I was awarded the Early Career Award from Division 29 and the American Psychological Foundation (APF) in 2012, and in this article, I provide an overview of my psychotherapy research career and insight gained along the way. Specifically, I will cover 3 main areas of my research: (a) psychotherapist effects, (b) multicultural processes in psychotherapy, and (c) romantic relationship interventions. First, although it is well known that some psychotherapists are better than others, the source of this expertise is not well understood. Across my studies, I have found notable variability in the ways that psychotherapists are able to effectively engage clients during sessions and this may be a key source of psychotherapist effectiveness. Next, I provide an overview of my studies examining clients’ perceptions of their psychotherapists’ multicultural orientation (MCO). For instance, across 9 studies, clients’ perceptions of their psychotherapists’ MCO accounted for 4% to 5% of the variance in clients’ psychological well-being and was strongly associated with clients’ alliance scores (weighted rs |.30| to |.64|). I also comment on the role of commitment in couple psychotherapy, by highlighting the importance of commitment uncertainty. Lastly, I provide some comments looking forward to potential themes in psychotherapy research and practice.

Keywords: therapist effects, process factors, common factors, multicultural orientation, romantic relationship

With much humility for those who have come before me and with much appreciation to those who have assisted me along this road, I was awarded the Early Career Award from Division 29 and the American Psychological Foundation (APF) in 2012. I have been dedicated to the study of processes and outcomes of psychotherapy and romantic relationships. Although there are likely many ways to compile the lessons from my work, I decided to take this opportunity to convey some perspectives on three themes that I believe are important to the field (or at a minimum, they are pretty interesting findings to me).

Theme #1: The Quest for Psychotherapist Effectiveness and Expertise

Over the next generation of research and practice, we will need to know more about how our research models fit for any specific therapist. Our research needs to help therapists do their job better, and to do so, we need to provide therapists a mix of information that combines empirically supported findings from the field with unique information based on their own performance and experience. Technology is enhancing our understanding of therapist effectiveness, and I hope we tailor feedback systems to individual therapists based on the unique dynamics in their practice. In the absence of doing so, we will likely continue having the discussion about the “research-practice” gap. Continuing along this frame, there are many aspects of the education process that are not well understood within our field. While we have a solid foundation of what therapy is, and in part how it works, there is less information about why therapy is great and why some therapists are better than others.

Previous research on psychotherapist effects has shown clearly that psychotherapists differ in their ability to effectively assist their clients achieve relief from their distress and make meaningful changes in their lives (accounting for approximately 5%–10% of the variance in client outcomes; see Baldwin & Imel, 2013 for review). These differences have sparked my interest to truly understand psychotherapy expertise. Understanding psychotherapists’ expertise has broad implications for training and education, defining empirically supported treatments, service delivery models, and quality of care standards. Accordingly, the next step is to identify those factors that are associated with psychotherapists’ effectiveness/expertise (or lack thereof). There are numerous potential psychotherapist factors that could meet these requirements; thus, a conceptual framework may be of assistance in the exploration of psychotherapist effects.1 There are three primary dimensions or criteria that will likely help distinguish among

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1 I will focus my attention on psychotherapist factors that are amenable to change (e.g., alliance ability) versus those that are more static (e.g., biological sex).
psychotherapist expertise factors: proximity, (in)common, and complexity.2

First, psychotherapist expertise should be evident in processes/outcomes that are more directly connected to the work during the therapy hour (vs. distally related), barring that these processes are at least moderately common and complex. Simply, psychotherapists’ expertise is likely to be most evident in clients’ immediate reactions to a session, such as the degree to which they are able to facilitate new insights or coping behaviors after a session for their clients. The more proximal therapeutic factors should highlight larger differences among psychotherapists as compared with distal factors, such as therapy outcomes or follow-up outcomes—as even the best psychotherapists are not immune to the overwhelming effects of social influences on their clients’ outcomes (e.g., losing a relationship or being victimized).

