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The Lake Wobegon Effect in China: An Examination of Self-Estimate Bias Among Chinese Psychotherapists

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The Lake Wobegon effect, characterized by individuals' tendency to overestimate their abilities, is a widely recognized phenomenon across various domains of human performance. This study examined the extent to which Chinese psychotherapists (N = 223), a group culturally influenced by the value of modesty, would demonstrate that effect. It also examined in a subsample the association between that effect and clinical experience (N = 63) as well as the justifications these therapists gave for the self-assessments of effectiveness that they had provided (N = 66). Participants rated themselves as above average, with the mean percentile rank of 71.4 (SD = 14.14; Mdn = 73), which is generally similar to results obtained in studies of Western therapists. Therapist experience level was not related to self-ratings of effectiveness. The evidence therapists reported using to arrive at their self-assessments primarily consisted of feedback they had received from others (44.7% of respondents) and their observations of clients' responsiveness to treatment (40.4%). Possible implications of these findings to the field are discussed.

Clinical Impact Statement

This study's finding that Chinese therapists, culturally inclined toward modesty, share their Western counterparts' tendency to overestimate their effectiveness compared to their peers has implications for their willingness to engage in continuing professional development.

Keywords: self-assessment bias, Lake Wobegon effect, therapist self-estimates of competence

For decades, U.S. radio host Garrison Keillor ended weekly stories about his fictious hometown with "That's the news from Lake Wobegon, where all the women are strong, all the men are good-looking, and all the children are above average." This became such a part of American popular culture that it was likely inevitable that psychologists would begin referring to people's tendency to overestimate their abilities as the "Lake Wobegon effect" (see, e.g., Kruger, 1999). That effect is evident in many domains of human performance. For instance, despite being statistically impossible, more than three quarters of drivers see themselves as "above average" (Svenson, 1981). In a now-classic study, 90% of college faculty rated their teaching ability similarly, with fully two thirds ranking themselves in the top quartile (Cross, 1977). Finally, Isaacs (2022) reported that feedback to below average advanced trainees at the Royal College of Pediatrics and Child Health had to be modified because they found it too upsetting. As Alicke and Govorun (2005) wryly observed, "most people are average, but few believe it" (p. 85).

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The tendency to overestimate one's abilities applies to psychotherapists as well. Walfish et al. (2012) found that their sample of U.S. mental health providers rated their overall clinical skills and performance at the 80th percentile relative to others in the same discipline. *None* of the 129 practitioners ranked their skills and abilities below the 50th percentile, and nearly a quarter placed themselves at the 90th or higher. Two later studies, both with samples of U.K. psychotherapists, obtained similar results. When Parker and Waller (2015) asked therapists to rate their effectiveness with (a) a general population of clients and (b) anxious clients, they rated themselves at the 65.7 and 66.9 percentiles, respectively. In the other study, Chow et al.'s (2015) sample of therapists rated their average performance at the 71st percentile. As with the Walfish et al. (2012) study, no practitioner ranked their outcomes "at or below average"—this despite the fact that all routinely tracked their effectiveness using standardized outcome measures. Moreover, Chow et al. (2015) found no statistically significant differences between the self-ratings of highly effective therapists (determined by their obtained client outcomes) and therapists with average client outcomes.

Probst et al.'s (2022) study employed a slight variant of the question asked of respondents in the previous studies. Rather than asking about overall clinical effectiveness, Austrian psychologists were asked to rate the quality of their therapeutic relationships. But even with this variant in how the question of effectiveness was framed to the respondents, the results ($M = 79.1$) were similar to those of Walfish et al. (2012), Chow et al. (2015), and Parker and Waller (2015).

