DELIBERATE PRACTICE OF PSYCHOTHERAPY IN THE SPANISH RESIDENT INTERN PSYCHOLOGIST PROGRAM

PRÁCTICA DELIBERADA DE PSICOTERAPIA EN EL PROGRAMA DE PSICÓLOGO INTERNO RESIDENTE ESPAÑOL

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Abstract

Despite the effectiveness of psychotherapy, there is evidence about its limitations and possibilities for improvement. Attending to the therapist it seems that clinical experience, traditional supervision and training in evidence-based treatments are not in themselves and separately a guarantee of greater efficacy.

Measures of routine outcome monitoring in psychotherapy have been designed and can increase its effectiveness. The use of these methods is relevant within a context of deliberate practice. This type of practice is characterized by setting goals and training in skills that exceed the current level of the practitioner. Within the psychotherapeutic field, deliberate practice can contribute to an improvement in the effectiveness of the therapist over time. This paper makes a review of these concepts and proposes a model of deliberate practice that can be applied to the Spanish PIR program context, justifying their relevance and emphasizing the use of video recording of sessions and instruments for outcome monitoring.

Keywords: *Psychotherapy, PIR, Monitoring, Practice, Deliberate, Training.*

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Resumen

A pesar de la eficacia de la psicoterapia, existe evidencia sobre sus limitaciones y posibilidades de mejora. Atendiendo al factor del terapeuta, parece que la experiencia clínica, la supervisión tradicional o la formación en tratamientos empíricamente validados no son en sí mismos y por separado una garantía de mayor eficacia. Se han diseñado instrumentos de monitorización rutinaria del resultado de la psicoterapia que pueden incrementar su eficacia. El uso de estos métodos es relevante dentro de un contexto de práctica deliberada. Este tipo de práctica se caracteriza por el establecimiento de objetivos y el entrenamiento en habilidades que exceden el nivel actual del practicante. Dentro del campo psicoterapéutico, la práctica deliberada puede contribuir a un aumento de la eficacia del terapeuta a lo largo del tiempo. Este artículo realiza una revisión de estos conceptos y propone un modelo de práctica deliberada aplicable al contexto del programa PIR español, justificando su pertinencia y enfatizando el empleo de sesiones grabadas en video junto con instrumentos de monitorización del resultado.

Palabras clave: *Psicoterapia, PIR, Monitorización, Práctica, Deliberada, Entrenamiento*

Context

According to a recent meta-analysis on the effectiveness of psychotherapy for patients with mental health problems, a patient who engages in psychotherapy improves on average more than 80% than those who do not (Wampold and Imel, 2015). Nevertheless, there is a wide margin of improvement in the results. This is justified by two facts: first, effectiveness has not increased since the first meta-analysis that evaluated the outcomes of psychotherapy (Smith and Glass, 1977), even in spite of research, training, and dissemination of evidence-based psychological treatments (American Psychological Association, 2012); and second, it is common to find that up to 50% of patients experience no improvement or even worsening during treatment (Lambert, 2013). In addition, one in four patients drops out from psychotherapy before achieving positive results (Swift & Greenberg, 2012).

When variables related to the intervention setting are considered, it has been found that when comparing active and structured treatments coming from different theoretical models, they are equally effective. This is also known as the "dodo bird" effect (Wampold et al., 1997). However, when therapists are compared with each other the differences explain a greater percentage of the variability in psychotherapy outcomes (Baldwin & Imel, 2013; Saxon & Barham, 2012; Wampold & Brown, 2005).

Psychotherapy training programs generally assume that clinical experience, supervision, or training in evidence-based treatments leads to better outcomes. However, there are studies that question an unequivocal relationship between effectiveness and therapist experience, finding no improvement over the years (Goldberg et al., 2016a; Owen, Wampold, Kopta, Rousmaniere, & Miller, 2015). Regarding supervision, despite being considered a central variable in clinical practice (Orlinsky, Botermans, & Rønnestad., 2019) there is little evidence on its role in the effectiveness of psychotherapy (Watkins, 2001; Rousmaniere, Babins-Wagner, Whipple, Barzins, 2014). Finally, a meta-analysis of 28 clinical trials found that neither adherence to an effective treatment, understood as adjustment to its intervention protocol, nor competence, understood as the ability to implement it according to treatment experts, were significantly related to better outcomes of psychotherapy (Webb, DeRubeis, & Barber, 2010).

The Spanish Internal Resident Psychologist (PIR in Spanish) program aims, among others, to train clinical psychologists to be capable of carrying out effective psychotherapeutic interventions in a wide range of patients and health care settings (Olabarría & García, 2011). In order to do so, applicants to the PIR program must first pass a demanding test of knowledge related to psychology, particularly on evidence-based treatments for psychological disorders. After passing this test, they must complete a four years residence program. During this period, they rotate through different settings in the mental health network of the Spanish national health system. Psychotherapeutic practice supervised by clinical psychologists with greater training and experience is one of the central aspects of the program,

as well as continuous training in aspects related to professional practice. Thus, they dedicate a large part of the 37.5 hours per week of work to these aspects, having accumulated a large number of hours of supervised practice at the end of their training period (for a review of the history and the PIR program, see Prado-Abril, Sánchez-Reales, Gimeno Peon, & Aldaz-Armendáriz, 2019).

Considering the evidence, it seems that none of the variables mentioned leads by itself and in an unequivocal way to an improvement in psychotherapy outcomes. This article proposes a review of two factors that have been the subject of recent research: outcome monitoring and deliberate practice. To this end, the PIR system is defended as appropriate for introducing these variables, and a model of deliberate practice is proposed based on actual experience in a Spanish hospital.

Monitoring of outcomes in psychotherapy

In recent years, systems have been created to measure the progress of psychotherapy in real time. The idea is to include instruments that are easy to apply and that evaluate outcomes session by session, along with other relevant aspects of the therapeutic process such as the working alliance. This practice is known as ROM (Routine Outcome Monitoring) (Lambert, 2010). Among the multiple ROM systems that have emerged in recent years, the most widely used in clinical trials to date are the Outcome Questionnaire System (OQ; Lambert et al. 1996) and the Partners for Change Outcome Management System (PCOMS; Miller, Duncan, Sorrel, & Brown, 2005), both with proven psychometric properties (Bringhurst, Watson, Miller, & Duncan, 2006; Miller, Duncan, Brown, Sparks, & Claud, 2003; Reese, Toland, & Kodet, 2012; Vermeersch et al., 2004).

-The OQ System contains the OQ-45 instrument, a 45-item self-assessment measure that is used session by session, assessing patient functioning in the dimensions of symptomatology (especially anxiety and depression), interpersonal problems and social performance, along with a quality of life subscale.

-The PCOMS, on the other hand, includes two short four-item scales: a) the Outcome Rating Scale (ORS), whose items evaluate through a continuum the same dimensions as the OQ; and b) the Session Rating Scale (SRS), whose items evaluate in the same way the working alliance, through the dimensions of quality in the relationship with the therapist, satisfaction with the goals or topics addressed, with the approach or method used, and at a global level, according to Bordin's conceptualization of working alliance (Bordin, 1979)

A recent meta-analysis of 24 studies evaluating the efficacy of these instruments found that in two-thirds of the studies the group treated with ROM improved more than the usual treatment group, with effect sizes in the small to moderate range. The effect was greater in those patients who were predicted to have a poor outcome, so that within this group those treated with ROM improved by up to twice as much as those not treated with ROM (Lambert, Whipple, & Kleinstäuber, 2018).

One of the reasons for how ROM may increase psychotherapy outcomes is that

it helps the practitioner to adjust their perspective of their patient progress through routine observation. Thus, it has been found that therapist ability to predict their patient progress is far less than patients believe (Hannan et al., 2005). In addition, they tend to overestimate their own effectiveness in relation to their peers. Walfish found that none of the 129 therapists of a survey rated themselves below average, and up to 25% estimated their own expertise at the 90th percentile (Walfish, McAlister, O'Donnell, & Lambert, 2012).

Another explanation that complements the previous one refers to the importance of the working alliance. This is one of the most researched factors in the contribution to psychotherapy outcomes. In fact, a meta-analysis of 190 studies showed that the working alliance explained up to 8% of the variability in outcomes. This percentage was consistent across studies using different sources, instruments and measurement points of the alliance, as well as in selecting studies whose authors considered it a priori as a factor of residual importance (Horvath, Del Re, Fluckiger, & Symonds, 2011). The contribution of the therapist to the working alliance has also been found to be one of the main factors explaining the difference in therapist effectiveness (Baldwin, Wampold, & Imel, 2007). Thus, those therapists who are most effective are likely to be so mostly because of their ability to establish a strong working alliance with a wide range of patients. In this case, ROM would act as a measure of contrast between the therapist perception, subject to the biases described, and the actual evolution of the patient progress and the working alliance. This may allow the difference between the two perceptions to be observed and the appropriate changes to be introduced into the treatment in a collaborative manner.

However, it is important to point out that ROM does not contribute in all cases to better psychotherapy outcomes. Up to a third of the studies in the aforementioned meta-analysis found no differences between ROM and treatment as usual (Lambert et al., 2018). Another meta-analysis, which included 18 studies evaluating the efficacy of the PCOMS system alone, found no effect in those studies that took place in psychiatric settings and with more severe patients (Østergård, Randa, & Hougaard, 2018). It appears that the effectiveness of ROM is greater in community and outpatient settings. This could be because in community settings collaboration and working partnership are central to psychotherapy, while in psychiatric settings treatment tends to be more structured and less flexible to modifications. This also applies at the level of the therapist: ROM can be a useful tool in the hands of a professional who is open and responsive to information that contradicts his or her impressions.

Deliberate practice in psychotherapy

Deliberate practice is defined as "individualized training in activities specially designed to improve specific aspects of performance through successive repetition and refinement" (Ericsson, 1996, pp. 278-279). It differs from routine practice of a discipline in that it is more focused on the acquisition of goals and skills beyond

the individual current level. To this end, deliberate practice includes the use of measures to check that progress has taken place. In this way, routine practice facilitates automation of skills more than improvement. In contrast, deliberate practice focuses on making current skills more flexible and to improve them based on an excellence criteria. Deliberate practice has been researched and applied in many disciplines such as music or medicine, and many of these now have a deliberate practice method and evidence of its role in performance improvement (for a review on the topic see Ericcson, 2006).

The evidence for deliberate practice in the field of psychotherapy is relatively recent but with favorable results. A study on the interaction between the characteristics of 69 therapists and their differences in effectiveness found that those who were more effective spent more time improving specific aspects of their psychotherapeutic practice, for example by watching videos of their sessions (Chow et al., 2015). In another study, a significant interaction was obtained between the effectiveness of a sample of 70 therapists and their self-assessments in professional self-doubt. Specifically, those therapists who showed high levels of professional self-doubt along with high levels of self-assertion were consistently more effective (Nissen-Lie et al., 2015). Thus, these data suggest that in order for the therapist to reflect on his or her aspects to be improved in a continuous and constructive way, it is important to reinforce the positive aspects of the self, for which is relevant that learning takes place in a safe context.

Despite evidence of the contribution of deliberate practice to performance improvement in other disciplines, psychotherapy has been slow to adapt and develop its own method. This is probably due to several reasons. First, unlike other disciplines, psychotherapy generally takes place in privacy and therapist work is not usually subject to observation and evaluation. Thus, the traditional method of supervision consists of the supervisee presenting a case to the supervisor based on the content of his or her memory and, in the best of cases, notes in the clinical history. Therefore, work material is already subject to omissions, distortions and additions with respect to what happened in the session. Secondly, in psychotherapy there is no standard of excellence easily recognized by the community, as there may be in music, sports or surgery. In fact, as seen above, there is no evidence that those who are considered experts in a particular model consistently achieve better outcomes with their patients (Webb et al., 2010). Finally, the object of psychotherapeutic work is the patient (or partner, family) and therapist dyad involved in the process. It is therefore a work that involves many variables belonging to each of them and their interaction. Thus, it is more complex to establish a routine of solitary deliberate practice, compared to, for example, a surgical simulation or the practice of a musical instrument.

Despite the limitations described above, Rousmaniere introduced a model of deliberate practice applicable to psychotherapy, which is structured around these five aspects (Rousmaniere, 2016):

1) Observing the psychotherapeutic work and establishing a baseline of effectiveness.
2) Getting expert feedback.
3) Setting small incremental learning goals just beyond current level of ability.
4) Engaging in repetitive behavioral rehearsal of specific skills.
5) Constantly assessing performance.

A prospective study has been conducted on the change in therapist effectiveness over time (Goldberg et al., 2016b), similar to that mentioned above (Goldberg et al., 2016a). However, this study systematically applied the recommendations described in the model proposed by Rousmaniere and other authors (Tracey, Wampold, Lichtenberg, & Goodyear 2014). The analysis of 153 psychotherapists who attended a total of 5128 patients during seven years showed, contrary to the previous study, an improvement in the average effectiveness at the mental health organization and therapists level, with an increase in the effect size of $d = 0.034$ each year (Goldberg et al., 2016b).

Deliberate practice in the Spanish PIR program

As stated above, completing the PIR program entails having acquired theoretical knowledge and supervised practical experience that are of great value to the clinical psychologist, and guarantees a minimum of quality care for psychotherapeutic work. In addition, the four-year residence experience provides useful theoretical and practical knowledge in other aspects not directly related to psychotherapy, such as clinical decision-making in the context of the national health system. However, it has been argued that neither training of evidence-based treatments, nor experience and supervision are in themselves sufficient conditions for better outcomes in psychotherapy. In parallel, the available evidence regarding ROM and deliberate practice in psychotherapy and its contribution to increasing its effectiveness has been summarized. Deliberate practice in the Spanish PIR program has been subject of recent reflection (Prado-Abril, Sánchez-Reales, & Inchausti, 2017; Prado-Abril, Gimeno-Peón, Sánchez-Reales, 2019; Revenga Montejano & Martín García, 2019).

In fact, the authors of the present paper argue that the context of supervised work over four years of the PIR program is the right one to implement deliberate practice methods for several reasons: firstly, practitioners rotate through different devices and with patients with different problems, which forces a continuous review and adjustment of their own therapeutic skills in different contexts; secondly, supervision by different therapists facilitates that practitioners receive a varied feedback about their own performance and different work models, which contributes to stimulate their self-reflection; and thirdly, spaces of regulated teaching provide the conditions to stimulate this practice given its integration in the working day and psychotherapeutic practice.

The following is an adaptation of Rousmaniere´s model of deliberate practice (Rousmaniere, 2016) applicable to the context of the PIR program, taking into

account each of its aspects:

1) Observing the psychotherapeutic work and establishing a baseline of effectiveness. To be able to improve it is necessary to know where to start from. Practitioners usually do not have information about their level of effectiveness when they start, for example, their rotation in a Mental Health Community Centre. Therefore, incorporating ROM into daily practice can help them contrast the degree to which their patients are improving as expected. As discussed, systems such as PCOMS provide brief and simple measures of psychotherapy outcomes and working alliance.
2) Getting expert feedback. In relation to this point and the previous one, practitioners usually do not have information about their own performance within the session, except only through their memory. Limitations of traditional supervision have been commented on, insofar as it is based on what is perceived and remembered by the supervisee. Recording clinical sessions and supervising them can provide both supervisee and supervisor with information about their performance from another perspective. This method of video supervision should be incorporated alongside traditional supervision and case formulation in the teaching spaces of the PIR program. An alternative to video is an audio recording of the session, which may be easier and less anxious for both therapist and patient, while gathering much of the relevant conversational information for supervision.

At this point it is also necessary to reflect on who constitutes an expert in psychotherapy. Given the insufficiency of data on the actual performance of psychotherapists, one possibility is to select a supervisor based on the practitioner consideration of his or her psychotherapeutic ability, along with the criteria of accessibility and availability inherent to the PIR program. It is common for practitioners to have the impression that certain professionals have a repertoire of knowledge and skills far superior to their own, and they may be eligible for the job of supervisor.

A relevant variable in this sense is the personal style of the therapist, defined as "a set of unique conditions that lead a therapist to operate in a particular way in his or her work" (Fernández-Álvarez & García, 1998). It is a multidimensional construct that includes the way of establishing the frame, the emotional expressiveness, the degree of commitment to their work, the way of attending or selecting the information in the session and the specific actions or interventions. It is evaluated by the therapist personal style questionnaire (EPT-C in Spanish) (Fernández-Álvarez, García, Lo Bianco, & Corbella, 2003), recently validated in the Spanish population (Prado-Abril et al., 2020). The personal style of the therapist has been compared according to psychotherapeutic orientation (Quiñones and Ugarte, 2019) or experience attending to a type of problem (Casari and Ison, 2019). A hypothesis to be contrasted would be that a supervisor whose therapeutic style was similar to that of the supervisee would favor his or her learning, through a shared framework of attitudes and behaviours regarding supervision and the therapeutic process. In this

case, this criterion could be considered in the selection of the supervisor.

3) Setting small incremental learning goals just beyond current level of ability. In the video supervision, the supervisor may select one or more relevant clinical scenes, either because of their importance in the psychotherapeutic process or because they illustrate a particular skill that the supervisee can improve. After this skill and the justification of its relevance is presented, a role-playing session can take place in which the supervisor shows the skill by playing the role of the therapist, and then the supervisee practices this skill and receives the appropriate feedback.

It is important to select skills that are within the supervisee zone of proximal development (Vygotsky, 1978), and in a context that is warm, safe and conducive to learning.

4) Engaging in repetitive behavioral rehearsal of specific skills. Once the supervision has been taken place, practitioners have opportunities to practice the learned skills, both in later sessions with their patients, and in role-playing or even alone, using the video as a stimulus with which to interact. As a guide of skills to be practiced, in a sample of 25 therapists it was observed that those who had high scores in the so-called interpersonal facilitation skills obtained better outcomes with their patients (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). These skills are verbal fluency, expression of a wide range of emotions, ability to persuade and give hope, warmth and empathy, ability to form a strong working alliance, and problem orientation. The practice of these skills was especially relevant in complex clinical situations, such as in the presence of an angry, withdrawn or self-punitive patient (Anderson et al., 2009).

On the other hand, there are classifications on therapeutic skills related to relevant variables in psychotherapy: with the structure of treatment, for example, how to close a session or elicit patient feedback; with fostering expectations of improvement, e.g., how to express confidence in treatment or provide an explanation of the patient problem in adapted language; with building a working alliance, e.g., how to mobilize readiness for change, promote a warm bond or address alliance ruptures; with the self of the therapist, e.g., how to manage countertransference, regulate one's anxiety or employ self-disclosure; and with the patient own variables, e.g., how to reinforce their strengths and tailor treatment to their values and beliefs (Chow et al. , 2015).

The practice of these and other skills in a deliberate way implies a process opposite to routine practice, since while the latter leads to the progressive automation of the therapist behavior, the former is directed to the awareness and flexibility of the behavioral repertoire of skills, in order to adapt to a wide range of clinical situations and patients.

5) Constantly assessing performance. To achieve a progressive increase in the effectiveness of psychotherapy, it is important to make a constant eva-

luation of one's performance. This is the only way to check whether the skills practiced and the topics addressed in session contribute to clinical improvement, without undermining the importance of extra-therapeutic factors (Norcross and Goldfried, 2019). To do so, it is essential to incorporate ROM into daily practice. In fact, an increase in the effectiveness of a sample of 20 therapists has been observed over the years following the introduction of ROM (Brattland et al., 2018).

In addition, the above-mentioned instruments can be complemented by other methods that provide a broader and richer view of the patient perspective. For example, one can watch a video of a session with the patient him or herself and ask him or her to point out the most relevant moments and their reasons. This allows access to their perspective moment by moment, a source of information of undoubted value in the process (Kagan, 1980; Bernard, 1989).

A pilot experience

During the academic year 2018-19, a workshop was implemented within the teaching program for clinical psychology and psychiatry at La Paz Universitary Hospital in Madrid, aimed at improving practitioners´ skills as psychotherapists and following the model of deliberate practice described above. Frequently held every two months, six sessions taken place throughout the course in a group format including all available practitioners. The duration was one hour, and participation as a supervisee was voluntary. During this first year all volunteers were in one of the last two years of the residency program and worked on psychotherapy interviews of patients in outpatient settings. The structure of the workshop is described below:

1. Pre-session work: the supervisee sends the recording of the interview to the supervisor, indicating the aspects of the interview with which he or she is not satisfied. The supervisor, in turn, reviews the recording, identifies a skill to be improved and selects one or more short (no more than 2 minutes) fragments in which the execution of the skill could be improved. Supervisor and supervisee agree from that moment on the skill to be worked on in the session. Although it was not included in the initial proposal, the review of the interviews led the supervisor to select some brief fragment that illustrated therapeutic skills well executed in the same session with the intention of strengthen the motivational component and reducing the fear of the supervisee to the group exposure of their difficulties in sessions.
2. Work in session: the session begins with the supervisee making a very brief contextualization of the case for the group, as well as a general summary of the interview and the difficulties presented. The supervisor introduces the skill to be worked on and explains it in a summarized way, sometimes including audiovisual elements. The visualization of the video fragments is made and the aspects of improvement are pointed out. At this point there is a brief pause in case there is a need for comments or clarifications and

then the skill is put into practice. In a role playing format, the supervisor plays the role of the therapist, modelling the execution of the skill, and the supervisee plays the role of the patient. If time is available, the roles are reversed or a pair practice is proposed among all group members. The session concludes with an exchange of impressions regarding the work and with indications of practice of the skill in its habitual performance.

In general terms, the difficulty most commonly observed in therapists in training is excessive pressure on one's own performance and a high degree of self-focus on the part of the supervisees, which makes it difficult for them to be receptive, present and focused on the people they are treating, a factor which can be influenced by both stable variables such as limited experience or a competitive hospital environment, and situational variables such as the recording context for supervision. The most notable skills are their ability to foster the relational bond, the analysis of the conflicts and a high level of personal disposition.

The skills worked in the different sessions in 2018-19 were

- Working with moments of ambivalence: tolerance, exploration, formulation (Oliveira, Gonçalves, Braga, & Ribeiro, 2016)
- Alliance ruptures and repairs: detection and technical alternatives (Safran and Krauss, 2014)
- Work on exceptions in dominant narratives (De Shazer, 1988)
- Maintaining therapeutic distance and reflective functioning in working with ambivalent-resistant attachment styles (Baim, Morison, & Hathaway, 2011)
- Intervention on indicators of experiential avoidance (Muller, 2010)
- Reconstruction and deployment of episodes of conflict (Dimaggio, Montano, Popolo and Salvatore, 2015)

As an example, we will detail the work with this last skill: during the interview there are several moments in which the patient gives a fragmented, partial account of recent life episodes and is not very receptive to the exploration. The narrative fragmentation seems to hide experiences and affections that are not very integrated in her conscience, and probably relevant in terms of her main conflicts. The therapist handles himself mainly on a semantic level, trying to give a general sense to the experience, and prescriptive, looking for solutions to little defined problems, but he feels disarmed. An alternative work is proposed and modelled, focusing more on the detailed unfolding of the episodes and the self-observation by the patient. The aim is that she can contact with these experiences and their relevant information for their self-organization, as proposed by techniques such as the systematic evocative unfolding (Rice and Saperia 1984), the Moviola (Guidano, 1995) or the unfolding of episodes in the work with personality disorders (Dimaggio et al., 2015).

3. Post-session work: the supervisees practice in their professional settings, in a natural environment and review their experience in the supervisory environments available to them.

After this first block of work, and coinciding with the incorporation of the new residents to the workshop, a discussion group is held over the functioning of the workshop. The newcomers experience the possibility of exposing themselves with a high component of fear, given their limited experience, while those who have gone through the process and have worked in previous sessions transmit a sense of learning and try to convey a culture of open work and safety. As possible elements of improvement for future editions, the following options are considered:

- Increasing the duration by half an hour in order to guarantee the practice of all the participants in the role playings.
- Divide the group in two, in order to increase containment, decrease the degree of exposure and allow greater involvement of all participants
- Assess the possibility of doing a differentiated job: general interview and interpersonal facilitation skills in the first two years of residence, and specific skills with more technical content in the third and fourth years.

Conclusions

Despite the established effectiveness of psychotherapy for patients with mental health problems, there is evidence of its potential for improvement. Furthermore, it seems that the difference among therapists explains a greater variability in outcomes than the difference among treatments. When considering therapist characteristics, variables such as clinical experience, supervision, or training in evidence-based treatments are not sufficient conditions for greater effectiveness. In this sense, the introduction of instruments for routine outcome monitoring or ROM can contribute to improving treatment outcomes by providing session-by-session information that can be modified and adapted to the patient needs. The use of ROM should take place in a context of deliberate practice, a type of practice specifically focused on goal setting and skill practice that is beyond the current level of ability. In this way, the PIR program provides a unique opportunity for deliberate practice, as it is a safe context with many spaces for reflection and supervision. In addition, on many occasions the program takes places within the beginning of professional practice in clinical psychology, making it especially important to carry out a reflected practice focused on the aspects to be improved. The recording of clinical sessions, supervision and practice of therapeutic skills, together with the use of ROM are aspects that should be incorporated into Spanish PIR programs, with the aim of contributing to greater effectiveness in the practitioner psychotherapeutic skills during and after the residency period.

References

American Psychological Association (2012, August 9). Resolution on the recognition of psychotherapy effectiveness. Retrieved from: https://www.apa.org/about/policy/resolution-psychotherapy

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*(7), 755–768. https://doi.org/10.1002/jclp.20583

Baim, C., Morrison, T. & Hathaway, J. (2011). *Attachment-based Practice with Adults: Understanding Strategies and Promoting Positive Change: A new practice model and interactive resource for assessment, intervention and supervision*. Brighton, United Kingdom: Pavilion.

Baldwin, S. A. e Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6ª ed., pp. 258– 297). New York, NY: Wiley.

Baldwin, S. A., Wampold, B. E. e Imel, Z. E. (2013). Untangling the alliance–outcome correlation: exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*(6), 842–852. https://doi.org/10.1037/0022-006X.75.6.842

Bernard, J. M. (1989). Training supervisors to examine relationship issues using IPR. *The Clinical Supervisor, 7*(1), 103-112. https://doi.org/10.1300/J001v07n01_08

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working Alliance. *Psychotherapy: Theory, Research, & Practice, 16*(3), 252-260. https://doi.org/10.1037/h0085885

Brattland, H., Koksvik, J. M, Burkeland O., Grave, R. W., Klöckner, C., Linaker, O. M. … Iversen, V. C. (2018). The effects of routine outcome monitoring (ROM) on therapy outcomes in the course of an implementation process: A randomized clinical trial. *J Couns Psychol*, *65*(5), 641–652. https://doi.org/10.1037/cou0000286

Bringhurst, D. L., Watson, C. W., Miller, S. D. & Duncan, B. L. (2006). The reliability and validity of the Outcome Rating Scale: A replication study of a brief clinical measure. *Journal of Brief Therapy, 5*(1), 23–30. Retrieved from: https://www.scottdmiller.com/wp-content/uploads/JBTORSReplication.pdf

Casari, L. e Ison, M. S. (2019). Estilo Personal del Terapeuta: comparación entre profesionales que trabajan en instituciones de adicciones y profesionales del área clínica general [Therapist Personal Styles: A Comparison Between Professionals Working in Drug Addiction Institutions and Professionals Working in the General Clinical Area]. *Revista Costarricense de Psicología*, *38*(1), 57-73. https://doi.org/10.22544/rcps.v38i01.04

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A. & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy, 52*(3), 337–345. https://doi.org/10.1037/pst0000015

De Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. London, United Kingdom: WW Norton & Co.

Ericsson, K. A. (2006). The Influence of experience and deliberate practice on the development of superior expert performance. In K. A. Ericsson, N. Charness, P. J. Feltovich & R. R. Hoffman (Eds.), *The Cambridge handbook of expertise and expert performance* (pp. 683–704). New York, NY: Cambridge University Press.

Dimaggio, G., Montano, A., Popolo, R. & Salvatore, G. (2015). *Metacognitive interpersonal therapy for personality disorders: A treatment manual*. London, United Kingdom: Routledge.

Fernández-Álvarez, H. & García, F. (1998). El Estilo Personal del Terapeuta: Inventario para su evaluación. In S. Gril, A. Ibáñez, I. Mosca & P. L. R. Sousa (Eds.), *Investigación en Psicoterapia* (pp.76-84). Pelotas, Brasil: Educat.

Fernández-Álvarez, H., García, F., Lo Bianco, J. & Corbella, S. (2003). Assesment Questionnaire on The Personal Style of the Therapist PST-Q. C*linical Psychology and Psychotherapy, 10*(2), 116-125. https://doi.org/10.1002/cpp.358

Goldberg, S. B., Rousmaniere, T., Miller, S., Whipple, J, Nielsen, S. L., Hoyt, W. T. & Wampold, B. E. (2016a). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology, 63*(1), 1-11. https://doi.org/10.1037/cou0000131

Goldberg S. B., Babins-Wagner R., Rousmaniere T., Berzins S., Hoyt W. T., Whipple J. L. y Wampold B. E. (2016b). Creating a climate for psychotherapist improvement: A case study of an agency focused on outcomes and deliberate practice. *Psychotherapy, 53*(3), 367-375. https://doi.org/10.1037/pst0000060

Guidano, V. (1995). A constructivist outline of human knowing processes. In Mahoney, M. J. (Ed.), *Cognitive and constructive psychotherapies: Theory, research, and practice* (pp. 89-102). New York, NY: Springer.

Hannan, C., Lambert, M., 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*(2), 155-163. https://doi.org/10.1002/jclp.20108

Horvath, A. O., Del Re, A. C., Fluckiger, C. & Symonds, D. (2011). Alliance in Individual Psychotherapy. *Psychotherapy*, *48*(1), 9-16. https://doi.org/10.1037/a0022186

Kagan, N. (1980). Influencing human interaction-Eighteen years with IPR. In A.K. Hess (Ed.), *Psychotherapy supervision: Theory, research, and practice* (pp. 262-283). New York, NY: Wiley

Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC: American Psychological Association.

Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (6ªed., pp. 169–218). Hoboken, NJ: JohnWiley.

Lambert, M. J., Hansen, N. B., Umphress, V. J., Lunnen, K., Okiishi, J., Burlingame, G. & Reisinger, C. W. (1996). *Administration and scoring manual for the outcome questionnaire* (OQ 45.2). Wilmington, DE: American Professional Credentialing Services

Lambert, M. J., Whipple, J. L. & Kleinstäuber, M. (2018). Collecting and delivering progress feedback: A meta-analysis of routine outcome monitoring. *PsychoTherapy, 55*(4), 520-537. https://doi.org/10.1037/pst0000167

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analogue measure. *Journal of Brief Therapy, 2*(2), 91–100. Retrieved from: https://scottdmiller.com/wp-content/uploads/documents/OutcomeRatingScale-JBTv2n2.pdf

Miller, S. D., Duncan, B. L., Sorrell, R. & Brown, G. S. (2005) The partners for change outcome management system. *J Clinical Psychology, 61*(2), 199–208. https://doi.org/10.1002/jclp.20111

Muller, R. T. (2010). *Trauma and the avoidant client: Attachment-based strategies for healing*. New York, NY: WW Norton & Company.

Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. & Monsen, J. T. (2015). Love Yourself as a Person, Doubt Yourself as a Therapist? *Clinical Psychology, Psychotherapy, 24*(1), 48-60. https://doi.org/10.1002/cpp.1977

Norcross, J. C. & Goldfried, M. R, (2019). *Handbook of Psychotherapy Integration* (3ªed.). New York, NY: Oxford University press.

Olabarría, B. & García, M. A. (2011). Acerca del proceso de construcción de la Psicología Clínica en Spain como Especialidad Sanitaria [On the construction of clinical psychology in Spain as a health specialty]. *Revista de Psicopatología y Psicología Clínica, 16*(3), 223-245. https://doi.org/10.5944/rppc.vol.16.num.3.2011.10363

Oliveira, J. T., Gonçalves, M. M., Braga, C. & Ribeiro, A. P. (2016). Cómo lidiar con la ambivalencia en psicoterapia: un modelo conceptual para la formulación de caso [How to deal with ambivalence in psychotherapy: a conceptual model for case formulation]. *Revista de psicoterapia, 27*(104), 83-100. https://doi.org/10.33898/rdp.v27i104.122

Orlinsky, D. E., Botermans, J. F. & Rønnestad, M. H. (2001). Towards an Empirically Grounded Model of Psychotherapy Training: Four Thousand Therapists Rate Influences on Their Development. *Australian Psychologist, 36*(1), 139-148. https://doi.org/10.1080/00050060108259646

Østergård, O. K, Randa, H. & Hougaard, E. (2018). The effect of using the partners for change outcome management system as feedback tool in psychotherapy: A systematic review and meta-analysis. *Psychotherapy Research, 30*(2), 195-212. https://doi.org/10.1080/10503307.2018.1517949

Owen, J., Wampold, B. E., Kopta, M., Rousmaniere, T. & Miller, S. D. (2015). As good as it gets? Therapy outcomes of trainees over time. *Journal of Counseling Psychology, 63*(1), 12-19. https://doi.org/10.1037/cou0000112

