidence and
“From a survey of approximately 5000 psychotherapists from many countries, personal therapy was ranked 2nd or 3rd among fourteen sources of influence.”

“Continual self-reflection is a prerequisite for developing expertise.”

and sense of competence and self-worth as a therapist” (p. 229). It should be noted that results are sometimes mixed and negative, particularly so if therapist are required to undergo personal therapy (e.g. Rizq & Target, 2010).

Finally, but not exhaustively, personal therapy was reported to influence their self-perceptions in the personal domain, not just in their role as therapists such as increased personal growth, improved relationships, increased self-awareness, self-knowledge, and self-acceptance, and also reduction of symptoms.

**Personal practice.** There are other ways than personal therapy to increase psychotherapists´ self-knowledge, self-insight and other outcomes typically associate with psychotherapists personal therapy. The term personal practice (Bennett-Levy & Finlay-Jones, 2018) refers to a type of experiential practice that includes personal therapy, but also includes others forms of psychotherapists´ experiential learning. “Relatedly, we use the term personal practice (PP) to refer to psychological interventions and techniques that therapists engage in individually or as a group that focus on their personal development: for some but not all therapists, an additional motivation for PP may be to enhance their therapist skills” (p. 1). The varieties in PP practices can be organized as (1) personal therapy, (2) meditation programmes (e.g. such as mindfulness based cognitive therapy and mindfulness based stress reduction and (3) self-practice/self reflection. I mention these practices as they are developmental resources available for psychotherapists to choose from in their quest to increase their skillfulness and develop expertise

**Clinical supervision.** Throughout their careers, also in more senior years, psychotherapists should seek clinical supervision. This recommendation is not only inspired by what I learned about life long career development at the University of Missouri-Columbia during my doctoral studies in the USA, and thereafter in Norway, but also by research on the topic. Stimulating literature on the topic is formulated by many (e.g. Bernhard & Goodyear, 2009; Ladany, Friedlander & Nelson, 2005; Watkins, 1997). As stated above, based on survey with data from the Society for Psychotherapy Research/Collaborative Research Network, clinical supervision was ranked 2nd or 3rd as a source of influence for professional development. From a more recent analysis (Orlinsky & Rønnestad, 2015), the proportion of therapists currently in supervision and personal therapy was analysed for different age cohorts. Seventy-three per cent of psychotherapists in their twenties were currently in supervision, a proportion that is not surprising and which dropped gradually for successively older cohorts of psychotherapists to 56 % for those 60 years or older. The fact that more than half of age 60+ psychotherapists reported to be currently in supervision, suggests that large proportions of psychotherapist throughout their professional lives are committed to do quality work, and suggests also a commitment to develop professionally.

The recommendation for psychotherapists to seek supervision throughout their career, activates the question if supervision may take different forms depending on the experience level of the supervisee. And indeed it may, although some principles of supervision have validity for all supervision. According to a developmentally sensitive model of supervision (Rønnestad & Skovholt, 2013), there are some common principles that are assumed to have validity for all supervision, while it is suggested that supervision can be more effective if the supervisor in addition is informed of how developmental tasks may change through the career.

**Continuous reflection.** More than thirty years ago, in my early formulations on supervision, I suggested that supervision methods of “clarification” and “facilitate reflection” was important for supervision at all experience levels, and thus may reflect the “sine que non” of supervision (Rønnestad & Winje, 1984, p. 12). About the same time I formulated a conceptual developmental model of supervision (Rønnestad, 1985) that highlighted the influence of the quality of reflection for developmental and stagnant development. Components of this model served as assumptions for later qualitative research on psychotherapist and counselor development. A central component of this model was psychotherapists ability to maintain a reflective stance, i.e. not aborting the reflection process when encountering challenges that seemed outside of what the therapist felt able to handle. It was assumed that this ability was nourished by therapists´ tolerance for ambiguity and awareness of the complexities of therapeutic work. The concept of premature closure was used to apply to psychotherapists’ unconscious defensive maneuvers in order to avoid recognizing their own limitation. This emphasis on reflection, initially formulated within a supervision context, has stayed with me, has passed the test of time in the collaboration with Tomas Skovholt as valid for psychotherapist development in general (e.g. Skovholt & Rønnestad, 1995; Rønnestad & Skovholt, 2003), and has thereafter been differentiated in a cyclical trajectories model of psychotherapist´s professional development and stagnation (Rønnestad & Skovholt, 2013).

