Nurturing Therapeutic Mastery in CBT and Beyond:
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Cognitive-behavioral therapy is the most widely researched and disseminated psychotherapy approach in existence. Studies have found the approach effective for a variety of presenting complaints and treatment populations compared to no treatment controls (Hofmann et al. 2012). Around the world, the approach dominates official lists of scientifically-sanctioned mental health treatments, including the National Institute for Health and Clinical Excellence in the U.K., and the National Registry of Evidence Based Practices and Programs in the U.S. (Wampold & Imel, 2015).

The CBT model posits that mental health problems result from dysfunctional beliefs and information processing errors and accompanying emotional dysregulation (Beck, 1979). Over the years, a number of CBT techniques and treatment protocols have been developed and standardized. Each aims at helping people identify, evaluate, and modify the distorted thinking believed to be at the core of various disorders. Behavioral strategies designed to enhance cognitive and emotional skills, as well as to increase engagement in activities associated with improved mood and functioning are also included.

Popularity and overall efficacy notwithstanding, research has failed to provide evidence that CBT is more effective than most other treatments, or that it works through the purported mechanisms of change (Wampold & Imel, 2015). When CBT is directly compared with other therapies designed to be therapeutic, no differences in effectiveness are found (Wampold & Imel, 2015). Moreover, dismantling studies to date have not found any specific ingredient is critical to the benefits of CBT (Ahn & Wampold, 2001; Bell, Marcus, & Goodlad, 2013). This evidence

suggests that an emphasis on adherence to any one method or treatment protocol as a means of improving the quality of mental health services is misguided (Evans, 2013). As presented in previous chapters of this volume, there are a number of critical therapeutic skills unrelated to particular protocols, which if practiced and mastered, would improve outcomes.

In the United Kingdom large amounts of money have been spent over the last five years training clinicians to use cognitive behavioral therapy (CBT). The expenditure is part of a well-intentioned government program aimed at improving access to effective mental health services (Griffiths & Steen, 2013, IPAT, 2011). And yet, the benefit of these expenditures is questionable (Mukuria et al., 2013). Consider a recent study by Branson, Shafran, and Myles (2015) that investigated 43 clinicians who participated in a year-long "high-intensity" CBT training that included more than 300 hours of training, supervision, and practice in CBT. The outcomes of 1247 service users were tracked using standardized measures administered at regular intervals. Not surprisingly, adherence to and competence in delivering CBT improved significantly throughout the training. However, contrary to expectations, results showed that greater adherence and competence, acquired through this CBT specific training, did *not* result in better outcomes. The therapists were, in other words, no more effective following the training than they were before.

While one might hope such findings would lead to questions regarding the relationship between the treatment method and outcome, the researchers chose instead to question whether "patient outcome should … be used as a metric of competence…" (p. 27). Said another way, despite the results, adhering to protocol was still viewed as more important than whether adherence improved outcomes!

Given our (the editors') understanding of the evidence about CBT, we were eager to have a chapter about developing expertise in CBT with improving outcomes as the goal. After attempts to find CBT authors who would take improving outcomes as opposed to adherence as critical to expertise failed, we approached Don Meichenbaum to gain some insight into this process. Meichenbaum is one the most prominent founders of CBT. Early on, he began studying transtheoretical patterns associated with expert performance in psychotherapy. In time, he developed a model of therapeutic expertise, identifying a core set of tasks that effective therapists use.

The editors were pleased that Meichenbaum agreed to be interviewed about his model of expertise and how his thinking about psychotherapy evolved from CBT to an emphasis on improving outcomes through deliberate practice.

<div align="center">The Interview</div>

Editors (Eds.) We are pleased to have you contribute to our discussion of how to nurture expertise in psychotherapists.

DM I am honored to be invited to contribute. This is a challenging issue that I have been struggling with for some time. I have been involved in training psychotherapists for over 40 years, as a clinical supervisor, as a consultant to various psychiatric treatment centers where the clientele range from children to the elderly. In addition, I have been offering Continuing Education for over 30 years. I have been concerned about what trainees and what participants take away from my instruction and supervision.

Eds. You are considered one of the founders of cognitive behavior therapy, and you initially conducted a number of innovative treatment outcome studies designed to

determine the relative efficacy of such therapeutic procedures as self-instructional training, stress inoculation training, cognitive restructuring procedures, and problem-solving approaches. How did your clinical research lead you to a more generic concern with the concept of "expertise" of psychotherapists?

