

The outcome of psychotherapy: Yesterday, today and tomorrow

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In 1963, the first issue of the journal *Psychotherapy* appeared. Responding to findings reported in a previous publication by Eysenck (1952), Strupp wrote of the 'staggering research problems' confronting the field and the necessity of conducting 'properly planned and executed studies' to resolve questions about the process and outcome of psychotherapy. Today, both the efficacy and effectiveness of psychotherapy has been well established. Despite the consistent findings substantiating the field's worth, a significant question remains the subject of debate: *How does psychotherapy work?* On this subject, debate continues to divide the profession. In this paper, a 'way out' is proposed informed by research on the therapist's contribution to treatment outcome and findings from studies on the acquisition of expertise.

'If we want to solve a problem that we have never solved before, we must leave the door to the unknown ajar.' Richard P. Feynman

In 1963, the population of the United States was approaching 190 million. The average worker earned just under \$6000 per annum. A first class stamp cost 4 cents, a gallon of gas, 29. The national debt stood at \$310 billion. Around the country, Americans were tuning into *The Beverly Hillbillies*, the nation's number one rated TV program. ZIP codes were introduced by the U.S. Postal Service and the Beatles released their first album, *Please Please Me*. A war in Vietnam was on, but few knew where the country was or what the fighting was all about.

In that year, membership of the *American Psychological Association* stood at 17,000 (Hilgard, 1987). The *Diagnostic and Statistical Manual* (DSM) was 130 pages in length, and listed 106 mental disorders. Treatment models numbered fewer than forty (Miller, Duncan, & Hubble, 1997; Wampold, 2001). The number of

states granting licenses to practice psychology was on the rise. In August, the same month that Reverend Martin Luther King delivered his, *I Have a Dream* speech from the steps of the Lincoln Memorial, the inaugural issue of *Psychotherapy* was published. Three months later, in Dallas, Texas, President John F. Kennedy was assassinated. In the tumultuous years that followed, the American experience and identity would be transformed. So, too, would the field of psychotherapy.

In the decades preceding the appearance of *Psychotherapy*, practice was mostly limited to physicians, and psychoanalysis and psychodynamic approaches predominated (Frank, 1992; VandenBos, Cummings, & DeLeon, 1992). Beginning in the 1950s, the prevailing paradigm came under scrutiny. Researchers within the emerging behavioural school were harshly critical, challenging the

scientific basis of Freudian theories and concepts. Hans Eysenck (1952) published a review of 24 studies which concluded that psychotherapy was not only ineffective, but potentially harmful. The conclusions provoked considerable public and professional attention, and were immediately disputed by proponents of psychotherapy (Luborsky, 1954; Rosenzweig, 1954).

Strupp's (1963) article in the first issue of *Psychotherapy*, and Eysenck's (1964) response, revisited the still unsettled debate. Although the efficacy of psychotherapy would remain in doubt for some time to come, the back and forth between the two sides served to highlight both the 'staggering research problems' (Strupp, 1963, p. 2) confronting investigators and the 'necessity of properly planned and executed experimental studies into this important field' (Eysenck, 1964, p. 97).

Fifty years later, much has changed. The U.S. population has increased by 40 percent. Owing to the frequent change in the cost of a first class stamp, the printed price has been replaced with the word, 'Forever'. At the time of writing this article, a gallon of gas fetches \$4.50, and the national debt is quickly approaching \$17 trillion. Only two members of the Fab Four are still alive. Vietnam, once an implacable enemy, is now a trading partner of the United States, and the two countries conduct joint naval training exercises.

Today, the *American Psychological Association* has 137,000 members. Licenses are required to practice independently as a psychologist in every state. Over 800,000 professionals are able to bill third party payers for mental health services (Brown & Minami, 2010). The Substance Abuse and Mental Health Service Administration's (SAMHSA) website lists 145 manualised treatments for 51 of the 365 mental disorders now contained in the DSM. This volume, in its fifth edition, has reached an astonishing 947 pages. Many psychologists, including the APA president, are calling for the abandonment of the DSM and transition to the World Health Organization's International Classification of Diseases (Bradshaw, 2012; Clay, 2012).

The principle disagreement between Strupp and Eysenck recorded in the first volume of *Psychotherapy* has been resolved. Not only is the efficacy of psychotherapy well established, but so is its effectiveness in real world clinical settings (American Psychological Association, 2012; Duncan, Miller, Wampold, & Hubble, 2010; Wampold, 2001). Despite the consistent findings substantiating the field's worth, a significant question remains unanswered: *How does psychotherapy work?* In Strupp's words (1963, p. 2), the field would '*not be satisfied with studies of therapeutic outcomes until [it] succeed[ed] in becoming more explicit about the independent variable*'—in particular, the contributions made by the client, the therapist, the treatment method, and commerce between the participants. Here, debate continues to divide the profession.