Support for an advice to encourage psychotherapists to continually reflect on their experiences in the professional domain can be found in the contributions by many. See for example: John Dewey (1933), who argued for the use of

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reflection to assist students in becoming critical thinkers, Donald Schön’s (1987) work on the reflective practitioner, APA’s (2006) argument that continual self-reflection is a prerequisite for developing expertise; several authors’ description of deliberate practice, and Jennings and Skovholt’s (2016) descriptions of master therapists.

5. How has research (psychotherapy or otherwise) influenced your views on therapeutic expertise and its development? Please provide one or two examples.

As shown above, my answers to the question of what hinders the development of expertise (Question 3) and how one might counter the hindering factors (Question 4) are largely informed by research on the professional development of psychotherapists. I will end by referring to research within feminist theory by Belenky, Clinchy, Goldberger and Tarule (1986) and to the concept of wisdom by Baltes and Smith (1990). The conceptual model by Belenky and collaborators was intended to describe women’s ways of knowing. However, their model may be generalized to understanding knowledge development that were observed among the optimally developed practitioners (both men and women) in the study by Skovholt and Rønnestad (1995). Belenky and collaborators described seven levels of ways of knowing. An assumption is that the highest level in the model, Constructed Knowledge, may also characterize many expert psychotherapists. About their highest level of knowledge, Belenky and collaborators wrote:

“All knowledge is constructed, and the knower is an intimate part of the known (p. 137) […] To see that all knowledge is a construction and that truth is a matter of the context in which it is embedded is to greatly expand the possibilities of how to think about anything (p. 138) […] Theories become not truth but models for approximate experiences (p. 138).” (cited in Skovholt & Rønnestad, 1995, p. 111)

The above view of knowledge converges to some extent with the conception of wisdom formulated by Baltes and Smith (1990), who by including awareness of uncertainty in ways of helping as one element of wisdom, reject certainty and precision in the prediction of human experience and behavior. Building on research on psychotherapist development and master therapists as referred to above, a final assumption is that expert psychotherapists will interact with their clients with a sense of confidence and mastery, while also recognizing and respecting the complexity of psychotherapeutic work.

References:


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“Paper and pencil inventories were woefully insufficient in capturing the qualitative changes in the patient’s subjective experience.”

Patricia Coughlin
NYC, USA

How can we define expertise or mastery in the practice of psychotherapy? It seems to me that this can only be measured by the outcomes we are able to achieve. Here, I am referring not just to quantitative outcome—like a shift on the Beck Depression Inventory—but real clinical change that makes a significant difference in the life of the patient. The quality of change is extremely important. David Malan, one of the first dynamic therapists to study outcome and conduct in-depth follow-up interviews with patients, found that paper and pencil inventories were woefully insufficient in capturing the qualitative changes in the patient’s subjective experience. He has argued that the quality of the patient’s well being and relationships can only be captured by an in-depth interview, in which specific examples of reported change are obtained.

In order to track my own process and outcome, I videotape all my sessions and conduct follow-up at 1, 5, and 10 years (I now have some 20-30 year follow-up data!). We can only see what we see and hear what we hear at any given moment. Having the videotape to review, when we are under no pressure to respond to patients, gives us another chance to observe and understand the patient, as well as detecting errors or blind spots that become apparent on second view. Having others view the tape, whether for supervision and consultation or teaching, adds value to this practice.

Patients are our best supervisors and give us valuable feedback. Again, I find specific verbal feedback more helpful than data from paper and pencil tests. This is done continually throughout treatment. In addition, by conducting follow up, I can assess whether change lasts and growth continues to expand, or there are reversals. Discovering what kind of patients I do well with and those groups with whom I struggle, gives me additional information I can use for my continued development.