Second, psychotherapy processes that are either too common or uncommon will likely provide little information about psychotherapists’ expertise. For instance, if all psychotherapists set goals with their clients, then it would not make sense to consider the use of goal setting as a meaningful way to discern psychotherapist expertise. Similarly, there is limited utility to examine psychotherapist factors that are uncommon (e.g., paradoxical interventions), as rarely used interventions would likely not apply to most clinicians. However, there are a couple caveats to understanding (un)common processes in psychotherapy. First, the degree to which processes are common will vary according to therapeutic approach (e.g., the use of homework may be less common in humanistic forms of treatment). Simply, context is important to consider when examining psychotherapist expertise. Second, when we dismiss some uncommon processes, there is a chance to overlook those psychotherapists’ factors that are rare signs of expertise. Thus, the degree to which an uncommon process should be uncommon versus is uncommon will likely be a vital component of psychotherapist expertise.

Third, the complexity dimension reflects the degree to which psychotherapists differ on relatively simple processes/outcomes as compared with relatively more complex processes/outcomes. For example, the degree to which psychotherapists elicit deeper change in their clients’ life functioning (i.e., relatively complex) as compared with symptom distress (i.e., relatively simple) could be evidence for this dimension. Arguably, the complexity dimension might be a function of training level, as what is complex for a beginning level psychotherapist is likely not as difficult for the licensed psychologist. Accordingly, there is likely no gold standard of what is complex however, inherent in psychotherapist expertise is the ability to navigate complex processes across varying conditions and clients.

We have some initial evidence for this triparte psychotherapist effects model (see Figure 1). In regard to proximity dimension, we found that psychotherapists accounted for 18% to 23% of the variance in their clients’ intersession thoughts/actions (e.g., doing homework or applying therapeutic lessons between sessions) and session outcomes (e.g., reconciling oppositional thoughts or developing new insights; Owen, Hilsenroth, & Rodolfa, in press; Owen, Quirk, Hilsenroth, & Rodolfa, 2012; Owen, Reese, Quirk, & Rodolfa, 2013). Session outcomes are typically rated for the most recent session, and similarly intersession thoughts/actions reflect what occurred between sessions. These psychotherapist effects are nearly three to five times larger than variance that psychotherapists account for in their clients’ overall psychotherapy outcomes. Consequently, more immediate outcomes may provide a unique vantage point to understand psychotherapists’ effectiveness.

For the commonality dimension, we discovered a controversial finding in which clients’ perceptions of cultural disrespect or microaggressions from their psychotherapists occur infrequently, which also resulted in lower psychotherapist variability (i.e., <1%; the event is a low base-rate occurrence, and thus it is unlikely to find differences among psychotherapists; Owen, Imel, Tao, et al., 2011; Owen, Tao, & Rodolfa, 2010). In this case, microaggressions in psychotherapy are an uncommon experience and are not associated with particular psychotherapists. Accordingly, the mark of expertise is not likely found in clients’ perceptions of their psychotherapists’ microaggressive statements. Rather, this finding raises the important and humbling recognition that even more effective psychotherapists can commit microaggressions and offend their clients. Yet, it could be that psychotherapists with more expertise are able to better monitor the therapeutic alliance to repair these ruptures and continue to be aligned with clients (Owen, Reese, Quirk, et al., 2013).

For the complexity dimension, psychotherapists’ ability to form quality alliances and the use of techniques would reflect moderately complex factors. For instance, across six studies, psychotherapists accounted for 7.16% of variance in client-rated alliance3 (Owen & Hilsenroth, 2011; Owen, Hilsenroth, & Rodolfa, in press; Owen, Quirk, Hilsenroth, et al., 2012; Owen et al., 2010; Owen, Tao, Leach, & Rodolfa, 2011; Owen, Rhodes, Stanley, & Markman, 2011a; American Psychological Association, 2003; Owen, Tao, Drinane, & Foo-Kune, 2013; Imel, Baldwin, Atkins, Owen, Baardseth & Wampold, 2011). In two other studies, psychotherapists differed in the degree to which they used psychodynamic/interpersonal or cognitive/cognitive–behavioral techniques (psychotherapists accounted for 15.8% of the variance in their use of techniques; Owen & Hilsenroth, 2011; Owen, Hilsenroth, & Rodolfa, in press). Consequently, these findings highlight that

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1 I envision that there are other meaningful factors that could be proposed and I welcome the expansion.