Despite these consistent findings, the study samples to date all have been drawn from Western countries. Whether such findings would hold among practitioners from cultures with different values is, therefore, an open question. As an example, consider China. In contrast to the United States and much of Europe, where individualism is dominant, modesty is a highly valued cultural norm (Kulkofsky & Wang, 2006). Children grow up with sayings like 木秀于林,风必摧之 (*The tree that grows tallest in the forest will always be first to be toppled by the winds*) or 出头的椽子先烂 (*the rafters that jut out rot first*).

Given the ubiquity of such messages, it is possible Chinese therapists might differ in their response to questions about how effective they are compared to their peers. Because no research has investigated the presence of the Lake Wobegon effect (also referred to as the "better-than-average" effect; Zell et al., 2020) among Asian therapists, it is useful to consider studies that have examined self-estimates in other skill domains. Wu (2018) had Chinese and American college students rate themselves on a range of skills (e.g., "How difficult is it to tell jokes that make people laugh?" and "How difficult is it to actually save the amount of money you planned to save?") and concluded that the Lake Wobegon effect was not universal, but instead tied to culture. Yet, Zell et al. (2020) reached a different conclusion from their comprehensive review and meta-analysis of self-assessment bias. They found that "although the BTAE [i.e., better-than-average-effect] varied by culture, it was generally robust in both European Americans and East Asians, which supports the position that self-enhancement is universal" (p. 132).

To determine the cross-cultural applicability of self-assessment bias findings, we replicated the studies by Walfish et al. (2012), Chow et al. (2015), and Parker and Waller (2015) with a sample of Chinese mental health practitioners. Specifically, we examined whether Chinese therapists exhibit a better-than-average effect when asked to compare their effectiveness with that of peers. In addition, we asked two questions intended to expand our understanding of therapist self-assessments of effectiveness. The first concerned whether the level of therapist experience might moderate the self-ratings. The second concerned the types of evidence that therapists used to arrive at their self-assessment of effectiveness.

Level of Experience as a Moderator of Self-Assessments

> With over 20 years of clinical experience, I have honed my skills in helping individuals overcome various mental health challenges

> My extensive background and expertise allow me to provide effective therapeutic interventions tailored to each client's unique needs

These fictitious quotes exemplify statements commonly found on therapists' business websites. They suggest that greater experience means greater therapeutic effectiveness. Yet, the data do not support that relationship. In fact, a large study by Goldberg, Rousmaniere, et al. (2016) found

that therapist effectiveness not only did not improve with time and greater experience but decreased. Germer et al. (2022) later replicated Goldberg, Rousmaniere, et al. (2016) with a cross-cultural sample, where they found "no association between therapists' experience and outcome" (p. 745).

Nevertheless, therapists do believe that they continue to improve with experience (Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2012), as illustrated by those sample website statements above. What remains underexplored is whether that belief is reflected in how therapists self-assess their effectiveness. For example, if therapists believe that they are getting better, but also believe that their peers are simultaneously doing so as well, would they retain a relatively constant sense of their rank within that peer group across time?

Neither Walfish et al. (2012), Chow et al. (2015), nor Probst et al. (2022) examined this question. But Parker and Waller (2015) found that the length of time therapists had been qualified for practice was correlated with self-ratings of skills at statistically significant, albeit modest, levels (*r*s of .26 and .27). We investigated whether this association held true for Chinese therapists as well.

Evidence Used in Arriving at the Self-Assessment

The small literature cited above consistently demonstrates that therapists overestimate their effectiveness in relationship to that of their colleagues. A reasonable follow-up question would concern the reasons therapists give for having made their self-assessments. To have that information could be useful to the field in determining ways to help therapists become more accurate. Park et al. (2016) noted that "humans are surprisingly good at explaining their decisions, even though their explanations do not necessarily align with their initial reasoning" (p. 1). The reasons therapists might give to support self-assessments may incompletely represent what actually informed their decision. But even if that is the case, it will suggest what they believe to be important. To explore that, this study asked respondents to identify the factors that had informed their decision.