I just finished a treatment this week with a patient who emphasized that it wasn’t just what we did together (though several specific processes were seen as extremely helpful), but who I am in my being that had such an impact on him. He said that he trusted me almost immediately—that I seemed solid, unflappable, and open to anything he had to reveal. He experienced me as someone with integrity and character, and felt my dedication was to him and his healing, rather than to any needs of my own. Over the years I have been struck by how common this kind of feedback has become. Patients report that being helped to face the feelings they had been avoiding was essential, but that it is who I am, and the kind of relationship that I offered them (one of collaboration and partnership), that was so important and impactful. This seems to be reflected in the literature on the supershrinks. They have a model of treatment they are passionate about and skillful in applying but are also flexible, approachable, genuine, responsive, and highly ambitious, challenging themselves and their patients to get the best results possible.

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Society for the Exploration of Psychotherapy Integration

“In order to track my own process and outcome, I videotape all my sessions and conduct follow-up at 1, 5, and 10 years.”

In many ways, I am my own control. I have been practicing dynamic psychotherapy for nearly 40 years. I was good but not great at the start, and became frustrated with my own lack of consistent results. I needed more than my original training provided – more than theory and more than offering interpretations. When I met Davanloo and trained in ISTDP, I was given the tools to intervene in a far more systematic and effective manner than ever before. The depth and breadth of change I was able to facilitate went up dramatically – and with a far wider spectrum of patients than I had previously been able to reach. Of course, I have also attended to my own development – am always reading, going to conferences and maintain my self-care – but it was finding a highly effective method that I was passionate about that really increased my effectiveness. I was motivated to become an expert and do the best work I could possible do.

As a teacher and supervisor I am aware that I can teach theory and technique but can’t teach character. I can’t teach integrity or tolerance of complexity and uncertainty. I can’t teach emotional attunement or courage in the face of anxiety and pain. However, these are qualities I can model and can help develop in trainees over time. So teaching and development are different. I feel strongly that we have neglected the personal development of the therapist to our peril. It’s not enough to teach skills but to develop people. We are the instrument and the vehicle of transmission of the treatment and, as such, we must be “in tune” to be effective. You can do skill exercises all day long, but if you don’t when to employ those skills in a particular case or how to do so with caring, it will fall flat, if not back fire all together. It’s complex.

Perhaps this is all in the way of saying that expertise is a life long endeavor. There are no short cuts to mastery. We know that the best therapists spend 7 times the amount of time as their average colleague learning, reflecting and developing their abilities between sessions. Is it time alone that makes the difference? I think not. Only those with passion and persistence are willing to devote that kind of time to their own development. So, again, it’s a complex mix of desire, passion, hard work, willingness to put in the time, to get feedback and to continue to grow that yields expertise.

We don’t seem to be very accurate in our own self assessment, so working alone and failing to get supervision is a huge hindrance to the development of expertise. Research has revealed that therapists whose outcomes fall in the lowest quarter rate themselves as being in the top quarter. Without feedback, we can be seriously off the track. Of interest, the top performers see themselves as good and competent but not great. They are humble and always want to do better. So our own inflated sense of ourselves, complacency and self satisfaction can be a huge hindrance. Paradoxically if someone thinks he is a master, they are probably not! Similarly if we idealize a method and cling to it rigidly, rather than applying it flexibly, we will hinder our own development and undermine treatment effectiveness.

By reading widely and often, we can keep ourselves abreast of the latest developments in the field. In addition to reading psychotherapy journals and books each month, I also read about adult development and have been heavily influenced by people like Robert Kegan. In particular, his emphasis on the importance on the necessity of moving beyond the first stage of adult development (socialized mind) to that of self authoriship is really a pre-requisite to the masterful application of psychotherapeutic techniques. Again, if we only teach theory and technique and don’t develop ways to help trainees move into the stage of self authorship, they won’t be able to become experts.

The literature on leadership has also germane to the topic of expertise in psychotherapy. Last summer I attended a week long workshop on leadership with Bob Anderson. His contention that the inner game always runs the outer game, is as true for therapists as it is for business leaders. Self reflection and self development are essential to the development of expertise.

In addition to the scholarly reading already mentioned, an immersion in the arts often facilitates the development of us as human beings. While I have no data to confirm this, I notice that most experts in psychotherapy read literature, attend the theater, watch films, and explore their own creativity. Most experts are geeks and polymaths – they are interested in lots of things. My interest in quantum physics, neuroscience and spirituality, as well as the arts, adds to my own complexity and enriches my work with patients. In the end, experts develop superior meta-cognitive skills and tolerate both complexity and uncertainty. Atul Gawande, the remarkable surgeon and writer, speaks to this in his article entitled “Failure and Rescue”. His writing has been a constant source of information and inspiration.