2 Effects are weighted based on number of clients and therapists in the sample.
psychotherapists vary in core processes in psychotherapy, and that these differences may accent where true psychotherapist expertise rests (i.e., in their ability to engage their clients in purposeful and meaningful work). These studies also highlight the potential to better understand empirically supported treatments and relationships via the actual therapist who is conducting the session. How therapists go about facilitating the relational and technical aspects of treatment appears to vary, and thus it may make better sense to focus on a person (therapist) as compared with a variable (e.g., alliance) approach to research.

Although this tentative model of psychotherapist effects and the findings from these studies are meaningful as differences among psychotherapists may help define expertise. Yet, like all good tests, these psychotherapist factors should be able to be discriminated among test-takers. The age old question of what makes an excellent psychotherapist may be best found in a simple two-step process: (a) first identifying those factors that distinguish among psychotherapists (as stated above) and (b) then to determine whether those psychotherapist factors account for the differences among psychotherapists in their client outcomes. At this point, most of my work has focused on the first step of this equation, with a slight dabbling into the latter step. For instance, in two studies, we found that psychotherapists’ average alliance ability accounted for 50% to 99% of the variance in client outcomes that were attributed to the therapist (Owen, Rhoades, Stanley, et al., 2011a; Owen, Duncan, Reese, Anker, & Sparks, in press). However, therapists’ average multicultural competencies accounted for <1% of the variance in client outcomes that were attributed to the therapist (Owen, Leach, Wampold, & Rodolfa, 2011). Consequently, my research, hopefully, has developed a pattern or method of understanding psychotherapist effects and should provide an avenue for identifying meaningful aspects of expertise in psychotherapy.

### Theme #2: Multicultural Processes in Psychotherapy

For decades the multicultural competencies movement has proffered the need for psychotherapists to have the knowledge, skills, and awareness (tripart model) to treat clients from diverse backgrounds (American Psychological Association, 2003). Despite the call to do so, there has been little evidence suggesting that psychotherapists who are more multiculturally competent have better psychotherapy outcomes. There have been two general approaches to address multicultural dynamics in psychotherapy: culturally adapting treatments and examining psychotherapists’ multicultural competencies. My work has been focused on the latter, as I believe psychotherapists are ultimately responsible to be effective in their treatments with clients, regardless of their cultural heritage. Indeed, psychotherapists have been shown to elicit different outcomes with their White clients as compared with their racial/ethnic minority clients, suggesting that psychotherapists’ cultural competence is distinct from their general competence (Imel et al., 2011; Owen, Imel, Adelson, & Rodolfa, 2012; also see Owen, Wong, & Rodolfa, 2009).

Unpacking how culture influences the psychotherapy process is challenging. Table 1 provides an overview of nine studies that we have conducted examining clients’ perceptions of (a) microaggressions, (b) psychotherapists’ multicultural competencies, and (c) psychotherapists’ multicultural orientation (MCO). Microaggressions