Gathered on one side are those who

have long argued that psychotherapy is analogous to medicine. From this point of view, psychologically informed interventions work in much the same way as penicillin treats infection. The hallmark of their position is that effective treatments must contain specific ingredients remedial to the

1999; Miller, Duncan, & Hubble, 2004). Instead of focusing on specific methods, they insist that mechanisms common to all approaches, no matter the theory or technique, are responsible for change. In addition to the instillation of hope, provision of a therapeutic rationale and strategies

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condition being treated. For this group, randomised clinical trials (RCTs) are the principal means of investigation, the findings of which are used to generate treatment guidelines, manuals, and lists of 'empirically supported' or 'validated' therapies (e.g., Barlow, 2004; Chambless & Hollon, 1998). They contend that for psychotherapy to advance as a science, psychologists must operationalise falsifiable hypotheses using specific methods (discrete independent variables), test those hypotheses, and teach students those methods that stand up to rigour and replication (Gambrill, 1990; Zuriff, 1985). The critical argument supporting this approach is that different therapies are differentially effective, and specific therapies are more effective than nonspecific treatment-as-usual (TAU).

Exponents for the other side insist that any suggestion psychotherapy is comparable to a medical intervention is grossly inaccurate (Frank & Frank,

for achieving change, the therapeutic relationship is most often cited as one, if not the most potent transtheoretical ingredient of psychotherapy (Bachlor & Horvath, 1999; Grenavage & Norcross, 1990; Norcross, 2010). Three converging lines of research are cited in support of these nonspecific factors as the most significant independent variables responsible for client change: (1) the absence of differential effectiveness when specific approaches are directly compared and when researcher allegiance and other biasing variables are controlled (Wampold, 2001); (2) dismantling studies which show that the contribution of specific techniques to treatment outcome is negligible (Duncan et al., 2010); and (3) research showing consistently greater variance in outcomes between psychotherapists in a given study than between the types of therapy they are practicing (Bemish, Imel, & Wampold, 2008; Beutler et al., 2004; Crits-Christoph & Mintz,



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1991; Crits-Christoph et al., 1991; Imel, Wampold, Miller, & Fleming, 2008; Kim, Wampold, & Bolt, 2006; Luborksy et al., 1986; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Okiishi, Lambert, Eggett, Nielsen, & Dayton, 2006; Shapiro, Firth-Cozens, & Stiles, 1989; Wampold & Bolt, 2006; Wampold, Mondin, Moody, & Ahn, 1997).

The failure to reach agreement about how psychotherapy works is not without consequence. To begin, how will the outcome of psychotherapy ever improve if the two major explanatory paradigms are in continuous dispute and the causal variables defy consensus? On that score, meta-analytic evidence shows outcome has changed little over the past 40 years despite overwhelming support of psychotherapy and a dramatic increase in the number of diagnoses and treatment approaches (c.f., APA, 2012; Smith & Glass, 1977; Wampold, Mondin, Moody, & Ahn, 1997; Wampold, Mondin, Moody, Stich et al., 1997).

The polarisation among researchers and inability to answer basic questions about the internal workings of psychotherapy also undermine the standing of the profession within the world of healthcare, especially among consumers. Nationwide surveys of potential users of psychotherapy find that a clear majority (77%) doubt its efficacy (APA, 2004; Therapy in America, 2004). Moreover, while 90% of people report they would prefer to talk about their problems rather than take medication, use of psychotropic drugs has continued to rise while visits to psychotherapists have steadily declined (Hubble, Duncan, Miller, & Wampold, 2010).

Some contend that the threat to the field's survival is so grave the profession's interest would best be served by setting the scientific issues aside and acting as though the medical model applies (Nathan, 1997). *Moving aggressively in the direction of developing and implementing empirically-validated treatment methods*, Wilson (1995) argues, 'would seem imperative in securing the place of psychological therapy in future health care policy' (p. 163). Doing otherwise, it is claimed, risks exclusion. Such assertions are entirely

understandable. Economic pressures on practitioners are powerful and real. Without a doubt, debate does not put food on the table.

For all that, an equally passionate call comes from the other side. *'The medicalisation of psychotherapy'*, Wampold (2001, p. 2) protests, 'might well destroy talk therapy as a beneficial treatment of psychological and social problems'. On the face of it, the premise has merit. Therapy is a fluid, dynamic process, one involving a complex and nuanced series of interchanges. Forcing clinicians to adopt 'truncated and prescriptive' treatments may well strip therapy of the very interpersonal processes critical to its success.