Expertise is a life long quest and requires continual development of both who we are and what we do. In fact, this was the thesis of my most recent book Maximizing Effectiveness in Dynamic Psychotherapy.
Thank you for giving me the chance to respond to these great questions. I appreciate the opportunity! As you may know, I have pretty strong ideas on all of these important topics, but I’m not always right, either!

1. **Please give us your personal definition of what constitutes an expert in psychotherapy practice (not as a researcher or academic).**

   In my opinion, the only way to assess expertise is by tracking patient progress with brief, highly reliable assessment tests. We require TEAM-CBT therapists to assess depression, anxiety, and anger severity, as well as suicidal urges, just prior to the start of every therapy session, and immediately at the end of every session, with no exceptions, using my Brief Mood Survey (BMS) consists of a number of brief, highly reliable assessment tests. Patients complete the BMS in the waiting room just before the session begins and immediately after the session is over, so that no therapy time is lost with testing.

   After the session, patients also rate therapists on the Evaluation of Therapy Session. This includes several extremely sensitive scales that assess therapist empathy, helpfulness, and other aspects of the therapeutic alliance. All the assessments are brief, user-friendly, and accurate.

   Some therapists wrongly believe that patients won’t be honest in filling out the scales. The opposite seems to be true. Patients are extremely honest, and at first, therapists who use the scales I have developed will be surprised to learn that they will initially receive failing grades on most or all of the scales from all or nearly all patients at most sessions. But with training and practice in how to respond effectively to negative feedback, most therapists report rapid and dramatic improvements in their ratings, along with fairly radical changes in how they interact with patients.

2. **How might we go about evaluating such expertise?**

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3. **What do you consider to be the main factors hindering the development of therapeutic expertise over time?**

   There are several factors. First, most therapists do not measure symptoms at the start and end of every therapy session. In fact, most do not use any types of assessment tests to track progress. My research on therapist accuracy indicates that most therapists are highly inaccurate in assessing patients’ symptoms, but therapists are not aware of this and wrongly believe they have a reasonable understanding of how their patients feel. In fact, my research indicates that therapist accuracy in judging depression, anxiety, and anger severity, as well as suicidal urges, is less than 10%. The same is true of the therapist’s perception of empathy and helpfulness: Their perceptions are very different from the perceptions of their patients. That’s why the assessment instruments are, to my way of thinking, absolutely mandatory.

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Second, training in psychotherapy is rather poor—again, this is my opinion only, and I apologize if I’m offending anyone!

Third, I believe that therapist codependency, narcissism and conflict phobia, as well as conflicts of interest, are powerful barriers to making patients accountable and to learning and implementing world-class therapy.

Fourth, I believe it is time to eliminate the schools of therapy, which compete like cults, or religions, and to develop a science based, data-driven form of therapy. The version of this that I have developed in collaboration with my colleagues is called TEAM-CBT. It is not a new school of therapy, but rather a new structure for understanding how all therapy works, and for doing therapy.

Fifth, one of the key components of TEAM is the rapid reduction of patient resistance, using fifteen new and innovative techniques. But few therapists know how to reduce resistance, so they end up feeling frustrated and trying to help patients who “yes but” them or resist in other ways. The new TEAM-CBT methods for rapidly reducing resistance are pretty revolutionary, and to my way of thinking, represent a major advance in psychotherapy.

4. How might therapists counter these hindering factors and reliably grow their therapeutic expertise over time, to the best of their ability?

Well, this will sound hopelessly narcissistic and self-promotional, but I would encourage interested clinicians to go to my website (www.feelinggood.com) and learn about TEAM-CBT, as well as the website of the Feeling Good Institute in Mt. View, California (www.feelinggoodinstitute.com). There are tons of free resources, such as my weekly Feeling Good Podcasts, as well as paid in person and online training opportunities. My book, Tools, Not Schools, of Therapy, can also be helpful. Again, I apologize for promoting my own approach, so take it with a grain of salt. But I think there is a lot there that can radically influence therapists who wish to boost their skills and improve clinical outcomes. The biggest reward for me is seeing patients suddenly and dramatically recover, and now I see this all the time, thanks to the new tools and methods.