Prado-Abril, J., Fernández-Álvarez, J., Sánchez-Reales, S., Youn, S. J., Inchausti, F. & Molinari, G. (2020). La persona del terapeuta: Validación española del Cuestionario de Evaluación del Estilo Personal del Terapeuta (EPT-C). *Revista de Psicopatología y Psicología Clínica, 24*(3), 131-149. https://doi.org/10.5944/rppc.24367

Prado-Abril, J., Gimeno-Peón, A., Inchausti, F. & Sánchez-Reales, S. (2019). Expertise, therapist effects and deliberate practice: The cycle of excellence. *Papeles del Psicólogo, 40*(2), 89-100. https://doi.org/10.23923/pap.psicol2019.2888

Prado-Abril, J., Sánchez-Reales, S., Gimeno Peón, A. & Aldaz-Armendáriz, J. A. (2019). *Clinical Psychology in Spain: History, Regulation and Future Challenges, 1*(4) 1-12. https://doi.org/10.32872/cpe.v1i4.38158

Prado-Abril, J., Sánchez-Reales, S. e Inchausti, F. (2017). En busca de nuestra mejor versión: pericia y excelencia en Psicología Clínica. *Ansiedad y Estrés, 23*(2-3), 110-117. https://doi.org/10.1016/j.anyes.2017.06.001

Quiñones, Á. y Ugarte, C. (2019). Investigación del estilo personal del terapeuta post-racionalista: Una revisión [Research of the personal style of the post-rationalist therapist: a review]. *Revista De Psicoterapia, 30*(112), 7-15. https://doi.org/10.33898/rdp.v30i112.281

Reese, R. J., Toland, M. D. & Kodet, J. (2012, Agosto). *Validity of a psychotherapy outcome measure: The Outcome Rating Scale*. Sesión de Póster presentado en The annual meeting of the American Psychological Association, Orlando, FL.

Revenga Montejano, S. & Martín García, A. (2019). Reflexiones sobre la formación en Psicología Clínica: el camino hacia la Pericia. *Revista clínica contemporánea, 10*(3), 1-15. https://doi.org/10.5093/cc2019a19

Rice, L. N. & Saperia, E. (1984). A task analysis of the resolutions of problematic reactions. In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapy process* (pp. 29-66). New York, NY: Guilford press.

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

Rousmaniere, T. G., Swift, J. K., Babins-Wagner, R., Whipple, J. L. & Barzins, S. (2014). Supervisor variance in psychotherapy outcome in routine practice. *Psychotherapy Research, 26*(2), 196-205. https://doi.org/10.1080/10503307.2014.963730

Safran, J. D. & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy*, *51*(3), 381-387. https://doi.org/10.1037/a0036815

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*(4), 535– 546. https://doi.org/10.1037/a0028898

Smith, M. L. & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*(9), 752–760. https://doi.org/10.1037/0003-066X.32.9.752

Swift, J. K. & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80*(4), 547–559. https://doi.org/10.1037/a0028226

Tracey, T. J. G., Wampold, B. E., Lichtenberg, J. W. y Goodyear, R. K. (2014). Expertise in psychotherapy: An elusive goal? *American Psychologist, 69*(3), 218-229. https://doi.org/10.1037/a0035099

Vermeersch, D. A., Whipple, J. L., Lambert, M. J., Hawkins, E. J., Burchfield, C. M. & Okiishi, J. C. (2004). Outcome Questionnaire: Is it sensitive to changes in counseling center clients? *Journal of Counseling Psychology, 51*(1), 38–49. https://doi.org/10.1037/0022-0167.51.1.38

Vygotsky, L. S. (1978). *Mind in Society: the Development of Higher Psychological Processes*. Cambridge, MA: Harvard University Pres.

Walfish, S., McAlister, B., O'Donnell, P. & Lambert, M. (2012). An Investigation of Self-Assessment Bias in Mental Health Providers. *Psychological reports, 110*(2), 639-644. https://doi.org/10.2466/02.07.17.PR0.110.2.639-644

Wampold, B. E. & Brown, G. S. (2005). Estimating variability in outcomes attributable to therapists: a naturalistic study of outcomes in managed care. *Journal of Clinical Psychology and Clinical Psychology, 73*(5), 914-923. https://doi.org/10.1037/0022-006X.73.5.914

Wampold, B. E. e Imel, Z. E. (2015). *The Great Psychotherapy Debate: The evidence fot What makes Psychotherapy Work*. New York, NY: Routledge.

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K. & Ahn, H.-n. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes.". *Psychological Bulletin, 122*(3), 203–215. https://doi.org/10.1037/0033-2909.122.3.203

Watkins, C. E. (2001). Does psychotherapy supervision contribute to patient outcomes? Considering 30 years of research. *The clinical supervisor, 30*(2), 235-256. https://doi.org/10.1080/07325223.2011.619417

Webb, C. A., DeRubeis, R. J. & Barber, J. P. (2010). Therapist adherence/competence and tratment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*(2), 200-211. https://doi.org/10.1037/a0018912