In short, the purpose of this study was to examine three research questions. The main question was whether Chinese therapists, whose culture prioritizes modesty in social interactions, would exhibit self-assessment bias. As well, we examined (a) whether therapist self-assessment bias is associated with years of clinical experience and (b) what types of information these therapists reported using to determine their self-estimates of effectiveness.

Method

Participants

Participants were 223 Chinese mental health professionals (counselors or therapists; psychiatrists) from the most recent five cohorts enrolled in a 2-year supervision training program conducted for the Clinical and Counseling Psychology Registration System (CCPRS) of the Chinese Psychological Society (see Goodyear et al., 2023). The data were gathered as part of a precourse survey, collected anonymously, for use in class rather than for research. Therefore, limited demographic information is available on the participants. The larger population of trainees from which the samples were drawn was comprised of 656 trainees in 12 cohorts across 6 years. Most ($N = 531$; 81%) were female; 125 (19%) were male. They reported a mean of 14.39 years of clinical experience ($SD = 1.59$). Most were certified by the CCPRS either as therapists ($N = 471$; 74.05%) or as assistant therapists ($N = 14$; 2.20%).

Participant Subsample

Specific only to the second and third research questions: Additional information was sought from the two most recent training cohorts, including years of clinical experience ($N = 63$) and the reasons offered for their self-ratings of effectiveness ($N = 66$). Data also were gathered about theoretical orientation from this subset of participants. The top two were as follows: (a) psychoanalytic/psychodynamic ($N = 41$; 39.4%) and (b) "I combine two or more" ($N = 37$; 35.6%). The remaining endorsed cognitive behavior therapy ($N = 10$; 9.6%), family systems ($N = 9$; 8.7%), person-centered ($N = 3$; 2.9%), gestalt ($N = 1$; 1.0%), and other ($N = 1$; 1.0%).

Measures

There were no questions that would permit identification of the respondents. The 10 items, which were intended to be used in teaching the

class, were in both English and Chinese. Examples included the following: "Which of the following theoretical orientations most closely describe your own?" "In the time since [the first class], how many supervisees have you had?" "As you have worked with these supervisees, what issues have come up that would be important for us to address in our class?" "What, if anything, needs to be made clearer?"

The Question Asked of All Participants

Of those 10 items, this was the one to which all participants responded:

Self-Estimates of Competence.

Compared to the typical therapist at your level of experience, where would you rate your yourself in terms of overall effectiveness? Use the slider below to indicate where you are in terms of percentiles. So, for example, if you believe you are equal to or better than 11 percent of all therapists, you would pull the slider to 11; if you believed you were equal to or better than 88 percent of all therapists, you would pull the slider to 88; and so on.

与你相同经验水平的典型咨询师相比,你会如何评价自己的整体咨询效果? 使用下面的滑块以百分数表示您所处的位置。 例如,如果你认为你比11%的咨询师更好,你会把滑块拉到11; 如果你认为你比88%的咨询师更优秀,你会把滑块拉到88,以此类推。

The Two Questions Asked of the Subsample

Two additional questions were asked of the smaller subset of participants whose data were used to (a) examine the possible relationship between years of clinical experience and self-estimate bias and (b) examine the reasons participants reported for deciding on their level of effectiveness. Those questions were as follows.

Years of Experience Providing Counseling Services.

How many years have you been: Providing counseling services to clients?

你从业多少年: 向当事人提供心理咨询服务的年限

Reasons for Self-Estimates.

On the previous (web) page, you provided an estimate of your overall effectiveness as a counselor. When you made that rating of your effectiveness, what were the things you were thinking of that helped you decide how effective you are compared to other therapists?

在上一页,你提供了你作为咨询师的整体效果的评估。当你对自己的治疗效果进行评估时,你认为有哪些因素能够帮助你判断自己与其他治疗师的治疗效果差异?