One of the most powerful learning tools we use, among others, is personal work for the therapists in our groups. Often, this involves the death of the therapist’s ego, which is necessary, in my opinion, if you want to learn world-class therapy skills. Then you can tell your patients, “I know how you feel, because I’ve been there myself. And I can show you the way out of the woods, as well. And what a joy that’s going to be!” This, in my experience, is a message that patients really want to hear. You reveal yourself as a human being, and as a compassionate professional, simultaneously.

If any therapists live in the San Francisco Bay Area, or plan to visit here, I offer TEAM-CBT training at Stanford every Tuesday evening, from 5 to 7:30. All therapists are welcome to join us, and there is no charge. We also have three to four hour hikes every Sunday morning, and we do personal work and practice techniques along the way. Again, if you plan to visit here, let me know so you can join us on a hike as well!

5. How has research (psychotherapy or otherwise) influenced your views on therapeutic expertise and its development? Please provide one or two examples.

Being a clinician, I cannot do controlled outcome research, but I have done a lot of causal modeling, using data collected over time, to learn how psychotherapy really works. I have published these studies in psychology journals, such as Journal of Clinical and Consulting Psychology and others. The goal of the research has been to identify the ingredients of therapeutic success or failure, regardless of the “school” of therapy. This research lead to TEAM-CBT, which stands for:

- **T = Testing:** We assess symptoms at the start and end of each session. It is like having an emotional X-ray machine for the first time. The feedback can be startling, but the benefit is that every session becomes a powerful learning experience for the clinician.
- **E = Empathy:** We have developed rigorous new empathy training methods.
- **A = (Paradoxical) Agenda Setting:** We bring the patient’s subconscious resistance to conscious awareness and melt it away quickly, before trying any methods to change the patient’s thoughts, feelings, or behaviors.
- **M = Methods:** We use 50 to 100 techniques based on more than a dozen schools of therapy to help patients change the way they think, feel, and behave.
“A novice practitioner thinks she’s an expert, while an expert practitioner thinks she is a novice.”

Measure what is of value to your clients, instead of valuing the measures we are told to use.”

1. Please give us your personal definition of what constitutes an expert in psychotherapy practice (not as a researcher or academic).

A novice practitioner thinks she’s an expert, while an expert practitioner thinks she is a novice. An “expert” in psychotherapy is someone who has deep principles not only of clinical knowledge, but someone who has process knowledge (i.e., the moment-by-moment interaction between client and therapist) and conditional knowledge (i.e., how you would work with someone who is depressed is different if she has a context of bereavement, compared to someone else who has a history of domestic violence).

Our training has been heavy on the clinical knowledge, and light (or absent) on the process and conditional knowledge. 1

2. How might we go about evaluating such expertise?

Client outcomes. Not the outcome of one of your clients, but an aggregation of at least 20 cases. I highly recommend a measure that you consistently employ in your clinical practice, preferably one that captures information about the well-being of your client, as opposed to a symptom specific measure. Measure what is of value to your clients, instead of valuing the measures we are told to use. After all, measurement precedes development.

An aside: Measures of adherence and clinical competence rated by experts in specific domains (e.g., CBT), though seemingly intuitive to measure, do not improve client outcomes. 2

3. What do you consider to be the main factors hindering the development of therapeutic expertise over time?

Competency.

4. How might therapists counter these hindering factors and reliably grow their therapeutic expertise over time, to the best of their ability?

It’s time to stop thinking of psychotherapy as an individual sport. We need coaches to elevate our game. Despite supervision being the “signature pedagogy” of our field, the traditional approach of clinical supervision is broken. Traditional supervision does not translate to better client outcomes. 3 Despite our feelings of “benefit,” there are six key reasons why we aren’t getting better outcomes from supervision:

1. Theory Talk

Often, the encounter in clinical supervision revolves around case discussion, theoretical formulation, case formulation, and even gossip (isn’t that when we talk about someone without him or her present?). This mostly fits under the umbrella

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"Traditional supervision does not translate to better client outcomes."

"We then spend our time working through the supervisee’s uncertainty."