DM   You are correct in noting my professional trajectory. In fact, recently I was invited by Routledge Publishers to conduct a retrospective of my publications over 40 years (Meichenbaum, 2017). This was an opportunity to reflect on my ongoing preoccupation with what constitutes the core tasks that "expert" psychotherapists engage in.

Eds.   How did you come to this position?

DM   The answer comes in three parts. First, I was impressed by the marked variability in the treatment outcomes of the therapists we were working with. Some therapists consistently achieved better outcomes than others. This finding is in accord with the findings of a number of researchers (Dawes, 1994; Baldwin & Imel, 2013; Wampold 2001, 2006; Wampold & Imel, 2015). Second, as a consultant to various treatment programs and as a provider of continuing education, I had a strong desire to be an "honest broker" and advocate for evidence-based interventions. My presentations were tempered, however, by the finding that all treatments that are intended to be therapeutic seem to be approximately equally effective. Thus, my interest turned to what are the behavior change principles and core psychotherapeutic tasks that are common to these varied treatment approaches.

The third and most critical contribution to my evolving views of expertise and psychotherapy was that I also wear a "professional hat" of being a

developmental psychologist. With a colleague, Andy Biemiller, we wanted to better understand "why smart children in school keep getting smarter, and other students fall further and further behind"? For example, by the time students reach high school, the spread between high and low achieving students could be as much as six grade levels. In some sense, the high-achieving students are "experts" in negotiating the demands of the school system (Meichenbaum & Biemiller, 1998).

Eds. How did your work on students' academic performance link with your training of psychotherapists?

DM In our work with students, I reviewed the research on the acquisition and structure of expertise (Ericsson & Charness, 1994; Ericsson et al., 2006; Shanteau, 1992). In fact, Neil Charness was a colleague at the University of Waterloo, in Ontario, Canada, where I worked for 40 years.

As a result of a number of observational studies of independent student learners (so-called "budding experts"), we developed a theoretical model that could be applied to the acquisition of expertise, including psychotherapy (Biemiller & Meichenbaum, 1992).

Eds. That is interesting. Can you describe the model and discuss its implications for the training of psychotherapists?

DM Figure 1 provides a pictorial presentation of the Model of Mastery. It is a three dimensional framework that includes an X Axis (horizontal), a Y Axis (vertical), and a Z Axis (diagonal). The X Axis represents a tutee's movement from easy to more difficult tasks that require more knowledge and skills. For school students, this may reflect moving from simple math problems to more difficult problems. For

novice psychotherapists, this may entail taking on patients with less complex straight-forward Adjustment Disorders to more complex high-demand, traumatized patients with chronic co-occurring disorders who have few social supports. The critical feature in moving along the X Axis is the nature of the "fit" between the tutee's competence and the task demands. An effective teacher or clinical supervisor attempts to match, and slightly challenge, the tutee and "scaffold" instruction, providing necessary supports and then reducing guidance and fading them as the tutee acquires skills.

The Y vertical Axis reflects further steps in the development of mastery. A tutee (either student or psychotherapist) moves from an initial point of being a complete novice (lack of knowledge, skills, experience) by means of deliberate practice to the point of task efficiency, where he or she can consolidate skills and performance. Such deliberate practice is goal-directed in achieving well defined specific tasks that the tutee seeks to master. It includes multiple repetitive opportunities to engage in the tasks and affords immediate feedback, highlighted errors and represents "teachable moments". As automaticity develops the tutee can learn to perform more than one skill set at a time.

In school, students may have opportunities to do and redo a particular academic task. For a psychotherapist, it may be working on ways to establish, maintain and monitor a therapeutic alliance, or deal with "ruptures" to such an alliance. Therapists can use session-by-session patient input to monitor the perceived fit and effectiveness of the therapeutic alliance, and alter the

psychotherapeutic approach accordingly (Lambert, 2010, Lambert & Shimokawa, 2011).

One of the goals of this deliberate practice is to help automatize performance (put the tutee on "auto-pilot"), so it frees up mental capacity. This consolidation process should be revisited on a regular basis when feedback indicates that performance errors have occurred.