Procedure

Goodyear et al. (2023) have described the training program, which is to prepare Chinese psychologists and psychiatrists to offer competency-based clinical supervision. The program spans nearly 2 years and includes two 30-hr classes. These classes typically have been delivered in-person over 5 days (although virtual training was offered during the COVID-19 pandemic). Additionally, supervision of the participants' supervision is offered after each class.

Approximately 2 weeks before the start of the second of those two classes, students are asked to complete an anonymous survey designed to learn about their supervision experiences (e.g., "In the time since [the first class], how many supervisees have you had?") and to determine issues they would like addressed in class (e.g., "As you have worked with these supervisees, what issues have come up that would be important for us to address in our class?" "What, if anything, needs to be made clearer?"). Data were collected using the Qualtrics survey platform.

The self-estimate of effectiveness originally was included in the survey for use in a specific class meeting focused on the fallibility of clinical judgment regarding level of competence and, therefore, the need for supervisors to view video recordings of supervisees' work and use routine outcome monitoring. In the most recent two cohorts, the questions regarding years of experience and reasons for self-estimates had been added to enrich class discussion. Typically, students are given one reminder message to complete the survey. Across the 12 cohorts, roughly two thirds of the students have responded.

Because there was no intention to publish these anonymous data at the time they were collected, participants had not been informed that their responses would be used for research. Once the decision was made to do that, a formal proposal was submitted to the Institutional Review Board of the University of Redlands. That Board approved our use of the data for this study.

Qualitative Data Analysis

Respondents' open-ended responses to the question of what evidence they had used to determine their level of effectiveness were analyzed thematically using steps described by Braun and Clarke (2006). Sixty-two respondents from the

two most recent cohorts provided responses. Most respondents provided at least two reasons, with some offering as many as five. This resulted in 112 coded responses.

An Excel sheet was created with the original answers in Chinese and English (using the translation function in Microsoft Word). One of the English-speaking members of the writing team (a) created categories of reasons as each of the English-translated responses were coded and then (b) created supraordinate categories into which the categories were clustered. The two Mandarin-speaking team members then returned to the original Chinese-language responses to independently code the responses and disagreed on 10 (8.9%). They then met to resolve differences through discussion. This also resulted in the merging of three of the original categories into other categories.

Results

Evidence of Self-Assessment Bias

The first question concerned whether Chinese psychotherapists would demonstrate self-estimate bias when comparing their effectiveness to that of their peers, using percentile ranks. If the respondents were accurate in their self-assessments, then the expected mean would be at the 50th percentile. A positive bias would be evident if the group mean exceeded the expected mean.

In this case, the mean percentile rank that the participants assigned themselves was 71.4 ($SD = 14.14$; $Mdn = 73$). The modal percentile rank was 80. Ninety-six percent of respondents placed themselves at or above the 50th percentile. Table 1 provides more specific information about the distribution.

Table 1
Chinese Psychotherapists' Self-Estimate Bias When Comparing Their Effectiveness to That of Their Peers, Using Percentile Ranks

Rated themselves at or above the	%	*n*
90th percentile	5.8	13
80th–89th percentile	32.7	73
70th–79th percentile	30.4	68
60th–69th percentile	16.5	37
50th–59th percentile	10.3	23
>50th percentile	4.0	9

Relationship Between Levels of Clinical Experience and Self-Ratings

With respect to the question of whether the amount of clinical experience would moderate the self-estimates of effectiveness, the results were statistically nonsignificant: $r(61) = .15$, $p = .248$.

Evidence Respondents Reported Having Used to Determine Effectiveness Levels

Table 2 reports the results of the thematic analyses of participants' responses to the open-ended question of how they determined their levels of effectiveness. The 14 categories are treated as subcategories under four supraordinate categories.

Two categories encompassed most of the responses. The larger of these (44.7% of the total responses) concerned feedback respondents had received from others who would be able to observe their work (clients, peers, or supervisors) or the effect of that work (clients' significant others). The next largest category concerned respondents' perceptions of clients' responsiveness to treatment (40.4% of the responses). This included client outcomes, quality of therapy relationships, dropout and retention rates, and length of treatment.