2. Pat on the back

What feels good doesn’t necessarily equate to what helps us grow. While it is important to take care of the supervisee’s ego, at times we fail to focus on the learner’s “growth edge”, that is, tending to the supervisee’s sense of self as a helper, and helping them stretch ever so slightly beyond that comfort zone.

3. The Lack of Monitoring Progress

You and I are an optimistic bunch. In the absence of real-time monitoring of outcomes and engagement, session-by-session, we fail to detect deterioration and lack of progress. Our self-assessments do not seem to correlate with client outcomes.  

Even when we do use routine outcome monitoring devices, like the Outcome Rating Scale (ORS) & Session Rating Scale (SRS), Outcome Questionnaire (OQ-45), or Clinical Outcome Routine Evaluation-Outcome Measure (CORE-OM), we fail to integrate this in the supervisory process in a meaningful fashion.

I once had a supervisee who insisted on his shortfall in helping a particular client. He didn’t have his ORS/SRS graph at hand. I insisted that he brought it in the following meeting. Here’s what the graph says: Outcomes were gradually improving, and alliance had a dip at the 2nd session but continued to pick up thereafter. And here’s what the supervisee initially said: The sessions were not helping this client.

We then spent our time working through the supervisee’s uncertainty, while holding in mind that the client is likely to be reporting benefit from the engagement. It turned out that the therapist was concerned about answering the referral concern posed by the referring psychiatrist, which wasn’t the client’s main issue at hand. We proceeded to work out how to focus on helping to the primary client, which is the patient seeking help, and how to address the secondary client, which was the referring psychiatrist.

From the marriage of data and clinical knowledge emerged a type of dialogue that is richer and aids clinical decision making.

4. Not Analyzing "The Game"

Too often, supervisors talk about how to help improve the therapist’s skills, without even really knowing how their supervisees work in-session! If Michael Jordan was to work on improving at specific parts of his game, Coach Phil Jackson would not settle for just sitting down and wax lyrical about three-point shots. They would sit down and scrutinize parts of the video recording of the game. In order for clinical supervisors to have an impact on helping their supervisees, they need to know their supervisees actual ways of interacting in-session.

5. The Lack of a Well-Defined Learning Objective

This may be one of the most vital and sorely lacking element in a practitioner’s professional development. A well-defined learning objective is key to helping a practitioner stretch and improve. A vast majority of practitioners and supervisors I meet at workshops don’t do this. We get lost on HOW to improve, instead of figuring out WHAT to work on that has leverage on actually helping our clients benefit from therapy.

Too often, we engage in clinical supervision on a case-by-case basis, with no coherent thread explicitly weaving in the therapist’s learning needs and clinical case concerns. It is vital to help therapists go beyond their zone of proximal development, but to do so, one’s current realm of ability and limitations needs to be well-defined. Once this is done, we need to help therapists stretch out of their comfort zone and move into a sweet spot called the learning zone, while making sure that they do not get too overwhelmed and tip over to the panic zone.  

6. The Lack of a Tight Feedback Loop

Finally, supervisors often fail to follow-through and find out if what they have discussed in supervision has had an impact on the clients that they have been talking about. Without a tight supervisor-to-supervisee-to-client feedback loop, we are prone to doing the same BS over and over again, thinking that since the supervisee is satisfied with the supervision, it must be helpful.

What we need is a system of learning that actually helps therapists improve, one therapist at a time. Here, the deliberate practice framework offers us a guide:

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“We need to help therapists stretch out of their comfort zone and move into a sweet spot called the learning zone.”

“I think more in terms of how to create engagement and impact.”

1. **Coach:** The role of a coach is central to a practitioner’s development. She can help create an instructive plan to improve on a specific area of a performance for a well-defined task, and use the other three points below to facilitate growth for the practitioner.

2. **Individualized Learning Objectives:** I encourage therapists to take the time to identify what to work on before the how. Go beyond case-by-case discussion and see what you need to learn in order to improve your performance. This would include establishing an ongoing learning and development plan in a clinical supervision context and optimizing the use of feedback. Scott Miller and I developed a tool for practitioners and their supervisors to help them in this process: The Taxonomy of Deliberate Practice Activities (TDPA; drop me an email to receive a copy of this).

3. **Feedback:** Without feedback, we would be making up reality. Real-time client feedback helps us to feed-forward the therapeutic process. And we need to elicit feedback in a more systematic fashion, as opposed to just asking our clients, “so how’s the session for you today?”.