To resolve the predicament in which the profession remains mired, three possible solutions are immediately apparent. First, both sides can continue to conduct more of the same type of research in the hope that new findings will emerge vindicating one, while forcing the other to capitulate. Second, end the problem by legislative fiat. In effect, owing to the pressing financial and political considerations, declare a winner, of necessity placing expedience above science. Third, find a middle way. In this scenario, the two warring camps finally move to the center, integrating their beliefs and best practices.

On review, each of these approaches is empirically plausible. It is the case though that, if having not already failed, they seem destined to do so. Taking each of the three solutions in order, the hope that with the right research design or line of investigation, a clear victor will come forth is—to put it bluntly—akin to an alchemist's optimism. After 50 years, and a massive expenditure of time, effort, and money, had one side or the other been right, lead would have been transformed into empirical gold long ago (Duncan et al., 2010). Numerous replications, meta-analyses, and critiques supporting both sides have been hailed as high truth on one side, and so much sound and fury on the other. Few have been sufficiently swayed to give up their claims or view of the evidence.

The second solution of defining practice by statute is well underway. In 2009, Cooper and Aratani found

that 90% of states were implementing strategies to support the use of 'evidence-based practices' (EBPs). With few exceptions, such efforts have equated EBP with lists of specific treatments for specific disorders (e.g., Addiction and Mental Health Services, 2011). In turn, reimbursement has been made contingent on an adherence to officially sanctioned therapies. At present, one looks in vain for evidence that these policies have ended divisions among researchers and clinicians regarding what constitutes a 'best practice', improved either outcome or access to care (Bohanske & Franczak, 2010), bolstered consumer confidence, or secured financial stability for clinicians. As for the latter, in the same period, psychologists' incomes have been in decline (APA Monitor, 2010; Cummings & O'Donohue, 2008).

Finally, what of the hope for finding a middle way? If the success of an integrative movement could be measured by the number of books and articles published, professional meetings held, or rhetorical eloquence of the advocates, then it would be reasonable to conclude a new age of cooperation and unity has already arrived. Of course, this has not happened, at all. Far from unifying the profession, an entire new movement has come on the scene, burdened by its own disagreements about what integration actually means and, at street level, how to put it into practice (Miller, Duncan, & Hubble, 2004; Norcross, 1997). Outside of the laboratory and the halls of academia, theories and techniques are accumulated rather than integrated on any level but that of the individual clinician, employed idiosyncratically rather than systematically. Like it or not, that is the reality on the ground.

The way out

After 50 years, and little success in deciding how psychotherapy works, we return to Strupp's (1963) proposition. Once more, *'It seems to me that we shall not be satisfied with studies of therapeutic outcomes until we succeed in becoming more explicit about the independent variable'* (p. 2). Hands down, for all concerned, the independent variable of consuming interest has been psychotherapy—the treatment

philosophy, theoretical constructions regarding etiology and cure, and associated procedures and techniques. Of lesser interest have been the recipients of care; in particular, their diagnosis or pathology, personality formation and malformations, life situation, socioeconomic status, environmental supports and stressors and, in more recent years, gender and ethnicity.

Although identified by Strupp (1963), far less attention has been paid to the contribution of the therapist (Beutler et al., 2004; Kim, Wampold, & Bolt, 2006; Wampold, 2010). Doing, performing, and delivering has consistently overshadowed the doer, performer, and deliverer. Looking past the therapist's contribution has been and continues to be an egregious error. Available evidence documents that the therapist is one of the most robust predictors of outcome among factors studied. Indeed, the variance of outcomes attributable to therapists (5–9%) is larger than the variability among treatments (0–1%), the alliance (5%), and the superiority of an empirically supported treatment to a placebo treatment (0–4%) (Duncan et al., 2010; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold, 2005).

Beginning in 1997, Garfield and other notable researchers, including Strupp (Strupp & Anderson, 1997; Luborsky, McClellan, Woody, O'Brien, & Auerbach, 1985; Luborsky, Mclellan, Diguier, Woody, & Seligman, 1997; Okiishi, Lambert, Nielsen, & Ogles, 2003) brought the therapist back to the table, in an emphatic critique of the profession's focus on treatment models and techniques. Not surprisingly, for those who believe that psychotherapy is analogous to medicine, therapist differences are considered a 'nuisance variable', noise to be filtered out via strict adherence to the treatment protocol. On the other side, the therapist is not only an interventionist, but also an intrinsic part of the intervention; not just the delivery mechanism, but an important part of what is delivered. Effectiveness, it is believed, results from a combination of therapists' 'desirable personal requisites' (Garfield, 1997, p. 41) and their ability to use whatever methods empower the

core conditions shared by all healing practices (c.f., Duncan, 2010). Simply put, one cannot remove the effect of the therapist without undermining the therapy.

reveal a single, underlying trait shared by top performers: deep domain-specific knowledge. In short, the best know more, perceive more, and remember more than their average

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Strupp (1963) foresaw the variability between therapists prior to the collection of the evidence which confirmed it: *'Let us stay, however, with the method of treatment and consider further its relation to outcomes. For this purpose let us disregard (what in reality cannot be disregarded) therapist variables and socio-environmental factors'* (p. 2). While Eysenck (1964) emphasised the need for clarity and precision in methods and measurement, Strupp (1963) grappled with the importance of the contextual nuances unfortunately reflected in *'crude...quasi documentation which has hopelessly befogged the issue'* (p. 2).