Two categories accounted for the remaining 15.1% of the responses. One 7.9% concerned therapists' experience levels, perceptions of their clinical acumen, and their self-efficacy. The remaining category (7.0) concerned the quality and extent of professional training.

Discussion

It is well-established that therapists in Western countries tend to overestimate their effectiveness in comparison to their peers (Chow et al., 2015; Parker & Waller, 2015; Probst et al., 2022; Walfish et al., 2012). This study examined whether therapists from a culture that values modesty would also exhibit self-assessment bias. Its findings suggest they did. We had no Western comparison group, and so we were unable to directly assess the relative magnitude of self-assessment bias of these Chinese therapists versus that of their Western colleagues. The data in Table 3 do suggest, though, substantial similarity between the percentile ranks that Chinese therapists in this study assigned themselves and those of Western therapists in prior studies.

Table 2
Evidence Therapists Reported Using to Determine Their Levels of Effectiveness

Type of evidence	Example (direct quotes translated from Chinese)	Proportion
Feedback from others		**44.7**
Clients (informal)	(1) Subjective feedback of the client; (2) the feelings and evaluations of the client	21.1
Supervisors	(1) Feedback given to me by my supervisor; (2) feedback from the supervisor	9.6
Peers	(1) Peer feedback; (2) communication and feelings in group supervision	6.1
Clients (measured)	(1) Client feedback, scales; (2) the feedback of visits	5.3
Client's significant others	(1) Feedback from family members of clients; (2) the feelings and evaluations of the client and the important others around him	2.6
Clients' responsiveness to treatment		**40.4**
Observed client outcomes	(1) Therapeutic effects on the client; (2) restoration of the client's mental functioning	19.3
Quality of the therapist–client relationship	(1) Counseling relationship; (2) the depth of the connection with the client	15.2
Clients' regular attendance/stability	(1) Whether the client visits regularly and steadily; (2) case continuity	3.6
Dropout rates	(1) Dropout rates; (2) dropout rates	1.8
Length of treatment	(1) Length of consultation	0.8
Therapist experience and confidence in their skill		**7.9**
Counselor self-efficacy	(1) The counselor's own … self-comfortable state; (2) self-efficacy	3.5
Clinical acumen	(1) Understanding of the case; (2) keen insight	2.6
Amount of clinical experience	(1) Years of employment; (2) personal experience accumulated in the past 20 years	1.8
Therapist training		**7.0**
The quality and extent of professional training	(1) Continuing education; (2) the professionalism of the training	7.0

Note. Values in bold denote the overall category.

People with higher levels of trait humility show less self-assessment bias (Teo et al., 2023). That privately held stance, though, is different than culturally informed, public expressions of humility. Therefore, whereas Chinese therapists may demonstrate more modesty when discussing their effectiveness in a public forum than would their Western counterparts, these results suggest that privately, they, too, estimate themselves to be above average.

These findings, together with similar findings with Western therapists, support Zell et al.'s (2020) conclusion of universal self-estimate bias. However, this bias applies at the group level. Within a particular group, (a) some therapists will be reasonably accurate in their self-assessments and (b) the magnitude and direction of self-assessment bias will vary by subgroup. For example, a highly replicated finding in social psychology is that people who are the *least* competent in a domain are the ones who *most* overestimate their competence (Dunning, 2011). On the other hand, "top performers … tend to underestimate their percentile rank relative to the people with whom they compare themselves" (Carter & Dunning, 2008, p. 85).

This tendency for top performers to underestimate their competence has been documented among psychotherapists as well. For example, the most effective therapists tend to be more self-critical and report making more mistakes (Najavits & Strupp, 1994), have higher levels of self-doubt (Nissen-Lie et al., 2013), and often are surprised to receive positive client feedback (Chow et al., 2015). In short, although self-estimate bias may be a universal phenomenon, important individual differences exist.