   Performance feedback needs to be complimented with learning feedback, that is, how you are learning. Learning feedback focuses on the critical learning task at hand, without criticizing the learner. Therefore, the delivery of nuanced feedback relies upon the coach or supervisor, to impart descriptive feedback in manageable chunks that encourage clinicians to reach beyond their comfort zone into the learning zone.

4. **Successive Refinement:** Repetition should not be confused with experience. The mere accumulation of experience does not equate to expertise. Once a learning objective is clear, it’s crucial for a practitioner to make gradual improvements, in the presence of performance and learning feedback. For more, I’ve spelled out 10 things to avoid in your deliberate practice.

5. **How has research (psychotherapy or otherwise) influenced your views on therapeutic expertise and its development? Please provide one or two examples.**

Music has been a great force in my life. When I think about psychotherapy, I often draw analogies from music and the other forms of aesthetic arts. For example, instead of trying to think in terms of psychotherapeutic theories, I think more in terms of how to create engagement and impact. Instead of thinking which model or approach I should use, I would be thinking about how I can create a sense of movement, dynamics and vitality in a session, that facilitates growth and development for each client.

In the development of expertise, we must also learn to hold lightly what we know, to explore what is not yet seen ahead of time i.e., to improvise. By improvisation, I do not mean “anything goes.” Rather, it means to be willing to create a new experience each time you enter into what the the poet David Whyte calls, “The conversational nature of reality.”

References:


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“The mere accumulation of experience does not equate to expertise.”

The Integrative Therapist: Call for Content

The Integrative Therapist wants you to be an author. We are seeking brief, informal, interesting and actionable articles with a personal touch. Think of the way you would talk to a colleague over lunch. Please limit references to those that are absolutely essential. Our bias is towards articles relevant to SEPI’s three missions: integration between researchers and clinicians, integration across cultures, and further development of psychotherapy integration.

Contributors are invited to send articles, interviews, commentaries, letters to the editor, photos, and announcements to Jeffery Smith, MD, Editor, The Integrative Therapist.

Submission Deadlines and Publication Dates
December 1 deadline for January 15 Issue
March 1 deadline for May 15 Issue
June 20 deadline for July 15 Issue
September 15 deadline for October 15 Issue

Specifications
- The preferred length of submissions is 1,250 words or less
- Block style, single spaced with an extra space between paragraphs
- No paragraph indentations, page numbering, headers or footers
- Use subheadings and bullet points freely
- Bare Minimum references should be single spaced, in approved APA-style format
- Please include a photo of the author or authors, minimum 50K file size each.
- Photos should be submitted as separate JPEG, TIFF, GIF, or BITMAP files.

All submissions should be sent in the body of an email to jsmd@howtherapyworks.com with the subject line “Contribution to Integrative Therapist.”

[8] On the topic of improvisation, I highly recommend the following books:
  - Derek Bailey’s On Improvisation
  - Keith Johnstone’s Impro
  - Patricia Madson’s Improv Wisdom
SEPI Questionnaire on Psychotherapy Expertise

Alexandre Vaz

Ladies and gentleman, another Newsletter issue means another Survey with our dear integrative community! This time around we asked SEPIans what they made of this whole psychotherapy expertise business.

You can now browse through all the survey answers in our archive. [Survey Link]

As a sample, here’s what Dr. Larry Beutler had to say:

Q1.
A — What is your first and best specific idea for how to improve your skills and results as a therapist?
Structure training programs to focus on specific skills or specific "principles" of change.

B — Regarding your first idea, what factors might inhibit its implementation?
There is resistance within graduate programs to giving up a theory-based training in favor of a (common and specific) skill-based training. People adhere strongly to models or "pure" theories and forget to be flexible -- the first principle of a therapist.

C — Again regarding your first idea, how might one overcome those inhibiting factors?
It might work to integrate theory based and principle/skill based training. We need to show educators/clinicians that integration can work with (rather than against) extant theories.

Q2.
A — What is your second specific idea for how to improve your skills and results as a therapist?
Ensure that the same clinicians who teach graduate courses also supervisor students in their extern assignments.