<table>
<thead>
<tr>
<th>Study number</th>
<th>Measure</th>
<th>Sample size client/therapist</th>
<th>Alliance r</th>
<th>Outcome r</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Owen et al., 2010)</td>
<td>MAWS</td>
<td>121/37</td>
<td>-0.33</td>
<td>-0.22 (SOS-10)</td>
</tr>
<tr>
<td>2 (Owen, Imel, Tao, et al., 2011)</td>
<td>RMCS</td>
<td>232/29</td>
<td>-0.29</td>
<td>-0.18 (SOS-10)</td>
</tr>
<tr>
<td>3 (Owen, Tao et al., 2013)</td>
<td>RMCS-R</td>
<td>120/33</td>
<td>-0.28</td>
<td>—</td>
</tr>
<tr>
<td>Overall weighted fixed effects</td>
<td></td>
<td></td>
<td>-0.30</td>
<td>-0.19 (SOS-10)</td>
</tr>
<tr>
<td>4 (Owen, Tao, Leach, et al., 2011)</td>
<td>CCCI-R</td>
<td>176/33</td>
<td>.73/.65*</td>
<td>.30 (SOS-10)</td>
</tr>
<tr>
<td>5 (Owen, Leach, Wampold, et al., 2011)</td>
<td>CCCI</td>
<td>143/31</td>
<td>—</td>
<td>.31 (SOS-10)</td>
</tr>
<tr>
<td>6 (Hook et al., 2013)</td>
<td>CCCI-R</td>
<td>134/134</td>
<td>.60</td>
<td>—</td>
</tr>
<tr>
<td>7 (Drinane &amp; Owen, 2013)</td>
<td>CCCI-R-4</td>
<td>295/46</td>
<td>.44</td>
<td>.19 (SOS-10)</td>
</tr>
<tr>
<td>8 (Owen, Jordan, Turner, et al., 2013)</td>
<td>CCCI-R</td>
<td>45/45</td>
<td>.76</td>
<td>—</td>
</tr>
<tr>
<td>Overall weighted fixed effects</td>
<td></td>
<td></td>
<td>.60</td>
<td>.25 (SOS-10)</td>
</tr>
<tr>
<td>6 (Hook et al., 2013)</td>
<td>CH</td>
<td>472/472</td>
<td>.75</td>
<td>—</td>
</tr>
<tr>
<td>7 (Owen, Leach, Wampold, et al., 2011)</td>
<td>CH</td>
<td>134/134</td>
<td>.60</td>
<td>—</td>
</tr>
<tr>
<td>8 (Owen, Jordan, Turner, et al., 2013)</td>
<td>CH</td>
<td>120/120</td>
<td>.74</td>
<td>.59 (PEI)</td>
</tr>
<tr>
<td>9 (Owen, Rao, Drinane et al., Submitted for publication)</td>
<td>CH</td>
<td>45/45</td>
<td>.47</td>
<td>—</td>
</tr>
<tr>
<td>Overall weighted fixed effects</td>
<td></td>
<td></td>
<td>.57</td>
<td>.16/.52 (SOS-10/PEI)</td>
</tr>
</tbody>
</table>

**Note.** a = the second correlation represents the association between the CCCI-R = Cross Counseling Counseling Inventory-Revised (LaFromboise et al., 1991) and the Real Relationship; MAWS = Microaggressions against women scale (Owen, Tao et al., 2010); SOS-10 = Schwartz Outcome Scale-10 (Blais et al., 1999); RMCS = Racial Microaggression in Counseling Scale (Constantine, 2007); RMCS-R = Racial Microaggression in Counseling Scale-Revised; CH = Cultural Humility Scale (Hook et al., 2013); PEI = Patient Estimate of Improvement (Hatcher & Barends, 1996).
sions are subtle and ambiguous forms of cultural bias, including direct and indirect insults, slights, or discriminatory messages. We have examined clients’ perceptions of racial/ethnic microagressions as well as gender-based microaggressions. These insidious forms of discrimination can have a negative impact on clients’ outcomes and are unfortunately not addressed often in therapy (only 24% were addressed; Owen, Tao et al., 2013). Clearly, we need to do better at facilitating a culturally accepting environment in psychotherapy.

Indeed, when psychotherapists are attuned to their clients’ cultural heritage, psychotherapy processes and outcomes are enhanced. Most of the studies examining clients’ perceptions of their psychotherapists’ cultural competencies have relied on the Cross-Cultural Competencies Inventory—Revised (CCCI-R) (LaFramboise, Coleman, & Hernandez, 1991). This measure was based on the triparte model of multicultural competencies (MCCs) (i.e., knowledge, skills, and awareness). Additionally, the measure was altered from an external rater measure to a client report measure. This transition was a simple solution to a measurement problem that has plagued the MCC psychotherapy literature. However, a recent study has demonstrated that the cross counseling counseling inventory-revised (CCCI-R) as a client-rated measure is lacking on many fronts. For example, there is little content validity for 16 of the 20 items (Drinane & Owen, 2013). Accordingly, a return to theory and sound measurement is clearly needed for multicultural research to advance.

Multicultural competencies should serve as a foundation for treatment; although, how these competencies are expressed in psychotherapy may be slightly different. In 2011, we published a study examining what we called psychotherapists’ multicultural orientation (MCO) (Dr. Karen Tao astutely identified this term). Although this term is not new, it is notably different, from multicultural competencies. Specifically, we noted “… MCO can be considered a ‘way of being’ with the client,” whereas “… multicultural competencies can be viewed as a ‘way of doing’ or perhaps how well a therapist engages in and implements her or his multicultural awareness and knowledge while conducting therapy” (pp. 274–275; Owen, Tao, Leach, et al., 2011). Under the theoretical wind of MCO, I have been developing a better picture of the necessary (but likely not sufficient) factors present during psychotherapy. Figure 2 displays the MCO model, which consists of three (at least) interrelated parts: cultural humility, opportunities (and missed opportunities), and cultural comfort.

Cultural humility reflects the intra- and interpersonal spirit inherent in MCO, wherein psychotherapists maintain an other-oriented perspective that involves respect, lack of superiority, and attunement (Hook, Davis, Owen, Worthington, & Utsey, 2013). Cultural humility will likely relate to several aspects essential to the therapeutic relationship, namely, the therapeutic process being experienced as culturally validating and the therapist being viewed as “real” about their strengths and limitations as it relates to cultural topics. This construct has initial empirical support (see Table 1), and with adequate measurement established, I foresee a bright future for cultural humility in psychotherapy research.

Cultural opportunities and missed opportunities are also the second pillar of psychotherapists’ MCO. There are many opportunities during a psychotherapy hour to explore and integrate clients’ cultural heritage. Unfortunately, many of those opportunities are overlooked or avoided. For example, after a client describes how recent distress has shaken his or her belief in God, a psychotherapist may ask more about the client’s faith. Alternatively, a psychotherapist could inquire more about the level of distress and events leading up to the distress. There may be numerous things that interfere with using a cultural opportunities in session (e.g., clients’ distress, psychotherapists’ ability to engage in a conversation about clients’ culture). Additionally, clients likely vary in the degree to which they desire discussion of their cultural heritage. The cultural variant of opportunities and missed opportunities may be an important facet of psychotherapists’ way of being with their clients and an exciting avenue for future research.

The last pillar of psychotherapists’ MCO, cultural comfort, likely influences the probability that psychotherapists initiate cultural conversations (e.g., opportunities) as well as the overall quality of the discussion. That is, psychotherapists who are more culturally comfortable will likely elicit direct or indirect conversations regarding clients’ cultural heritage, resulting in a platform or an invitation for clients to explore their cultural identity and experiences in a positive therapeutic environment. Moreover, psychotherapists’ comfort may also enhance their own understanding of different cultural ways of being, which, in turn, may further increase their comfort and confidence in psychotherapy.

How MCO or MCCs differ from other related constructs, such as the alliance or empathy, are great questions with few answers. For instance, in many studies, the correlation between MCCs and alliance has been high ($r > .60$). Yet, two things may commonly co-occur (e.g., ice cream and drowning deaths) but still be distinct constructs (e.g., we define ice cream differently than we do drowning). In one study, we found that clients’ perceptions of their therapist’s MCCs were structurally distinct from clients’ rating of the alliance (Drinane & Owen, 2013). Thus, it appears clients perceive these elements as interrelated, yet they still occupy distinct conceptual space. Practically speaking, it would be difficult (although not impossible) to be rated high on multicultural competencies while being rated low on alliance quality. These facets of the therapeutic relationship should vary in the same direction; however, it is likely a mistake to confuse the two as being synonymous. At the end of the day, I hope for more psychotherapy research specifically examining cultural processes. There is still a long way to go (e.g., measures, longitudinal studies) for the multicultural psychotherapy literature. For instance, there are no known studies that correlated clients’ view of their therapists’ MCCs at Session 3 with therapy outcomes in a longitudinal model. This design is basic and foundational to process research. Yet, more
Theoretical clarity should engender advancements in our research, which ultimately can influence psychotherapy practice.

**Theme #3: Couples and Commitment in Psychotherapy**

Much of my research on couples’ interventions falls into the category of relationship education or psychoeducation groups (Owen, Antle, & Barbee, in press; Owen, Chapman, Quirk, et al., 2012; Owen, Manthos, & Quirk, 2013; Owen, Quirk, Inch, et al., 2012; Owen, Rhoades, Stanley, et al., 2011a; Owen & Rhoades, 2012). These interventions typically aim to prevent relational discord (vs. treat it), although there are many clients who attend these programs who are notably distressed. Throughout these studies as well as studies examining the nature of commitment in couple psychotherapy (e.g., Anker, Owen, Duncan, & Sparks, 2010; Owen, Duncan, Anker, & Sparks, 2012; Owen, Rhoades, Stanley, & Markman, 2011b; Owen & Quirk, in press), I have begun to wonder whether the standard protocol for couple therapy studies need to be revisited. In particular, we should describe couple outcomes as a function of the partners’ relationship goals (e.g., to work on improving the relationship or to clarify whether to continue the relationship). Wondering whether the relationship is viable is a relatively common goal in couple psychotherapy. But there is a problem with this as a goal for couple psychotherapy. However, ending a relationship can create an unique situation for couple psychotherapy researchers. Consider, for example, a couple seeks treatment in hopes of clarifying their commitment to the relationship and over the course of treatment they decide to end the relationship. What are we to make of such an outcome? Is this a treatment failure? The couple appeared to reach clarification. Clinically, this is likely a scenario most couple psychotherapists have faced and yet there is no systematic way of treating this dynamic in couple psychotherapy research.

In one study, we found that more than one third of couples had at least one partner who wanted to clarify whether the relationship should continue (Owen, Duncan, Anker, et al., 2012), and in a current couple psychotherapy trial, we have found >30% of partners were notably uncertain about their commitment to the relationship at intake. The potential impact of understanding and contextualizing couple psychotherapy outcomes via partners’ goals is not trivial. For instance, by defining couple therapy outcomes as relationship satisfaction, even those who would like to end their relationship could distort the effectiveness of couple therapy by up to 50%. Simply, understanding partners’ relationship goal can help contextualize the outcomes and provide a better picture of the type of outcomes from couple therapy (e.g., individual well-being may be a good outcome for everyone, even those who separate).

Beyond the practical application to couple psychotherapy studies, we need to have a better understanding of couple’s commitment (and uncertainty) on the process of psychotherapy (Owen, Rhoades, Stanley, Shuck, & Fincham, 2013). Many treatment guidelines for couple psychotherapy assume that couples would like to improve their relationship and have useful methods and theoretical models to enhance couples’ relationships. Yet, we know little about how to navigate the commitment issues so many couples bring to therapy. In my humble opinion, the concept of commitment uncertainty, or partners’ wavering sense of couple identity and long-term vision of the relationship, is clinically relevant. For example, in our preliminary data, we found that partners’ commitment uncertainty was a better predictor of therapy outcomes than other baseline predictors (e.g., communication, relationship satisfaction).

