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Beyond The Competency Model of Therapist Trainings - Developing Expertise Through Deliberate Practice

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The purpose of the present paper is to describe how Deliberate Practice (DP) can be used to assist individual therapists develop expertise and improve their ability to effect change in their clients' psychotherapy outcomes. The author provides a targeted review of this literature and articulates a method of training therapists based on this relatively new and exciting concept. The initial training of psychotherapists represents an important milestone in an often lifelong career and one that is marked with a continuous professional development trajectory. While it is particularly important to achieve competency in many foundational skills and techniques during training, this method of training and continuous development of therapists does relatively little to engage individual practitioners based on their individual needs, which are said to be vast. Individual therapist effects account for a large proportion of the variance of client outcomes. However, historically, the individual therapist has been given little consideration. DP seeks to move beyond the standardized competency framework and provide a highly individualized training regime to therapists based on their individual deficits identified through data mining and linked to factors of therapy practice that have demonstrated to impact client outcomes; and as such, they can be leveraged by therapists. The findings of this review are used to inform seven recommendations for practitioners, training institutes, and regulatory bodies to consider for the initial and continuous development of therapists.

KEYWORDS: Deliberate practice, therapists training, expertise, therapist development, therapist effects

Developing Expertise Through Deliberate Practice

Psychotherapy has become a more professionalized service throughout the world and currently many countries have statutory regulation or quasi-regulation in an effort to produce ethical, competent, and effective practitioners. However, the research foundations for psychotherapy efficacy are steeped in a long and often acrimonious rivalry from within the profession (Wampold, 2013). Schoolism and competing theoretical orientations can be traced back to the Freudian era and are still very much in existence today. Hans Eysenck (1952) in a review of the extant literature concluded that eclectic and psychoanalytic therapies were no more effective than no treatment at all. Controversy was to follow, with calls for potential clients to be informed of these findings on ethical grounds; in many respects, the within field fighting contributed to the lack of effectiveness of psychotherapeutic interventions being established within the research literature in the years to follow. Notwithstanding these issues, in time, empirical support for psychotherapy began to emerge. Largely, this evidence was due to innovations in research power such as the control trial (CT) and the meta-analysis. CT's are an experimental methodology where a person is often randomly assigned to active treatment, a control, or a waitlist to examine the effectiveness of the experiential treatment compared to another control (Wampold, 2013). During the 1970s many studies had been carried out confirming the effectiveness of psychotherapy, regardless of the type of approach to treatment (Bergin, 1971), these studies of equivalence as they are known, have been replicated throughout the literature (Steinert et al., 2017; Stiles et al., 2008; Wampold & Imel, 2015). However, it was the emergence of the meta-analysis that allowed differentiated studies to be

pooled together to give an overall effect size for psychological therapies, and this method demonstrated the fields prowess.

The meta-analysis brings together similar studies that are homogenous and pools together their effect sizes and reports on overall effectiveness. An important study, Smith, and Glass (1977) utilized this statistical analysis to review 375 studies and found that the average treated person was better off than 60-82% of those receiving no treatment. Indeed, it is now accepted that the general aggregated effectiveness of psychotherapy sits around 0.80 (Lambert, 2013; 2015; Wampold & Imel, 2015). Hence, psychotherapy has been established as an effective treatment modality with effect sizes on par with, and even exceeding some medical treatments based on numbers needed to treat (NNT), (Lemma et al., 2011). Indeed, this is not where the comparison to the medical model ends, controversy around evidence-based treatments situated within a medical model paradigm of specific treatments for specific disorders has garnered considerable attention within the psychotherapeutic discourse (e.g., Cuijpers et al., 2019).

The evidence-based practice movement

The American Psychological Association defines evidence-based practice as the “integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (Evidence-Based Practice in Psychology, 2006, p. 273). However, in recent times, evidence-based practice has come to be understood as empirically supported treatments (EST) that are supported by a specific type of evidence, the randomized control trial. Empirically supported treatments are largely based on CBT protocols, are manualized, and characterized by their supposedly specific ingredients that treat specific ‘disorders’ (e.g. Chambless and Crits-Christoph, 2006; Chambless and Hollon, 1998). While we have moved on from the debate as to the effectiveness of psychotherapy, a mechanism of change discourse is still an issue for some. That is, are treatment modalities the specific ingredient of change, or are factors common across approaches responsible for the change in clients (Cuijpers et al., 2019; Wampold & Imel, 2015). While many would conclude that both are key mechanisms in the change process, treatment modalities are often focused on more heavily by practitioners and training providers. Indeed, there has been a proliferation of so-called evidence-based treatments added to the field in recent years. Considering the backing and status that these treatments have received by institutions such as the American Psychological Association (APA), it is not beyond reason to assume that the field of psychotherapy has progressed over the last several decades as measured by clients' outcomes. Yet, this is not supported within the literature (Truijens et al., 2018; Vinnars et al., 2005; Wampold and Imel, 2015).

Moreover, while other fields have seen improvements in outcome development across the last 50 years (Erickson, 2006). Weisz et al. (2019) demonstrate that the mental health field has not improved as measured by client outcomes in the same period. Using statistical analyses, Weisz et al. (2019) examined 453 RCT's spanning 53 years, involving nearly 32,000 children treated for several psychological and social issues. The findings suggest that the mean effect sizes increased non-significantly for anxiety; decreased non-significantly for ADHD; and decreased significantly for depression and conduct disorder. While several caveats were noted, reconciling these findings with the number of new treatments added to the field is difficult for the author. At the same time, outcome studies with adults across ‘diagnosis’ reflect these findings (Miller et al., 2013). When we match this research with individual therapists not getting better with time and experience (Goldberg et al., 2016; Chow et al., 2014), a point I will come back to later in this paper, it illuminates some possible limitations of our current systems of training therapists and their on-going professional development.

Therapist training

The literature has historically been somewhat ambiguous when it comes to the professional training of counselors and psychotherapists. While Bergin (1971) found a positive outcome between therapist experience and client outcomes, other research is not so supportive, leading Christensen and Jacobson (1994) to suggest that training doctoral-level psychotherapists were not justified. Research examining therapist experience (level of training & years practicing) on outcomes has had mixed results, with at most modest supportive findings and at worse negative findings (Berman & Norton, 1985; Goldberg et al., 2016a; Huppert et al., 2001; Lyons & Woods, 1991; Okiishi et al., 2006; Stein & Lambert, 1995; Wampold & Brown, 2005). Further, Lambert (2015, p.88) tells us that ‘training programs are also highly diverse with little agreement across the world about the type and amount of training necessary for effective practice.’ Thus, the implications here are that we are not aware of the type, length, level, and duration needed to train therapists to optimal levels.

Regarding the level of training, Owen et al. (2015) showed that psychotherapy training produces a small-sized growth in therapists’ clients’ outcomes, however, this was mediated by initial client distress. Said another way, therapists improved slightly with clients who were not as distressed at baseline, however, with more distressed clients, no such improvements were exhibited, irrespective of trainee level (practicum, predoctoral intern, postdoctoral fellow). In fact, student therapists (Dyason et al., 2019) and paraprofessionals (Atkins et al., 1984; Berman & Norton, 1985; Christen & Jacobson, 1994; Hattie et al., 1984), often have client outcomes as good as established professionals. It has not been identified why there is relatively little difference between professional practitioners and those without professional qualifications. However, it may be linked to Anderson et al. (2009) contention that it is considered that a well-defined set of facilitative interpersonal skills are what makes psychotherapy effective. This would be consistent with the idea of evidence-based relationships outlined by (Norcross and Wampold, 2011).

Erekson et al. (2017) longitude study found that the magnitude and speed of change produced by established doctoral psychologists did not improve, and in general slowed slightly as they progressed to later training stages. Goldberg et al. (2016b) also in a longitudinal study of therapist effectiveness demonstrated that therapists’ outcomes diminished slightly over time. Hill et al. (2015 p.184) in a study of psychodynamic therapists document that therapists attribute their development to ‘graduate training, individual and group supervision, research participation, and working with clients’. Hill and Knox (2013) reported that therapists perceived that hands-on experiences with clients, personal therapy, and supervision were the most helpful factors in their growth. However, neither of the above studies linked these experiences to actual client outcomes.