B — Regarding this second idea, what factors might inhibit its implementation?
Academic clinicians don’t want to be seen by students outside of the classroom. They feel some ownership over the classroom things that are taught and fail to note that clinician practitioners tend to move away from theories toward a more pragmatic perspective. They can use that to make sure that classroom content and clinic content are related.

C — Again regarding your second idea, how might one overcome those inhibiting factors?
It starts at the level of the person -- either get a student interested in doing this or get a flexible supervisor interested.
Roots and Gifts of Integrative Psychotherapy: Invitation to Prague


The topic of our conference, Roots and Gifts of Integrative Psychotherapy, is inspired by the saying which calls Prague the Heart of Europe. We are curious what is in the “heart” of integrative psychotherapy. How is it rooted, what is the gain of psychotherapy integration in current psychotherapy practice, research and training? We believe that the conference focus on psychotherapy competencies can help answer these questions.

Jan Roubal, Jana Kostínková

Our keynote speakers will explore the topic of psychotherapy competencies from different perspectives. Bernhard Strauß (Institute of Psychosocial Medicine and Psychotherapy, University Hospital Jena, Germany) will introduce, how psychotherapy research could stimulate psychotherapy integration. Renate Geuzinge (University for Humanistic Studies and the Dutch Institute for Interpersonal Neurobiology, Utrecht, Netherlands) will show, how to give your wholehearted therapeutic efforts neurobiological roots in the client’s brain. Tomáš Řeháček (Center for Psychotherapy Research, Masaryk University, Brno, Czech Republic) will explore, what competencies make a good therapist.

There is a shadow side of the wonderful idea of psychotherapy integration. The free spirit of integrative movements which overcomes the artificial borders between psychotherapy approaches brings also the risk of having no borders at all. Many things can be integrated in psychotherapy, but how do we know, that it makes sense, that it works for the clients, that it fulfills the good practice standards?

We admire how SEPI deals with this dilemma. The free and respectfully open approach to different ways of integration is balanced with practice honestly reflected in the light of theory and research, as we know it from SEPI conferences and other activities. Yet another tradition for keeping the quality standards in the psychotherapy integration movement is represented by the European Association for Integrative Psychotherapy (EAIP). This organization tries to keep two tasks: First, under the umbrella of the European Association for Psychotherapy (EAP), it accredits training institutes and individuals according to commonly shared standards of the training content, teaching methods, and quality evaluation. Second, it offers a platform for integrative psychotherapists for meeting and inspiring each other, mainly by organizing regular conferences.

European Association of Integrative Psychotherapy (EAIP) Conference in Prague pays a tribute to Ken Evans (+ 2015), past president of EAIP. Ken was the major initiator of the development of humanistic and integrative psychotherapy in Europe over twenty-five years. It was his wish to organize EAIP conference in Prague and we are very happy that we can fulfill his wish now.

Our keynote speakers will explore the topic of psychotherapy competencies from different perspectives.
The 9th EAIP conference will take place in Prague under the auspices of the Charles University in Prague. It will be organized by two Czech integrative trainings accredited by EAIP: Training in Psychotherapy Integration, which is based on the concept of “personal therapeutic approach” (Řiháček & Roubal, 2017a; Roubal & Kostínková, 2017b), focusing on and fostering the idiosyncratic style and person of the therapist in a research-informed fashion. And, a training program Integrative System of Psychotherapy (“Instep”), which is based on the assimilative model of integration with Gestalt therapy as the ground approach.

The conference will take place in the historic spaces of Charles University, only a few tens of metres from the Charles Bridge and Prague Castle. Prague - the capital of the Czech Republic situated on both banks of the Vltava River is a beautiful city with a rich history. Thanks to its location in the centre of Europe, Prague has always been an important crossroads of trade and culture. Prague, often called “Golden” or “Hundred-spired”, belongs to the architecturally unique European towns, attractive for tourists from around the world.

Visitors find themselves enjoying a living museum of European architecture. Its well-preserved monuments represent more than 1000 years of cultural development in Central Europe. Prague is known for its historical venues and offers not only historical and architectural jewels but also an extensive range of theatres, museums and many concert halls. There are also wonderful restaurants to enjoy typical Czech meals and especially traditional Czech beer. We cordially invite you and hope to see you at the Conference in the beautiful and historic city of Prague.

https://www.facebook.com/eaipconference/

References: