

Research shows that training in specific techniques and theories contributes little to effective psychotherapy outcomes. What are well-intentioned clinicians who want to improve their skills to do? Read *The Field Guide to Better Results*. This book offers readers a practical roadmap to making their sessions more successful and enjoyable while helping them grow as therapists (and as people). I highly recommend this book.

—**PAUL J. LESLIE, EdD**, AUTHOR OF *THE ART OF CREATING A MAGICAL SESSION: KEY ELEMENTS FOR TRANSFORMATIVE PSYCHOTHERAPY*

One of the biggest questions facing practicing clinicians today is how to improve and to personalize psychological interventions based on the available research literature. This outstanding book will teach readers how to tackle this important task and how to develop their clinical skills further. It provides the necessary research basics as well as deliberate practice training examples to improve treatment options and make use of available monitoring tools. Comprehensive and fun to read, this volume helps to move the practice of psychological therapy forward.

—**WOLFGANG LUTZ, PhD**, DEPARTMENT OF PSYCHOLOGY,
UNIVERSITY OF TRIER, TRIER, GERMANY

This field guide offers a user-friendly path on how to engage in deliberate practice in order to achieve better treatment outcomes. The authors provide detailed exercises on how to become more effective psychotherapists. Kudos!

—**DONALD MEICHENBAUM, PhD**, RESEARCH DIRECTOR OF THE MELISSA INSTITUTE FOR VIOLENCE
PREVENTION AND TREATMENT, CORAL GABLES, FL, UNITED STATES

An eminently original, engaging, and practical book that draws together the latest research findings to help therapists of all orientations improve their work. “Deliberate practice” is a major new innovation in the training and development of psychotherapists, and this field guide—written by leading figures in the psychotherapy world—provides unique, step-by-step guidance to applying its method and insights.

—**MICK COOPER, DPhil**, PROFESSOR OF COUNSELLING PSYCHOLOGY,
UNIVERSITY OF ROEHAMPTON, LONDON, ENGLAND

This book has a wonderful combination of providing state-of-the-art scientific evidence on what makes therapists effective in understandable language, and hands-on exercises for clinicians to improve their effectiveness. It is truly unique in that sense!

—**KIM de JONG, PhD**, SENIOR ASSISTANT PROFESSOR OF CLINICAL PSYCHOLOGY,
LEIDEN UNIVERSITY, THE NETHERLANDS

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Introduction

How to Use The Field Guide to Better Results

Scott D. Miller and Mark A. Hubble

You can't use an old map to explore a new world.

—ALBERT EINSTEIN

Welcome to *The Field Guide to Better Results* (FG). Books in this genre number in the thousands. A quick search on the internet reveals field guides can be purchased on almost any topic—from ants to zebras, moths to mushrooms, ocean floors to mountain tops, dinosaurs to UFOs and the extraterrestrials who pilot them. Using a combination of short summaries, illustrations, charts, and advice, their specific purpose is to help the user quickly and efficiently identify, locate, and distinguish key characteristics defining the subject of interest—in this instance, the first field guide ever published on using deliberate practice (DP) to improve therapist effectiveness.

The FG is the follow-up to *Better Results* (BR; Miller et al., 2020). It is best seen as a companion volume, the need for which became evident long before the first work was completed. Although applied across a variety of performance domains (e.g., chess, music, medicine, athletics), DP is a relatively new topic in psychotherapy (Miller & Hubble, 2011; Miller et al., 2007). Conflicting viewpoints regarding its nature and use are already on the rise (Rousmaniere, 2016, 2019). And, in truth, despite the detailed principles and practices described in BR, much of the framework provided required further investigation and exposition based on emerging science. In addition, the practitioners we encountered who were trying to apply DP to their professional development wanted

<https://doi.org/10.1037/0000358-001>

The Field Guide to Better Results: Evidence-Based Exercises to Improve Therapeutic Effectiveness,
S. D. Miller, D. Chow, S. Malins, and M. A. Hubble (Editors)
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more—in particular, explicit guidance in a readily accessible format about what to practice deliberately and how.

While reviewing the galley proofs of *BR*, mindful of the work left to be done, we began reaching out to researchers known for their expertise on the factors responsible for the effectiveness of psychotherapy (e.g., client, therapist, relationship, hope and expectancy, and structure). Each was invited to (a) review the latest empirical literature on a specific factor, (b) distill evidence-based principles for empowering it, and last, (c) create exercises practitioners could immediately perform to strengthen the operation of the principles in their clinical work. Without exception, all agreed to contribute.

In Chapter 3, Joshua K. Swift, Jesse Owen, and Scott D. Miller focus on the contribution to outcome made by the client. Research shows who they are; what qualities, traits, and experiences they bring to therapy; and what influences in their life outside of treatment have the largest effect on results. In Chapter 4, Helen A. Nissen-Lie, Erkki Heinonen, and Jaime Delgadillo direct their attention to what pioneering researcher Sol Garfield (1997) once called “the neglected variable” in psychotherapy: the therapist. Turns out, *who* does the therapy is of critical importance, far more so than any method or approach. John C. Norcross and Christie P. Karpiak, in Chapter 5, delineate the characteristics of productive helping relationships, adding the nuance and detail necessary to enable practitioners to customize their connection to each client. Helping clinicians understand the role of hope and expectancy and how beliefs in the effectiveness of a given course of mental health care can be supported and strengthened is the subject of Chapter 6 by Michael J. Constantino, Heather J. Muir, Averil N. Gaines, and Kimberly Ouimette. Finally, in Chapter 7, Nicholas Oleen-Junk and Noah Yulish address the last of the factors responsible for the effectiveness: structure. Structure includes the therapeutic rationale, associated techniques and rituals, the timing of interventions, and the treatment context or setting. Regardless of a clinician’s preferred way of working, this chapter shows how to organize and execute care for maximum benefit.