Fortunately, a large body of research outside of psychotherapy now provides a new, clearer direction that takes into account both the need for clear measurement and the importance of contextual influences on methodology that drive better outcomes (Colvin, 2008; Ericsson, 2009a; Ericsson, Charness, Feltovich, & Hoffman, 2006). These findings are less concerned with the particulars of a given area of performance than how mastery of any human endeavour is acquired. Across a variety of fields, including sports, music, medicine, mathematics, teaching, computer programming, and more, the subject of these studies has been the individual performer, and the question of interest has been, *'Why are some better than others?'*

In sharp contrast to the field of psychotherapy—with its rival paradigms, competing schools, and disparate conclusions—investigations

counterparts. The same research identifies a universal set of processes that both account for how domain-specific knowledge is acquired and furnish step-by-step directions anyone can follow to improve their performance within a particular discipline (Ericsson, Charness, Feltovich, & Hoffman, 2006).

In summary, no matter one's allegiance, the hope has been that knowing how psychotherapy works would give rise to a universally accepted standard of care which, in turn, would yield more effective and efficient treatment. However, if the outcome of psychotherapy is in the hands of the person who delivers it, then attempts to reach accord regarding the essential nature, qualities or characteristics of the enterprise are much less important than knowing how the best accomplish what they do.

Looking to the future, the application of research methods and findings from the field of expertise and expert performance provides the way out of the field's current balkanisation and stalemate. Such research is already underway, and the initial results are informative and provocative (Miller & Hubble, 2011; Miller, Hubble, & Duncan, 2007; Miller, Hubble, Duncan, & Wampold, 2010).

The road best travelled: Improving outcomes one therapist at a time

A fundamental finding of the research on superior performance is that talent is not a function of genetics, degrees earned, title, privilege, or experience. In short, talent is made. It

results from a process of an altogether different nature, beyond traditional professional preparation and the mere investment of time.

Informed by findings reported by researchers (Ericsson, 1996; Ericsson, 2009a; Ericsson, 2009b; Ericsson et al., 2006; Ericsson, Krampe, & Tesch-Romer, 1993) and writers (Colvin, 2008; Coyle, 2009; Shenk, 2010; Syed, 2010) on the subject of expertise, Miller, Hubble, and Duncan (2007) identified three components critical for superior performance. Working in tandem to create a 'cycle of excellence', these include: (1) determining a baseline level of effectiveness; (2) obtaining systematic, ongoing, formal feedback; and (3) engaging in deliberate practice. Each is discussed in turn.

To be the best requires knowing how one fares in a given practice domain. Interestingly enough, the exact methods by which top performers determine their baseline are highly variable, defying any simple attempt at classification and replication (Miller et al., 2007). What can be said with certainty is that the best are constantly comparing what they do to their own 'personal best', the performance of others, and existing standards or baselines (Ericsson, 2006). Fortunately, in the realm of psychotherapy, numerous well-established outcome measures are available to clinicians for assessing their baseline (c.f., Froyd & Lambert, 1989; Ogles, Lambert, & Masters, 1996). Additionally, computerised data bases exist which allow therapists to make real time comparisons of their results with national and international norms (Lambert, 2012; Miller, Duncan, Sorrell, & Brown, 2005). It is also worth noting that since the time of the debate between Strupp (1963, 1964) and Eysenck (1964), several methods have emerged for operationalising and standardising the concepts of clinical improvement and treatment failure (c.f., Hedges & Olkin, 1985; Jacobson & Truax, 1991; Ogles, Lambert, & Fields, 2002). While each conceptualisation and measurement scheme has both benefits and drawbacks, these techniques show a considerable improvement beyond the 'befogged' understandings and

interpretations of 50 years ago (Strupp, 1963).

Nevertheless, though measures and norms are now widely available, surveys indicate that few clinicians actually employ them in their day-to-day work (Phelps, Eisman, & Kohout, 1998). Indeed, the collection of outcome data of any sort is rare. Curiously, despite the low utilisation, Bickman and associates (Bickman et al., 2000) found in their own survey, that a large percentage of therapists hold interest in receiving regular reports of client progress. Later, Hatfield and Ogles (2004) conducted

a survey with a national sample of licensed psychologists to investigate this discontinuity. As before, clinicians expressed interest in having reliable outcome information. Among the reasons given by those choosing not to use outcome measures, the top two were, 'practical (e.g., cost and time) and philosophical (e.g., relevance) barriers' (p. 485).