This study also found that participants' clinical experience was unrelated to their self-estimated levels of competence. This differs from Parker and Waller's (2015) findings. But despite their findings of statistical significance, the actual

Table 3
Descriptive Information for Extant Studies of Therapist Self-Estimates of Effectiveness Compared to That of Their Peers

Study	*M* Percentile rank	*SD*	*N*
Walfish et al. (2012)	80.6	9.1	129
Probst et al. (2022)[a]	79.1	14.3	229
Chow et al. (2015)	70.9	17.4	16
Present study	71.4	14.1	223
Parker and Waller (2015): General client population	65.7	14.3	195
Parker and Waller (2015): Anxious clients	66.9	15.3	195

Note. This proportion is of the total number of reasons ($N = 112$) across 62 respondents.
[a] Probst et al. (2022) addressed the perceived quality of therapy sessions rather than overall clinical effectiveness.

correlations in Parker and Waller's study between experience and self-assessments were quite modest, accounting for 6% and 7%, respectively, of the outcome variance. Therefore, until more evidence becomes available, it is reasonable to hypothesize that even though therapists believe they are getting better with experience (Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2012), they also are assuming the same of their peer group. To the extent this is true, their rating of absolute standing against that reference group would remain relatively constant across time.

The evidence respondents reported that they used to decide how to self-assess their effectiveness against their peers was comprised primarily of (a) what others had told them (i.e., the feedback they had received from various sources) and (b) what they observed in their work with clients (in terms of relationship quality, outcomes, dropout rates, and so on). But it is difficult to study thinking processes as they cannot be directly observed (K. A. Ericsson, 2017). Therefore, we cannot be sure that the respondents actually were taking these factors into account when they made their self-assessments (see Nisbett & Wilson, 1977).

A reasonable hypothesis is that respondents rated themselves intuitively and then provided post hoc rationalizations. Some of what they report (e.g., levels and type of training) have no known link to therapeutic effectiveness. But some evidence that they report attending to (e.g., formal feedback from clients) *can* provide a pretty good estimate of whether the therapist is being effective.

Even if our participants had accurate information about their own performance, they had no information about the performance of the other therapists against whom they were comparing themselves. This inability to benchmark may be a major factor in therapists' tendency to overestimate effectiveness. In fact, Moore and Cain (2007) found that one reason people overestimate their performance is that they have more evidence about their own performance than they do about that of others.

Practice Implications

Our discussion of practice implications is based on two premises. The first is that self-estimate bias contributes to observed ceiling effects in psychotherapy effectiveness; the second, which draws from the social psychology literature (e.g., Kruger & Dunning, 1999), is that it is possible for therapists to become more accurate in their self-appraisals. Psychotherapy is very effective (Wampold & Imel, 2015). But as both Miller et al. (2018) and Rousmaniere et al. (2017) have observed, its effectiveness has remained unchanged across time, despite the proliferation of new models promising better results. Moreover, therapists as a group tend to plateau in their effectiveness relatively early in their careers and then not to improve (Germer et al., 2022; Goldberg, Rousmaniere, et al., 2016). In fact, there is evidence that the typical therapist may become *less* effective with experience (Goldberg, Rousmaniere, et al., 2016).

If psychotherapy is to become more effective on average, therapists need to become more effective across time and that likely will require focusing on one therapist at a time to improve performance (Miller et al., 2016). The good news is that this is possible (see Goldberg, Babins-Wagner, et al., 2016) if the individual therapist realizes that there is room for improvement and

then engages in the hard work necessary to improve.

Two circumstances conspire to reduce the likelihood that therapists will do this. The first is that therapists continue to believe they are improving as they gain experience (Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2012), despite the evidence to the contrary (see, e.g., Tracey et al., 2024). The second is that they tend to believe they already are "above average," which has been the focus of this article.