While supervision is considered the signature pedagogy of the field, the evidence for how this impacts client outcomes is scant, at best. However, therapists find supervision beneficial for many reasons (Wheeler & Richards, 2007). Watkins (2011, p.235) suggests that ‘We do not seem to be any more able to say now (as opposed to 30 years ago) that psychotherapy supervision contributes to patient outcome.’ Rousmaniere, et al. (2016) illustrate that the supervisor variance in client outcome is less than 1%. Watkins (2019) provides a critical review of the literature once again, suggesting; ‘evidence-based supervision appears to be more of a hope and dream; supervision models generally lack empirical evidence and evidence is weak for any client outcome correlations. Also, explicitly stated as a training pedagogy is personal therapy. While intuitively most will understand its importance and benefit (Bennett-Levy, 2019; Rabu et al., 2019), several issues regarding how this aspect of training is used have been noted in the literature.

Anecdotally, it is often suggested that counsellors and psychotherapists should use therapy and are often mandated to therapy to address their personal issues as these can impede their abilities to provide care to their clients. The empirical support for this rationale is rather limited, with no research demonstrating a correlation between personal therapy and client outcomes (Rabu et al., 2019). Further, the ethical position of mandating therapy by course providers promotes some ethical questions. In a systematic review and meta-analysis of mandated therapy for trainees, Murphy et al. (2018) found equal measures of positive and negative experiences. They go on to conclude that there are ethical issues to consider for those who mandate trainee therapists into personal therapy, not least that it is to be utilized as an experiential pedagogy and not to act as a curative function for personal issues. Although learning methods to manage counter-transference has shown to be effective in a meta-analysis (Hayes et al., 2018), many methods of personal development can be utilized to achieve this, not just therapy (Bennet-Levy, 2019). Indeed, personal therapy is recommended for issues with chronic counter-transference (Hayes et al., 2018).

Goldberg et al. (2016a) demonstrated that years of experience, differential caseloads, level of qualification, and theoretical orientation did not make a difference to practitioner client outcomes over time. Yet, these are some of the core domains we consider in order to establish professionalism and expertise within our current systems. Herschell et al. (2010, p.448) elucidated that ‘studies evaluating utility of reading, self-directed trainings, and workshops have documented that these methods do not routinely produce positive outcomes and has led researchers such as Tracey et al. (2014; 2015) to suggest the field is without expertise.

It would seem that many types of training are based on a competency framework. That is standardized training regimes that have explicit methods of teaching skills linked to theories or concepts. Of course, it is necessary to become proficient in learning our craft, and competencies are needed. However, much of what such training/CPD regimes are teaching may have a little additional bearing on client outcomes, especially if these pieces of training are geared towards learning new modalities of therapy, which have an outcome variance of between 0-1% (Wampold & Imel, 2015, Wampold, 2017). Instead, linking the learners' individual needs based on the factors we know to contribute to client outcomes, and the use of data should be considered. Especially deficits in areas that have shown to have large impacts on client outcomes (for further reading on this see, Wampold & Imel; Wampold, 2015; Duncan et al., 2011; Miller et al., 2020).

Individual therapist effects

Individual therapist effects account for between 5-9 times more of the outcome variable than the difference between theory and techniques (Baldwin & Imel, 2013; Firth et al., 2019; Wampold & Imel, 2015). Wampold and Brown's (2005) meta-analysis suggests that client gender, age, or diagnosis provided, as well as therapist age, gender, experience, and professional degree accounted for little of the variability in outcomes among therapists. More, individual practitioners produce dropout rates in the range of 1.2%-73.2%, while others consistently exhibit practices whereby their clients deteriorate while in their care (Saxon et al., 2017; Okiishi et al., 2003).

The wider research literature demonstrates that deterioration in adult psychotherapy is aggregated at 8-10% (Hansen et al., 2002; Lambert and Ogles, 2004) with children deterioration estimated at 24 % (Nelson et al., 2013). At the same time, early attrition is concerning ranging from 20% to 85% (de Hann et al., 2013; Garcia and Weisz, 2002; Kazdin, 1996) depending on the study and definition of drop out. Although these statistics are aggregated, individual therapists vary in each of these domains, shining a light on the magnitude of the individual therapist effect on treatment outcome.

