THERAPIST COMPETENCE IN DYNAMIC INTERPERSONAL THERAPY AND ITS ASSOCIATION WITH TREATMENT OUTCOME

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I, Tamara Ventura Wurman, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Abstract

The study of the association between therapist competence and patient improvement has provided inconsistent results (Crits-Christoph, Gibbons, & D, 2013; Luborsky, McLellan, Woody, O’Brien, & Auerbach, 1985; Sandell, 1985). It has been claimed that these findings can be partly explained by the lack of an appropriate operationalisation of therapist competence (Barber, Sharpless, Klostermann, & McCarthy, 2007).

This dissertation reports on a study that replicates previous results which demonstrates no significant association between treatment fidelity and outcome, and the development of the Therapist Competence Scale (TCS), which aims to provide an appropriate operationalisation of competence in Dynamic Interpersonal Therapy (DIT). The TCS was derived from a thematic analysis of consultations with experts, and includes items on competence, incompetence, and global competence, as well as a measure of patient complexity.

Data for this dissertation were based on a randomised controlled trial (REDIT study) (Lemma, Target, & Fonagy, 2011b). The reliability of the TCS was studied employing Classical Test Theory and Generalizability Theory. Validity was studied through non-parametric correlations, and analyses derived from a Confirmatory Factor Analysis. The association between competence, as operationalised by the TCS-, and treatment outcome, was studied using multilevel modelling, in which sessions were nested within patients, and patients were nested within therapists.

The results provided initial evidence for the reliability and validity of the TCS. Competence was associated with patient improvement (e.g., effectiveness), as well as with a faster rate of recovery (e.g., efficiency). Additionally, a quadratic relationship was found between competence at the level of individual sessions and outcome. Finally, a significant interaction between therapist competence and patient complexity was found, suggesting that competent therapists achieve better outcomes when treating difficult patients.
With further research, the TCS could contribute to elucidating the psychotherapeutic mechanisms of change, and may potentially inform standards of psychotherapeutic training and professional practice.
The contributions of this dissertation’s studies go beyond the academic field of psychodynamic psychotherapy research. The operationalisation and measurement of therapist competence, as well as the study of its relationship with psychotherapy outcomes could shed light on several essential issues regarding the treatment of individuals suffering from enduring mental health difficulties. Firstly, this dissertation will enhance understanding regarding the “active ingredients” of psychotherapy, which would enable the design of psychotherapeutic treatments that have a predictable and positive effect on patients’ mental health. Thus, the findings of this dissertation may allow us to develop more effective and efficient trainings for psychotherapies, which would bring about greater benefits to patients. Furthermore, understanding what the construct of therapist competence entails would enable us to better appreciate the effect of specific therapeutic interventions and the viability and appropriateness of each choice based on specific variables associated with the states and traits of the patient - which include therapeutic relation, external context, timing and phase of therapy, among other factors. Hence, psychotherapy research could place greater priority on the study of “how” and “when” to deliver psychotherapeutic interventions, alongside focusing on the development of manualised interventions, which until now have not been found to be significantly related to better treatment outcomes (Truijens, Zühlke-van Hulzen, & Vanheule, 2018). Moreover, operationalising therapist competence, along with extensive further research, may help shape the pedagogic strategies adopted for the training of the next generation of psychotherapists, alongside influencing priorities assigned to acquiring various techniques employed in accordance with specific diagnoses and/or severity categories of patients. Psychotherapy training may be modified in order to align clinical practice with well-recognised beneficial and therapeutic practical elements, -conceptualised in terms of therapist competence-, which could redefine the aims of training and its educational standards, as well as the standards of practice of a professional psychotherapist. Therefore, further research on therapist competence and its effect on outcomes could support professional practice by facilitating referral
processes, clearing the way for patients' recovery, and clarifying the process of supervision. The findings of this dissertation may help researchers, practitioners, supervisors, and -most importantly- patients.
Table of Contents

List of Tables  12
List of Figures  15
Acknowledgments  17

Part I: Literature Review  19

Introduction  20

Chapter 1: Therapist Competence and Psychotherapy Research  22
1.1 Why is it Important to Study Therapist Competence?  22
1.2 Competence: Definitions and Controversies  27
1.3 Assessing and Operationalising Competence  30
1.3.1 Treatment Integrity  30
1.3.2 Treatment Manuals  32
1.3.3 Measuring Competence  35
1.4 Challenges in Assessing Competence  38
1.5 Conclusion  40

Chapter 2: Process-Outcome Studies: Relationship Between Treatment Integrity and Treatment Outcome  42
2.1 Therapist Adherence and Treatment Outcome  42
2.2 Therapist Competence and Treatment Outcome: Overall Association  47
2.3 Therapist Competence and Treatment Outcome: Specific Attitudes and Interventions  59
2.4 Conclusion  62

Chapter 3: Psychodynamic Competence and Competencies  65
3.1 Introduction  65
3.2 The Development of Competence  65
3.3 Psychodynamic Competencies  69
3.3.1 The Therapist as an Observer, Listener and Reflective Agent  69
3.3.2 The Therapist Management of the Affective Environment
   and Emotional Content of the Session  70
3.3.3 The Therapist’s Interventions  72
3.3.4 The Therapist’s Tasks  73
3.4 The Therapeutic Alliance  77
3.4.1 General and Specific Competencies that Facilitate the
   Therapeutic Alliance  78
3.4.2 Competencies Associated with the development of the
   Therapeutic Alliance  79
3.4.3 Competencies Associated with the Maintenance of the
   Therapeutic Alliance  79
3.5 Frameworks Therapist Competence in Psychodynamic Psychotherapy 81
3.5.1 Killingmo et al., 2014  81
3.5.2 Tuckett, 2005  83
3.5.3 Lemma et al., 2008  86
3.6 Conclusion  90

Chapter 4: Overview of Studies’ Aims, Research Questions, and Hypotheses  93
4.1 Statement of the Problem  93
4.2 Purpose Statement  94
4.3 Overview of Studies’ Research Questions and Hypotheses  95

PART II: Research Studies  99

Chapter 5: Methodology  100
5.1 Introduction  100
5.2 REDIT: Trial Design  100
5.3 REDIT: Sample Size Calculation  101
5.4 REDIT: Assessments and Outcome Measures  102
5.5 REDIT: Randomisation  102
5.6 REDIT: Interventions  103
5.6.1 Dynamic Interpersonal Therapy (DIT)  103
Chapter 6: Treatment Fidelity and Clinical Outcome in the REDIT Study

6.1 Introduction 107
6.2 Methodology 110
6.2.1 The REDIT study 110
6.2.2 Sample of recordings 110
6.2.3 Raters and Training 111
6.2.4 Measures fidelity and outcome 111
6.2.5 Data analysis 113
6.3 Results 119
6.3.1 Descriptive Statistics 119
6.3.2 Correlations and Collinearity Tests 120
6.3.3 Therapists’ Total Adherence and Competence Scores 121
6.3.4 Multilevel Models 123
6.4 Discussion 133

Chapter 7: Development of the Therapist Competence Scale (TCS) 141
7.1 Introduction 141
7.2 Methodology 142
7.2.1 Semi-structured Interview Development 145
7.2.2 Data Collection 147
7.2.3 Participants 148
7.2.4 Generating Nodes and Searching for Themes 149
7.3 Results 151
7.3.1 Competence Definitions group 161
7.3.2 Core Competencies group 162
7.3.3 Framework of Competencies group 173
7.3.4 Observable Competence group 188
7.3.5 Competence in DIT group 190
Chapter 10: Therapist Competence and its Association with Patient’s Clinical Outcomes

10.1 Introduction
10.2 Methodology
10.2.1 The REDIT study
10.2.2 Sample of recordings
10.2.3 Raters
10.2.4 Measures therapist competence and outcome
10.2.5 Data analysis
10.3 Results
10.3.1 Descriptive Statistics
10.3.2 Multilevel models
10.4 Discussion

Part III: General Discussion, Study Implications and Final Remarks

Introduction
State and Implications of Current Research to the Study of the Association between Therapist Competence and Outcome
Conceptual Factors
Methodological Factors
Operationalising Therapist Competence
Reliability of the TCS
Convergent and Discriminant Validity of the TCS
Therapist Competence and Treatment Outcome
General Implications of the Study
Future Research
Final Remarks
References
Appendices
List of Tables

Table 2.1 Psychodynamic Competence and Outcome Studies 54
Table 5.1 Demographical Characteristics of Patients 105
Table 6.1 Adherence Measure 112
Table 6.2 Competence Measure 112
Table 6.3 Descriptive statistics of Fidelity and Outcome Measures 120
Table 6.4 Normality Test of Fidelity and Outcome Measures 120
Table 6.5 Spearman’s rho Fidelity Measures 121
Table 6.6 Collinearity Diagnostics 121
Table 6.7 Therapists’ Mean Adherence Scores 122
Table 6.8 Therapists’ Mean Competence Scores 122
Table 6.9 Fixed and Random effects for the two-level predictor-model of HDRS-17 at the end of treatment in relation to Treatment Adherence scores 124
Table 6.10 Fixed and Random effects for the three-level predictor-model of HDRS-17 throughout treatment in relation to Treatment Adherence scores (Model 2) 125
Table 6.11 Fixed and Random effects for the three-level predictor-model of HDRS-17 throughout treatment including the square of adherence as variable (Model 3) 128
Table 6.12 Fixed and Random effects for the two-level predictor-model of HDRS-17 at the end of treatment in relation to Therapist Competence scores (Model 4) 129
Table 6.13 Fixed and Random effects for the three-level predictor-model of HDRS-17 throughout treatment in relation to Therapist Competence scores (Model 5) 130
Table 6.14 Fixed and Random effects for the three-level predictor-model of HDRS-17 throughout treatment including the square of Competence as a variable (Model 6) 133
Table 7.1 Semi-structured Interview Questions 147
Table 7.2 Competence Definitions group 152
Table 7.3 Core Competencies group 152
Table 9.7 Factor Loadings and Squared values for the Items of the Competence Subscale 275
Table 9.8 Factor Loadings and Squared values for the Items of the PI Subscale 276
Table 10.1 Descriptive statistics of Competence, Incompetence, Global Competence, Patient Complexity and HDRS-17 296
Table 10.2 Normality Tests 297
Table 10.3 Model 1 298
Table 10.4 Model 2 299
Table 10.5 Model 3 301
Table 10.6 Model 4 304
Table 10.7 Likelihood Ratio Test between Models 305
List of Figures

Figure 6.1 Mean scores for adherence and competence by therapist 123
Figure 6.2 Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of adherence scores at the session level 126
Figure 6.3. Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of adherence scores at the participant level 126
Figure 6.4. Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of adherence scores at the therapist level 127
Figure 6.5 Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of competence scores at the session level 131
Figure 6.6. Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of competence scores at the participant level 131
Figure 6.7. Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of competence scores at the therapist level 132
Figure 7.1. Six-group classification of the core themes 151
Figure 9.1. Box-whisker Competence Subscale 253
Figure 9.2. Box-whisker plot Incompetence Subscale 253
Figure 9.3. Box-whisker plot Global Competence 254
Figure 9.4. Box-whisker plot Patient Complexity 254
Figure 9.5. Box-whisker plot CPPS-ER 255
Figure 9.6. Box-whisker plot PI Subscale 255
Figure 9.7. Box-whisker plot CB Subscale 256
Figure 9.8. Box-whisker plot WAI-O-S 256
Figure 9.9. Box-whisker plot Bond Subscale 257
Figure 9.10. Box-whisker plot Task Subscale 257
Figure 9.11. Box-whisker plot Goal Subscale 258
Figure 9.12. Scatterplot Competence Subscale vs CPPS-ER 261
Figure 9.13. Scatterplot Competence Subscale vs WAI-O-S 261
Figure 9.14. Scatterplot Incompetence Subscale vs CPPS-ER 262
Figure 9.15. Scatterplot Incompetence Subscale vs WAI-O-S 262
Figure 9.16. Scatterplot Competence Subscale vs PI Subscale 267
Figure 9.17. Scatterplot Competence Subscale vs CB Subscale
Figure 9.18. Scatterplot Incompetence Subscale vs PI Subscale
Figure 9.19. Scatterplot Incompetence Subscale vs CB Subscale
Figure 9.20. Scatterplot Competence Subscale vs Bond Subscale
Figure 9.21. Scatterplot Competence Subscale vs Task Subscale
Figure 9.22. Scatterplot Competence Subscale vs Goal Subscale
Figure 9.23. Scatterplot Incompetence Subscale vs Bond Subscale
Figure 9.24. Scatterplot Incompetence Subscale vs Task Subscale
Figure 9.25. Scatterplot Incompetence Subscale vs Goal Subscale

Figure 10.1. Prediction of HDRS-17 scores by the fixed effect of the interaction between Competence at the session level and Time
Figure 10.2. Prediction of HDRS-17 scores by the fixed effect of the interaction between Competence at the session level and Time
Figure 10.3. Prediction of HDRS-17 scores by the fixed effect of squared Competence at the session level
Figure 10.4. Prediction of HDRS-17 scores by the fixed effect of the interaction between Competence at the therapist level and Patient Complexity at the participant level
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PART I:
Literature Review
Psychotherapy research has attempted to understand the factors that lead to patient improvement, recognising the importance of examining the relationship between the psychotherapeutic process and the effectiveness of treatments (M. J. Lambert, 2013). Thus, “process-outcome” research involves the study of the “mechanisms of change” which are the psychotherapeutic factors “that are hypothesised to have a causal relation with treatment outcome” (Crits-Christoph et al., 2013, p.299).

It has been suggested that therapist competence could be a fundamental process variable, as it has an effect on treatment outcomes (L. Beutler et al., 2004; M. J. Lambert, 2013). However, there is a gap in current knowledge regarding what constitutes psychodynamic competence and in reference to how to both operationalise and reliably assess it. Furthermore, there is a gap in the current understanding of the specific relationship between therapist competence and treatment outcome (Barber et al., 2007; M. J. Lambert, 2013; Luborsky et al., 1985; Sandell, 1985).

The first three chapters of this dissertation will present a literature review that aims to examine the evidence that has addressed these gaps in knowledge regarding therapist competence in psychodynamic psychotherapy for adult patients. Chapter 1 will encompass a review of the literature that examines the importance, purpose and challenges of studying therapist competence in psychodynamic psychotherapy. Chapter 2 will report the process-outcome studies in psychodynamic psychotherapy that have examined the relationship between therapist competence and treatment outcome. In Chapter 3 an overview of the limited-domain competencies relevant to psychodynamic psychotherapy will be presented. By reviewing the literature regarding therapist competence, these three chapters aim to explain the context in which this dissertation’s studies, and the new operationalisation of therapist competence, come about. By the end of the literature review, the gaps in knowledge and the research problems will be clearly stated, followed by the

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1 For a detailed description of how the literature search was conducted, please see Appendix A.
outline of the different studies, research questions and hypotheses of this dissertation.
Chapter 1: Therapist Competence and Psychotherapy Research

1.1 Why is it Important to Study Therapist Competence?

Therapist competence has been a topic of interest in psychotherapy that dates back decades (Kaslow, 2004; Nelson, 2007). The competencies movement in psychology arose with the aim of bringing greater accountability to the profession. The movement challenged the assumption that competence is automatically attained through doctoral education and clinical training, arguing for the need of an explicit demonstration of therapist competence. Due to the unfortunate fact that competence is frequently identified by its absence (Kitchener & Anderson, 2011), the competencies movement has attempted to determine the knowledge, skills and values that constitute competence as well as the means to reliably assess it. The competencies movement has attempted to develop a competence framework to guide: (1) qualifications for licensure and public protection; (2) psychology doctoral program accreditation; and, (3) an operationalisation and assessment of training outcomes (Falender & Shafranske, 2012; Nelson, 2007). In this context, Kaslow (2004) described eight domains of psychologist competencies that need to be studied and assessed. One of them, the intervention competence, will be the focus of the present dissertation.

Research in psychoanalytic/psychodynamic psychotherapy has shown interest in therapist intervention competence due to its possible effect on treatment outcomes. Process-outcome studies have provided evidence that supports the efficacy of psychoanalysis and psychoanalytic psychotherapy (Gerber et al., 2011; Gibbons, Crits-Christoph, & Hearon, 2008; Shedler, 2010). However, it is still unclear why and how specific interventions have an effect on the patient. Psychotherapy research has primarily focused in studying how specific types of psychotherapy may be related to treatment outcome. Conversely, patient, dyad and therapist effects have been less studied as predictors of treatment outcome (M. J. Lambert, 2013).

Therapist effects has been defined as “the effect of a given therapist on patient outcomes as compared to another therapist” (M. J. Lambert, 2013, p.
Accordingly, this definition establishes that high-quality therapists are the ones whose patients have the best treatment outcomes. Thus, determining who is a high-quality therapist can only be done after knowing the post-treatment outcome and cannot be established in the pre-treatment phase according to supervisors’ opinions or peer-nominations. Therefore, understanding what characteristics, attitudes and behaviours of the therapists account for their differences in effects, appears to have significant importance.

Differences between therapists in their effects has been observed since the beginnings of psychotherapy, and thus a substantial amount of research on the therapists’ variables that might account for this phenomenon has been conducted (L. Beutler et al., 2004). A recent surge of interest in therapist effects is due to the current availability of sophisticated statistical analyses (e.g., multilevel modelling), which are suitable for studying this particular matter considering that they model how patients are nested within therapists. Nesting is particularly important for studying variables to which both, patient and therapist, contribute to, such as the alliance and outcome. Multilevel modelling allows to disentangle patients’ and therapists’ contributions to process-outcome variables, which then enables to determine how these two sources of variability predict outcome. A significant number of studies, using multilevel models, have established that around 5% to 8% of the variance in patient outcome is attributable to the therapist; with larger effect sizes found in naturalistic studies than in RCTs (Barkham, Lutz, Lambert, & Saxon, 2017). Although the variability attributable to the therapist is smaller than the variability ascribed to the patient, this proportion is statistically and clinically relevant, considering that 15% to 20% of therapists consistently bring about better outcomes, while 15% to 20% of therapists are less effective than others. Additionally, therapist effects are more prominent with more distressed and challenging patients than with others that manifest higher psychic functioning (Barkham et al., 2017). However, this finding should be considered taking into account its limitations. The current understanding of therapist effects is based on specific treatment modalities (short-term, manualised, cognitive-behavioural therapy) and measures (self-report), as well as populations derived from university counselling centres or managed care patients. Therefore, data available regarding therapist effects may not be representative of other populations, measures and treatment
modalities. Furthermore, the studies that have investigated therapist effects have not considered in the analyses the many complexities of the psychotherapeutic change process, such as the many moderators and mediators of change, or the intertwining of patient and therapist variables. Additionally, it is important to notice that the variability demonstrated by multilevel models in therapist effects might be reflective of differences in the therapist’s responsiveness, meaning the ability “to do the right thing at the right time, where the right thing varies with shifting client requirements, therapeutic approach and other circumstances” (C. Hill & Castonguay, 2017, p. 327). Thus, variables that describe stable characteristics of the therapist, tend to be less successful in predicting clinical outcomes (Barkham et al., 2017). Therefore, these limitations should be considered when interpreting results regarding therapist effects.

Notwithstanding the fact that therapist effects are relatively small, ultimately, the differences among therapists may have a significant effect on public health. However, despite the existence of therapist effects, little is known about the reasons behind the variability in their effectiveness. Hence, it is essential to understand why some therapists are better than others in order to work towards improving the outcomes of poor-performing clinicians. The differences between therapists are presumably associated with some aspect of the therapists’ attitudes and/or behaviours. It is important to unveil such variables using multilevel statistical modelling, considering that is the most appropriate method to disentangle between-therapist and within-therapist variability in process-outcome studies in order to isolate, predict, and explain between-therapists’ effects on patient outcome (C. Hill & Castonguay, 2017).

Before the development of multilevel models, process-outcome studies used simple correlational analyses and did not consider that patients were nested in therapists, therefore, they did not disentangle the different contributions to outcome variance. These studies found that the following therapist variables were related to positive outcomes: alliance, cohesion, empathy, goal consensus and collaboration, positive regard, congruence/genuineness, asking for patients’ feedback, repairing alliance ruptures, managing counter-transference, self-disclosure, and relational interpretations (C. Hill & Castonguay, 2017; J. Norcross, 2011; J. C. Norcross,
Although these variables are associated with patients’ outcomes, research conducted on most of them has not found a statistically significant association with therapist effects (Constantino, Boswell, Coyne, Kraus, & Castonguay, 2017). On the other hand, multilevel model studies on therapist variables have found that four variables are significantly related to therapist effects. There is strong evidence for the ability of the therapist to foster a good therapeutic alliance. Concurrently there is limited evidence for the other three variables concerning the therapist: facilitative interpersonal skills, self-doubt, and deliberate practice. Importantly, a number of variables have not been found to be significantly related to therapist effects: demographics (e.g., age, gender, race/ethnicity), self-reported interpersonal skills, theoretical orientation, or professional degree (Constantino et al., 2017; Wampold, Baldwin, & Imel, 2017). Overall, the work on the predictors of therapist effects is just beginning. Currently, more variables need to be studied, and existing findings need to be replicated.

Several other variables have been proposed as potential predictors of therapist effects. Important variables among these are: 1) therapists’ responsivity, meaning their ability to flexibly attune the dose, implementation, and timing of interventions; 2) therapists’ presence, meaning their awareness of and openness to the patient; 3) therapist ability to be aware of, regulate and use their inner experience during the session to help foster patients’ change; 4) therapist competent delivery of technical, relational, conceptual, and cultural skills; 5) therapists’ automatisation of basic skills and superior abilities in complex skills such as information processing and appropriate reactions to complex situations; 6) therapists’ creativity and flexibility in their ways of thinking and being; 7) therapists’ use of relationship-oriented interventions; and, therapists’ use of humour (L. Castonguay & Hill, 2017). It is noticeable that all these variables refer to the quality with which the therapist delivers psychotherapeutic interventions to patients. Hence, a competent therapeutic practice is an important variable that could explain, at least partially, the variability in therapist effects.

Therefore, it is relevant to study therapist competence, a factor that could potentially predict the observed variability in treatment outcome in relation to therapist effects. To study therapist competence it is essential to operationalise
it. This is a challenging task, hitherto only attempted in a number of instruments. For example, the Psychotherapy Process Q-sort (Jones, 2000), besides facilitating the assessment of the therapeutic process by quantitatively describing the interventions (adherence) (Zimmermann et al., 2015), it also facilitates, to a certain degree, the operationalisation of psychoanalytic competencies. However, this and other instruments are not appropriately designed to evaluate therapist competence. The PQS is primarily a general measure that distinguishes between different kinds of psychotherapy, but that does neither specify nor discriminate the complexity encompassed in the notion of psychoanalytic competence.

In psychoanalysis, competence has been defined as “the capability to work with and understand unconscious dynamics by adhering to specific internal attitudes and maintaining certain frames” (Parth & Loeffler-Stastka, 2015, p. 1). Due to the elusiveness of the Unconscious, the task of operationalising competence is a great challenge, as it requires a detailed description of the psychoanalytic process. In order to operationalise competence, a series of research steps have been proposed (Parth & Loeffler-Stastka, 2015). The first step encompasses describing and delimiting what is understood as general psychoanalytic competence. Secondly, experts’ descriptions of the current understanding of therapist competence should be obtained, with the aim of defining competencies in depth, doing justice to their complexity, and concurrently reviewing existing definitions looking for consensus on possible developments of the concepts. The third step entails operationalising competence “into an empirically implementable instrument that allows for the analysis of clinical data” (Parth & Loeffler-Stastka, 2015, p. 2). This instrument would allow studying and documenting therapist competence in practice, and to understand how competencies are effectively used. This would allow to communicate, compare and review different competencies in clinical practice, a fundamental element to study therapist effects.

Therapist effects may have substantial impact on patients’ outcomes in the public health context. Studying therapist competence, in an appropriately designed study, could elucidate the understanding of the individual differences in treatment outcomes among patients. This would inform training alternatives and improve clinicians’ performance. In order to study therapist competence, it
is crucial to operationalise what it encompasses. Thus, general and particular
 descriptions of therapeutic competence should be obtained from experts so as
to develop an empirically implementable instrument that would allow studying
therapeutic competence in clinical practice.

1.2 Competence: Definitions and Controversies

Competence has been considered a holistic and qualitative account of the
therapist’s technique in a particular clinical context (Tadic, Drapeau, Solal, de
Roten, & Despland, 2003; Waltz, Addis, Koerner, & Jacobson, 1993). It has
been defined as the therapist’s ability in “providing a therapeutic milieu, in
conceptualising the patient’s distress and problems within a specific theoretical
framework, and in applying recognised techniques or methods consistent with
the goals of treatment” (Shaw et al., 1999, p. 838). This definition captures
satisfactorily the notion that competence refers to the quality and skillfulness of
the therapist’s interventions however, it is too broad to describe what do we
understand by competent clinical work.

A more accurate definition of competence proposed by Barber et al. (2006)
conceptualised competence as the particular delivery of each item of a
treatment manual. This definition of competence originates from the line of
research that studies treatment integrity. Treatment integrity refers to the
degree to which treatment is delivered and implemented as it was originally
intended (Perepletchikova & Kazdin, 2005), and it encompasses three
characteristics: (1) adherence, meaning, the extent to which the therapist uses
the prescribed therapeutic interventions, (2) competence, meaning the level of
the therapist judgment and skillfulness, and (3) treatment differentiation,
meaning, the degree in which treatments differ from each other in relevant
dimensions (Perepletchikova, Treat, & Kazdin, 2007). Although this definition
separates competence from adherence, their conceptual overlap remains,
considering that in order to deliver a competent therapy, the therapist has to be
aware of both, the qualitative as well as the quantitative (adherence) aspects
of therapy. To clarify the difference between adherence and competence
Barber et al. (2008) re-defined competence as the “skill, acumen, and judgment
with which interventions are delivered. The quality of an intervention is determined not only by a strict adherence to the treatment manual, but also by the overall sense of ‘appropriateness’ of the application of techniques and the therapist’s sensitivity to the contextual elements of treatment” (p. 463). Thus, the essential difference between adherence and competence is the sort of knowledge that each indicates. Adherence indicates that the therapist possesses the knowledge of “how” to intervene, independently of the context. Conversely, competence always depends on the context, requiring knowledge of “when” and “when not” to intervene (Barber et al., 2007). Although the overlap between adherence and competence is still present in this definition, it also implicitly expresses that at times, in order to deliver a competent therapy, the therapist must be flexible in how adherent he/she is to the treatment manual. Psychotherapy is a multifaceted, relational and unique process for every therapist-patient dyad. Hence, psychotherapy is not a clearly structured process, and competence cannot be simply defined as adherence to an empirically supported manual. Rather, competence requires a highly complex performance that demands the integration of various skills, flexibility and continuous reflection about the encounter with the patient (Binder & Betan, 2012).

As mentioned above, the quality of therapist performance is basic to the definition of competence, as Sperry (2010) proposed: “Competency is the capacity to integrate knowledge, skills, and attitudes reflected in the quality of clinical practice that benefits others, which can be evaluated by professional standards and be developed and enhanced through professional training and reflection” (p. 5). There are two issues that are controversial in this definition, the implicit association of competence with a positive treatment outcome, and the association of competence with the therapist’s experience and training. Defining a therapist whose patients have positive treatment outcomes as competent, may be misleading. Firstly, because it would only allow to define competence in the post-treatment phase and therefore, it would not be possible to distinguish the concepts of competence and outcome from one another. Secondly, a treatment could have positive effects for many reasons and not only as a result of the therapist, therefore defining as competent a therapist whose patients benefit from treatment would not allow to distinguish
competence from other determinants of treatment outcome. Additionally, a therapist’s attitudes and behaviours may be considered competent and still lead to neutral or negative treatment outcomes, for example when treating a particularly difficult patient. Thus, the importance of defining competence independently from treatment outcome becomes clear. On the other hand, defining competence according to the amount of experience of a therapist can also be deceptive. Although traditionally in psychotherapy research, therapist competence has been equated with therapist experience, no clear associations have been demonstrated between these variables (Chow et al., 2015; Eells, 2003; Kraus et al., 2016; Tracey, Wampold, Lichtenberg, & Goodyear, 2014; Wampold & Brown, 2005). However, experience may facilitate the therapeutic process and lower patients’ dropout rates (Rønnestad et al., 2018; Shaw & Dobson, 1988). Thus, it is important to differentiate therapist competence from therapist experience and years of training.

Other definitions have highlighted specific aspects included in the construct of therapist competence. Kaslow (2004) understood competence as the average acceptable performance level that meets professional and ethical standards of practice, and that is demonstrated through the therapist’s knowledge, skills, and attitudes. In this definition, knowledge refers to understanding the theoretical basis of clinical work. Skills denote the capacity to implement knowledge and technical interventions, selecting suitable strategies to address specific clinical situations. Attitudes denote the commitment and values to professional development (Binder & Betan, 2012). Strupp, Butler, and Rosser (1988) proposed that a personal attachment to the patient is fundamental to the construct of competence considering that a mechanical delivery of interventions does not result in competent treatment. The therapist’s interventions are part of an elaborate sequence of transactions between therapist and patient. These transactions have specific meanings in reference to the relationship between therapist and patient and derive their therapeutic effectiveness from the interpersonal context of the therapeutic situation. Thus, the therapist’s contribution to this interpersonal context is a fundamental constituent of his/her overall competence.

In conclusion, it is essential to define therapist competence in the most accurate possible manner. It is necessary to distinguish competence from
adherence, treatment outcome, and years of clinical experience. Building on the preceding definitions, a helpful conceptualisation of competence could be “the habitual and judicious use of communications, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” (Epstein & Hundert, 2002, p. 226). In order to understand competence further it is necessary to study in depth the quality of knowledge, skills, attitudes, implementation of a particular model of therapy, the interpersonal relationship, and other contributions that the therapist delivers in the therapeutic encounter.

1.3 Assessing and Operationalising Competence

1.3.1 Treatment Integrity

It is fundamental to demonstrate therapist competence, together with the other components of treatment integrity, in order to ensure the internal validity of psychotherapy research studies. Demonstrating internal validity is a prerequisite in order to evaluate the effects of technique and to compare the outcomes between different psychotherapeutic modalities. However, during the last decades, research has focused in the non-specific components of psychotherapy, rather than in different psychotherapeutic techniques, in the prediction of treatment outcomes. This has been a result of the similar treatment outcomes found across different therapeutic modalities (Shapiro & Shapiro, 1982a; Smith & Glass, 1977; Wampold et al., 1997), a phenomenon denominated the “dodo bird verdict” (Luborsky, Singer, & Luborsky, 1975). Nevertheless, the notion that all therapeutic modalities lead to similar outcomes is controversial. Most studies that have explored this association are methodologically weak, have small sample sizes and therefore low statistical power. The latter may explain the non-significant findings regarding technique as a predictor of treatment outcome. Moreover, meta-analytic studies test hypotheses by creating effect sizes, which constitute averages between-patients scores in the different domains under study. In the process of averaging, it is common that variability caused by other factors, such as the
technique, becomes hidden. On the other hand, in individual studies, between-patient variance in treatment outcome has often been ascribed to patient characteristics, which are easier to measure than technique. Most importantly, most studies that have compared outcomes between different psychotherapeutic modalities have not adequately evaluated treatment integrity. Therefore, the role of technique in treatment outcome has remained in the background despite the “dodo bird verdict” being a controversial issue (Bhar & Beck, 2009; Kazdin, 1986; Piper, Joyce, McCallum, & Azim, 1993).

Treatment integrity has been conceptualised as the extent to which treatment is implemented as it was originally intended (Perepletchikova & Kazdin, 2005), and, as mentioned above, it encompasses the concepts of adherence, competence, and treatment differentiation (Perepletchikova et al., 2007). In order to compare the efficacy of different psychotherapeutic modalities it is essential to ensure treatment integrity, considering that without an adequate implementation of the therapies it is not possible to evaluate whether one of them has better outcomes than another. If treatment integrity is not corroborated it may be that finding one therapy superior or equal to another could be due to poor adherence, competence or differentiation (Bhar & Beck, 2009; Perepletchikova et al., 2007). Nevertheless, only 8.9% of psychotherapy studies report adherence, and just 1.5% of them report therapist competence (Perepletchikova et al., 2007). Therefore, Bhar and Beck (2009) have questioned the results of the studies that compared cognitive-behavioural therapy (CBT) and short-term psychodynamic psychotherapy (STPP) without finding significant differences between them in their outcomes (Leichsenring, Rabung, & Leibing, 2004). In their research, Bhar and Beck (2009) used the Implementation of Treatment Integrity Procedures Scale (ITIPS) (Perepletchikova et al., 2007), which assesses the quality of treatment integrity procedures in particular studies. The ITIPS requires that researchers establish a strategy to monitor treatment integrity. Therefore, adherence and competence should be adequately defined in reference to the treatment manual and assessed accordingly. The assessment should be made through direct evaluations (e.g., evaluation of audio tapes) rather than through indirect observations (e.g., self-reports). Additionally, there should be an evaluation of the potential biases in measurement. Finally, the results of treatment integrity
measurement should be reported (Perepletchikova et al., 2007). Bhar and Beck (2009) found that no study in the meta-analysis (Leichsenring et al., 2004) met the criteria for adequately implementing treatment integrity.

Therefore, therapist competence, together with adherence and treatment differentiation, constitute treatment integrity. Although treatment integrity is essential to demonstrate the internal validity of psychotherapeutic studies, which is fundamental to evaluate the effects of technique and compare the outcomes between different psychotherapeutic modalities, it is rarely measured and reported.

1.3.2 Treatment Manuals

The use of treatment manuals is essential to ensure treatment integrity. Treatment manuals allow the systematisation of technique and the discrimination between different modalities of therapy, which improves the internal validity of comparative outcome research, and enables the possibility of distinguishing the active ingredients of therapy. Therefore, if therapy is delivered with care, the resulting differences when comparing the therapeutic technique to a control condition can be attributed to the defining characteristics of the manualised technique (independent variable) (Piper & Ogrodniczuk, 1999). Furthermore, treatment manuals allow to create measures of and to assess adherence and competence in the delivery of a treatment. Therefore, treatment manuals are helpful to disseminate a validated therapy and are particularly important for psychotherapy research and training (M. J. Lambert & Ogles, 1988; Luborsky & Barber, 1993; Luborsky & DeRubeis, 1984; Piper & Ogrodniczuk, 1999; Waltz et al., 1993; Wilson, 1996).

Besides their value for research and training, it has been suggested that treatment manuals are considerably useful in clinical practice. Fonagy (1999) observed that “treatments that are unstructured, unfocused, and delivered without predetermined goals and objectives tend to be ineffective when contrasted with carefully crafted, well-thought-out, clearly specified and, above all, structured interventions” (p. 443). In delivering psychodynamic psychotherapy, it is common for the therapist to experience confusion
considering the unpredictable changes in goals and focus. A lack of competence may lead the therapist to an excessive use of proscribed interventions and incoherent explanatory frameworks, becoming vulnerable to enactments in the absence of a therapeutic strategy. Under these circumstances, only a coherent and clear framework can assist the therapist to withstand the inevitable interpersonal pressures of the therapeutic situation (Fonagy, 1999).

Nevertheless, manuals have been criticised for reducing psychotherapy into a mechanical exercise, taking away the subtleties and complexities of the process. Furthermore, a strict adherence to manuals compromises therapist competence (Garfield, 1996; Silverman, 1996; Strupp & Anderson, 1997) and the therapeutic relationship (Addis, Wade, & Hatgis, 1999). Moreover, although initially the emergence of treatment manuals brought about the hopeful idea that training and skills would be enhanced by the greater specification of clinical practice components, up until now this has been controversial (Strupp et al., 1988). Hitherto, therapeutic manuals have mostly been used to secure treatment “adherence” and therefore ensure the internal validity of short-term treatment research studies (Binder, 1999). However, after years of experience, the ability of manuals to enhance training has been questioned (Strupp & Anderson, 1997). Although manuals promote the use of therapeutic interventions and strategies, studies have consistently shown weak associations between adherence to treatment manuals and outcomes (Binder, 1993a; Butler & Strupp, 1993; Truijens et al., 2018). Conversely, there are several studies that show an association between the competent delivery of manualised psychodynamic psychotherapy and positive treatment outcomes (Barber, Crits-Christoph, & Luborsky, 1996; Crits-Christoph, Cooper, & Luborsky, 1988; Piper et al., 1993). Evidence has shown that manualised training promotes the acquisition of established techniques but does not necessarily lead to their skillful use. Thus, it is possible for a therapist to be highly adherent to a manualised treatment model but to implement it in an incompetent way. Indeed, attending too much to adherence may decrease the level of competence (Henry, Strupp, Butler, Schacht, & Binder, 1993). The problem of high adherence and low competence is particularly vexed for psychodynamic psychotherapy, where the conflict between controlling
The technique for research purposes stands in opposition to the process of therapy for clinical reasons. This conflict has largely contributed to the division between dynamically oriented clinicians and researchers. Clinicians have questioned whether the techniques promoted by research are representative of the techniques used in clinical practice, considering research therapy as overly controlled and superficial. Unfortunately, this division between clinicians and researchers has hindered the development of knowledge (Piper & Ogrodniczuk, 1999).

The Vanderbilt II study (Henry, Strupp, et al., 1993) attempted to examine the impact of training therapists to a manualised psychodynamic psychotherapy (TLDP). Sixteen therapists were trained in TLDP for a year, a training that included supervisions, didactic learning and clinical training. After the training, therapists had greater adherence to the manual and were almost twice as active. However, after the training, therapists made more “complex communications” which usually contained criticism and were considered counter-therapeutic. Furthermore, there was an increase in hostile communications and the therapists showed less warmth, less friendliness and more negative attitudes. In attempting to understand the results, the authors indicated, “we are forced to hypothesize that although the ‘treatment was delivered,’ the therapy (at least as envisioned) did not always occur” (Henry, Schacht, Strupp, Butler, & Binder, 1993, p. 438). Moreover, the interventions post-training appeared to be mechanical, as if “their spontaneity and intuition are curtailed, whereas patients sometimes feel ‘subjected’ to a treatment in a manner that overlooks their individual needs” (Henry, Schacht, et al., 1993, p. 438). Furthermore, the Vanderbilt II study showed no evidence of better outcomes after training the therapists. Therefore, too much attention to adherence might result in mechanical, hostile and self-conscious therapists who do not necessarily provide better treatment outcomes. These findings suggest that training should focus on assessing the therapist’s competence, more than their adherence, emphasising the therapist’s sensitivity to contextual cues when providing interventions (Piper & Ogrodniczuk, 1999). In the Vanderbilt II study it was found that training in the prescribed manualised psychotherapy was more successful in teaching the therapist to follow the manual than in teaching clinical skills (Binder, 1993b).
Hence, the use of treatment manuals is crucial for improving treatment adherence and therefore the internal validity of comparative outcome research. Furthermore, treatment manuals may help to deliver a more focused, clear and structured therapy. However, although manuals can promote the acquisition of established techniques they do not necessarily lead to their skillful use. Indeed, it has been suggested that attending too much to adherence may decrease the level of competence and lead to worse treatment outcomes. Therefore, training should focus more on competence than on adherence in order to enhance treatment outcomes. Nevertheless, the understanding and operationalisation of what constitutes a competent clinical performance is still limited (Binder, 1999).

1.3.3 Measuring Competence

In order to study therapeutic competence, it is necessary to operationalise this concept and create measures to assess it. However, a clear, straightforward and accessible measure of competence has not been developed yet. Studies that have attempted to measure competence mostly rely on subjective ratings (Orlinsky & Howard, 1986). Considering that the ratings represent the judge’s overall assessment of the competence of a particular therapist, differences between scores and the components of competence, are not operationalised. Operationalising competence would have valuable practical implications, however the task poses great challenges. An important issue pertains to the difficulty in distinguishing competence—the quality in the execution of interventions—from measures of adherence that evaluate the presence or absence of therapists’ behaviours. As mentioned above, treatment manuals have allowed to verify adherence, considering to what extent the therapist carries out the prescribed techniques, and the degree to which particular interventions are avoided (C. E. Hill, O’Grady, & Elkin, 1992; Waltz et al., 1993). However, although treatment manuals have attempted to delimit therapist competence, its descriptions are mostly equivocal and unclear. Indeed, measures of adherence tend to include a certain degree of skillfulness considering that only assessing the frequency counts of specific techniques is an inadequate measure of adherence. However, a separate, accessible and
clear operationalisation of competence has not been developed yet. Another
difficulty in operationalising competence is defining it on the basis of positive
treatment outcomes. Although it may seem evident to use treatment outcome
as the criterion of skill, it is important to recognise that an important aspect of
being a competent therapist is the ability to accept the limitations on influencing
patients, as well as recognising that, for certain patients and conditions, no
amount of competent psychotherapy can lead to positive outcomes. Patients
may change or fail to change for multiple, unknown and not well-understood
reasons. Therefore, attempting to operationalise competence in terms of
positive outcomes is unrealistic considering the current state of the art.
However, it is reasonable to assume that a skillful use of psychodynamic
technique facilitates the therapeutic process and that the therapist’s
competence has a positive and observable effect on the patient (Strupp et al.,
1988). Furthermore, the construct of therapist competence includes the notion
of therapist responsiveness which refers to consistently doing the right thing,
which could variate with each patient, at different times. Therefore, it could be
difficult to achieve an absolute and stable operationalisation of competence
considering that the construct would need to encompass the notion that
interventions change from moment to moment, and from patient to patient
(Stiles & Horvath, 2017)

Despite these challenges there have been a few attempts to develop
reliable measures of competence. Barber and Critis-Christoph (1996)
developed the Penn Adherence/Competence Scale for Supportive-Expressive
Dynamic Psychotherapy. The scale includes 45 items which are independently
rated on a seven-point Likert-type scale for both adherence and competence,
depending on how much the therapist performed a specific behaviour and how
well the intervention was carried out, respectively. However, the quality of the
intervention was not objectively defined and was subjectively rated by judges.
This resulted in a low inter-rater reliability (0.42) between judges for
competence ratings in both sub-scales. Therefore, the absence of an objective
operationalisation of therapist competence hinders the possibility to assess it
in a reliable manner.

Likewise, Butler, Henry, and Strupp (1995) attempted to measure
adherence and competence in Time-Limited Dynamic Psychotherapy (TDLP;
In order to do so, they developed the Vanderbilt Therapeutic Strategies Scale (VTSS) that consists of two sub-scales. The first subscale, the Psychodynamic Interviewing Style subscale, measures the frequency of exploratory and expressive interventions, as well as the dynamic therapeutic stance. The second subscale measures Specific Strategies of TDLP, focusing on the therapist task of addressing the patient’s maladaptive interpersonal patterns. In order to assess whether the VTSS accurately captured therapist competence, its results were correlated to an overall competence rating made by the therapists’ supervisors. The supervisors’ rating significantly correlated with the Interviewing Style subscale but not with the Therapeutic Strategies subscale. While recognising that the supervisor’s ratings constitute highly subjective data, the low correlation of the latter subscale to competence corroborates the difficulty of creating a measure that assesses competence in an accurate manner.

Another attempt to operationalise competence was developed by M. F. Hoyt (1980) who evaluated the correlation between expert therapists’ opinions regarding their own performance, with competence ratings of an independent judge. It was observed that both, therapists and independent observers, rated sessions as “good” when the therapists’ actions promoted the patients’ expression of feelings and thoughts, and when the meanings underlying the patient’s manifest reactions were explored.

Barber et al. (2007) reviewed data regarding the reliability of several psychodynamic competence measures: the PACS-SET (Barber & Critis-Christoph, 1996), ACS-SEC (Barber, Krakauer, Calvo, Badgio, & Faude, 1997), and STCRF (Svartberg, 1989). Each instrument demonstrated a high internal consistency coefficient (.95, .97 and .71, respectively), indicating that if one intervention was given a high competence score, a related intervention would probably be rated similarly. Nevertheless, interrater reliability estimates for these measures tended to be low to moderate (.73, .43 and .70, respectively). Poor inter-rater reliability was suggested to be due to one of the following issues: 1) different understandings of competence between judges; 2) dissimilarities in the amount of attention given by judges to different elements of treatment delivery; (3) the challenges in operationalising therapist competence; and, (4) the employment of homogeneously competent therapists.
in RCTs, which leads to a small variance in competence ratings considering that therapists are selected for their competence (Barber et al., 2007; C. E. Hill, Spiegel, Hoffman, Kivlighan Jr, & Gelso, 2017). It has been recommended, in order to improve the inter-reliability ratings to: (1) aggregate multiple competence scores of multiple raters; (2) train raters in the use of competence measures so as to standardise their interpretation of specific competency items; and, (3) train raters across research sites, as systemic differences can emerge between judges that received different trainings (Barber et al., 2007). The criterion validity of these measures was supported by the high internal consistency estimates and by the ability of the measures to discriminate among treatments. However, several factors might limit the validity of these measures: (1) no tests for the different applications of the measures has been conducted, although they have been used with diverse patient populations; (2) the limited attention paid to therapist and patient diversity issues, which might affect competence in tailoring interventions; and, (3) the lack of clarity of how these measures can be used for similar but not identical disorders/treatments from the ones that they were originally developed for (Barber et al., 2007). In conclusion, these competence measures constitute an initial stage toward the development of measures that the field requires in order to document therapist competence, however their limitations still have to be understood and addressed.

The skillful delivery of psychodynamic technique is an essential component of competence. Developing more accurate, reliable and valid measures to study therapeutic skills may allow to define what a competent performance is and its role in the therapeutic process (Strupp et al., 1988).

1.4 Challenges in Assessing Competence

There are still several unanswered questions regarding how to improve the assessment and operationalisation of competence. Firstly, most competence measures have been developed for RCTs that use manual-based treatments. Therefore, there is limited knowledge regarding how to assess competence in more general settings using these or other instruments.
Secondly, the potential impact of diversity in competence assessments has not been fully explored. For example, the possibility that some therapists could be more competent with patients who are similar should be considered. Additionally, the possibility that therapist of different backgrounds are dissimilar in their level of competence and/or that diversity variables moderate treatment outcome, should also be considered when assessing competence (Barber et al., 2007).

Another challenge regarding the assessment of competence refers to situating thresholds of competence in order to distinguish between different levels of skill at different points in the training of a psychotherapist. In order to determine these thresholds, a clear definition of an “acceptable” level of competence should be established. Furthermore, reliable measures possessing breadth, depth and construct validity would be required (Barber et al., 2007).

Other questions regarding how to best assess competence have not yet been answered. It has been suggested that the specific therapeutic context (e.g., stage of therapy) should be taken into consideration when assessing competence in order to evaluate interchanges that are representative and also relatively unusual. Other recommendations involve the assessment of the therapist ability to adequately handle extreme therapeutic situations, -such as dealing with patient hostility or handling boundary transgressions-, as they may be more representative of the therapist competence and flexibility than behaviours during “business as usual” therapy (Barber et al., 2007).

Special problems arise in comparative studies with different therapists in each treatment condition. The critical issue is how to establish whether therapists, in two different treatment modalities, have an equal level of competence. The problem lies in the intrinsic differences in the ways in which proponents of the compared treatments view competence. Furthermore, in addition to the conceptual differences, there are also disparities in the measures used to rate competence. This hinders the possibility of comparing therapist competence in two treatment modalities. As a possible solution, it has been proposed to only measure the unspecific components of therapies, such as the therapeutic alliance (Elkin, 1999). However, this would not address the issue appropriately considering that essential interventions would be left out of
the competence assessment.

Another challenge concerns achieving an operationalisation of competence that is valid to different psychotherapeutic paradigms. Theorists and researchers will unavoidably have to confront the issue of competence between and within paradigms of psychotherapy. Interesting challenges may emerge as it is possible that competence viewed from an intraparadigmatic perspective may be judged as incompetent from an extraparadigmatic viewpoint (Barber et al., 2007).

Finally, assessing and operationalising competence is a complex task and there are several challenges that should be considered. Although operational definitions are required to carry out controlled research, by nature they are inherently incomplete. Therefore, therapist competence is not assessed in itself, but rather an operationalisation of that construct (Barber et al., 2007): “Reification is an ever-present threat, and this could very well lead to premature intellectual foreclosure of a key psychological construct with significant professional ramifications” (Barber et al., 2007, p. 499).

1.5 Conclusion

In the current chapter, the importance, purpose, and challenges of studying therapist competence in psychodynamic psychotherapy have been reviewed. It was outlined that process-outcome psychotherapy research has suggested that therapists contribute to treatment outcome in a small but important proportion. However, despite the knowledge of the existence of therapist effects, little is known about the reasons underlying the variability in their effectiveness. Therapist competence has been proposed as an important factor that could explain, at least partly, the variability in therapist effects. Furthermore, in this chapter the importance of studying therapist competence has been explained, -as a fundamental component of treatment integrity-, in order to demonstrate the internal validity of research studies and examine the effects of the psychotherapeutic technique delivered, in clinical outcomes.

Therapist competence poses important challenges for its definition, operationalisation and assessment. Particularly, because of the difficulty of
accurately defining the construct, distinguishing it from treatment adherence, therapist experience and positive clinical outcomes. Additionally, the complexity of operationalising therapist competence results from the difficulty of conceptualising elusive unconscious processes; and, from the need for the construct to encompass the notion of therapist responsiveness, which entails different therapeutic attitudes and behaviours, at different moments, and with different patients.

Despite these challenges, it is fundamental to understand what constitutes a competent and skillful practice in order to operationalise it, and develop more accurate, reliable and valid measures to assess therapist competence and its role in the psychotherapeutic process.

In the next chapter, research studies that have addressed the role of competence in the psychotherapeutic process and its association with treatment outcome will be revised, by first presenting the current knowledge regarding the relationship between psychotherapeutic technique and clinical outcome.
Chapter 2: Process-Outcome Studies: Relationship Between Treatment Integrity and Treatment Outcome

2.1 Therapist Adherence and Treatment Outcome

An essential matter to understand the association between a competent practice and treatment outcome is to achieve an overall comprehension of the relationship between technique and clinical outcome. Thus, a fundamental question is whether adhering closely to a treatment manual brings about better or worse treatment outcomes. It has been suggested that greater flexibility in manual implementation –conceptualised as “adherence flexibility”- results in better treatment outcomes when delivering psychodynamic therapy (Owen & Hilsenroth, 2014). This idea had already been proposed more than two decades ago in a study that found that slavish adherence to CBT for depression worsened the alliance, thereby interfering with therapeutic change (L. Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). Since this study, several researchers explored this matter and, as a way of systematising the results, a meta-analysis was put together. The meta-analysis, that examined the relationship between adherence to technique and treatment outcome, only found a small effect size ($r = .02$), suggesting that adherence to the manual plays little role in determining symptom change (C. Webb, DeRubeis, & Barber, 2010). However, the meta-analysis was criticised because its question was too broad: “does adherence to any model of therapy, with any type of disorder/patient population, with any duration of treatment, lead to good outcome?”. Thus, the meta-analysis averaged very heterogeneous studies, making it negatively biased. An example of the latter was the average of two studies that had used very different measures to assess treatment techniques. The average between the studies effect sizes showed no effect, even when one of them had found a large effect size ($r = 0.60$) in the use of cognitive interventions and symptom change (P. Critis-Christoph, personal communication, September 12, 2016) (Feeley, DeRubeis, & Gelfand, 1999; M. J. Lambert, 2013). Therefore, it was suggested that in order to properly address the original question it was pivotal to examine more specifically the studies that
investigate the relationship between adherence and outcome in terms of the different therapeutic modalities, outcome measures, duration of therapy, and populations (L. Castonguay et al., 1996; Feeley et al., 1999). Moreover, the meta-analysis was criticised because the inclusion/exclusion criteria used to select studies were unclear (M. Hilsenroth, personal communication, September 14, 2016). Furthermore, the meta-analysis findings were challenged by later studies (Gregory, personal communication, September 12, 2016). Gregory A. Goldman and Gregory (2009b) found that adherence to dynamic deconstructive psychotherapy (DDP) was positively related to improvement in BPD symptoms ($\rho = 0.64$) and most secondary outcomes. Additionally, a separate study suggested that treatments with a specified set of techniques, such as DDP, DBT, MBT, Schema therapy, Supportive Therapies and TFP, may be helpful for different individuals depending on their particular symptoms (Gregory A. Goldman & Gregory, 2010).

Adherence has a complex relationship with treatment outcome, and in order to understand it several studies must be reviewed (J. P. Barber, personal communication, September 12, 2016). It has been indicated that the competent delivery of expressive/interpretative techniques, but not adherence to them, was predictive of treatment outcome in a sample of depressed patients (Barber et al., 1996). Nevertheless, this lack of association between adherence and outcome was examined further. Subsequently, research studies found that moderate adherence to the treatment manual was associated with better outcomes, contrarily to high and low levels of adherence (Barber et al., 2008; Butler et al., 1995). Therefore, a non-linear relation was proposed between adherence and outcome, which conceptualises the premise that addresses the intuition that too little adherence or too much adherence may result in poorer treatment outcomes, and perhaps be the cause of lack of progress in complex patients. High levels of adherence might reflect a lack of flexibility on the part of the therapist to respond to the patient’s specific needs. Thus, a negative correlation could be expected between a “rigid” adherence to the manual and outcome. On the other hand, a low degree of adherence, meaning a failure to deliver the treatment manual, would also result in negative outcome. (Barber et al., 2006).

Research studies have suggested that nonlinear models might be relevant
to study the association between adherence and outcome, and linear models might be useful to understand the relation between competence and outcome (Barber et al., 2006; Despland et al., 2009). The latter was corroborated by Barber (2009) who found a moderate effect size ($d = 0.44$) and a curvilinear relation between adherence and outcome. Competence was associated in a linear way to outcome. Therefore, regarding the role of techniques on treatment outcome it was suggested that the use of intended interventions may have unintended consequences; and, that at times, outcome is associated with the use of unintended interventions or even a combination of both intended and unintended interventions. This is in line with Katz et al. (2018) finding regarding that flexibility incorporating a limited amount of cognitive-behavioural techniques into psychodynamic therapy can bring about better clinical outcomes.

Other studies that have confirmed the curvilinear relationship between adherence and outcome have attempted to understand the possible reasons behind this phenomenon. McCarthy, Keefe, and Barber (2016) found that moderate levels of psychodynamic and process-experiential interventions were found to be predictive of better outcomes than were very low or very high levels of these interventions. Considering that these techniques aim to facilitate the experience of emotions, a moderate use of psychodynamic/experiential interventions may have represented the “just right” level at which the patient could begin to make use of the interventions to change his/her symptomatology. A smaller “dose” of psychodynamic/experiential interventions may not have been enough to trigger these processes. On the other hand, a higher “dose” of psychodynamic/experiential interventions may have flooded the patient too quickly with intolerable emotions, or may have represented an inflexible approach that overlooked the patient’s clinical presentation, resulting in poorer treatment outcomes. However, considering that the curvilinear relation was observed using correlational methods, an opposite direction of the relationship between adherence and outcome cannot be excluded. Therefore, it could be suggested that patients who are likely to improve may also have qualities that draw the therapist to intervene at a moderate level. On the other hand, patients who are unlikely to improve may exhibit characteristics that make the therapist intervene much less or much more than he/she might for
other patients (McCarthy et al., 2016). Overall, the curvilinear relation between adherence and outcome may explain the equivocal association between these factors when only a lineal relation is explored. Thus, the indeterminate results of previous research might have “either represented a single leg of the curvilinear relation or might have represented a linear model being forced on curvilinear data” (McCarthy et al., 2016, p. 308).

Only a few studies have explored the curvilinear relation between adherence and outcome. Piper, Azim, Joyce, and McCallum (1991) found partial support for the curvilinear hypothesis. Høglend et al. (2006) found that patients randomly assigned to psychodynamic therapy improved when they received moderate or low levels of transference interpretations. Furthermore, McCarthy et al. (2016) found that moderate levels of psychodynamic expressive techniques predicted greater symptom improvement compared to lower or higher levels. Therefore, the curvilinear relation between adherence and outcome may exist. Barber et al. (2006) found that when the therapeutic alliance was strong, adherence was rather unimportant, considering that these patients improved regardless of the actual technique. However, in cases where the alliance was poor, patients improved more when their therapists adhered moderately to the manual. Nevertheless, in another research study that examined a supportive-expressive dynamic therapy for cocaine dependence, Barber et al. (2008) found conflicting results, meaning that when a strong alliance was present, low levels of adherence were related to a more positive outcome compared to instances where therapists were moderately adherent to the technique. The authors interpreted these findings suggesting that emphasising events related to drug use may have been painful for patients, particularly when these events are shared with a therapist to whom they feel close to (i.e., have a good alliance). Therefore, therapy may have increased stress levels and led patients to use cocaine in order to cope with their emotional states. Another suggested explanation was that if patients were actively using cocaine, exploring the psychodynamic causes for drug use may not have been the first therapeutic priority. Instead, these patients may have first needed counseling and behavioural help to control their physical cravings (Barber et al., 2008).

Researchers have indicated that rather than assessing adherence to
technique, the most important matter is studying the mechanisms of change in psychotherapy (M. Hilsenroth, personal communication, September 14, 2016). Measuring adherence should not be an aim in itself without the appropriate examination of the association between this variable and treatment outcome. Adherence to technique is only relevant if it benefits patients, is not an end goal in itself, and it only constitutes an interesting variable inasmuch as it represents a potential mechanism of change that affects clinical outcomes (Owen, Drinane, Idigo, & Valentine, 2015).2

The study of “adherence flexibility” poses a relevant question in reference to the usefulness of treatment manuals. This question makes reference to what has been conceptualised as the “prescriptive model” of psychotherapy, which has been claimed to be a strategy that aims to instruct therapists “what to do” on the basis of scientific findings (P Luyten, 2015). However, not even the most empirically supported psychotherapy is prescriptive, and none of them have each and every aspect rooted in research findings. Conversely, most treatment manuals are not cookbooks that prescribe every single step in detail, but rather provide general principles, techniques, and interventions for clinicians to rely on in the various stages of treatment. Manuals are not felt to be a harness that hinders being flexible in treatment, nor do they promote one theory to the level of absolute truth. For example, practitioners trained in DIT and MBT frequently indicate that training in these manualised treatments has increased their capacity to respond flexibly to unexpected situations in treatment (Bateman & Fonagy, 2009; Gelman, McKay, & Marks, 2010). Another good example is the Improving Access to Psychological Therapies (IAPT) initiative, which has identified, among other findings, a set of meta-competences that all therapists, regardless of their theoretical orientation, should have. These meta-competences include the capacity to apply the theoretical model “flexibly in response to the client’s individuals needs and context” (Lemma, Target, & Fonagy, 2010). It is important to remark that IAPT competencies are not merely based on “clinical wisdom”, but on treatments that demonstrated efficacy. Therapists should be alerted against the position that “supports the freedom of

2 See Appendix B for notes regarding the assessment of adherence to treatment manuals.
each therapist to work in the way that best fits their personality” and to do “what feels right at the time” in treatment. There is great variability between therapists in their effectiveness (L. G. Castonguay, Boswell, Constantino, Goldfried, & Hill; Crits-Christoph & Gallop, 2006; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010). Most clinicians need all possible support in order to know what is effective and what is not with each patient (Goldfried, Raue, & Castonguay, 1998). Therefore, it is not possible to leave up to the individual clinician to do “what feels right at the time” in treatment. Studies of videotaped sessions—in the context of training and supervision—show how much each therapist can still learn, and how much room there is for improvement of skills. Therefore, prescriptive models are needed, but as models that support the clinician and offer ways to improve clinical practice. Psychotherapy is more than the mere application of research findings, but also more than an art. Good psychotherapy combines theory-driven research and clinical practice. These are not distinct enterprises, but are components of a broader critical and reflective attitude. Researchers and practitioners have a major responsibility in this regard. Rather than dividing the field, which might have been an appropriate response to naive and simplistic views in the past, researchers and practitioners should be open to new developments and knowledge about the workings of the human mind (P. Luyten, personal communication, September 14, 2016).

In conclusion, manuals can support the clinical practice of therapists with different levels of effectiveness, particularly when they are used in a flexible manner and the clinician is responsive to the patient’s needs. When manuals are used as clinical guides and as books of therapeutic principles, they can help provide better treatment outcomes for patients. However, manuals should not be used in a rigid way, losing sight of the idiographic analysis of single cases. Specific treatments are not unique—but patients are. Experienced therapists know that the work requires the tailoring of any approach to a particular patient’s unique circumstances.

2.2 Therapist Competence and Treatment Outcome: Overall Association

The empirical association between dynamic technique and treatment
outcome is uncertain (Barber, Muran, McCarthy, & Keefe, 2013). By and large, research on psychodynamic interventions and treatment outcome has been equivocal. Studies have found no effect (Barber et al., 1996; DeFife, Hilsenroth, & Gold, 2008; Ogrodniczuk, Piper, Joyce, & McCallum, 2000); a favourable association (Ablon & Jones, 1998; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Mariëlle Hendriksen et al., 2011; Hilsenroth, Ackerman, Blagys, Baity, & Mooney, 2003; Luborsky et al., 1985); and an unfavourable relation (Barber et al., 2008). Furthermore, as mentioned above, the only meta-analysis that studied the association between adherence to technique and outcome, in different psychotherapeutic modalities, did not find significant associations (C. Webb et al., 2010). The lack of association between technique and outcome raises the question of how specific techniques can have an effect in the therapeutic process. In order to answer this question, some studies have explored the interaction between alliance, technique and outcome (Barber et al., 2008; Gaston et al., 1998). Other researchers have examined the effect of the therapist responsiveness to the patient and its relation to treatment outcome (Stiles, Honos-Webb, & Surko, 1998). Alternatively, some researchers have studied how a competent implementation of dynamic techniques is associated with treatment outcome (Barber et al., 1996).

The relationship between therapist competence and outcome remains uncertain. Several studies have addressed this issue reporting contradictory results. Therapist’s competence has predicted a better treatment outcome in a few psychodynamic psychotherapy studies (Crits-Christoph et al., 2013; Luborsky et al., 1985) but not in others (Sandell, 1985). Interestingly, it has even been found that a competent delivery of therapy can predict worse outcomes (Svartberg & Stiles, 1994). However, in this last study the conceptualisation of competence overlapped with the definition of adherence, making its results debatable (Barber et al., 2008). In a study that examined the effects of a supportive-expressive therapy in cocaine use, competence was associated with negative treatment outcomes. Nevertheless, this finding could be equivocal considering that the particularities of the pathology –cocaine use-, could make the delivery of counseling techniques, for this group of patients, more appropriate (Barber et al., 2008). On the other hand, there is evidence
that fewer technical errors, as measured by the Vanderbilt Negative Indicators Scale, are associated with better treatment outcome in brief psychodynamic psychotherapy, and in experiential psychotherapy (Sachs, 1983). Furthermore, it has been demonstrated that competence predicts outcome beyond the patient’s pretreatment characteristics (O’Malley et al., 1988).

Svartberg and Stiles (1992) examined the relationship between competence and outcome in a pilot study of psychodynamic, short-term (20 sessions), anxiety provoking psychotherapy. It was found that competence in an early session did not predict treatment outcome. Several reasons were suggested in order to understand the low predictive power of competence. Firstly, it is possible that the measures used to assess therapist competence were inadequate, partly due to the overlap with adherence measures. Furthermore, the lack of association between therapist competence and outcome may have resulted due to the restricted range of competence scores. Additionally, the low sample size may explain a lack of power to demonstrate the effects of therapist competence on treatment outcome. Finally, the predictive power of competence may have been underestimated as only self-reported measures of change were used.

Barber et al. (1996) evaluated whether adherence and competence to supportive-expressive dynamic techniques were associated with outcome beyond patient variables. Four therapists treated twenty-nine depressed patients and were rated by two independent judges for adherence and competence. Competence and adherence were rated on Session 3 with the Penn Adherence-Competence scale for Supportive-Expressive therapy. The authors examined the associations between adherence-competence and outcome, measured with the Beck Depression Inventory (BDI). It was found that adherence to supportive or expressive techniques did not predict further change in outcome (residualised BDI score from Session 3 to termination). Therefore, the frequency of expressive techniques was not associated with an improvement in depressive symptoms. In reference to competence, it was found that the relatively competent delivery of expressive techniques predicted a subsequent decrease in depression. The latter was not the case for the competent use of supportive techniques. Furthermore, the authors studied whether an early symptomatic change (from Session 1 to 3) led to a better level
of adherence. They found that the lesser the early improvement on depressive symptoms the lesser the adherence to expressive interventions. This finding is in agreement with the notion that it is easier to adhere to expressive techniques when the patient is benefiting more from the treatment. Concurrently, early symptomatic improvement did not necessarily predict a further competent delivery of therapy on the part of the therapist. The examination of the effect of competence on treatment outcome, controlled for the early symptomatic improvement and adherence, showed that relative competence in the delivery of expressive techniques predicted a subsequent improvement in depressive symptoms. This finding was consistent, even when controlling for other “non-specific variables” such as general therapeutic skills and alliance. Therefore, specific skills are important for brief psychodynamic therapy beyond the “common factors” of the therapeutic process. The effects of additional aspects of expressive techniques, such as the timing, wording, management of resistances and links made by interpretations, remained to be studied. Examining these issues would improve the understanding of what a competent delivery of expressive techniques entails.

Svartberg, Seltzer, and Stiles (1996) studied self-concept development during a psychodynamic, short-term, anxiety-provoking psychotherapy (STAPP; Sifneos, 1992). Although therapists had postgraduate clinical experience and were highly trained in STAPP, competence was not significantly associated with improvement rate during treatment (t= 2.05, p= 0.057). However, the effect size estimate (r= .51, large) indicated a trend for patients to improve faster towards self-freeing when in treatment with more competent therapists. It is important to remark that the competence measure in this study did not take into account general therapeutic skills and had serious overlaps with adherence scales.

It has been suggested that the therapeutic alliance moderates the association between competence and outcome. Despland et al. (2009) evaluated the relationship between therapeutic alliance, competence and outcome in very brief (4-session) psychodynamic psychotherapy. No associations emerged between competence and outcome, meaning that despite the training in the specific psychotherapy and the years of experience, a high level of therapist competence did not guarantee a positive outcome.
However, the effects of alliance moderated the link between competence and treatment outcome. Contrary to less competent therapists, competent therapists establish a growing alliance with their patients in the course of therapy. Therefore, competence is certainly a requisite to facilitate a positive outcome, although not enough to result in it considering that the evolution of the alliance needs to be taken into account. Other studies regarding alliance, competence and outcome have shown that experienced therapists establish better therapeutic alliances with their patients in terms of agreeing with them on the goals and tasks of treatment. However, experienced therapists do not necessarily develop a better bond with their patients (Mallinckrodt & Nelson, 1991). Additionally, Crits-Christoph et al. (2006) found that the patients’ ratings of therapeutic alliance increased (moderate effect size) with the training of the therapist in a program called alliance-fostering therapy.

Huppert et al. (2001) examined the relationship between competence and outcome in adults with panic disorder. Although this study examined therapist competence in CBT is relevant to mention because it found that therapists with above and below average outcomes had similar measures of therapist competence and adherence. Several reasons were suggested to explain these results. Firstly, that technique in itself is not the only important factor related to outcome. Secondly, that therapists rated high on competence and adherence could have demonstrated a ceiling effect of these variables. Finally, it was suggested that more sensitive measures of competence could have yielded differences in outcomes between therapists (Huppert et al., 2001; Levy, 2016).

Competence has a complex relationship with treatment outcome. It has been indicated that while the relationship between the two is positive, is weaker than expected. This inconsistency may be due to several factors that can be broadly grouped into statistical/methodological and conceptual domains. Regarding the statistical/methodological factors, the association between competence and outcome may be small just because it is difficult to detect. In order to maximise detection, future studies would likely benefit from including large samples of patients and therapists. The effect of competence on outcome may also be small because therapists in studies have a restricted range of competence. This may be due to Randomised Controlled Trials (RCTs)
tendency to rely on experienced and/or well-trained therapists; therefore, there is a narrow range of competence among the participating therapists, which may result in a low variability in competence and/or outcome scores. Studies examining a wider range of competence and outcome may help clarify the relationship between the two. Furthermore, competence may be a proximal but not distal predictor of outcome or have different relations to outcome at different stages of therapy. Longitudinal studies of competence and outcome are needed to address this possibility. Additionally, there may be inconsistencies between study results because none shared the same methodology to model the association between competence and outcome (Barber et al., 2007). For example, inconsistencies in study results could be the consequence of conceptualising outcome differently, either as the total amount of change achieved (i.e., effectiveness) or as the rate of change (i.e., efficiency). Considering that these two conceptualisations of outcome could bring about different results, it has been recommended that both of them should be estimated (Barkham et al., 2017). Finally, a fundamental matter underlying the inconsistency in the association between competence and outcome is the use of unsuitable statistical methods to study this relationship. Examining the association between competence and outcome entails the analysis of a multilevel data structure, in which sessions are nested in patients, and patients nested in therapists. In order to achieve accurate results, and disentangle the different contributions of patient and therapist to outcome-, nested data should be analysed with multilevel statistical models (Wampold et al., 2017).

Inconsistencies in the relationship between competence and outcome may also be due to conceptual issues. Adherence and competence are conceptually distinct, but the degree to which they have been separated has not been uniform across measures. Adherence may have a very complicated relationship with outcome, and failing to fully separate out adherence may obfuscate any association between competence and outcome. Furthermore, competence may not have a direct relation with outcome but may instead be a moderator of the effects of other process variables. For instance, therapeutic alliance or adherence may both be predictors of treatment outcome in the presence of competence. Not enough studies have examined the interactive effects of competence, alliance, and adherence. Moreover, a quadratic
association might be another way in which competence affects outcome. Therefore, the highest skill in the delivery of certain interventions may not be what is related to outcome as we expect; rather, a more moderate level of competence could be a better predictor of improvement. Finally, most measures of competence assess only limited-domain competence. It is indeed conceivable that positive treatment outcomes may result from competence demonstrated within a single domain, but it is also possible that demonstrating global competence (or even competence across multiple domains) may be more consistently predictive of outcome (Barber et al., 2007).

Operationalising competence is a challenging task. Therefore, it is important to develop measures that capture flexibility, contextual responsiveness, nuance, and depth when assessing competence. Adherence and factual knowledge are much easier to assess and operationalise than competence. However, considering the many potential implications for the field, it is important that to avoid any tendencies towards oversimplification or an exclusive focus on that which is easiest to observe and catalogue (Sharpless & Barber, 2009).

In conclusion, the association between therapist competence and treatment outcome remains uncertain. Studies that have addressed this issue have reported contradictory results. Research studies that have found a negative association between competence and treatment outcome could be debated due to the overlapping definitions of adherence and competence utilised. Important methodological and conceptual issues that concern the study of competence should be assessed and addressed in order to increase the understanding of the relationship between therapist competence and treatment outcome.
## Psychodynamic Competence and Outcome Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Therapy</th>
<th>Patients</th>
<th>Therapist</th>
<th>Outcome Measures</th>
<th>Competence Measure</th>
<th>Correlation/Comparison</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandell, 1985</td>
<td>MTP</td>
<td>20</td>
<td>Psychologists. Majority trained in other therapies rather than MTP</td>
<td>4 Case summaries throughout therapy made by author were evaluated by 3 blind judges</td>
<td>4-valued variable in accordance with qualification norms in Swedish university</td>
<td>-0.1</td>
<td>Weakly negative effect of therapist's competence on outcome</td>
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<td>Svarberg &amp; Stiles, 1994</td>
<td>STAPP</td>
<td>15</td>
<td>7 Therapist: 2 psychiatrists, 5 psychologists. Median 5 years clinical experience Trained in STAPP</td>
<td>SCL-90</td>
<td>STAPP Competence Rating Form 11-items list of therapeutic strategies with guidelines of use. Judges 5-point scale</td>
<td>0.57 (SCL-90)</td>
<td>Therapist's competence inversely related to patient's improvement</td>
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<tr>
<td>Barber et al., 2008</td>
<td>Randon</td>
<td>487</td>
<td>Therapist that underwent didactic and experiential training</td>
<td>Addiction Severity Index Psychiatric severity composite score</td>
<td>Judges with at least 6 years of experience in SET completed adherence/competence scale for</td>
<td>F (1, 99) = 4.06, P&lt;.05</td>
<td>ASI Drug composite at 6 months r= .25</td>
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<tr>
<td>Study</td>
<td>Intervention</td>
<td>Group</td>
<td>Control</td>
<td>Outcome Measures</td>
<td>Correlation</td>
<td>Negative Factors</td>
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<td>Sachs, 1983</td>
<td>Brief Psychodynamic Therapy vs Experiential Therapy</td>
<td>18 depressed male college students</td>
<td>7 highly experienced</td>
<td>Patient's global improvement assessed by patient, therapist and independent clinician</td>
<td>Correlation with total VNIS ratings for both therapies: Therapist rating of global improvement - .58 (p&lt;.01) Therapist rating of decrease in overall disturbance - .59 (p&lt;.01) Clinician rating of global improvement - .51 (p&lt;.05) Clinician rating of decrease in overall disturbance - .51 (p&lt;.05)</td>
<td>Negative factors in therapy are inversely related to outcome</td>
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<td>Study</td>
<td>Participants</td>
<td>Measures</td>
<td>Methods</td>
<td>Findings</td>
<td>Interpretation</td>
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<td>O’Malley et al., 1988</td>
<td>35 depressed outpatients, 11 experienced therapists trained in IPT</td>
<td>HRDS, SAS, Self-report of change</td>
<td>Assessment by supervisors of performance in 4th session: Therapist Strategy Rating Form and process Rating Form Therapist self-rated effectiveness</td>
<td>Therapist performance measures explained 23% of the variance of patient-rated change beyond initial patient characteristics F (3, 25) = 7.33 p &lt; .05</td>
<td>Supervisors ratings associated with lower termination rates of apathy F (3, 29) = 3.29 p &lt; .05 Competence contributed significantly to the prediction of patient-rated change and change in apathy associated with depression but not to measures of social adjustment at 16 weeks</td>
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<td>Svartberg &amp; Stiles, 1992</td>
<td>15 Highly educated outpatients, 8 postgraduate manual-SAPS STAPP Used by STRCF for adherence and competence</td>
<td>SCL-90, SAS</td>
<td>Increase in R² 0.6 (SCL-90) 0.9 (SAS-SR) 0 (DAS)</td>
<td>Competence in early session does not relate to outcome</td>
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<td>Study</td>
<td>Design Description</td>
<td>Sample Characteristics</td>
<td>Measures Used</td>
<td>Findings/Results</td>
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<td>Barber et al., 1996</td>
<td>SEP (16 sessions)</td>
<td>anxiety diagnoses 29 depressed outpatients</td>
<td>guided STAPP training 4 trained therapists</td>
<td>Beck Depression Inventory, Health Sickness Rating Scale, Penn Adherence Competence Scale for Supportive Therapy, STRCF for adherence and competence of STAPP Used by judges evaluating tapes.</td>
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<td>Termination BDI: -.53 p&lt;.01 (competence expressive) .21 (not significant) (Competence supportive).</td>
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<tr>
<td>Svarberg et al., 1996</td>
<td>STAAP, follow up for 2 years</td>
<td>13 Highly educated outpatients, anxiety diagnoses</td>
<td>7 postgraduate manual-guided STAPP training</td>
<td>T=2.05 p&lt;.057 Therapist competence not significantly related to improvement rate during treatment</td>
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<td>Despland et al., 2009</td>
<td>Brief 4-session format based in psychoanalytic therapy (BPI)</td>
<td>78 outpatients</td>
<td>15 therapists trained in psychodynamic psychotherapy. All had BPI training, different amount of years of experience</td>
<td>Helping Alliance Questionnaire SCL-90-R Outcome not linked to competence (Z=-.72 estimate = -.00; SE=0.01; p&lt;.47) No direct link between competence and outcome. Only in dyads with alliance change, competence was positively related to outcome</td>
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Note 1. SEP= Supportive Expressive Psychotherapy; CBT= Cognitive Behavioural Psychotherapy; DC= Drug Counselling; MTP= Mann’s Time-limited Psychotherapy; STAPP= Short-term Anxiety Provoking Psychotherapy; SE= Supportive Expressive; GDC= Group Drug Counselling; IDC= Individual Drug Counselling; CT= Cognitive Therapy; SCL-90= Symptom Checklist-90; DAS= Dysfunctional Attitude Scale; FAI= Facilitative Alliance Inventory; HRDS= Hamilton Rating Scale for Depression; SAS= Social Adjustment Scale; INTREX= Introject Questionnaire; SCL-90 R= Symptom Checklist 90 Revised
2.3 Therapist Competence and Treatment Outcome: Specific Attitudes and Interventions

Research studies have attempted to examine the relationship between the competent delivery of specific psychotherapeutic techniques and treatment outcome. Silberschatz, Fretter, and Curtis (1986) studied which interpretation feature, - “suitable” interpretation vs “type” of interpretation-, was a better predictor of in-session patient progress. The suitability of an interpretation was defined according to the extent to which interpretations were plan-compatible. Plan-compatibility was specified as the degree to which the interpretation was consistent with the dynamic formulation of the patient, which was developed by a group of external clinicians. Interpretation type referred to whether the intervention was either transference or non-transference related. The patients’ in-session responses were assessed with the Experiencing Scale ((Klein, Mathieu, Gendlin, & Kiesler, 1969). The authors found that the suitability of interpretations was a better predictor of patient change than the type of interpretation. Some authors have linked the suitability of interpretations with therapist empathy (Luborsky, Barber, & Crits-Christoph, 1990), which is positively correlated to outcome (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988).

Research studies have found that the accuracy (Crits-Christoph et al., 1988) or correspondence of interpretations (Piper et al., 1993) is associated with positive outcome in psychodynamic psychotherapy. Crits-Christoph et al. (1988) studied patients with mixed psychiatric diagnoses treated with moderate-length psychodynamic psychotherapy. It was found that the accuracy of interpretations in addressing the patient’s relational patterns had a positive and significant association with outcome, even after controlling for the quality of the therapeutic alliance and for general errors in treatment techniques. However, accurate interpretations were not found to have a greater impact in the context of a good therapeutic alliance. This suggests that specific psychodynamic techniques have an effect on treatment outcome, beyond the non-specific factors of psychotherapy. Piper et al. (1993) explored two characteristics of interpretations –concentration and correspondence- along with their association with therapeutic alliance and outcome. Concentration
referred to the dose of interpretation and was defined as the ratio of transference interpretations to the total number of interventions. Correspondence of interventions was defined as the degree of correlation between the interpretation’s content and the content of the therapist’s formulation. An inverse relationship between correspondence and both therapeutic alliance and outcome was found. Furthermore, as the degree of concentration decreased, correspondence changed from having a negative to having a positive effect on treatment outcome. Therefore, the pattern of low concentration and high correspondence of transference interpretations was associated with a better treatment outcome.

Other studies have focused on measuring the absence of behaviours on the part of the therapist that may negatively impact therapy. Kepecs (1979) studied incorrect statements made by therapists, which take the patient away from the therapeutic situation. Buckley, Karasu, and Charles (1979) explored the viewpoints of supervisors regarding their trainees’ mistakes. They found that the supervisor’s main concerns were related to specific issues such as: (1) wanting to be liked by the patient; (2) making inappropriate transference interpretations; (3) delivering premature interpretations; (4) lacking awareness of the countertransference; and, (5) being incapable of tolerating silences. A series of studies found that poor outcomes were associated with the therapists’ inflexible reliance on one specific stance or technique, without taking into account the patient’s needs (Butler et al., 1995; Strupp, 1980a, 1980b, 1980c, 1980d). Furthermore, Sachs (1983) found a significant association between the Errors in Technique subscale of the Vanderbilt Negative Indicators Scale and negative treatment outcome. Moreover, Hayes, Gelso, and Hummel (2011) meta-analysis on the management of counter-transference, found that countertransferential reactions are modestly and inversely related to clinical outcomes (overall weighted effect $r= -0.16$, $p=0.002$, $k=10$ studies). A second meta-analysis found that counter-transference management was related to better clinical outcomes ($r=0.39$, $p <0.001$, $d=0.84$, $k=9$ studies) (Hayes, Gelso, Goldberg, & Kivlighan, 2018). These studies’ exploration of the association between therapists’ errors, countertransference management and treatment outcomes are fundamental for a thorough understanding of competence in
psychodynamic psychotherapy (Strupp et al., 1988).

Besides studies that have addressed the association between specific psychodynamic techniques and outcome, research has examined how particular attitudes displayed by the therapist may be linked to patient improvement. T. Anderson, Ogles, Patterson, Lambert, and Vermeersch (2009) studied how the therapist responses to patients, in terms of what they denominated facilitative interpersonal skills (FIS), were related to treatment outcomes. They presented to 25 therapists, a video of a challenging patient, and assessed the therapists’ responses in terms of their warmth, fluency, emotional expression, persuasiveness, empathy, hopefulness, alliance-bond capacity and problem focus. The therapists’ scores on these FIS were analysed in a multilevel model, and were found to be strong predictors of patient improvement in psychotherapy (correlation = 0.47 between FIS and outcome). In a similar study, Schöttke (2017) found that the performance of psychotherapy trainees in a group interaction, after watching a provocative film, predicted the outcomes of the patients seen during their training, if the performance was rated high in: 1) clarity of communication; 2) empathy and attunement; 3) warmth and respect; 4) willingness to cooperate; and, 5) management of criticism. The importance of the therapist FIS for treatment outcome has been replicated by a number of studies that have used multilevel modelling, and additionally confirmed by a systematic review/meta-analysis (T. Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016; T. Anderson, McClintock, Himawan, Song, & Patterson, 2016; T. Anderson et al., 2009; Diener, Hilsenroth, & Weinberger, 2007; Elliott, Bohart, Watson, & Murphy, 2018; Farber, Suzuki, & Lynch, 2018; Kolden, Wang, Austin, Chang, & Klein, 2018; Lingiardi, Muzi, Tanzilli, & Carone, 2018; Peluso & Freund, 2018; Wampold et al., 2017).

Furthermore, another study regarding therapist specific attitudes, found that therapist self-doubt, meaning his/her uncertainty of how to best to deal effectively with particular patients, predicted better treatment outcomes. Thus, the more the therapist expressed personal self-doubt, the more the patient improved, suggesting that effective therapists are reflective of their professional practice and question their capacity to help patients (Nissen-Lie et al., 2016; Nissen-Lie et al., 2017). Similar studies have confirmed the relationship
between the therapist reflective and introspective abilities, and treatment outcome (Cologon, Schweitzer, King, & Nolte, 2017; Lingiardi et al., 2018).

In conclusion, there are few research studies that have examined the relationship between competency in delivering specific psychotherapeutic techniques and treatment outcomes. Hitherto, the main findings are that a low concentration and high correspondence of transference interpretations is positively associated with outcome. Additionally, warm, reflective and empathic therapists with a capacity to problem focus, bring about better outcomes. Concurrently, therapist errors and counter-transferential reactions may have a negative effect in treatment outcomes. Future research should aim to determine how and which specific psychodynamic interventions affect treatment outcome.

2.4 Conclusion

In this chapter, a literature review regarding the relationship between psychotherapeutic technique and treatment outcome, and more specifically the association between therapist competence and patient improvement, has been presented.

Regarding the association between psychodynamic technique and treatment outcome, it was outlined that a greater flexibility in the implementation of treatment manuals, - “adherence flexibility”-, is associated with patient improvement (Owen & Hilsenroth, 2014). Indeed, a curvilinear relationship between treatment adherence and outcome has been suggested as it has been found that moderate levels of psychodynamic and process-experiential interventions were found to be predictive of better outcomes than were very low or very high levels of these interventions (McCarthy et al., 2016).

The notion of “adherence flexibility” undoubtedly questions the usefulness of treatment manuals. However, if treatment manuals are used as clinical guides that can be flexibly employed with the aim of providing better treatment outcomes to patients, their value is undeniable. Most therapists need all possible support in order deliver effective interventions to the patient (Goldfried et al., 1998). Therefore, it is not possible to leave up to the individual clinician to do “what feels right at the time” in treatment. Thus, treatment
manuals are needed in order to provide models that support the clinician to improve his/her clinical practice, inasmuch as they are used flexibly without losing sight of the uniqueness of each patient and of the importance of timing interventions.

Furthermore, in this chapter the literature regarding the relationship between therapist competence was reviewed. It was indicated that the association between competence and patient improvement remains uncertain, considering that several studies have addressed this issue reporting contradictory results (Crits-Christoph et al., 2013; Luborsky et al., 1985; Sandell, 1985). Several conceptual and methodological/statistical factors have been suggested to explain the inconsistencies in the findings regarding the association of therapist competence and outcome. A conceptual factor that might explain the inconsistencies in the relationship between competence and outcome refers to the difficulties of operationalising competence, due to the complexity of demonstrating competence across multiple domains, and of distinguishing it from treatment adherence. Additionally, it might be that competence does not have a direct relation to outcome but may instead moderate the effects of other process variables, such as the therapeutic alliance. Moreover, competence may have a curvilinear relationship with outcome, or there may be a ceiling effect over which higher levels of competence do not bring about better treatment outcomes.

In addition, several methodological/statistical factors could explain the inconsistencies in the relationship between competence and outcome, including: the small number size of the studies that have explored this association; the narrow range of competence displayed by therapists that participate in RCTs which could result in a low variability in competence and/or outcome scores; the scarcity of studies that have explored the effects of competence longitudinally; the use of different methodologies and divergent conceptualisations of outcome across studies; and, the use of unsuitable statistical methods that do not consider the multilevel structure of the data intrinsic to the study of the relationship between competence and outcome (Wampold, Baldwin, & Imel, 2017).

This literature review also addressed the association between the competence in displaying particular attitudes, delivering specific
psychodynamic techniques, and treatment outcome. Research has found that warm, reflective and empathic therapists with a capacity to problem focus, bring about better outcomes. Additionally, a low concentration and high correspondence of transference interpretations is positively associated with outcome. Concurrently, therapist errors and counter-transferential reactions may have a negative effect on patient’s improvement. Future research should aim to determine how and which other specific psychodynamic interventions may relate to treatment outcome. In the next chapter, a detailed revision of these limited-domain competencies will be presented.
Chapter 3: Psychodynamic Competence and Competencies

3.1 Introduction

Being a psychodynamic psychotherapist implies significant challenges associated with the personal and emotional involvement that this therapeutic modality necessitates. Therapists are required to take part in an intense emotional therapeutic relationship and, at the same time, be able to observe, be aware and reflect together with the patient. Moreover, the therapist has to participate in a relationship with the patient without being able to use his/her own conventional repertoire of social communication. Furthermore, addressing the unconscious processes of the patient requires the therapist to be in contact with his/her own emotions and difficulties, which can make him/her feel vulnerable and exposed (Strømme, 2012). Taking this into consideration, the following chapter will review how therapists become competent clinicians. Furthermore, this chapter will present the literature review regarding the competencies required to skillfully deliver psychodynamic psychotherapy. Finally, this chapter will describe three frameworks of competence that allow for a more accurate understanding of how therapists should use the psychodynamic techniques in clinical practice.

3.2 The Development of Competence

Psychotherapy research has traditionally maintained that competence is acquired through experience and training. Although this association has been questioned (Berman & Norton, 1985; Durlak, 1979; Eells, 2003; Herman, 1993; Shapiro & Shapiro, 1982b), several models that describe the attainment of competence throughout time have been proposed (Larry E Beutler, 1997; Binder & Betan, 2012). It has been suggested that it is possible to differentiate novice therapists from expert therapists according to the working models they conceive of their patients and the manner they organise knowledge (Binder & Betan, 2012). Novice therapists tend to over-rely in theoretical concepts that
are disconnected from clinical experience, leading to a fragmented, superficial and sketchy understanding of the therapeutic situation. This dissociation between theory and practice makes it difficult for novice therapists to identify meanings and enactments while they are occurring in the session. However, as the therapist develops and gains experience over time, conceptual and experiential knowledge becomes integrated in a way that abstractions acquire practical meaning. Therefore, expert therapists are able to conceive meaningful understandings of their patients (Binder, 1999). Additionally, expert therapists are open to question, verify, and update their understanding and easily recognise and disregard irrelevant information (Binder & Betan, 2012).

Theoretical or declarative therapeutic knowledge is learned in didactic seminars, supervision and through treatment manuals. However, reading and discussing about the therapeutic techniques does not make the therapist skillful in its performance. Declarative knowledge is not enough for the therapist to understand when and how to apply therapeutic theoretical concepts (Bennett-Levy, 2006; Binder & Betan, 2012). The lack of such understanding hinders the therapist’s capacity to access spontaneously his/her declarative knowledge during the session. This typically occurs to novice therapists. “No matter how proficient the therapist is in thinking about therapy, he or she may not be proficient at actually doing therapy” (Binder, 1999, p. 711). On the other hand, expert therapists have an artistry, finesse, virtuosity and a knowing-how to conduct themselves in the therapeutic situation that cannot be appropriately explained through their declarative knowledge (Binder, 1999). Schon (1983) elaborated this notion in the concept of “knowing-in-action”, meaning that experts are capable of spontaneously recognise significant patterns, make contextual judgments and carry out relevant actions. “Knowing-in action” has also been denominated “procedural knowledge”, which results from the integration over time of experiences, theoretical concepts, techniques used in practical contexts, action strategies and appraisals of its consequences. Procedural knowledge has been associated with therapeutic competence considering that particular situations will evoke in the therapist unique specifications and actions that are likely to bring about goal-relevant consequences in a way that is non-conscious and progressively automatised with clinical experience (Binder, 1999; Binder & Betan, 2012; Dreyfus, Drey-

The transformation of declarative knowledge into procedural knowledge brings about implicit knowledge that underpins condition-action sequences. Within a certain domain, particular situations will tend to recur and become more or less routine. Competent therapists will automatically become aware of the patterns in these routine situations (Bennett-Levy, McManus, Westling, & Fennell, 2009; Binder & Betan, 2012). The accumulation of clinical experience over time leads therapists to think in a type of reasoning that has been called “analogical reasoning” (Buchanan, Davis, & Feigenbaum, 2006) in which new problems are automatically compared with similar previously managed situations. The recognition of patterns evoked by past successful condition-action sequences, progressively becomes automatic, transforming the therapist’s behaviour. This acquired tacit character of the therapist activity enables him/her to be more alert to counter-transferential reactions and their associated effects (Binder & Betan, 2012). Competent therapists have a large range of theories, clinical experiences, and inquiry strategies, which allow them to recognise the current interpersonal patterns, and meanings in the therapeutic process. Moreover, competent therapists can adapt and refine the working models of their patients when new information emerges. Therefore, expert therapists are exceptional because of their ability in doing the correct thing at the right time, without an arduous search for the best move (Binder, 1999; Binder & Betan, 2012).

However, it is not the learned response to routine situations that makes a therapist competent. Experts have an enhanced capacity to make use of their procedural knowledge to address clinical situations even when they are ambiguous and unique (Binder & Betan, 2012). This ambiguity and uniqueness of clinical situations is what Schon (1987) designated as the “indeterminate zone”. Clinical situations are “indeterminate zones” inasmuch as clinical problems are multiple and ill defined; patients have unparalleled meanings and form unique therapeutic relationships; and, contexts are unstable and uncertain. Therefore, the psychotherapeutic situation is one that continuously changes its form and meanings and for that reason therapeutic competence entails more than the routinary application of interventions, as therapeutic manuals prescribe (Binder, 1999). Evidence has shown (Holyoak, 1991) that
expertise entails the ability to adapt and “switch among alternative strategies, the ability to make an appropriate response to a situation that contains unpredictability” (Binder, 1999, p. 713).

This adaptive flexibility is the most essential component of therapeutic competence: the ability to intuitively adjust, improvise and reshape the understandings and strategies in accordance to the continuous changes of therapy (Binder, 1999; Holyoak, 1991; Schön, 1983, 1987). However, it is crucial to understand that a competent improvisation will be characterised not only by highly specialised and automatised procedural knowledge, but also by a highly regulated capacity to reflect in several ways on one’s performance (Glaser, 1989; Schön, 1983, 1987). Therapeutic interventions are adaptively creative as well as shaped within the parameters of the relevant discipline in a self-regulated manner (Binder, 1999). This capacity to recognise, regulate and modify one’s own actions and mental processes has been denominated as the “meta-recognition skills” (M. S. Cohen, Freeman, & Wolf, 1996). These skills include the capacity to reflect on both, past actions and while in the midst of present action. Self-reflection helps reshape therapeutic performance, making it accurately attuned to the particular context (Binder, 1999). Improvisation and its implicit self-reflection are particularly important in managing negative therapeutic processes and interpersonal enactments (Binder, 1999; Binder & Betan, 2012; Safran, Crocker, McMain, & Murray, 1990).

There are not many empirical studies that have attempted to study what differentiates novice from expert therapists. Eells (2003) compared the views of novices, experienced therapists and expert therapists in reference to six clinical vignettes. Expert therapists, as opposed to novice and experienced therapists, considered that the available information provided in the clinical vignettes was inadequate for developing a case formulation, being aware of the need for more information in order to understand the case more accurately. Furthermore, experts recommended longer treatments than the ones suggested by experienced and novice therapists. This finding is in agreement with Blatt, Sanislow III, Zuroff, and Pilkonis (1996) observation that more effective therapists estimate longer therapeutic periods in order to achieve positive outcomes than less effective therapists. It has been suggested that experts are able to represent the patient’s problems in a more abstract and
meaningful way than novice therapists, who classify problems in agreement to more superficial properties. Therefore, experts understand their patients better and make treatment recommendations in agreement to this (Eells, 2003).

Overall, expert therapists are capable of improvising in circumstances where established working models do not suffice. They are able to conceptualise the patients’ problems in a more meaningful and abstract manner. Expert therapists recognise interpersonal patterns while they are participating in them, understanding these patterns in reference to previous experiences that involve therapists’ actions and patients’ responses. Subsequently, expert therapists have the ability to fit interventions in accordance to their experience and immediate circumstances, assessing the consequences and adjusting interventions in reference to the feedback of the interaction with the patient (Binder, 1999).

3.3 Psychodynamic Competencies

Psychodynamic theory encompasses multiple ideas developed throughout the 120-year history of the psychoanalytic movement. These theories have attempted to understand human nature in order to alleviate patient suffering (Summers & Barber, 2012). Despite the diversity of theories, most psychodynamic practitioners agree on the core techniques that constitute psychodynamic therapy (Blagys & Hilsenroth, 2000). In the following paragraphs the literature review regarding the different psychodynamic techniques, tasks, and their competent delivery will be described.

3.3.1 The Therapist as an Observer, Listener and Reflective Agent

The therapist’s ability to listen and observe is essential to the psychotherapeutic process. In order to competently listen and observe, the therapist must resist the urge to direct the interaction and should create psychic space for the patient’s issues to unfold without the disturbances of the therapist’s preconceptions and interests.
The therapist must be attentive to the patient’s verbal and nonverbal communications. Additionally, the therapist should consider the content as well as the process of the dialogue. Therefore, the therapist must listen to the sequence, the context, the emotional tone, and the style of presentation of the patient’s communications.

Furthermore, in listening to the patient it is important that the therapist considers that anything the patient says may potentially be in reference to the therapeutic situation, although initially it may appear unrelated. Therefore, it is important that the therapist attempts to see the links in the material at their different layers. The therapist should know that the patient’s underlying concerns unconsciously shape a seemingly random succession of thoughts into a specific direction.

The therapist must also be attentive to sudden changes of topic and to exaggerated remarks on the part of the patient as these may indicate an underlying opposing dynamic process. For example, when a patient strongly refers that he never wants to do something is probably because, beneath the surface, he wants to. Likewise, patients that appear as self-sacrificing often have a strong and hidden underlying anger.

In order to accurately observe and listen to the patient, it is essential that the therapist is aware of his/her own countertransference, which guides the therapist’s understanding of the patient’s unconscious communications and conceptualisation of his/her relational patterns (Sublette & Novick, 2004). In order to do this, it is crucial that the therapist has the capacity for self-reflection, which requires the therapist to make use of his/her own internal emotional world, bodily and fantasy experience when in interaction with a patient (Sarnat, 2010).

3.3.2 The Therapist Management of the Affective Environment and Emotional Content of the Session

The affective environment of the session is essential to guide the focus of the therapeutic process. Therapists should be empathic, caring and warm towards their patients for the purpose of establishing an environment of trust
(L. E. Beutler, Forrester, Holt, & Stein, 2013). The therapist should explore, attune and respond to the patient’s emotions expressed in the session. Therefore, the therapist should inquire about the context, feelings and meanings behind emotions in order to understand the patient’s defences, wishes, and conflicts (Fowler & Perry, 2005; Luborsky, 1984). Furthermore, the therapist should “read” the patient’s nonverbal communications, such as posture, facial expression, respiratory rate and physical activation in order to tune into the patient’s unconscious affective experiences (Katzman & Coughlin, 2013). The therapist should employ the right evocative language and non-verbal cues to attune to the patient’s emotional life and experiences (Fowler & Perry, 2005; Sherer & Rogers, 1980).

It is fundamental that the therapist does not become overwhelmed by the patients’ affects and helps them feel “safe” when expressing their emotional experiences. Therefore, the therapist should be able to tolerate affect in him/herself and others, understanding interpersonal conflict and bearing uncertainty.

The therapist should respond adequately to the patients’ emotions, by remaining silent when appropriate, or by making reflective remarks such as: “It seems that you are feeling abandoned by your partner” or “You feel I was cruel to you by not returning the phone call”. The therapist should validate painful affects as normal human reactions, making sense of the distressing emotions by understanding them in context (Summers & Barber, 2012).

The competent therapist titrates the emotional “temperature” of the session, attempting to keep it “warm” enough for the patient to genuinely experience feelings without being intolerably overwhelmed or flooded by them. Furthermore, it has been suggested that helping patients experience their feelings in the session is essential for them to integrate and regulate overwhelming emotional experiences (Fosha, Siegel, & Solomon, 2009; Ogden, Pain, Minton, & Fisher, 2005). In order to work-through affective experiences, it is necessary that the therapist stimulates an intermediate level of anxiety to promote psychic change. If the anxiety is too low, the patient will not feel a need to change. If the anxiety is too high, the patient will not be able to think and therefore no therapeutic change can be achieved (Carryer & Greenberg, 2010; Cozolino, 2010; Katzman & Coughlin, 2013).
Research has found that helping patients experience previously avoided and distressful affects allows them achieve therapeutic change. Helping patients to work through their defensive avoidances in order to access their affective experiences is pivotal to transform maladaptive into adaptive functioning (Ecker, Ticic, & Hulley, 2012; Weinberger, 1995).

Focusing on affect allows the patient’s unconscious to emerge in the session, constituting a new kind of experience that is pivotal for change because it facilitates the creation of profound moments of meeting (Stern, 2004).

3.3.3 The Therapist's Interventions

The main therapeutic psychodynamic interventions are clarification, confrontation, interpretation and supportive techniques. The process of clarification is fundamental for progress in therapy. The therapist must know how to explore and ask questions in a non-judgmental and empathic manner, in a way that the patient does not feel intruded upon. In clarifying, it is important to meet the patient where he/she is, working from the surface of the material (Sublette & Novick, 2004).

Confrontation involves pointing out recurrent behaviours, that are harmful to the patient, of which he/she is usually unaware. Behind these repetitive behaviours there are usually powerful forces at work that lead the patient to self-deception. Therefore, confrontation necessitates firmness and insistence on the part of the therapist. Confrontations are more productive when delivered in reference to the here-and-now relationship between the patient and therapist as it provides objective and immediate data and does not need to be construed from events of the outside world (Sublette & Novick, 2004).

Interpretation has been considered the main psychodynamic technique. Interpreting implies placing the patient's maladaptive, repetitive and harmful behaviours into context, understanding the deeper truths that lead the patient to behave in a particular way. It is pivotal that prior to making an interpretation the therapist has listened, clarified, confronted and empathised with the patient. In order to successfully deliver an interpretation, it is useful for the therapist to
frame the patient’s behaviours into their historical context, understanding why they came about in the first place. It is fundamental that the therapist attends to the patient response to interpretations. If the patient resonates with the therapist’s understanding it is possible to continue with the rest of the formulation. However, if the patient disagrees it is necessary to explore this and try a different direction (Sublette & Novick, 2004). Under most circumstances, therapists abstain from making interpretations until the therapeutic alliance has been established. Indeed, a negative reaction to an interpretation must alert the therapist of the possibility that the interpretation was delivered too early or at a moment when the alliance was insufficiently established (Fowler & Perry, 2005).

Supportive interventions include reflections, clarifications, and empathic statements (Cooper, Bond, Audet, Boss, & Csank, 1992). Supportive technique, in opposition to expressive technique which increases self-understanding through the therapist’s interpretations, strengthens the level of functioning and the existing defences (Luborsky et al., 1990). Supportive interventions help reduce the patient’s anxiety, promote self-esteem, and contribute to the maintenance of a therapeutic alliance (Barber, Stratt, Halperin, & Connolly, 2001). Thus, supportive interventions build rapport with the patient, which subsequently promotes more expressive disclosures. Indeed, it has been observed that supportive interventions are pivotal for the therapeutic alliance, and that transference interpretations, as mentioned above, are more effective when a strong alliance is present (Fowler & Perry, 2005).

3.3.4 The Therapist’s Tasks

The basic tasks that a therapist should perform competently are: (1) setting and maintaining the therapeutic frame; (2) assessment; (3) defining a therapeutic focus; (4) collaboratively elaborating a comprehensive narrative with the patient; and, (5) helping the patient work through his/her resistance to change. The therapist ability to set and maintain the therapeutic frame with the patient has been considered an essential therapeutic task. In a first interview, the therapist should negotiate with the patient the time, limits and outline of
therapy, highlighting the interpretative and exploratory nature of the process. Additionally, the intensity, course of treatment, and the patient’s and therapist’s roles should be established at the beginning of treatment. The frame should be provided in a polite and considerate manner, conveying respect for the potential anxieties that may be aroused in the patient. First impressions are critical in establishing rapport, therefore therapists should communicate both, the details of the frame while fostering an inviting atmosphere of interest where the patient can feel comfortable to disclose (L. E. Beutler et al., 2013; Summers & Barber, 2012). An essential aspect of setting the therapeutic frame and boundaries is the therapist ability to resist the patient’s wish to cast him/her into a social role. The therapist must be able to maintain a relative anonymity, not sharing his/her personal needs with the patient, which is essential to elicit the transference (Sublette & Novick, 2004; Trimboli, Keenan, & Marshall, 2016).

In psychodynamic therapy, the assessment must consider the person as a whole, attending to the: conscious and unconscious conflicts, emotional experience, self-experience, interpersonal patterns, internalised relational patterns, and the defences. The assessment should lead to a conceptualisation of the patient’s dynamics by carefully considering his/her actions, avoidance, affects, fantasies, personal history, childhood experiences, current life issues, symptoms, as well as the transference elicited in the therapist. The core conflict will be present in important relationships and emerge at pivotal life events. A competent formulation will include how the patient has attempted to manage this conflict in the past, taking into account his/her defences, and identifications (Summers & Barber, 2012). The therapist should integrate all these information into a coherent and ever-evolving dynamic formulation (Sarnat, 2010).

Regarding the notions of self-experience, the therapist should assess the patients’ sense of self, exploring their ability to sustain a coherent and stable identity over time. The therapist should assess the patient’s significant relationships throughout life, understanding the predominant interpersonal themes. Moreover, the therapist should assess risk and the need for interdisciplinary collaboration in the patient’s treatment (Binder & Betan, 2012; Thomas & Hersen, 2010).

Defining a focus refers to agreeing with the patient on how to conceptualise his/her problem and thus decide how to address it together. A competent
therapist will collaboratively develop the focus with the patient, and will differentiate it from the treatment goals, which are the endpoint of therapy. Although it is not up to the therapist to make the final decision about the treatment goals, it is his or her responsibility to propose an appropriate and reasonable focus. The therapist must explain the focus to the patient in a simple and understandable language, and should remain open to the patient’s reactions and ideas about it (Summers & Barber, 2012). The competent therapist will provide a focus that takes into consideration the patient’s motivation and resources, and that has a breadth that it is possible to address. Keeping the therapeutic focus means that the therapist is in charge of the timing and pacing of the session, not allowing the patient to digress too much from it. Maintaining the focus also entails that the therapist encourages the patient to direct their attention into their psychic world, particularly to his/her affective experiences (Katzman & Coughlin, 2013). Defining and working in a focused manner its pivotal considering that research has shown that therapists have better treatment outcomes when they are actively involved in the therapeutic process, when they stimulate the patient’s participation, and when they make focused interventions (Duncan, Miller, & Sparks, 2011; Katzman & Coughlin, 2013; J. C. Norcross, 2002).

The competent therapist will help out the patient elaborate a comprehensive narrative, which is built up in a collaborative way. The narrative is developed through questions and hypotheses that start from the surface of the patient’s awareness to then move to deeper layers so as to enhance the patient’s self-understanding, which is a basic prerequisite for therapeutic change. The competent therapist must challenge the patient’s old narrative in a tolerable manner, helping the patient see the limitations and how limiting his or her narrative has been. As it is elaborated, the new narrative will include a more articulated and comprehensive view of the patient’s experiences and conflicts, to the point that it will provide an understanding to the patient of how the past has shaped his or her current experiences (Summers & Barber, 2012). Therefore, elaborating a new narrative enhances the degree of the patient’s insight or self-understanding which has been significantly associated with outcome (Luborsky et al., 1990).

Insight and therapeutic relationship have complementary roles considering
that the understanding and knowledge of the self can only develop in a relationship in which the therapist attempts to understand the patient’s mind through their interaction. Ideally the therapist intervenes only after understanding and tolerating the transference-countertransference situation, avoiding reacting directly to it. By “being” with the patient, using the self-reflective capacity, the therapist is able to help the patient move from reactivity to thinking, creating thoughtful and well-metabolised interventions (Sarnat, 2010).

Finally, an essential task the therapist has is helping the patient to work through his/her resistance to change. Fonagy, Luyten, Allison, and Campbell (2017) have proposed a relevant model to understand the therapist’s role in promoting patient’s change. These authors have suggested that resistance to change is based on the difficulty of the patient to trust and learn from social experiences. These authors define epistemic trust as the adaptation that enables individuals to receive relevant social knowledge which promotes their personal development. In situations where the individual’s early learning environment is characterised by unreliable communicators (i.e., abusive early environments), the development of epistemic trust is hindered, as it becomes more adaptive to remain vigilant and closed off to social knowledge. Epistemic vigilance often presents as the misattribution of intention and the assumption of malicious motives underlying other people’s behaviours. Furthermore, in a state of epistemic mistrust, the individual cannot receive or internalise information that may be relevant for their own development. As a consequence, the person is unable to modify stable beliefs about the world, which results in a rigid and “hard to reach” personality. A competent therapist, responsible for the treatment of an individual with epistemic mistrust, learns to recognise the patient’s personal narrative and to gradually help them increase their epistemic trust by: (1) establishing a collaborative work with the patient; (2) demonstrating that they see the patient’s problems from their perspective; (3) recognising them as agents of their own life; (4) marking the patient’s experiences which evidences that the therapist ackowledges the patient’s emotional states; (5) using ostensive cues to denote that the information transmitted has personal relevance to the patient and has generalizable social value; and, (6) by conveying an attitude that the patient has things to teach to the therapist.
Through these interventions, the therapist provides a model of interaction that increases the patient's epistemic trust, driving forwards the psychotherapeutic process (Fonagy, Luyten, & Allison, 2015; Fonagy et al., 2017). It is relevant to mention that the epistemic trust theory represents one of many ways of understanding patient's resistance. Additionally, this theory is not a novel one, but systematises previous psychodynamic understandings of resistance to change. Nevertheless, the theory of epistemic trust was included in this chapter because it includes a proposal of strategies that the therapist can use in order to help the patient overcome his/her resistance to change (L. Beutler, Moleiro, & Talebi, 2002)

3.4 The Therapeutic Alliance

One of the most essential skills of a therapist is the ability to create and maintain the therapeutic alliance, which is essential for the patient to benefit from psychotherapy. The therapeutic alliance has been conceptualised as the bedrock of psychotherapy and it includes the bond between therapist and patient, as well as the agreement between both parts on the tasks and goals of treatment. Therefore, the therapeutic alliance is a mutual construction of therapist and patient (Bordin, 1979). Several studies have found a positive association between a stronger alliance and treatment outcome (Horvath, Del Re, Flückiger, & Symonds, 2011; Luborsky et al., 1990). A strong alliance established early in the treatment is essential for the viability and success of therapy (L. Castonguay, Constantino, & Holtforth, 2006; Pachankis & Goldfried, 2007; Safran & Muran, 2006; Safran, Muran, & Eubanks-Carter, 2011).

Only 25% of the therapeutic alliance variance is explained by the patient's qualities (Moras & Strupp, 1982), meaning that therapist effects and technique are primordial factors for the development of the therapeutic alliance (Summers & Barber, 2012). Indeed, there are several therapist competencies that have been categorised as essential to create and maintain the therapeutic alliance. In the following paragraphs, these competencies will be described.
3.4.1 General and Specific Competencies that Facilitate the Therapeutic Alliance

There are general and specific competencies that facilitate the therapeutic alliance. The general competencies include: explaining to the patient what psychotherapy is about and its procedures, understanding what the patient is emotionally looking for, and allying with the healthy side of the patient. In order to create the therapeutic alliance, the therapist must have faith in the therapy and in the patient, be supportive, warm, enthusiastic, interested and focused in the patient’s patterns and problems. (Laska & Nordberg, 2016; Strupp et al., 1988; Summers & Barber, 2012). Confident, extroverted therapists that enjoy the therapeutic work tend to be more actively engaged in the therapeutic process which in turn leads to greater alliance ratings (Heinonen, Lindfors, Laaksonen, & Knekt, 2012; Marcolino & Iacoponi, 2003). Dunkle and Friedlander (1996) showed that therapists that are less hostile, feel comfortable in close relations and perceive more social support are able to establish stronger bonds with their patients.

The specific psychodynamic competencies that facilitate a good therapeutic alliance include: linking current feelings to past emotional experiences, focusing on relational patterns over time, and defining the patient’s recurrent experiential patterns (Owen & Hilsenroth, 2011). Grace, Kivlighan Jr, and Kunce (1995) found that therapists that explicitly discussed the patients’ non-verbal communications were able to improve the quality of their alliances. Moreover, the early interpretation of the patient’s core conflicts results in a stronger therapeutic alliance (Crits-Christoph, Barber, & Kurcias, 1993). Other specific psychodynamic competencies that facilitate a good therapeutic alliance are: clarifying the sources of distress, exploring the in-session process, facilitating the expression and experience of affect, and the willingness to explore distressful topics (Hilsenroth & Cromer, 2007). Furthermore, understanding and empathising with the patient’s pain, particularly before interpreting the patient’s resistances or transference, improves the therapeutic alliance (Summers & Barber, 2012).
3.4.2 Competencies Associated with the Development of the Therapeutic Alliance

Empirical studies that have examined the competencies associated with the development of the therapeutic alliance have distinguished the ability of the therapist to maintain a therapeutic stance and to adjust to the patient’s relational needs (Binder & Betan, 2012). The therapist’s stance refers to engaging the patient in a way that he/she feels understood, respected and positively connected to the therapist. This includes the ability to listen, to be emphatic, curious and reciprocal. Therapists who express warmth, interest in the patient subjectivity, confidence, flexibility, curiosity, empathy, respect, trustworthiness and clarity in communication have demonstrated to establish positive alliances (Ackerman & Hilsenroth, 2003; Jungbluth & Shirk, 2009). Furthermore, the therapist promotion of a collaborative relationship that attends, explores and addresses interpersonal topics and affective experiences through supportive techniques has also been positively associated with a strong alliance. Conversely, a rigid and critical therapist that inappropriately self-discloses leads to the development of a negative alliance (Ackerman & Hilsenroth, 2003). Therefore, in fostering the therapeutic alliance, “it is not so much what the therapist must do but rather how the therapist is with the patient” (Binder & Betan, 2012, p. 33), because being willing to be led by the patient’s narrative, experiences, wishes and needs, and responding emphatically convey a genuine wish to deeply understand the patient.

3.4.3 Competencies Associated with the Maintenance of the Therapeutic Alliance

Empirical studies that have examined the competencies associated with the maintenance of the therapeutic alliance have distinguished the ability of the therapist to recognise and manage ruptures in the alliance and the

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3 See Appendix C for detailed explanation of the therapist competences that facilitate the development of the therapeutic alliance.
Responsiveness of the therapist (Binder & Betan, 2012; Safran et al., 2011)

Ruptures in the alliance are a common phenomenon (Binder & Betan, 2012). It has been demonstrated that the capacity of the therapist to repair ruptures in the relationship is essential for the strengthening of the therapeutic alliance (Safran et al., 1990). There are different types of alliance ruptures. Confrontation rupture is when the patient explicitly expresses his or her hostility and discontent. A withdrawal rupture is when the patient, therapist or both, emotionally disengage from the relationship even when they appear to be working together. Another form of rupture is called the “angry patient”, which occurs in response to something the therapist has or has not done. In all these forms of rupture there is hostility that is expressed directly or indirectly. Therefore a competent therapist must know how to manage hostility (Binder & Betan, 2012; Safran, muran, & Rothman, 2006). Firstly, the therapist must identify the disruption in the relationship with the patient, tolerating the associated negative affects. Secondly, the therapist must disengage from participating in the dysfunctional interaction, inviting the patient to explore together what has taken place between them. The therapist should overcome the reflex to pull away from difficult negative affects, facing the uncomfortable emotions, and helping the patient explore, understand and accept them (Moltu, Binder, & Nielsen, 2010; Safran et al., 2011).

Therefore, in order to address ruptures in the alliance it is fundamental for the therapist to be self-aware, to affect-regulate and have interpersonal sensitivity. It may be that implicit emotional memories are accountable for the patient’s reactivity and suffering (Muran, Safran, Eubanks-Carter, Muran, & Barber, 2010). Therefore, working through these previously avoided feelings in the here-and-now of the session, and then linking them to a disconfirming experience, may help the patient to reconsolidate these traumatic memories in a way that they are no longer activated (Ecker et al., 2012). Therefore, repairing alliance disruptions may be related to the notion of therapy being a “corrective emotional experience” (Alexander & French, 1946), and it has been associated with better clinical outcomes (Eubanks, Muran, & Safran, 2018).

Responsiveness is the ability of the therapist to remain attuned to the patient and to the therapeutic relationship. Despite of the prescribed adherence to a specific treatment manual, the therapist must respond flexibly to the
situations that arise during therapy with the aim of maintaining the therapeutic alliance. It is an essential skill of the therapist to identify subtle changes that may imply that a negative process has taken place in the interaction with the patient (Binder & Betan, 2012; Hatcher, 2015).

3.5 Frameworks of Therapist Competence in Psychodynamic Psychotherapy

It has been proposed that several steps need to be followed in order to operationalise therapist competence in psychodynamic psychotherapy. The first step entails the definition and description of general psychoanalytic competencies. Secondly, a thorough and expert-based description of theoretical and clinical psychoanalytic competencies must be obtained. The aim is to re-evaluate existing definitions of competencies, attempting to find consensus on the possible developments of the concepts, in order to arrive into a definition that does justice to the complexity and ambiguity that involves working with the unconscious. The third step entails operationalising these concepts into an implementable instrument that would allow to empirically analyse the way clinical competencies are used in clinical practice (Parth & Loeffler-Stastka, 2015). The first step has been addressed by Killingmo, Varvin, and Strømme (2014). Furthermore, the first and second step have been undertaken by the European Psychoanalytic Federation Working Party on Education (Tuckett, 2005) and by the British Psychological Society’s Centre for Outcomes Research and Effectiveness (CORE) (Lemma, Roth, & Pilling, 2008). In the following sections these frameworks will be presented.

3.5.1 Killingmo et al., 2014

In a study that aimed to characterise novel therapists’ competence, Killingmo, Varvin and Strømme (2014) developed the concept of strategic thinking, which refers to the capacity of the therapist to continuously reflect on the therapeutic means and aims, giving emotional coherence and meaning to the therapeutic attitude, technique and exchange. Strategic thinking was
considered the basic dynamic competence, which comprises three components in its definition. The first component of strategic thinking is the ability of the therapist to allow patients to express themselves at their own rhythm, tolerating their silences without actively intervening to control the dialogue. Accordingly, therapists should not act because of a pressing desire to “help” or “do” something. The second component of strategic thinking is the therapist’s drive towards the subjective experience of his/her patients. The third component is the ability of the therapist to maintain a benevolent and respectful stance towards patients, without being judgmental about their behaviours, feelings and fantasies. Therefore, strategic thinking refers to a particular way of being present in the relationship with the patient. The therapist makes a “silent invitation” to the patient to enable psychic contents to emerge, allowing things that were not previously experienced, to surface, to become verbalised and reflected upon. However, strategic thinking is not just the ability to listen attentively and openly, but also the capacity to grasp nuances in the verbal and non-verbal material that suggest that there is a sub-text expressed at another layer and that has a different meaning from the manifest one.

Accordingly, it is possible to differentiate between a “low” and “high” level of strategic thinking. In the “low” level, the therapist is able to listen to the patient and therefore create a productive therapeutic space. However, he/she lacks the ability to understand the underlying meanings of the patient’s communications and the ability to intervene appropriately. In the “high” level of strategic thinking, the therapist is able to create a therapeutic space for the patient’s conscious and unconscious communications, as well as to take advantage of this space in an interpretative manner (Killingmo et al., 2014).

In reference to strategic thinking, four levels of competence have been defined: (1) strategic thinking, (2) partial strategy, (3) absence of strategy; and, (4) the anti-therapeutic relation. The first category includes the “high” and “low” level of strategic thinking. The partial strategy refers to a therapeutic situation that is characterised by the use of strategic thinking up until a certain moment of the session, in which the therapist steps out of the therapeutic stance. The absence of strategic thinking is distinctive because of the absolute lack of this competence. Finally, the anti-therapeutic relation refers to therapists whose attitudes and/or behaviours are in opposition to the therapeutic aims of dynamic
This framework of therapeutic competence is particularly helpful because it attempts to organise the notion of competence around one core competence defined as strategic thinking. The understanding of strategic thinking is valuable in order to determine whether a specific therapist is being competent or not, independently of treatment outcomes, adherence and years of clinical experience. However, the same feature that makes this framework advantageous is its major drawback. Understanding therapist competence solely according to strategic thinking risks disregarding important insights on how and when to deliver specific interventions, and perform particular tasks with a patient. Therefore, relevant features that qualitatively characterise the attitudes, behaviours and interventions of the therapist are overlooked in this particular framework.

3.5.2 Tuckett, 2005

Tuckett (2005) developed a framework of psychoanalytic competence that aims to make explicit the implicit knowledge of what constitutes competent psychoanalytic work. The objective was that this framework would enable to empirically demonstrate and assess the outcome of training in psychoanalysis, and to develop a common language between psychoanalysts and professionals from other disciplines. This framework attempts to take into consideration the subtleties and challenges of psychoanalytic practice, understanding that there is more than way to practice psychoanalysis, but also avoiding the idea that “anything goes”. Therefore, this competence framework constitutes a “disciplined pluralism” that is empirically supported by a demonstration of analytic capacity. Using grounded theory, Tuckett (2005) drew from the discussions between European IPA Institutes, criteria and clinical descriptions of what would more or less constitute a competent psychoanalytic practice. As a result, he outlined that the psychoanalytic task requires three specific

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4 See Appendix D for a detailed description of these levels of therapist competence.
capacities: (1) the ability to create an internal and external setting that enables the analyst to sense unconscious meanings and affects (significant data); (2) the ability to conceive what is perceived and sensed; and (3) the ability to deliver interpretations based on the latter and then conceive the effects of these interpretations. Although different psychoanalytic schools may have divergent ideas as to how to create the setting, all schools would probably agree on what the significant data are, or on how to conceptualise and deliver interpretations. These three capacities were conceptualised in the following frames: (1) participant-observational, (2) conceptual, and (3) interventional (Tuckett, 2005).

The participant-observational frame focuses on the manner the therapist relates and manages the therapeutic situation, and on what he/she is capable to perceive in the interaction with the patient. The essential aspect is the way the therapist listens, observes and reflects on the patients’ associations and affects, as well as on the therapist’s own emotional response. This frame has been conceptualised as the “countertransference position” (Faimberg, 1992), conveying that the psychic functioning of the therapist is focused on listening to what the patient says or cannot say. This requires the ability to tolerate, contain, wonder about, and bear the transference, rather than being reactive to it. Therefore, the participant-observational frame requires receptivity, tolerance to silence, and openness to expressions of the unconscious, as well as the ability to tolerate uncertainty and not understanding what is happening in the session while maintaining an active curiosity. Therefore, the participant-observational frame entails the abilities to: (1) wait for the patient’s material to make sense, however the wait should not be excessive in a way that may frustrate or opt out the patient; (2) reflect and respond analytically rather than “acting in” or intervening too often guided by a wish to repair or by the fear of not being loved by the patient (particularly when the patient presents with a problematic situation related to destructive, gratifying or transgressive meanings); (3) perceive and reflect on the patient’s resistance rather than “fighting” it or reacting to it; (4) listen to conscious and unconscious emotional levels of communication; (5) be aware of the possible blind spots and their meanings within the therapeutic relationship; (6) reflect on the intervention’s effects on patient and therapist, picking up unconscious responses and noticing when an intervention might be misused by the patient or become overvalued by the
therapist; and, (7) reflect on his/her own understandings and behaviours, noticing and reflecting on “mistakes”, but not too defensively (Tuckett, 2005).

The conceptual frame refers to the ability of the therapist to manage specific conceptual tasks, such as identifying and conceptualising the transference and countertransference, and the development of the therapeutic process in a way that has a “ring of truth”. The conceptual frame refers to the ability of the therapist to reflect and understand the latent meanings of the patient’s material within a particular psychoanalytic model that works as a specific frame of reference. Essential to the conceptual frame are the following abilities: (1) to understand the unconscious latent thread(s) running through the sessions and their place in the analysis; (2) to picture the transference, countertransference and the effect of the interpretations on the patient; and (3) to understand how psychoanalysis works in general terms and how does it work for a particular patient (Tuckett, 2005).

The interventional frame refers to the therapist’s ability to formulate and deliver appropriate interventions. Although psychoanalysis is a technical procedure, it is also an art that depends on many specific ingredients. There are many types of interventions and each one can take many forms, including abstaining from intervening and allowing silence. Furthermore, the content of interventions will differ according to a myriad of hermeneutic possibilities. Therefore, this third frame, is particularly dependent on the great number of viewpoints of modern psychoanalysis. Consequently, the main indicators to recognise whether an intervention is a competent one, is the judgement as to whether the intervention: seems to be at the right emotional level for the patient, is not over-intellectualised, and has coherence with what else the analyst is doing. Thus, the competency of an intervention does not depend on agreement between assessors on what has been said or even on how it was said. The main indicator to recognise a competent intervention is the consistency of the interventions with the therapist’s participant-observational stance, and his/her conceptualisation. Other features that characterise the competency of the therapist’s interventions are: (1) the balance of affective and intellectual themes in the interpretations; (2) the timing of interpretations; (3) that interventions promote the psychoanalytic process and psychic change; (4) that interventions appropriately describe the transference experience to the patient; and (5) that
interventions are aimed to elaborate unconscious relationships within the patient’s psyche (Tuckett, 2005).

This framework of therapeutic competence is particularly valuable because it classifies psychoanalytic competence in three main tasks or components which allow, on one hand, to describe and assess the competence of a particular therapist and, on the other hand, allow for the pluralism of ideas of the different schools of psychoanalysis. Therefore, the general categories outlined by the frames, - that do not specify in detail the therapist’s attitudes and behaviours-, allow to construe an operationalisation of therapist competence that most psychoanalytic schools would agree with. However, leaving aside other specifications of competence also constitutes a disadvantage in its operationalisation. For example, the content and depth of an interpretation may be different for a Contemporary Freudian and a Kleinian analyst (Sandler, Dare, Holder, & Dreher, 1992), however both of them would agree that a competent interpretation must be appropriate for the emotional level of the patient and coherent with the overall understanding that the therapist has regarding the patient. In conclusion, this framework of therapeutic competence is helpful to define what is understood as a “good enough” therapist for most psychoanalytic schools, however disregarding the specifics of how to competently deliver psychoanalytic technique in the therapeutic situation.

3.5.3 Lemma et al., 2008

Lemma et al. (2008) developed a framework of the competences required to deliver effective psychoanalytic/psychodynamic psychotherapy. The framework originated in the context of Improving Access to Psychological Therapies (IAPT), a programme that, among others, promoted the identification of the evidence-based competences to deliver effective psychotherapies. Furthermore, the competence framework was developed in order to inform the

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5 See Appendix E for the complete version of the Framework of Psychodynamic/Psychoanalytic Competence.
standards of psychoanalytic/psychodynamic psychotherapy in the context of the National Occupational Standards (NOS).

The development of the framework began by identifying the psychoanalytic/psychodynamic strategies that had demonstrated the strongest evidence of efficacy in clinical controlled trials. These trials offered manualised therapies, and monitored the therapist performance to ensure treatment adherence. This made possible to extract the competences outlined by the treatment manuals that had shown positive outcomes in the clinical trials. The development of the competence framework was overseen by an Expert Reference Group (ERG) to ensure that the right trials were identified and that the extraction of competences was systematic and appropriate. The treatment manuals studied provided once or twice weekly, time-limited, individual (adults) psychoanalytic/psychodynamic psychotherapy. Additionally, the interventions were delivered in the context of publically-funded psychotherapy (Lemma et al., 2008).

The competences extracted from the treatment manuals were classified in five groups: (1) generic competences; (2) basic psychoanalytic/psychodynamic competences; (3) specific psychoanalytic/psychodynamic therapy techniques; (4) meta-competences; and, (4) problem specific competences and specific adaptations psychoanalytic/psychodynamic therapy skills.

The generic competences refer to the ones implemented in any psychological therapy. The generic therapeutic competences include the therapist’s abilities to: (1) draw on knowledge of mental health problems; (2) work with patients from different demographic groups, backgrounds, lifestyles, beliefs, and religions; (3) engage the patient; (4) foster and maintain a good therapeutic alliance; (5) undertake a generic assessment; (6) manage endings; (7) assess and manage risk of self-harm; (8) use measures to guide therapy and monitor outcomes; and, (9) to make use of supervision.

The basic psychoanalytic/psychodynamic therapy techniques are the essential ones for structuring the delivery of psychoanalytic/psychodynamic interventions. These competencies include the abilities of the therapist to: (1) draw on knowledge of the principles of psychoanalytic/psychodynamic therapy; (2) assess the suitability for psychoanalytic/psychodynamic therapy; (3)
formulate; (4) engage the patient; (5) maintain an analytic/dynamic focus; (6) work with unconscious communication; (7) help the patient become aware of unconscious feelings; (8) help the patient explore the unconscious dynamics that influence their relationships; (9) identify and manage difficulties in the therapeutic relationship; (10) establish and manage the therapeutic frame and boundaries; and, (11) work with both, the patient’s internal and external reality.

The specific psychoanalytic/psychodynamic techniques constitute the core interventions that are used in most psychodynamic therapies. These competencies include the abilities of the therapist to: (1) make interpretations; (2) work in the transference; (3) work with the countertransference; (4) recognise and work with the defences; and, (5) work through the termination phase of therapy.

The meta-competences are the abilities that allow the therapist to be aware of when and why to deliver, -and when no to-, a particular intervention. The metacompetences represent higher-order abilities that allow the therapist to tailor the treatment to a specific patient at different moments. The metacompetences include the abilities to: (1) maintain an “analytic attitude”; (2) make use of the therapeutic relationship as a vehicle for change; (3) apply the analytic/dynamic model flexibly in response to the patient’s individual needs and context; (4) establish an appropriate balance between interpretative and supportive work; and, (5) identify and apply the most appropriate analytic/dynamic intervention for the individual patient.

Finally, the problem specific competencies are the ones outlined in particular treatment manuals. This dissertation looked into the specific adaptation developed in the Dynamic Interpersonal Therapy (DIT) manual. DIT represents an evidence-based brief psychodynamic approach for the treatment of depression. DIT techniques are grounded on the competence framework for psychoanalytic/psychodynamic therapies, which sets up the competencies that have good research evidence of efficacy. DIT is based in techniques that are well-known in short-term focal psychodynamic psychotherapy, which are structured and made accessible through a treatment manual. DIT consists in a brief protocol (16 sessions) that assists psychodynamically trained practitioners to work according to a specific dynamic focus relevant to the difficulties frequently encountered by patients that suffer from depression.
DIT is an interpersonal approach, focusing on the patient’s relationships, internal and external, as they relate to the problem(s) in the patient’s current life, giving rise to symptoms of depression. Unlike other interpersonal approaches, DIT systematically focuses on the current activation of unconscious, object relationships that are meaningfully connected to the depressive symptoms. Additionally, DIT encompasses a dynamic approach in so far as it is concerned with helping the patient understand the interplay between external and internal reality, as it relates to a problematic circumscribed relational pattern. Thus, DIT addresses the patient’s unconscious realm of experience.

The competencies included in the DIT manual encompass the therapist’s abilities to: (1) draw on knowledge of the developmental model underpinning the understanding of depression, the difficulties experienced by depressed patients, as well as of the aim and focus of treatment; (2) establish and maintain the therapeutic stance; (3) assess the severity of the patient’s depression; (4) assess and formulate the quality and patterning of the patient’s current and past interpersonal functioning; (5) engage the patient; (6) help the patient identify their aims for therapy; (7) work to the agreed focus; (8) focus the content of the interventions; (9) work collaboratively with the patient towards an understanding of the transference experience; (10) support the patient’s mentalizing stance in relation to the interpersonal affective pattern (IPAF); (11) encourage interpersonal change; (12) integrate routine outcome monitoring into the therapeutic process; and (13) explore the unconscious and affective experience of ending.

Overall, the competence framework proposed by Lemma et al. (2008) is valuable in terms of systematising the vast literature on psychodynamic technique and competence. Furthermore, this framework puts forward a highly structured package of competencies that have been supported by the evidence in terms of bringing about better clinical outcomes in patients. Nevertheless, it is pivotal to notice that this framework does not present a novel understanding of psychodynamic competence, it rather compiles and organises already well-

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6 See Appendix F for a detailed characterisation of the competencies required for open-ended and brief psychodynamic psychotherapy.
known clinical skills. Therefore, this framework of competence –and in particular systematisation of competences proposed by the DIT manual- only assemble previously established psychodynamic ideas on technique. Furthermore, this framework presents an overly comprehensive and detailed description of therapist skill, which does not allow us to develop a measure of therapist competence that is feasible to apply in routine clinical practice. In conclusion, this framework is helpful because it systematises evidence-based psychodynamic competences, however it does not facilitate the measurement of this construct in practice.

3.6 Conclusion

This chapter aimed to describe the development of competence and the specific competencies with which to deliver particular psychodynamic techniques, as well as to discuss three different frameworks of psychodynamic competence.

As mentioned above, the development of competence is built up towards the expert therapist level, in which the clinician is characterised by the ability to improvise, where established models of practice do not appear to help the patient. Expert therapists abstractly and meaningfully conceptualise the patient’s difficulties, recognising and understanding the interpersonal patterns while they are participating in them with the patient. Additionally, the expert therapist is able to adjust the interventions according to his/her experience and immediate circumstances, as well as to adapt the interventions in reference to the feedback of the interaction with the patient in the session (Binder, 1999).

Furthermore, in this chapter several psychodynamic psychotherapeutic competencies were described, including the ability of the therapist to observe, listen and reflect, as well as the therapist capacity to manage the emotional content of the session. Additionally, the competent delivery of specific techniques, such as clarification and confrontation, was reviewed. Furthermore, this chapter described how a competent therapist achieves an appropriate balance between expressive and supportive interventions. Moreover, the importance of: competently keeping the frame and boundaries of therapy;
conducting competent assessments; appropriately defining a therapeutic focus; as well as, collaboratively building a narrative with the patient, were outlined in this review. Finally, the importance of the therapist competencies that foster and maintain the therapeutic alliance with the patient, were stressed and explained in detail, considering the essential role of the alliance for the patient’s therapeutic improvement (Safran et al., 2011).

In the last part of this chapter, three frameworks of therapist competence were reviewed. Firstly, the framework developed by Killingmo et al. (2014), that built around the concept of strategic thinking, was described. As explained above, strategic thinking refers to the ability of the therapist to have the patient’s therapeutic aims and means constantly in mind, which allows the therapist to deliver the interventions in an emotionally coherent way. Strategic thinking was described involving both, the ability to listen openly and attentively, as well as the therapist capacity to grasp the nuances in the patient’s communications, understanding the meanings underlying them. A second framework of competence was conceptualised by Tuckett (2005), who proposed that a competent therapist should have three important general competencies: 1) the ability to create an internal and external setting that enables the analyst to sense unconscious meanings and affects (participant-observational competence); (2) the ability to conceive what is perceived and sensed (conceptual competence); and (3) the ability to deliver interpretations based on the latter and then conceive the effects of these interpretations (interventional competence). Finally, Lemma et al. (2008) put forward a framework of competence that resulted from the identification of evidence-based competencies essential for the delivery of effective psychodynamic psychotherapy. These evidence-based competencies were described in detail and classified into five groups (1) generic competences; (2) basic psychoanalytic/psychodynamic competences; (3) specific psychoanalytic/psychodynamic therapy techniques; (4) problem specific competences and specific adaptations psychoanalytic/psychodynamic therapy skills; and, (5) metacompetences.

Although these frameworks make a valuable contribution to understanding therapist competence, they describe the competencies in either general terms (Killingmo et al., 2014; Tuckett, 2005), or in an overly detailed
and comprehensive manner (Lemma et al., 2008). Therefore, none of these frameworks allows to operationalise clearly and systematically the different psychodynamic competencies a therapist should have; nor to develop a measure that would enable a feasible assessment of therapist competence. In the following chapters of this dissertation a new operationalisation and measure of therapist competence will be proposed with the aim of enabling the study of this essential process-outcome variable in practice.
Chapter 4: Overview of Studies' Aims, Research Questions, and Hypotheses

4.1 Statement of the Problem

As indicated in the literature review, although psychotherapy research has suggested that therapists contribute to outcome in a small but important proportion, little is known about the reasons that underpin the differences in their effectiveness. Notwithstanding the fact that therapist competence has been proposed as a fundamental determinant of the differences in therapist effects, the association between competence and patient improvement remains uncertain (Crits-Christoph et al., 2013; Luborsky et al., 1985; Sandell, 1985).

Several factors have been suggested in the psychotherapy research literature that might hinder the study of the association between therapist competence and clinical outcome. First and foremost, there is an inherent difficulty in defining and operationalising competence. Particularly, in psychodynamic psychotherapy, conceptualising competence entails putting together an objective definition of the unconscious and subjective processes that underpin the therapist’s attitudes and behaviours within a session. Furthermore, there is an intrinsic complexity in defining what constitutes global and single domain competence, across the different psychodynamic schools of thought. Moreover, there is a deep-rooted difficulty of defining competence separately from the frequency of delivery of particular psychodynamic interventions and therefore, conceptualising competence distinguishing it from adherence to treatment protocols. Additionally, the complexity of operationalising competence results from the need for the construct to encompass the notion of therapist responsiveness, which entails a changing definition considering that it includes different therapeutic attitudes and behaviours, at different moments, and with different patients.

These challenges have hitherto hampered the development of a reliable and valid instrument to measure therapist competence in psychodynamic psychotherapy. As mentioned in the literature review, a number of frameworks that have aimed to operationalise therapist competence have been developed.
However, none of these frameworks has allowed to assemble a reliable and valid instrument that can measure therapist competence clearly, systematically, comprehensively, and feasibly. Indeed, the lack of such instrument has hampered the study of the relationship between therapist competence and outcome.

Nevertheless, there are a number of other conceptual, methodological and statistical factors that have hindered the study of the association between therapist competence and patient improvement. Hitherto, psychotherapy research has assumed that a direct and linear relation exists between competence and outcome. However, it is possible that competence may have an indirect association with outcome by, for example, moderating the effects of other process variables; and/or that it may have a quadratic relationship with outcome. Additionally, there might be a ceiling effect for competence on outcome, meaning that over a specific level of competence, higher degrees of it, do not bring about better treatment outcomes. However, none of these possibilities have been appropriately studied. Furthermore, other methodological factors that could have hampered the study of the relationship between competence and outcome are the narrow range of competence displayed by therapists that participate in RCTs which could result in a low variability in competence and/or outcome scores; and, the scarcity of studies that have explored the effects of competence longitudinally. Finally, the use of unsuitable statistical methods that do not consider the multilevel structure of the data intrinsic to the study of the relationship between competence and outcome, may have obscured the real association between these variables (Wampold, Baldwin, & Imel, 2017).

4.2 Purpose Statement

Taking into consideration the challenges and difficulties of studying the effects of therapist competence, this dissertation aimed to study the association between therapist competence in DIT and treatment outcome. In order to do so, this thesis aimed to operationalise and develop a reliable and valid
instrument that could measure therapist competence in DIT, systematically and feasibly.

Therefore, this dissertation consisted of five separate studies which aimed: 1) to examine the association between therapist competence and treatment outcome within the REDIT study, employing an unsystematic instrument to measure therapist competence in DIT; 2) to qualitatively analyse expert clinicians’ viewpoints on competence in DIT in order to provide a basis for operationalising and developing a measure of psychodynamic therapist competence; 3) to study the reliability of the therapist competence measure developed in the previous study; 4) to investigate the convergent and discriminant validity of the therapist competence measure developed in this dissertation; and, 5) to study the association between therapist competence in DIT, measured with this dissertation’s instrument, and patient clinical outcomes. The specific research questions and hypotheses of each of these studies will be described in the following section.

4.3 Overview of Studies’ Research Questions and Hypotheses

Study 1 was designed to examine the association between therapist competence in DIT and treatment outcome, defined by the Hamilton Depression Rating Scale (Hamilton, 1960), within the REDIT study. An additional goal was to examine the relation between adherence to the DIT manual and treatment outcome. In this study, therapist competence and treatment adherence were measured employing the instruments provided by the DIT manual (Lemma, Target, & Fonagy, 2011a), whose psychometric characteristics had not been previously studied. Based on previous findings of the literature, regarding the study of the association between competence and outcome, and the association between adherence and outcome-, and considering the undetermined reliability and validity of the treatment integrity instruments, it was hypothesised that there would be no significant association between these variables. It was also hypothesised that there would not be a quadratic relation between adherence and outcome, and between competence and outcome, as it had been previously suggested by the literature (Barber et
Study 2 was designed to examine qualitatively expert clinicians’ viewpoints on what constitutes therapist competence in DIT, in order to operationalise the construct and subsequently develop an instrument that would allow to measure therapist competence in DIT systematically and comprehensively. The research questions of this study were: 1) According to expert clinicians’ viewpoints, what attitudes and behaviours of a DIT therapist are considered competent?; 2) According to expert clinicians’ viewpoints, what attitudes and behaviours of a DIT therapist are considered incompetent?; 3) How would expert clinicians operationalise and measure competence and incompetence in DIT?. Considering the exploratory nature of this study and its research questions, no formal hypotheses were formulated before the beginning of the study. After conducting the thematic analysis of the experts’ viewpoints on competence, this study included the creation of the Therapist Competence Scale (TCS). As will be described in detail in the following chapters, the TCS included a competence subscale, an incompetence subscale, a global competence rating and a patient complexity rating. The items were scored in a Likert-type scale, with the exception of the incompetence subscale items, which were rated in a binary fashion.

Study 3 was designed in order to examine the internal consistency and interrater reliability of the newly developed therapist competence instrument, the TCS. Considering the large number and similar nature of the items of the competence subscale, it was hypothesised that they would have a good/high internal consistency and interrater reliability. Concurrently, it was hypothesised that the global competence rating would be scored similarly to the single-domain competency items, and that it would have good/high inter-rater reliability. Taking into account the binary nature of the incompetency items, it was predicted that only a fair/moderate internal consistency and interrater reliability would be found between them. Furthermore, considering the difficulty of capturing the complexity, openness and psychological resources of the patient in a single item, it was hypothesised that the patient complexity score would only have a fair/moderate interrater reliability.

Study 4 was designed to examine the convergent and discriminant validity of the TCS. The research questions of this study were: 1) Is the therapist
competence in DIT construct, operationalised in the TCS, different from the conceptualisation of treatment adherence?; 2) Does the therapist competence construct, operationalised in the TCS, capture the necessary competencies associated with the “common factors” of psychotherapy, in the delivery of DIT?; and, 3) Does the therapist competence construct, operationalised in the TCS, capture competencies other than the ones associated with the “common factors” of psychotherapy, in the delivery of DIT? Several hypotheses were tested in this study. Firstly, it was predicted that the TCS would correlate partially to measures of treatment adherence, considering that adherence is a prerequisite, but not equivalent, to therapist competence. Concurrently, it was predicted that the TCS would capture the competences associated with the development of a good therapeutic alliance. However, it was hypothesised that the TCS would only correlate partially to measures of alliance, indicating that therapist competence in DIT goes over and above the techniques related to fostering a positive therapeutic alliance with the patient.

Study 5 aimed to examine the relation between therapist competence, -as operationalised by the TCS-, and treatment outcome. The fundamental research question of this study was, is therapist competence, -as operationalised by the TCS-, associated with the patient’s clinical outcome in DIT? The design of this study specifically aimed to overcome important gaps in the literature regarding the study of the relation between competence and outcome in psychodynamic psychotherapy. Therefore, linear as well as non-linear relations between therapist competence and patient improvement were studied. Additionally, the design of this study considered exploring the longitudinal effect of competence on outcome, as well as the use of multilevel statistical models in order to examine this association. Furthermore, this study was designed to investigate the interaction between patient complexity and therapist competence. It was hypothesised that there would be a significant association between competence and treatment outcome, and based on the literature review findings, it was predicted that this relation would be more relevant in patients with higher symptomatology at baseline. Moreover, it was hypothesised that competence would have an effect on outcome scores, as well as an impact in the rate of patient recovery. Additionally, considering the inconsistencies of the literature review findings regarding a positive association
between competence and outcome, it was predicted that part of the association between competence and outcome would be linear, while other portions of it would have a non-linear relationship. Finally, it was hypothesised that there would be a significant interaction between therapist competence and patient complexity, the former being of critical importance to more complex patients.
PART II: Research Studies
Chapter 5: Methodology

5.1 Introduction

This section will describe the methodological features shared by the different studies described in the subsequent chapters included in the second part of the dissertation. The methodological elements specific to each study, will be described separately in the relevant chapter.

In particular, this section will describe the Randomised Evaluation study of Dynamic Interpersonal Therapy (REEDIT), the trial that provided the sample of sessions in order to examine the assessment of therapist competence in Dynamic Interpersonal Therapy (DIT), and its association with other variables measured in the programme, including treatment outcomes. The design, sample, procedures, and demographic characteristics of the REEDIT trial participants, will be outlined in this section.

5.2 REEDIT: Trial Design

The REEDIT trial aimed to examine the effectiveness of DIT, -a treatment for moderate to severe depression in adults within IAPT services-, by comparing DIT with a low-intensity treatment (LIT) condition in terms of their clinical outcomes. Additionally, the REEDIT trial aimed to assess the feasibility of comparing the treatment of adults suffering from depression with DIT and Cognitive Behavioural Therapy (CBT), within IAPT services. Therefore, the REEDIT trial encompassed two simultaneously conducted studies: the first was an RCT to establish whether DIT was more effective than LIT, and the second study evaluated the feasibility of randomising patients to one of the two high-intensity treatments (HIT), either DIT or CBT.

As mentioned above, the REEDIT trial was conducted within IAPT services, which offers patients with common mental disorders (depression and anxiety), a stepped-care model whereas low-intensity (Step 2) or high-intensity (Step 3) treatments, are provided depending on clinical need. Participants were
recruited from four sites: two sites for the DIT vs LIT comparison, and two separate sites for the DIT vs CBT comparison. Participants that did not recover in the LIT, were offered HIT after completing 4-6 months of guided self-help treatment.

Participating patients were recruited from November 2012 to January 2015. Patients consecutively referred in four metropolitan IAPT sites were 18-65 years; met Diagnostic and Statistical Manual for Mental Disorders, fourth edition (DSM-IV) criteria for a major depressive episode (American Psychiatric Association, 1994); scored >14 on the 17-item version Hamilton Depression Rating Scale (HRSD-17) (Hamilton, 1960) and >10 on the Patient Health Questionnaire (PHQ-9) (Kroencke, Spitzer, & Williams, 2001). If the referred patients were identified as likely to require high-intensity treatment after triage, they were approached to participate in the study. Exclusion criteria were current psychotic symptoms or bipolar disorder, and clinical contraindication to short-term psychotherapy including: current use of antipsychotic medication; complex personality disorder; historic or current self-injury or para-suicide; historic or current eating disorder; and, current excessive use of drugs or alcohol. Furthermore, non-English speakers, those who had participated in another clinical trial within the past year in which they had received CBT or STPP for depression, those who had had previous unsuccessful CBT, and those with highly unstable or insecure life arrangements were excluded from the trial.

The trial was granted ethical approval by NHS Research Ethics Committees and was registered with the International Standard Randomised Controlled Trial Register Number (ISTCRN38209986; ISTCRN06629587)

5.3 REDIT: Sample Size Calculation

The recruitment of participants for the RCT that compared DIT vs LIT, was powered for a superiority trial. An a priori power analysis indicated that in order to detect a mean difference of 5 (SD=5.62) on the Hamilton Rating Scale for Depression (HRSD), a sample of 54 participants (27 in each group) would entail a power of 90% and a 5% of type I error rate. For this comparison, at 6 months, the DIT arm included 48 participants, and the LIT arm included 31
participants. Therefore, the study was well powered to detect superiority in the comparison between DIT vs LIT. No sample size calculations and a priori power analysis was performed for the comparison between DIT and CBT (CBT n=15 participants at 6 months), considering that the latter arm was only included for the purpose of assessing the feasibility of randomisation.

5.4 REDIT: Assessments and Outcome Measures

Clinicians at recruiting IAPT sites referred suitable patients to the trial team. Baseline assessments were conducted by a research assistant, to evaluate the eligibility of the referred patients for the trial. This included structured clinical interviews and self-report measures. Participants were followed up mid-treatment (3 months; approximately 90 days) and after the end of treatment (6 months; approximately 180 days). Those in the DIT arm were followed up on average 12 months (approximately 360 days) after randomisation to establish whether treatment gains were maintained.

The primary outcome measure was change in mean scores on the 17-item version of the HRDS at 6 months indicating full or partial remission (Hamilton, 1960), rated by research assistants who were blind to treatment allocation.

5.5 REDIT: Randomisation

The randomisation of participants was conducted by an administrator independent of the trial, blind to the trial hypotheses and conditions, and based at a different location from the research team. Subsequent to the completion of a baseline assessment by the research team, minimisation criteria, including age, sex, and depression severity, were e-mailed with the request for randomisation. Depending on the recruitment site, participants were randomised to either DIT or LIT, or to DIT or CBT, using a minimisation algorithm with an 80% bias to minimise imbalance in a ratio of 3:2:1 for the three treatment groups.
5.6 REDIT: Interventions

5.6.1 Dynamic Interpersonal Therapy (DIT)

DIT is a brief psychodynamic psychotherapy (16 sessions) to treat patients suffering from depression and anxiety. The DIT treatment manual was developed based on the psychodynamic/psychoanalytic Competence Framework (Lemma et al., 2008). Therefore, DIT was designed in line with the psychodynamic approaches that had shown the strongest empirical evidence for efficacy, according to the outcomes of controlled trials.

DIT is an intervention informed by attachment and mentalization theory (Lemma et al., 2010; Lemma, Target, & Fonagy, 2011c; P. Luyten & Blatt, 2012), and therefore conceptualises the symptoms of depression as a response to interpersonal difficulties that are perceived as threats to attachments (loss/separation) and to the self. Thus, DIT conceptualises depression as a temporary disorganization of the attachment system precipitated by current relationship problems, which in turn bring about a range of distortions in feelings and thought processes that are quintessential to the depressive disorder. The therapeutic focus of DIT is to help the patient elaborate the thoughts and feelings that result of this emotional “crisis”, as these emerge in the context of the therapeutic relationship.

Hence, DIT is grounded in the established clinical observation that patients that suffer from depression invariably present difficulties in their interpersonal relationships. The DIT therapist reformulates the symptoms of depression as indicators of relational disturbances, which the patient does not understand, or understands in a maladaptive fashion, attributing to himself/herself and to others motivations which are either unlikely or unhelpful. Thus, DIT aims to help patients improve their ability to cope with current interpersonal difficulties through better understanding their subjective reactions to them as threats, making implicit anxieties and concerns explicit, and improving their ability to reflect on their own and others’ thoughts and feelings. Once the patient is helped to make changes in the way he/she approaches difficulties in relationships, depressive symptoms are typically alleviated.
The DIT therapist has two core related aims: a) to help the patient understand the connection between his/her presenting symptoms and what is happening in his/her relationships by identifying a core, unconscious, repetitive pattern of relating that becomes the therapeutic focus; b) to encourage the patient’s capacity to reflect on his/her own states of mind, enhancing his/her ability to manage interpersonal difficulties. Clearly, these are interdependent foci as mental state understanding, in the context of relationship problems, will benefit the quality of the relationship and, conversely, addressing relationship challenges will benefit a person’s capacity to appreciate the way mental states lead to actions in the context of significant relationships.

In conclusion, the essential rationale of DIT is to enhance the patient’s capacity to think and understand changes in mood and interpersonal functioning. DIT addresses character problems in a very limited way, and does not aim to go beyond the difficulties most clearly linked to the maintenance of depression.

DIT was delivered within IAPT services by trained DIT practitioners with an approved DIT supervisor. Participants were offered 16 weekly sessions, each lasting approximately 1 hour.

5.6.2 Low-intensity treatment

LIT consisted of fortnightly individual sessions (maximum=9) with a Psychological Wellbeing Practitioner (PWP) using a self-guided manual-based programme commonly used in IAPT services (Coull & Morris, 2011).

5.6.3 Cognitive-behavioural therapy

CBT was delivered within IAPT services by trained CBT practitioners under supervision following the standard IAPT high-intensity protocol (Roth & Pilling, 2015). All CBT therapists were accredited by the British Association of Cognitive and Behavioural Psychotherapy, and offered CBT following a cognitive therapy model (Beck & Haigh, 2014). Participants were offered 14–18 sessions of CBT over a 16–24-week period, each session lasting approximately 1 hour.
5.7 REDIT: Participant Patients

The final sample included 142 patients (56% moderately, 24% severely and 20% very severely depressed on the HRSD-17). Of these, 68 were randomised to DIT, 20 to CBT and 54 to LIT, until the end of DIT treatment (minimal treatment control). Only the DIT participants were analysed in the different chapters of this dissertation.

The mean age at baseline of the DIT participating patients was 36.6 years (SD= 11.3). The minimum age was 19 years, and the maximum 67 years. 32.4% of the DIT participating patients were males and 67.6% females, and 72.1% of the participants were white/white British (Table 5.1).

Table 5.1
*Demographical Characteristics of Patients*

<table>
<thead>
<tr>
<th>Demographical Variable</th>
<th>DIT patients (n=68)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>36.6 (11.3)</td>
</tr>
<tr>
<td>Sex (%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>22 (32.4%)</td>
</tr>
<tr>
<td>Female</td>
<td>44 (67.6%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White/White British</td>
<td>49 (72.1%)</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>3 (4.4%)</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>6 (8.8%)</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>6 (8.8%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Declined to state</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>30 (44.1%)</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>14 (20.6%)</td>
</tr>
<tr>
<td>Married</td>
<td>8 (11.8%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>6 (8.8%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>1 (1.5%)</td>
</tr>
<tr>
<td>Separated</td>
<td>4 (5.9%)</td>
</tr>
<tr>
<td>Declined to state</td>
<td>2 (2.9%)</td>
</tr>
</tbody>
</table>
5.8 REDIT: Participating Therapists

Seventeen DIT therapists saw an average of 4.2 patients (SD = 3.0, range: 1–12). Ten PWPs offered LIT, each seeing an average of 5.3 patients (SD = 3.0, range: 3–10). Thirteen CBT therapists saw an average of 1.54 patients (SD = 0.66, range: 1–3). All sessions were audio-recorded.

From the 17 DIT therapist, only ten provided further personal information. The DIT therapists’ average age was 52.6 years (SD=5.4). Ninety percent of the DIT therapist were female, 90% of them were white, and 50% were married. The DIT therapists had in average 22.9 years (SD=11.2) of experience working with mental health patients, and 50% had a doctorate qualification. All DIT therapists primarily practiced brief psychodynamic psychotherapy.
Chapter 6: Treatment Fidelity and Clinical Outcome in the REDIT Study

6.1 Introduction

The aim of this study was to examine treatment adherence and therapist competence in the delivery of DIT in the REDIT trial, and to investigate the relationship between treatment fidelity and the patients’ clinical outcomes. There are fundamental reasons that make the study of treatment fidelity a critical matter. Essentially, ensuring treatment fidelity allows to draw accurate conclusions about the efficacy of the therapy delivered, and identify the key ingredients of a model of treatment that are related to patients’ clinical outcomes. In the following paragraphs an overview of the concept of treatment fidelity and its relevance for studying the association between treatment and clinical outcomes, will be described.

Research on the efficacy of manual-based interventions requires rigorous treatment fidelity monitoring and evaluation (Carroll, Kadden, Donovan, Zweben, & Rounsaville, 1994). Treatment fidelity refers to the faithfulness with which therapists implement treatments as established by the manualised protocol (Perepletchikova et al., 2007), and is encompassed by two key components: 1) treatment integrity, which entails ensuring that therapists conduct the interventions with appropriate levels of adherence and competence according to the treatment manual; and 2) treatment differentiation, which involves demonstrating that the experimental intervention differs from an intervention that serves as the control condition (Perepletchikova & Kazdin, 2005). Thus, assessment of treatment fidelity provides information regarding the feasibility of implementing a treatment manual (Dusenbury, Brannigan, Falco, & Hansen, 2003).

Furthermore, treatment fidelity is essential in order to ensure the internal validity of a study. Compromises to internal validity may be brought about by an incorrect delivery of the therapy, such as the omission of prescribed treatment components or the addition of proscribed elements. Thus, significant results in a treatment-outcome study could be due to an effective delivery of the therapy or to Type I error that occurred because unintended elements were
added to the therapeutic intervention. Conversely, non-significant results could be secondary to a non-effective treatment, or to Type II error due to an inadequate implementation of the intervention (Perepletchikova et al., 2007). Regardless of whether research finds a large treatment effect or lack of effect, failure to address and ensure treatment fidelity undermines the credibility of the study outcomes (Borrelli et al., 2005).

Therefore, an essential aim of studying treatment fidelity is to enhance scientific confidence that changes in outcomes are due to the intervention researched. Treatment fidelity allows one to: (1) draw accurate conclusions about the efficacy of a treatment; (2) replicate studies; (3) identify the essential ingredients of a model of treatment; (4) reduce random and unintended intervention variability in order to improve statistical power; (5) test theoretical questions; and, (6) disseminate clinical findings (Bellg et al., 2004; Borrelli et al., 2005; Moncher & Prinz, 1991; Resnick et al., 2005).

In order to draw accurate conclusions regarding the efficacy of a treatment, research studies have not only certified and assessed fidelity through validated instruments (K. F. Stein, Sargent, & Rafaelis, 2007), but also have explored the association between treatment fidelity and outcome. A fairly large number of studies have investigated the association between treatment adherence and outcome in research settings. The results of these studies have been mixed (Miller & Binder, 2002; Perepletchikova & Kazdin, 2005). Several studies have found that strong adherence reflects therapist inflexibility and overreliance on the treatment protocol, which undermines the development of a good therapeutic alliance (L. Castonguay et al., 1996; Henry, Strupp, et al., 1993). Other studies have found that greater adherence predicts better clinical outcomes (Frank, Kupfer, Wagner, McEachran, & Comes, 1991; Huey Jr, Henggeler, Brondino, & Pickrel, 2000), and that adherence in the initial sessions either predicts (Feeley et al., 1999) or is predicted by (Barber et al., 1996) early symptom improvement. An exceptional study by Barber et al. (2006) examined both, the linear and quadratic effects of adherence on the outcomes of drug counseling for cocaine users. Results showed that an intermediate level of adherence, representing a balance between manual adherence and clinically flexible deviation, predicted better outcomes in drug use and depression symptoms than did high (rigid) adherence or low (lax)
treatment adherence.

A smaller number of studies have explored the association between competence and outcome. The results of these studies have also been inconsistent. A number of studies have found that competence has a moderate effect in predicting clinical outcomes (e.g., Barber et al., 1996; Shaw & Dobson, 1988). Other studies have found that competence is not associated with clinical outcomes (e.g., Barber et al., 2006). The paucity of research in studying the association between competence and outcome is probably a reflection of the inherent difficulties in developing a clinically valid assessment tool, and a rigorous operationalisation of therapist competence. In order to assess competence, the therapist’s skill in the treatment model, the appropriateness and timing of interventions, and the level of responsiveness to the patient (Stiles et al., 1998), should be evaluated. It is difficult to assemble a group of unbiased judges that have the ability to assess this degree of sophistication. Moreover, the assessment of competence should be based on thorough knowledge of the patient and the therapeutic context. Ideally, this should involve observing multiple sessions per case, which requires a significant expenditure of resources and time (Waltz et al., 1993).

The current study, aimed to study the feasibility of delivering DIT with high levels of treatment integrity, and to explore the relationship between adherence and competence in DIT, and clinical outcomes. Therefore, treatment adherence and competence were assessed and documented. The measurement of adherence considered the unique ingredients that distinguish the DIT treatment protocol, in order to determine the degree to which the manual was followed during the delivery of treatment (Mowbray, Holter, Teague, & Bybee, 2003). The quantification of competence in this study considered the elements that characterised the quality in which the therapist delivered DIT (K. F. Stein et al., 2007). Although it is essential to assess treatment integrity and its relationship to outcome in order to examine the effectiveness of specific treatments, the operationalisation and assessment of adherence and competence, as well as the study of the association between treatment integrity and outcome, pose several conceptual and methodological/statistical difficulties to the researcher, which will be addressed in this study.
6.2 Methodology

6.2.1 The REDIT study

The study of treatment fidelity was conducted by rating audio-recorded sessions from the REDIT study, by assessing adherence and competence with the measures provided by the DIT treatment manual (Lemma et al., 2011a). The REDIT study constituted the context in which this study was developed and therefore it is described in detail in the methodology section of this dissertation. In the current study, treatment fidelity was studied only across the DIT arm of the REDIT trial.

6.2.2 Sample of recordings

One hundred and seventy-two audio-recorded DIT sessions were coded in order to study treatment adherence and therapist competence in the REDIT trial. The audio-recorded sessions were selected following a stratified random procedure (computer-generated), conducted by a separate researcher. The stratification aimed to select sessions from the initial, middle and end phase of DIT in a 1:1:1 proportion. However, one of these sessions was not randomly selected since it was considered that rating the session where the therapist delivers the IPAF to the patient was essential in order to assess competence and adherence in the rest of that patient’s sessions. Therefore, the IPAF session of every participant was always included (where possible), and often corresponded to either the 4th or 5th session of the therapy of each patient.

Since a number of patients dropped out, the final sample for this study included: 50 patients with one session from each phase of treatment; 8 patients with 2 sessions from different phases of treatment; 6 patients with one sampled session. The selected sample included the 17 therapists that participated in the trial, as well as the total number of participants (n=68).
6.2.3 Raters and Training

The expert judges in this study were two postgraduate level therapists. The first judge was one of the developers of DIT manual and its treatment integrity measures (Lemma et al., 2011a). The second judge completed the DIT clinical training in which, the therapy manual and its application were practiced and assessed. Additionally, the second judge trained in the implementation of the treatment integrity measures. Nine audiotapes were rated and discussed conjointly between the two judges in order to clarify the criteria for rating the audio-recorded DIT sessions. The interrater reliability between judges was assessed, which was found to be 0.9 for both measures of treatment integrity. Subsequently, the second judge proceeded to rate the remainder 163 sessions.

6.2.4 Measures fidelity and outcome

Two measures, developed specifically to assess treatment fidelity in DIT (Lemma et al., 2011a), were applied in order to assess treatment adherence and therapist competence in a DIT session. The adherence measure includes seven essential tasks that a DIT therapist should follow, which are rated categorically (YES/NO) according to their presence or absence in a particular session. The competence measure is a Likert-type scale that comprises twelve items that describe the skills that a DIT therapist should demonstrate in a session. These items are rated from not at all characteristic (1), to highly characteristic (6). The psychometric characteristics of these instruments have not been examined and this study was the first one to employ them. Therefore, the treatment fidelity measures used in this study have not been validated (Table 6.1 and 6.2).
### Table 6.1
**Adherence Measure**

<table>
<thead>
<tr>
<th>Item</th>
<th>Adherence Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The therapist works collaboratively with the patient on formulating and/or discussing an IPAF</td>
</tr>
<tr>
<td>2</td>
<td>The therapist focuses on the patient’s states of mind (wishes, feelings, fantasies including the patient’s needs to avoid their exploration) more than on his behaviour</td>
</tr>
<tr>
<td>3</td>
<td>The therapist focuses primarily on current interpersonal experiences</td>
</tr>
<tr>
<td>4</td>
<td>The therapist maintains an active, supportive stance</td>
</tr>
<tr>
<td>5</td>
<td>The therapist focuses discussion on the relationship between the therapist and patient in order to further the exploration of the IPAF</td>
</tr>
<tr>
<td>6</td>
<td>The therapist encourages the patient to experience and express feelings, wishes and fantasies, in the session</td>
</tr>
<tr>
<td>7</td>
<td>The therapist allows the patient to stay focused on the IPAF</td>
</tr>
</tbody>
</table>

### Table 6.2
**Competence Measure**

<table>
<thead>
<tr>
<th>Item</th>
<th>Competence Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The therapist works collaboratively with the patient on formulating and/or discussing an IPAF</td>
</tr>
<tr>
<td>2</td>
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</tr>
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</tr>
<tr>
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</tr>
<tr>
<td>6</td>
<td>The therapist encourages the patient to express wishes and fantasies in the session</td>
</tr>
<tr>
<td>7</td>
<td>The therapist encourages the patient to stay focused on the IPAF</td>
</tr>
<tr>
<td>8</td>
<td>Wording and discussion of the IPAF is understandable to the patient so that he or she can contribute</td>
</tr>
<tr>
<td>9</td>
<td>The therapist effectively elicits interpersonal narratives</td>
</tr>
<tr>
<td>10</td>
<td>The therapist is able to support change without directly telling the patient what to talk about or do</td>
</tr>
<tr>
<td>11</td>
<td>The therapist helps the patient to experience and express feelings in the session</td>
</tr>
<tr>
<td>12</td>
<td>The therapist helps the patient to reflect on recurrent patterns in his or her actions, feelings and experiences</td>
</tr>
</tbody>
</table>
The primary outcome of this study was the participants’ symptoms of depression, which were assessed by research assistants blind to treatment allocation, who rated the 17-item Hamilton Depression Rating Scale (HDRS-17) (Hamilton, 1960). The HDRS-17 is a structured interview that quantifies the severity of depressive symptoms in patients already diagnosed with a depressive disorder. The psychometric properties of the instrument are good. The HDRS internal consistency ranges between 0.46–0.97, and its interrater reliability (Pearson coefficient) ranges between 0.82-0.98. Additionally, it has shown adequate convergent and discriminant validity (Bagby, Ryder, Schuller, & Marshall, 2004). The HDRS-17 was rated at baseline, as well as at the 8th (middle of treatment), and 16th (end of treatment) week assessments.

6.2.5 Data analysis

The association between treatment adherence and clinical outcome; and, between therapist competence and clinical outcome was studied using linear multilevel modelling. Multilevel statistical models are suitable when data is nested, and allow to account for individual change in the presence of missing data (Singer, Willett, & Willett, 2003). In this study two hierarchical structures were examined. Firstly, a two-level model was considered in which level 1 was represented by the participant patients, and level 2 was represented by the therapists. In this model, outcome was represented by HDRS-17 scores at the end of treatment. Additionally, the association between adherence, competence, and treatment outcome was investigated in a model that consisted of three levels: (1) session, (2) participants and (3) therapists. In this three-level structure, participants and therapists were treated as random effects. The outcome variable studied was the change in the HDRS-17 scores from baseline to the end of treatment.

The first and simpler model to study the relationship between adherence and outcome consisted of a two-level model that included the participant patients at level 1 and the therapists at level 2. This model included a variable that represented adherence at the patient level (average of adherence), and another variable that represented the baseline level of symptomatology at the
patient level. Additionally, in this model therapists were treated as a random effect. Following Steele (2008), this model (Model 1) was specified as:

\[ y_{it} = \beta_0 + \beta_1 a_{1it} + \beta_2 h_{2it} + u_i + e_{it} \]

where, \( y_{it} \) represents HDRS-17 at the end of treatment for participant \( i \) and therapist \( t \); \( a_{1it} \) represents adherence at the patient level with a slope coefficient of \( \beta_1 \); \( h_{2it} \) represents HDRS-17 at baseline at the participant level with a slope coefficient of \( \beta_2 \); \( u_i \) represents the random effect of therapist; and, \( e_{it} \) represents the residual error. \( \beta_0 + \beta_1 a_{1it} + \beta_2 h_{2it} \) is termed the fixed part of the model and \( u_i + e_{it} \) represents the random part of it. The fixed part of the model specifies the overall mean association between HDRS-17 at the end of treatment, and the variables average adherence and HDRS-17 at baseline. Therefore, the fixed part of the model represents the association between the fixed variables and outcome that occurs in the average therapist. Conversely, the random part of the model represents how the specific relationship between individual therapists and outcome, differ from the mean relationship.

However, this model only considered a two-level hierarchy, where the data undoubtedly belongs to a three level structure composed by sessions nested in participants, and participants nested in therapists. Leckie (2013) has suggested that naively fitting three-level data into two-level models leads to misattribute the variation to the two included levels. Therefore, a three-level model (Model 2) was considered to study the association between adherence and treatment outcome, which was specified as:

\[ y_{jit} = \beta_0 + \beta_1 a_{1jit} + \beta_2 a_{2it} + \beta_3 a_{3t} + \beta_4 \chi + v_t + u_{it} + e_{jit} \]

\[ v_t \sim N (0, \sigma^2 v) \]
\[ u_{it} \sim N (0, \sigma^2 u) \]
\[ e_{jit} \sim N (0, \sigma^2 e) \]
where, \( y_{jit} \) represents HDRS-17 scores throughout treatment for session \( j \), participant \( i \), and therapist \( t \); \( a1jit \) represents adherence at the session level with a slope coefficient of \( \beta_1 \); \( a2it \) represents adherence at the participant level with a slope coefficient \( \beta_2 \); \( a3t \) represents adherence at the therapist level with a slope coefficient \( \beta_3 \); and, \( \chi \) represents time with a slope coefficient of \( \beta_4 \). The random effects of therapist, participant and residual errors are assumed independent of the three predictor variables. In this model \( \sigma^2 v \) represents the between-therapist variance, and \( \sigma^2 u \) represents the within-therapist variance after adjusting for the predictor variables (Leckie, 2013)

Furthermore, the association between adherence and outcome was studied taking into account the hypothesis mentioned above regarding a quadratic relation between adherence and outcome (Barber et al., 2006) within a three-level model. This model’s predictors included, in addition to the second model’s predictors, the square of adherence at the level of the session, participant and therapist. This model (Model 3) was specified as:

\[
y_{jit} = \beta_0 + \beta_1 a1jit + \beta_2 a2it + \beta_3 a3t + \beta_4 a1jit \times a1jit + \beta_5 a2it \times a2it \\
+ \beta_6 a3t \times a3t + \beta_7 \chi + vt + uit + e_{jit}
\]

where \( a1jit \times a1jit \) represents the square of adherence at the session level with a slope coefficient of \( \beta_4 \); \( a2it \times a2it \) represents the square of adherence at the participant level with a slope coefficient of \( \beta_5 \); and \( a3t \times a3t \) represents the square of adherence at the therapist level with a slope coefficient of \( \beta_6 \). In this model participant and therapist were treated as random effects.

The study of the association between competence and outcome included three models, analogous to the ones used to assess the relation between adherence and outcome. The development of the models followed the same rationale employed for the design of the models to study the effect of adherence on outcome. Therefore, the first and simpler model designed to study the relationship between competence and outcome consisted of a two-level model that included the participant patients at level 1 and the therapists at level 2. This model included a variable that represented competence at the
patient level (average of competence), and another variable that represented the baseline level of symptomatology at the patient level. Additionally, in this model therapists were treated as a random effect. Following Steele (2008), this model (Model 4) was specified as:

\[ y_{it} = \beta_0 + \beta_1 c_{1it} + \beta_2 h_{2it} + u_i + e_{it} \]

where, \( y_{it} \) represents HDRS-17 at the end of treatment for participant \( i \) and therapist \( t \); \( c_{1it} \) represents competence at the patient level with a slope coefficient of \( \beta_1 \); \( h_{2it} \) represents HDRS-17 at baseline at the participant level with a slope coefficient of \( \beta_2 \); \( u_i \) represents the random effect of therapist; and, \( e_{it} \) represents the residual error. \( \beta_0 + \beta_1 c_{1it} + \beta_2 h_{2i} \) is termed the fixed part of the model and \( u_i + e_{it} \) represents the random part of it.

Considering that the data structure was intrinsically organised in a three-level hierarchy, the relation between competence and outcome was studied in a model that included three levels. Following Leckie (2013), this model (Model 5) was specified as:

\[ y_{jit} = \beta_0 + \beta_1 c_{1jit} + \beta_2 c_{2it} + \beta_3 c_{3t} + \beta_4 \chi + v_t + u_{it} + e_{jit} \]

\[ v_t \sim N (0, \sigma^2 v) \]
\[ u_{it} \sim N (0, \sigma^2 u) \]
\[ e_{jit} \sim N (0, \sigma^2 e) \]

where, \( y_{jit} \) represents HDRS-17 scores throughout treatment for session \( j \), participant \( i \), and therapist \( t \); \( c_{1jit} \) represents competence at the session level with a slope coefficient of \( \beta_1 \); \( c_{2it} \) represents competence at the participant level with a slope coefficient \( \beta_2 \); \( c_{3t} \) represents competence at the therapist level with a slope coefficient \( \beta_3 \); and, \( \chi \) represents time with a slope coefficient of \( \beta_4 \). The random effects of therapist, participant and residual errors are assumed independent of the three predictor variables. In this model \( \sigma^2 v \)
represents the between-therapist variance, and $\sigma^2 u$ represents the within-therapist variance after adjusting for the predictor variables (Leckie, 2013).

The third model considered to study the relation between competence and outcome took into account the suggestion made by Barber et al. (2007) that indicated that competence might have a quadratic relation with treatment outcome. The predictors of this three-level model included, in addition to the previous model’s predictors, the square of competence at the level of the session, participant and therapist. Therefore, this model (Model 6) was specified as:

$$y_{jit} = \beta 0 + \beta 1c1jit + \beta 2c2it + \beta 3c3t + \beta 4c1jitXc1jit + \beta 5c2itXc2it + \beta 6c3tXc3t + \beta 7X + vt + uit + ejit$$

where $c1jitXc1jit$ represents the square of competence at the session level with a slope coefficient of $\beta 4$; $c2itXc2it$ represents the square of competence at the participant level with a slope coefficient of $\beta 5$; and $c3tXc3t$ represents the square of competence at the therapist level with a slope coefficient of $\beta 6$.

This study conducted two multiple imputation procedures to impute the missing data in both, the two-level as well the three-level models. In total, 20 HDRS-17 scores out of 68 scores (29.41%) were missing at the end of treatment in the data employed to conduct the two-level models. A Little’s test was conducted indicating that the data was not missing at random. Twenty imputations were conducted using the following independent variables in the imputation procedure: age, gender, competence (at participant and therapist level), and adherence (participant and therapist level). Additionally, in order to account for the nested structure of the data, the command included indicator variables for the clusters in the imputation model (Eddings & Marchenko, 2011). Therefore, therapist was included in the imputation model as an indicator variable for the cluster it represented.

In total, 37 HDRS-17 scores out of 204 scores (18.13%) were missing from different time-points (baseline, middle treatment, and end of treatment/3 time-points per patient) in the data employed to conduct the three-level models.
A Little’s test was conducted indicating that the data was not missing at random. Twenty imputations were carried out using the following independent variables in the imputation procedure: time, age, gender, competence (at session, participant and therapist level), and adherence (at session, participant and therapist level). Additionally, in order to account for the nested structure of the data, the command included indicator variables for the clusters in the imputation model (Eddings & Marchenko, 2011). Therefore, therapist and participant were included in the imputation model as indicator variables for the clusters they represented. All the analyses and multiple imputation were conducted using Stata 14.2.

A post hoc power analysis was conducted with MLPowSim applying the appropriate guidelines for hierarchical models (Browne, Lahi, & Parker, 2009). The estimates for the simpler three-level models of adherence and competence (Model 2 and 5) were calculated using the Z-score method for balanced data. However, considering that this study’s dataset was not balanced, power was estimated employing three number of time-points per therapist and participant. The power of Model 2 was 1 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 1, respectively. The power of Model 2 was 1 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 2, respectively. The power of Model 2 was 1 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 3, respectively. Additionally, power was calculated with different numbers of participants per therapist. The power of Model 2 was 0.87 when the number of therapists, patients by therapists and time-points per patient were 17, 1, and 3, respectively. The power of Model 2 was 0.99 when the number of therapists, patients by therapists and time-points per patient were 17, 4, and 3, respectively. The power of Model 2 was 1 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 3, respectively. Nevertheless, it is important to remark that when the number of therapists was reduced to 16, the model had virtually no power ($\beta=0.057$). The latter suggests that it is likely that the model had low power, which is difficult to estimate due to the hierarchical and unbalanced nature of the dataset.
The same post hoc power analysis was conducted for Model 5. The power of Model 5 was 0.045 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 1, respectively. The power of Model 5 was 0.046 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 2, respectively. The power of Model 5 was 0.043 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 3, respectively. Additionally, the power of Model 5 was 0.062 when the number of therapists, patients by therapists and time-points per patient were 17, 1, and 3, respectively. The power of Model 5 was 0.056 when the number of therapists, patients by therapists and time-points per patient were 17, 4, and 3, respectively. The power of Model 5 was 0.043 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 3, respectively. Possibly the latter estimates are more accurate calculations of the power of Model 5.

6.3 Results

6.3.1 Descriptive Statistics

For ratings that included all 3 time-points per participant, the mean adherence total score was 19.26, suggesting that most participants received high levels of treatment adherence (maximum total adherence score = 21). Likewise, the mean competence total score was 161.52, also suggesting that most participants received high levels of therapist competence (maximum total competence score = 216). At baseline, most participants had a HDRS-17 score that indicated a moderate to severe level of depression. At the end of treatment, most participants had a HDRS-17 score that indicated a mild level of depression (Table 6.3).
At the participant level, total adherence scores and total competence scores presented a non-normal distribution. Likewise, HDRS-17 scores at baseline and at the end of treatment had a non-normal distribution (Table 6.4).

Table 6.3
*Descriptive statistics of Fidelity and Outcome Measures*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence Total (3 sessions)</td>
<td>50</td>
<td>9</td>
<td>21</td>
<td>19.26</td>
<td>3.02</td>
<td>21</td>
</tr>
<tr>
<td>Competence Total (3 sessions)</td>
<td>50</td>
<td>86</td>
<td>195</td>
<td>161.52</td>
<td>28.94</td>
<td>172</td>
</tr>
<tr>
<td>HDRS-17 (baseline)</td>
<td>67</td>
<td>14</td>
<td>30</td>
<td>18.46</td>
<td>4.16</td>
<td>17</td>
</tr>
<tr>
<td>HDRS-17 (end of treatment)</td>
<td>55</td>
<td>0</td>
<td>27</td>
<td>10.43</td>
<td>6.60</td>
<td>8</td>
</tr>
</tbody>
</table>

6.3.2 Correlations and Collinearity Tests

The total adherence and competence scores, at the participant level, were highly and positively correlated. Additionally, these variables showed an average variance inflation factor greater than 1, suggesting the presence of multicollinearity (Field, 2013) between these variables (Table 6.5 and 6.6).
Table 6.5
Spearman’s rho Fidelity Measures

<table>
<thead>
<tr>
<th>Competence Average</th>
<th>Adherence Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.807</td>
</tr>
</tbody>
</table>

Table 6.6
Collinearity Diagnostics

<table>
<thead>
<tr>
<th>Variable</th>
<th>VIF</th>
<th>1/VIF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence (average participant)</td>
<td>4.15</td>
<td>0.24</td>
</tr>
<tr>
<td>Competence (average participant)</td>
<td>4.08</td>
<td>0.24</td>
</tr>
<tr>
<td>Hamilton baseline</td>
<td>1.05</td>
<td>0.94</td>
</tr>
</tbody>
</table>

Note. Regression dependent variable: HDRS-17 (end of treatment); regression predictors: HDRS-17 (baseline), average adherence per participant, average competence per patient.

6.3.3 Therapists’ Total Adherence and Competence Scores

At the therapist level, the adherence mean score was 6.42 points (adherence maximum score = 7 points; range displayed 4.61 - 7), indicating that most therapists demonstrated high levels of treatment adherence. Concurrently, at the therapist level, the mean competence score was 53.84 points (competence maximum score 72 points; range displayed 34.94 – 63.16), indicating that most therapists delivered interventions in the higher range of competence scores. Considering that therapist 14 only had one patient, who was only rated in 2 time-points instead of 3, no mean scores for adherence and competence are available for this specific therapist (Tables 6.7 and 6.8).
Table 6.7  
**Therapists’ Mean Adherence Scores**

<table>
<thead>
<tr>
<th>Therapist</th>
<th>N</th>
<th>Adherence Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>7.00</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>6.62</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>7.00</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>4.83</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>5.00</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>4.61</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>7.00</td>
</tr>
<tr>
<td>8</td>
<td>6</td>
<td>6.833</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>6.833</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td>7.00</td>
</tr>
<tr>
<td>11</td>
<td>4</td>
<td>6.50</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>7.00</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>6.66</td>
</tr>
<tr>
<td>15</td>
<td>5</td>
<td>6.86</td>
</tr>
<tr>
<td>16</td>
<td>1</td>
<td>6.00</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>7.00</td>
</tr>
</tbody>
</table>

Table 6.8  
**Therapists’ Mean Competence Scores**

<table>
<thead>
<tr>
<th>Therapist</th>
<th>N</th>
<th>Competence Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>63.16</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>51.79</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>60.50</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>42.00</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>43.00</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>34.94</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>54.33</td>
</tr>
<tr>
<td>8</td>
<td>6</td>
<td>57.16</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>57.50</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td>61.33</td>
</tr>
<tr>
<td>11</td>
<td>4</td>
<td>59.41</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>62.22</td>
</tr>
<tr>
<td>13</td>
<td>1</td>
<td>57.00</td>
</tr>
<tr>
<td>15</td>
<td>5</td>
<td>58.80</td>
</tr>
<tr>
<td>16</td>
<td>1</td>
<td>46.33</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>60.00</td>
</tr>
</tbody>
</table>
Figure 6.1 illustrates the findings mentioned above, indicating that most therapists displayed high levels of treatment adherence and competence.

![Figure 6.1. Mean scores for adherence and competence by therapist.](image)

6.3.4 Multilevel Models

As mentioned above, Model 1 (Table 6.9) included two levels (participants and therapists) and examined the fixed effects on outcome of adherence at the participant level, and HDRS-17 at baseline, as well as the random effect of therapist. It was found that adherence at the participant level had a positive and significant ($p = 0.024$) association with HDRS-17 scores at the end of treatment, indicating that higher levels of adherence brought about worse treatment outcomes. The HDRS-17 scores at baseline also had a positive and significant association with HDRS-17 scores at the end of treatment. The variance attributable to differences between therapists was minimal (ICC = 2%). Furthermore, it is noticeable that this two-level model did not provide a better fit than a single-level model (LR test vs linear model: $\chi^2(2) = 0.72$  Prob $>\chi^2 = 0.198$)
Model 2 (Table 6.10) examined the association between adherence and outcome in a three-level model. As mentioned above, this model included the fixed effects of time, and treatment adherence at the level of the session, participant, and therapist. Additionally, the random effects of participants and therapists were studied. In none of the levels was adherence significantly associated with HDRS-17 scores throughout treatment. In this model, only time was negatively and significantly associated with treatment outcome. Furthermore, the variance attributable to differences between therapists was minimal (ICC = 5.87e-20), while differences within-therapists accounted for most of the variance (ICC = 51%).
Considering the different variables included in Model 1 and Model 2, and the subsequent different number of observations between the models, it was not possible to conduct a Likelihood Ratio test in order to assess which model provided a better fit for the data.

Although no association was found between adherence at the session and at the participant level and outcome in Model 2, Figures 6.2 and 6.3 illustrate a very mild trend in which, higher levels of adherence are associated with worse clinical outcomes. However, it is not possible to make any
conclusions from these observations, particularly considering the broad standard errors found.

Figure 6.2 Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of adherence scores at the session level.

Figure 6.3. Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of adherence scores at the participant level.
Figure 6.4 illustrates the association between adherence scores at the therapist level and HDRS-17 throughout treatment, indicating a mild trend in which higher levels of adherence are associated with better treatment outcomes. However, it is not possible to make any conclusions from these observations, particularly considering the broad standard errors found.

*Figure 6.4. Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of adherence scores at the therapist level.*

As mentioned above, Model 3 (Table 6.11) explored the hypothesis indicated in the literature regarding a quadratic association between adherence and outcome. There were no significant associations between the squared adherence scores at any of the different levels and HDRS-17 scores throughout treatment. Furthermore, there were no significant associations between adherence scores at any of the levels and clinical outcome. Only time had a significant and negative association with HDRS-17 scores. The differences within-therapists explained 49% of the variance.
As mentioned above, Model 4 (Table 6.12) included two levels (participants and therapists) and it examined the fixed effects of competence at the participant level, and HDRS-17 at baseline, as well as the random effect of therapist. No significant associations were found between competence at the participant level and outcome. HDRS-17 scores at baseline had a positive and significant association with HDRS-17 scores at the end of treatment. The variance attributable to differences between therapists was minimal (ICC = 4%). Furthermore, it is noticeable that this two-level model did not provide a better fit than a single-level model (LR test vs linear model: $\chi^2(2) = 0.72$ Prob $>\chi^2 = 0.198$).

<table>
<thead>
<tr>
<th>Variable by session</th>
<th>Coefficient</th>
<th>SE</th>
<th>p</th>
<th>95% CI</th>
<th>ICC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence by participant</td>
<td>0.47</td>
<td>7.44</td>
<td>0.94</td>
<td>[-14.11, 15.06]</td>
<td></td>
</tr>
<tr>
<td>(Adherence by therapist)$^2$</td>
<td>-0.05</td>
<td>0.16</td>
<td>0.74</td>
<td>[-0.38, 0.27]</td>
<td></td>
</tr>
<tr>
<td>(Adherence by participant)$^2$</td>
<td>-0.006</td>
<td>0.68</td>
<td>0.99</td>
<td>[-1.35, 1.33]</td>
<td></td>
</tr>
<tr>
<td>(Adherence by therapist)$^2$</td>
<td>2.97</td>
<td>1.89</td>
<td>0.11</td>
<td>[-0.73, 6.69]</td>
<td></td>
</tr>
</tbody>
</table>

**Random Effects**

- Residual: 14.03 (2.14 [10.40, 18.92])
- Within: 13.94 (3.96 [7.98, 24.35])
- Therapists Between: 1.45e-16
- Therapists: 5.18e-18

*Note. SE = standard error; CI = confidence interval; ICC = intraclass correlation coefficient. LR test vs linear model: $\chi^2(2) = 27.78$ Prob $>\chi^2 = 0.000$*
Model 5 (Table 6.13) examined the association between competence and outcome in a three-level model. As mentioned above, this model included the fixed effects of time, and competence at the level of the session, participant, and therapist. Additionally, the random effects of participants and therapists were studied. In none of the levels was competence significantly associated with HDRS-17 scores throughout treatment. In this model, only time was negatively and significantly associated with treatment outcome. Furthermore, the variance attributable to differences between therapists was minimal (ICC = 2.60e-14), while differences within-therapists accounted for most of the variance (ICC = 52%).
Considering the different variables included in Model 4 and Model 5, and the subsequent different number of observations between the models, it was not possible to conduct a Likelihood Ratio test in order to assess which model provided a between fit for the data.

Although no association was found between competence at the session and at the therapist level and outcome, Figures 6.5 and 6.7 illustrate a very mild trend in which higher levels of competence are related to better clinical outcomes. Conversely, Figure 6.6 illustrates a very mild trend in which higher levels of competence is related to worse treatment outcomes. However, it is not possible to make any conclusions from these observations, particularly considering the broad standard errors found.

### Table 6.13

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>SE</th>
<th>p</th>
<th>95% CI</th>
<th>ICC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>24.97</td>
<td>4.14</td>
<td>0.00</td>
<td>[16.85, 33.10]</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>-4.00</td>
<td>0.42</td>
<td>0.00</td>
<td>[-4.82, -3.17]</td>
<td></td>
</tr>
<tr>
<td>Competence by session</td>
<td>-0.01</td>
<td>0.05</td>
<td>0.70</td>
<td>[-0.12, 0.08]</td>
<td></td>
</tr>
<tr>
<td>Competence by participant</td>
<td>0.07</td>
<td>0.16</td>
<td>0.66</td>
<td>[-0.25, 0.40]</td>
<td></td>
</tr>
<tr>
<td>Competence by therapist</td>
<td>-0.17</td>
<td>0.17</td>
<td>0.32</td>
<td>[-0.51, 0.16]</td>
<td></td>
</tr>
<tr>
<td>Random Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residual</td>
<td>14.16</td>
<td>2.16</td>
<td></td>
<td>[10.49, 19.10]</td>
<td></td>
</tr>
<tr>
<td>Within Therapists Between</td>
<td>15.87</td>
<td>4.37</td>
<td></td>
<td>[9.25, 27.23]</td>
<td>0.52</td>
</tr>
<tr>
<td>Therapists</td>
<td>7.92e-13</td>
<td></td>
<td></td>
<td></td>
<td>2.60e-14</td>
</tr>
</tbody>
</table>

Note: SE = standard error; CI = confidence interval; ICC = intraclass correlation coefficient. LR test vs linear model: chi²(2) = 31.58  Prob >chi² = 0.000
Figure 6.5 Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of competence scores at the session level.

Figure 6.6. Linear prediction of HDRS-17 scores throughout treatment according to the fixed effect of competence scores at the participant level.
As mentioned above, Model 6 (Table 6.14) explored the hypothesis indicated in the literature regarding a quadratic association between competence and outcome. There were no significant associations between the squared competence scores at any of the different levels and HDRS-17 throughout treatment. Furthermore, there were no significant associations between competence scores at any of the levels and clinical outcome. Only time had a significant and negative association with HDRS-17 scores. The differences within-therapists explained 51% of the variance.
6.4 Discussion

This study aimed to examine the relationship between treatment adherence and clinical outcomes, as well as therapist competence and clinical outcomes. However, no significant association was found between these variables, besides the positive and significant association between adherence at the participant level and outcome in Model 1 (two-level model). The latter
finding suggests that the higher the treatment adherence, the worse the clinical outcomes, reflecting a well-known notion in psychotherapy research in which slavish adherence to the treatment manual might interfere with therapeutic change (L. Castonguay et al., 1996). Barber et al. (2006) suggested that high levels of adherence might reflect a lack of flexibility on the part of the therapist to respond to the patient’s specific needs. Indeed, several studies have found that only moderate levels of treatment adherence are associated with patient improvement, contrarily to high and low levels of adherence (Barber et al., 2008; Butler et al., 1995). The latter has based the hypothesis regarding a non-linear relation between adherence and outcome, which addresses the intuition that too little adherence or too much adherence may result in poorer treatment outcomes, and perhaps be the cause of lack of progress in complex patients (Barber et al., 2006).

Furthermore, the finding of a positive and significant association between adherence at the participant level and outcome in Model 1, was examined in terms of the significant effect of time found in the 3-level models analysed. Considering that the effect of adherence in Model 1 faded in Model 2, when time was added as a variable, led the author to examine a possible interaction between adherence and time in the 2 and 3-level models reported. However, no significant interactions were found, suggesting that the positive and significant association between adherence at the participant level and outcome in Model 1 could not be accounted for in terms of the moderating effect of time.

It is important to notice that the positive and significant association between adherence at the participant level and outcome was only found in the two-level model studied, and not in the three-level model that explored the association between these variables (Model 2). Although, as mentioned above, it was not possible to conduct a Likelihood ratio test to examine which of these two models provided a better fit for the data, it is well-known that fitting data that belongs to a three-level structure into a two-level model might lead to erroneous conclusions regarding the variation attributable to the two included levels. Therefore, this may lead to misleading assumptions regarding the relative importance and significance of the different sources of variation in the data (Leckie, 2013). Thus, in this study, the results regarding the association
between adherence and outcome obtained in Model 1 should be analysed with caution, understanding that Model 2, -the three-level model-, conceptually provides a more accurate representation of the data and its structure.

As mentioned above, no significant association was found between adherence and outcome in Model 2 and 3; and no significant relation was found between therapist competence and outcome in the different models analysed. This is in line with C. Webb et al. (2010) meta-analysis of 36 studies, which found effect sizes, - in the adherence-outcome and competence-outcome relationships-, not significantly different from zero. This suggests that neither adherence nor competence are significant predictors of the patients’ clinical outcomes. A second meta-analysis (Zarafonitis-Müller, Kuhr, & Bechdolf, 2014) that studied the effect of adherence and competence in CBT on clinical outcomes, found a small but significant effect of competence on the patients’ clinical improvements ($r = 0.24$), but no significant effects of adherence on outcome. Although both meta-analyses support minimally the association between treatment fidelity and outcome, the second meta-analysis suggests that a competent delivery of therapy may contribute to clinical outcome, whereas the solely adherent implementation of therapy does not impact the patients’ improvement.

There are several issues that could explain the lack of association between adherence and outcome; and, between competence and outcome found in this study. Firstly, an important limitation of this study was the fact that the instruments employed to measure adherence and competence were newly developed for the purposes of the REDIT trial, without their psychometric properties, -reliability and validity-, having been properly examined beforehand. The validation of treatment integrity measures is essential in order to determine that the instruments are actually assessing adherence and competence. Thus, assuming that the treatment integrity scales include the characteristics of interest without providing supporting evidence, jeopardises the credibility of its results. Therefore, a separate assessment of the validity of adherence and competence measures is needed before investigating the association between treatment integrity and outcome (Perepletchikova & Kazdin, 2005).

The adherence measure employed in this study included 3 items unique to DIT treatment (items 1, 5 and 7); and four items essential but not unique to
DIT (items 2, 3, 4 and 6). Perepletchikova and Kazdin (2005) have suggested that measures of adherence should additionally encompass items that are compatible but neither unique nor essential to the treatment, as well as items that are proscribed by the specific treatment. Therefore, it could be suggested that the adherence measure did not represent appropriately the level of treatment adherence in DIT.

Similarly, Perepletchikova and Kazdin (2005) have suggested that more precise measures of competence should include an independent verification of how sensitively the treatment manual is delivered to specific patients. Thus, the competence measure should take into account the stage of therapy, as well as the patient difficulty which may have an effect on the therapist behaviour. Neither of these two elements were included in the DIT competence measure, which may have compromised the results found in this study.

Furthermore, this study used a measure of competence which predefined specific therapist attitudes, behaviours and skills, and did not account for the necessary flexibility intrinsic to the construct of therapist competence. The latter could have hindered an appropriate assessment of therapist competence. Operationalising and measuring competence is a complex task considering, -as mentioned above-, that this construct should include the concept of therapist responsiveness, which refers to the notion that therapists adapt their intervention to the unfolding context of the session, patient’s characteristics and behaviours. Therapists do not deliver predetermined levels of an intervention. Instead, therapists intervene in a responsive way, according to the emerging events in therapy (C. A. Webb et al., 2012). Thus, an accurate operationalisation of competence should not predefine specific therapist attitudes and behaviours.

Moreover, the two measures used to examine treatment integrity were highly correlated suggesting either that, the instruments did not correctly operationalise adherence separately from competence, and/or that there is a real overlap between both treatment fidelity constructs. Indeed, there is an inherent difficulty in disentangling these two conceptualisations, considering that a competent implementation is impossible without adherence to the treatment manual; and that, adherence alone is insufficient to ensure a competent delivery (Perepletchikova et al., 2007). However, Barber et al.
(2007) have emphasised the importance of developing measures of competence that distinguish this conceptualisation from the notion of adherence. They stress that the concepts of adherence and competence are conceptually distinct and failing to fully separate them out may obfuscate any association between competence and outcome.

Furthermore, another limitation that could have influenced the high correlation between adherence and competence, is that in this study these variables were rated only by one judge, which could have biased the ratings. Moreover, the high correlation between adherence and competence could have resulted from the fact that the same judge assessed the same participant and the same therapist in more than one opportunity, which indicates that the sample of rated sessions was not independent. Nevertheless, it is not possible to discard that the instruments used to examine adherence and competence did not operationalise these concepts correctly. Therefore, more research on the validity of the results should be conducted.

Special attention should be granted to the specific findings that no association was found between adherence and outcome; nor, between the square of adherence scores and outcome. As mentioned above Barber et al. (2006) had suggested a quadratic relationship between adherence and outcome; in that low and high levels of treatment adherence predict worse clinical outcomes than a moderately adherent therapist. However, there is little consensus regarding what constitutes a suboptimal vs a sufficient degree of treatment adherence necessary to have an effect on the desired clinical outcomes (Haug et al., 2016). Nevertheless, in this study neither a linear nor a non-linear relation was found between adherence and outcome. Possibly, this finding could be a result of the narrow range of adherence scores displayed in this study at the session, participant and therapist level. As in other RCTs, the REDIT therapists were selected, trained, and monitored to high levels of adherence, which affected the variability of adherence scores, restricting them to the higher range. The small variability in adherence scores may have hindered the evaluation of the relationship between adherence and outcome. Future studies examining a wider range of adherence scores and outcome may help clarify the relationship between these two variables.
Likewise, no association was found between competence and outcome; nor between the square of competence scores and outcome. Although competence scores were more broadly distributed than the adherence ratings, competence scores still were confined to the higher range of possible ratings. Therefore, it may also be possible that the lack of association between competence and outcome was a result of the small variability in the scores, which may have hampered the study of the relation between these variables (Barber et al., 2007).

In this study, a relevant limitation that could have obscured the association between treatment fidelity and outcome is the presence of third variable effects that were not considered in the analyses, such as patient’s characteristics (e.g., symptom severity, motivation to change), or relationship factors (e.g., therapeutic alliance). These effects may be related to both fidelity and outcome, and thereby indirectly account for the observed results. It is likely that other psychotherapy-process variables may moderate the association between adherence, competence, and clinical outcomes. C. Webb et al. (2010) indicated that the therapeutic alliance could moderate the relationship between treatment fidelity and outcome. Similarly, Weck, Grikscheit, Jakob, Höfling, and Stangier (2015) found a moderating effect of alliance on the relation of adherence and outcome, suggesting that the better the therapeutic alliance, the stronger the impact of adherence on clinical outcomes. Furthermore, they found that alliance mediated the association between competence and outcome. There are several sources of variability that may affect treatment integrity. Future research should focus on identifying and studying these factors.

Nevertheless, this study does not allow us to discard the hypothesis that neither adherence nor competence are related to treatment outcome. This hypothesis is in line with Huppert et al. (2001) who examined the relationship between treatment integrity and outcome in adults with panic disorder. It was found that therapists with above and below average outcomes had similar measures of therapist competence and adherence, suggesting the possibility that technique in itself is not the only important factor related to outcome. However, the finding may have also resulted from a possible ceiling effect for adherence and competence on outcome, indicating that there might be a level
of these variables above which, there is no further impact on patient improvement (Huppert et al., 2001; Levy, 2016).

In addition to the limitations mentioned above, this study had several other weaknesses. Firstly, only a sample of sessions of the full data-set was rated in order to increase the feasibility of the study. However, this significantly reduced the sample size at every level of analysis, therefore decreasing the overall power of the study. Additionally, the data had an unbalanced structure, considering that therapists treated different number of participants, that participants attended different number of sessions, and that different number of sessions were rated per participant. The latter may have also reduced the power of the study, decreasing the possibility of finding an effect of treatment integrity on outcome. Another important limitation is that only one judge coded all the sessions. Moreover, the same judge assessed the same participant and the same therapist in more than one opportunity. Therefore, although inter-rater reliability was initially assessed, the fact that the remaining portion of sessions were only rated by one judge may have biased the ratings. Furthermore, the same judge rated concurrently every session for adherence and competence, which may have biased the results of both scales, making their scores not independent. An additional limitation of this study is that it did not control for therapist and patient characteristics known to interfere with the effect of integrity on outcome, such as therapist motivation and patient complexity (Perepletchikova & Kazdin, 2005). Moreover, the fact that the study of treatment integrity was conducted within an RCT in which both, therapists and patients, are highly selected and therefore not representative of the real-world population of therapists and patients, limits the generalizability of the results. Finally, an additional limitation of this study was attempting to fit a linear model to an ordinal variable, such as adherence. However, the findings of these analyses were replicated when examining adherence as a binary variable in the 3-level models studied, suggesting that the results of this study were not due to the unevenness of the adherence measure.

In conclusion, in this study several conceptual and methodological factors limited an appropriate investigation of the associations between adherence, competence and treatment outcome. Understanding these conceptual and methodological limitations, which are representative of the
challenges of customary treatment integrity studies-, laid the groundwork for
the following studies of this dissertation. Therefore, the following chapters will
attempt to address these limitations by following several steps. Firstly, an
empirically-based operationalisation of therapist competence will be developed
in order to assemble an instrument that will aim to assess therapist competence
rigorously and comprehensively. Furthermore, this measure will attempt to
account for therapist responsiveness and to disentangle the construct of
competence from the notion of adherence. Subsequently, the psychometric
characteristics of this measure will be investigated. Following the studies for
the preliminary validation of the measure, the relationship between therapist
and outcome will be explored through the employment of this new measure.
Additionally, the study of competence proposed will take into consideration the
effect of third variables, such as patient complexity, in the study of the
association between therapist competence and outcome. Only by accurately
and appropriately operationalising therapist competence, and by studying its
relationship to outcome in an adequate statistical model, it will be possible to
understand the effect of therapist competence on patient improvement.
Chapter 7: Development of the Therapist Competence Scale (TCS)

7.1 Introduction

The aim of this study was to develop an empirically-based operationalisation of therapist competence in order to assemble a valid and reliable instrument that would assess psychodynamic therapist skill rigorously and comprehensively.

Hitherto, the gold standard to assess therapist competence in psychodynamic psychotherapy has been rating therapists’ in session performance using scales that operationalise the behaviours involved in the competent delivery of therapy. However, it has been claimed that there is a need for further refinement of the observation-based instruments that measure competence in order to make them more reliable and valid in the measurement of therapist skill (Barber et al., 2007; Muse, McManus, Rakovshik, & Thwaites, 2017).

In order to develop an operationalisation and measure of competence with improved validity and reliability, this study employed qualitative methods as means to inform the process of item generation. It has been proposed that by conducting qualitative interviews prior to scale development, key information from relevant participants (e.g., expert clinicians) can enrich the quality of the research (Padgett, 2016; Weiss, 1995). Indeed, Padgett (2016) describes a multimethod combination in which an initial qualitative study is used to explore concepts and to identify hypotheses that later inform the development of the quantitative rating scale. In essence, grounding scale development in real life observations is particularly useful to improve the validity of the items and the inquires of quantitative research. In addition, by describing where the items were first located and how they were formed, provides important insight that reveals the theoretical viewpoints and assumptions of the authors of those items, highlighting what knowledge or expertise they privileged as well as the domains that were omitted. Additionally, revealing the processes by which scale items were first located and then edited, grounds those items in context, adding to the confidence placed in the instrument (Rowan & Wulff, 2007).
Scale development has been informed by qualitative methodology in several psychotherapy research studies (Bearss et al., 2016; Rowan & Wulff, 2007). Nevertheless, this approach has not been previously employed in item development for therapist competence rating scales. Studies that have developed measures of therapist competence have based their item generation on relevant treatment manuals and research literature, as well as on previously developed rating scales (Kohrt et al., 2015; Muse et al., 2017; Nuro et al., 2005; Reiser, Cliffe, & Milne, 2018). It is possible that the little attention given to item generation may have hampered the validity and reliability of the operationalisation of competence in these instruments. Considering that in scale development the primary goal is that the measures’ items will represent the best possible desirable questions, this study employed qualitative methodology in order to ensure that expert clinicians’ understanding of therapist competence were captured by the instrument.

In the next sections, the steps that have been followed to develop the TCS will be described.

7.2 Methodology

The TCS intends to provide a clinically relevant account of the competencies and incompetencies displayed by a therapist, taking into consideration the complexity displayed by a specific patient in a DIT session. In order to develop the TCS, semi-structured interviews to DIT expert clinicians were analysed using qualitative methodology so as to operationalise their understanding, viewpoints and experiences regarding therapist competence in practice, within the framework of competence for DIT (Lemma et al., 2008). Due to the exploratory nature of the research question, and the aim of acquiring a rich and complex understanding of therapist competence, thematic analysis -a flexible qualitative methodology not subjected to theoretical constrictions- was employed.

Thematic analysis is a method that aims to identify, analyse and report themes/patterns within data (Boyatzis, 1998). Thematic analysis involves searching repeated patterns of meaning across the dataset in a recursive
fashion, constantly moving backwards and forward between the dataset, the
coded extracts of data, and the analysis of the data. Among the different
qualitative approaches, thematic analysis has the advantage of being
essentially independent of theory and thus can be applied across a range of
epistemological approaches, and as expected it is compatible with
constructionist and essentialist psychology paradigms (Potter & Wetherell,
1987; Vivien, 1995). Therefore, thematic analysis is a flexible research tool, not
subscribed to any theoretical commitments, which can provide a complex,
detailed and rich account of the data (Braun & Clarke, 2006).

There are several questions a researcher needs to answer before
undertaking thematic analysis. Thematic analysis can have either a
realist/essentialist approach or a constructionist one. An essentialist approach
refers to the report of experiences, meanings and the reality of participants. On
the other hand, a constructionist approach examines the ways in which
realities, experiences, and events are the outcomes of a range of discourses
that operate within society (Braun & Clarke, 2006). In the current study, the
researcher chose to undertake a thematic analysis with a realist/essentialist
approach considering that the objective of the study was the operationalisation
of therapist competence in DIT, rather than understanding the socio-cultural
context and conditions that affect the expert clinician discourse on competence.

A second decision that needs to be made before embarking a thematic
analysis is to determine what will constitute a theme at the moment of analysing
the dataset. A theme is defined as an important matter in the dataset that
pertains to the research question and that represents a patterned meaning or
response (Braun & Clarke, 2006). A specific meaning or response may
constitute a theme when it appears a number of instances across the dataset.
However, more instances do not necessarily mean that the theme in itself is
more important. In the current study, the author decided that the keyness of a
theme would not necessarily depend on quantifiable measures, instead it would
depend on whether it captured something important in order to operationalise
therapist competence in DIT.

Considering that the dataset was obtained through a semi-structured
interview that asked for several relevant issues regarding therapist
competence, it was decided to conduct a rich thematic description of the entire
dataset. Therefore, in order to get a sense of the predominant and important themes that would help operationalise therapist competence, the overall dataset was analysed rather than only concentrating on a specific theme.

In addition, it was decided that the analysis would be a “theoretical” one rather than an inductive thematic analysis. A “theoretical” thematic analysis is driven by the researcher’s theoretical interest in the area and is thus more explicitly driven by predefined concepts. This is in opposition to an inductive or “bottom-up” thematic analysis (Braun & Clarke, 2006). Considering the theoretical background regarding therapist competence in DIT given by the framework of competences (Lemma et al., 2008), it only seemed appropriate to guide the identification and coding of the dataset in accordance to it. Hence, the DIT competences framework (Lemma et al., 2008) provided a blueprint to guide the exploratory nature of the current research.

Finally, it was decided that the thematic analysis would revolve around a semantic/ explicit level instead of at a latent/interpretative level (Boyatzis, 1998). A semantic approach identifies themes from the explicit meanings of the data. In this case, the analysis involves a progression from description, where the data is organised in patterns of semantic content, to interpretation, where there is an attempt to theorise on the broader significance of the patterns’ meanings and implications. In opposition, a “latent” thematic analysis goes beyond the level of semantic content to identify the underlying assumptions that shape the semantic content of the data (Braun & Clarke, 2006). Considering the difficulties of operationalising therapist competence in brief psychodynamic psychotherapy and in order to avoid a premature foreclosure of the concept (Barber et al., 2007), it appeared pertinent to explore the concept from a semantic level.

The thematic analysis aimed to answer the following research questions: (1) How do expert clinicians define therapist competence?; (2) What do expert clinicians consider to be the core or essential elements of therapist competence?; (3) How do expert clinicians conceptualise the competencies proposed by the Framework of Competence in Psychodynamic/ Psychoanalytic therapy and DIT (Lemma et al., 2008)?; (4) What attitudes and/or behaviours constitute the observable or objective aspects of therapist competence?; (5)
What are the specific competencies that a DIT therapist should demonstrate?; and, (6) What is an incompetent attitude or behaviour in a therapist?

7.2.1 Semi-structured Interview Development

A semi-structured interview was specifically designed to examine therapist competence in DIT. The interview questions were formulated based on the psychodynamic/psychoanalytic and DIT frameworks of competence (Lemma et al., 2008). Initially, 162 questions were derived from these frameworks, which were reviewed with Professor Peter Fonagy. The redundant questions were removed, as well as the ones that would provide answers that would not allow to objectively operationalise competence. After this first review the semi-structured interview included 21 questions, 7 of which explored general aspects of therapist competence, and 14 that referred to specific competencies. This second version of the interview was piloted with 2 PhD students to explore how the questions would work in practice. Following the two pilot interviews, 4 questions of the semi-structured interview were removed due to their confusing wording and redundancy. These questions were: (1) Thinking about the therapeutic stance in DIT, could you give an example?; (2) In observing a DIT session, what characteristics or behaviours of the therapist would inform you that he/she is competently arriving at an accurate IPAF collaboratively with the patient?; (3) What are the most common pitfalls of a DIT therapist?; and (4) How does a competent therapist maintain an analytic attitude while working with the premises of a brief psychodynamic psychotherapy?

The final version of the semi-structured interview included 17 open-ended questions (Table 7.1). The first seven questions explored general aspects of therapist competence in psychodynamic psychotherapy. The other ten questions enquired about specific DIT competencies.

7 See Appendix G.
8 See Appendix H.
9 See Appendix I.
The 12 interviews were conducted following a semi-structured format, allowing the researcher to reply to participants’ responses, developing and elaborating emerging themes together, as appropriate. Therefore, the questions only provided a guide to the interview, which developed beyond them according to the participants answers and the direction of the conversation.

At the end of each semi-structured interview, participants were invited to reflect on the research and on their experience of thinking about therapist competence.
### Table 7.1

**Semi-structured Interview Questions**

<table>
<thead>
<tr>
<th>Competence: General Questions</th>
<th>Competence: Specific Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you understand competence in a psychotherapist?</td>
<td>In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is engaging the patient?</td>
</tr>
<tr>
<td>Thinking from your clinical experience, what do you think are the essential components of therapist competence?</td>
<td>In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is contributing to the creation and maintenance of the Therapeutic Alliance?</td>
</tr>
<tr>
<td>In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is being a competent psychotherapist?</td>
<td>In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she accurately understands the patient?</td>
</tr>
<tr>
<td>Thinking clinically of therapist competence, could you give an example?</td>
<td>How would a competent therapist deal with the emotional content of the session? How does a competent therapist arrive into an analytic/dynamic formulation?</td>
</tr>
<tr>
<td>What do you think are the key qualities a therapist should develop in order to provide DIT?</td>
<td>How does the competent therapist facilitate, listen and respond to the patient’s unconscious communications? How does the therapist competently help the patient become aware of the feelings and the defences mobilised in an interpersonal relationship?</td>
</tr>
<tr>
<td>What do you understand as an incompetent psychotherapist?</td>
<td>What differentiates a competent from an incompetent therapist in the process of arriving and making an interpretation? In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is competently understanding and using the transference?</td>
</tr>
<tr>
<td>Could you give an example of an incompetent psychotherapist?</td>
<td>How does a competent therapist recognize and work competently with the defences?</td>
</tr>
</tbody>
</table>

### 7.2.2 Data Collection

An email invitation to participate in a semi-structured interview regarding therapist competence in DIT, was sent out to 41 DIT approved supervisors. Information regarding the purpose of the study, the names of the responsible investigators, as well as the possibility of receiving a final copy of the results,
was included in the invitation. Twelve expert clinicians replied indicating their interest in participating in the interview.

Before the beginning of each semi-structured interview, the researcher informed the participant of the main aims of the study and provided a written summary of them through an information sheet\(^\text{10}\). Additionally, the researcher emphasised the voluntary nature of the participant’s collaboration, explained that all information would be treated confidentially, and informed the participant that the interviews would be audio-recorded. If the participant agreed to participate, he/she signed an informed consent\(^\text{11}\). No financial compensation was offered to those who chose to participate in the interview.

Following UCL research ethical guidelines, it was confirmed that no ethical approval was required to conduct the interviews considering that participants were not defined as vulnerable, and that the participation in the interviews would not induce undue anxiety or psychological stress (UCL Research Ethics, 2018).

The semi-structured interviews lasted between 60 and 90 minutes and took place at the participant’s workplace.

Verbatim transcriptions of the audio-recorded sessions were carried out by an external agency. The data-set consisted of 131,355 words that were analysed using NVivo Software 11.0 for Mac.

7.2.3 Participants

A purposive sampling technique was used in order to include expert DIT clinicians in the study. It was pre-defined that an "expert" clinician would be one with a supervisor level of practice in DIT. The supervisor level of practice in DIT involves: (1) completing a five day full time training course and passing the final role playing; (2) delivering DIT to two patients under weekly supervision; (3) supervisor’s positive assessment of the therapist’s session tapes and clinical case essay in order to achieve the DIT Practitioner accreditation; (4)

\(^{10}\) See Appendix J.

\(^{11}\) See Appendix K.
completion of two further supervised cases; (5) two years' experience as a psychodynamic supervisor of psychodynamic practice; (6) a reference from a line manager about the supervisory capability of the candidate; (7) a recommendation from the candidate’s original DIT supervisor; (8) six months of working as a DIT supervisor of at least three DIT cases, with monthly consultations on the supervision from an approved DIT supervisor, followed by a recommendation from this supervisor; and (9) attendance at a half-day CPD workshop on DIT, which may involve assessment of a supervisor’s recorded supervision work or assessment of a supervisor’s feedback on a trainee’s work.

In total 12 clinicians participated in the interview, of which 9 (75%) were women. Ten of the 12 participants provided further demographical data. The mean age was 54.37 years (SD=6.25), ranging from 46 to 64 years. The mean number of years working with the DIT model was 7 years (SD= 1.19), ranging from 5 to 8 years. Five participants had a Master’s degree, while 3 participants had a PhD as the highest level of qualification.

7.2.4 Generating Nodes and Searching for Themes

Initially, the entire dataset was read several times in order to get an overview of its content. Nodes were identified as “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p.63). Each basic idea given in response to the interview was coded using its semantic content, so that all responses capturing a similar content and wording would be identified within the dataset. Responses to the interview that included several semantic contents were given multiple nodes. The nodes were identified and then matched with data extracts that demonstrated that node. All the meaningful basic segments of information were coded and then combined together within each node (Braun & Clarke, 2006). After the majority of the transcripts had been analysed, the nodes did not keep expanding in number or depth. Thus, it was considered that the codes had reached the level of saturation (Morse, 1995).

Subsequently, once all the data was coded, the nodes were sorted into “themes”, a broader level of categorisation. Essentially, by analysing the nodes
it was considered how they might combine together to form an overarching theme. The themes were generated in an iterative process by testing the content of the group of nodes against the content of the dataset several times by returning to the data and reformulating the themes.

Considering that the purpose of the study was to capture in detail what constitutes a competent attitude or behaviour, themes were categorised into “core themes” that allowed to achieve a greater degree of characterization. Therefore, the dataset was reorganised in a hierarchical way, going from the upper level of core themes, to the medium level of themes, to the level of nodes, the most basic unit of qualitative content.

Once the candidate themes and core themes were devised, the categories were refined and reviewed. The aim was for the data within themes to cohere together meaningfully. It became evident that some themes did not have enough data to support them, others were collapsed together into one theme, while several others were broken down into separate themes. Additionally, themes and core themes were renamed in order for them to convey a clearer meaning.

Finally, the validity of each theme in relation to the overall dataset was considered. It was noticed that there were themes and core themes that appeared to be redundant. However, on a closer examination it became evident that these themes were answers to similar but not identical research questions, and therefore removing them from the hierarchy would have meant to lose relevant data. In order to solve this difficulty, the core themes were categorised into 6 groups according to specific aspects of competence and incompetence that the study aimed to operationalise. The six groups into which the core themes were organised were: (1) Definitions of Competence; (2) Competence within the theoretical background of the “Framework of Competence for Psychodynamic/Psychoanalytic Therapy and DIT”; (3) Core Competencies; (4) Observable aspects of competence; (5) Competence in DIT; and, (6) Incompetence.
7.3 Results

The results of the thematic analysis were organized into 6 groups defined by the research questions. The “Competence Definitions” group contains 17 themes (Table 7.2). The “Core Competencies” group includes 8 themes and 66 nodes (Table 7.3). The “Framework of Competencies” group comprises 18 core themes, 36 themes and 128 nodes (Table 7.4). The “Observable Competence” group contains 17 themes (Table 7.5). The “Competence in DIT” group includes 14 themes and 27 nodes (Table 7.6). The “Incompetence” group encompasses 6 themes and 47 nodes (Table 7.7). Overall, the thematic analysis revealed 18 core themes, 128 themes, and 268 nodes. Due to the large number of codes, a selection of the most relevant themes will be presented below\textsuperscript{12}.

\textbf{Figure 7.1. Six-group classification of the core themes.}

\textsuperscript{12} See Appendix L for the complete version of the thematic analysis.
Table 7.2
**Competence Definitions group**

<table>
<thead>
<tr>
<th>Competence Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ability to Quickly Make Links and Deliver Interpretations</td>
</tr>
<tr>
<td>• Art and Science</td>
</tr>
<tr>
<td>• Clinical Judgment</td>
</tr>
<tr>
<td>• Competence Equals Positive Outcome</td>
</tr>
<tr>
<td>• Competence vs Fidelity vs Outcome</td>
</tr>
<tr>
<td>• Delivering Individualised Interventions</td>
</tr>
<tr>
<td>• Difference Between Competence and Outcome</td>
</tr>
<tr>
<td>• Formal vs Innate Competence</td>
</tr>
<tr>
<td>• Generic Attributes</td>
</tr>
<tr>
<td>• Having an Innate Understanding of Transference</td>
</tr>
<tr>
<td>• Knowledge, Skill, Training and Experience</td>
</tr>
<tr>
<td>• Model to Understand</td>
</tr>
<tr>
<td>• Skills derived from Theory</td>
</tr>
<tr>
<td>• Strong Sense of Understanding</td>
</tr>
<tr>
<td>• Specific Attributes</td>
</tr>
<tr>
<td>• Therapist Own Therapy</td>
</tr>
<tr>
<td>• Using Theory Creatively</td>
</tr>
</tbody>
</table>

Table 7.3
**Core Competencies group**

<table>
<thead>
<tr>
<th>Core Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Analytic Attitude</td>
</tr>
<tr>
<td>• Attentive to Unconscious Communications</td>
</tr>
<tr>
<td>• Attunement</td>
</tr>
<tr>
<td>• Analytic Attitude</td>
</tr>
<tr>
<td>• Displaying Uncertainty</td>
</tr>
<tr>
<td>• Insight</td>
</tr>
<tr>
<td>• Non-Judgmental Stance</td>
</tr>
<tr>
<td>• Promoting the Patient’s Interest in Their Own Mind</td>
</tr>
<tr>
<td>• Balances, Adaptations, When and When Not, Timing</td>
</tr>
<tr>
<td>• Ability to Prudently Share the Transference/Countertransference</td>
</tr>
<tr>
<td>• Adapting Techniques to the Patient’s Character Structure</td>
</tr>
<tr>
<td>• Adapting Interventions to the Current Therapeutic Relationship</td>
</tr>
<tr>
<td>• Balance Between Being Active and Allowing for Silences</td>
</tr>
<tr>
<td>• Flexibility</td>
</tr>
<tr>
<td>• Interventions According to the Patient’s Trajectory in the Therapy</td>
</tr>
<tr>
<td>• Interventions Appropriate to Phase of Therapy</td>
</tr>
<tr>
<td>• Knowing When and When Not to Take Action</td>
</tr>
<tr>
<td>• Knowing When and When Not to Intervene</td>
</tr>
<tr>
<td>• Taking Distance to Observe</td>
</tr>
<tr>
<td>• Timing</td>
</tr>
<tr>
<td>• Keeping the Patient in Mind, Prioritising Their Interests, and Treating Them as Agents</td>
</tr>
<tr>
<td>• Acknowledging the Patient’s Sense of Agency</td>
</tr>
</tbody>
</table>
• Ethical Practice
  • Giving the Patient a Constructive View of Themselves
  • Having the Patient in Mind
  • No Agenda
  • Prioritising the Patient’s Interests
  • Promoting the Patient’s Independence

• Occupy Therapist Role
  • Acknowledge the Asymmetry of the Therapeutic Relationship
  • Confidence to Try Things Out in the Session
  • Occupy the Role of a Therapist

• Techniques and Skills
  • Assessment
  • Assess the Patient’s Suitability for Psychodynamic Psychotherapy
  • Engaging the Patient with Therapy
  • Enjoy the Work as a Psychotherapist
  • Formulation
  • Frame and Boundaries
  • Interpretation
  • Generic Skills
  • Managing the Patient’s Expectations of Therapy
  • Mentalizing
  • Short, Clear and Economical Interventions
  • Use of Humour
  • Work Through the End of Therapy

• Therapeutic Relationship and Alliance
  • Alliance: Goals and Tasks
  • Developing a Normal Human Relationship with Boundaries
  • Environment of Safety
  • Fostering a Relationship that Allows Challenge
  • Fostering Trust
  • Showing Interest, Empathy, and Attention

• Therapist Self-Awareness, Self-Regulation, Capacity to Think
  • Being Able to Use Supervision
  • Capacity to Understand Creatively
  • Capacity to Think
  • Continuous Learning
  • Differentiate Transference From Own Blindspots
  • Humility
  • Knowing Own Blindspots
  • Manage Uncertainty
  • Therapist Foundations
  • Therapist Own Therapy
  • Therapist Self-Regulation
  • Using Self-Awareness to Understand the Patient

• Understanding and Intervening at Multiple Levels
  • Capacity to Intervene at Multiple Levels
  • Delivering a Genuine Acknowledgment of the Causes Behind Patient’s Difficulties Causes “Click” (i.e., sudden understanding)
• Understand Personal Dynamics and Object Relations in Practice
• Understanding and Using the Here and Now of the session
• Understanding and the Implications of It
• Understanding and its Implications, followed by an Appropriate Intervention

Table 7.4

Framework of Competencies group

Framework of Competencies

• Accurately Understanding the Patient
  o Patient’s Reactions as Signs of Being Accurately Understood
    ▪ Judge by Patient’s Reactions to Therapist
    ▪ Patient Change of Behaviour, Thought Process, or Emotions
    ▪ Patient Elaborates Further
    ▪ Patient’s Reactions When Feels Not Understood
    ▪ Patient Owns the Therapist Idea
  o Therapist Attitudes and Behaviours
    ▪ Asking Patient for Feedback
    ▪ Countertransference
    ▪ Enough Evidence for an Intervention that Makes Sense
    ▪ Getting Alongside the Patient to Understand
    ▪ Theoretical Model
    ▪ Therapist Does Not Have Absolute Certainty
    ▪ Timing
    ▪ Tracking Unconscious Communications
    ▪ Truth vs Accuracy

• Alliance
  o Therapist Attitudes
    ▪ Not Knowing Stance
    ▪ Therapist Believes in the Therapeutic Process
    ▪ Therapist Conveys Humanity
    ▪ Therapist Survives the Patient’s “Attacks”
    ▪ Use of Humour
  o Therapist Curiosity, Attunement, and Reparation
    ▪ Being on the Side of the Patient and Repairing
    ▪ Interest, Understanding and Attunement
    ▪ Modifying the Interventions According to the Patient’s Feedback
  o Therapist is Mindful of the Patient’s Way of Relating
    ▪ Implications of the Patient’s Narrative to the Relationship
    ▪ Mindful of the Patient’s Particular Way of Relating
    ▪ Patient’s Difficulties to Trust
    ▪ Transference in Mind
  o Therapist Tasks
    ▪ Agreement Between Therapist and Patient to Understand the Unconscious
    ▪ Compassion and Boundaries
• Goals, Bonding and Conveying Care
  • Making Connections in the Material
  • Therapeutic Frame
    o Therapist Treats the Patient as an Agent
      ▪ Collaboratively Agree on Therapeutic Goals
      ▪ Patient is Active
  • Arriving at a Dynamic Formulation
    o Process and Delivery
      ▪ Collaborative Process
      ▪ Delivery Considering Alliance
      ▪ Delivery Expressing Doubt
      ▪ Delivery Linking the Past to the Session
    o Sources
      ▪ Cautionary Tale
      ▪ Development and History of Patient
      ▪ Gathering Information from Different Sources
      ▪ Meaning of Communications
      ▪ Patient in the Room
      ▪ Use of Countertransference
    o Systematisation
      ▪ Conflict
      ▪ IPAF and Affective Patterns
      ▪ Knowing the Defence Mechanisms
      ▪ Understanding the Patient in Terms of Psychoanalytic Theory
  • Assessment and Trial Interpretation
  • Countertransference
  • Defences
    o Assessment
      ▪ Assessment
      ▪ Assessing the Patient’s Past and Present Reactions
      ▪ Recognising the Defences in the Room
    o Delivery and/or Challenge
      ▪ Challenge if Patient is Capable of Coping
      ▪ Challenging
      ▪ Challenge When Therapy is Stuck
      ▪ Long vs Brief Therapy
      ▪ Not at the Beginning of Therapy
      ▪ Recognise the Struggle the Defences Mean for the patient
      ▪ Respect the Defences
      ▪ Show the Cost of the Defence
  • Emotional Content of the Session
    o Affect Regulation
      ▪ Affect Regulation
      ▪ Mentalizing With Overwhelmed patient
      ▪ When and When Not to Allow the Patient’s Evacuation of Emotions
    o Containment
      ▪ Attunement (not Empathy) and Exploration
• Containment
• Helping the Patient Grieve
• Sit with the Patient’s Feelings
• Therapist Ability to Think
• Therapist Changes Together with Patient
• Therapist Processes Countertransference
• Using Supervision

- Empathy
  o Being Sensitive but not Sentimental
  o Sensitivity While Bringing the Patient to Understand

- End of Therapy: Working Through
  o Length of Psychotherapy
  o Unconscious Fantasies

- Engaging the Patient
  o Interest and Understanding in the Patient’s unique Experience
    ▪ Deeply Understanding and Validating Individual Experience
    ▪ Following the Patient Verbal and Non-Verbal Communications
    ▪ Formulating and Sharing an Understanding of the Transference
    ▪ Making the Patient Feel Understood, Contained, Not Judged
    ▪ Working with the Defences
    ▪ Working with What is Urgent and Immediate to the Patient
  o Patient Signs of Engagement
    ▪ Checking the Patient Relational Changes
    ▪ Interest of the Patient
    ▪ Patient Responses
  o Techniques Associated with Alliance
    ▪ Ability to Repair Ruptures
    ▪ Engagement as an Inseparable Element from Alliance
    ▪ Explaining what Therapy is About and Respecting the Setting
    ▪ Therapist Own Therapeutic Relationship with Their Own Therapist

- Interpersonal Feelings and Defences
  o Delivery and Working Through
    ▪ Delivery Sequence: First on the Patient’s Side
    ▪ Describe Contradictions
    ▪ Solving Contradictions
    ▪ Tolerance
    ▪ Willingness to be Surprised
    ▪ Working Through the IPAF to Deactivate
  o Techniques
    ▪ Clarification, Confrontation, Interpretation
    ▪ Enquiry
    ▪ Helping to Explore Unconscious Feelings
    ▪ Mentalization
• Interpretation
  o Elements to Consider Before Delivering an Interpretation
    ▪ Favouring Transference Interpretations with Judgment
    ▪ Not Always Make Interpretations
    ▪ Transference vs Other Interpretations: According to the Patient’s Interest
    ▪ Understanding Transference, Countertransference and Defences
    ▪ With Sensitivity
  o Process of Delivering an Interpretation
    ▪ Arriving Together with Patient: Importance of Timing
    ▪ Based on Enough Evidence
    ▪ Competent Sequence
    ▪ Delivery in a Constructive Way
    ▪ Only Interpret with Purpose
    ▪ In Patient’s Own Language
    ▪ Tentatively Shared with Patient/ Collaborative Work
• Intervention: Supportive, Inquisitive or Interpretative
• Mentalizing
  o Mentalizing as a Primary Competence
  o Promoting Mentalizing
• Risk Assessment
• Titrating Interventions
  o Challenging the Defences
  o Intuition and Experience
  o Mindful of Specific Defences
• Transference: Understanding and Use
  o Differentiating Transference from Real Relationship
  o Recognise the Transference to Understand the Patient
    ▪ Attentive to Unconscious Contents
    ▪ Communications Reflect the Relationship
    ▪ Link to IPAF
    ▪ Total Situation
  o Therapeutic Use of Transference
    ▪ Evaluating the Patient’s Use of Transference Interpretations
    ▪ Not Necessarily Make Interpretations
    ▪ Not Observable in the Session but Still Present
    ▪ Recognise, Deliver and Challenge
    ▪ Testing Something New
• Unconscious Communications
  o Facilitating
    ▪ Facilitate by Balancing the Amount of Structure of the Session
    ▪ Facilitate Free Association
    ▪ Frame and Boundaries
  o Listening
    ▪ Attentive to Unconscious Contents
    ▪ Attentive to Form rather than the Content of Communications
- Countertransference
- Dreams and Slips of the Tongue
- Looking for What is Being Defended Against
- Non-verbal Communications and the Sessions Atmosphere
- Symptoms
  - Respond
    - Putting Unconscious Content into Words Tentatively
    - Respond Allowing for the Patient’s Unwanted Feelings
    - Respond Linking the Present to the Past
    - Respond When the Patient is Open
    - Surface to Depth

Table 7.5
**Observable Competence group**

<table>
<thead>
<tr>
<th>Observable Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Balance Between the Therapist and the Patient’s Lead</td>
</tr>
<tr>
<td>• Curious Stance for Mind Contents (rather than for Behaviours)</td>
</tr>
<tr>
<td>• Eliciting and Exploring Interpersonal Dynamics</td>
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<tr>
<td>• Engaging the Patient</td>
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<tr>
<td>• Expanding the Patient’s Understanding</td>
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<tr>
<td>• Exploring, Identifying, Naming and Articulating Emotions</td>
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<tr>
<td>• Focus on Affective Relational Patterns</td>
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<tr>
<td>• Gathering Enough Information to Understand</td>
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<tr>
<td>• Interpretations that Link External Experience with the Therapeutic Relationship</td>
</tr>
<tr>
<td>• Intervening in a Sensitive Way</td>
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<tr>
<td>• Intervening in Multiple Levels</td>
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<tr>
<td>• Interventions are Mindful of the IPAF</td>
</tr>
<tr>
<td>• Listening Skills and Self-Correction</td>
</tr>
<tr>
<td>• Marked Mirroring</td>
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<tr>
<td>• Mentalize Interpersonal Dynamics</td>
</tr>
<tr>
<td>• Reference to a Psychodynamic Framework</td>
</tr>
<tr>
<td>• Unconscious Content</td>
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</tbody>
</table>

Table 7.6
**Competence in DIT group**

<table>
<thead>
<tr>
<th>Competence in DIT</th>
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<tbody>
<tr>
<td>• Activity and Visibility</td>
</tr>
<tr>
<td>o Active Stance</td>
</tr>
<tr>
<td>o Communicative and Visible Therapist</td>
</tr>
<tr>
<td>• Assessing Whether Patient Can Work in DIT</td>
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<tr>
<td>• Collaborative Work</td>
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<tr>
<td>o Capacity to Collaboratively Formulate Focus</td>
</tr>
<tr>
<td>o Patient’s Feedback</td>
</tr>
<tr>
<td>• Creativity and Playfulness</td>
</tr>
<tr>
<td>• Directive to Focus</td>
</tr>
</tbody>
</table>
• Directive Without Losing Analytic Attitude
• Elasticity vs Flexibility
• Hardnosed, Persistent and Focused
• Link Back to IPAF
• Not Interpret If Not Linked to the IPAF

• Elicit Interpersonal Narratives
• Expectations for Change
  o Explore Need for Therapy After Ending
  o Get Patient to Have insight, Not Necessarily Change
  o Manage Expectations
• General Exploration, Focus in Recent Events
• Incompetence in DIT
  o Concrete, Not Using Countertransference
  o Not Carrying Out the Phases’ Tasks
  o Not Quickly Creating Trust with the Patient
  o Not Having a Focus in the Interventions
• Interpretation
  o Supportive Rather Than Expressive Interventions
  o Once Focus is Shared with the Patient, Make Interpretations
• Positive Attitude towards DIT
  o Convey Hope for Change
  o Positivity About Brief Psychotherapy
  o Trust and Tolerance for Uncertainty
• Quickness
  o Ability to Quickly Find a Focus and Share it with the Patient
  o Ability to Quickly Make a Relationship with the Patient
  o Clarity of Thought
• Stick to Model and Phases
  o Work Through the Ending
• Transference
  o Acknowledge Transference in order to Take It Out of the Way
  o Meaning of the Transference to the Psychotherapeutic Process

Table 7.7
Incompetence group

<table>
<thead>
<tr>
<th>Incompetence</th>
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</thead>
<tbody>
<tr>
<td>Enactment, Concrete interventions, Not Thinking</td>
</tr>
<tr>
<td>o Becoming Overwhelmed by the Patient</td>
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<tr>
<td>o Chaotic Therapist</td>
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<tr>
<td>o Colloquial Therapist</td>
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<tr>
<td>o Direct Answers</td>
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<tr>
<td>o Failure to Pick Up Difficulties and Collusion with the Patient</td>
</tr>
<tr>
<td>o Giving Advice</td>
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<tr>
<td>o Giving Homework</td>
</tr>
<tr>
<td>o Giving Manic Solutions</td>
</tr>
<tr>
<td>o Inability to See the Layers of Meaning</td>
</tr>
<tr>
<td>o Inability to Think: Anxious and Concrete Therapist</td>
</tr>
<tr>
<td>o Interventions that Lead to Enactments</td>
</tr>
</tbody>
</table>
- Misuse of Transference
  - Narrowing Down Without Understanding
  - Not Understanding, Getting Stuck
  - Quickly Reassuring the Patient
  - Unawareness of the Effect of Interventions
- Inability to Foster Therapeutic Alliance
  - Coldness and Rigidity
  - Inability to Maintain the Alliance
  - Not Keeping the Patient in Mind
  - Not Listening to the Patient
  - Patient Becomes Less Interested
  - Silence and Disconnection
- Differentiate “Incompetencies” from “Incompetent” Therapist
- Interventions Not Adapted to the Context, Patient. Not Considering Consequences of Interventions
  - Disrespect for the Patient’s Defences and/or Challenging Them Too Soon
  - Delivering the Treatment Manual Without Care for the Patient
  - Delivering Interpretations Independently of Where the Patient is At
  - Not Prioritizing the Patient’s Interests
  - Overlooking the Patient’s Coping Mechanisms
  - Overwhelming the Patient (non-Mentalizing)
  - Responding in a Non-Sensitive Way
  - Saying the Wrong Things to the Patient (Irresponsible Therapist)
  - Unethical
- Lacking Basic Skills to Intervene
  - Bad Timing, Slow in Making Connections in the Material
  - Giving the Patient a Destructive View of Themselves
  - Inability to Promote Change
  - Not Continuing to Learn
  - Not Gathering Enough Information to Understand
  - Not Having a Therapeutic Model in Mind
  - Not Respecting the Frame and Boundaries
  - Not Saying Anything
  - Saying the Wrong Things to the Patient (Therapist that Misunderstands)
  - Theory but No Skill
  - Too Little or Too Much Silence
  - Using Unclear Wording for the Patient
- Therapist Mental Health Issues
  - Blaming the Patient for Their Own Incompetence
  - Therapist’s Own Mental Health Problems
  - No Self-Awareness, Blindspots, Not Receiving Feedback
  - Saying the Wrong Things to the Patient (Narcissistic Therapist)
7.3.1 Competence Definitions group

Participants disagreed with the customary notion that therapist competence brings about positive treatment outcomes. Conversely, participants considered that equating competence to positive treatment outcomes constitutes a circular definition where it is impossible to distinguish between both concepts. Participants considered that competence does not necessarily result in positive treatment outcomes in any given case, because patient related issues may also affect the outcome. Thus, the clinical outcome may be poor even when the therapist is competent.

Participants distinguished between two types of competence. The first type refers to the exhaustive list of attitudes, behaviours and skills that a therapist should demonstrate. The second type refers to the therapist “innate” talent to understand and treat patients. Participants conveyed that the “innate” competence is related to the therapist personality, life wisdom, psychic sophistication, experience of being a patient, and own developmental journey. All these factors would make the therapist better suited to understand and treat patients. Participants suggested that an “innately” competent therapist has a special sensitivity to understand in depth unconscious communications, and to recognise what is happening in the transference.

A number of participants agreed that the paradox of attempting to define competence is that by offering a general idea of what competence is, -by defining how the therapist should behave with every patient-, the quintessential reality of competence is overlooked. The essence of competence is the ability of the therapist to individualise, contextualise and time the interventions. Competence is about the flexibility in adapting the techniques to a particular patient at a specific time, recognising when and when not to intervene. Therefore, defining competence in a generic way, goes against the very essence of what competence is.

Several participants highlighted that for an intervention to be competent, it has to be rooted in a specific treatment model. Nevertheless, participants conveyed that competence is not just about being consistent with the treatment model, but is the skillfulness with which the therapist effectively delivers the interventions and techniques derived from a specific treatment model.
Participants understood competence as the ability of the therapist to see and understand the patient’s material when is “hot” in the here-and-now of the session. A competent therapist not only should be capable of understanding the connections between the patient’s material, external situation and transference quickly, but also should be able to verbalise these links in a way that the patient can receive them although they are shocking and surprising. Therefore, a competent therapist should have an excellent management of language, delivering clear and economical interventions, which should be adapted to the specific time/phase of the patient’s therapy.

7.3.2 Core Competencies group

7.3.2.1 Analytic Attitude

Participants defined the analytic attitude as the capacity of the therapist to maintain awareness of the unconscious processes that take place in psychotherapy. Therefore, the therapist is able to keep in mind that the patient’s verbal and non-verbal communications have an unconscious meaning. The therapist should be attuned and attentive to the broader range of communications in a non-judgmental way:

“It’s about attunement to where the patient is at and out of that also comes the capacity to be with, to sit with, to know, to identify, to sometimes name, to explore the affect…”

Another competency related to the analytic attitude is the ability of the therapist to help the patient have a growing awareness and interest in their own psyche and unconscious:

“The overall aim, I think is to promote independence and health and maturity so that eventually the person leaves and he’s able to rely on his own mind to understand his problems. Facilitating insight for instance with the
patient whether it through interpretation or holding or clarification is very important.”

7.3.2.2 Balances, Adaptations, When and When Not, Timing

Participants agreed that a competent therapist adapts the interventions to the specific patient. Firstly, by using theoretical knowledge in a flexible and creative way, according to the individual patient:

“…They're free to move within the model…they are not following a tick box…they're also there, stopping, slowing the person down if they don't understand, asking the right questions, but then making some links or showing that they have an understanding that's dynamic, that they are aware of resistance to change, that they are aware of how defensive a person might be so that they can make it more real in the moment.”

A competent therapist should adapt the interventions to the patient’s level of functioning, level of intelligence, personality, state of the relationship with the therapist, and to the state of the therapeutic alliance in a particular moment. Moreover, the therapist interventions should be delivered at a time that the patient can receive them:

“For example, if you interpret something in the following session that you only understood after the previous session, that may not work for the patient because they may no longer really be in touch with what it is that you are referring back to. The timing is quite relevant. It has to be close enough that the patient is still in the state of mind that you're trying to help them understand or at least they can clearly remember it.”

In relation to this theme, participants indicated that a competent therapist is able to recognise when and when not to intervene:
“She was quite upset but also grateful to be disagreed with and told she was talking complete non-sense. But if I said that halfway through the story, I think she was still trying her hardest to persuade herself and me that she definitely did think that. And it was really only when she had been listening to herself talking rubbish and trying not to notice it. But when I pointed it out, she knew that was right. And so, the timing in that case was important. She could hear it because a bit of her had already started realising it, without being conscious of that.”

An issue of critical relevance is the ability of the therapist to distinguish when and when not to act, particularly when the patient is at risk. In these situations, the therapist should be able to adapt to the patient’s needs and actively address the patient’s risk.

Participants agreed that a competent therapist should assess whether sharing the countertransference would be helpful for a particular patient. If the therapist decides to share his/her internal states, this should always be done with prudence and judgment:

“I think one’s got to be judicious about what you share about your internal states. I don’t think one would essentially want someone to be as blunt as say, ‘Well… I’m feeling immensely bored…Even if that might be true, it might also be insensitive, and even offensive and provocative. But, I think if you could find a way…this patient I’m thinking about now is someone who when she used to talk to me, I used to feel immensely stupid. I felt like I couldn’t follow her properly and…it emerged that she often felt stupid. She felt that actually she was unable to really talk to people in a confident way…I can’t quite remember how I put it to her then, but it would have been maybe something like, when she talks to me she expects that I should feel rather unable to follow her…It was introducing a relational experience…to invite the patient in a way to be curious about this…she did to actually start to really explore the fact and it turned out that she’d had a learning disability at school, and she always felt rather inferior that in some way got enacted in the relationship with me”
7.3.2.3 Keeping the Patient in Mind, Prioritising their Interests, and Treating them as Agents

Participants indicated that a core competence is the ability to help the patient feel stronger, capable of mentalizing his/her own difficulties, allowing him/her to be an active agent in his/her life. Therefore, the therapist should promote the patient's independence, by facilitating insight and change.

An essential component of treating the patient as an agent, is understanding that therapy is a collaborative process of exploration and development for both, the therapist and the patient. Therefore, the therapist should collaboratively build meaning with the patient, without having an agenda:

“…It’s a process of exploration and development for two people in the room. There is no programme, there is no trajectory that needs to be adhered to…in terms of going in there with an agenda that needs to be left at the door…What I want to say first and foremost…the therapist fundamentally takes on that they don't know. They're hoping that the patient can expand and explore and help them understand”

Several participants considered that the therapist should always prioritise what is best in the patient’s interest, by being fair and respecting the patient’s rights and freedom of choice:

“I think a competent therapist…should be familiar enough with…what the options are for the patient and should discuss with them at the beginning…They should have the patient’s best interests and freedom of choice in mind and that should be communicated. I think it’s really not competent when a patient goes along and because the therapist has a training in a specific thing… They just say this is what we are going to do and I’ll charge you this…They don’t really get informed consent from the patient to what it is that they are offering and they don’t recognise that the patient might have other alternatives that might help them more. I think an aspect of being competent is to begin the therapy with an honest discussion with the patient about what the therapist can offer
and what else the patient might want to consider. And put the patient's well-being first”

7.3.2.4 Occupy Therapist Role

Several participants considered that a competent therapist is able to trust in his/her own instincts and to try things out with the patient. The therapist should not remain in a safe place in therapy that does not help the patient:

“If you're not willing to take some risks and ask the questions that people are too frightened to talk about or what isn't being said then you stay in very safe territories and it doesn't go anywhere”

“Is courage to make links where there needs to be links. A courage to observe things which might be difficult to observe”

Participants conveyed that a competent therapist uses his/her role, not feeling insecure, but having a sense of authority of what the role means. The therapist needs to believe in him/herself and the therapy that is delivering:

“Is feeling that you have authority, almost so that you can be, because I was listening to someone and she was saying all the right things but in such a tentative way that it didn't feel like she could really occupy her position as a therapist.”

7.3.2.5 Techniques and Skills

Participants indicated that there are generic skills that are common to all modalities of psychotherapy, such as the ability to listen attentively and to show empathy. Among these skills, participants considered particularly relevant the ability of the therapist to engage the patient, by sharing an understanding of the patient’s difficulties that he/she has not seen before:
“...To go back to the example of the man with his long time depressing marriage, if I say something about his relationship with his wife...he’s actually so bored with the subject...that there’s almost nothing anyone could say that would really surprise him...But what surprises him more and makes him more interested...is the idea that there’s a way that he behaves with me and uses the relationship with me that’s quite similar to what he describes with her. But he believes that there are completely different relationships...he thinks his wife is really stupid and boring...and he thinks that I’m intelligent and interesting... But he actually treats me, without being conscious of it, in a very similar way in a contemptuous and degrading way that he has described to treating her...But if I can show him in the here and now...is just the thing he describes with her...then he’s really amazed because he thinks how could I possibly be regarding you in the same way as I regard her because you’re the opposite. So then he takes it on. He takes more ownership of that side of himself...”

Participants indicated that a core competence is the capacity of the therapist to assess and formulate the patient’s difficulties, understanding the causes and meanings behind them:

“...to really get a good, a really good understanding of the patient’s history... you’ve got to have some understanding of their relationships and how they’ve come to have this presentation that they’re sitting in front of you with...formulation is really key”

Several participants considered a core competence the ability to use humour in a therapeutic way:

“(He) is very good at using not interpretations really, but ironic comments that are almost sarcastic and humorous...the patient might say something like, ‘I never do this, I can’t bear it when people behave like that’... and the analyst might say something like, ‘Except when you do’. Implicitly disagreeing with the patient but in a playful way, and the patient could be shocked that they could ever be like that.”
Several participants agreed that the competent therapist is able to make short, clear, economical interventions, that might not be completely explained but they work when there is a relationship and understanding with the patient.

Participants emphasised the relevance of keeping the frame and boundaries of therapy to provide a sense of constancy and safety to the patient:

“The ability to maintain the frame…One is the physical frame which I think is important. There is stability in the place, the time, the frequency. That gives a sense of safety to the patient…the fact that you are meeting to discuss the patient’s problems you are not meeting to discuss the therapist’s problem. Boundaries are very important…you have to be reliable, you have to be on time, you have to finish on time… is very important in order to provide a sense of constancy.”

7.3.2.6 Therapeutic Relationship and Alliance

Participants agreed that a core competence is the ability of the therapist to form a therapeutic alliance with the patient, a relationship of trust where the patient and the therapist feel safe to explore difficult contents. Additionally, it is important that the therapist fosters a normal human relationship that has boundaries, which are essential for delivering interventions within the psychotherapeutic process:

“To create and maintain a relationship in which those things are possible…It’s also to do with being-- having a setting, a personal setting in which you treat the patient with courtesy and interest, and you remember what they’ve told you before. And you’re reliable, so don’t cancel appointments all the time. And also, that has a human-- definitely a human warmth about it. I think to me, therapists are more competent if they are able to create a normal human relationship within clear boundaries. I don’t think it’s as competent when a therapist is--
behaves in a very stiff and formal, almost cold way, a rigid way with a patient. I think that's less competent because I think it makes it harder for the patient to form an attachment relationship with a therapist. The therapist is not...emotionally accessible for them”

7.3.2.7 Therapist Self-Awareness, Self-Regulation, Capacity to Think

Most participants indicated that a core competence of the therapist is the self-awareness of his/her own feelings and thoughts, and the ability to articulate those in a meaningful way in order to understand the patient and what he/she is bringing to the relationship. This competence includes also the ability of the therapist to think, after an enactment, how the patient's mind impacted the therapist one. Additionally, the therapist should be aware of his/her own blindspots, and should be able to differentiate when what he/she is feeling belongs to the patient and when what he/she is feeling belongs to his/her own personality:

“After a few sessions of this particular person working with this patient, it was thought in supervision, perhaps quite unhelpfully, to stop...this particular patient went off...and received absolutely no benefit from this changing the care plan..., was to come back into...brief psycho-dynamic work, and express really difficult feelings about feeling rejected and abandoned by the therapist...what transpired as the work progressed is that it was disclosed that he had been adopted and all of a sudden, the penny dropped for the therapist and the supervisor...as we had completely enacted it....The handing over, and what came out of that, and what needed to be done, was the therapist, in a very skilful and helpful way...to use that as a springboard to access a configuration that was so fundamental to this patient in their way of experiencing themselves, in relationship to other people...it was conveyed that although, as a service, unconsciously we'd slipped up and we'd done the very thing that was least wanted, that out of that, some sense could be made and some meaning could be found that would help this person become more able to envisage what they do in the world...You can't be the perfect therapist to the patient all the time,
but what the therapist has done is that they've really displayed a capacity to metabolise, and sit with, and basically unpick...a projective identification that has allowed learning on both parts. For me...if a therapist is displaying competence, there are two people in the room changing, and that's the crucial thing."

Participants highlighted that the competent therapist will be able to think in the room with the patient, and to be open to the patient’s influence while at the same time drawing on knowledge to understand the communications. Thus, the therapist should be able to retain the capacity to think, to see, and to experience in the session with the patient. Only in this way the therapist will be able to understand the patient in a unique, individual and creative way:

“That you don't have to know the answers...we're being curious and not knowing...that you can really think with someone to make sense and to try and get some coherence about what might be going on for them. You need to be willing to be lost and overwhelmed and to feel that you can trust that you will come out the other end, and that you can still retain a capacity to think”

Participants considered that in order to be able to think, the therapist should tolerate the ambiguity and uncertainty that is intrinsic to the exploratory process. Additionally, participants considered that a therapist life experience was helpful in order to manage complex feelings:

“I think a competent therapist is someone I think who most probably can manage with a certain level of ambiguity, with uncertainty...a colleague who you feel he’s immensely solid with patients. He’s not too frightened; he’s not out of touch either. He’s not naïve or grandiose, but you feel actually that if people come and tell him things that are quite difficult or unpleasant, or scary or whatever, he takes it in his stride. I think it’s a converse of having someone who feels that they’ve had life experience, handling complexity in some way. You can manage complex feelings, or you can hear things that you’re not so easily shocked.”
Participants concurred in that the therapist should have his/her own experience of being in psychotherapy in order to help the patient:

“I think you need to be analysed yourself so that you’re not unaware of your own contribution to the situation, because I think if you feel fully aware of your own issues, you can be there in a much more open and genuine way to have proper encounter with someone”

7.3.2.8 Understanding and Intervening at Multiple Levels

Most participants coincided in that a competent therapist is able to intervene in multiple levels. Therefore, by being attuned to the patient the therapist can understand the patient’s internal state, external relationships and transference situation. The therapist holds an understanding of the patient in mind that they can sensitively share in the session, expanding the patient’s understanding of the implications of their difficulties:

“..They do what we call marked mirroring so they're able to show that they know how the patient feels, and that they're always able to present an understanding of what the client is saying…That actually expands the clients horizon in a certain way, but their understanding is in line with where they're trying to take the client to…She's able to respond to the increased depression that the client is feeling, and then be sympathetic with the struggle that the person has with self-esteem…and link that to the situation in the therapy where…they feel that the therapy should have done better, but they also feel humiliated that they haven't done any better for the therapist and link that to their internal relational-affective pattern that the person is working on”.

Participants conceptualised the competence of intervening at multiple levels as encompassing three steps. The first step is the ability of the therapist to understand the unconscious meanings of the patient’s communications. The second step is the ability of the therapist to understand the implications of the unconscious meanings of the patient’s communications to the therapeutic
relationship in the here-and-now of the session. The last step, is the ability of
the therapist to intervene competently in accordance with these understandings:

“*My thinking about it is usually the client is outlining a state of affairs… and
the therapist… first of all, understand the communication then appraise it to
come to what does this… mean in terms of the multi-layered nature of human
communication. What does this communication mean or imply in terms of the
client’s life outside of the therapy, the situation that they’re in, the way they are
looking at that situation, and then, what does it imply about the situation in the
therapy, why are they saying it now and what does it mean in terms of the
current situation for the client in the consulting room? Taken that together, how
does my supervisee respond to that? People tend to fall, sometimes, at the first
hurdle*”

Several participants agreed that the therapist’s interventions are competent
when they are delivered in a genuine way, creating a subjective experience that
feels immense to the patient, because something he/she was unaware of
becomes verbalised. The latter produces a “click” experience in the patient who
is then able to understand something different or with another depth.

“I *think the patient feels that something about their experience has been
acknowledged, recognised…something that they’ve been unaware of, or
perhaps haven’t quite put together in that way before…where someone can
actually express something in a more genuine way…., their head and heart are
a bit more connected…you can often see or hear when something actually
clicks into place a bit, and you actually feel this, something deepening in a way,
something is being grappled…sometimes you will see or hear, sometimes it is
about a change in the tempo of speech…..”
7.3.3 Framework of Competencies group

7.3.3.1 Accurately Understanding the Patient

Participants emphasised that the best indicator of the therapist accurately understanding the patient, is the patient’s reaction to the therapist’s interventions. The patient may become silent, or change the rhythm of his/her affects and thought processes. Patients may also react by elaborating the material further, owning the idea expressed by the therapist, and/or bringing about new contents, disclosing or remembering relevant material. This change in the patient’s behaviour does not need to happen right after the therapist intervention, it can also occur a few sessions later.

Most participants indicated that in accurately understanding, the therapist gets alongside with the patient’s experience and feelings. Accurately understanding the patient is providing him/her the experience of being understood in a deep and meaningful way, not just telling them what they already know, but also saying something new. The experience of being understood is quite profound and immensely moving for both individuals.

Participants agreed that it is possible to say that a therapist accurately understands the patient if he/she is following the patient’s unconscious communications, seeing the depth of the material rather than the surface of it. An indication of this is that the therapist acknowledges and names the contradictions presented by the patient between the manifest and latent contents, or shows the latent material in a straightforward way:

“…The therapist might say ‘I know you’ve just said to me that actually you’ve had quite a good week but in fact I experience you very differently in the room today…You look very tensed. You can't even look at me.’ That would be, to me, an indication that the therapist is trying to really get to an accurate understanding because there is a disjunction between the surface communication and what the patient and the therapists observing of the patient’s nonverbal behaviour in this example.”
Several participants conveyed that it is possible to say that the therapist accurately understands the patient when his/her interventions make sense from what has been happening in the therapy, meaning that the interventions are based on enough evidence. Additionally, participants concurred that the timing of the interventions is a pivotal issue when assessing whether the therapist accurately understands the patient:

“Accuracy cannot, to my mind, be determined on the spot because you could be absolutely accurate about what you're picking up but the patient is not ready… to listen to it… I think the intervention has… to go with what the patient can bear to hear that will become the accurate intervention”

Participants highlighted that a competent therapist remains open to the fact that the interventions are not necessarily accurate and right. Therefore, the therapist is flexible and open to change his/her way of thinking according to what is happening with the patient. The therapist does not have certainty and does not treat his beliefs as facts; he/she is rather flexible about them. Therefore, several participants concurred in that a therapist that accurately understands is concurrently asking the patient whether what was said makes sense to him/her or not. If the patient agrees with what the therapist has said but it feels that in the countertransference he/she does not, it can be checked out with the patient asking for feedback.

7.3.3.2 Alliance

. A competent therapist contributes to the creation of the therapeutic alliance by conveying his/her humanity, by being humble, by recognising his/her own struggles. Additionally, the therapist fosters and maintains the alliance by surviving to the patient's attacks, by persevering, by being there for the patient consistently trying to understand and work something out. By conveying this tenacity to the patient, the therapist expresses that he/she feels close to them.

Several participants expressed that a competent therapist helps create and maintain the therapeutic alliance by showing interest and curiosity in the
patient, by keeping the patient in mind, by following the verbal and non-verbal cues, and by remembering what the patient has said in the past. Therefore, the therapist forms a relationship based on understanding and attunement.

Participants concurred in that it is pivotal for the therapist to have the skill of repairing ruptures in the alliance. The therapist creates and maintains the therapeutic alliance by conveying to the patient that he/she is on his/her side trying to help, especially when the alliance is broken. When there are ruptures in the relationship the patient’s experience has to be acknowledged and validated by the therapist in order to repair the alliance:

“You may say... ‘Thank you for bringing it into my attention because that wasn’t my intention, but I can see that that’s how you experienced it. Perhaps we really need to think about what happened, what was it that I said that made you feel that I was being so critical of you.’ And, you may say, ‘Well, perhaps I did come across very critically, and that’s interesting because I wonder what it was.’ You’d be curious about yourself as well as them... You may say, ‘Look, I completely misunderstood that’”

Participants conveyed that in order to maintain the alliance the therapist’s interventions should always consider the goals of the therapy, constantly reminding the patient the purpose of coming to treatment. By focusing on the goals of treatment across the interventions, the therapist conveys to the patient that he/she cares, which enhances the bond with the patient. Therefore, the therapist creates a bond with a purpose:

“That’s like a lighthouse that you always aim to head towards. Whatever you say is said to maintain the therapeutic alliance, so that the patient will see the purpose of them coming to see you... All the time you have to remind them why it is that they’re coming to see you and in what way that's helpful for you and for them... You care, you create a bond but you create a bond for a purpose. It’s not called an alliance it’s called therapeutic alliance.”

7.3.3.3 Arriving at a Dynamic Formulation
Participants agreed that in order to arrive into a dynamic formulation the therapist must gather information from different sources and then integrate this knowledge.

“A good formulation will be able to link these three areas, the past, the present and the relationship in the room…it's in the space in the room, that most information is available. It will happen out there and you can note it out there, but you're not going to experientially understand it, to the same extent”

Participants indicated that in order to arrive into a dynamic formulation the therapist should understand the meaning behind the patient’s communications, which define the conflict of the patient. Most participants agreed that a competent therapist arrives at an analytic/dynamic formulation working collaboratively with the patient. Therefore, a competent therapist shares his/her dynamic formulation with the patient not as a sure thing, but expressing doubt, as an hypothesis, waiting to hear the response of the patient to co-construct the formulation collaboratively.

Additionally, several participants expressed that the competent way of delivering a dynamic formulation is by linking the patient’s past history to something that has happened in the session. In this way, the therapist makes the formulation more understandable and interesting to the patient.

7.3.3.4 Defences

Participants suggested that a competent therapist learns about the patient’s defences by exploring how he/she has reacted to difficult situations in the past. However, it is better when the therapist can rely in an assessment of the defences that were displayed in an interaction in the session.

Most participants agreed that a competent therapist should be respectful of the patient’s defences, understanding the reasons behind them. Therefore, the therapist should be respectful of both, the defences and the difficulties that
originally led to them. Being respectful of the defences is particularly important in brief work, where the therapist should not aim to disarm them.

Several participants suggested that one way of working with the patient’s defences is not necessarily by challenging them but by showing the patient the cost of using them.

Participants expressed that the patient’s defences can only be challenged when there is enough trust and a solid relationship with the therapist. The competent therapist challenges the defences with sympathetic interest and compassion. Additionally, participants concurred in that a therapist should only challenge the defences when the patient has the resources, the capacity and/or external support to cope with the feelings underneath the defence.

7.3.3.5 Emotional Content of the Session

Several participants stated that a competent therapist deals with the emotional content of the session by helping the patient regulate their emotions. The competent therapist helps patients experience a range of affective states of varying intensities, in tolerable limits. Therefore, when the patient becomes easily overwhelmed by emotions the therapist should attempt to bring down the intensity of the affective state, whereas when patients are disconnected from their emotional states, the therapist should attempt to bring affects to their attention:

“I think by trying to keep it within useful limits. So, if there's a patient who's extremely distressed or extremely depressed, or in any extreme affect stage, it's difficult to work with them in a talking therapy because they basically can't concentrate or have much of a dialog. So, in that case, one would have to try to moderate that state, bring them down to something like a more normal level of stress or excitement or misery or whatever the affect is. Assuming…they are not completely unemotional…Managing their emotions, I think it's a matter of acknowledging them, trying to help keep them to a level that is bearable. Making sense of them, being able to help the patient to understand more than
they did at the beginning about why they feel this way, and including perhaps something that's really surprising to them.”

Participants concurred in that the therapist should help patients mentalize their emotions instead of becoming overwhelmed by them. However, participants indicated that a competent therapist would allow the evacuation of raw emotions when the patient has recently experienced an external traumatic situation. Nevertheless, when the emotional hyperarousal of the patient has to do with transference issues, the therapist should attempt to lower the intensity of emotions by using mentalizing techniques:

“I suppose if you have a patient who has just come from a very arousing incident whether it's an argument with someone or they have been at a funeral and there is something quite disturbing and traumatic that has happened, I can imagine that I might be more inclined to give them space to just evacuate what it is that they feel. Whereas if a patient…for example, who comes to the session and then lets a lot of anger towards me, it's very much located in the transference let's say, I think there I might be more inclined to try to de-arouse them a bit but then to make sense. Because I think that that's more workable with than something that's coming from outside that is very pressing and very traumatic…”

Participants stated that the therapist should attune to the patient’s feelings. Thus, the therapist should be attentive to both, the expressed and non-expressed feelings, remaining open to their exploration:

“It's about attunement to where the patient is at and out of that also comes the capacity to be with, to sit with, to know, to identify, to sometimes name, to explore the affect. If a therapist is clearly expressing in the session with the patient that affect is welcome, and that there is affect there, and that it can be thought about and born by both. That feels to me as a competent therapist at work.”
Participants agreed that a competent therapist should be aware of and work through his/her counter-transferential feelings, so that they do not become enacted with the patient. Additionally, the therapist should be able to differentiate which of these feelings are the patients’ and which belong to the therapist’s own blindspots.

Overall, the therapist offers his/her own mental apparatus, a part of himself/herself, to deal with the emotions of the patient. Thus, the therapist changes in the psychotherapeutic process together with the patient, through containment, understanding and digestion of the patient’s feelings.

7.3.3.6 Engaging the Patient

Participants indicated that a competent therapist engages patients by making them feel understood. The therapist is someone that understands and contains the patient’s anxieties and difficulties without being judgmental.

Additionally, the therapist should understand the uniqueness of the patient’s experience, not closing the understanding to soon, not concretising it, but exploring its underlying meanings, and validating the patient’s feelings.

Several participants highlighted that the therapist engages the patient when he/she is able to pick up from the communications what is more urgent in the immediate situation:

“If a person is very highly aroused and in that time of aroused state, you’re giving a long interpretation, you would see that you’re not engaging with the patient. I think you’re more preoccupied with what you think needs to be said rather than where the patient is at.”

Participants indicated that it is possible to assess whether the patient is engaged in therapy in accordance to how he/she responds to the therapist communications, verbally and non-verbally. An engaged patient elaborates or is attentive to what the therapist is saying and remembers material of previous sessions. Furthermore, the patient’s posture and tone of voice may convey his/her connection to the therapist.
Participants agreed that in order to understand the patient’s feelings and defences mobilised in interpersonal situations, the therapist should conduct a polite enquiry to elicit information:

“To think about it from the other person’s perspective. For example, a patient who comes in and recounts an argument they’ve had with their partner and they are simply recounting it and saying how terrible he was. And they said this and they did that… ask them to think about what it felt like at the time. You might actually start to get them to unpack what was going on, and think about what was going on underneath their partner’s accusation”

Several participants expressed that when exploring the patients’ feelings and defences the first step is to make them feel understood. Only after it is possible to explore other perspectives of the interpersonal situation.

Participants emphasised the importance of helping the patient explore unconscious feelings that may emerge in interpersonal situations in order to understand the conflict and defences mobilised in a set of specific circumstances. However, a number of participants suggested that a competent therapist should be aware of how much affect the patient can tolerate in reference to a specific situation. Thus, interventions should be titrated taking into consideration how defended the patient is.

In order to help the patient work through the defences and feelings mobilised in interpersonal situations, the therapist should first deliver his/her understanding of the patient’s interpersonal conflicts by both, describing the contradictions in the patient’s account, as well as by helping the patient solve the apparent contradictions in the story. Therefore, a competent therapist draws the patient’s attention to the contradictions in their narrative, trying to understand alongside them the affects, defences, and the different perspectives in a particular interpersonal situation.
Most participants agreed that in order to deliver competent interpretations it is necessary for the therapist to have an understanding of both the patient’s transference/countertransference dynamics, as well as the patient’s defences:

“Someone I was supervising was working with a male patient towards the end of their dynamic interpersonal therapy, so they were in the goodbye phases. He came in, in...one of the later sessions saying that he’d had a lot of difficulties with a plumbing company...they made a mess of the work. He was a bit better off doing it himself, and then he was rather suspicious of them as a reputable company. What was skilful...was that the therapist...(acknowledged) what that experience was like for him...how difficult it was and how he felt about it. But, at the same time, she was able to quite skilfully elaborate that experience into things that resonated more generally with his relationships. He didn't feel he could depend on people. He was often suspicious about what their intended motivation was...Partly he was beginning to fear that he didn't really want to ever need anyone because he always felt let down...And, then able to move into talking about that in relation to where they were in the therapy, and that actually what had his experience been”

Several participants considered that transference interpretations have a powerful, lasting and memorable impact on the patient, because they are delivered at the same time that a particular situation is taking place in the session. Nevertheless, participants also agreed that the therapist must judge whether to take something up in the transference or to focus on the outside world with something the patient is concerned about. Participants considered that a competent therapist is able to deliver both kinds of interpretations and understand which type to deliver at a specific time. However, at times it might not be sensitive to deliver interpretations at all:
“I was delivering a seminar and going through a case synopsis of a client who came to the session complaining that she’s bereaved of her father. Very difficult death, sudden, horrific and she came to the session…and said, ‘You know, actually, I’m just angry all the time. I’ve just had my car parking space stolen. I was gearing up to get into the car parking space and someone stole it.’ Students said, ‘You could interpret her car parking space— you could interpret things get taken away from her like her car parking space and her dad.’ Although that student was on the right track of…it was clumsy because comparing her father to a car parking space somehow didn’t feel…right for the patient”

Almost all participants agreed that a competent way of delivering interpretations is by arriving at them slowly and alongside with the patient, holding the patient’s hand as they arrive at it, saying the interpretation for the patient but with the patient.

Additionally, several participants coincided in that a competent interpretation should be based on enough information already discussed with the patient.

A number of participants considered that there is a specific sequence that helps deliver interpretations in a competent manner. Firstly, the therapist should deliver supportive interventions, validating the patient’s feelings. Only when the patient feels safe enough, it is possible for the therapist to make links and deliver interpretations. The delivery of the interpretation should feel constructive and not punitive to the patient. Additionally, the therapist should deliver interpretations as hypotheses that need to be tested together with the patient:

“All of these will be said in a tentative way so that the patient feels there’s a collaborative effort to understand their mind. A competent therapist is the person who provides some evidence for how they understand the patient’s mind, presents it tentatively and actively tries to engage the patient in helping them to understand how accurate or not, that picture of their pattern is.”
Several participants agreed that a competent therapist delivers interpretations in a language that belongs to the patient, using the words and thinking the patient uses:

“…Trying to find the words that the patient would use…she is really good at that. Find the language that the patient would use and put, -the way they would construe that-, that's not just words, it's their thinking, she's able to emulate. She's thinking like the patient in the room. Which is really quite…an art to be able to…”

7.3.3.9 Intervention: Supportive, Inquisitive or Interpretative

Participants considered that a competent therapist must know when to prioritise supportive interventions over expressive ones. Supportive interventions should be favoured when the therapist senses that the patient is feeling fragile and/or overwhelmed. However, expert clinicians expressed that the therapist must not collude staying with the patient only in their comfort zone by not asking difficult questions or not delivering interpretations.

7.3.3.10 Mentalizing

Most participant considered helping the patient mentalize is a primary/basic competence that every therapist should have. Participants agreed that helping the patient recover his/her ability to mentalize should take place before the therapist delivers any other intervention to the patient. Therefore, participants coincided in that the therapist should know which interventions support mentalizing and which interventions might hinder mentalization processes.

7.3.3.11 Titrating Interventions
Participants agreed that the therapist must titrate the delivery of interventions. The right timing to make a specific intervention is guided by clinical intuition and experience, which makes this issue hard to operationalise.

Participants expressed that in order to titrate interventions and meet the patient where he/she is at, it is necessary to know the patient’s defences. Thus, it is necessary that the intervention itself addresses the specific need of the patient to protect him/herself:

“I am primarily guided, I suppose, by my evolving formulation of how the patient functions. For example, if I'm picking up that a patient has very strong narcissistic defences that keep them together. I'm obviously going to be very mindful that the intervention I make has to address that need to protect themselves against a particular view of themselves that would be too threatening to their psychic equilibrium.”

7.3.3.12 Transference: Understanding and Use

Most participants referred that an important competency is the ability to understand the unconscious meanings underlying the patient’s transference relationship with the therapist. The therapist should have in mind that there might be relevant unconscious meanings particularly when a transference issue is kept away from the discussion.

Participants considered that a competent therapist understands that anything the patient says in the therapy reflects in some way what is happening in the therapeutic relationship and has an impact on it. Therefore, in order to understand and use the transference the therapist must be open to the relationship with the patient, putting him/herself “out there”, and not feeling the relationship with the patient as something neutral or distant:

“I suppose keeping on thinking about it in your mind, so listening to the material and thinking, ‘Does this have implications for the transference?’ If they’re talking about a very punitive boss, you’d have to think, ‘Do they feel like I’m punitive?’”
Therefore, most participants agreed that the therapist should understand that anything the patient says in the therapy is a reflection of the total transference situation:

“That row is an event that occurred, that they're reflecting on that you want to understand, the context that the row occurred. You also want to understand what it means for them to be talking about that row, what they think about that row now they're reflecting on it with you. But you also want to understand what it has meant to them to talk about that row, having told you about that, what you might be thinking about that row with them, how your views of them might have been impacted on them talking about that. All these are the different layers of understanding that event of them to…and you can easily get lost in any one of them and the transference, to me, -and in this I totally agree with Betty Joseph-, is the totality of that.”

A number of participants considered that a competent use of the transference does not necessarily involve interpreting it. Another alternative is to describe the transference situation, linking it to a separate issue relevant to the patient that might challenge his/her beliefs about him/herself:

“They might say something like, I think that in a number of important relationships who you end up feeling that people don't really have time for you and maybe sometimes even feel that with me. They are not really focusing on the transference but they're including it in what they're talking about.”

Participants suggested that an important competency is the ability of the therapist to be attentive and understand the use the patient is making of the transference interpretations:

“It would be how they made the interpretation and whether they're receptive to the patient's experience of the interpretation track the use that patient makes of the interpretation. For example, you have patients who love transference interpretations but not because they're actually making use of the
pattern they are highlighting but because they are gratified by the apparent intimacy that it sort of presents them with. They like you saying you feel this towards them because in that moment they are responding to feeling very fused with you. This is all about us, you're very interested in me, we have a relationship and actually what you've actually said doesn't make any difference. If it was that kind of patient what I be looking for in a competent therapist is someone who said, ‘At one level you are responding to my interpretation but I get the impression that actually what you're responding to is not what I've said, but the fact that every time we talk about what's going on between us you go into this fantasy of us as a couple, where you feel safe and everything is good and actually your mind stops working at that point.’ That for me would be an example of a competent therapist who doesn't just stop at making the transference interpretation but looks at how the patient uses it.”

Participants concurred in that a competent therapist is able to recognise and deliver his/her understanding of the transference in a sensitive and challenging way to the patient.

Participants considered that a competent therapist is the one who leads the patient to test something new, to try out and experiment something spontaneous in the therapeutic relationship.

Several participants referred that an essential competency is the capacity of the therapist to differentiate the issues that belong to the transference relationship with the patient, from the ones that belong to the real relationship with him/her.

7.3.3.13 Unconscious Communications

Participants referred that the frame and boundaries of the therapy are essential to create an environment of safety for the patient, which is in itself pivotal to facilitate the emergence of unconscious communications from the patient:
“Are they attending to details such as when appointments happen, at what time? Are they regular or are they the same time each week? If they're not, is that thought about if it's brought up at all in the sessions. Being mindful of and careful about those details. Looking out for them is potential insights into what might be going on in a client's inner world so that that can be brought out and thought about and used therapeutically with the client.”

Participants considered that the therapist facilitates the patient’s unconscious communications by promoting free association from the patient and by not having an agenda in mind for the therapeutic process.

Participants referred that the more structured a session is, the less it facilitates the emergence of the patient’s unconscious communications. Therefore, the therapist has to find a balance between the required structure to deliver therapy and the necessary space in order to facilitate the patient’s unconscious communications. Participants suggested that this balance is maintained by keeping the frame and boundaries of therapy, which are essential to structure the sessions. However, other issues could be left unstructured to facilitate unconscious communications.

Most participants suggested that in order to understand the patient’s unconscious communications it is essential for the therapist to have a psychotherapeutic model in mind. Additionally, in order to listen and understand the patient’s unconscious communications the therapist must be more attentive to how the patient communicates than to what he/she is saying.

Participants referred that a fundamental way the therapist listens and understands the patient’s unconscious communications is by being attentive to his/her own countertransference:

“They need to be able to reflect on their own responses, reactions, reflections and employ a capacity to unpick and unravel those responses and reflections, and what potentially of theirs and what aren’t, which is a very difficult skill for all of us.”
Most participants considered that a competent way of responding to the patient’s unconscious communications is by progressing from surface to depth, starting from the issues that are closer to consciousness.

The competent therapist responds to the patient’s unconscious communications by putting into words the latent meaning of the session. The way of putting the unconscious content into words is never with certainty, but tentatively, leaving space to think together with the patient.

7.3.4 Observable Competence group

Participants described a series of observable competencies meaning, competencies that are easy to operationalise and distinguish when listening and/or observing a psychodynamic session

7.3.4.1 Balance Between the Therapist and the Patient’s Lead

Participants considered an observable competency the capacity of the therapist to attain a balance between what the patient is interested in talking about and what the therapist considers to be important to address in the context of the therapeutic process.

7.3.4.2 Curious Stance for Mind Contents (rather than for Behaviours)

Several participants considered an observable competence the ability of the therapist to show curiosity towards the patient, particularly to the patient’s communications related to psychic contents rather than to the communications that are only focused in behaviours.

7.3.4.3 Eliciting and Exploring Interpersonal Dynamics
Participants indicated that an observable competence is the ability of the therapist to elicit and explore the patient’s interpersonal relationships, analysing them together with the patient from every angle.

7.3.4.4. Expanding the Patient’s Understanding

Participants regarded as an observable competency when the therapist not only reflects back to the patient what he/she is feeling, but expands the patient’s understanding of their own feelings and thoughts.

7.3.4.5 Focus on Affective Relational Patterns

Participants referred that it is possible to assess whether a therapist is being competent if he/she focuses in the relational and affective dynamics that unfold in the therapeutic relationship, as opposed to focusing on the patient’s cognitive functioning.

7.3.4.6 Intervening in a Sensitive Way

Another observable competency, according to the participants, is the ability of the therapist to show empathy and sensitivity in relation to how the patient is feeling when delivering an intervention:

“The tone of voice, the what’s said and the come development over time of the material between the two people in a session shows that the therapist is paying attention, thinking, saying things that are not just repeating back what the patient said”

7.3.4.7 Marked Mirroring
A pivotal observable competency, described by the participants, is marked mirroring. This refers to the ability of the therapist to convey to the patient, mainly through non-verbal/intrinsic communication, that they are able throughout the session to present an understanding of what the he/she is saying and feeling.

7.3.4.8 Mentalize Interpersonal Dynamics

Participants expressed that the ability of the therapist to help the patient mentalize the different perspectives of a particular interpersonal situation, is an observable competency. This means that the therapist helps the patient explore the different viewpoints of the people involved in a specific interaction.

7.3.5 Competence in DIT group

7.3.5.1 Activity and Visibility

Participants referred that in order to competently provide DIT, the therapist must maintain an active stance during the session and have a specific purpose in mind.

Additionally, participants stated that a competent DIT therapist has to be visible and communicative to the patient and not become a “blank screen”. The therapist should to be willing to inform the patient considerably, while at the same time knowing when to listen to the patient, giving him/her space.

7.3.5.2 Collaborative Work

Participants considered that an essential competence for DIT is the ability of the therapist to formulate and to share this formulation with the patient in order to elaborate it collaboratively, agreeing on it as the focus of work. It is not something the therapist develops on his/her own, it is rather something that the patient feels his/her own as well.
Additionally, participants considered that the therapist should check how the patient is using and not using the interventions, reviewing how the patient is feeling as the therapy goes along.

7.3.5.3 Directive to Focus

Participants referred that an important competence in DIT is the ability of the therapist to be directive and focused in the work while retaining an analytic attitude, meaning not becoming too cognitive or losing sight of the patient’s unconscious. This means that the therapist must be directive while tuned to the unconscious communications, evolving transference and the capacity to interpret.

Participants considered that the therapist should be *elastic* instead of *flexible*. This means, that the therapist can allow him/herself to deviate or stretch from the agreed therapeutic focus, but going back to it. This means that the therapist is able to go off-track of the therapeutic focus but never completely or permanently.

Several participants indicated that the therapist must not get lost in the past history of the patient but prioritise working on the agreed focus. The therapist must be persistent and hold his/her vision of the patient across the interventions. Accordingly, an important competence of the therapist is the ability to link back what the patient is saying to the IPAF, maintaining the focus of the therapy.

7.3.5.4 Elicit Interpersonal Narratives

Participants coincided in that an essential competence in DIT is the ability of the therapist to elicit interpersonal narratives:

“*Certainly, within DIT, the therapist would need to be able to elicit interpersonal material and…help the patient make those links, and they would*...
need to understand and take a detailed history of the symptom and encourage the patient to talk about that.”

7.3.5.5 Expectations for Change

Several participants considered that the aim of DIT is to help the patient have more insight of his/her difficulties. This is the most important goal of DIT because not every patient will be able to make behavioural changes during the short course of the therapy. Therefore, participants referred that the therapist should manage the patient’s expectations of what it is possible to achieve in a time-limited psychotherapy.

7.3.5.6 General Exploration, Focus in Recent Events

Participants considered that the therapist, does a general exploration in order to formulate the patient difficulties, but focuses in what has been more recent for the patient. The most important issues for DIT are recent experiences and the here-and-now of the session.

7.3.5.7 Incompetence in DIT

Most participants considered that one of the major risks of DIT is to become too concrete, not paying attention to countertransference, and holding on to enactments. Therefore, an important incompetence of DIT therapist is to lose sight of the unconscious realm:

“And I think one of the two things which can happen is that in brief therapy people can really forget about working with the countertransference and holding onto the unconscious enactment. And it can become quite concrete and then, the main flavour of psychodynamic work which is about the unconscious can get lost. I think this particular model brings that challenge”
Participants coincided in that an incompetent DIT therapist is the one that does not conduct the tasks of each phase of the treatment manual.

Participants considered incompetent a DIT therapist that does not have a focus for the therapy.

7.3.5.8 Interpretation

Because DIT is a Brief Psychodynamic Psychotherapy, participants referred that it should provide mainly supportive interventions rather than expressive ones. Delivering too many interpretations risks the therapy becoming stuck, which is particularly difficult in short-term therapy. However, although DIT is primarily a supportive psychotherapy, there must be a balance where the therapist titrates when he/she can be more challenging by delivering interpretations.

7.3.5.9 Positive Attitude towards DIT

Participants indicated that in order to competently provide DIT, the therapist must consistently and explicitly convey and instil hope for the potential change of the patient. It is essential for the therapist to believe in the value of brief therapy without considering it a bad alternative to long term therapy.

7.3.5.10 Quickness

Participants considered that the therapist should have clarity of thought and be able to quickly make links within the session. The therapist has to swiftly find the focus of therapy and should be open enough to share it with the patient.

Additionally, it is essential that the therapist quickly forms a relationship of trust and openness with the patient. This means than in a “few minutes” the
therapist should show that he/she is credible, respectful, interesting, giving the impression of someone the patient can trust

7.3.5.11 Stick to Model and Phases

Participants considered that a competent DIT therapist has to stick to the therapeutic model and to the tasks that need to be achieved in each phase of the therapy.

7.3.5.12 Transference

Because DIT is a brief psychotherapy there is less time to explore the transference relationship, and also a greater risk for the therapy to become stuck when reviewing the transference with the patient. Therefore, participants considered that a competent DIT therapist deals with the transference by acknowledging it but then reassuring the patient that transference is not what the therapist feels.

Participants considered that a competent DIT therapist should early in the course of the therapy understand what are the particular transference implications to the psychotherapeutic process, to name them and be aware of them with the patient so they do not interfere with the psychotherapeutic process.

7.3.6 Incompetence group

7.3.6.1 Enactment, Concrete Interventions, Not Thinking

Several participants considered that an incompetent therapist is unable to think and explore the different possible perspectives of what the patient is bringing to the session. Therefore, the therapist can easily become concrete in his/her interventions and/or get trapped in enactments:
“I have had to work with one person (in supervision) particularly I thought who could not A, understand, and then B, see the enactment, acknowledge it…The whole thing was about getting angry with a patient in terms of what was said, had felt very under attack. Reacted badly, got into a very adversarial kind of way of relating in a session. Was incredibly defensive about what had gone on and couldn't, wouldn't (understand it)”

Participants agreed on that an incompetent therapist is one that cannot understand enactments. Thus, the therapy can easily become stuck:

“Occasionally if I get really frustrated listening to a recording…sometimes something very critical gets enacted and the therapist just keeps going for it…you think ‘this isn't going anywhere…or it's a very elusive quality…or there's no feeling in the room, or it's very intellectualised maybe.’ I suppose sometimes there's very little linking going on to the material.”

Participants indicated that the inability of the therapist to pick up unconscious communications might lead to collusion. The latter is particularly likely to happen when the therapist does not address the negative transference and/or difficult feelings from the patient:

“An example of that is somebody who doesn't take it up when the patient is consistently very late for their sessions, which I'll take to be a communication from the patient, but because that therapist…is always under huge pressure. They're actually quite pleased if a patient is late because they can make a phone call or do their email…they never seem to say anything to the patient about that…I think that would be an example of incompetence; that they are both missing something that needs to be understood…There's a there's a failure to pick up and address something…and give more meaning…It's a missed opportunity to understand… It's also a collusion”

Participants considered that a therapist is incompetent when he/she cannot see the layers of meaning in the patient’s material:
“A therapist who the patient sort of texts her and she replies through texting in a very non-thoughtful manner…a text exchange, that would lead me to worry about what’s happening. Particularly, if the therapist has no reflection that there is something potentially problematic. This therapist presented it to me as saying he was in a crisis…There was an incapacity to imagine that that behaviour could have layers of meaning and impact on the way that patient and therapist relate. It’s sticking to a very concrete level”

Participants referred that another way of being concrete, is when the therapist quickly reassures the patient, acting fast and superficially, without thinking and/or without gathering enough information to understand. Additionally, giving the patient advice, homework and/or direct answers to their questions is an incompetent way of intervening, because leads to a relationship that might be comfortable for the patient but that does not allow him/her to think, neither work psychologically. Thus, an incompetent therapist closes a topic too soon, narrowing it down without really exploring it. Consequently, the patient cannot understand what is happening and therefore an aspect of him/her becomes split-off.

Participants concurred that a therapist may lose the ability to think and trust his/her own judgment when he/she is overwhelmed with the patient, becoming overly anxious or afraid of the effect of their interventions on the patient. They are particularly afraid that the patient may disapprove or become angry at an intervention.

7.3.6.2 Inability to Foster Therapeutic Alliance

Participants referred that a cold, rigid, and stiff therapist is less competent because he/she makes it harder for the patient to form an attachment relationship:

“I think somebody who is so reserved or awkward or high-bound by their theoretical framework that they can’t relate on a human level to a patient is to
my mind not a very competent therapist. Because they’re not going to make a warm and trusting relationship”

Additionally, participants coincided in that an incompetent therapist often forgets important information about the patient. Thus, it becomes difficult for the therapist to elaborate on the patient’s material because he/she is not retaining the patient in mind:

“…the therapist two minutes later won’t be able to remember the name of the person or will get it wrong. And you can hear the patients in different sessions feeling depressed and detaching…because it’s quite hurtful because someone wasn’t really listening or that interested…I think being able to keep in mind…not being able to retain the picture of the patient which you can make clear to them is a sign of incompetence”

Several participants considered incompetent when there are prolonged silences in the session, signalling a disconnection between therapist and patient.

“You think that psychoanalytic work is being silent, and neutral and not saying anything. Actually, that is often I think quite unhelpful… I’d rather someone is engaging with the person, and trying to understand something…rather than creating almost a void into which the patient can very quickly either feel that they’re on their own, and that they don’t have support”

7.3.6.3 Interventions Not Adapted to the Context, Patient. Not Considering Consequences of Interventions

Participants considered that incompetence is when the patient gets worse in the course of treatment and the therapist is unaware of it, and/or unable to address that with the patient. Often the latter happens when the therapist delivers the treatment manual automatically, not learning from the individual patient, nor adapting the interventions to that specific patient.
Participants expressed that an incompetent therapist will make an interpretation driven more by their own ideas or in a mechanistic way, rather than driven by what the patient needs at a specific time. Thus, an incompetent therapist delivers interpretations not thinking about the patient, nor adapting them to the therapy context. Additionally, an incompetent therapist delivers interpretations that are mainly self-gratifying for him/her.

Participants considered that an incompetent way of dealing with the patient’s defences is treating them disrespectfully, not understanding the underlying struggle the patient has. Furthermore, it is incompetent to challenge a defence too soon because it leaves the patient exposed and leads to ruptures in the alliance.

Participants considered incompetent when the therapist interventions do not show sensitivity to the complexity of the patient’s difficulties. Additionally, they are irresponsible because they do not consider the potential effects his/her interventions may have on the patient:

“Because they're stupid. I use the term stupid with a specific meaning. They don't understand the patient, they say the wrong thing, they're insensitive, they undermine the patient, they are self-centred, they're narcissistic, they care more about their self-esteem”

Participants referred that an incompetent therapist is an unethical one, someone who is abusive, or exploitative of the patient or neglectful. Furthermore, a therapist that has power struggles with the patient is highly incompetent.

Furthermore, participants considered that an incompetent therapist overwhelms the patient for example, making them sad or angry, instead of helping them mentalize their emotions.

7.3.6.4 Lacking Basic Skills to Intervene

Several participants stated that an incompetent therapist does not have a model of therapeutic principles in mind.
Participants referred that it is incompetent when the therapist does not keep the frame or boundaries of psychodynamic work.

A therapist that cannot deliver the interventions at an appropriate timing for the patient was considered incompetent by the participants. This includes therapists that are slow in making connections or therapists that do not think of possible meanings until way after the moment the patient can make use of them.

Participants considered incompetent a therapist that cannot express himself/herself clearly. This occurs when therapists are ambiguous, or use jargon, or speak for so long that the patient forgets where they started.

Several participants considered incompetent a therapist that intervenes without having gathered enough information that would allow him/her to understand the patient’s situation.

Participants referred that it is incompetent when therapists do not allow for silences, leaving no space to think in the session. On the other hand, it is incompetent when therapists become too silent, without helping the patient communicate.

Participants agreed that an incompetent therapist is the one that gives the patient a destructive view of themselves that leads the patient to self-hatred and depression instead of wanting to make positive changes in their lives.

7.3.6.5 Therapist Mental Health Issues

Participants referred that therapists that blame their patients for their own difficulties are highly incompetent. These therapists tend to focus on the patient's difficulties, blaming the patient for the lack of progress in therapy.

Most participants expressed that narcissistic, self-centred therapists, or therapists that cannot take in criticisms, are unable to maintain an alliance with the patient, and therefore are incompetent:

“I think they were emotionally immature. They conveyed to me a predisposition for quite primitive relating. Could not tolerate difficult feelings inside of themselves and wanted to remove them at any cost. That doesn't make a competent therapist.”
“One of the things that I think contributes to incompetence is certainty. People who really feel they know things and that they’re there to impart that to their patients I think they can be incompetent, because actually it lacks a degree of questioning of oneself. Rigidity of ideas, if you just think things are always this, or always that, a kind of more binary position…”

Therefore, participants indicated that an incompetent therapist is one that doesn’t have self-awareness, does not have insight of the effect of his/her actions, does not know his/her own blindspots and when they might interfere with the therapy.

7.4 Development of the TCS

7.4.1 First version of the TCS

The items of the first version of the TCS were construed to reflect the themes that emerged of the thematic analysis. Item selection followed the principle of portraying comprehensively and faithfully the expert clinicians’ conceptions of competence. This version was composed of two subscales, the competence and incompetence subscales; and, two overall ratings, the global competence and patient complexity ratings.

The patient complexity rating was included in the scale in order for the TCS to deliver a competence score contextualised according to the difficulty displayed by the patient in the session. For this reason, the patient complexity rating was included in the scale despite not being derived from the thematic analysis.

The competence subscale and global competence rating were scored in a 4-point Likert scale. The incompetence scale was scored using a binary rating. Patient complexity was rated according to an ordinal scale

13 See Appendix M.
(mild/moderate/severe). Overall, the first version of the TCS included 219 items (Table 7.8).

<table>
<thead>
<tr>
<th>Table 7.8</th>
<th>TCS First version</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TCS: First version</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Competence Subscale</strong></td>
<td></td>
</tr>
<tr>
<td>Domain 1: Analytic Attitude (8 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 2: Fostering Epistemic Trust (10 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 3: Issues Regarding Judgment, Flexibility, Adaptations and Judgment (9 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 4: Therapeutic Use of Generic Skills and Techniques (19 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 5: Fostering and Maintaining the Therapeutic Alliance (10 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 6: Therapist’s Self-Awareness, Self-Regulation, and Capacity to Think (6 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 7: Understanding and Intervening at Multiple Levels (4)</td>
<td></td>
</tr>
<tr>
<td>Domain 8: Ability to Engage the Patient (10 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 9: Arriving at a Dynamic Formulation (8 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 10: Accurately Understanding the Patient (5 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 11: Management of the emotional Content of the Session (9 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 12: Understanding the Patient’s Interpersonal Feelings and Defences (6 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 13: Facilitating, Listening, Responding to Unconscious Communications (11 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 14: Delivery of Interpretations (13 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 15: Understanding and Using the Transference (9 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 16: Management of the Defences (7 items)</td>
<td></td>
</tr>
<tr>
<td>Domain 17: Specific DIT Competencies (23 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Incompetence Subscale</strong></td>
<td></td>
</tr>
<tr>
<td>Enactments, Concrete Interventions, and Not Thinking (12 items)</td>
<td></td>
</tr>
<tr>
<td>Inability to Foster the Therapeutic Alliance (6 items)</td>
<td></td>
</tr>
<tr>
<td>Not Adapting and Not Considering the Consequences of Interventions (11 items)</td>
<td></td>
</tr>
<tr>
<td>Lacking Basic Skills to Intervene (10 items)</td>
<td></td>
</tr>
<tr>
<td>Therapist Mental Health Issues (6 items)</td>
<td></td>
</tr>
<tr>
<td>Not Accurately Understanding the Patient (1 item)</td>
<td></td>
</tr>
<tr>
<td>Incompetence in DIT (4 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Global Competence Rating (1 item)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Complexity Rating (1 item)</strong></td>
<td></td>
</tr>
</tbody>
</table>
7.4.2 Second version of the TCS\textsuperscript{14}

A major revision of the first version of the TCS was conducted by the author and Professor Peter Fonagy by examining the items qualitatively. Five principles guided the development of the second version of the TCS. Firstly, all items should describe a competence/incompetence that was possible to objectively observe when listening to an audio-recorded session. All items that were not verifiable were removed from the scale in order to improve the reliability of the scale.

The second principle was that all items should outline a competency/incompetence that could be observed in any session, independently of the phase of therapy. Therefore, all items that referred to specific situations or to the particular aims of each phase of DIT, were removed from the scale, in order to avoid large amounts of missing data. Additionally, items that referred to attitudes/behaviours displayed by the patient rather than the therapist, were removed.

Throughout the revision of the scale it was observed that items could be organised according to high order competencies that encompassed many low-order competencies. It was thought that structuring the scale using a hierarchy would help operationalise in a better way the different high-order competencies. This arrangement would allow the removal of various redundant items, while maintaining the capacity of the scale to characterise in detail each of the major competencies and incompetencies. Thus, the hierarchical structure would improve the depth and breadth to the scale.

The fourth principle that guided the development of the second version of the TCS was that the wording of the item should be theoretically neutral. This was decided in order for the items to only reflect DIT competencies and psychodynamic/psychoanalytic competencies, without theoretical restrictions.

Finally, the fifth principle that was followed to develop the second version of the scale was to arrange the items in terms of the aims that a therapist has in every DIT session instead of organising them according to domains of

\textsuperscript{14} See Appendix N.
competence. The idea underlying this principle was for the scale to be arranged in accordance to clinical objectives rather than being a purposeless item checklist. Following the same line, clinical examples for each of the items were added in order to improve the applicability and reliability of the scale.

The second version of the TCS was composed by the same subscales and overall ratings. It was scored in the same manner as the first version of the scale. However, it included 84 items. (Table 7.9 and 7.10).
<table>
<thead>
<tr>
<th>Competence Subscale</th>
<th>TCS: Second version</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim 1:</strong> To Create Psychic Space where it is Possible to Think T with the Patient (2 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 2:</strong> Containment, Making the Patient Feel Understood (2 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 3:</strong> Help the Patient Think (1 item)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 4:</strong> To Foster the Patient’s Epistemic Trust (3 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 5:</strong> To Centre the Psychotherapeutic Work around the Unconscious Processes (2 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 6:</strong> The Therapist is Able to Think About Himself/Herself (4 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 7:</strong> Promoting Psychic and Behavioural Change (2 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 8:</strong> Help the Patient Grieve (1 item)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 9:</strong> To Create an Environment of Safety (2 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 10:</strong> To Foster and Maintain the Therapeutic Alliance (2 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 11:</strong> To Engage the Patient with Therapy (3 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 12:</strong> Promoting Mentalizing (3 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 13:</strong> To Have in Mind the Patient’s Traits and States of Mind (9 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 14:</strong> Promote and Expand the Patient’s Self-Knowledge and Self-Awareness (1 item)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 15:</strong> Promote the Patient’s Awareness of His/Her Relational Patterns (3 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 16:</strong> To Help the Patient Self-Regulate Emotions (2 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Aim 17:</strong> Managing the Patient’s Defences (2 items)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Incompetence Subscale</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enactments, Concrete Interventions, and Not Thinking (8 items)</td>
<td></td>
</tr>
<tr>
<td>Inability to Foster the Therapeutic Alliance (4 items)</td>
<td></td>
</tr>
<tr>
<td>Not Adapting and Not Considering the Consequences of Interventions (10 items)</td>
<td></td>
</tr>
<tr>
<td>Lacking Basic Skills to Intervene (7 items)</td>
<td></td>
</tr>
<tr>
<td>Therapist Mental Health Issues (6 items)</td>
<td></td>
</tr>
<tr>
<td>Not accurately understanding the patient (1 item)</td>
<td></td>
</tr>
<tr>
<td>Incompetence in DIT (2 items)</td>
<td></td>
</tr>
<tr>
<td><strong>Global Competence Rating (1 item)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Complexity Rating (1 item)</strong></td>
<td></td>
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</tbody>
</table>
Table 7.10

**TCS First version: Items Removed**

<table>
<thead>
<tr>
<th>Competence Subscale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not observable/objective items</td>
</tr>
<tr>
<td>1. The therapist tolerates the uncertainty and ambiguity that is associated with not understanding what is happening in the session with the patient. The therapist is capable of showing this uncertainty to the patient, conveying the importance of thinking, and the fact that psychotherapy is a collaborative process, where meaning is co-constructed between therapist and patient.</td>
</tr>
<tr>
<td>2. The therapist listens to the patient and makes links with a free-floating attention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item specific to tasks or phases of therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The therapist is able to make an assessment of the patient</td>
</tr>
<tr>
<td>2. The therapist is able to assess the patient’s suitability for psychodynamic psychotherapy</td>
</tr>
<tr>
<td>3. The therapist is capable of assessing the patient’s level of risk, and modify his/her interventions accordingly</td>
</tr>
<tr>
<td>4. The therapist is able to manage the patient’s expectations of therapy. The therapist clarifies to patient what can be achieved, and what not, within the timeframe of therapy, and considers the patient’s need for further therapy after finishing the current one. Additionally, the therapist conveys that ultimately change comes if the patient is motivated and committed to work towards it</td>
</tr>
<tr>
<td>5. The therapist prepares the patient for planned interruptions in the treatment by helping them explore their conscious and unconscious responses to breaks</td>
</tr>
<tr>
<td>6. The therapist ensures that the patient is clear about the rationale for the intervention offered</td>
</tr>
<tr>
<td>7. The therapist is attentive to his/her countertransference, and to the patient’s dreams and slips</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Items that refer to an attitude/behaviour of the patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The therapist engages the patient getting him/her to be responsive to the therapist’s verbal and non-verbal communications. The therapist gets the patient to: a) be attentive to the therapist communications; b) elaborate the therapist communications; c) remember material from previous sessions; d) convey changes in his/her affective tone (for example, through tone of voice, posture); and, e) be in the route of making changes in the way they relate to others.</td>
</tr>
<tr>
<td>2. The therapist accurately understands the patient, bringing about an observable change in the patient’s: a) tempo or rhythm; b) emotions or affective tone; c) usual behaviour in the session; d) material, therefore the patient can bring about new material or allow for old material to be elaborated in a different way; e) thought processes and</td>
</tr>
</tbody>
</table>
ability to make links; f) capacity to trust; g) memories; or, h) ownership of the idea conveyed by the therapist.

3. The therapist bases his/her interventions on enough information and evidence that has already been discussed with the patient
4. The therapist interventions make sense from what has been happening in the therapy.
5. The interventions are based on enough evidence provided by the patient

Incompetence Subscale

Redundant items

1. The therapist does not understand and/or is unable to think about what the patient is communicating; thus, the therapy becomes easily stuck
2. The therapist gives the patient advice, homework and/or direct answers to their questions. Therefore, the therapist fosters a relationship that might be comfortable for the patient but that does not allow him/her to think, or work psychologically. Therefore, the therapist interventions are concrete by giving fast, specific and material solutions to his/her patients
3. The therapist frequently communicates in a colloquial way with the patient (can be considered under frame and boundaries)
4. The therapist allows for prolonged silences in the session
5. The therapist does not carry out the tasks of each phase of the treatment manual.
6. The therapist is unable to quickly create a relationship of trust with the patient.
7. The therapist gives the patient a destructive view of themselves
8. The therapist misunderstands the patient and says wrong things to them, leaving the patient alone and/or perplexed.

Not observable/objective items

1. The therapist is either too slow in making links in the patient’s material or does not think of possible meanings until way after the moment the patient could really have been helped by them.

Items that refer to an attitude/behaviour of the patient

1. As a consequence of the therapist behaviours, the patient becomes less interested and less connected to the therapist and the therapy
7.4.3 Third version of the TCS\textsuperscript{15}

There were no further changes in the individual items of the third version of the TCS. However, two important modifications were made. Firstly, the general guidelines for the application and rating of the scale were included. Additionally, it was considered that the competence subscale and the global competence rating should be scored in a 7-point Likert scale (0-6 points), rather than in a 4-point one, in order for the TCS to have a better capacity to distinguish degrees of competence between therapists. The patient complexity rating also changed from being scored in an ordinal scale (mild/moderate/severe) to be rated in a 6-point Likert scale, in order to better identify different levels of complexity between patients (Table 7.11).

\textsuperscript{15} See Appendix O.
<table>
<thead>
<tr>
<th>Competence Subscale and Global Competence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Limited:</strong> The feature described is either not present in the session and/or it is not possible to assess (Score = 0)</td>
</tr>
<tr>
<td><strong>Basic:</strong> The therapist demonstrates a significant absence of skill or an inappropriate performance which is likely to have negative therapeutic consequences (Score = 1-2)</td>
</tr>
<tr>
<td><strong>Good:</strong> The therapist’s performance is appropriate with an evident degree of skill. However, the therapist either demonstrates the competency in a limited way, restricted to a specific aspect of the competency or to particular moments of the session; or, there are problems or inconsistencies in the therapist’s performance of the specific competency (Score = 3-4)</td>
</tr>
<tr>
<td><strong>Advanced:</strong> The therapist consistently demonstrates a high level of skill with only few and minor problems. The therapist demonstrates the ability to carry out the competency in a range of ways and in moments of varying complexity during the session. The therapist demonstrates breadth and depth in the performance of the competency. (Score = 5-6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Complexity Subscale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild.</strong> The patient appears to be very straightforward to work with. The patient is motivated and engaged with the therapy. The patient has enough psychological resources to deal with the therapeutic process. The patient has high level of (epistemic) trust, he/she is open and receptive to most of the therapist’s interventions (Score = 1-2)</td>
</tr>
<tr>
<td><strong>Moderate.</strong> The patient is at times challenging to work with. The patient may be ambivalent towards therapy. The patient has some psychological resources to deal with the therapeutic process. The patient has a moderate level of (epistemic) trust, he/ she receives some of the therapist’s interventions but remains closed to others (Score = 3-4)</td>
</tr>
<tr>
<td><strong>Severe.</strong> The patient appears to be challenging to work with. The patient may be unmotivated or disengaged from therapy. The patient appears not to have the necessary psychological resources to deal with the therapeutic process. The patient has a high level of (epistemic) vigilance, and has difficulties to hear and listen to the therapist’s interventions (Score = 5-6)</td>
</tr>
</tbody>
</table>
7.4.4 Fourth version of the TCS

The third version of the TCS was piloted by a PhD student and the author of the study by rating three audio-recorded sessions of DIT. The face validity and applicability of the items was examined and several changes were made. Firstly, two items were considered to be redundant and were removed from the scale (Table 7.12). Secondly, modifications were made to the guidelines for rating incompetence. It was agreed that for an incompetence item to be present in the session, it would have to be a prominent aspect of the session or be present the majority of the time. Finally, several changes in the wording of the items were made in order to avoid high levels of inference from the raters (Table 7.13).

Table 7.12

<table>
<thead>
<tr>
<th>Items removed from third version of the TCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The therapist is able to find a balance in the use of the therapeutic model. The therapist uses the principles of the intervention model adapting them to the patient’s needs, but also ensuring that all relevant components are being included.</td>
</tr>
<tr>
<td>The therapist only challenges the defences when there is enough trust and a solid therapeutic relationship. Additionally, the therapist only challenges the defences, when the patient has the resources, the capacity, and the external support to cope with the feelings underneath the defence.</td>
</tr>
</tbody>
</table>

16 See Appendix P.
Table 7.13
Third version of the TCS: Modified items

<table>
<thead>
<tr>
<th>Competence Subscale</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>6. The therapist uses ostensive cues to alert the patient that the intervention that is about to be delivered is important to him/her. Then, the therapist delivers an intervention whose content is personally relevant for the patient and that is in harmony with his/her intentions and interests, in a sense that can be taken by the patient with a sense of ownership.</td>
</tr>
<tr>
<td>11. The therapist conveys that he/she is aware of the emotional impact of the patient's communications, realising his/her own feelings and thoughts, and using them in a meaningful way in order to understand the patient’s material and the relationship with him/her</td>
</tr>
<tr>
<td>16. The therapist organises each session in accordance to the therapeutic focus (IPAF) and to the tasks that need to be achieved in each phase of therapy. Therefore, the therapist is persistent and holds his/her vision (IPAF) of the patient across interventions</td>
</tr>
<tr>
<td>19. The therapist perseveres and is consistently trying to understand the patient’s material and to puzzle out his/her difficulties. The therapist is there for the patient even when he/she is the target of the patient’s negative transference. The therapist survives the patient’s attacks, tenaciously trying to understand what has taken place, conveying to the patient that he/she cares for him/her.</td>
</tr>
<tr>
<td>25. The therapist maintains a focus in the patient’s internal states, sustaining this despite the challenges posed by the patient</td>
</tr>
<tr>
<td>31. The therapist delivers short and clear interventions, in a language that belongs to the patient, so that it is easier for him/her to understand them and take them in</td>
</tr>
<tr>
<td>39. The therapist is able to formulate and/or verbalise the IPAF, which includes identifying what is the patient’s self-representation, other representation, and which are the most important affects and defences employed by the patient. The therapist understands and links the material the patient brings to therapy to the IPAF in order to maintain the therapeutic focus</td>
</tr>
<tr>
<td>43. The therapist is respectful of the patient’s defences, and understands the reasons behind them. The therapist works with the defences by naming the defence and its costs for the patient. Additionally, the therapist works with the defences by acknowledging and understanding the struggle that leads the patient to feel the need to defend himself/herself.</td>
</tr>
</tbody>
</table>
Incompetence Subscale

6. When an enactment takes place, the therapist is unable to handle and/or understand his/her own countertransference and/or his/her participation in the interaction with the patient

15. The therapist makes interventions driven more by his/her own ideas, than by what is happening in the session with the patient. Thus, the therapist delivers interventions not thinking about the patient, nor adapting them to the therapeutic context

17. The therapist treats the patient’s defences disrespectfully, not understanding the underlying struggle that leads the patient to feel the need to defend himself/herself. The therapist points out the defences, or challenges them too soon in the therapy, without thinking of the consequences that this might have, threatening the patient’s psychic balance

36. The therapist does not understand the patient, causing a break in the therapeutic process.

Note 1. Modifications underscored

7.5 Discussion

This study achieved its purpose of operationalising and developing a measure of therapist competence in DIT. Indeed, the TCS provides a description and classification of a range of therapist core competencies and incompetent attitudes and behaviours that may be displayed in the delivery of Dynamic Interpersonal Therapy (DIT). The development of the TCS is deeply rooted in the work of Lemma et al. (2008) who compiled the Framework of Competences for Psychoanalytic/Psychodynamic therapy and DIT. Additionally, as the main purpose of the TCS was to be clinically relevant, it was also developed from the themes that emerged of the qualitative analysis of expert DIT clinicians’ conceptualisations of therapist competence.

The TCS is composed of 2 subscales and 2 global ratings. The first subscale includes 42 core competencies that are grouped according to 17 fundamental aims that a DIT therapist has in a session: (1) to create psychic space where it is possible to think together with the patient; (2) containment; (3) to help the patient think for himself/herself; (4) to foster the patient’s epistemic trust; (5) to centre the psychotherapeutic work around unconscious
processes; (6) to be able to think about himself/herself in the room with the patient; (7) to promote the patient's psychic and behavioural change; (8) to help the patient grieve; (9) to create an environment of safety; (10) to foster and maintain the therapeutic alliance; (11) to engage the patient in therapy; (12) to promote mentalizing; (13) to have in mind the patient's traits and states of mind; (14) to promote and expand the patient's self-knowledge and self-awareness; (15) to promote and expand the patient's knowledge and awareness of his/her relational patterns; (16) to help the patient self-regulate emotions; and, (17) to manage the patient's defences.

The TCS second subscale comprises 38 incompetent attitudes and behaviours that a therapist can display in a session, which are classified into 7 groups: (1) enactments and/or concrete interventions; (2) inability to foster the therapeutic alliance; (3) not adapting the interventions to the patient/context and not considering the consequences of the interventions; (4) lacking the basic skills to intervene; (5) therapist's mental health issues; (6) not accurately understanding the patient; and (7) incompetence in DIT.

Additionally, the TCS includes two global ratings. The first one aims to provide an overall impression of the therapist competence in a session. The second global rating intends to present a general estimation of the patient's clinical complexity and availability to work psychotherapeutically.

The TCS items describe the therapist competencies and incompetencies in terms of behavioural and linguistic cues which can be objectively observed by a rater that has an understanding of psychodynamic psychotherapy processes. In order to ensure interrater reliability, coding descriptions and examples for each of the items were included in the scale. The TCS unit of observation is the entire session in order for it to capture behaviours that may have low base rates (Hogue, Liddle, & Rowe, 1996). The competencies subscale and the global competence rating are scored according to a 7-point Likert scale. The incompetence subscale is rated in a binary fashion, according to whether the described attitude and/or behaviour is present or absent from the session. The patient complexity rating is scored according to a 6-point Likert scale.

This is the first study that uses qualitative methods to inform the development of a scale in brief psychodynamic psychotherapy. Using
qualitative inquiry can be particularly useful for the development of scales in order for the items to be grounded in real life situations and observations (Rowan & Wulff, 2007).

The thematic analysis followed an inductive approach, guided by the operationalisation of competence proposed by the Framework of Competence in DIT and psychodynamic/psychoanalytic therapy (Lemma et al., 2008). Although the results of the thematic analysis were to a great extent in line with the theoretical approach, they also expanded its conceptualisation by adding clinical depth and breadth to the competencies descriptions. Thus, one of the substantial contributions of this study is the operationalisation of competence not only in terms of “what” the therapist should do, but also “how” he/she should do it.

Additionally, the large number of items in the competence subscale allows for the description of a broad range of therapist’s attitudes and behaviours that goes beyond the descriptions of the common factors of psychotherapy (Weinberger, 1993). Therefore, the competence subscale enables the assessment of competence according to specific psychotherapeutic techniques, as well as the examination of the competencies that foster the therapeutic alliance, among other factors common to all psychotherapies.

The study also presents an original contribution by being the first one to operationalise therapist incompetence in the psychotherapeutic process. Unlike the competence subscale, the incompetence subscale does not differentiate between “levels of incompetence”, but assesses whether specific incompetencies were present or absent in a session. Thus, the competence and incompetence subscales elaborate on the established understanding of therapist competence. Accordingly, a competent therapist should not only demonstrate a high level of skill in the delivery of interventions, but also should be cautious to avoid incompetent attitudes and behaviours.

The two global ratings of the scale allow the assessment in general terms of the therapist performance and the level of difficulty of the patient. Although the patient complexity rating did not emerge from the thematic analysis, its inclusion in the scale was considered important in order to understand therapist competence and incompetence in context. Indeed, a
therapist may be more competent if he/she displays the same level of skill with a complex patient rather than with a less complex one. However, the patient complexity rating requires a great level of inference and depends on the coder level of expertise. Therefore, the patient complexity scores may not be reliable and should be analysed with caution.

The assessment of therapist competence in DIT requires an understanding of relational dynamics and of how unconscious processes impact verbal and non-verbal communications. Operationalising competence in an observational measure therefore, has intrinsic limitations. For example, it may be difficult to observe the emotional impact of a behaviour or to capture what is missing from the session. Additionally, the perspectives of the therapist and patient cannot be reliably assessed. Furthermore, the therapist formulation of the case, critical to understand the strategies employed throughout the treatment-, is not an observable process. Therefore, although the study attempted to operationalise competence based on observable and objective descriptions, a level of subjectivity and inference in the TCS items was unavoidable. This is the most fundamental difficulty in operationalising competence. Only studying how the TCS works in practice, will allow the qualitative improvement of the individual items.

The current study has several methodological limitations that need to be considered when examining the results. Firstly, the thematic analysis was conducted entirely by the author of the study and no reliability assessments were made. This may have impacted the coding of the results and increased the risk of random error. Additionally, there are several characteristics of the author that may have affected the coding process and the selection of items for the TCS, such as being a patient of an open-ended psychodynamic psychotherapy, and being theoretically inclined towards a Kleinian (Spillius, 1988) approach to psychoanalysis. These characteristics of the author may have led to coder and interpretive bias. However, methodological issues related to the qualitative analysis and the formulation of themes were discussed and reviewed together with the study primary supervisor.

Another methodological limitation that could have impacted the reliability of the results is that no triangulation of the data was carried out. Therefore, the
inevitable level of subjectivity in analysing and interpreting the data (Willig, 2012) was not addressed by checking the results with the study participants.

Only 12 of 41 expert DIT clinicians replied to the email invitation to participate in the therapist competence semi-structured interview, generating a response rate of 29.26%. The results might therefore have been affected by response bias which can therefore limit the generalizability of the results. Additionally, the responders consisted mostly of clinicians with an academic background, who may have self-selected for the interview based on their familiarity with the Framework of Competences (Lemma et al., 2008) and their openness to scrutiny, leading to a potential confirmation bias.

Overall, the thematic analysis of semi-structured interviews to DIT expert clinicians allowed the operationalisation of therapist competence and incompetence, and the development of the TCS. The study has a number of limitations that need to be kept in mind when applying the TCS and should be addressed by future research.
Chapter 8: Interrater Reliability of the TCS

8.1 Introduction

The current study aimed to examine the interrater reliability of the TCS, in order to assess the precision with which it captured therapist competence and incompetence in DIT audio-recorded sessions.

In the psychotherapy research field, several steps have been taken in order to develop a measure that allows for the documentation of therapist competence. However, hitherto the limited reliability of these instruments has been a concern. The estimates of interrater reliability for competence measures has been reported as low in the literature, particularly when ratings of few judges are averaged in the estimate (Vallis, Shaw, & Dobson, 1986). Barber et al. (2007) have suggested that the poor interrater reliability of competence measures might be due to several difficulties, such as: (1) different raters have dissimilar understandings of therapist competence; (2) different raters prioritise disparate aspects of the delivery of treatment; and, (3) difficulties in operationalising competence, among others. The current study aimed to address these difficulties by generating a detailed operationalisation of therapist competence, and training the raters in the understanding of therapist competence provided by the TCS.

In psychometric studies, the assessment of reliability plays a vital role. By and large, reliability is understood as the extent to which an instrument is consistent and precise, generating similar results when administered repeatedly to measure the same phenomenon (Carmines & Zeller, 1979). Thus, interrater reliability is conceptualised as the degree of similarity between the scores of two or more raters in reference to a particular construct measured according to specific criteria (Shrout & Fleiss, 1979). In any given sample of scores, the total variation may be conceived as being composed by a true variation and error variation (constituted of random error and systematic error). The true variation represents the actual or real differences in the construct under study. Random error refers to variations in the scores due to chance, while systematic error represents the bias that affects the measurements in a specific direction in a relatively consistent fashion. Therefore, reliability could
also be defined as the proportion of true variation to total variation, in the scores of a specific measure (Crocker & Algina, 1986). In the current study, the reliability, and specifically, the interrater reliability of the TCS, was examined. In order to clearly distinguish what constituted the true variation of competence, and separate it from other sources of error, -such as the raters or the items of the scale-, particular importance was given to understand the different components of error in the measurements. Therefore, this study took into consideration the pitfalls of past studies that had evaluated the reliability of scales exclusively using the methodology proposed by Classical True Score Theory (CTST) (Feldt & Brennan, 1989), which only accounts for a single source of error in the measurements. Not considering more than one source of error in the measurements can bring about inaccurate results regarding the reliability of a scale. The latter is particularly important in datasets where the methodology followed to conduct the measurements brings about various sources of error that need to be distinguished in order to appropriately study reliability, without overestimating or underestimating it. Prior to the beginning of this study it was acknowledged that at least two sources of error, -the items and raters-, should be accounted for in the investigation of the TCS reliability. Thus, this study took an innovative approach to study the reliability of the TCS by employing Generalizability Theory (GT), -a methodology that disentangles and separately analyses the different sources of error in the measurements. In the following sections, these two different frameworks to estimate reliability, -namely the CTST and GT-, will be described in the context of their application to study the interrater reliability of the TCS.

8.1.1 Classical True Score Theory

The CTST (Feldt & Brennan, 1989) provides a useful theoretical framework to study reliability. CTST conceptualises scores as derived from a random sample of the population of possible scores, and considers them a composite of two hypothetical components: a true score (T) and a random error component (E). T constitutes the mean of the test scores over many repeated administrations of the same test to the same subject, and E is the discrepancy
between the observed score of the subject and its true score. Therefore, the
relationship between the score (X), T and E can be summarised in the following
equation:

\[ X = T + E \]  \hspace{1cm} (1)

One of the main limitations of the CTST is that considers that
measurement error derives only from one source, and therefore it cannot
adequately distinguish between the different possible sources of measurement
error. Furthermore, CTST does not consider the possible interaction between
different causes of error, which may originate additional sources of
measurement error.

As mentioned above, interrater reliability is the degree of agreement
between the scores of two or more raters with regard to a particular construct
measured according to specific criteria (Shrout & Fleiss, 1979). Therefore, the
reliability between raters depends on the consistency and dependability of the
measurements, and a “high interrater reliability indicates that the raters used
the same criteria to evaluate a performance and that they understood and
applied the criteria similarly” (p. 57, Mervis & Spagnalo, 2007). One of the
several methods to assess interrater reliability in CTST is the Intraclass
Correlation (ICC). The ICC is the proportion between the variance of the
variable of interest to the total variance, and therefore is “the proportion of the
variance of the observed scores that is due to true differences in the variable of
interest” (p. 963, Bloch & Norman, 2012). Thus, the ICC can be conceptualised
according to the following formula:

\[ ICC = \frac{\text{True Variance}}{\text{True Variance} + \text{Error Variance}} \]  \hspace{1cm} (2)

In order to separate the true variance from the error variance, the ICC
calculation employs the analysis of variance (ANOVA) methodology to partition
the variance of scores into different components (Fan & Sun, 2014). Shrout and
Fleiss (1979) developed guidelines to select among three types of the ICC, which are based on the assumption that a random sample of “n” participants is rated independently by “k” raters, on one or more dimensions of interest. The first type of study (ICC (1,1)), is one in which each participant is rated by a single rater, or in which each participant is rated by a different set of raters, randomly selected from the population of raters. Therefore, this form of ICC study is utilised when a different group of raters scores each participant. In the second type of study (ICC (2,1)), each rater, -selected from a larger population-, rates every participant. Therefore, this type of study is required when the same group of randomly selected raters score all the participants from a pool of subjects or objects. In the third type of study (ICC (3,1)), every participant is rated by each of the raters, which are the only raters of interest for the particular study. This form of ICC is therefore used when the same group of fixed raters score all the participants that belong to a pool of objects or subjects (Shrout & Fleiss, 1979). The most common form used in psychometric studies is the second type of ICC (2,k), which is calculated according to the following formula:

\[
\text{ICC (2,k)} = \frac{\text{BMS} - \text{EMS}}{\text{BMS} + \frac{\text{RMS} - \text{EMS}}{n}}
\]

(3)

Where, BMS= between subject mean square
EMS= error mean square
RMS= between raters mean square
k= number of raters
n= number of subjects tested

The ICC is a number that ranges between 0 and 1, where 0 indicates that all the variability in scores is due to error, and 1 indicates that all the variability is due to true differences in the phenomenon under study. It is important to notice that the ICC represents a variance and therefore, if there is no variation in the phenomenon under study, the ICC would be 0, despite all
events having the same rating. The latter helps to differentiate the concepts of agreement and reliability. If there is no variability in the phenomena under study, the agreement in scores would be 100%. In contrast, the ICC is a measure of discrimination, meaning that it assesses the ability of an instrument to differentiate between high and low scorers. Therefore, the more homogenous the sample, the lower the reliability according to the ICC. Thus, when assessing reliability, the variance of the population under study should be specified (Bloch & Norman, 2012).

It is noticeable that in the ICC formula there is only one term representing measurement error. Conceptually, there are at least three sources of error included in the error term of the ICC: the random error, the systematic error, and the error secondary to the interaction of the instrument and the phenomenon under study. Customarily, there are various sources of error in any measurement, associated with the phenomenon studied, the rating methods, the instrument, the occasion, and situational issues, among other factors. These sources of error are not possible to disentangle using the ICC, considering that error is represented in the formula only by one term, which does not allow to distinguish between the different components of the error variance (Bloch & Norman, 2012).

8.1.2 Generalizability Theory

The GT (Shavelson & Webb, 1991) provides a theoretical framework to evaluate the reliability of scores in a more flexible way than the CTST (Cronbach, Gleser, Nanda, & Rajaratnam, 1972; Shavelson, Webb, & Rowley, 1989). GT identifies the multiple sources of error variation in the measurements, and allows for the estimation and isolation of the different variance components (Shavelson & Webb, 1991). In the following paragraphs, a general overview of GT will be described.\(^\text{17}\)

GT relies on the analysis of variance (ANOVA) method to partition the total variance into variance components that belong to different sources (Fan &

\(^{17}\) See Appendix Q for a detailed account of the theory.
Based on the estimation of the variance components, GT derives generalizability and dependability coefficients which are essential to understand in depth the reliability of measurements (Brennan, 2003).

One unique characteristic of GT is that it conceptualises two types of studies and universes. A G study entails the collection of data from a universe of admissible observations that is defined by several factors or facets determined by the researcher. The results of a G study usually consist on a set of estimated random effect variance components for the measurements, derived from the universe of admissible observations (Brennan, 2003). The second type of study, derived from GT, is the Decision (D) study. The D study examines how the generalizability coefficients would change in different circumstances, using the information of the G study in order to inform a decision in a particular universe. Thus, a D study uses the information provided by the G study to plan the best possible application of the measurement to a specific purpose, minimising error and maximising reliability. Hence, in a D study the researcher redefines the universe to which he/she aims to generalize the results to (N. M. Webb, Shavelson, & Haertel, 2006).

There are several concepts that are essential to understand GT. Firstly, the object of measurement or facet of differentiation should be distinguished as the phenomenon of interest for the study. The estimated variance component of the facet of differentiation constitutes therefore, the true variance of the phenomenon/subject under study (Brennan, 2001; Shavelson & Webb, 1991; Shavelson et al., 1989).

The facets that define the universe of observations are called facets of generalization, considering that these are the facets that the researcher is interested in for the generalization of the results. Thus, a change in language is implicit to the use of GT; instead of being interested in what is the interrater reliability, GT studies to what extent is it possible to generalise the results across raters. This change in understanding can be applied to any other facet under study (Bloch & Norman, 2012). It is important to notice that the generalizability coefficient of a G study with only one facet is equivalent to the ICC, considering that it only defines a single source of error (Fan & Sun, 2014). However, GT allows for the definition of various facets that are likely to become sources of error in a specific measurement.
Furthermore, GT distinguishes between random and fixed facets of generalization. GT considers as random facets all the facets that are of interest for generalization to another random level. The facets that the researcher is not interested in generalizing are designated as “fixed facets of generalization”. Fundamentally, fixed facets contribute to the variance of interest (true variance) and the random facets contribute to the error variance. Evidently, the fixed facets represent the conditions that are replicated from the original study, while the random facets represent a sample of a “universe” of possible conditions (Bloch & Norman, 2012).

Furthermore, GT distinguishes *stratification facets*, which are facets that are not of interest for generalization, but account for the different strata or nesting in the data. For example, a study that defines items and raters as facets, and in which all raters score all items for every object of measurement, the design of the study is considered to be *crossed*. However, if only some raters score a selection of the items, while other raters score another selection of the items, the design of the study is considered to be *nested*. This distinction in the design is a relevant aspect of G studies, considering that all crossed facets interact, which in itself brings about another source of measurement error. On the contrary, nested facets do not interact, which can be explained in reference to the previous example. If only some raters scored a selection of the items, it is not possible to conclude that there is an effect of raters in items, -or vice versa-, considering that not all items were scored by all raters (Bloch & Norman, 2012).

A G study provides an estimation of the different variance components which reflect the magnitude of error that results from generalizing from an individual score to a universe score (Shavelson & Webb, 1991). The estimated variance components are essential to calculate the generalizability coefficient. See Table 8.1 for possible G coefficients and their interpretations.
The estimation of the variance components is based on the theoretical composition of the mean squares for each source of error (also called “Expected Mean Square”). The variance components serve as the basis for calculating generalizability coefficients (Fan & Sun, 2014). In the current study,

<table>
<thead>
<tr>
<th>Object of measurement</th>
<th>Fixed Facets of generalization</th>
<th>Random Facets of generalization</th>
<th>Question</th>
<th>Classical Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person</td>
<td>Day, Item</td>
<td>Rater</td>
<td>To what extent can I generalize from one rater to another?</td>
<td>Inter-rater reliability</td>
</tr>
<tr>
<td>Person</td>
<td>Day, Rater</td>
<td>Item</td>
<td>To what extent can I generalize from one item to another?</td>
<td>Internal Consistency</td>
</tr>
<tr>
<td>Person</td>
<td>Rater, Item</td>
<td>Day</td>
<td>To what extent can I generalize from one item to another?</td>
<td>Test-retest reliability</td>
</tr>
<tr>
<td>Person</td>
<td>Day</td>
<td>Rater, Item</td>
<td>To what extent can I generalize from one rater on one item to another rater/item?</td>
<td></td>
</tr>
<tr>
<td>Person</td>
<td>Item</td>
<td>Day, Rater</td>
<td>To what extent can I generalize from one rater and day to another?</td>
<td></td>
</tr>
<tr>
<td>Person</td>
<td>Rater</td>
<td>Day, Item</td>
<td>To what extent can I generalize from the same rater on one item and day to another?</td>
<td></td>
</tr>
<tr>
<td>Person</td>
<td>Day, Item, Rater</td>
<td></td>
<td>To what extent can I generalize across all facets to a comparable overall test?</td>
<td></td>
</tr>
</tbody>
</table>

Note: Adapted from Bloch and Norman (2012)
which considers sessions (s) as the object of measurement; and raters (r) and items (i) as facets of generalization, the formula for the total observed score variance estimated using the expected mean squares in a random-effects ANOVA is:

\[
\sigma^2(\text{XSIR}) = \sigma^2(s) + \sigma^2(i) + \sigma^2(r) + \sigma^2(si) + \sigma^2(sr) + \sigma^2(ir) + \sigma^2(sir)
\]

(4)

(Brennan, 2003; Fan & Sun, 2014)

The expected score for an individual over the facets in the universe of generalization is called “universe score”. However, considering that the sample size of the current study (D study) is limited, the variance components are obtained by dividing the G study variance components by the study sample sizes. Thus, for the current study the estimated random effects variance components are:

\[
\begin{align*}
\sigma^2(s) & \quad \frac{\sigma^2(i)}{ni} & \quad \frac{\sigma^2(r)}{nr} & \quad \frac{\sigma^2(si)}{ni} & \quad \frac{\sigma^2(sr)}{nr} & \quad \frac{\sigma^2(ir)}{ninr} & \quad \frac{\sigma^2(sir, e)}{ninr} \\
\end{align*}
\]

(5)

(Brennan, 2003; Fan & Sun, 2014)

Generalizability coefficients have two components. The first one, \(\tau\) (tau), consists of all the variance components (main effects and interactions) related to the object of measurement and the fixed facets of the study. The second component, -the “error term”-, called either \(\Delta\) (DELTA) or \(\delta\) (delta), includes the main effects and interactions (\(\Delta\)) or only the interactions (\(\delta\)) of the facets of generalization and the object of measurement. The terms \(\Delta\) and \(\delta\) refer to the absolute or relative error coefficients, respectively. If the researcher is interested in interpreting a score in relation to all other scores in the study, the main effects (variance given by each single facet) of the facets of generalization are unimportant, considering that main effects will have the same impact in all scores (i.e., all scores will be equally higher or lower). Therefore, when the
researcher is interested in relative decisions, the main effects of the generalizability facets should be omitted from the error term. Concurrently, in the calculation of relative decisions, the error term should include the variance that results from the interaction between facets of generalization and the object of measurement, since these have a differential effect in the phenomenon under study (i.e., the interaction between individuals and items indicates that the item effect is not consistent for all respondents). However, it is important to notice that the interactions between the facets of generalization that do not include the object of measurement should not be part of the error term of a relative decision, considering that these kinds of interactions would affect all the subjects under study in an equivalent way. Conversely, if the researcher is interested in absolute scores, then main (systematic) effects, as well as the interactions between facets, should be included in the error term. Thus, the term \( \Delta \) represents the absolute error, and \( \delta \) represents the relative error. Therefore, for each facet of differentiation and each facet of generalization there are two possible generalizability coefficients, one related to an absolute decision \( \gamma/(\gamma+\Delta) \), and another to a relative decision study \( \gamma/(\gamma+\delta) \) (Bloch & Norman, 2012).

In the current study where session (s) is the object of measurement, the universe score variance for the random model is:

\[
\sigma^2(\tau) = \sigma^2(s)
\]  
\[\text{(6)}\]  
(Brennan, 2003; Fan & Sun, 2014)

Concurrently, the generalizability coefficient for a relative decision involving the object of measurement session (s) in the current study design is:

\[
Ep^2 = \frac{\sigma^2(\tau)}{\sigma^2(\tau) + \sigma^2(\delta)} = \frac{\sigma^2(s)}{\sigma^2(s) + \left(\frac{\sigma^2(si)}{ni} + \frac{\sigma^2(sr)}{nr} + \frac{\sigma^2(sir,e)}{nirmr^2}\right)}
\]  
\[\text{(7)}\]  
(Brennan, 2003; Fan & Sun, 2014)
The formula for the dependability coefficient for an absolute decision involving the same facets is:

\[
\varphi = \frac{\sigma^2(\tau)}{\sigma^2(\tau) + \sigma^2(\Delta)} = \frac{\sigma^2(s)}{\sigma^2(s) + \left(\frac{\sigma^2(i)}{ni} + \frac{\sigma^2(r)}{nr} + \frac{\sigma^2(si)}{ni} + \frac{\sigma^2(sr)}{nr} + \frac{\sigma^2(ir)}{ninr} + \frac{\sigma^2(sir,e)}{ninr}\right)} 
\]

(8)

(Brennan, 2003; Fan & Sun, 2014)

The formulas displayed consider all the facets of generalization as random. However, GT also allows to fix a facet, which results in a restricted universe of generalization compared to the universe of generalization of the random model. It is noticeable that for an analysis to be meaningful, there must be at least one random facet, considering that if all facets are fixed, no generalization is involved and all the error variance, by definition, would be zero (Brennan, 2003; Fan & Sun, 2014).

In the current study, simplified univariate procedures were employed to perform a mixed-model analysis, particularly to study the random effects of raters and items (Table 8.2) (Brennan, 2003; Fan & Sun, 2014).

<table>
<thead>
<tr>
<th>Table 8.2</th>
<th>Random Effects Variance component for Random and Mixed Model D Study for the S x I x R design</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I, R Random</td>
</tr>
<tr>
<td>$\sigma^2(s)$</td>
<td>$\tau$</td>
</tr>
<tr>
<td>$\sigma^2(i)=\sigma^2(i)/ni$</td>
<td>$\Delta$</td>
</tr>
<tr>
<td>$\sigma^2(\tau)=\sigma^2(\tau)/nr$</td>
<td>$\Delta, \delta$</td>
</tr>
<tr>
<td>$\sigma^2(si)=\sigma^2(si)/ni$</td>
<td>$\Delta, \delta$</td>
</tr>
<tr>
<td>$\sigma^2(sr)=\sigma^2(sr)/nr$</td>
<td>$\Delta, \delta$</td>
</tr>
<tr>
<td>$\sigma^2(ir)=\sigma^2(ir)/ninr$</td>
<td>$\Delta$</td>
</tr>
<tr>
<td>$\sigma^2(sir)=\sigma^2(sir)/ninr$</td>
<td>$\Delta, \delta$</td>
</tr>
</tbody>
</table>

*Note. Adapted from Brennan (2003). S= session; I= item; R= rater.*
Therefore, in the current study with a S x I x R design, when I is considered a fixed facet, the generalizability and dependability coefficients, respectively, are:

\[
E_r^2 = \frac{\sigma^2(s) + \frac{\sigma^2(si)}{ni}}{\sigma^2(s) + \left(\frac{\sigma^2(si)}{ni} + \frac{\sigma^2(sr)}{nr} + \frac{\sigma^2(sir,e)}{nirn}\right)}
\]

(9)

\[
\varphi = \frac{\sigma^2(s) + \frac{\sigma^2(si)}{ni}}{\sigma^2(s) + \left(\frac{\sigma^2(r)}{nr} + \frac{\sigma^2(si)}{ni} + \frac{\sigma^2(sr)}{nr} + \frac{\sigma^2(ir)}{nir} + \frac{\sigma^2(sir,e)}{ninr}\right)}
\]

(10)

(Brennan 2003)

It is important to notice that the denominator of the dependability coefficient does not include the main effect for items.

In order to study the standardized interrater reliability, in which there is a correlation between the scores assigned by two raters to the same items, it is necessary to compute a generalizability coefficient that fixes the item facet. Therefore, in the current study, with a S x I x R design, equation (9) will be used to compute the generalizability coefficients of the inter-rater reliability.

In the current study with a S x I x R design, when R is considered a fixed facet, the generalizability and dependability coefficients, respectively, are:

\[
E_p^2 = \frac{\sigma^2(s) + \frac{\sigma^2(sr)}{nr}}{\sigma^2(s) + \left(\frac{\sigma^2(si)}{ni} + \frac{\sigma^2(sr)}{nr} + \frac{\sigma^2(sir,e)}{ninr}\right)}
\]

(11)
$$\phi = \frac{\sigma^2(s) + \frac{\sigma^2(sr)}{n_i}}{\sigma^2(s) + \frac{\sigma^2(I)}{n_i} + \frac{\sigma^2(si)}{n_i} + \frac{\sigma^2(sr)}{n_r} + \frac{\sigma^2(ir)}{n_{inr}} + \frac{\sigma^2(sir,e)}{n_{inr}}}$$

(12)

(N. M. Webb et al., 2006)

In order to study the internal consistency between the items, scored by the same raters, it is necessary to compute a generalizability coefficient that fixes the rater facet. Therefore, in the current study, with a $S \times I \times R$ design, equation (11) will be used to compute the internal consistency generalizability coefficient (Bloch & Norman, 2012).

8.2 Methodology

8.2.1 The REDIT study

The study of the reliability of the TCS was conducted by rating audio-recorded sessions from the REDIT study. The REDIT study constituted the context in which this study was developed and therefore it is described in detail in the methodology section of this dissertation.

8.2.2 Sample of Recordings

Twenty-five audio-recorded DIT sessions were sampled and coded in order to study the reliability of the TCS. The audio-recorded sessions were selected following a stratified random procedure (computer-generated). The sampling method was stratified in order to select sessions from the initial, middle, and end phase in a 1:2:1 proportion. The stratification aimed to mainly select middle phase sessions, which are considered to be more representative
of the therapeutic techniques used in DIT than initial and end phase sessions, which are restricted by the specific therapeutic tasks of these phases.

The selected sample was composed of 7 sessions from the initial phase; 12 sessions from the middle phase; and, 6 sessions from the end phase of DIT.

The selected sample included 16 of the 17 therapists that participated in the trials, and 25 participant patients. From the selected therapists, nine of them were present in two separate sessions, while seven were present in only one of the sampled sessions.

8.2.3 Raters and Training

In the present study, the author and a PhD student completed the training in the use of the TCS, and served as raters. The training included reading the TCS, its instructions, items, scoring guidelines and examples for each indicator. The latter was followed by a discussion of each of the items, between the two raters, in order to agree in the criteria for rating. Subsequently, the two raters coded three DIT audio-recorded sessions that were not included in the analyses. The first session was rated conjointly in order to arrive to a mutual practical understanding of the items. The second and third sessions were rated separately, but each rating was followed by a discussion between the raters about the criteria used to rate each of the items.

8.2.4 Procedure

The twenty-five sampled sessions were coded independently by the author and the second rater with the TCS, after listening to the complete audio-recorded DIT session. Each audio-recorded session was rated on a single opportunity by each of the judges. Each rater coded the sessions at different times, and no discussion between the judges occurred during this process. The raters were not informed of which specific therapist would be assessed in each of the tapes. However, blindness could not be guaranteed as the coders could
recognise the voice of the specific therapist, after rating them in more than one opportunity.

8.2.5 Data Analysis

The scores obtained from the ratings of the two judges were analysed with the two theoretical frameworks presented, namely the CTST and the GT.

Firstly, an average score per session for each of the subscales of the TCS, was computed for each one of the raters. Subsequently, the interrater reliability across sessions for each of the subscales was calculated. Interrater reliability was studied employing the two-way random ICC, considering that both judges rated all the items, and that the raters were chosen randomly (i.e. the main research question would not have changed if the raters changed).

Secondly, a two-way random ICC was calculated for each of the TCS items of the competence subscale, as well as for the global competence and patient complexity ratings, in order to study the reliability of the items separately. Considering that the incompetence items are binary, the agreement between raters was calculated with Cohen’s kappa (J. Cohen, 1960; Hallgren, 2012).

After these analyses based on CTST, a G study was conducted. Several steps were followed in order to design a G study. Firstly, the dependent variable was defined. In the current study the dependent variable was defined as the scores of the TCS and its subscales, considering that the aim was to assess the reliability of the scale. It is relevant to mention that the literature allows for the application of GT to categorical and ordinal variables, as well as to non-parametric distributions of the data (Bloch & Norman, 2012). Therefore, GT was employed independently of the distribution of the dependent variable, and the types of variables the TCS includes.

The second step in the design of the G study was to define the object of measurement. In this study, the object of measurement was the therapist in a specific session. Considering that therapist competence can change from session to session, and from patient to patient, it was decided that the object of measurement or facet of differentiation would be the therapist in the particular
context of a unique session. Additionally, considering that the aim of the study was to assess the reliability of the raters, and not to examine therapist effects, it was decided to not treat sessions as nested in therapists, in order to simplify the design of the study.

The third step was to define which were the facets of generalization or possible sources of error in the measurement. In the current study, two facets of generalization were considered, namely the items of the TCS and the raters. Since all therapists in sessions were rated by both raters, who scored all the TCS items, the design was considered to be "crossed". Additionally, the design was considered to be “balanced” given that all facets were mutually crossed and there was no missing data.

The analyses in a G study include the following procedures: (1) calculating group means; (2) calculating mean-square differences for groups; (3) estimating group variances; (4) estimating variance components for effects; and, (5) calculating the appropriate generalizability and dependability coefficients (Bloch & Norman, 2012). Steps 1-4 represent a standard ANOVA approach, while step 5 calculations are carried out separately. For this study, SPSS was employed to carry out steps 1-4. Mushquash and O’Connor (2006) presented their syntaxes which they wrote in order to perform generalizability analyses in SPSS, among other software. The SPSS syntaxes can be accessed at https://people.ok.ubc.ca/brioconn/gtheory/ gtheory.html. For the current study, -a two-facet crossed design (S x R x I)-, the following syntax was used:

```
VARCOMP score BY session rater item
/RANDOM = session rater item
/METHOD = ML
/OUTFILE = VAREST CORB ('varco.sav')
/DESIGN = session rater item session*rater session*item rater*item
/INTERCEPT = INCLUDE.
```

It has been shown that the results of the generalizability analyses performed by SPSS are the same as the ones obtained with other software specifically developed for GT analyses (Teker, Guler, & Uyanik, 2015).
However, an important observation is that SPSS converts negative predicted variance values to zeroes.

The generalizability and dependability coefficients that considered all facets of generalization as random, were calculated according to the equations (7) and (8), respectively. The interrater reliability was calculated according to equation (9) and the internal consistency of the subscales according to equation (11).

The variance estimates and generalizability/dependability coefficients were calculated only for the competence and incompetence subscales. The global competence and patient complexity ratings consist only of one item, and therefore would fit in a one-facet design. The generalizability coefficient for a one-facet study is equivalent to the ICC (Bloch & Norman, 2012). For this reason, the global competence and patient complexity ratings were excluded from the generalizability analyses.

8.3 Results

The ICCs for the competence and the incompetence subscales, as well as for the global competence rating across sessions indicated a good interrater reliability (0.75 < ICC > 0.90). The patient complexity rating across sessions displayed a moderate interrater reliability (0.5 < ICC > 0.75) (Koo & Li, 2016) (Table 8.3).