What We Can Do as a Field

When therapists compare their effectiveness to that of their peers, they are creating an internal norm group, using idiosyncratic criteria, and applying those criteria in self-serving ways. Therapist effectiveness is a complex concept, which contributes to people's self-serving assessments of themselves (Dunning et al., 1989).

The field has a varied understanding of how to determine therapist expertise (e.g., Hill et al., 2017), leading to a somewhat unclear definition of effectiveness. It may be then that a first step is to clearly operationalize what "effectiveness" means and then ensure that therapists have a means to assess that. Notably, two of the three sources of evidence participants reported using to determine levels of effectiveness (Table 2) can be operationalized, with established measures (i.e., observed client outcomes and quality of the therapist–client relationship), which is consistent with arguments that Miller et al. (2016), Tracey et al. (2014), and others have made.

A key step would be for therapists to routinely use one of those measures in their clinical practices. Indeed, Muir et al. (2019) have made the case that it may be unethical *not* to do so. Therapists need information about how they are performing.

It is likely, though, that this is necessary but insufficient. Chow et al. (2015) found, for example, that although therapists in their study were using client feedback measures, their self-estimate of effectiveness compared to peers was similar to that of therapists in other studies, including this one. To counteract self-estimate bias requires that therapists also have the opportunity to compare data about their own performance with that of therapists who are using the same instruments with similar client populations. For example, Okiishi et al. (2003) collected agency-wide data on therapists that enabled them to assess the relative effectiveness of each therapist in that agency. What if that sort of data were routinely available to therapists so that they had the opportunity to monitor their typical clinical results in relationship to those of their colleagues? Better yet, what if those sorts of comparative data were available and the clinician who also then had the opportunity to consider that they were learning within the context of a supportive consultative or supervisory relationship?

Until we are prepared as a field to provide therapists with those opportunities, it is likely that they will continue to overestimate their effectiveness in relationship to their peers. As the data from this study suggests, this will be true regardless of the therapists' country or culture.

Because this was the first study to examine whether Chinese therapists would demonstrate a self-estimate bias, it adds to our understanding of the extent to which this may be a universal tendency among therapists. Because this study employed data that were obtained for teaching rather than research purposes, there were no demographic data that might have been used to examine how unaddressed variables like personal history and societal expectations exert potentially complex influences on results.

Our primary finding was that this sample of Chinese therapists demonstrated a better-than-average (i.e., Lake Wobegon) effect when they were asked to rate their therapeutic effectiveness. The data in Table 3 suggest that the magnitude by which they overestimated their skill seems generally similar to that of Western therapists. But to more confidently make that inference would require a sample that included both Chinese and Western therapists, matched on key variables. Not having such a comparison group was a limitation of this study.

Three quarters of the participants were certified by the CCPRS, which has rigorous competency criteria (Chinese Psychological Society, 2018). They were not, therefore, representative of the general population of Chinese therapists, who typically receive training through workshops and independent institutes rather than graduate school (Hsuan-Ying, 2015). Consequently, our sample's CCPRS-certified therapists' self-estimates of effectiveness compared to "the typical therapist at your level of experience" might reflect accurate self-assessment more than they do a self-assessment bias. We have no way to determine this.

Nevertheless, only 4% of the participants gave themselves a below average effectiveness rating: If the noncertified participants (one quarter of the sample) had provided unbiased self-assessments, this proportion would have been substantially higher. This supports our study's primary conclusion of self-estimate bias among Chinese therapists. It is possible, though, that the *magnitude* of the bias (i.e., the 71st percentile mean) that we report might have been influenced by the question's wording. For example, a question like "If you are CCPRS-certified, how would you rate your effectiveness compared to the typical CCPRS-certified therapist at your experience level?" could yield different results than we obtained.

In summary, the findings of this study should be interpreted in light of these limitations with respect to comparison groups, demographic information about participants that might help the field better understand these self-estimates, and the fact that this group was not representative of Chinese therapists in general. All are issues that warrant exploration in future research.

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