Fully aware of the realities of clinical practice, and in an effort to overcome the obstacles to routine outcome measurement, Miller and Duncan (2000) developed, tested, and disseminated two brief, four-item measures (Duncan et al., 2003; Miller, Duncan, Brown, Sparks, & Claud, 2003)¹. The first, the *Outcome Rating Scale* (ORS) assesses client progress and, when aggregated, can be used to determine a therapist's overall effectiveness. The second, the *Session Rating Scale* (SRS), measures the quality of the therapeutic relationship, a key element of effective therapy (Bachelor & Horvath, 1999; Norcross, 2010). Written and oral forms are available at no cost and have been translated into 20 different languages. Both scales take less than a minute to complete and score. Owing to their brevity and simplicity, adoption and

usage rates among therapists has been shown to be dramatically higher (89%) as compared to other assessment tools ([20–25%] Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Miller et al., 2003).

The second element in fostering superior performance is obtaining feedback. Howard, Moras, Brill, Martinovich, and Lutz (1996) were among the first to suggest that formal, routine measurement of client progress could be used for optimising treatment. In 2001, Lambert and colleagues reported results demonstrating that providing feedback to clinicians

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about client progress doubled the rate of clinically significant and reliable change, decreased deterioration by 33%, and reduced the overall number of treatment sessions. Over the past decade, research has continued and accelerated. For example, studies involving the ORS and SRS have shown that exposure to feedback as much as triples the rate of reliable change while cutting deteriorations rates in half (Anker, Duncan, & Sparks, 2009; Lambert & Shimokawa, 2011; Reese, Norsworthy, & Rowlands, 2009; Reese, Toland, Slone, & Norsworthy, 2010). According to Lambert (2010), 'it is time [for clinicians] to routinely track client outcome' (p. 260).

Lambert's proprietary, outcome management system, has been approved as evidence-based by the Substance and Mental Health Services Administration National Registry of Evidence-based Programs and Practices (SAMHSA NREPP). The ORS and SRS, interpretive algorithms, and normative database, collectively known as 'Feedback Informed Treatment' (FIT), were carefully reviewed and listed on SAMHSA's registry in February 2013 (see www.nrepp.samhsa.gov/

ViewIntervention.aspx?id=249). Implementation materials developed by the International Center for Clinical Excellence (ICCE), including six 'how to' manuals, received perfect scores for training and support resources, and quality assurance procedures. The process summarised in the manuals conforms to the *American Psychological Association's* (APA) definition of evidence-based practice. Of note, the definition combines 'the integration of the best available research' with clinical expertise in 'the monitoring of patient progress (and of changes in the patient's circumstances, e.g., job loss, major illness) that may suggest the need to adjust the treatment (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment)' (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273, 276–277).

As powerful an effect as feedback exerts on outcome, it is not enough for the development of expertise. As the literature on superior performance shows in other fields, more is needed to enable clinicians to learn from the information provided. De Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) found, for instance, that not all therapists benefit from feedback. In addition, Lambert reports that practitioners do not get better at detecting when they are off track or their cases are at risk for drop out or deterioration, despite being exposed to 'feedback on half their cases for over three years' (Miller et al., 2004, p. 16). In effect, feedback functions like a GPS, pointing out when the driver is off track and even suggesting alternate routes, while not necessarily improving overall navigation skills or knowledge of the territory and, at times, being completely ignored.

Learning from feedback requires an additional step: engaging in deliberate practice (Ericsson, 1996; Ericsson, 2006, Ericsson, 2009b; Ericsson, Krampe, & Tesch-Romer, 1993). Deliberate practice means setting aside time for reflecting on feedback received, identifying where one's performance falls short, seeking guidance from recognised experts, and then developing, rehearsing, executing, and evaluating a plan for improvement. Research indicates that

elite performers across many different domains devote the same amount of time to this process, on average, every day. In a study of violinists, for example, Ericsson and colleagues (1993) found that the top performers had devoted two times as many hours (10,000) to deliberate practice as the next best players and 10 times as many as the average musician. In addition to helping refine and extend specific skills, engaging in prolonged periods of reflection, planning, and practice engenders the development of mechanisms enabling top performers to use their knowledge in more efficient, nuanced, and novel ways than their more average counterparts (Ericsson & Stasewski, 1989).

