The Outcome of Psychotherapy: Yesterday, Today, and Tomorrow

Scott D. Miller, Mark A. Hubble, Daryl L. Chow, and Jason A. Seidel
International Center for Clinical Excellence

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" (p. 2) confronting the field and the necessity of conducting "properly planned experimental 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.

*Keywords:* psychotherapy, outcome, excellence, practice-based evidence, therapist variability

In the decades preceding *Psychotherapy*’s appearance, 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 behavioral school were harshly critical, challenging the scientific basis of Freudian theories and concepts. *Hans J. Eysenck* (1952) published a review of 24 studies concluding 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%. 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. More than 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) Web site lists 145 manualized treatments for 51 of the 365 mental disorders now contained in the *DSM*. This volume, in its fourth edition, has reached an astonishing 943 pages. A fifth edition is in the works, and 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 penicillin treats infection. The hallmark of their position is that effective treatments must contain specific ingredients remedial to the condition being treated. For this group, randomized 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 operationalize falsifiable hypotheses using specific methods (discrete independent variables), test those hypotheses, and teach students those methods that stand up to rigor 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 with a medical intervention is grossly inaccurate (Frank & Frank, 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 installation of hope, provision of a therapeutic rationale, and strategies for achieving change, the therapeutic relationship is most often cited as one, if not the most, potent transtheoretical ingredient of psychotherapy (Bachorl & Horvath, 1999; Grencavcag & 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 that show 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 (Benish, Imel, & Wampold, 2008; Beutler et al., 2004; Crits-Christoph & Mintz, 1991; Crits-Christoph et al., 1991; Imel, Wampold, Miller, & Fleming, 2008; Kim, Wampold, & Bolt, 2006; Laborsky et al., 1986; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Okishii, Lambert, Eggert, Nielsen, Dayton, & Vermeersch, 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 (cf., APA, 2012; Smith & Glass, 1977; Wampold, Mondin, Moody, & Ahn, 1997; Wampold, Mondin, Moody, et al., 1997).

The polarization 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 health care, 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, although 90% of people report they would prefer to talk about their problems rather than take medication, use of psychotropic drugs has continued to rise, whereas visits to psychotherapists have steadily declined (Duncan, Miller, Wampold, & Hubble, 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 medicalization 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 expediency 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 (Cooper and Aratani, 2009) 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 & 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 et al., 2004; Norcross, 1997). Outside of the laboratory and the halls of academia, theories and techniques are used idiosyncratically rather than systematically, accumulated rather than integrated on any level but that of the individual clinician. 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 slightly 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 et al., 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 et al., 2007; Wampold, 2005).

Beginning in 1997, Garfield and other notable researchers, including Strupp (Strupp & Anderson, 1997; Luborsky, McClellan, Woody, O’Brien, & Auerbach, 1985; Luborsky, McClellan, Diguer, Woody, & Seligman, 1997; Okishi, 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 (cf., Duncan, 2010). Simply put, one cannot remove the effect of the therapist without undermining the therapy.

Strupp (1963) foresaw the variability between therapists before the collection of the evidence that 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 socioenvironmental factors” (p. 2). Although Eysenck (1964) emphasized 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, 2009b; Ericsson, Charness, Feldtovich, & Hoffman, 2006). These findings are less concerned with the particulars of a given area of performance than how mastery of any human endeavor 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 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 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 et al., 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
obtaining systematic, ongoing, formal feedback; and (3) engaging
performance. Working in tandem to create a “cycle of excellence,” these
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(ERICsson, 2006). Fortunately, in the realm of psychotherapy, nu-
continuously comparing what they do to their own “personal best,”
& Tesch-Romer, 1993) and writers (Colvin, 2008; Coyle, 2009;
Shenk, 2010; Syed, 2010) on the subject of expertise, Miller et al.
(2007) identified three components critical for superior perform-
Working in tandem to create a “cycle of excellence,” these
include: (1) determining a baseline level of effectiveness; (2)
attaining 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
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ing 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, nu-
cerous well-established outcome measures are available to cli-
icians for assessing their baseline (cf., Froyd & Lambert, 1989;
Ogles, Lambert, & Masters, 1996). Additionally, computerized
databases exist that 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
operationalizing and standardizing the concepts of clinical im-
provement and treatment failure (cf., Hedges & Olkin, 1985;
Jacobson & Truax, 1991; Ogles, Lambert, & Fields, 2002). Al-
though each conceptualization and measurement scheme has both
benefits and drawbacks, these techniques show a considerable
improvement beyond the “befogged” understandings and interpre-
tations of 50 years ago (Strupp, 1963).
Nevertheless, though measures and norms are now widely avail-
able, surveys indicate that few clinicians actually use 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 use, 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, Hat-
field and Ogles (2004) conducted a survey with a national sample
of licensed psychologists to investigate this discontinuity. As be-
fore, clinicians expressed interest in having reliable outcome in-
formation. 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 lan-
guages. 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 with 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 optimizing treatment. In 2001,
Lambert and colleagues (Lambert et al., 2001) reported results
demonstrating that providing feedback to clinicians 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 deterioration rates
in half (Anker, Duncan, & Sparks, 2009; Lambert & Shimokawa,
2011; Reese, Norsworthy, & Rowlands, 2009; Reese, Toland,

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 com-
pleting the tool owing 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, & Ajax, 1980) during his neu-
ropsychology 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.
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), are currently under review by SAMHSA. In 2012, moreover, the International Center for Clinical Excellence (ICCE) released a series of six “how-to” manuals for implementing routine outcome measurement in individual and agency settings (Bertolino & Miller, 2012). The process summarized 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, pp. 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 3 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, 2009a; 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 recognized 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 et al. (1993) found that the top performers had devoted two times as many 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 expertise, 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, McAlister, O’Donnell, and Lambert (2012), therapist self-appraisal is not a reliable measure of effectiveness. The findings also provide preliminary 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 related to outcome (Chow, Miller, Kane, & Thorton, n.d).

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 criticized 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 behavioral 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 article 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, Nafziger, & 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 appears that practitioners must be engaged in the process outlined above—in essence, continuously reaching for objectives just beyond their current ability (Miller, Hubble, & Duncan, 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 emphasize 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 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 Neimeyer, 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 continuing education 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 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.

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—able evidence makes clear that superior performance does not
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—

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 toward 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 in behavioral 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 organization created and published a document detailing four “core competencies” for applying the findings from the expertise literature to the practice of psychotherapy (Miller, Maeschalke, Axsen, & Seidel, 2011). The first core competency is in the research foundations of FIT, including familiarity with research on the therapeutic alliance; behavioral health care 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 behavioral health care 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 generalizability 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; 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 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.

References


Baldwin, S., Wampold, B., & Imel, Z. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and