We have decades of research suggesting that commitment is foundational to relationship health and stability. Yet, how as therapists do we help partners navigate those times when partners question what the future entails, feel uncertain about their desired identity as a couple, consider alternative partners, and yet still have moments where they feel devoted to their partner? How do we conceptualize the nature of uncertainty? In my viewpoint, commitment uncertainty may relate to other attachment or personality facets (e.g., avoidant attachment; Quirk, Owen, Shuck, & Fincham, 2013); however, it is likely unique from these aspects and reflects a state-like process that is relationship/time specific. In the psychotherapy room, these are the times where couples challenge the stability of the relationship with comments such as “well, maybe if you don’t like this, I should just leave.” How therapists are able to contain the uncertainty is likely one step to ensuring a positive safe working relationship for both partners. Additionally, therapists likely need to help bring clarity and counter the mutual avoidance about the foundational aspects of the relationship that have been shaken, such as what is tearing away at the couple identity (Luebcke, Owen, Keller, Shuck, & Rhoades, 2013).

Ultimately, commitment uncertainty will likely be a promising conceptual framework for couple therapy when working with couples who struggle with the decision to continue their relationship. Moving forward, I hope to see new treatment guidelines for addressing couples with high levels of commitment uncertainty. Moreover, as a field, we need to have clear guidelines for reporting outcomes for couple therapy studies. In particular, we should have a better sense of couples’ goals for their relationship as it relates to outcome. Also, we should examine and report, when possible, individual and couple outcomes to fully capture the complexity of couple therapy.

**The Next Steps?**

My career focus thus far has been a combination of directed energy toward areas listed above, coupled with a constant influence of new information. I find my research agenda adding to an ongoing conversation with other scholars, practitioners, and the public. As such, I will continue to follow and add to this conversation as it unfolds naturally with new innovations and the ever changing sociopolitical landscape. Thus, I will keep addressing the questions that move our collective thinking forward. Given this position, I will take this unique opportunity to comment briefly about some topics in psychotherapy research that I believe will be important for the conversation in psychotherapy research and practice.

**The Role of Big Data and Fancy Pants Statistics**

With the use of technology, it is becoming increasingly easier to gather big data sets, with tens to hundreds of thousands of clients. As a self-identified statistical geek, this gets me really excited about the potential questions that can be addressed with big data. The advances in statistical methods and the technology to conduct
these analyses are becoming more commonplace. At the same time, I worry that this movement may come at a cost if we are not careful. Here are two sources of my concern, which may be unfounded, but I doubt it.

First, the research–practice gap is likely to widen (vs. shrink) if we are not able to better translate our findings from advanced statistical procedures into real-world practical implications for psychotherapists. This is not a new idea, but I believe that it might become more pressing, as many articles published in our main-stream journals use these advance methods. There is clearly a two-way street here with psychotherapists enhancing their understanding of these methods and with researchers developing the art of translating complex analyses to therapeutic activities. I am not sure I have perfected this art yet, but more attention is needed from our field as we train researchers to ensure that this accomplished, such as developing specific translational trainings for researchers, and vetting findings with practice groups.

My second concern is that psychotherapy data collection can be a messy business. Anyone who has conducted a psychotherapy study can attest that the best laid plans do not always come to fruition. Although this is not unique to psychotherapy data, I see additional complications when collecting data in naturalistic settings. In fact, my experience tells me that there might be other issues that can truly complicate big data. My suggestion would be to develop new reporting standards that ensure the fidelity of big data such as requirements for qualifying a case as completed and random responding checks. These issues will hopefully help guide naturalistic data collection in a way that can give the practitioners and the public more confidence ala other reporting guidelines (e.g., STROBE, CONSORT, TREND).

Psychotherapist Expertise

Moving forward, I see the quest for therapist expertise unfolding in two main ways. First, psychotherapists are likely to receive more requests for accountability, and tracking outcomes with all of their clients is likely to be part of this process. What outcomes to track and how best to track outcomes will likely need more attention, but the variety of brief measures and technology assist therapists in this process. With accountability also comes the opportunity to use the information for self-reflection and hopefully identify areas of expertise. Accordingly, psychotherapists can use basic and simple assessment processes to better understand their ability and ultimately help facilitate professional development.

Second, I hope that as a field, we (re)consider the role of psychotherapists in the process of psychotherapy. Getting more specific regarding what psychotherapy processes are foundational (common to most psychotherapists), interactive (grounded in the unique client-therapist relationship), or highlight psychotherapists’ expertise (actions associated with psychotherapists who have better outcomes) will be useful in defining what is truly psychotherapist expertise. Moving from a variable-centered approach (e.g., treatments, processes) to a person-centered approach (which client or which therapist) likely engender more interest in closing the research–practice gap. For example, consider the following questions: (a) what treatment is most effective for depressive conditions or is alliance associated with therapy outcomes? These questions reflect a variable-focused approach, where we care most about the treatment or relational mechanism. Following this logic would assume that all therapists are open to learn the magical ways to conduct therapy (assuming this one way of conducting therapy is advantageous) or that all therapists can or should navigate the alliance in the same manner. However, we know that even given high levels of training, psychotherapists differ widely over the course of therapy in their approach to treatment with any given client (Imel et al., 2012; Owen & Hilsenroth, 2013). In contrast, I think we should be considering the following questions: what therapists do best using cognitive-behavioral treatment (CBT) for the treatment of depression or which therapists are best able to form high quality alliances and use this as meaningful change mechanism? These questions are likely much more interesting and realistic for the dissemination and implementation process.

Understanding Complex Interactions

Over several different domains, I believe that researchers will need to do a better job at examining the complex interactions that typify psychotherapy. There are several areas in which we (including myself) tend to ignore the complexity faced by psychotherapists on a daily basis. For example, in many multicultural studies, we assume or imply the importance of clients’ cultural identity. That is, we might assume, for a client who identifies as an Asian American female, that her racial/ethnic identity is salient to the process of therapy, and potentially more so than her gender identity (or other cultural identities not assessed/disclosed). While this might well be the case, I believe there are ways to better capture the intersectionality of multiple identities in our cultural process psychotherapy research, such as assessing clients’ cultural identities via open-ended questions and assessing the saliency of these identities (Hook, et al, 2013; Owen, Jordan, Turner, et al., 2013). Consequently, it is an imperative that our research embodies the complex interrelated identities.

Additionally, I believe we need to do a better job fully capturing the complex interactions between facets that are typically thought to be more relational (e.g., alliance, empathy) and the more technique (e.g., challenges, interpretations)-related aspects of therapy (e.g., Owen & Hilsenroth, 2011; Owen, Hilsenroth, & Rodolfa, in press). At times, we report on these facets as if they are stand-alone processes, where a psychotherapist could do “the alliance” or “techniques.” Rather, the complexity likely lies within the therapeutic dyadic relationship, wherein the nuance of techniques and relational components are cocreated and likely interact for the betterment of clients’ well-being. Thus, being able to capture the unique aspects of the dyadic experience in session, coupled with the variations found over the course treatment could advance our understanding of how best to approach interventions. To this end, in-session activity has typically been difficult barrier to codify in process research; yet, with advances in technology, I hope that new strategies will advance our ability to address these dynamics.

In conclusion, my initial journey as a psychotherapy researcher, educator, and psychotherapist has been highly rewarding. I continue to be vastly interested in several aspects of the psychotherapy world and hopefully focus (or lack thereof) will never leave me bored or stagnated. I am truly honored to have been selected as the Early Career Psychologist for Division 29 and hope this overview of my work has inspired some new conversations about relationships and psychotherapy.
References


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