Turning to psychotherapy, research on the alliance is illustrative. Studies have consistently found a moderate, yet robust, correlation between the quality of the therapeutic relationship and outcome (Baldwin Wampold, & Imel, 2007; Horvath, Del Re, Fluckiger, & Symonds, 2011). At the same time, neither training in the alliance nor experience conducting therapy has proven particularly predictive of clinician effectiveness (Horvath, 2001; Anderson et al., 2009). In attempting to 'untangle the alliance–outcome correlation', Baldwin, Wampold, and Imel (2007) examined a group of 81 clinicians and found that 97% of the difference in outcome between the practitioners was attributable to therapist variability in the alliance. By contrast, client variability was unrelated to outcome. The results show that some therapists are consistently better at establishing and maintaining helpful relationships than others. Evidence that the difference is attributable to their possession of deeper, domain-specific knowledge can be found in a related study by Anderson, Ogles, Patterson, Lambert and Vermeersch (2009).

In brief, Anderson et al. (2009) examined therapist effects using a sample of 25 providers treating clients in a university counseling center. The clinicians were asked to respond to a series of video simulations to test for 'facilitative interpersonal skills' (FIS). Each simulation presented a difficult clinical situation, complicated by a client's anger, dependency, passivity, confusion, or need to control the

interaction. Differences in client outcomes between therapists were found to be unrelated to therapist gender, theoretical orientation, professional experience, and overall social skills. Instead, the best results were obtained by those who exhibited deeper, broader, more accessible, interpersonally nuanced knowledge as measured on the FIS task. No matter the client's presenting problem or style of relating, top performers were able to respond collaboratively and empathically, and far less likely to make remarks or comments that distanced or offended a client.

Acquiring such understanding, perception, and sensitivity is a common goal for clinicians. Researchers have found that 'healing involvement'—a practitioner's experience of engaging, affirming, being highly empathic, staying flexible, and dealing constructively with difficulties encountered in the therapeutic interaction—is the pinnacle of therapists' aspirations (Orlinksy & Ronnestad, 2005). And yet, the study by Anderson et al. (2009) suggests that some end up having such knowledge while others, of equal experience and social ability, do not.

Two research projects are underway by members of the ICCE community. One is a randomised clinical trial of deliberate practice applied to training therapists—a longitudinal study being conducted at the University of North Carolina Wilmington School of Social Work. Upon entry to the two-year program, beginning students are being given a battery of assessments, including: (a) the FIS inventory, a video-interactive tool designed to measure alliance building, (b) the *Values in Action Inventory of Strengths* (VIA-IS), which measures character strengths, and (c) a demographic questionnaire. During their first year, all students receive the traditional training curriculum. In year two, students are randomly split into two groups, with group one continuing the traditional training, and the other, experimental group receiving the traditional training plus a program of deliberate practice aimed at improving trainees' skills in alliance formation and maintenance (i.e., ongoing measurement, feedback,

and practice opportunities under varying conditions). The hypothesis of the study is that hours spent in deliberate practice activities will be more predictive of outcome than participation in traditional training, clinician character strengths, and other demographic variables. It is hoped that this RCT will address, in part, Strupp's (1963) question regarding the '*variance introduced by the person of the therapist practicing them—his degree of expertness, his personality, and attitudes*' (pp. 1–2). Results are not yet available.

The second research project examines the relationship between outcome and practitioner demographic variables, work practices, participation in professional development activities, beliefs regarding learning and personal appraisals of therapeutic effectiveness. Although preliminary, results from this study are in line with earlier research on the factors that account for expertise. Similar to Anderson et al. (2009) and others (Wampold & Brown, 2005), therapist gender, qualifications, professional discipline, years of experience, and time spent conducting therapy are unrelated to outcome or therapist standing within the study sample. Similar to findings reported by Walfish, McAllister, O'Donnell, and Lambert (2012), therapist self-appraisal is not a reliable measure of effectiveness. The findings also provide the first evidentiary support for the key role deliberate practice plays in the development of expertise among highly effective clinicians; specifically, the amount of time therapists reported spending engaged in solitary activities intended to improve their skills was a significant predictor of outcome (Chow, Miller, Kane, Thornton, & Andrews, in preparation).

In all, the evidence at hand indicates that the findings from the expertise literature likely apply to the domain of psychotherapy. Furthermore, the three activities—knowing one's baseline, obtaining feedback, and engaging in deliberate practice—likely provide the means for achieving the gains in outcome that have for so long eluded the field. If the results reported here hold up to further investigation, it would suggest that a shift in focus is required. Instead of

trying to improve outcomes merely through the study of psychotherapies in general (i.e., premises, models, and associated procedures), the future of the profession may be better served by working to improve the outcome of each and every therapist.