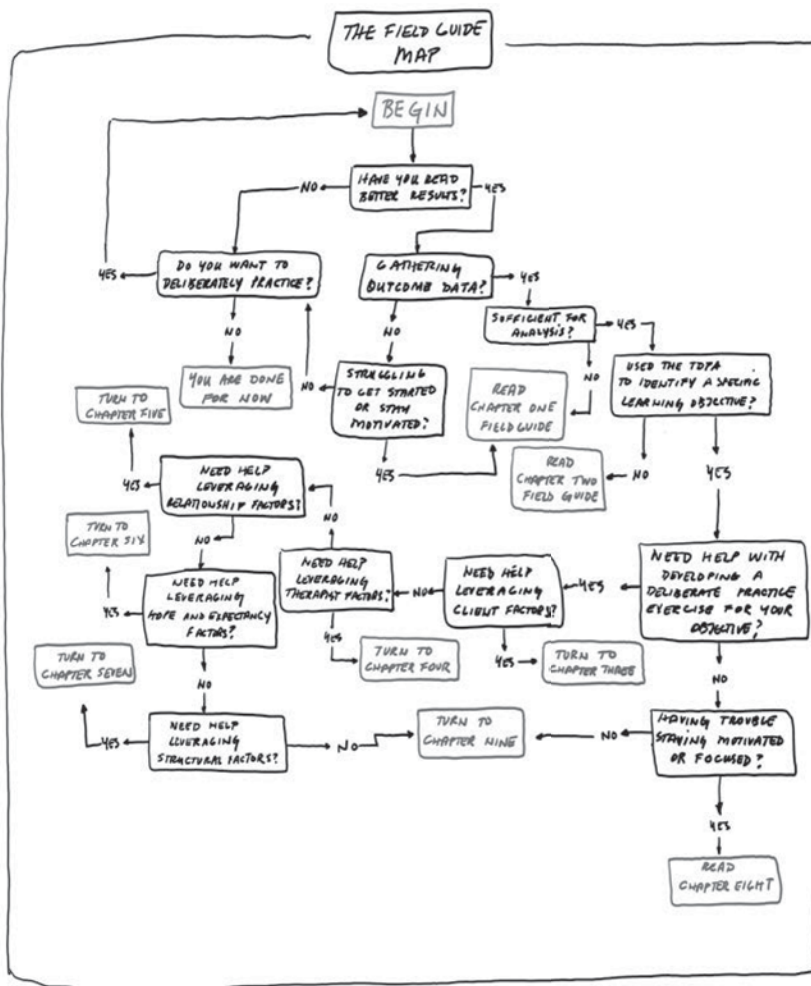
Beyond the identification of evidence-based principles and specific exercises, some clinicians reported wanting more help than was provided in *BR* for getting started and sustaining their DP efforts. Expressed, too, was an interest in how to narrow down potential professional development targets to the single learning objective, which, when reached, would yield the greatest return on investment. In the first chapter, Scott D. Miller and Mark A. Hubble offer insight and advice for practitioners who, despite being interested in DP, have yet to move past the “this-is-a-good-idea” phase. Later in the book, in Chapter 8, Sam Malins, Scott D. Miller, Mark A. Hubble, and Daryl Chow address what to do when one’s implementation is marked by fits and starts. Finally, in the second chapter, Daryl Chow, Scott D. Miller, and Mark A. Hubble offer solutions for those feeling overwhelmed in their attempt to select the best learning objective from among the many possibilities. As first introduced in *BR*, the Taxonomy of Deliberate Practice Activities in Psychotherapy (Chow & Miller, 2022) plays a key

role in helping practitioners develop an individualized, step-by-step professional development plan (a revised and updated version can be found in Appendix A).

Unlike *BR*, the *FG* is not designed to be read from cover to cover. Instead, it's best thought of as a reference work, a resource to consult whenever a specific question, decision point, or challenge arises in one's application of DP. Like any field guide, the section that has the most relevance depends on where the person is and what they need to know or be able to do *now*.

If you are ready to get going with the *FG*, consult the map in Figure 1. It will help identify "where you are" in your implementation of DP and point you to the next step. For convenience and to help you stay on track, key decision points selected from the map are included at the beginning and end of each chapter.

FIGURE 1. The Field Guide Map



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1

Identifying Your “What” to Practice

Scott D. Miller and Mark A. Hubble

The illiterate of the 21st century will not be those who cannot read and write, but those who cannot learn, unlearn, and relearn.

—ALVIN TOFFLER

DECISION POINT

Begin here if you have read the book *Better Results* and

- have not started gathering outcome data or are experiencing difficulty getting started or maintaining the motivation to measure your performance *or*
- are measuring your performance but have not collected sufficient data to establish a reliable, evidence-based profile of your therapeutic effectiveness.

No question. Practitioners are a motivated bunch. They want to improve. They value learning. They are committed to professional development. In the largest, most comprehensive survey conducted to date, 86% of clinicians reported being “highly motivated” to transcend their current level of performance (Orlinsky & Rønnestad, 2005).

<https://doi.org/10.1037/0000358-002>

The Field Guide to Better Results: Evidence-Based Exercises to Improve Therapeutic Effectiveness, S. D. Miller, D. Chow, S. Malins, and M. A. Hubble (Editors)

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It starts early. Admission to graduate programs is highly competitive, with ratios of 300 applicants to 8 positions being commonplace (Info Learners, 2022). Once in, the work continues, even intensifies: classes, practica, exams, theses, and dissertations. “Curriculum creep” has come to define graduate education, with the number of required hours increasing 25% over the last 30 years (Caldwell, 2015). Thousands of hours of supervision follow—a practice most clinicians deem critical to their professional development and of help throughout their careers. Close behind is personal therapy. Most go (Bike et al., 2009; Norcross, 2005). And not just for a single course but returning time and again. By the way, those who do not report the *lowest* experience of “felt progress” and *highest* career “regress and stasis” (Orlinsky & Rønnestad, 2005, p. 121).

There is more. Graduate education does not end with graduate school. Though required for licensure, practitioners enthusiastically pursue continuing education. They do so to maintain and update their knowledge and skills (Neimeyer et al., 2009; Neimeyer & Taylor, 2011). In the United States, psychologists—the authors conservatively estimate¹—spend \$38 million per year on such activities. This amount excludes the costs of travel, lodging, food, supplementary learning materials (e.g., books, videos), and for some, lost revenue.

Given clinicians’ dedication to lifelong learning, it should come as no surprise the arrival of deliberate practice (DP) on the professional scene has attracted considerable interest. Before 2007, the term had never been heard, much less used in the context of psychotherapy research or training. That year, Miller, Hubble, and Duncan introduced the field to the work of Swedish psychologist K. Anders Ericsson. In numerous studies conducted over 3 decades, he and other researchers had documented how DP, regardless of domain (e.g., sports, music, medicine, chess, teaching), was responsible for superior performance. On review of this work, Miller et al. (2007) proposed DP provided an answer to a question that had long eluded the field—one that pioneering outcome researcher Michael Lambert only a few years earlier had characterized as “a mystery.” To wit, why are some therapists *consistently* and *significantly* more effective than others?

When subsequent research confirmed the most effective therapists devote a larger amount of time to DP than others (Chow et al., 2015), practitioners—always hungry for guidance and direction—responded, “Just tell us how to do it and what to practice, and we’ll do it.” As commendable as this openness and willingness to learn is, unfortunately, if given what they ask for, no doubt, the gains desired will never be realized.

That last sentence bears rereading.

Turns out, the promise of DP is in danger of being undermined. Historically, the mental health professions have never suffered from a shortage of experts ready and willing to tell practitioners what to do to be effective (Hubble et al., 1999). The premise has, and continues to be, practice this method or that

¹The estimate was derived by multiplying the number of licensed psychologists in the United States by the hours of continuing education required to maintain their licensure and the average cost of each continuing education hour as of 2021.

technique until proficiency is reached, and professional growth is assured. Not surprisingly, in the 15 short years since DP was first introduced to psychotherapy, a series of books have appeared applying the term to mastering specific treatment models (e.g., cognitive behavior therapy, emotion-focused therapy), even promising certification as a therapist or coach in the process. Though few in number at present, studies within the field have followed suit, frequently mistaking repetition and rehearsal for *deliberate* practice (Chow et al., 2022). *They are not the same*. The fallacy of this approach, as detailed in Chapter 2 of *Better Results* (BR; Miller, Hubble, & Chow, 2020), is research evidence convincingly demonstrates training in specific theories and their associated techniques contribute little, if anything, to outcome.

So, what should practitioners do instead?

Before embarking on a course of professional development, each must answer the question “What do *I* need to target to improve my particular results?” Although it may sound bold, failing to provide a detailed, evidence-based, and therapist-specific answer to this question all but guarantees (a) clinician effectiveness will remain flat, as has been seen in the field for the past 40 years or (b) decline, as studies of individual therapist outcomes show happens, regardless of the amount of time, money, and energy invested in learning something new (Germer et al., 2022; Goldberg et al., 2016; Prochaska et al., 2020; Wampold & Imel, 2015). For all that, the demands of daily clinical work often make the promise of “do this and you’ll help more people” difficult to resist.

PRINCIPLES FOR IDENTIFYING YOUR WHAT

In what follows, four evidence-based principles are identified and described, each aimed at helping practitioners prepare for effective DP. The principles are, in turn, operationalized in a set of exercises found at the end of the chapter.

Principle 1: Avoid the Athenian Trap

Clearly, K. Anders Ericsson and colleagues were not thinking of how to pitch their ideas to the masses when, in their original 1993 article on expertise published in the *American Psychologist*, they wrote, “In contrast to play, . . . deliberate practice . . . is not inherently enjoyable, [and] generates no immediate . . . rewards” (p. 368). Both experience and subsequent research confirm the accuracy of their observations (Miller, Madsen, & Hubble, 2020).

Plainly put, DP is hard work. Once a modicum of proficiency has been achieved in a particular performance domain, interest in pushing oneself typically wanes (Ericsson & Pool, 2016). Moreover, as confidence increases—generally far outstripping actual, measured ability—most turn their attention to something more stimulating. It is not solely a question of motivation or willpower. The brain, hardwired for novelty, naturally selects and rewards the “new and different” (Bunzeck & Düzel, 2006).

The allure of the unfamiliar is as old as recorded history. Consider: In the Biblical book of Acts, the citizens of Athens are described as “spend[ing] their time doing nothing but talking about and listening to the latest ideas” (17:21). So pervasive was this behavior, even the celebrated Greek historian and general, Thucydides (460–400 BCE), described the Athenian people as routinely “deceived with the novelty of speech” (Barnes, 1981).

When it comes to professional development, it is as though therapists live in a modern-day version of Athens. Talk of fresh, exciting discoveries, cutting-edge research, and improved theories and methods is constant and inescapable, all breathlessly reported. The underlying promise? The “state-of-the-art” is one workshop or certification away.

To have any chance of being successful in using DP to improve therapeutic effectiveness, therapists will need to immunize themselves against the “Athenian trap.” Isolation, boredom, frustration, uncertainty, comparing oneself with others (and failing in the comparison), and enduring extended periods of little or no apparent progress are part of the process. They are also potent triggers. In all likelihood, others exist, varying from one person to the next.

At the end of this chapter, you will find an exercise designed to improve your chances of both mobilizing and maintaining the motivation required for DP.

Principle 2: Finding Your What

The idea that improvement depends on practice is hardly new. References to enhancing a person’s skills or abilities through focused concentration and effort date back more than 2 millennia (Amirault & Branson, 2006; Ericsson, 2006b). Though DP includes the word *practice*, it is altogether different. The highly individualized nature of the process separates it from what practice is most commonly considered to be. Truly, the goal of DP is neither proficiency nor mastery. Rather, it is all about continuously reaching for objectives that lie just beyond one’s current ability. Accomplishing this task relies on a data-derived identification of “what” specifically each individual needs to target to improve their performance. As emphasized in *BR*, one must begin with identifying the “what” before the “how” (see Miller et al., 2020, pp. 43–47).

Over the last 2 decades, several outcome measurement systems have been developed, tested, and utilized in real-world clinical settings (Miller, Hubble, & Chow, 2020). Most include detailed metrics which enable the clinician-user to develop an evidence-based profile of their work—what, where, and with whom they excel and, more important, where they fall short or could make improvements. Detailed information was provided about one of the most widely used—The Partners for Change Outcome Management System—in *BR* (Miller, Hubble, & Chow, 2020, pp. 51–57).

While the technological capacity to identify one’s “growth edge” is now widely available, some therapists struggle to begin using measures or, once started, employ them consistently in their work. To be frank, ongoing, real-time assessment of clinical performance using standardized scales is new

to the profession—so much so most have never heard of it, much less received any formal training in the process (Hatfield & Ogles, 2007; Madsen et al., 2021). As is true with almost every endeavor, a learning curve exists. In the case of the two instruments described in *BR*, their simplicity belies the difficulty research shows clinicians encounter when implementing them in their daily work (Brattland et al., 2018). Another consideration—beyond lack of knowledge, training, or experience—is the attitude of the clinician. Not surprisingly, the evidence documents some are more open to the performance feedback measurement provides (de Jong et al., 2012).

If the foregoing were not enough, therapists need to be prepared; the feedback received can be highly disruptive. No, it *is* highly disruptive. No, it *must be* highly disruptive to qualify as DP. In a series of intriguing studies, Chow and colleagues (Chow et al., 2022; Miller et al., 2015) found engaging in DP delivered a blow to therapist confidence. The good news is the reduction in self-assurance enabled therapists first to consider and then make changes in their behavior, thereby resulting in measured improvements in performance. Such findings are entirely consistent with evidence from other investigations demonstrating therapists higher on professional self-doubt and humility establish stronger therapeutic relationships and achieve better outcomes (Nissen-Lie et al., 2010; Nissen-Lie & Rønnestad, 2016; Tao et al., 2015; see also Chapter 4, this volume).

As a case in point, take the example of Brooke Mathewes, an accomplished and well-regarded psychotherapist working in the United States. For all her success in the profession, the passion of her life is horses. As a child, she dreamed of being a cowgirl, decorating her bedroom with toy horses, horse paintings, and books about horses. The curtains were even hung with wrought-iron horseshoes.

Talk with Brooke and, in short order, the conversation inevitably turns to the time she spends at McGinnis Meadows Ranch. There, she’s had the privilege of being mentored by Shayne, one of the world’s most celebrated “horse whisperers”—a person with an uncanny, almost magical ability to engage and heal animals with a history of mistreatment, if not outright abuse.

From the outset, Brooke was a highly motivated student. Her goal? Replicate her mentor’s success. Toward that end, she spent hours watching him work, observing his every move: his voice, how he walked, the movement of his hands, even the angle of his feet in the stirrups. Contributing to her mounting frustration, he would often say, “Watch closely now. If you blink, you’ll miss it.”

Brooke recalls, “I must have been blinking a lot.”

Continuing, “Early on, my confidence was badly shaken. I’d ridden for years, spent uncountable hours with horses, but couldn’t match, or see what Shayne was doing. Even when he gave me explicit directions, I still couldn’t make it work. That’s when my thoughts would turn harsh. *‘I’m never going to get this. Cowgirl-shmowgirl. I’m just not good enough.’*” Many times, Brooke was tempted to give up. Pack up her tack, saddle, and boots and go back to riding at the stable near her home.

Pausing, she then shares, “In time, and with Shayne’s ongoing encouragement and coaching, I became better at finding my ‘sweet spot of discomfort,’ actively seeking out experiences that pushed me beyond what I could do at the moment, but not so far as to risk being crushed whenever I fell short of the mark.” How Brooke achieved this balance, ultimately improving her ability to attune to horses *and* transferring her understanding to clinical work, is described in depth in the *Psychotherapy Networker* article, “Meet You in McGinnis Meadows” (Mathewes & Miller, 2020). Suffice it to say, the first step is befriending doubt, seeing it as a bridge to learning and not as a referendum on one’s performance.

Principle 3: Connecting Your “What” to the “Right Stuff”

Physicians at Vienna General Hospital had a major problem. In the mid-1840s, women giving birth at this premier facility were dying—at a rate of 25% to 30%. The cause was well-known, accepted medical science dating back to the “father of medicine” himself, Hippocrates (460–370 BCE). Miasma was the culprit. Bad air. Fog, pollution, defilement, and emanations from rotting organic matter. In the words of Roman architect Marcus Vitruvius Pollio (70–15 BCE), it was “mist from marshes . . . blow[ing] toward the town at sunrise . . . waft[ing] into the bodies of inhabitants” (Karamanou et al., 2012, p. 52).

The solution? Eliminate waste. Clean the streets. Urge people to close their doors and windows. Two millennia later, the same explanation held sway. “All smell is disease,” asserted the English social reformer, Sir Edwin Chadwick (1800–1890), giving rise to an entire movement aimed at improving public health. And in truth, such strategies were followed by reductions in the spread of certain diseases (e.g., cholera). On the obstetrics ward, however, miasma was not deterred. It remained a killer—a tricky, even cunning one at that.

Enter Ignaz Semmelweis. For him, something about prevailing medical wisdom did not add up. Literally. Midwives working at the same hospital, he observed, had a death rate 6 times lower than the medical staff. Following the death of a colleague who fell ill after puncturing a finger while performing an autopsy, Semmelweis had an epiphany. Contact with corpses was somehow associated with morbidity and mortality. He suggested all contact with patients be preceded and followed by handwashing (Miller, Madsen, & Hubble, 2020). In no time, the mortality rate in the maternity ward plummeted, dropping to the same level as that of midwives. Similar results were obtained when he implemented the same practice in another hospital in Pest, Hungary.

One might expect such a discovery, in addition to bringing about the abandonment of miasma theory, would have earned Semmelweis many honors and awards. It did neither. In fact, his views were rejected by his colleagues and the field alike. Handwashing simply could not compete with bad air, in theory or practice. In 1865, after penning what many consider one of the most important volumes on infectious diseases in history, friends lured him

into visiting a mental asylum. Convinced his unrelenting and strident advocacy of handwashing was a sign of mental instability, they forcibly detained him. In a cruel twist of fate, the injuries he sustained in the process became infected, and he died of septicemia 2 weeks later.

Nowadays, of course, the benefits of sanitation are universally accepted. Handwashing, in particular, is considered a “best practice.” Indeed, decades of research show it to be the single most effective way to prevent the spread of infections. Science has also discovered why good hygiene works. It kills germs. Such information was not available to Semmelweis or his contemporaries. His was a hunch—one that defied 2,000 years of medical understanding. As sad as it is, what happened is not at all surprising. Unable to connect the declining death rate on the obstetrics ward with the factor responsible for the success of handwashing, his ideas were rejected, and with the benefits of general sanitation efforts elsewhere, belief in miasma continued.

The parallel between the story just shared and contemporary psychotherapy could not be more obvious. Standard interventions such as confronting dysfunctional thoughts, initiating saccadic eye movements, raising emotional awareness, facilitating understanding of internal conflicts, and enhancing communication skills are the miasma “abatement” strategies of our day. Indeed, despite 50 years of theorizing and research, scant evidence exists documenting a causal connection between the use of *any* specific method or technique and treatment outcomes (Wampold & Imel, 2015). Accordingly, making such procedures the primary focus of one’s deliberate practice is about as likely to lead to an improvement in therapeutic effectiveness as closing the windows of one’s home will stop the spread of disease.

Achieving better results requires connecting an individual’s performance objectives to factors that actually have leverage on outcomes. A general review of these empirically established elements can be found in Chapter 11 of *BR* (Miller, Hubble, & Chow, 2020, pp. 115–122). Detailed reviews of the supporting research for each, along with evidence-based principles and exercises, are provided in subsequent chapters of the *Field Guide*—specifically, 3, 4, 5, 6, and 7. In the meantime, recall, in order of influence, the factors include (a) client and extratherapeutic factors, (b) alliance and relationship, (c) therapist effects, (d) hope and expectancy, and (e) structure. More, they form the basis of the Taxonomy of Deliberate Practice Activities in Psychotherapy (TDPA; Chow & Miller, 2022; see Appendix A of this volume)—a tool designed to (a) help align your “what” with the factors likely to exert the greatest impact on performance, (b) design effective DP exercises, and (c) monitor progress of your professional development efforts (Miller, Hubble, & Chow, 2020, pp. 179–192). Unfortunately, experience has shown, if one’s theoretical premises and pre-suppositions are not carefully examined and, if need be, ruthlessly challenged, no amount of time and effort will make a difference.

Refer to the end of this chapter for two exercises that will help you examine your core beliefs, bring how you work into bold relief, and consequently, derive the most benefit from completing the TDPA.

Principle 4: Keep Your Eyes on the Next Step (Not the Prize)

The distance between Camp 4 and the summit of K2—the world's second-highest peak—is a mere 2,100 feet. Given an average human stride of 30 inches, that amounts to 840 steps. Based on the numbers alone, it would seem a relatively easy task. And yet, only 377 people have ever succeeded, fewer than have been to outer space! By comparison, climbing Everest is a cakewalk. Despite being taller, 10 times as many have reached the top. Even then, nearly one in five dies trying, a rate that increases 60% when K2 is the objective.

Understanding why people commit massive amounts of time, effort, and resources to such pursuits, even risking their lives, has been the subject of many articles and research studies. Is it the competitive spirit? Natural human curiosity? A desire for fame or notoriety? The pride of achieving a goal few would even consider attempting? Or is it simply as famed British mountaineer George Mallory (who perished on his third attempt at Everest) replied, "Because it's there."

The very same question faces those who would engage in DP: *Why do it?* DP consumes a significant amount of time. Progress often comes in small increments and at a rate that is positively glacial. On top, the typical incentives (e.g., money, status, advancement, validation) are rarely, if ever, commensurate with the investment. That is why, right up to his death, K. Anders Ericsson remained puzzled about what motivated those who choose to engage in DP—calling it the "million-dollar question."

Turns out, as is the case with mountain climbers, the reasons therapists give for continuously pushing the limits of their performance vary. Some feel ethically compelled, duty bound to offer the best to their clients. For others, it is the satisfaction, even joy, that comes with ongoing learning and professional growth.

Setting questions of motivation aside, perhaps the more, if not most important consideration is how to make oneself ready for the sustained effort DP demands. As a rule, determination, no matter how great, will, in time, succumb to poor preparation. The good news is that preparation works in tandem with determination *when* one maintains a singular focus on the next step needed to accomplish a just noticeable difference over what one was able to do before. While the empirical evidence in this area is thin, experience indicates those who are successful relish the achievement of each advance as much as or more than reaching the final, desired outcome (Colvin, 2008). Instead of keeping your eye on the prize, prize each step.

Returning to K2, by the final stage of their ascent, climbers have generally been in transit for months. Even getting to the base of the mountain is an ordeal, requiring 7 or 8 days of difficult trekking over rocky terrain on narrow paths. Then, there are the first three camps, each one at a higher altitude than the last. The terrain is treacherous, the air increasingly thin, generally forcing climbers to stay for days along the way to rest and acclimatize. Many are forced to backtrack multiple times just to "catch their breath"—a process that can take 3 to 4 weeks! Without exception, those who make it to Camp 4 find

themselves short of supplies, physically and mentally exhausted, and starved for oxygen. They are also facing the most dangerous part of the climb, the spot responsible for the majority of deaths on K2. It is known as “the bottleneck,” and it’s not technically difficult, but the house-sized columns of glacial ice bordering the near vertical crevasse (known as *seracs* and *couloir*, respectively) have a tendency to give way unexpectedly. Given the context, each step short of the summit *is* a remarkable accomplishment.

While not putting their lives on the line, therapists do face a bottleneck of sorts. Actually, two. First, unlike the feeling of accomplishment climbers experience on reaching the summit of K2, few, if any, incentives exist for therapists choosing to engage in DP. Beyond the absence of direct financial rewards for superior results—after all, being average pays the same rate—current standards of care do not require clinicians to work at improving their effectiveness. In the *Ethical Principles of Psychologists and Code of Conduct*, for example, the word “effective” does not appear a single time. Rather, practitioners need only “provide services . . . with populations and in areas . . . within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional expertise” (Standard 2.01, Boundaries of Competence, American Psychological Association, 2017, p. 5). Perversely, that means, as Miller, Madsen, and Hubble (2020) pointed out, “a practitioner who competently delivers an unhelpful, even deadly service . . . [is ethically] superior to one who is actually helpful but working beyond” (p. 952) what they are currently capable of doing—the very heart of DP.

The second and far greater challenge for therapists hoping to improve via DP is their current level of effectiveness (see *BR*, pp. 49–58). Evidence from practicing clinicians shows most are remarkably effective, returning outcomes on par with those reported in tightly controlled randomized trials—investigations in which it should be noted study clinicians have many advantages over their real-world counterparts (e.g., access to the best, ongoing training and supervision, lower and less complex caseloads; Minami et al., 2008; Reese et al., 2014; Saxon & Barkham, 2012; Stiles et al., 2008). Said another way, were K2 the objective, the average practitioner would typically be *starting* their DP journey at Camp 4! The remaining steps before their “summit,” while not technically difficult, are bound to be the steepest and most slow going. What is more, unlike any prior professional development experiences, the path forward is subject to life circumstances and conditions (e.g., family, job, health, finances, the ease of an established way of working vs. trying something new) that can, without warning, upend the best intentions.

Think of it this way: If you are reading this book, chances are you have finished graduate school and are working in an applied setting. It may be difficult to recall, but at one time, *that* was your objective—to be a full-fledged, working therapist. Of course, doing so was preceded by preschool and kindergarten, the elementary grades, junior and senior high school, and then college. Along the way, you took hundreds of tests and completed an untold number of long-forgotten reading and homework assignments.

With effort and focus, you can likely remember the sense of pride you felt on passing the final exam for a challenging undergraduate course, despite having many more to complete before graduating. How about the sense of relief you experienced when you finished collecting data for your thesis or dissertation? More than likely, you did so even though crunching the numbers, writing up the results, and defending your project before your faculty committee remained. And what about passing the licensing exam? We are sure you will agree doing so was a significant achievement, although finding a job, building a practice, and establishing yourself in the profession was yet to be realized.

The point? Though your final objective may still be before you, it need not detract from the satisfaction you experience with each step. Indeed, reaching your summit will require as much. Otherwise, we run the risk of remaining in the demotivating state of continuous presuccess failure (Adams, 2013).

SUMMARY

Effective DP begins with identifying “what” you specifically need to target to improve your effectiveness. Because the pattern of performance strengths and weaknesses is different for each clinician, no prepackaged, one-size-applied-to-all set of skills or exercises will work. Therapists hoping to achieve better results do well to avoid anyone promising otherwise (Principle 1: Avoid the Athenian trap). Instead, the process begins with each establishing an evidence-based profile of their work, using a valid and reliable set of measurement tools to identify what they do well and where they could do better (Principle 2: Finding your what). To ensure that what we practice makes a difference, it must then be connected to factors that actually have leverage on outcome (Principle 3: Connecting your what to the right stuff). Research shows most of what is popularly believed to be responsible for the efficacy of psychotherapy contributes little or nothing to the outcome (e.g., treatment models and techniques, professional and post-graduate training, supervision). Now in its sixth revision, the TDPA is specifically designed to help connect individual practitioner performance improvement efforts to what really makes a difference. The next chapter provides tips for maximizing the utility of the tool based on feedback from users gathered since its publication in *BR*. Chief among the suggestions is helping develop the single DP objective necessary to accomplish a just noticeable difference in what one was able to do before (Principle 4: Keep your eyes on the next step).

EXERCISES FOR IDENTIFYING YOUR WHAT

In what follows, the principles identified in the previous section are linked to specific DP exercises. While several may strike you as compelling or interesting, avoid the temptation to “get to work.” Instead, read through them all,

choosing those specifically tied to your current professional development objectives.

Principle 1: Avoid the Athenian Trap

The isolation, boredom, frustration, uncertainty, and extended periods of little or no apparent progress can disrupt the DP efforts of even the most dedicated. Given that the specifics will be different for each individual, it can be helpful to take the time to identify your triggers—what might tempt you from the focus required for success. So, whether using paper and pencil or an electronic device, list yours, being as detailed and specific as possible.

To help you get started, consider the following questions:

- *What specifically could tempt you to forgo DP in favor of less demanding, more enjoyable, but ineffective professional development activities?*
- *What role, if any, do people, places, emotional states, prior training, clinical beliefs, experiences, and so forth play in thwarting the focused, ongoing effort and concentration required for DP?*

Once you have identified your specific triggers,

- *Recall a time in the past when you were tempted to stray but stayed on course. Include experiences outside the professional realm (e.g., learning a second language or to play a musical instrument).*
- *What role, if any, did people, places, emotional states, personal beliefs and experiences, and so forth play in supporting and sustaining your commitment to success?*
- *How will you incorporate and use the natural human predisposition for novelty into your DP plan?*

Finish by providing answers to the following questions:

- *On a scale from 0 to 10, where 0 denotes none and 10 absolute certainty, rate your current level of confidence in your ability to manage triggers.*
- *Identify a circumstance that you might encounter that would lower your current rating.*
- *Imagine what it would take to raise your rating by a single point.*

Principle 2: Finding Your What

Introducing measurement into one’s clinical performance can be highly disruptive; the process of administering scales and reviewing the results may undermine confidence. Fortunately, the evidence indicates disruptions that result in reductions in self-assurance can enable therapists to accept and make needed changes in how they work, thereby resulting in stronger therapeutic relationships and better outcomes.

The following exercise is designed to help you embrace your doubt, seeing it as a bridge to learning and not as a referendum on your performance. Take the time necessary to reflect on and respond to the following questions:

- *Identify several circumstances—whether as a clinician or in your personal life—when you felt doubt about your knowledge, skills, or ability to succeed.*
- *Contrast the times when you embraced the doubt necessary for change or surrendered to it and gave up. Recall in as much detail as possible the context (i.e., where you were, who you were with, your thoughts, feelings, and actions).*
- *Imagine what feelings, thoughts, and behaviors will arise for you while “inhabiting” your sweet spot of discomfort. How will you stay focused on what you are learning versus giving in to a sense of incompetence and feelings of shame that so often accompany failed attempts?*

Principle 3: Connecting Your What to the Right Stuff

Getting to the Source of Your Success (Part 1)

Effective DP requires connecting an individual’s performance objective to factors that have leverage on outcomes. As noted earlier and reviewed in detail in Chapter 2, the TDPA is specifically designed to help align our professional development efforts with what matters most for improving our results.

There is more. Early on in *BR*, we recommended creating a schematic or blueprint for how you do therapy sufficiently detailed enough that another practitioner could understand and replicate it—literally, “step into your shoes” and work how you work (Miller, Hubble, & Chow, 2020, p. 29). The purpose of the exercise was to make it possible for clinicians to pinpoint where in their work they could intervene once their “what” had been identified. To illustrate, did the “what” occur throughout the course of therapy or at certain points (i.e., beginning, middle, or end)? Was it related to one’s theoretical premises (e.g., a point of view that undermined the formation and maintenance of the therapeutic relationship)? Was it linked to the overall plan of action (e.g., strategies and objectives that failed to elicit the client’s active participation)? Or finally, was the “what” connected to one’s use of a particular technique or its execution?

Feedback received following the publication of *BR* revealed this exercise to be among the most difficult in the volume to complete. Many readers reported having difficulty knowing where to begin (e.g., start with their preferred theory, what they typically do in a first session, describing the temporal sequence of their work). Others, when prompted to describe their work as a series of “if-then” propositions (e.g., IF the client presents as highly reactive, THEN I adopt a more flexible, nondirective stance; IF the client reports depression at the first visit, THEN I assign a “thought log” as homework), struggled to structure, categorize, and even recall how they made the moment-to-moment decisions that inform their actions.