But engaging in deliberate practice in moving from initial steps of acquisition to consolidation is not sufficient to evidence mastery and develop expertise. The tutee needs to continue up the Y Axis to the point of becoming a mindful, reflective, deliberate consultant, to themselves and to others. It is in this consultative role where situational awareness develops, as the tutee can self-monitor, observe and "own" his/her skills. In order to develop mastery, the student or psychotherapist needs to develop conditional strategic knowledge knowing when and how to implement the skill set, but can also describe the process, and even teach it to others. The learner must come to spontaneously use language or some other form of mental representation (diagrams, semantic webs) in a way to direct others and him or herself.

As the tutee moves up the Y Axis with more and more difficult demanding tasks (moving concurrently along the X Axis), he or she calls upon meta-cognitive, executive skills, and can even shift goals.

But the journey to expertise is not yet complete. The tutee needs to learn how to apply the acquired skills to new tasks, in new situations, and in innovative ways. In short, the tutee (student or psychotherapist) needs to move along the Z

Axis. There are two ways to negotiate the Z Axis (OUT and BACK). The training sessions can take the form of what is called, <u>Near Transfer</u>. The training opportunities can closely approximate the initial training tasks that were used in the acquisition of the skill set. One can "criterion cheat", making the training tasks similar to the transfer tasks. In this way, the tutee can apply his or her knowledge and skills in a methodical, and perhaps, innovative manner to new tasks, settings and patients.

A second way to negotiate the Z Axis is to confront the student or psychotherapist with an "authentic" challenging task, and have the tutee deduce, infer and problem- solve ways to figure out and apply his or her knowledge and skills, which is called <u>Far</u> <u>Transfer</u>.

The Z (OUT) dimension denotes the planning and application complexity of a task, as tutees apply their knowledge and skills to new tasks in novel situations. The learners acquire or generate strategies for planning new tasks - - transferring or generalizing their knowledge and skills. As noted, the tasks may vary from <u>near transfer</u> (tasks and contents similar to training) to <u>far transfer</u> ("authentic" applied tasks that require high levels of skill integration and complex decision making). Tutees move from merely consuming knowledge to constructing knowledge, tasks and procedures.

Tutees may move OUT from the initial simplified learning settings to complex "authentic" tasks. They may also move BACK from "authentic" complex tasks to focusing on the acquisition of further needed skills and strategies. This bidirectional movement is a dynamic interactive process.

In summary, the proposed Model of Mastery means that in order to develop "expertise", individuals need to:

(1) move from simple to more complex difficult tasks (patients) (X Axis);

(2) move from being a novice to becoming proficient by means of deliberate practice, to the point whereby they consolidate their skills that frees up mental capacity all the way to the point of becoming a consultant to themselves, as well as to others. In this way, they now come to "own" their skill set and can teach them to others (Y Axis).

(3) apply and extend their knowledge and skill sets to new tasks (patients), settings, and to do so in innovative, creative ways. They can do so by applying their skills to an increasing challenging set of transfer tasks, or they can do so by engaging in "authentic" real-life tasks, even inventing new applications. In order to become an "expert" in any area, an individual needs to move OVER, UP and OUT, along the three dimensions proposed by Model of Mastery. If you want to become an "expert" at something, the individual has to learn to perform more challenging tasks, on their own, as a result of deliberate practice, and apply these skills in new ways on novel tasks in different settings. According to this analysis, deliberate practice is embedded in the journey toward expertise.

The development of such expertise by means of deliberate practice in implementing the Core Tasks of Psychotherapy will contribute to the ultimate objective of helping patients achieve their treatment goals that they have collaboratively established with their therapists.

Eds.	How did the three dimensional Model of Mastery contribute to your training of

psychotherapists?

DM. In order to answer your question, let us take one Axis at a time. Keep in mind that when the contributors to this volume call for deliberate practice, the critical question is what specific skill sets should psychotherapists deliberately practice?

Eds. Exactly!

DM Research indicates that the most robust predictor of therapy outcomes is the quality of the therapeutic alliance (TA). The amount of change attributable to TA is seven times that of the specific treatment model, or specific treatment techniques. In fact, the specific treatment accounts for no more than 15% of variance of treatment outcomes. In comparison, some 36% of the treatment outcome is attributed to the person of the therapist, which is 3 to 4 times that of the specific treatment approach (Sperry & Carlson, 2013). But as Miller et al., (2008) highlighted, it is the availability of timely quality feedback from patients on a session-by-session basis that is critical to the development of expertise in any area.

In terms of the Model of Mastery, this translates into the need for psychotherapists to engage in deliberate practice with more and more challenging patients (namely, across the X Axis of level of difficulty), and to actively solicit patient feedback on an ongoing basis.