One issue of concern is that practitioners are generally poor at identifying clients not benefiting from therapy (Hannan, 2005; Hatfield et al., 2011; Lambert et al., 2005; Lambert, 2013). Indeed, it is proposed that practitioners routinely and vastly overestimate their effectiveness (Chow et al., 2015; Hannon et al., 2005), and find it difficult to identify those at risk of poor outcomes. One way to mitigate against some of these negative effects, and indeed therapist ability to identify such issues, is the use of feedback systems (see Brattland et al., 2018; Lambert et al., 2018). That is, tracking the process and outcome of care on a session-to-session basis, using the resulting information to tailor care in real-time. Muir et al. (2019) argue that therapists have an ethical obligation to do this to limit the extent of poor outcomes.

The between-practitioner difference is often very large (Muir et al., 2019; Baldwin et al., 2007; Saxon et al., 2017; Baldwin & Imel, 2013; Firth et al., 2019; Johns et al., 2019), those most effective practitioners can work with clients presenting with more severe symptomatology and gain better results (Firth et al., 2019; Johns et al., 2019; Saxon & Barkham, 2012). Moreover, these highly effective therapists in the top quartile achieve outcomes more than twice that of those in the bottom (Wampold & Brown, 2005). Okiishi, et al. (2003, p.1) demonstrated that ‘therapists whose clients showed the fastest rate of improvement had an average rate of change 10 times greater than the mean for the sample. The therapists whose clients showed the slowest rate of improvement exhibited an average increase in symptoms among their clients’.

At the same time, therapist effectiveness is not necessarily a global construct and a practitioner with expertise in treating one issue, such as anxiety may not necessarily be effective in treating a different one, such as anxiety with comorbid issues (Kraus et al., 2011; Kraus et al., 2016). Thus, with differences of this magnitude across individual therapists, one is justified in calling into question the current training regimes and the standardized competency framework in place. DP offers a method to assist with making improvements in these areas based on individualized therapist needs.

Deliberate Practice

It has been argued by Tracey et al. (2014) that counseling and psychotherapy is a field lacking in expertise. In part, this is reflected by studies demonstrating that little progress is made by therapists after their initial training (Clement, 1994; Goldberg et al., 2016a; Tracey et al., 2015). However, emerging psychotherapeutic research on expertise referred to as Deliberate Practice (DP) has been highlighted as a way forward within the literature; the path to mastery has been set out (Chow et al., 2015; Erickson, 2006; Miller et al., 2018;2019; Rousmaniere, 2017;2019).

This method of development emerged in the literature with psychologist Anders Ericsson and his research on expertise and performance across diverse professions. More recently, (Chow et al., 2015; Goldberg et al., 2016a; 2016b; Miller et al., 2018; Rousmaniere, 2016:2019) have examined this concept in relation to counseling and psychotherapy development as measured by client outcomes. DP is a method of targeting skills where deficits have been empirically identified. Notably, for counselors and psychotherapists, DP requires five processes that are not present in traditional psychotherapy training or CPD: 1) observing your own work, 2) getting expert feedback 3) setting incremental learning goals just beyond your ability 4) repetitive behavioral rehearsal of specific skills, and 5) continuously assessing performance (Ericsson, 2006; Miller et al., 2018).

Chow (2015, p.337) posits that ‘consistent with the literature on expertise and expert performance, the amount of time spent targeted at improving therapeutic skills was a significant predictor of client outcomes. Identifying empirically, areas of individual therapeutic deficit that are just beyond your current ability for development through repetition and refinement is the

idea behind deliberate practice (Ericsson and Lehmann 1996; Chow et al., 2015; Rousmaniere, 2016). It is argued that the top performers engage in longer periods of solitary DP. That is, they repetitively practice and refine their skills outside of clinical practice for longer than their peers. Goldberg et al. (2016b) demonstrated that when feedback systems are utilized as a part of a concerted DP framework, therapists improve outcomes at a small but meaningful $d = 0.034$ each year, based on a 7-year research study, which is the first of its kind.

Rousmaniere (2017) provides a 3-step framework of DP that practitioners can leverage; develop their baseline effectiveness; receive ongoing feedback; and engage in deliberate practice. As Ericsson (2006, p.28) points out; ‘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’.

Discussion

Psychotherapy is an effective treatment modality for those who engage in and complete a course of treatment with an effective practitioner. While the field of counseling and psychotherapy has had many issues going as far back as the Freudian era, much ground has been covered with the emergence of differential research methodologies and discourses. At the same time, areas that we can improve in have been identified in the extant literature. Therefore, I propose the following recommendations for practitioners, training institutes, and regulatory bodies in order to help improve these practices.