Summary conclusions

The question that gave rise to the exchange between Strupp (1963) and Eysenck (1964) in the inaugural issue of this journal has been settled by the accumulation of five decades of evidence, including a correction of what Eysenck criticised as a lack of '*a set of reasonable criteria which have a certain degree of reliability and objectivity*' (p. 99). The efficacy and effectiveness of psychotherapy are well established, based on '*standards stated and follow-ups carried out*' (Eysenck, 1964, p. 99), and benefiting from continual refinements of what constitutes effectiveness, whether in the behavioural terms preferred by Eysenck or the intrapsychic judgments of clients preferred by Strupp (Eid & Larsen, 2008). The second question of how it works—in particular, the independent variable of importance—far from moving the profession forward, has fragmented the field leaving outcomes unchanged for just as many decades. In point of fact, no matter how the curative elements of psychotherapy have been construed or taught, be they specific technical operations, transtheoretical healing factors, or some combination thereof, the field has not created new generations of superior clinicians.

The way out as proposed in this paper necessitates setting aside historical perspectives, traditions, and even biases—and embracing a different view of psychotherapy. As Norcross (1999) has observed, the '*ideological cold war may have been a necessary developmental state, [but] its days have come and passed*' (p. xvii). Indeed, once attention is turned to the performance of the individual practitioner, as the weight of the research on expertise is directing, then it would make eminent sense to regard therapeutic practice as craft.

A craft is defined as '*a collection of learned skills accompanied by experienced judgment*' (Moore, 1994, p. 1).

Consistent with both the research on psychotherapy and the literature on the acquisition of expertise, no particular personal qualities or talents are required for entry (Ericsson, Krampe, & Tesch-Romer, 1993). Anyone, with a modicum of instruction, can learn how to do the basic tasks and achieve outcomes commensurate with professionals already practicing (Atkins & Christensen, 2001; Nyman, Nafzinger, & Smith, 2010). No amount of theory, coursework, continuing education, or on-the-job experience will lead to the development of the 'experienced judgment' required for superior performance. For that, it would appear that practitioners must be engaged in the process outlined above—in essence, continuously reaching for objectives just beyond their current ability (Miller, Duncan, & Hubble, 2007).

The implications for the future of research, professional preparation and development, licensure and certification, are nothing less than major. From a craft perspective, professional training would emphasise the development of evidence-based therapists at least as much as, if not more than, the dissemination of the evidence base for specific therapies, what Strupp (1963) called '*the person of the therapist practicing them*' (p. 1). In practice, this could translate into easing admission criteria so that a larger number of candidates may enter training programs. Prospective matriculants into graduate programs focused on producing the best clinicians that psychology has to offer might learn that graduation depends not only on learning about psychotherapy, but also on being capable of reliably producing positive results. To that end, trainees would be exposed to clients early in their training, routinely measured, and given ample opportunity to practice basic skills (e.g., alliance formation) under varying conditions (e.g., Anderson et al., 2009).

In addition, educators may improve the readiness of their incoming graduate students by experimenting with undergraduate psychology curricula oriented to elements of clinical quality beyond the learning of facts and methods; perhaps including

opportunities for clinical volunteer experiences (e.g., crisis hotlines, safe houses, residential treatment) for those who express interest in clinical training and who want to begin assessing their performance as budding clinicians and

such training has been successful, it is especially important that these efforts are systematically tracked and clinician data pooled together develop better methods for assessing and improving the impact of these activities.

in behavioural health. Members can choose to participate in any of the 100-plus forums, create their own discussion groups, immerse themselves in a library of documents and how-to videos, access outcome tools, and most important, request and receive performance-oriented feedback from their peers.

The following year a task force within the organisation created and published a document detailing four 'core competencies' for applying the findings from the expertise literature to the practice of psychotherapy (Miller, Maeschalck, Axsen, & Seidel, 2011). The first core competency is in the research foundations of FIT, including: familiarity with research on the therapeutic alliance; behavioural healthcare outcomes; expert performance and its application to clinical practice; and the properties of valid, reliable, and feasible alliance and outcome measures. The second competency is in FIT implementation: integrating consumer-reported outcome and alliance data into clinical work; collaborating with consumers about collecting feedback regarding alliance and outcome; and ensuring that the course and outcome of behavioural healthcare services are informed by consumer preferences. The third competency, measurement and reporting, focuses on measuring and documenting the therapeutic alliance and outcome of clinical services on an ongoing basis with consumers; and on providing details in reporting outcomes sufficient to assess the accuracy and generalisability of the results. The fourth competency is continuous professional improvement: determining one's baseline level of performance; comparing one's baseline level of performance to the best available norms, standards, or benchmarks; developing and executing a plan for improving baseline performance; and seeking performance excellence by developing and executing a plan of deliberate practice for improving performance to levels superior to national norms, standards, and benchmarks. Researchers are already using the site to formulate research questions, solicit participants for studies on expertise in psychotherapy, and using software to investigate

...effective therapists report making more mistakes and being more self-critical than their less effective counterparts.

learning the discipline of continually assessing and finding ways to improve their clinical outcomes.