But a big feature of developing a good therapeutic alliance is for the patient and therapist to mutually agree upon the treatment goals and methods by which to achieve the patient's goals ("pathways thinking" and being "practically optimistic" in order to nurture the patient's level of hopefulness) (Bordin, 1979; Horvath et al. 2011).

Thus, a second core set of tasks that psychotherapists need to deliberately practice are motivational interviewing and collaborative goal-setting procedures.

As Goldfried observed (2012), the patient should hold the belief, "My

therapist really understands and cares about me," and the therapist should hold the belief,

"I really enjoy working with this patient." The patient's trust and confidence in the

therapist that he/she is competent and interested in the patient's well-being is predictive of

outcome (Norcross, 2002; Skovholt & Jennings, 2004).

An effective TA may develop as early as the first session, but an effective TA must

be firmly in place by the third session, if treatment is to be successful (Sperry & Carlson,

2013).

> "It is the therapist and not the treatment that influences the amount
>
> of therapeutic alliance that occurs. Relationship skills at developing a
>
> therapeutic alliance is the cornerstone of therapeutic alliance (Sperry
>
> & Carlson, 2013, p. 86).

The use of patient rating scales and Socratic probes, and the therapist's adjustment of

treatment accordingly, are predictive of treatment outcomes.

It is the adjustment of treatment interventions that are in response to patient

feedback that is a critical aspect of being a successful psychotherapist. Expert therapists

tend to be more reflective and work harder between sessions, seeking mentoring

opportunities (Miller et al., 2008). In terms of the proposed Model of Mastery, in order to

develop expertise individuals have to move up the Y Axis to the point of being a

"consultant" to themselves, as well as to others (including their patients). Both the

therapist, and the patient, have to "own" their newly developed skills, and moreover, "take

credit" for the changes they have brought about. A core task for psychotherapists is to

deliberately practice ways to have their patients engage in self- attributional training that

nurtures personal agency and self-efficacy. Patients need to see the connections between their efforts and resultant changes, and become more situationally aware of the consequences of their efforts and interventions (Duncan et al.,2010; Messer & Wampold, 2002).

In short, therapists who achieve better outcomes have developed a way of teaching their patients how to become their own therapists. Expert therapists teach their patients how to take the therapist's voice with them. For instance, the therapist teaches patients how to become "experts" in achieving their treatment goals, and ways to improve the quality of their lives. Consider the potential value of psychotherapists asking their patients the following question: "***Let me ask you a somewhat different question. Do you (the patient)ever find yourself, in your everyday experiences, asking yourself the kind of questions that we ask each other right here?***"

The Model of Mastery highlights that there is also a need to have psychotherapists, not only move across the X Axis, and up the Y Axis, but to also move out and back along the Z Axis. In order to truly become an "expert" at any skill, there is a need to apply, extend, generalize, and invent new and creative applications of their skill sets. Psychotherapists need to apply their knowledge and skills to "authentic" challenging new and complex cases. Psychotherapists require knowledge and skills on how to increase the likelihood of transfer and generalization in order to help their patients achieve "lasting changes". Expert therapists do not merely "train and hope" for such transfer, but they build in specific ways their patients can move out along the Z Axis (Meichenbaum & Biemiller, 1998).

Eds.   Let us see if we have captured what you are proposing. You have highlighted three main

features that characterize psychotherapists who achieve better treatment outcomes:

(1) the development, maintenance and monitoring of the quality of the therapeutic alliance with more and more challenging patients;

(2) the self-reflective activity to use such patient feedback on an ongoing basis to adjust their treatment approach accordingly, in order to become more meta-cognitively active, or what you call being in a consultative role with themselves, as well as with others, including their patients. Interestingly, you are proposing that therapists who achieve better results, teach their patients how to become "experts" themselves, in using the principles of deliberate practice;

(3) finally, you have proposed that effective therapists challenge, cajole, nurture and support their patients to undertake these activities on new and challenging tasks, in new situations and settings with significant others.

DM Indeed, three basic features characterize "expert" psychotherapists who obtain better treatment outcomes, namely, (a) the ability to establish, maintain and monitor on an ongoing basis the quality of the therapeutic alliance that has been implemented in a culturally-sensitive manner; (b) the ability to become more strategically knowledgeable, self-aware and reflective as they operate in a consultative role to their patients and to themselves in order to alter treatment accordingly; (c), the ability to increase the likelihood of their patients achieving "lasting changes" by their incorporating into their treatment protocols behavioral generalization guidelines. Insofar as psychotherapists deliberately practice implementing these Core Tasks of Psychotherapy, they will improve their patient's treatment outcomes.

