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EXPERTISE, THERAPIST EFFECTS AND DELIBERATE PRACTICE: THE CYCLE OF EXCELLENCE

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La Práctica (Clínica) Basada en la Evidencia se define como la integración de la mejor investigación disponible con la pericia clínica y las características, preferencias y cultura del paciente. Del mismo modo, la variable terapeuta empieza a mostrar su influencia decisiva en el resultado de los tratamientos psicológicos. En este trabajo se pone el énfasis en la figura del terapeuta en el contexto del programa de formación PIR de especialistas en Psicología Clínica de nuestro Sistema Nacional de Salud. Se revisan los constructos pericia, efectos del terapeuta y se presenta la Práctica Deliberada como un sistema de entrenamiento que puede ayudar a mejorar los resultados de los clínicos y sus tratamientos. Se realizan recomendaciones concretas para mejorar el modelo de supervisión durante la residencia PIR y se discuten algunas de las implicaciones y limitaciones del estado actual de la cuestión.
Palabras clave: *Pericia, Efectos del terapeuta, Práctica Deliberada, Psicoterapia, Psicología Clínica.*

Evidence-based (clinical) practice is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences. Similarly, the therapist factor is beginning to show its decisive influence on the outcome of psychological treatments. This paper emphasizes the therapist factor in the context of the PIR training program of clinical psychology specialists within the Spanish National Health System. Expertise and therapist effects are reviewed, and deliberate practice is presented as a training system that can help clinical psychologists to improve their outcomes and treatments. Specific recommendations are made to improve the supervision model during PIR training, and the implications and limitations of the topic are discussed.
Key Words: *Expertise, Therapist effects, Deliberate practice, Psychotherapy, Clinical Psychology.*

A psychotherapy session is taking place in an outpatient mental health center. The patient, a 35-year-old woman, is being interviewed by a first-year resident intern psychologist (PIR in Spanish). Next to the resident is his supervisor, a clinical psychologist who is observing the development of the therapeutic process and is taking notes on the supervisee's performance. At the end of the consultation, the resident and his supervisor spend some time reflecting on the session. The latter begins by pointing out the strengths and successes of the PIR's intervention, to then spend a significant amount of time talking about those aspects that the resident can practice and improve. Specifically, in this case advice is given about specific moments during the session in which it would have been opportune to perform empathic reflexes congruent with the patient's emotional state. Similarly, certain aspects of non-verbal language that would have been relevant are also noted. Once these elements of potential improvement are listed, the supervisor suggests to the PIR specific examples on how to carry out these interventions in future sessions. For his part, the resident will take this advice into account and will be especially alert in the future to the indicators that designate the suitability of putting into practice the recommendations, skills and techniques shown by the clinical psychologist.

The previous description is a real example taken from the training history of one of the authors of this paper, as well as a common experience among the residents in our country. During the residency in clinical psychology there are many hours of supervision, both formal and informal, in which PIRs participate. However, few experiences leave such an imprint and are as influential in the professional development of the future clinical psychologist as those in which immediate and live feedback is obtained on their performance. They are *hot* situations and, consequently, produce a more meaningful learning than the usual formal deferred supervision, leaving a more lasting imprint on the memory. The direct observation of the PIR's performance, either live or by video recording, provides an excellent opportunity for another professional, preferably an expert in the field, to guide the novice in their professional development process, helping them to become aware of their strengths and weaknesses. Above all, the aim is to design a specific improvement plan, focused on the weaknesses shown, which enables the progressive incorporation of more refined relational and technical skills with the goal of gradually increasing the effectiveness of their interventions and the satisfaction of the patients to whom they provide their services.

This approach, focused on the professional in training, is not

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only justified by the teaching characteristics of the PIR program, but it is also supported by the empirical literature that emphasizes the importance of the therapist variable in the outcome of psychological treatments (Castonguay & Hill, 2017). As will be developed throughout the present paper, the challenge lies in discovering which are the characteristics that make the clinician an expert in their field of action. Some studies have begun to clarify this issue and we have data that shows the relationship of certain technical and relational characteristics of clinicians with the outcomes of psychological treatments (e.g., Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016). In the same vein, various organizations and authors emphasize the importance of taking these aspects into account in the residents' training plans until they are integrated into a future evidence-based clinical practice (APA Presidential Task Force on Evidence-Based Practice, 2006; Beck, Castonguay, Chronis-Tuscano, Klonsky, McGinn, & Youngstrom, 2014; Hill & Knox, 2013; Prado-Abril, Sánchez-Reales, & Inchausti, 2017).

Once the characteristics of the expert clinicians have been identified, and after evaluating the extent to which the resident and/or the specialist present them in their behavioral repertoire, the next challenge is to find an effective method of training these skills that fits the needs of each resident to progressively improve their level of performance. Traditionally it has been assumed that this function was fulfilled by supervision, continuing education courses, attendance at workshops, personal psychotherapy, or the accumulation of clinical experience (Hill & Knox, 2013; Rousmaniere, Goodyear, Miller, & Wampold, 2017). However, there is no consistent evidence to show that these methods by themselves are sufficient for the clinician to improve their performance, at least not when performance is defined as improvement in the clinical outcomes of their patients. Possibly, part of the solution may come from the research available on experts in other disciplines and the way in which they develop and train their skills until they are automated (Ericsson, 2006). This is a method known as Deliberate Practice (DP) which is beginning to emerge, also in the field of psychological treatments, as an alternative to the traditional systems of teaching, training, and supervision of clinical psychologists (Rousmaniere, 2016; Rousmaniere et al., 2017).

In this way, from now on, we will attempt to connect the indissoluble links that occur between expertise, therapist effects, DP, and its most visible result: excellence in clinical practice and in the application of psychological treatments in a varied myriad of care contexts and clinical situations. To do this, we will (a) review the concept of clinical expertise and the factors that constitute its nuclear characteristics; (b) place special emphasis on the literature that highlights the therapist factor as an essential ingredient of the effectiveness of psychological treatments; (c) present DP as one of the central characteristics of clinicians that improve their performance over time; and finally, (d) reflect on the implications that the analysis of excellence imposes on the current training of residents and clinical psychologists.

CLINICAL EXPERTISE: BECOMING AN EXPERT

Becoming an expert in clinical psychology and psychotherapy are goals that every resident and specialist should seriously consider. However, achieving above-average performance is not a simple or frequent task (Baldwin & Imel, 2013; Barkham, Lutz, Lambert, & Saxon, 2017). This is probably because the path to clinical excellence is long, challenging, hard work, sacrificial, solitary, often frustrating and requires perseverance. It is a continuous approach towards a better performance that is not exhausted, but progressively expands the horizon. It is always a provisional status at risk of vanishing if work is not continued. In other words, becoming an expert is difficult and involves a sustained demand over time, throughout the professional career. At this point, perhaps excellence has more to do with an attitude and a way of understanding clinical practice than with achieving a status or a certain role in the field of mental health. In any case, expertise is a fundamental component of clinical practice that the American Psychological Association (APA) places at the core of evidence-based practice (EBP), defined as *"the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences"* (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). Therefore, we should begin to consider expertise as the center of gravity upon which to articulate the design of both the PIR training programs and the continuous training of specialists. For example, listing the empirically supported therapies (ESTs), and applying them to the margin of context that allows their effectiveness, is not a clinical practice with much history in terms of improving the performance of clinicians (Norcross & Wampold, 2018); apart from the other risks involved in the excessive loyalty to a particular brand of psychotherapy (Gimeno-Peón, Barrio-Nespereira, & Álvarez-Casariego, 2018a). On the other hand, possessing the necessary skills to masterfully apply a psychological treatment and indicate its suitability with a particular patient, in a given healthcare context and in tune with the socio-cultural markers of reference, is to begin to approach that interpersonal context in which the techniques can offer their appropriate effectiveness (Prado-Abril, Sánchez-Reales, & García-Campayo, 2016).

Almost any discipline, whether scientific, technical, artistic or of another kind, encompasses people whose performance is above average. They are the professionals who are considered experts in the field. The *masters of the art* in question. Unfortunately, the term expert has received and continues to receive an excessive and disproportionate use that makes its operative and explicit definition extremely difficult (Ericcson, Charness, Feltovich, & Hoffman, 2006). However, there are interesting proposals in this regard. An approach that we could call *classical* considers that experience in itself is the key to expertise. However, as Ericcson (2006) points out, extensive experience in a given domain is necessary but not sufficient to become an expert. In fact, Ericcson (2006) shows that after

achieving a sufficient degree of performance to work independently, many professionals remain at the same level throughout their career without any improvement being observed in the execution of their work.

Regarding the field of psychotherapy and clinical psychology, recently the definition and characterization of expertise has begun to be the subject of debate, both in the national (Pérez-Álvarez, 2019; Prado-Abril et al., 2017) and international scenario (Castonguay & Hill, 2017; Miller, Hubble, & Chow, 2018). Psychotherapy is one of the main competences and domains of performance of clinical psychologists. Not in vain, the term psychotherapy appears up to twenty-three times in the PIR training program (Order SAS/1620/2009). In our healthcare field, the fact that professionals are experts in what they do has a relevance perhaps greater than in other fields since the result of the execution of the services offered has a direct impact on the mental health of citizens. Patients share an important part of their lives with us and at least some level of effectiveness is expected of us. In this therapeutic relationship the *person* of the clinical psychologist is the main instrument through which the services provided by our specialty are delivered. As a result, their teaching, training and level of expertise are essential elements to keep the tool calibrated.

As previously stated, part of the topic on psychotherapy expertise has focused on describing the characteristics that a professional must meet in order to be considered an expert. Tracey, Wampold, Lichtenberg, and Goodyear (2014) state that aspects such as the reputation or the results of the clinician have generally been taken into account and are committed to establishing the equivalence between expertise and performance improvement as a result of greater experience, but with an emphasis on achieving better outcomes over time. In addition, Tracey et al. (2014) point out that experts differ from novices in that the former have a broader knowledge base, a more efficient cognitive organization of their knowledge and greater automation of decision making and the application of therapeutic procedures. In short, from this perspective it is proposed that the key aspect to considering someone as an expert is the outcome. These must improve over time and be susceptible to empirical confirmation with an objective measure, such as, for example, the outcome of the patient who goes for treatment (Gimeno-Peón, Barrio-Nespereira, & Prado-Abril, 2018b; Goodyear, Wampold, Tracey, & Lichtenberg, 2017). Finally, DP is proposed as the main method of training to achieve better results over time (Goodyear et al., 2017; Tracey et al., 2014). On the other hand, other authors hold a different point of view, focused on performance rather than results, defining expertise as *"the manifestation of the highest levels of ability, skill, professional competence, and effectiveness"* (Hill et al. al., 2017, p. 9). It is a complementary perspective, although broader than the previous one, that takes into account both the relational and technical aspects. Succinctly, the group led by Hill proposes eight criteria for assessing expertise: performance, cognitive functioning, client outcomes, experience, personal and relational qualities of the therapist, credentials, reputation, and therapist self-assessment (or minimization of the cognitive biases of the therapist). In addition, they point out four possible ways to reach the level of expert in psychotherapy: practical experience with patients, receiving supervision, participating in personal psychotherapy, and becoming involved in DP (Hill et al., 2017).

In sum, clinical expertise is not just about learning a type of technique or training in a specific psychotherapeutic approach under a more or less structured learning program. It is something more. It is an associated effect, an attitude and a procedure that is related to the individual professional. Therefore, there is also no simple or quick way to develop it. Rather it is a continuous search process of the best excellence in clinical practice that, as we will see, requires specific learning and maintenance procedures tailored to each person.

THERAPIST EFFECTS: THE STUDY OF THE MOST EFFECTIVE CLINICIANS

In the case of the patient illustrated at the beginning of the article, it should be noted that after that session she did not go back to another consultation. As we do not have objective information, it can be assumed that the case was a therapeutic failure. Now, imagine the following hypothetical situation: the same patient is treated for the same problem, in the same outpatient mental health center, where she also receives the same type of intervention and with the same live supervision. The only different variable is that the PIR is another person. If in these circumstances there were a therapeutic success, the patient continuing to attend consultancy until she reaches her goals satisfactorily, it would be possible to think that some distinctive characteristic of the resident, during the session, had been an important factor in the outcome of the treatment. Precisely a result of this type is what is known in psychotherapy research as *therapist effects*. The variable of the therapist effects is a transtheoretical construct that can be conceptualized as a common factor present in different forms of psychotherapy and that is usually defined as the percentage of the variance of the outcome of psychotherapy that is explained by the individual professional, regardless of the effect of other aspects such as the type of treatment, the techniques used or the diagnosis of the patient (Baldwin & Imel, 2013; Barkham et al., 2017; Castonguay & Hill, 2017).

Therapist effects have been ignored, or considered a confounding variable, for decades in psychotherapy research. However, in the same way as expertise, in recent years this has gained interest within the scientific community as one of the most important predictors of the effectiveness of psychological treatments (APA, 2013; Chow, 2014; Miller, Hubble, & Duncan, 2007; Okiishi, Lambert, Eggett, Nielsen, Dayton, & Vermeersch, 2006; Okiishi, Lambert, Nielsen, & Ogles, 2003). Its relevance has been highlighted, recently, in the extensive and

very appreciable review coordinated by Castonguay and Hill (2017), which, as the culmination of this stimulating and emerging interest, establishes the current state of the art and guides the research agenda of the future. As a summary, several meta-analyses present the percentage of variance of the treatment outcomes that are explained by therapist effects. Baldwin and Imel (2013) found a percentage of 5% that increased to 7% in naturalistic settings. Wampold and Imel (2015) obtained a value that ranged between 3-7%. Saxon and Barkham (2012) report a 6.6% variance in the outcome of psychotherapy. And, recently, after thoroughly reviewing all of the available research, Barkham et al. (2017) conclude that the percentage is between 5% and 8%, indicating that the effect size depends on the patient's initial severity. That is, the more severe the patient's case, the greater the importance of the therapist effects (Inchausti, Prado-Abril, Sánchez-Reales, Vilagrà-Ruiz & Fonseca-Pedrero, 2018). This, on the other hand, is a habitual intuition among the judicious residents who have accumulated certain experience. It is in complexity and uncertainty where the expertise and mastery of a particular clinician is best expressed.

Although on average clinicians working in the field of mental health manage to achieve improvements for their patients significantly (Lambert, 2013; Wampold & Imel, 2015), the study of therapist effects reveals a reality as uncomfortable as it is important: some clinicians are more effective than others and, sometimes, these differences are of a considerable size. For example, in the study by Saxon and Barkham (2012) involving 119 therapists, who treated a total of 10,786 patients, covering a period of almost 8 years, the rate of patients who recovered per professional presented an important variability between 23.5% and 95.6%, with an average recovery rate of 58.8%. In this study, the severity of the cases was a moderating variable. The therapist predicted 3% of the variance of the results when the less severe cases were analyzed, a percentage that increased to 10% when the group of the most severe cases was analyzed.

Results like the previous ones show a reality with a notable impact on clinical practice. There is an acceptable general effectiveness among clinicians, but also extraordinary clinicians (supershrinks) and clinicians with a very poor impact on their patients (pseudoshrinks) (Okiishi et al., 2003). This aspect makes it necessary to contemplate objective measures of monitoring of performance and effectiveness (Ericsson, 2006; Gimeno-Peón et al., 2018b; Goldberg et al., 2016a), since when the performance self-assessment has been studied by the clinicians themselves there has been a notable tendency to overestimate their positive outcomes and underestimate their failures or rates of deterioration. Specifically, in the study by Walfish, McAlister, O'Donnell, and Lambert (2012), 25% of the clinicians surveyed, in comparison with the other clinicians of the study, indicated that their expertise and performance was in the 90th percentile, the average was located in the 80th percentile and none of the participants considered themselves to be below the 50th percentile. In the same direction, in the study by Hannan et al. (2005) the clinicians estimated that 91% had positive results, when the objective figure was 40%, and they were especially ineffective in identifying patients who not only did not improve but who were also getting worse, which they detected successfully in only 2.5% of the cases. In other words, both studies focus on the difficulty that clinicians have in reporting objective feedback on their own performance, especially those with a clearly deficient performance that are far from considering themselves as pseudoshrinks.

The above is transcendental from the perspective presented here. Since most clinicians consider that their level of performance is optimal, they do not show enough interest or motivation to engage in activities aimed at training and improving their therapeutic skills. In this way, the cycle closes (contrary to the cycle of excellence) which maintains the false belief that clinical practice is sufficient. However, we have already noted in the previous pages that the evidence does not confirm that experience alone is related to better outcomes throughout the professional cycle (Ericsson, 2006; Ericsson et al., 1993; Goldberg et al., 2016a, 2016b; Goodyear & Rousmaniere, 2017; Miller, Hubble, & Chow, 2017; Rousmaniere, 2016; Rousmaniere et al., 2017). If one thinks for a moment about other disciplines the fallacy that this belief involves becomes evident. For example, a professional pianist would reject the possibility of maintaining his level of execution by dedicating himself exclusively to giving concerts without doing any kind of practice between performances.

These differences between clinicians, or their relative position with respect to the group average, are relatively stable over time and are expressed with a wide range of patients (Kraus et al., 2016; Wampold & Brown, 2005). Contrary to the assumption that certain clinicians are more expert with some patients than with others, empirical evidence indicates that good clinicians tend to be experts in a wide variety of dysfunctional conditions and clinical situations. Recently, Barkham et al. (2017) report that around 15-20% of therapists obtain better results in a significant and generalized way, while another 15-20% are less effective, as represented by the well-known *law of variability*. Likewise, it has been proven that the most effective therapists tend to obtain results 50% higher than those that show an average efficacy, in addition to having a 50% lower dropout rate (Miller, Hubble, Chow, & Seidel, 2013). Similar results had been previously obtained by Okiishi et al. (2006) where the most effective therapists (defined as those who showed a performance that was in the top 10% of the sample) had results that were twice as good as those that were least effective (whose results were in the bottom 10% of the performance distribution) and registered half of the dropouts. On the other hand, Brown, Lambert, Jones, and Minami (2005) estimated that the amount of change produced in the patients of the most effective therapists was almost three times greater than that of the average.

At this point, the compulsory question is: *what are these brilliant clinicians doing or how are they doing it?* Before entering fully into the issue, Table 1 summarizes the main characteristics of effective clinicians, as well as some variables that do not predict a superior performance or the achievement of the highest standards of execution and expertise over time.

Some variables will be more surprising than others because historically they have been considered to be nuclear to good practice and have been present in the majority of training programs in clinical psychology and psychotherapy. Especially striking is the lack of empirical support presented by the fundamental tool in the work of clinicians that is supervision. Rousmaniere, Swift, Babins-Wagner, Whipple, and Berzins (2014) found that supervisors explain less than 1% of the variance of psychotherapy outcome. Other reviews of the available literature have not found conclusive results that indicate that supervision makes therapists more effective (Alfonsson, Parling, Spännargård, Andersson, & Lundgren, 2018; Watkins, 2011). Something similar can be said about the clinicians who undergo personal psychotherapy and the influence on their subsequent clinical performance. To date, all we can say is that the data are inconclusive (Malikioski-Loizos, 2013).

CHARACTERISTICS OF THE MOST EFFECTIVE CLINICIANS

Wampold et al. (2017) have reviewed the available studies on the distinctive variables of the most effective clinicians and have concluded that there is sufficient evidence to consider that they present at least four characteristics (see Table 1). They are able to establish solid and warm therapeutic alliances across a range of patients, they have facilitative interpersonal skills (FIS) in their personal repertoire, they have doubts about the quality of their professional performance, and they are involved in DP. The latter will be subject to a more extensive analysis in an independent section, and the other three will be revised below.

The ability to establish a solid therapeutic alliance across a range of patients

The alliance is the most studied construct in the research on the psychotherapeutic process. Nearly 300 studies have shown its robust influence on the outcomes of psychological treatments (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Flückiger, Del Re, Wampold, & Horvath, 2018; Horvath, Del Re, Flückiger, & Symonds, 2011). Although it is a variable of the encounter between the characteristics of the clinician and the patient (Prado-Abril et al., 2016, 2017), several studies suggest that the quality of the alliance is more influenced by the contributions of the therapist than by those of the patient (Baldwin & Imel, 2013; Baldwin, Wampold, & Imel, 2007; Del Re et al., 2012). In fact, Baldwin and Imel (2013) estimate the therapist's contribution to the variability of the scores of the alliance between clinicians and patients to be 9%. In addition, regarding the professionals who consistently obtain better than average results, the key lies not only in their ability to form strong and warm alliances, but also to do so for a wide range of patients who present an important heterogeneity of characteristics, personality traits, clinical problems, and severity levels. This makes us in line with Baldwin et al. (2007) when they point out that these data imply the importance of including, in training programs, work on how to build and maintain adequate therapeutic relationships and the culture of systematically monitoring the state and quality of the alliance through specific strategies (Gimeno-Peón et al., 2018b; Inchausti et al., 2018; Prado-Abril, García-Campayo y Sánchez-Reales, 2013). It involves training residents with the *focus on the relationship*.

Facilitative interpersonal skills

The FIS construct encompasses a series of characteristics or traits that are found in varying degrees in clinicians: verbal fluency, warmth, empathy, emotional expression, persuasiveness, hopefulness, alliance-bond capacity and the ability to understand the problem presented by the patient (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). In summary, FIS are related to the general ability to *"perceive, understand, and communicate a wide range of interpersonal messages, as well as a person's ability to persuade others with personal problems to apply suggested solutions (…) and abandon maladaptive patterns"* (Anderson et al., 2009, p. 759). There is a significant relationship between FIS and treatment outcome (Anderson et al., 2009, Anderson, McClintock, Himawan, Song, & Patterson, 2015; Anderson et al., 2016). In addition, it has been proven that the age of the

TABLE 1
POSSIBLE VARIABLES MEDIATING THE THERAPIST EFFECTS

Variables related to the clinicians' effectiveness
Ability to establish a solid therapeutic alliance across a range of patients (Del Re et al., 2012).Facilitative interpersonal skills (Anderson et al., 2016).Professional self-doubt (Nissen-Lie et al., 2015).Deliberate practice (Chow et al., 2015).
Variables unrelated to the clinicians' effectiveness
Mere accumulation of experience (Beutler et al., 2004, Chow et al., 2015, Goldberg et al., 2016b, Wampold & Brown, 2005).Age and gender (Chow et al., 2015; Wampold, Baldwin, Grosse-Holtforth, & Imel, 2017).Interpersonal skills self-reported by the clinician (Wampold et al., 2017).Theoretical orientation (Wampold et al., 2017).Adherence to a protocol and competence in specific aspects of a treatment (Webb, DeRubeis, & Barber, 2010).Supervision (Alfonsson, Parling, Spännargård, Andersson, & Lundgren, 2018; Watkins, 2011).Personal psychotherapy (Malikioski-Loizos, 2013).

professionals correlates positively with FIS (Anderson et al., 2009), which suggests that these skills can be trained and developed with effort over time. Other research groups have studied similar skills, also obtaining a favorable impact on the treatment outcomes. This is the case of the interpersonal variables, clear and positive communication, empathy and communicative attunement, respect and warmth, managing of criticism, and willingness to cooperate (Schöttke, Flückiger, Goldberg, Eversmann, & Lange, 2016).

Professional self-doubt

The act of the clinician reporting on their own difficulties with the patients (assessed through a scale that includes items that refer to aspects such as not being sure about the best way to intervene with a patient, a lack of confidence that they are helping the patient or feeling unable to understand the essence of his/her problems, among others) is positively related to the results when, in addition, the self-doubt is accompanied by the clinician's positive assessment of him or herself (Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013; Nissen-Lie et al., 2017). A therapist who shows these characteristics will obtain better outcomes, especially when developing a constructive and active coping style to deal with the difficulties encountered in their cases. For example, seeking to solve the difficulties by reflecting on the problem, seeking expert supervision, implementing strategies to solve problems, or working on their areas of improvement by practicing therapeutic skills through DP. In short, what these authors point out is that the therapist effects, in part, lie in the complex interaction between the personal and professional characteristics of the clinician.

Other characteristics that require more empirical research

There are other factors that have been the focus of attention and that promise auspicious avenues of study. For example, it has been found that therapists with secure attachment obtain better results when treating more severe patients (Schauenburg et al., 2010). In addition to the attachment style, other characteristics that have been proposed as promising elements to consider in the study of the therapist effects are responsiveness, presence and countertransference management (Castonguay & Hill, 2017).

So far, what the available empirical evidence indicates about the therapist effects can be summarized as follows: there are clinicians that obtain better results than others and this is especially evident in the treatment of the most severe patients; the differences between one and the other reside in certain characteristics; and consistent empirical support is available for the ability to form strong therapeutic alliances with a wide variety of cases, the presence of a series of specific interpersonal characteristics (FIS), and the tendency to doubt gently with regards to their own effectiveness. Finally, DP is another of the variables involved and we will deal with this next.

DELIBERATE PRACTICE: THE PRACTICAL EXPERIENCE THAT DOES IMPROVE PERFORMANCE

DP was originally proposed and defined by Ericcson et al. (1993) as the method that allows a professional to become an expert in his field. Expertise is not something innate; what differentiates experts in a particular domain of performance is the amount of effort and time spent on improving their skills. In line with the previous authors, Chow (2014) defines DP as those activities carried out with systematic effort that focus on improving one's performance, which are carried out over extended periods of time, with the guidance of a mentor who provides immediate feedback on the execution, progressively improving the practice by means of repetition and successive refinement. These activities must have specific characteristics so that we can consider them as part of DP. In order for DP to lead to the development and improvement of professional performance, it is necessary for the training to focus on achieving some type of goal that involves a certain level of challenge; that is, it must involve a skill whose execution is one step ahead of the current performance level of the individual. In the classical sense this is established as the *zone of proximal development*. In addition, it is necessary for this type of training to be carried out for long periods of time and for the results to be monitored, so that they guide the successive practice and the subsequent improvement. Thus, DP is necessary both in the learning of new skills and abilities and in their maintenance and subsequent improvement (Chow, 2014; Ericcson et al., 1993; Rousmaniere, 2016; Rousmaniere et al., 2017).

The pioneering research by Chow et al. (2015) finds, in a sample composed of 69 therapists and 4,580 clients, that the therapist effects explain 5.1% of the treatment outcomes. Subsequently, out of a sub-sample composed of 17 professionals and 1,632 clients, they analyze the relationship between certain variables associated with the clinicians and the outcome. In coherence with the literature previously presented in this manuscript, characteristics such as age, gender, years of experience, the care burden and the level of theoretical integration are not found to be predictive. In contrast, the variable that was a significant predictor of patient outcomes was the time clinicians spent on DP activities. The clinicians in the study responded to a questionnaire in which the items concerned their professional development and activities related to their work. To evaluate DP, an *ad hoc* instrument was designed, the *Retrospective Analysis of Psychotherapists' Involvement in Deliberate Practice* (RAPIDpractice, Chow et al., 2015), with the objective of measuring the time that therapists devoted to activities with the aim of improving their performance. The results of the research showed that the amount of time dedicated alone to DP was a significant predictor of the outcomes of patients who sought treatment. The differences between clinicians were analyzed after grouping them in quartiles according to their patients' outcomes after the treatments. The results revealed that the clinicians of the fourth

quartile (those whose performance was above 75% of those in the sample), with respect to the clinicians of the other three quartiles, allocated an average of 2.81 times more time per week to DP activities carried out alone.

Proposals to implement Deliberate Practice in clinical training

While the study by Chow et al. (2015) has limitations such as the small sample size, the use of self-reported data with a retrospective nature, the uniqueness of being one of a kind and, consequently, the need for replication studies, it shows that DP is a promising method for residents and clinical psychologists to train and work, whilst becoming closer to their best version. Another problem, no less important, is that there still does not exist an explicit, consensus and operational definition of what DP means. However, we do have proposals and approaches on how to implement it in professional training and development. On this point, Rousmaniere (2016) was the first author to dedicate a complete handbook to the application of DP in psychotherapy training. Starting from the proposal of Ericsson (2006), he suggests a method that consists of several steps. The first step is to record the treatment sessions. Recordings of particularly difficult cases in which no improvements are obtained, or where the phenomenon of stagnation of the relationship occurs, would be the most favorable for viewing with a more expert supervisor. The role of the supervisor would be to provide the supervisee with feedback on their performance and design a plan with specific goals to be achieved through practicing skills. These goals must be in the supervisee's zone of proximal development. Once the goals have been defined, the most appropriate activities for reaching them will be agreed upon and the resident and/or the clinician will have to dedicate time to rehearsing and repeating the behaviors related to the therapeutic skills until they progressively reach the target performance. The final step is to systematically evaluate and monitor the results obtained in the usual practice to objectify the progress. In the original source you can find, if the reader is interested, specific exercises for becoming involved in DP on one's own (Rousmaniere, 2016).

For their part, Chow and Miller (2015) have developed the *Taxonomy of Deliberate Practice Activities Worksheets*. This is an instrument that consists of two versions, one for the supervisor and another for the supervisee, which describes five domains in which to apply DP in psychotherapy: structure, hope and expectations, therapeutic alliance, patient variables, and therapist variables. For each domain, a list of related activities to be evaluated is presented on a 10-point Likert scale according to the clinician's performance. The supervisor must know the clinician's work (for example, observing fragments of their sessions recorded on video), help them to select one to three activities on which to work in order to improve, and they must specifically focus on one of them, establishing specific, measurable, achievable goals for a specific period of time.

The *cycle of excellence* has been defined as an individualized three-step plan specifically aimed at developing expertise and turning supervisees into experts in the field of psychological treatments (Miller et al., 2017; Prado-Abril et al., 2017; Rousmaniere et al., 2017). The cycle begins by obtaining, in the first place, a baseline of the starting effectiveness of the supervisee. This must be done through an objective, rigorous and systematic evaluation. The second step is to provide continuous and immediate feedback to the supervisee with the goals of improving the outcomes, reducing the number of dropouts, detecting cases in which deterioration is observed and, ultimately, helping to evaluate in fine detail the learning process of the clinician and the evolution of their treatments. On this point, a distinction is made between performance feedback (outcome measures) and learning feedback (observations the supervisor makes about the supervisee's skills, errors to be corrected, technical issues, etc.) The last step has to do with the successive refinement of clinical skills. This is the part most closely associated with DP. Once the skills that require training have been detected, their current performance level assessed, and the improvement objectives defined, it is about dedicating time to DP. Preliminary evidence has been found that supports the effectiveness of this training method. For example, Goldberg et al. (2016a) conducted a study over eight years involving 5,128 patients and 153 clinicians from a mental health agency in Canada. During this period, the patient outcomes were monitored, and the clinicians were given feedback on their results, a space in which to share them and to receive advice from external consultants that are experts in the field and, finally, DP suggestions for practicing and working on difficult cases. The results at the end of the study consisted of an improvement of the overall treatment outcomes of the health agency over time, with intra-subject changes also being observed in the clinicians.

Now, let us return to the description at the start of this article. Imagine that the resident had done the session alone and recorded it on video. Suppose it is delivered to a supervisor who provides very specific feedback, focused on specific skills and techniques. The supervisor, in the same way as happened in that experience, can point out weaknesses such as the absence of empathic comments at precise moments. So, they both agree that the learning goal is to improve performance in the recognition of the patient's emotions in order to make empathic comments consistent with the emotional tone of the session and to monitor that, in addition, the patient actually feels understood due to the comments of the resident. With this goal in mind, the supervisor will design a specific training plan for the resident. Perhaps, as proposed by Rousmaniere (2016), they could revisit the recording of the last session and, silencing the volume or pausing the video, repeat aloud the comments that they did not originally make and that relate to the suggestions of the supervisor, who will review the recordings of the following sessions to assess the extent to which the resident is improving

in the target skill. They continue in this way, automating the basic aspects of the skill and adding progressive goals of greater complexity to refine the skill and master it. In other words, practice, practice and more practice, with a well-designed plan and proper supervision, to develop increasingly precise skills, performed better each time (Chow, 2017). For those professionals interested in the field and in this way of working, Miller et al. (2017) have produced an interesting proposal, which is summarized in Table 2.

The role of the supervisor in Deliberate Practice

A training method based on DP requires great effort from the person in training, but also from the supervisor. Previously, there has been a lack of consistent empirical support for traditional supervision. It is no coincidence that in DP literature the term *coach* is usually used instead of the usual *supervisor*. This difference in terminology aims to emphasize that the person who assumes this role has an active role with a clear motivational component and the goal of instilling enthusiasm to the supervisee. The supervisor in the DP method must take time to understand how the supervisee works, to detect the skills that need training, to help them organize the practice they need in order to improve, at the same time as being a supportive figure, aware that DP is demanding and difficult.

In the proposal by Rousmaniere et al. (2017) for integrating DP into clinical supervision, briefly, the following functions of the supervisor are presented: to explain and demonstrate models for an effective clinical practice; to determine the zone of proximal development of each therapist; to provide feedback and guidance to the supervisee in a consistent and accessible manner; to offer emotional support to increase the morale of the apprentice and cushion the emotional challenges inherent in DP; and to teach the supervisee how to work appropriately in various professional domains and fields of action. The reader interested in this subject and in a supervisory model aimed at developing the expertise of the supervisee can obtain a more detailed understanding from Goodyear and Rousmaniere (2017).

TABLE 2
A GUIDE TO STARTING DELIBERATE PRACTICE

Structure and automate the DP Reserve one hour a week for DP, plan how to use it, prepare reminders on electronic devices and record therapy sessions.
Establish a reference point Look at the results obtained, reflect and write down what you have learned, watch a recording of a representative session of your best work, have it reviewed by your supervisor and obtain feedback.
Playful experimentation Review about 5-10 minutes of video from your own session, pause it and think constructively about other ways you could have done it, look at the patient's feedback and see if it surprises you, etc.
Support Search until you find a supervisor who is willing to analyze fragments of the recordings, to include in the discussion information about outcomes, alliance, patient variables, etc. and, in order to help you establish learning objectives that guide your professional development, form a small community of people with the same interest in DP and in achieving excellence. *At the end of the day, it's a lonely and hard-working route. Seek allies.*

DISCUSSION

Expertise, becoming an expert, the cycle of excellence and, certainly, our work in clinical psychology, are not at all simple. The effort required is considerable and there are various obstacles to its generalization as a teaching and training system. Part of the difficulty has been related to the lack of visibility and recognition of the results by the interested audience (Chow et al., 2015). For example, musicians and footballers are exposed to an audience that will judge their performance and results. However much it hurts to have to recognize it here, this does not happen with clinical psychologists or in the field of mental health in a remotely serious way. It is a field of action, and a profession, where the monitoring of results and their public presentation has clearly been a pending issue for a long time. Undoubtedly, the lack of objective and immediate feedback is one of the main obstacles to clinicians becoming involved in DP, developing expertise and pursuing excellence throughout their professional careers. Such an important aspect of clinical practice, we insist, cannot be left out of the planning process of the structures involved and in the hands of the personal characteristics of the professionals (Prado-Abril et al., 2017). However, the way to approach the question is extremely complex if we look at the experience of the study by Goldberg et al. (2016a), which exemplifies the resistance that a proposal of these characteristics can activate in clinicians. Previously, the part of the study that showed the benefits, for patients and professionals, of implementing a feedback system of results and training in DP in a health agency was indicated. Going into more depth in the study, the aforementioned agency decided to implement this research in 2008, so it was mandatory for clinicians to evaluate objectively the outcomes of their treatments. Although the intention was to improve performance and not to judge or punish the clinicians with the worst results, after taking this measure, in the following four months, 40% of the clinicians decided to leave their job at the agency.

Another obstacle is the profusion of models of psychotherapy with copyright which, at present, despite there being four major psychotherapeutic approaches, leaves close to 500 types of psychological treatment (Gimeno-Peón et al., 2018a). The excess of treatments based (or not) on evidence and of action protocols diverts the focus of attention from the clinician who ultimately is the one who makes the treatments work, in the same way that the pianist makes music even if he/she needs an instrument as a vehicle for his/her talent. Obviously, it is necessary to work based on a model with guidelines, parameters and specific principles, but at the same time it must

be borne in mind that adherence to a protocol and competence in it is not enough to obtain positive results (Webb, DeRubeis, & Barber, 2010). The flexibility of the clinical psychologist is much more decisive (Norcross & Wampold, 2018). It is also important to remember that the resolution of the APA (2013) establishes the general effectiveness of psychotherapy and stresses that the available evidence shows that the results of psychological treatments are more influenced by the characteristics of the patients, the contextual variables and the characteristics of the clinicians, than by the type of treatment or the theoretical model of ascription. Clinicians must keep this order of priorities in mind, but at the same time they must not enter into a psychotherapeutic *anarchism* since we also know that psychotherapy far from not working and being innocuous can actually cause harm (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). There are better treatments than others for certain clinical circumstances, and there are clinicians who consistently obtain the best and the worst results (Baldwin & Imel, 2013; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Okiishi et al., 2003; Wampold & Brown, 2005).

Emphasizing the main obstacles, this review shows a very serious finding. Not all clinicians obtain the same efficacy in their performance and, to a certain extent, the results of the study of the Canadian agency are disturbing. In the same way, the study by Imel, Sheng, Baldwin, and Atkins (2015) shows, by means of a simulation, that removing from a sample of clinicians the ones with the worst results would significantly improve public health. While this issue is controversial, we do need to improve. And in this study, we present a proposal that is reasoned, evidence-based and, while not easy, it is certainly possible. This proposal shares some of the recommendations of Castonguay et al. (2010) who note that perhaps the priority in the training of clinicians and psychotherapists, right from when they take their first steps as residents, is to make them aware of the possibility that patients can worsen and to address the possible harmful effects of psychological treatments. In this sense, the idea would be to teach clinicians to use effective interventions, but in a flexible way and with sensitivity to the needs of the patient so that they are used in the right time and context, not in an uncritical and inflexible way. In part, the proposal suggests changing the focus of treatment to redirect and focus on the PIR and/or the clinician. There is enough evidence of sufficient quality for us to take seriously that good clinical psychologists are capable of forming therapeutic alliances that fit different types of patients, they have in their repertoire and they use facilitative interpersonal skills, reflection and self-doubt regarding their own performance. They work hard to improve their blind spots with a large amount of solo work and by exposing themselves to the feedback of their mentors. Perhaps we must begin to contemplate how, when and where we are going to teach these skills to our residents so that they incubate the importance of pursuing excellence throughout their professional careers.

Although we have reviewed the controversial, or minimal, empirical status of supervision, this should not lead us to think that it is not necessary or useful. We believe that the data warn us of the need to review, modify, and update the supervision models. In this sense, the literature on DP focuses on the effectiveness of individualized supervision, focused on the practice of relational skills and specific techniques, which promotes conscious and systematic practice between sessions (Goodyear & Rousmaniere, 2017). Maybe this is the way to go. However, DP requires the figure of a supervisor with certain characteristics to be effective in improving the results of the supervisee. But what if there is no one to adopt this role or, if there is, they do not have the necessary technical means? Continuing with our clinical description at the beginning of this article, the available research indicates that one of the most important predictors of the outcome of a treatment is the clinician's empathy perceived by the patient (e.g., Norcross & Wampold, 2011) and this was one of the difficulties that the resident had in the example session. Consequently, the PIR could autonomously organize their clinical practice in such a way that they monitor their own performance. At the end of each session, they could use standardized instruments that allow them to obtain immediate feedback (e.g., the subscale of Empathy from the Barret-Lennard Relationships Inventory, 1962). If lower scores than expected were obtained, the resident could look for ways to improve their capability. For example, studying and practicing the use of empathic reflexes, based on manuals that specifically address this issue, as is the case of some sections of *Motivational Interviewing* (Miller & Rollnick, 2015) or other psychotherapy manuals that offer practical exercises to improve this skill and other ones. Successive applications of the scale allow you to know if your performance is improving and the adjustments to make in your training process. Beginning with the culture of systematic monitoring of variables such as empathy, the alliance and other key variables of the treatment outcomes, may be a good starting point for residents interested in DP as a way of improving their performance. The residency period is a particularly important moment in establishing the foundations of the efficacy of the future clinician (Budge et al., 2013).

Finally, in this analysis of the therapist effects and of expertise, in this *search for our best version*, it is essential not to fall into an undesirable therapist-centrism (Norcross & Wampold, 2011). We have critically pointed out some drawbacks of the model of ESTs (Gimeno-Peón et al., 2018a). The search for evidence-based clinicians is not exempt from the same risks if caution is not exercised. At this point, it is appropriate to emphasize that the most important variable that has the greatest influence on the outcome of a psychotherapeutic process is that of the patient characteristics (APA, 2013; Bohart & Wade, 2013; Wampold & Imel, 2015). The patient is the true protagonist of the treatment and the element that gives meaning to our profession.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

REFERENCES

Alfonsson, S., Parling, T., Spännargård, Å., Andersson, G. & Lundgren, T. (2018). The effects of clinical supervision on supervisees and patients in cognitive behavioral therapy: A systematic review. *Cognitive Behaviour Therapy, 47*, 206-228.

Anderson, T., Crowley, M. E. J., Himawan, L., Holmberg, J. K. & Uhlin, B. D. (2016). Therapist facilitative interpersonal skills and training status: A randomized clinical trial on alliance and outcome. *Psychotherapy Research, 26*, 511-529.

Anderson, T., McClintock, A. S., Himawan, L., Song, X. & Patterson, C. L. (2016). A prospective study of therapist facilitative interpersonal skills as a predictor of treatment outcome. *Journal of Consulting and Clinical Psychology, 84*, 57-66.

Anderson, T., Ogles, B. M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A. (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. *Journal of Clinical Psychology, 65*, 755–768.

American Psychological Association [APA] (2013). Recognition of psychotherapy effectiveness. *Psychotherapy, 50*, 102-109.

APA Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *The American Psychologist, 61*, 271-285.

Baldwin, S. A. & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th Ed., pp. 258–297). Hoboken, NJ: Wiley.

Baldwin, S. A., Wampold, B. E. & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*, 842-852.

Barkham, M., Lutz, W., Lambert, M. J. & Saxon, D. (2017). Therapist effects, effective therapists, and the law of variability. In L. G. Castonguay & C. E. Hill (Eds.), *How and why are some therapists better than others?* (pp. 13-36). Washington, DC: American Psychological Association.

Barrett-Lennard, G. T. (1962). Dimensions of therapist response as causal factors in therapeutic change. *Psychological Monographs: General and Applied, 76*, 1-36.

Beck, J. G., Castonguay, L. G., Chronis-Tuscano, A., Klonsky, E. D., McGinn, L. K. & Youngstrom, E. A. (2014). Principles for training in Evidence-Based Psychology: Recommendations for the Graduate Curricula in Clinical Psychology. *Clinical Psychology Science and Practice, 21*, 410-424.

Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S. & Wong, E. (2004). Therapist variables. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th Ed., pp. 227-306). Hoboken, NJ: John Wiley & Sons.

Bohart, A. C. & Wade, A. G. (2013). The client in psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th Ed., pp. 219-257). Hoboken, NJ: Wiley.

Brown, G. S., Lambert, M. J., Jones, E. R. & Minami, T. (2005). Identifying highly effective psychotherapists in a managed care environment. *American Journal of Managed Care, 11*, 513-520.

Budge, S. L., Owen, J. J., Kopta, S. M., Minami, T., Hanson, M. R. & Hirsch, G. (2013). Differences among trainees in client outcomes associated with the phase model of change. *Psychotherapy, 50*, 150-157.

Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R. & Hill, C. E. (2010). Training implications of harmful effects of psychological treatments. *American Psychologist, 65*, 34-49.

Castonguay, L.G. & Hill, C.E. (Eds.) (2017). *How and why are some therapists better than others?* Washington, DC: American Psychological Association.

Chow, D. (2014). *The study of supershrinks: Development and deliberate practices of highly effective psychotherapists* (Doctoral Thesis). Curtin University, Australia. Retrieved from: https://espace.curtin.edu.au/handle/20.500.11937/45

Chow, D. (2017). The practice and the practical: Pushing your clinical performance to the next level. In D. S. Prescott, C. L. Maeschalck & S. D. Miller (Eds.), *Feedback-Informed Treatment in Clinical Practice: Reaching for Excellence* (pp. 323-342). Washington, DC: American Psychological Association.

Chow, D., & Miller, S. D. (2015). *Taxonomy of deliberate practice activities worksheets*. Chicago, IL: International Center for Clinical Excellence.

Chow, D., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy, 52*, 337–345.

Del Re, A. C., Flückiger, C., Horvath, A. O., Symonds, D. & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance–outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review, 32*, 642–649.

Ericsson, K. A. (2006). The influence of experience and deliberate practice on the development of superior expert performance. In K. A. Ericcson, N. Charness, P. J. Feltovich & R. R. Hoffman (Eds.), *The Cambridge handbook of expertise and expert performance* (pp. 685- 705). New York, NY: Cambridge University Press.

Ericsson, K. A., Charness, N., Feltovich, P. J. & Hoffman, R. R. (Eds.) (2006). *The Cambridge handbook of expertise and expert performance*. New York, NY: Cambridge University Press.

Ericsson, K. A., Krampe, R. T. & Tesch-Römer, C. (1993). The role of deliberate practice in the acquisition of expert performance. *Psychological Review, 100*, 363-403.

Gimeno-Peón, A., Barrio-Nespereira, A. & Álvarez-Casariego, M. T. (2018a). Psicoterapia: Marca registrada [Psychotherapy: Trademark]. *Revista de la Asociación Española de Neuropsiquiatría, 38,* 131-144.

Gimeno-Peón, A., Barrio-Nespereira, A. & Prado-Abril, J. (2018b). Monitorización sistemática y feedback en psicoterapia [Routine outcome monitoring and feedback in psychotherapy]. *Papeles del Psicólogo, 39,* 174-182 doi: 10.23923/pap.psicol2018.2872

Goldberg, S. B., Babins-Wagner, R., Rousmaniere, T., Berzins, S., Hoyt, W. T., Whipple, J. L., ... & Wampold, B. E. (2016a). Creating a climate for therapist improvement: A case study of an agency focused on outcomes and deliberate practice. *Psychotherapy, 53*, 367-375.

Goldberg, S., Rousmaniere, T. G., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. & Wampold, B. E. (2016b). Do psychotherapists improve with time and experience? A longitudinal analysis of real world outcome data. *Journal of Counseling Psychology, 63*, 1–11.

Goodyear, R. K. & Rousmaniere, T. (2017). *Helping therapists to each day become a little better than they were the day before.* In T. Rousmaniere, R. K. Goodyear, S. D. Miller & B. E. Wampold (Eds.), *The cycle of excellence: Using deliberate practice to improve supervision and training* (pp. 67-95). Hoboken, NJ: John Wiley & Sons.

Goodyear, R. K., Wampold, B. E., Tracey, T. J. & Lichtenberg, J. W. (2017). Psychotherapy expertise should mean superior outcomes and demonstrable improvement over time. *The Counseling Psychologist, 45*, 54-65.

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K. & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, 61*, 155-163.

Hatcher, R. L. (2015). Interpersonal competencies: Responsiveness, technique, and training in psychotherapy. *American Psychologist, 70*, 747–57.

Hill & Knox (2013) Training and supervision in psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th Ed., pp. 775–811). Hoboken, NJ: Wiley.

Hill, C. E., Spiegel, S. B., Hoffman, M. A., Kivlighan Jr, D. M., & Gelso, C. J. (2017). Therapist expertise in psychotherapy revisited. *The Counseling Psychologist, 45*, 7-53.

Horvath, A. O., Del Re, A. C., Flückiger, C. & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*, 9–16.

Imel, Z. E., Sheng, E., Baldwin, S. A., & Atkins, D. C. (2015). Removing very low-performing therapists: A simulation of performance-based retention in psychotherapy. *Psychotherapy, 52*, 329-336.

Kraus, D. R., Bentley, J. H., Alexander, P. C., Boswell, J. F., Constantino, M. J., Baxter, E. E. & Castonguay, L. G. (2016). Predicting therapist effectiveness from their own practice-based evidence. *Journal of Consulting and Clinical Psychology, 84*, 473-483.

Kraus, D. R., Castonguay, L., Boswell, J. F., Nordberg, S. S. & Hayes, J. A. (2011). Therapist effectiveness: Implications for accountability and patient care. *Psychotherapy Research, 21*, 267–276.

Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th Ed., pp. 169-218). Hoboken, NJ: Wiley.

Malikiosi-Loizos, M. (2013). Personal therapy for future therapists: Reflections on a still debated issue. *European Journal of Counselling Psychology, 2*, 33–50.

Miller, S. D., Hubble, M. A., & Chow, D. (2017). Professional Development. In T. Rousmaniere, R. K. Goodyear, S. D. Miller & B. E. Wampold (Eds.), *The cycle of excellence: Using deliberate practice to improve supervision and training* (pp. 23-47). Hoboken, NJ: John Wiley & Sons.

Miller, S. D., Hubble, M. A. & Chow, D. (2018). The question of expertise in psychotherapy. *Journal of Expertise, 1,* 121-129.

Miller, S. D., Hubble, M. A, Chow, D., & Seidel, J. A. (2013). The outcome of psychotherapy: Yesterday, today, and tomorrow. *Psychotherapy, 50*, 88–97.

Miller, S. D., Hubble, M. A. & Duncan, B. L. (2007). Supershrinks: Learning from the field's most effective practitioners. *Psychotherapy Networker, 31*, 26-35.

Miller, W. R., & Rollnick, S. (2015). *La entrevista motivacional: Ayudar a las personas a cambiar [The motivational interview: Helping people change]* (3rd Ed.). Barcelona: Paidós.

Nissen-Lie, H. A., Monsen, J. T., Ulleberg, P. & Rønnestad, M. H. (2013). Psychotherapists' self-reports of their interpersonal functioning and difficulties in practice as predictors of patient outcome. *Psychotherapy Research, 23*, 86–104.

Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. C. & Monsen, J. T. (2015). Love yourself as a person, doubt yourself as a therapist? *Clinical Psychology & Psychotherapy, 24*, 48-60.

Norcross, J. C. & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*, 98-102.

Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D. & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*, 1157-1172.

Okiishi, J. C., Lambert, M. J., Nielsen, L. & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology & Psychotherapy, 10*, 361-373.

Pérez-Álvarez, M. (2019). La psicoterapia como ciencia humana, más que tecnológica [Psychotherapy as a human science, more than a technological one]. *Papeles del Psicólogo. Advance online publication*. doi: 10.23923/pap.psicol2019.2877

Prado-Abril, J., García-Campayo, J. & Sánchez-Reales, S. (2013). Funcionamiento de la terapia cognitivo-interpersonal en los trastornos de la personalidad: Estudio de dos casos [Efficacy of interpersonal-cognitive therapy in personality disorders: Two cases]. *Revista de Psicopatología y Psicología Clínica, 18,* 139-149. doi: 10.5944/rppc.vol.18.num.2.2013.12770

Prado-Abril, J., Sánchez-Reales, S. & García-Campayo, J. (2016). Dificultades en el manejo cognitivo-interpersonal del trastorno narcisista de la personalidad: Estudio de caso [Difficulties in interpersonal-cognitive management of narcissistic personality disorder: A case study]. *Revista Argentina de Clínica Psicológica, 25,* 317-325.

Prado-Abril, J., Sánchez-Reales, S. & Inchausti, F. (2017). En busca de nuestra mejor versión: Pericia y excelencia en Psicología Clínica [Searching for our best version: Expertise and excellence in Clinical Psychology]. *Ansiedad y Estrés, 23,* 110-117. doi: 10.1016/j.anyes.2017.06.001

Rousmaniere, T. (2016). *Deliberate practice for psychotherapists: A guide to improving clinical effectiveness*. New York, NY: Routledge.

Rousmaniere, T., Goodyear, R. K., Miller, S. D. & Wampold, B. E. (Eds.). (2017). *The cycle of excellence: Using deliberate practice to improve supervision and training*. Hoboken, NJ: John Wiley & Sons.

Rousmaniere, T. G., Swift, J. K., Babins-Wagner, R., Whipple, J. L. & Berzins, S. (2014). Supervisor variance in psychotherapy outcome in routine practice. *Psychotherapy Research, 26*, 196-205.

Saxon, D., & Barkham, M. (2012). Patterns of therapist variability: Therapist effects and the contribution of patient severity and risk. *Journal of Consulting and Clinical Psychology, 80*, 535-546.

Schauenburg, H., Buchheim, A., Beckh, K., Nolte, T., Brenk-Franz, K., Leichsenring, F.,... & Dinger, U. (2010). The influence of psychodynamically oriented therapists' attachment representations on outcome and alliance in inpatient psychotherapy. *Psychotherapy Research, 20*, 193-202.

Schöttke, H., Flückiger, C., Goldberg, S. B., Eversmann, J. & Lange, J. (2017). Predicting psychotherapy outcome based on therapist interpersonal skills: A five-year longitudinal study of a therapist assessment protocol. *Psychotherapy Research, 27*, 642-652.

Tracey, T. J., Wampold, B. E., Lichtenberg, J. W. & Goodyear, R. K. (2014). Expertise in psychotherapy: An elusive goal? *American Psychologist, 69*, 218-229.

Walfish, S., McAlister, B., O'Donnell, P. & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports, 110*, 639-644.

Wampold, B. E. & Brown, J. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*, 914-923.

Wampold, B. E., Baldwin, S. A., Grosse-Holtforth & Imel, Z. E. (2017). What characterizes effective therapists? In L. G. Castonguay & C. E. Hill (Eds.), *How and why are some therapists better than others?* (pp. 37-54). Washington, DC: American Psychological Association.

Wampold, B. E. & Imel, Z. E. (2015). *The great psychotherapy debate: The research evidence for what works in psychotherapy* (2nd Ed.). New York, NY: Routledge.

Watkins, C. E. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *Clinical Supervisor, 30*, 235–56.

Webb, C. A., DeRubeis, R. J. & Barber, J. P. (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*, 200-211.