- 1) One of the most proficient and pragmatic methods of improving the outcomes of clients who are deteriorating or not benefiting from our care is to utilize standardized measures of outcome and process. Eliciting feedback in this way is robustly supported in the literature for improving client outcomes for this population of people (Brattland et al., 2018; Lambert et al., 2018). Practitioners should identify the correct measures for their individual context and engage in this practice on a session- to- session basis.
- 2) Training providers may wish to integrate these feedback methods into the core training of counsellors and psychotherapists early on in practitioner initial training. Additionally, the supervisory process should also entail the use of feedback measures in order to base clinical decisions on objective data. While personal therapy should have a clear pedagogical aim linked to course learning outcomes, rather than as a curative purpose. Other personal practices such as mindfulness and self-reflection should be also considered as alternatives to mandated therapy.
- 3) Regulation bodies may wish to examine the ethical duty of care and how the research on deterioration and null outcomes are managed within routine practice. As far back as 1994 Clement suggested that therapists have an ethical obligation to systematically evaluate their outcomes, indeed, he suggested that it is unethical to not monitor them. In a review of the ethical practice of psychotherapy literature, Barnett (2019) argues that changes in the practice of psychotherapy and in our knowledge base require an updating of the profession’s code of ethics on an ongoing basis. To this end, we can conclude that the present review and those that have preceded it should be considered as ethical imperatives.
- 4) Deliberate Practice is an area still in its infancy. However, the studies that have been conducted show its effectiveness. However, this type of individualized learning and development takes work and involves linking practice to those areas shown to impact outcomes and the mining of data to target specific deficits. Thus, the following recommendations should be considered at the practitioner, training, and regulation levels.

- 5) Established practitioners may wish to target their professional development activities towards deficits in practice. That is, non-randomized errors identified through mining their data across demographics and constructs. Of course, one needs to understand where they are currently situated in order for improvements to be tracked. Hence, my previous recommendation that practitioners use feedback measures that can be aggregated for effect sizes. There are several systems available that provide clinical data in these formats. Practitioners can then follow the DP framework; namely, develop your baseline of effectiveness, we should be aiming for the often-cited 0.80. Get ongoing feedback from a consultant. This can be based on outcome measures and recorded therapy sessions where deficits in data and recorded therapy sessions are linked to the aspects of therapy that have shown to impact client outcomes. Finally, engage in DP. That is, practice and refine these skills outside of the clinical hour, and receive feedback on these refinements from a consultant.
- 6) Training institutes may wish to integrate deliberate practice into training regimes early on in a practitioner's development. While the competency framework is important for learning initial engagement skills and techniques that can be benchmarked, this method of therapist development is standardized and does little to identify those aspects of the individual therapist development where deficits occur. Considering the difference in practitioner ability to effect change, DP represents one method to provide a highly individualized training regime at a therapist's growth edge.
- 7) Regulation bodies play an important part in the ongoing continuous professional development of therapists practice. In fact, many institutes will mandate therapists to engage in continuous professional development in order to foster high standards of competency and improve knowledge and skills. However, as articulated previously, ongoing CPD based on competency may not affect client outcomes over or above the methods currently utilized by therapists. Of course, therapists should have the autonomy to choose their CPD activities based on preferences, needs, and interests. However, I would recommend that such bodies mandate that some percentage of a practitioner's CPD portfolio is based within a DP paradigm.

Conclusion

This targeted review aimed to address the question of how the initial training and continuous development of therapists can be enhanced by moving beyond the competency model of training. The field has made great strides over the last several decades. We can now say with certainty that psychotherapy is an effective treatment modality on par with many medicines. Yet, why should we settle for this when there is more we can achieve. The findings and recommendations of this paper suggest that improving the effectiveness, and thus outcomes for clients can be achieved by addressing individualized deficits in practitioners ability to effect change. A deliberate practice paradigm has been put forward to complement the competency framework used by those involved in the training and ongoing development of therapists. Such an approach seeks to highly individualize the training and ongoing development of therapists by identifying their idiosyncratic deficits through mining data and feedback, and deliberately practicing these areas outside of the clinical hour, and at their growth edge of development.

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