Similarly, licensure to practice psychotherapy or quality certifications could be granted, in part, on achieving and maintaining a baseline level of performance equal to established outcome benchmarks. Postgraduate training would also change. As Niemeyer, Taylor, and Wear (2009) point out, *'If continuing education is a natural expression of a profession's ongoing evolution, then professional psychology can be viewed as suffering a significant developmental delay'* (p. 617). Although most states, for example, mandate a number of CE hours to maintain licensure to practice independently, the process is largely self-regulated. With a few notable exceptions (e.g., ethics), practitioners select the events they attend. Direct measures of learning are uncommon and performance measures for the participants completely absent. No process is in place for identifying skill or knowledge deficits in need of remediation and no concrete plan is required for continual professional development or the assessment of whether such a plan results in any change in clinical outcomes. From an expertise perspective, the current system is at best ineffective and, at worst, perilous. It reinforces clinicians' well-documented propensity to inflate their effectiveness and see themselves as developing professionally when, in fact, they are not (Walfish et al., 2012; Orlinsky & Ronnestad, 2005). Considering the potential lag (likely a year or more for many full-time psychotherapists) between clinical training and the accumulation of sufficient data to determine whether

With regard to research, the application of findings from the field of expertise to psychotherapy is in its infancy. As a result, the potential areas for investigation are numerous. For example, available evidence makes clear that superior performance does not occur in a vacuum. The best flourish in supportive communities—what has been termed, *'cultures of excellence'* or *'communities of practice'* (Miller & Hubble, 2011). Although some aspects (e.g., error-centric learning environment, opportunities for reflection and deliberate practice built into daily workflow) are known, more research is needed to identify the characteristics of settings that prove optimal for the development and maintenance of expert performance.

Another potentially promising line of research would explore the practice patterns of top performing therapists. A study by Najavits and Strupp (1994) found, for instance, that effective therapists report making more mistakes and being more self-critical than their less effective counterparts. Other research shows that clinicians' experience of difficulties in practice accounts for most therapist variance in alliance ratings (Nissen-Lie, Monsen, & Ronnestad, 2010). Results such as these immediately suggest the possibility of studies exploring methods for helping practitioners develop an open, even welcoming, attitude towards errors.

In December 2009, the ICCE was launched (www.centerforclinicalexcellence.com). Similar to sermo.com for physicians, the site provides a free, international, web-based community for clinicians and researchers dedicated to excellence

interesting outcome patterns as well as the conversational data generated by clinicians interacting on the site.

Strupp and Eysenck began a pointed debate 50 years ago on matters of consequence facing the field. Their pointed exchange revealed important weaknesses in need of redress.

Some, such as the general efficacy of psychotherapy, have been successfully addressed. Others, including how it works and can work better, continue to divide the field. Beyond that, psychotherapy as a whole, and individual practitioners in particular, face a number of stark challenges in the future, not the least of which is remaining competitive. The authors believe that focusing on what makes for a great performance currently holds the most promise for meeting these challenges and advancing the understanding and practice of psychotherapy.

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Endnotes

1. The ORS was developed following the first author's long use of the Outcome Questionnaire 45 (OQ), a tool developed by his professor, Michael J. Lambert, Ph.D. At a workshop Miller was teaching on routine outcome measurement in Israel,

he mentioned the time the measure took to administer as well as the difficulty many of his clients experienced completing the tool due to its required literacy level. A psychologist in attendance, Haim Omer, Ph.D., suggested bypassing the language dependent items and using a visual analogue scale to capture the major domains assessed by the longer tool. Miller's experience with the Line Bisection Test (Schenkenberg, Bradford, and Ajax, 1980) during his neuropsychology internship and subsequent work on the development of scaling questions at the Brief Family Therapy Center (Berg and Miller, 1992; Miller and Berg, 1995) led him to suggest to his colleague, Barry Duncan, Psy.D. that a measure be created with four lines, each 10 centimeters in length, representing the four domains of client functioning assessed by the OQ 45 (Miller, 2010a). A similar process led to the creation of

the SRS (Miller, 2010b). Once again, a mentor and supervisor, Lynn Johnson, Ph.D., developed a 10-item likert scale for assessing the quality of the therapeutic interaction (including alliance [Johnson, 1995]). The author had used the scale but wanted a simpler, briefer scale to fit with the demands of an inner city clinic. The measure was shortened and converted into a visual analogue scale capturing the major elements of a good therapeutic alliance as originally defined by Bordin (1979). Together with Barry Duncan, Psy.D. and others, measures for children, young children, and groups were added and tested for reliability, validity, and feasibility.

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AUTHOR NOTES

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