"Expert" psychotherapists do not view themselves as experts, but continually seek

feedback from their patients, colleagues and supervisors on their personal journey to becoming more effective catalysts of change.
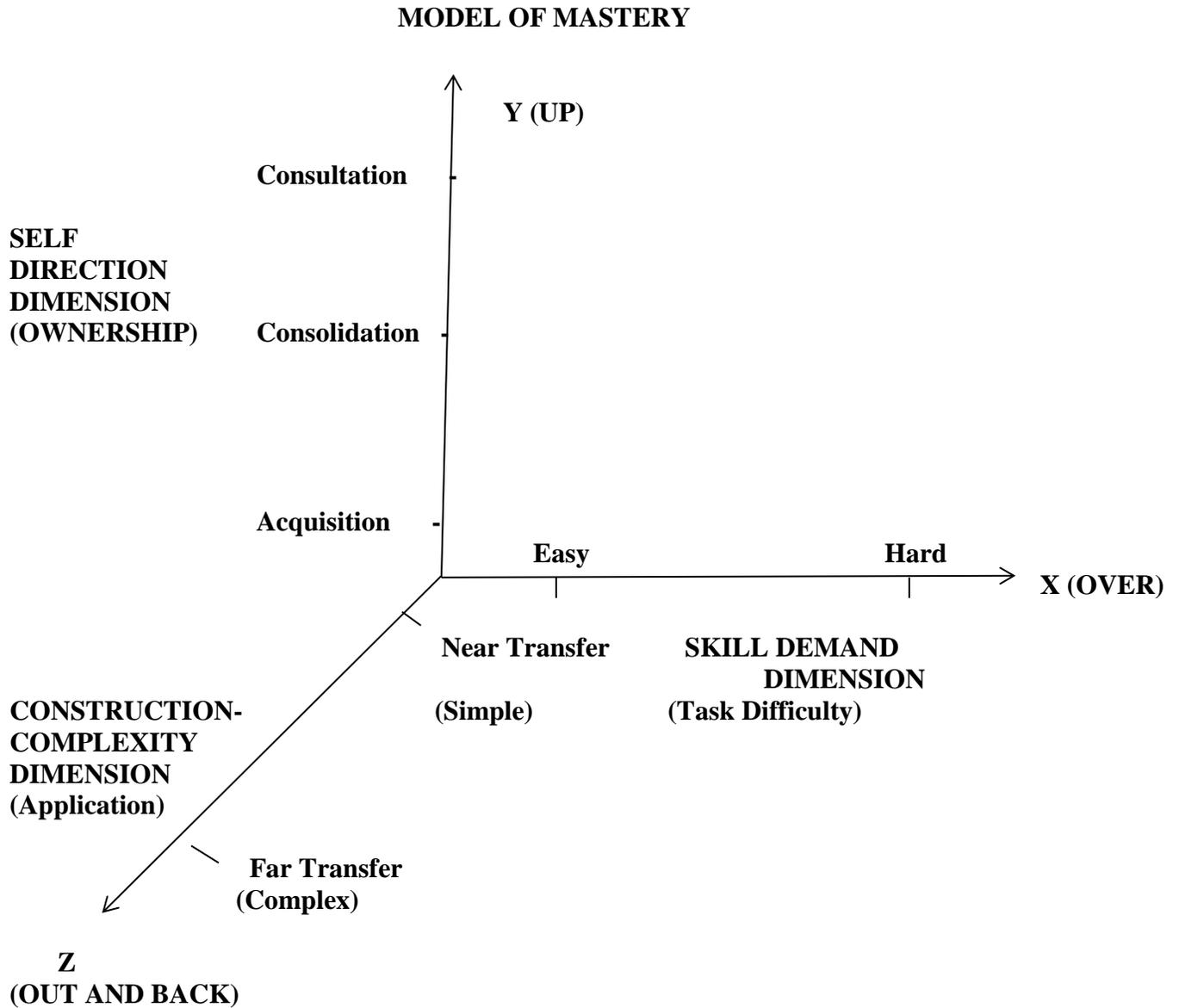
MODEL OF MASTERY

Figure 1. The Model of Mastery

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