On reflection, mindful of the experiences shared by readers, we realized more structure was needed to make completing the exercise possible. In consultations, we found ourselves suggesting a framework presented by Marvin Goldfried (1980) in his classic article, “Toward the Delineation of Therapeutic Change Principles.” There, he recommended conceptualizing one’s therapeutic work as “involving various levels of abstraction”:

At the highest level . . . we have the *theoretical framework* to explain how and why change takes place, as well as an accompanying *philosophical stance* on the nature of human functioning. . . . At the lowest level . . . , we have therapeutic *techniques* or clinical *procedures* that are actually employed during the intervention process. . . . [To these, add] a level of abstraction somewhere between theory and technique which, for want of a better term, we might call *clinical strategies* . . . [or] *principles* of change . . . clinical heuristics that implicitly guide our efforts during the course of therapy. (p. 994, italics in original)

Goldfried’s (1980) three levels of abstraction are listed from highest to lowest in Table 1.1, which can serve as a template for creating a blueprint of your therapeutic approach. To these, a fourth can be added. Termed “metatheory,” it is a higher order concept representing the assumptions on which our theories are based. With regard to psychotherapy, Wampold (2001) identified two. The first, commonly known as the medical model, posits the efficacy of psychotherapy depends on the clinical procedure being specifically remedial to the

TABLE 1.1. Goldfried’s Levels of Abstraction

Level of abstraction	How is this represented in your work?		
	Beginning	Middle	End
Metatheory			
Theoretical framework			
Clinical strategies			
Techniques			

Note. Data from Goldfried (1980).



FIELD GUIDE TIP

Need help with a concrete example of applying Goldfried’s classification to a popular therapeutic approach? Turn to pages 54–56 in Chapter 3.

disorder being treated. The second, the contextual model, holds the benefits of psychotherapy primarily accrue through social processes characteristic of all human interaction (e.g., relationship, connection, shared beliefs and values, negotiated agreements, and persuasion).

If you have not already done so, take the time now to create your therapy blueprint using the framework provided. Recreating the table in a spreadsheet makes the process easy and ensures ample space for details and future modifications. As you do so, note how the various levels come into play at different points—beginning, middle, and end—in your performance of psychotherapy.

Getting to the Source of Your Success (Part 2)

With your blueprint in hand, the next step is to identify how your work—from start to finish and across the levels of abstraction—leverages the five factors responsible for outcome (i.e., client and extratherapeutic factors, alliance and relationship, therapist effects, hope and expectancy, and structure). Make a note if and when you find presuppositions, beliefs, or actions that may impede, obstruct, or undermine or cannot be directly connected to any of the factors (see Table 1.2). Completing this exercise now will help you use the TDPA to identify those DP activities with the greatest potential for improving your effectiveness.

Recall, as discussed in *BR*, time and experience lead to the development of automaticity (pp. 27–29). We literally become able to act without thinking. While enhancing efficiency, the problem, Ericsson (2006a) pointed out, is we “lose conscious control over the production of [our] actions” (p. 694). We literally do not remember *how* we do what we do. As a result, our ability to make specific intentional adjustments to our work is compromised.

Regaining consciousness is a necessary first step—one, experience shows, many find challenging. If you are struggling to complete your blueprint or connect your work to the five factors, consider starting with a smaller task, such as

- *reviewing a recent treatment plan and clinical notes;*
- *recording and reviewing a session, taking time to note your decisions and actions; and*
- *reflecting on a conversation with a colleague in which you discussed a case, noting the words you used and what you emphasized and omitted from your description.*

TABLE 1.2. Connecting Your Work to the Factors With the Right Stuff

Level of abstraction	How is this represented in your work and what factor is being leveraged?		
	Beginning	Middle	End
Metatheory			
Theoretical framework			
Clinical strategies			
Techniques			

Principle 4: Keep Your Eyes on the Next Step**Appreciating Each Step**

The evidence is clear. Nearly 90% of clinicians are “highly motivated” to transcend their current level of performance. The problem is improving effectiveness comes slowly, with the pace of progress dramatically disproportionate to the time and effort required. To combat the risk of giving up, learn to prize each accomplishment along the way. Toward this end, reflect on an earlier accomplishment (e.g., playing a musical instrument, learning a new language, finishing college or graduate school):

- *Create a timeline of the decisions, choices, and actions leading up to your achievement.*
- *In as much detail as possible, recall how you felt as you reached each milestone.*
- *Note how you addressed setbacks or failures you encountered before reaching your objective.*
- *What role did others play (or not) in addressing setbacks or failures encountered while reaching for your objective?*
- *Describe how you thought about your final objective at each step along the way.*

Now, take a moment to reflect on a time when you started out but stopped before reaching your final objective (e.g., playing a musical instrument, learning a new language or skill, writing an article or book):

- *Create a timeline of the decisions, choices, and actions leading up to when you stopped.*
- *In as much detail as possible, recall how you felt as you reached each milestone.*
- *Note how you addressed setbacks or failures you encountered before reaching your objective.*
- *Describe how you thought about your final objective at each step along the way.*
- *List any differences between the time you stopped and when you reached your objective in how you approached each step.*

Word Work

DP is inherently incremental and cumulative. Progress comes in a series of small steps instead of a sudden, dramatic, or radical change in how you work. As such, preparation, pacing, patience, and endurance are key. Bearing this in mind, take a moment to imagine you are planning to participate in a marathon:

- *List as many words that come to mind about what you need to prepare to complete the race.*

Now, imagine you will be participating in a sprint (e.g., 50 or 100 meters):

- *List as many words that come to mind about what you need to prepare for to maximize your performance.*

1. Note the differences between the words you generated, striking any the two lists have in common. With your plan to apply DP to your professional development in mind, develop one strategy for each unique word you associated with preparing for a marathon.

DECISION POINT

What to do next:

- If you have sufficient performance data for analysis but have yet to use the TDPA to develop a specific, individualized learning objective, turn to Chapter 2.
- If you have used the TDPA to establish a specific, individualized learning objective, but are struggling to stay focused or motivated, turn to Chapter 8.
- If you have completed the TDPA and need help developing a DP exercise for your specific objective, turn to
 - Chapter 3 for client factors
 - Chapter 4 for therapist factors
 - Chapter 5 for relationship factors
 - Chapter 6 for hope and expectancy factors
 - Chapter 7 for structure

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