<table>
<thead>
<tr>
<th>Table 8.3</th>
<th>ICC two-way random for two raters across sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICC</td>
</tr>
<tr>
<td>Competence Subscale</td>
<td>0.794</td>
</tr>
<tr>
<td>Incompetence Subscale</td>
<td>0.846</td>
</tr>
<tr>
<td>Global Competence</td>
<td>0.756</td>
</tr>
<tr>
<td>Patient Complexity</td>
<td>0.524</td>
</tr>
</tbody>
</table>
Tables 8.4 and 8.5 display the interrater reliability per item of each of the subscales. Fifteen items of the competence subscale showed a good interrater reliability ($0.75 < \text{ICC} > 0.90$). Twenty-five items of the competence subscale resulted in moderate interrater reliability ($0.5 < \text{ICC} > 0.75$). Only two items had very poor interrater reliability ($\text{ICC} < 0.5$) (Koo & Li, 2016). Item 26 displayed an ICC = 0.157; and item 32 an ICC = 0.355.
<table>
<thead>
<tr>
<th>Competence Subscale Item</th>
<th>ICC</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.584</td>
<td>0.018</td>
</tr>
<tr>
<td>2</td>
<td>0.663</td>
<td>0.005</td>
</tr>
<tr>
<td>3</td>
<td>0.775</td>
<td>0.000</td>
</tr>
<tr>
<td>4</td>
<td>0.817</td>
<td>0.000</td>
</tr>
<tr>
<td>5</td>
<td>0.772</td>
<td>0.000</td>
</tr>
<tr>
<td>6</td>
<td>0.609</td>
<td>0.013</td>
</tr>
<tr>
<td>7</td>
<td>0.685</td>
<td>0.003</td>
</tr>
<tr>
<td>8</td>
<td>0.636</td>
<td>0.008</td>
</tr>
<tr>
<td>9</td>
<td>0.748</td>
<td>0.001</td>
</tr>
<tr>
<td>10</td>
<td>0.777</td>
<td>0.000</td>
</tr>
<tr>
<td>11</td>
<td>0.788</td>
<td>0.000</td>
</tr>
<tr>
<td>12</td>
<td>0.819</td>
<td>0.000</td>
</tr>
<tr>
<td>13</td>
<td>0.704</td>
<td>0.002</td>
</tr>
<tr>
<td>14</td>
<td>0.790</td>
<td>0.000</td>
</tr>
<tr>
<td>15</td>
<td>0.601</td>
<td>0.014</td>
</tr>
<tr>
<td>16</td>
<td>0.803</td>
<td>0.000</td>
</tr>
<tr>
<td>17</td>
<td>0.637</td>
<td>0.008</td>
</tr>
<tr>
<td>18</td>
<td>0.646</td>
<td>0.007</td>
</tr>
<tr>
<td>19</td>
<td>0.791</td>
<td>0.000</td>
</tr>
<tr>
<td>20</td>
<td>0.536</td>
<td>0.033</td>
</tr>
<tr>
<td>21</td>
<td>0.756</td>
<td>0.000</td>
</tr>
<tr>
<td>22</td>
<td>0.695</td>
<td>0.003</td>
</tr>
<tr>
<td>23</td>
<td>0.764</td>
<td>0.000</td>
</tr>
<tr>
<td>24</td>
<td>0.616</td>
<td>0.011</td>
</tr>
<tr>
<td>25</td>
<td>0.749</td>
<td>0.001</td>
</tr>
<tr>
<td>26</td>
<td>0.157</td>
<td>0.339</td>
</tr>
<tr>
<td>27</td>
<td>0.720</td>
<td>0.001</td>
</tr>
<tr>
<td>28</td>
<td>0.669</td>
<td>0.004</td>
</tr>
<tr>
<td>29</td>
<td>0.713</td>
<td>0.002</td>
</tr>
<tr>
<td>30</td>
<td>0.812</td>
<td>0.000</td>
</tr>
<tr>
<td>31</td>
<td>0.768</td>
<td>0.000</td>
</tr>
<tr>
<td>32</td>
<td>0.355</td>
<td>0.145</td>
</tr>
<tr>
<td>33</td>
<td>0.704</td>
<td>0.002</td>
</tr>
<tr>
<td>34</td>
<td>0.615</td>
<td>0.012</td>
</tr>
<tr>
<td>35</td>
<td>0.631</td>
<td>0.009</td>
</tr>
<tr>
<td>36</td>
<td>0.748</td>
<td>0.001</td>
</tr>
<tr>
<td>37</td>
<td>0.826</td>
<td>0.000</td>
</tr>
<tr>
<td>38</td>
<td>0.749</td>
<td>0.001</td>
</tr>
<tr>
<td>39</td>
<td>0.643</td>
<td>0.007</td>
</tr>
<tr>
<td>40</td>
<td>0.601</td>
<td>0.014</td>
</tr>
<tr>
<td>41</td>
<td>0.728</td>
<td>0.001</td>
</tr>
<tr>
<td>42</td>
<td>0.794</td>
<td>0.000</td>
</tr>
</tbody>
</table>
Cohen’s kappa (J. Cohen, 1960) was calculated to study the interrater reliability of each of the incompetence subscale items. Cohen’s kappa measures inter-rater agreement in categorical items and takes into account the possibility of the agreement occurring by chance. Therefore, it was a more robust statistic to calculate the interrater reliability of the items of the incompetence subscale. Two items displayed an almost perfect agreement between raters (\( \kappa \geq 0.81 \)). One item showed a substantial agreement between raters (\( 0.61 < \kappa < 0.80 \)). Nine items displayed a moderate agreement between raters (\( 0.41 < \kappa < 0.60 \)). Five items showed a fair agreement between raters (\( 0.21 < \kappa < 0.40 \)). Four items displayed a slight agreement between raters (\( 0 < \kappa < 0.20 \)) (Hallgren, 2012). However, for 17 items of the scale a Cohen’s kappa was not possible to obtain considering that either one or both raters scored the item as “absent” in every session (Table 8.5).
Table 8.5  
*Cohen’s Kappa for the individual items of the Incompetence Subscale*  

<table>
<thead>
<tr>
<th>Incompetence Subscale Item</th>
<th>Cohen’s Kappa</th>
<th>Significance</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.390</td>
<td>0.014</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0.441</td>
<td>0.027</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0.483</td>
<td>0.005</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>0.528</td>
<td>0.003</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by rater 2</td>
</tr>
<tr>
<td>6</td>
<td>0.865</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>0.336</td>
<td>0.085</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>0.595</td>
<td>0.003</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by rater 1</td>
</tr>
<tr>
<td>10</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by raters 1 and 2</td>
</tr>
<tr>
<td>11</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by raters 1 and 2</td>
</tr>
<tr>
<td>12</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by raters 1 and 2</td>
</tr>
<tr>
<td>13</td>
<td>0.254</td>
<td>0.171</td>
<td>No 1s scored by rater 1</td>
</tr>
<tr>
<td>14</td>
<td>Cannot be computed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>0.120</td>
<td>0.339</td>
<td>No 1s scored by rater 1</td>
</tr>
<tr>
<td>16</td>
<td>Cannot be computed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by raters 1 and 2</td>
</tr>
<tr>
<td>18</td>
<td>0.194</td>
<td>0.102</td>
<td>No 1s scored by rater 2</td>
</tr>
<tr>
<td>19</td>
<td>0.213</td>
<td>0.278</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by rater 2</td>
</tr>
<tr>
<td>21</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by rater 1</td>
</tr>
<tr>
<td>22</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by raters 1 and 2</td>
</tr>
<tr>
<td>23</td>
<td>0.834</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>0.627</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>0.506</td>
<td>0.004</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>0.576</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>-0.068</td>
<td>0.656</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by rater 2</td>
</tr>
<tr>
<td>29</td>
<td>0.449</td>
<td>0.025</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by raters 1 and 2</td>
</tr>
<tr>
<td>31</td>
<td>Cannot be computed</td>
<td></td>
<td>No 1s scored by raters 1 and 2</td>
</tr>
</tbody>
</table>
The estimates of the variance components of the competence subscale ratings are displayed in Table 8.6. The major variance component of the scores (47%) was attributable to the therapist competence in a session, the object of measurement. This is followed by the interaction between the therapist competence in a session and the raters, which signifies that competence in a session was rated differently by the two raters. No variance was attributed to the main effect of raters.

<table>
<thead>
<tr>
<th>Variance Component</th>
<th>Estimate</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Var (session)</td>
<td>0.660</td>
<td>47%</td>
</tr>
<tr>
<td>Var (rater)</td>
<td>0.000</td>
<td>0%</td>
</tr>
<tr>
<td>Var (item)</td>
<td>0.045</td>
<td>3.2%</td>
</tr>
<tr>
<td>Var (session x rater)</td>
<td>0.345</td>
<td>24.6%</td>
</tr>
<tr>
<td>Var (session x item)</td>
<td>0.058</td>
<td>4.1%</td>
</tr>
<tr>
<td>Var (rater x item)</td>
<td>0.028</td>
<td>1.9%</td>
</tr>
<tr>
<td>Var (error)</td>
<td>0.266</td>
<td>18.9%</td>
</tr>
</tbody>
</table>

Based on these variance components, the generalizability and dependability coefficients were calculated. Briesch, Swaminathan, Welsh, and Chafouleas (2014) have suggested that the same criteria to examine the ICC should be applied to interpret the generalizability and dependability coefficients. Accordingly, the generalizability and dependability coefficients of the competence subscale, showed good reliability for relative and absolute
decisions. Additionally, the competence subscale displayed a good level of interrater reliability, and an excellent internal consistency (Table 8.7).

Table 8.7
*Generalizability and Dependability Coefficients Competence Subscale*

| Generalizability Coefficient (all facets random) | 0.788 |
| Dependability Coefficient (all facets random) | 0.787 |
| Interrater Reliability (item fixed) | 0.790 |
| Internal Consistency (rater fixed) | 0.994 |

Most of the variance in the measurement of the incompetence subscale was attributable to the error term. Only 14.8% of the variance was attributable to the object of measurement. The interaction between sessions and items explained 19% of the variance, which signifies that items that were rated high in one session did not necessarily score high in another session. See Table 8.8 for the results in detail.

Table 8.8
*Variance Components Incompetence Subscale*

<table>
<thead>
<tr>
<th>Variance Component</th>
<th>Estimate</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Var (session)</td>
<td>0.018</td>
<td>14.8%</td>
</tr>
<tr>
<td>Var (rater)</td>
<td>0.001</td>
<td>0.8%</td>
</tr>
<tr>
<td>Var (item)</td>
<td>0.012</td>
<td>9.9%</td>
</tr>
<tr>
<td>Var (session x rater)</td>
<td>0.006</td>
<td>4.9%</td>
</tr>
<tr>
<td>Var (session x item)</td>
<td>0.023</td>
<td>19%</td>
</tr>
<tr>
<td>Var (rater x item)</td>
<td>0.007</td>
<td>5.7%</td>
</tr>
<tr>
<td>Var (error)</td>
<td>0.054</td>
<td>44.6%</td>
</tr>
</tbody>
</table>

Based on these variance components, the generalizability and dependability coefficients were calculated. The generalizability and dependability coefficients of the incompetence subscale, showed good reliability for relative and absolute decisions. Additionally, the incompetence subscale displayed a moderate level of interrater reliability and internal consistency (Table 8.9).
Table 8.9
*Generalizability and Dependability Coefficients Incompetence Subscale*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalizability Coefficient</td>
<td>0.806</td>
</tr>
<tr>
<td>(all facets random)</td>
<td></td>
</tr>
<tr>
<td>Dependability Coefficient</td>
<td>0.775</td>
</tr>
<tr>
<td>(all facets random)</td>
<td></td>
</tr>
<tr>
<td>Interrater Reliability</td>
<td>0.648</td>
</tr>
<tr>
<td>(item fixed)</td>
<td></td>
</tr>
<tr>
<td>Internal Consistency</td>
<td>0.731</td>
</tr>
<tr>
<td>(rater fixed)</td>
<td></td>
</tr>
</tbody>
</table>

8.4 Discussion

This study aimed to examine the inter-rater reliability of the TCS from two conceptual frameworks, the CTST and GT. The competence and incompetence subscales showed a good interrater reliability according to CTST. However, according to GT, only the competence subscale retained a good interrater reliability, while the incompetence subscale displayed a moderate level. This suggests, considering the ability of GT to differentiate between sources of measurement error, that the ICC for the incompetence subscale was possibly exaggerated secondary to the similarity between the items. The denominator of the ICC formula contains the variability between raters in the measurement, but does not separate this effect from the one secondary to the variability between items. Therefore, a high degree of similarity between items, -that is not accounted for-, could have falsely magnified the homogeneity between raters. However, when GT is employed and the sources of measurement error are differentiated, it is possible to assess the real effect of raters and items in the measurement, which resulted in a lower interrater reliability in the incompetence subscale.

Despite the good interrater reliability of the competence subscale, a session (therapist) by rater interaction was apparent, suggesting that the agreement between raters was better for some therapists-in-sessions than for others. Similarly, in other psychotherapy process G studies, W. T. Hoyt (2002) and Crits-Christoph et al. (2011) found an important therapist by rater variance when therapists were the target of ratings. There may be specific
characteristics in the therapists that make the reliability between raters more difficult. Future research may examine the relationship between therapists’ characteristics and the degree of agreement between raters, in order to understand how specific therapists’ features influence interrater reliability.

The results of this G study indicate that therapist competence and incompetence can be rated with a good degree of relative and absolute reliability; and with a moderate to good level of interrater reliability from audio-recorded DIT sessions. In addition, therapist variability in a session, was the larger component of the variance in the competence subscale. This indicates that the variance in the measurement was primarily composed by the true variance of the object of measurement. The good reliability and interrater reliability, as well as the ability to measure meaningful therapist-to-therapist variability using the TCS, indicates that it is possible to study competence as a psychotherapy process construct in the context of brief psychodynamic psychotherapy.

The competence subscale had an excellent internal consistency which suggests that the items of this subscale measure a similar construct. However, it is important to take into account that the high internal consistency could also suggest that the items might be measuring redundant aspects of competence. Conceivably, the TCS would benefit from a factor analysis in order to explore the presence of underlying components in the subscale, which would allow to discard redundant items.

Despite the good generalizability and dependability coefficients of the incompetence subscale, a lower internal consistency of the subscale was evidenced. Additionally, the error term was the major component of the variance of this subscale. These results suggest that non-studied facets of the incompetence subscale impacted its reliability. Furthermore, these results suggest that the incompetence subscale only has a moderate ability to capture the construct of therapist incompetence. The agenda of future research might examine the content and relationship between the incompetence items, in order to improve their internal consistency.

The interrater reliabilities at the item level varied considerably. This is a common finding among rating scales (Barber, 2003; Karterud et al., 2013). Some items displayed good reliability, while others had a low reliability. Two
items of the competence subscale had a very poor interrater reliability (ICC < 0.5). Item 26 displayed an ICC = 0.157; and item 32 an ICC = 0.355. However, these ICCs did not coincide with the actual scores for these two items, which were similar between the two raters in every session. Considering that the numerator of the ICC formula takes into account the variance between items, this matter was explored. The variance of item 26 was 1.029, and the variance of item 32 was 1.016. The mean variance of the competence subscale items was 1.361. Therefore, it is possible that the lower variance in the scores of items 26 and 32 resulted in a lower ICC, secondary to a higher agreement between raters and a lower variability between the items’ scores.

The majority of the items of the incompetence subscale could not be examined in terms of their interrater reliability since the variability per item, for one or both raters, was equal to zero. Hence, it was not possible to determine the observed agreement and the agreement by chance between raters. Items 15, 18, 27, and 36 of the incompetence subscale showed only a slight agreement between raters. The content of these items was examined however, no particular pattern emerged from the content of these items to explain the low interrater reliability. Nevertheless, it is important to notice that the occurrence of the events described by these items in routine clinical practice is very rare. Therefore, the possibility of removing these items from the scale should be considered.

In reference to the methodology, several advantages characterised GT over CTST. Firstly, GT estimates the multiple sources of measurement error, modelling more accurately the results than methods that only account for a single source of error, as CTST. Secondly, GT provides a unified approach to estimate different, and any number of sources of measurement error (Vanleeuwen, 1997). Furthermore, GT allows for the estimation of interactions between the different sources of measurement error (Thompson, 1992). This is in opposition to CTST, which assumes that the different sources of error overlap without considering the possibility of interaction. Another advantage of GT is that it allows for parameters to be regarded either as fixed or random, while CTST only allows for the study of fixed parameters (Embretson & Hershberger,
Overall, GT was a more appropriate and accurate methodology to study the reliability of the TCS.

This study has several limitations. Firstly, it is worth noting that the sample size of sessions and the limited number of raters may have affected the results to some extent. Future research should investigate the replicability of the results with a larger sample of sessions and with a greater number of raters. A second limitation of the study is that it is not known whether the findings generalise beyond the context of the DIT manual-based treatment trial. It is possible that in naturalistic studies a greater variability in therapist competence and incompetence would be found. Greater variability in therapist effects might enhance both, the generalizability coefficients as well as the interrater reliability of the TCS.

In summary, the results reported in this study found that the TCS is a reliable instrument to measure therapist competence. Additionally, the TCS showed a moderate-good level of interrater reliability. Therefore, the TCS overcame a known limitation of other instruments that measure intervention competence, which have generally displayed low levels of interrater reliability (Barber et al., 2007). Therefore, the TCS may be a useful tool to measure and study therapist competence as a psychotherapy process variable. However, the results of this study should only be considered as initial estimates of the reliability of the TCS. Further studies are needed for more robust conclusions.
Chapter 9: Convergent and Discriminant Validity of the TCS

9.1 Introduction

The aim of the present study was to explore the ability of the TCS to distinguish therapist competence in DIT from other relevant constructs. Firstly, the extent to which the TCS could differentiate between therapist competence and adherence was examined. Additionally, the ability of the TCS to distinguish between techniques related to the common factors of psychotherapy (Weinberger, 1993) and specific DIT/Psychodynamic interventions, was investigated. Thus, this study explored the convergent and discriminant validity of the TCS with previously validated measures designed to assess treatment adherence and the therapeutic alliance.

The validity of a scale is defined as the degree to which “an instrument indeed measures the latent dimension or construct it was developed to evaluate” (Raykov & Marcoulides, 2011, p.184). The validity of a measure can be examined in several ways. One of them is the study of construct validity, which encompasses the notions of convergent and discriminant validity (Boateng, Neilands, Frongillo, Melgar-Quinonez, & Young, 2018). Construct validity refers to the “extent to which an instrument assesses a construct of concern and is associated with evidence that measures other constructs in that domain and measures specific real-world criteria” (Boateng et al., 2018, p.14). Convergent validity, -a component of construct validity-, refers to the degree to which the scores of an instrument are related to “measures of other constructs that can be expected on theoretical grounds to be close to the one tapped into by this instrument” (Boateng et al., 2018, p. 14). Thus, convergent validity studies the extent to which two instruments assess same or similar constructs. On the other hand, discriminant validity, assesses the degree to which two instruments can differentiate between two constructs, which are expected not to be related (Boateng et al., 2018; Raykov & Marcoulides, 2011). In this study the convergent and discriminant validities of the TCS were examined, assessing them in relation to the Comparative Psychotherapy Process Scale-External Rater form (CPPS-ER) (Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005), and the Working Alliance Inventory-Shortened Observer-rated version.
The TCS aimed to operationalise therapist competence in order to assess it in audio-recorded DIT sessions. One of the greatest challenges of operationalising and assessing therapist competence is distinguishing it, -the quality in the delivery of interventions-, from treatment adherence, which examines the presence or absence of specific therapist interventions (Perepletchikova & Kazdin, 2005). Adherence is the degree to which a therapist delivers the interventions stipulated by the treatment manual, while minimising the utilisation of extra-manual interventions (Barber et al., 2007; C. E. Hill et al., 1992; Waltz et al., 1993). Thus, treatment adherence can be specified in terms of the frequency of interventions, and conceptualised as the extent to which a treatment has been actually delivered (Barber et al., 2007). Instruments that assess adherence, tend to additionally measure the degree of skilfulness in the delivery of interventions, considering that only examining the frequency counts of specific techniques is an inadequate measure of adherence. On the other hand, adherence is an essential prerequisite of competence, as it is impossible to deliver a specific treatment competently without being adherent to it (Barber et al., 2007). Therefore, an important degree of overlap between therapist competence and treatment adherence is expected. Barber et al. (2007) have suggested that it is theoretically possible to differentiate competence from adherence. Additionally, it has been suggested that for integrity instruments to be useful they need to differentiate between adherence and competence (Hogue et al., 2008). However, instruments that measure these constructs have not been consistently able to distinguish between them (McLeod et al., 2018). Therefore, one of the aims of the current study was to investigate whether the therapist competence construct, operationalised in the TCS, was different from treatment adherence. It was hypothesised that the TCS should correlate partially, but not completely, to a measure of treatment adherence, considering that adherence is a prerequisite, but not equivalent, to therapist competence.

Additionally, the TCS aimed to capture the competence with which therapists deliver generic and specific techniques in a DIT session. There are several competencies that have been related to the delivery of the generic or “common factors” of psychotherapy, such as the therapeutic alliance. On the
other hand, there are competencies particularly related to the delivery of specific psychotherapeutic techniques (i.e. transference interpretations). The relevance of each group of psychotherapeutic techniques, and their effect on treatment outcome, is still a source of controversy (Owen, Hilsenroth, & Rodolfa, 2013). On one hand, it has been claimed that specific techniques only account for 15% of the clinical outcome variance, half of what is accounted by the common factors of psychotherapy (M. J. Lambert, 1992; M. J. Lambert & Barley, 2001). On the other hand, there is an increasing number of studies that support the claim that the use of specific techniques has, in addition to the common factors of psychotherapy, an important impact on treatment outcome (Larry E Beutler et al., 2003). Similarly, Owen et al. (2013) argued that “curative” psychotherapeutic factors go beyond the establishment of a good therapeutic alliance. In fact, it has been claimed that the therapeutic alliance and specific therapist techniques contribute in a similar fashion to the treatment outcome variance (about 10%), and that both are interrelated (Larry E Beutler, 2002). Indisputably, only by identifying the different psychotherapeutic components, it will be possible to better determine the relationship between the common and specific factors of psychotherapy, and their effect on treatment outcome. Thus, an important goal of this study was to examine the extent to which the TCS could capture the competencies that foster a good therapeutic alliance, while at the same time demonstrate that the overall therapist competence goes over and above the techniques related to the alliance. Therefore, it was hypothesised that the TCS should correlate partially, but not entirely, to the therapeutic alliance, considering that therapist competence is related to both, common and specific psychotherapeutic techniques.

In the next sections of this chapter the study of the TCS convergent and discriminant validity will be described.
9.2 Methodology

9.2.1 The REDIT study

The study of the convergent and discriminant validity of the TCS was conducted by rating audio-recorded sessions, from the REDIT study, with the TCS, the CPPS-ER and the WAI-O-S. The REDIT study constituted the context in which this study was developed and therefore it is described in detail in the methodology section of this dissertation.

9.2.2 Sample of Recordings

Ninety-nine audio-recorded DIT sessions were coded in order to study the convergent and discriminant validity of the TCS. The audio-recorded sessions were selected following a stratified random procedure (computer-generated). The stratification aimed to mainly select middle phase sessions, which are considered to be more representative of the therapeutic techniques used in DIT than initial and end phase sessions, which are restricted by the specific therapeutic tasks of these phases. The selected sample was composed of 12 sessions from the initial phase; 80 sessions from the middle phase; and, 7 sessions from the end phase of DIT.

The selected sample included the 17 therapists that participated in the trials, as well as the total number of participants (n=68). From the selected participating patients, 31 had two sessions rated for this study, while 37 had only one session coded.

9.2.3 Procedure

The ninety-nine sessions were coded by the author with the TCS after listening to the complete audio-recorded DIT session. The scoring of the CPPS-ER and the WAI-O-S was conducted by the author, independently of the TCS rating.
9.2.4 Measures

9.2.4.1 Comparative Psychotherapy Process Scale-External Rater form (CPPS-ER)\(^\text{18}\)

The CPPS-ER was developed by Hilsenroth et al. (2005) in order to assess the use of psychodynamic-interpersonal (PI) and cognitive-behavioural (CB) techniques in a psychotherapy session. Therefore, the CPPS-ER is a measure of how adherent the therapist is to these two types of psychotherapeutic interventions.

The scale was devised based on two literature reviews of comparative psychotherapy process that aimed to identify the interventions that differentiate cognitive-behavioural therapies from psychodynamic-interpersonal ones (Blagys & Hilsenroth, 2000, 2002). The CPPS-ER is composed of 20 items, that are rated in a 7-point Likert scale that range from 0 (not at all characteristic) to 6 (extremely characteristic). From the 20 items, 10 correspond to the PI scale and 10 to the CB scale.

The psychometric properties of the CPPS have been established. Both subscales have demonstrated acceptable to excellent internal consistency. The Cronbach’s \(\alpha\) of the PI subscale ranges from 0.82 to 0.92. The Cronbach’s \(\alpha\) of the CB subscale ranges from 0.75 to 0.94 (R. E. Goldman, Hilsenroth, Owen, & Gold, 2013; Hilsenroth, 2007; Hilsenroth et al., 2005). Additionally, the CPPS interrater reliability has ranged from good (ICC between .6 and .74) to excellent (ICC ≥ .75) across multiple studies (G. A. Goldman & Gregory, 2009a; R. E. Goldman et al., 2013; Hilsenroth et al., 2005; M. Stein, Pesale, Slavin, & Hilsenroth, 2010).

In this study, the CPPS-ER showed an overall acceptable internal consistency (Cronbach’s \(\alpha\)= 0.74). In addition, the PI subscale demonstrated a good internal consistency (Cronbach’s \(\alpha\)= 0.88), as well as the CB subscale (Cronbach’s \(\alpha\)= 0.84).

\(^{18}\) See Appendix R.
9.2.4.2 Working Alliance Inventory – shortened observer-rated version (WAI-O-S)\textsuperscript{19} 

The WAI was developed based on Bordin (1979) conceptualisation of the therapeutic alliance. Bordin (1979) formulated a pan-theoretical model of the therapeutic alliance that encompassed the presence of a therapeutic bond, and the agreement, between therapist and patient, on the tasks and goals of therapy.

The WAI has been widely used in psychotherapy process research (Martin, Garske, & Davis, 2000), and was originally developed by Horvath and Greenberg (1989). The short form of the scale was devised by and Tracey and Kokotovic (1989) (WAI-S), while the observer version (WAI-O) was created by Tichenor and Hill (1989).

The WAI-O-S includes 12 items that measure the quality of the therapeutic alliance on a 7-point Likert scale, that ranges from 1 (Never) to 7 (Always). Ten items are positively worded, and 2 are negatively worded. The WAI-O-S is constituted of three subscales, -the Bond, Task and Goal-, each of which includes 4 items.

The WAI-O-S has demonstrated a good to excellent internal consistency (Cronbach’s $\alpha$ ranges from 0.88 to 0.95) (Myers & Hayes, 2006; Zilcha-Mano, Dinger, McCarthy, & Barber, 2014), as well as a good to excellent interrater reliability (ICC ranges from 0.74 to 0.81) (G. A. Goldman & Gregory, 2009a; Myers & Hayes, 2006). However, the assessment of the psychometric properties of the subscales has demonstrated a high level of inter-correlation (correlation coefficients range from 0.70 to 0.93), which makes questionable the distinctiveness of the 3 components of the therapeutic alliance (Falkenström, Granström, & Holmqvist, 2014).

In the current study the WAI-O-S showed an overall excellent internal consistency (Cronbach’s $\alpha= 0.96$). In addition, the Bond subscale demonstrated an excellent internal consistency (Cronbach’s $\alpha= 0.94$), as well as the Task subscale (Cronbach’s $\alpha= 0.93$) and the Goal subscale (Cronbach’s $\alpha= 0.90$). Additionally, these 3 subscales displayed a high level of inter-correlation (correlation coefficients range from 0.719 to 0.907).

\footnote{19 See Appendix S.}
9.2.5 Data Analysis

The convergent and discriminant validity was studied by examining the strength of association between the TCS, the CPPS-ER, and the WAI-O-S. Taking into account the non-normal distribution of the scores, Spearman’s rho correlations were computed. The correlations between the scales scores were examined. Additionally, the correlations between the subscales of the TCS, CPPS-ES, and WAI-O-S were investigated.

Due to multiple testing Bonferroni corrections were conducted when appropriate, to examine whether the correlation coefficient was statistically significant to establish the evidence for convergent and discriminant validity (Swank & Mullen, 2017). However, in this study it was more important to establish the power to detect a correlation equal or larger than 0.4, considering that the constructs compared, -especially competence and adherence-, are theoretically related and are measured using a common methodology. Therefore, it was particularly important to establish whether the study had enough power to detect convergent validity between these constructs beyond the evident variance they share. Thus, a post hoc power analysis indicated that the study had 99% power to detect a large effect size (correlation of 0.4 or larger) (Swank & Mullen, 2017), with a 5% of type I error, in the sample that included 99 participants. In this study, the assessment of the TCS convergent and discriminant validity through correlations, was conducted using SPSS 25.

Considering the particular challenge that entails establishing discriminant validity between instruments that measure competence and adherence, further analyses were conducted to examine this issue in greater depth. As it has been established in the literature, discriminant validity denotes that a latent variable accounts for more variance in the observed variables associated with it than: 1) measurement error or other unmeasured influences; or 2) other constructs that belong to the same conceptual framework. If this is not corroborated, then the validity of the construct is questionable (Fornell & Larcker, 1981). Fornell and Larcker (1981) proposed a method to examine the discriminant validity of two or more factors which consists in comparing the
Average Extracted Variance (AVE) to the shared variance between constructs. Discriminant validity is then established if the AVE for each construct is greater than its shared variance with any other construct. The AVE estimate is the average amount of variation that a latent construct accounts for in the observed variables to which is theoretically related. For example, in the case of this study, the latent construct competence will correlate with observed variables, -items 1 to 42 of the TCS-, which are theoretically related to its construct. This correlation is denominated factor loading. The square of each of these correlations represents the amount of variation in each observed item, that the latent construct accounts for. The average of this variance across all observed variables generates the AVE. On the other hand, shared variance is the amount of variance that a variable is able to explain in another construct. The shared variance is computed by calculating the square of the correlation between two variables. In other words, the shared variance is the proportion of variance in observed variables relating to another theoretical construct, and the AVE is the average amount of variance in observed variables associated with a related and specific latent construct. Particularly important to the method of comparing the shared variance vs AVE, is the notion of measurement error (Farrell, 2010). Indeed, the formula to compute the AVE proposed by Fornell and Larcker (1981) includes the measurement error estimated from a confirmatory factor analysis output, as it is defined as,

$$AVE = \frac{\sum_{i=1}^{p} \lambda y_i^2}{\sum_{i=1}^{p} \lambda y_i^2 + \sum_{i=1}^{p} \text{Var}(e)}$$

where p is the number of indicators of the construct, \(\lambda y_i\) are the factor loadings, and \(\text{Var}(e)\) is the error variance indicator. The use of AVE and shared variance estimates that account for measurement error allows to provide a more stringent evaluation of the discriminant validity (Farrell, 2010), and in this study it allows us to take into consideration in the calculations the variance shared between competence and adherence due the similar measurement procedures they necessitate. In this study, the confirmatory factor analysis was conducted in Stata 14.2.
9.3 Results

9.3.1 Descriptive Statistics

The descriptive statistics of the TCS, CPPS-ER, and WAI-O-S score are displayed in Table 9.1.

<table>
<thead>
<tr>
<th>Table 9.1</th>
<th>Descriptive Statistics of the TCS, CPPS-ER and WAI-O-S scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Competence subscale</td>
<td>99</td>
</tr>
<tr>
<td>Incompetence subscale</td>
<td>99</td>
</tr>
<tr>
<td>Global Competence rating</td>
<td>99</td>
</tr>
<tr>
<td>Patient Complexity</td>
<td>99</td>
</tr>
<tr>
<td>CPPS-ER</td>
<td>99</td>
</tr>
<tr>
<td>PI subscale</td>
<td>99</td>
</tr>
<tr>
<td>CB subscale</td>
<td>99</td>
</tr>
<tr>
<td>WAI-O-S</td>
<td>99</td>
</tr>
<tr>
<td>Bond subscale</td>
<td>99</td>
</tr>
<tr>
<td>Task subscale</td>
<td>99</td>
</tr>
<tr>
<td>Goal subscale</td>
<td>99</td>
</tr>
</tbody>
</table>

The distribution of the TCS, CPPS-ER, WAI-O-S scores, and their subscales was examined. The Kolmogorov-Smirnov test was significant for all scales and subscales (Table 9.2).
Considering the non-normal distribution of the scales' scores, the presence of outliers was explored through the Stem-and-Leaf plots of each of the scales and subscales (See Figures 9.1-9.11)

<table>
<thead>
<tr>
<th></th>
<th>Kolmogorov-Smirnov</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence subscale</td>
<td>.110</td>
<td>.005</td>
</tr>
<tr>
<td>Incompetence subscale</td>
<td>.190</td>
<td>.000</td>
</tr>
<tr>
<td>Global Competence rating</td>
<td>.178</td>
<td>.000</td>
</tr>
<tr>
<td>Patient Complexity</td>
<td>.208</td>
<td>.000</td>
</tr>
<tr>
<td>CPPS-ER</td>
<td>.103</td>
<td>.011</td>
</tr>
<tr>
<td>PI subscale</td>
<td>.093</td>
<td>.036</td>
</tr>
<tr>
<td>CB subscale</td>
<td>.158</td>
<td>.000</td>
</tr>
<tr>
<td>WAI-O-S</td>
<td>.104</td>
<td>.010</td>
</tr>
<tr>
<td>Bond subscale</td>
<td>.150</td>
<td>.000</td>
</tr>
<tr>
<td>Task subscale</td>
<td>.145</td>
<td>.000</td>
</tr>
<tr>
<td>Goal subscale</td>
<td>.131</td>
<td>.000</td>
</tr>
</tbody>
</table>
Figure 9.1. Box-whisker plot Competence Subscale

Figure 9.2. Box-whisker plot Incompetence Subscale
Figure 9.3. Box-whisker plot Global Competence

Figure 9.4. Box-whisker plot Patient Complexity
Figure 9.5. Box-whisker plot CPPS-ER

Figure 9.6. Box-whisker plot PI Subscale
Figure 9.7. Box-whisker plot CB Subscale

Figure 9.8. Box-whisker plot WAI-O-S
Figure 9.9. Box-whisker plot Bond Subscale

Figure 9.10. Box-whisker plot Task Subscale
The competence subscale and the global competence rating did not have any outlier scores. The incompetence subscale presented one outlier observation (score=27). The patient complexity rating showed three outliers (scores 5, 6 and 6). The CPPS-ER scale presented two outlier observations (scores 22 and 23). The PI subscale displayed 4 outliers (score 10, 13, 15, and 15). The CB subscale presented 4 outliers (scores 36, 37, 38, 41) and two extreme outlier observations (scores 48 and 55). The WAI-O-S showed three outliers (scores 10, 16 and 16). The Bond subscale had three outliers (scores 8, 10, and 12). The Task subscale presented three outliers (scores 8, 8, and 10). Finally, the Goal subscale had one outlier (score -6). The Kolmogorov-Smirnov test remain significant for all scales and subscales after excluding the outlier observations.

9.3.2 Correlations between Scales

Due to the non-normal distribution of the data, Spearman coefficients were examined in order to study the correlations between the TCS, CPPS-ER and the WAI-O-S (Table 4). In order to avoid Type I error due to multiple testing, Bonferroni correction was conducted (α= 0.05/15= 0.003). Regarding the TCS, a very high negative correlation (ρ=-0.939) was found between the competence and incompetence subscales. No significant correlations were found between the competence or incompetence subscales, and the patient complexity rating.
A low positive correlation ($\rho=0.392$) was found between the competence subscale and the CPPS-ER. Concurrently, a low negative correlation ($\rho=-0.285$) was found between the incompetence subscale and the CPPS-ER. No significant correlation was found between the patient complexity rating and the CPPS-ER.

A moderate positive correlation ($\rho=0.626$) was found between the competence subscale and the WAI-O-S. The incompetence subscale showed a moderate negative correlation ($\rho=-0.539$) with the WAI-O-S. Furthermore, a low negative correlation ($\rho=-0.465$) was found between the patient complexity rating and the WAI-O-S.

All results remained significant after Bonferroni correction, with the exception of the correlation between the incompetence subscale and the CPPS-ER.
Table 9.3
*Spearman’s rho correlations between TCS, CPPS-ER and WAI-O-S*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence Subscale</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incompetence Subscale</td>
<td>-0.939**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Competence</td>
<td>0.957**</td>
<td>-0.904**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Complexity</td>
<td>-0.139</td>
<td>0.072</td>
<td>-0.077</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPPS-ER</td>
<td>0.392**</td>
<td>-0.285**</td>
<td>0.393**</td>
<td>0.041</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>WAI-O-S</td>
<td>0.626**</td>
<td>-0.539**</td>
<td>0.565**</td>
<td>-0.465**</td>
<td>0.255*</td>
<td>1.000</td>
</tr>
</tbody>
</table>

*Note 1. ** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed)*
Scatterplots were used in order to visually examine the relationship between the TCS, the CPPS-ER and the WAI-O-S (Figures 9.12-9.15). The competence subscale displayed a positive, weak and linear relationship with the CPPS-ER. Concurrently, the competence subscale showed a positive, linear relationship of moderate strength with the WAI-O-S. No linear relationship was found between the incompetence subscale and the CPPS-ER. A negative relationship of moderate strength was found between the incompetence subscale and the WAI-O-S. No clusters were found in any of the associations.

Figure 9.12. Scatterplot Competence Subscale vs CPPS-ER

Figure 9.13. Scatterplot Competence Subscale vs WAI-O-S
However, due to the presence of outlier scores, new correlation coefficients were obtained after excluding the outlier observations (Table 9.4). The correlation between the competence subscale and the CPPS-ER increased in magnitude, but remained in a positive low level. The correlation between the competence subscale and the WAI-O-S changed minimally. The
strength of association between the incompetence subscale and the CPPS-ER increased (\(\rho=-0.416\)), while the correlation between the incompetence subscale and the WAI-O-S showed little change. The correlation between patient complexity and the WAI-O-S showed a small change, however remaining as a negative low-level correlation. All results remained significant after conducting Bonferroni corrections.
Table 9.4
Spearman’s rho correlations between TCS, CPPS-ER and WAI-O-S (excluding outliers)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
<th>Competence Subscale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence Subscale</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incompetence Subscale</td>
<td>-0.932**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Competence</td>
<td>0.953**</td>
<td>-0.893**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Complexity</td>
<td>-0.164</td>
<td>0.106</td>
<td>-0.087</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPPS-ER</td>
<td>0.492**</td>
<td>-0.416**</td>
<td>0.492**</td>
<td>0.033</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>WAI-O-S</td>
<td>0.638**</td>
<td>-0.567**</td>
<td>0.568**</td>
<td>-0.493**</td>
<td>0.286**</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Note 1. ** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed)
9.3.3 Correlations between Subscales

The Spearman coefficient between the TCS, and the CPPS-ER and WAI-O-S subscales was examined (Table 9.5). In order to avoid Type I error due to multiple testing, Bonferroni correction was conducted (α= 0.05/36= 0.001). A high positive correlation (ρ=0.851) was found between the competence subscale and the PI subscale. A low negative correlation (ρ=-0.372) was found between the competence subscale and the CB subscale. Concurrently, moderate positive correlations were found between the competence subscale and the three WAI-O-S subscales.

The incompetence subscale displayed a high negative correlation with the PI subscale (ρ=-0.810), while it showed a low positive correlation (ρ=0.436) with the CB subscale. Moderate negative correlations were found between the incompetence subscale and the Task and Goal subscales. A low negative correlation (ρ=-0.433) was found between the incompetence subscale and the Bond subscale.

No significant correlations were found between the patient complexity rating and the CPPS-ER subscales. Low negative correlations were found between the patient complexity rating and the three subscales of the WAI-O-S.

All correlations remained significant after conducting Bonferroni corrections.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Competence Subscale</th>
<th>Incompetence Subscale</th>
<th>Global Competence</th>
<th>Patient Complexity</th>
<th>PI Subscale</th>
<th>CB Subscale</th>
<th>Bond</th>
<th>Task</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence Subscale</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incompetence Subscale</td>
<td>-0.939**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Competence</td>
<td>0.957**</td>
<td>-0.904**</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Complexity</td>
<td>-0.139</td>
<td>0.072</td>
<td>-0.077</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PI subscale</td>
<td>0.851**</td>
<td>-0.810**</td>
<td>0.854**</td>
<td>-0.050</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CB subscale</td>
<td>-0.372**</td>
<td>0.436**</td>
<td>-0.353**</td>
<td>0.195</td>
<td>-0.255*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bond</td>
<td>0.526**</td>
<td>-0.433**</td>
<td>0.474**</td>
<td>-0.485**</td>
<td>0.269**</td>
<td>-0.191</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>0.603**</td>
<td>-0.517**</td>
<td>0.537**</td>
<td>-0.411**</td>
<td>0.415**</td>
<td>-0.095</td>
<td>0.791**</td>
<td>1.000</td>
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</tr>
<tr>
<td>Goal</td>
<td>0.633**</td>
<td>-0.562**</td>
<td>0.577**</td>
<td>-0.422**</td>
<td>0.486**</td>
<td>-0.114</td>
<td>0.719**</td>
<td>0.907**</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Note 1. ** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed)
Scatterplots were used in order to visually examine the relationship between the TCS, the subscales of the CPPS-ER and the WAI-O-S (Figures 9.16-9.25). A strong linear positive relationship was found between the competence subscale and the PI subscale. A weak negative linear relationship was found between the competence subscale and the CB subscale. Concurrently a strong, negative linear relationship was observed between the incompetence subscale and the PI subscale. A weak, negative linear relationship was found between the incompetence subscale and the CB subscale, however several outliers scores were observed. Moderate, positive and linear relationships were found between the competence subscales and the three WAI-O-S subscales. Concurrently, negative, moderate and linear relationships were found between the incompetence subscale and the three WAI-O-S subscales. No clustering was observed.

Figure 9.16. Scatterplot Competence Subscale vs PI Subscale
Figure 9.17. Scatterplot Competence Subscale vs CB Subscale

Figure 9.18. Scatterplot Incompetence Subscale vs PI Subscale
Figure 9.19. Scatterplot Incompetence Subscale vs CB Subscale

Figure 9.20. Scatterplot Competence Subscale vs Bond Subscale
Figure 9.21. Scatterplot Competence Subscale vs Task Subscale

Figure 9.22. Scatterplot Competence Subscale vs Goal Subscale
Figure 9.23. Scatterplot Incompetence Subscale vs Bond Subscale

Figure 9.24. Scatterplot Incompetence Subscale vs Task Subscale
Spearman coefficients were re-calculated after excluding outlier observations. The competence subscale correlations with other subscales showed little change. Only the correlation between the competence subscale and the Bond subscale changed from a moderate to a low positive one ($\rho=0.476$). The Spearman coefficients between the incompetence subscale, PI and CB subscales did not display relevant changes. Likewise, the correlations between the incompetence subscale and the Bond, Task and Goal subscales only showed negligible changes. The correlations between the patient complexity rating and the Task and Goal subscales did not display relevant changes. The Spearman coefficient between the patient complexity rating and the Bond subscale showed a moderate negative correlation ($\rho=-0.513$).
### Table 9.6
*Spearman’s rho correlations between TCS, CPPS-ER and WAI-O-S subscales (excluding outliers)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Competence Subscale</th>
<th>Incompetence Subscale</th>
<th>Global Competence</th>
<th>Patient Complexity</th>
<th>PI Subscale</th>
<th>CB Subscale</th>
<th>Bond</th>
<th>Task</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence Subscale</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incompetence Subscale</td>
<td>-0.932**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Competence</td>
<td>0.953**</td>
<td>-0.893**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Complexity</td>
<td>-0.164</td>
<td>0.106</td>
<td>-0.087</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PI subscale</td>
<td>0.867**</td>
<td>-0.818**</td>
<td>0.861**</td>
<td>-0.055</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CB subscale</td>
<td>-0.364**</td>
<td>0.403**</td>
<td>-0.338**</td>
<td>0.164</td>
<td>-0.251*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bond</td>
<td>0.476**</td>
<td>-0.394**</td>
<td>0.422**</td>
<td>-0.513**</td>
<td>0.235*</td>
<td>-0.202</td>
<td>1.000</td>
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<td></td>
</tr>
<tr>
<td>Task</td>
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<td>-0.536**</td>
<td>0.539**</td>
<td>-0.442**</td>
<td>0.455**</td>
<td>-0.113</td>
<td>0.754**</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>0.677**</td>
<td>-0.631**</td>
<td>0.609**</td>
<td>-0.438**</td>
<td>0.554**</td>
<td>-0.165</td>
<td>0.678**</td>
<td>0.893**</td>
<td>1.000</td>
</tr>
</tbody>
</table>

*Note 1.* ** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed)
9.3.4 Discriminant Validity between Competence Subscale and PI Subscale

A confirmatory factor analysis was conducted in order to estimate the shared variance and the AVE coefficient for both, competence and adherence, considering the measurement error in the calculations. In these calculations, competence and adherence, were predefined as the two latent constructs of the confirmatory factor analysis (CFA), as the study aimed to establish the discriminant validity between these two measures/constructs. Therefore, the standardised coefficients of the factor loadings for the observed variables, -the items of the competence subscale and the items of the PI subscale-, were calculated in reference to competence and adherence, respectively (Tables 9.7 and 9.8). The goodness of fit of the model displayed disparate results. On one hand the model's chi square (p =0.000) and the Standardized Root Mean Square Residual (SRMR = 0.048) supported the model’s fit. However, the Root Mean Square Error of Approximation (RMSEA= 0.104) and the Comparative Fit Index (CFI= 0.843), did not confirm the goodness of fit of the model. It is important to remark that no other CFA models were estimated in this study considering that the primary aim of the analyses was to calculate the shared variance and AVE, and not to make a precise estimation of the factors of the constructs under study.
Table 9.7
Factor Loadings and Squared valued for the Items of the Competence Subscale

<table>
<thead>
<tr>
<th>Competence Subscale Item</th>
<th>Standardised Coefficient of Factor Loadings $\lambda$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.9075137</td>
</tr>
<tr>
<td>2</td>
<td>0.8812861</td>
</tr>
<tr>
<td>3</td>
<td>0.9456814</td>
</tr>
<tr>
<td>4</td>
<td>0.9105492</td>
</tr>
<tr>
<td>5</td>
<td>0.908793</td>
</tr>
<tr>
<td>6</td>
<td>0.886058</td>
</tr>
<tr>
<td>7</td>
<td>0.9212475</td>
</tr>
<tr>
<td>8</td>
<td>0.8983091</td>
</tr>
<tr>
<td>9</td>
<td>0.9471017</td>
</tr>
<tr>
<td>10</td>
<td>0.9022553</td>
</tr>
<tr>
<td>11</td>
<td>0.9234926</td>
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<tr>
<td>12</td>
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</tr>
<tr>
<td>13</td>
<td>0.9416944</td>
</tr>
<tr>
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<td>0.9416944</td>
</tr>
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<td>15</td>
<td>0.8028445</td>
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<td>16</td>
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<td>0.9280952</td>
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<td>0.9214297</td>
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<td>23</td>
<td>0.9265589</td>
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<tr>
<td>24</td>
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<td>0.9380508</td>
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<td>0.920709</td>
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<td>41</td>
<td>0.8924662</td>
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<td>42</td>
<td>0.8598519</td>
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</table>
Table 9.8

<table>
<thead>
<tr>
<th>CPPS-ER Item (PI Subscale)</th>
<th>Standardised Coefficient of Factor Loadings $\lambda$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.7644152</td>
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<td>0.8841879</td>
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<td>0.6784692</td>
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<td>10</td>
<td>0.740998</td>
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<td>0.7914526</td>
</tr>
<tr>
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<td>0.9246896</td>
</tr>
<tr>
<td>16</td>
<td>0.16847</td>
</tr>
<tr>
<td>19</td>
<td>0.4837635</td>
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</table>

In accordance with the AVE formula, the AVE coefficient for competence (AVE= 0.202) and adherence (AVE=0.470) were computed. Additionally, the standardised covariance between competence and adherence (0.841) obtained in the confirmatory factor analysis was employed to calculate the shared variance between the constructs, which was 0.708. Therefore, considering that both AVE coefficients were smaller than the shared variance between competence and adherence, discriminant validity could not be established between the constructs.

9.4 Discussion

The current study aimed to examine the convergent and discriminant validity of the TCS in order to investigate its ability to assess therapist competence and incompetence in comparison to other validated instruments that measure constructs in similar domains. Specifically, this study aimed to evaluate the construct validity of the TCS, and therefore its ability to capture therapist competence, and to separate it from the constructs of treatment adherence and the therapeutic alliance (Boateng et al., 2018).

The ability of the TCS to distinguish between therapist competence and treatment adherence was first examined through the study of the correlations between the subscales of the TCS, and the CPPS-ER and its subscales. A high
positive correlation was found between the competence subscale and the PI subscale, whilst a high negative correlation characterised the relationship between the incompetence subscale and the PI subscale. These findings suggest that the construct measured by the TCS overlaps with the construct of treatment adherence in this sample. Accordingly, the TCS did not clearly differentiate between therapist competence and adherence in this study. Although a moderate degree of overlap between these two instruments was hypothesised, due to the impossibility for a therapist to be competent but not adherent to the model of therapy delivered, a high Spearman coefficient between the competence subscale and the PI subscale suggest that the TCS was not able to disentangle competence from adherence. Additionally, the study of the discriminant validity between the competence subscale and the PI subscale, by the comparison of the AVE coefficients and the shared variance between competence and adherence, did not support the discriminant validity of these measures in this particular study, even when accounting for measurement error. Thus, the commonalities between these constructs seemed more relevant than the relation each construct had with its own observed variables (items), even when considering the shared method to assess competence and adherence. It is likely that the restricted variability in both, the competence as well as the adherence scores, may have hampered the study of the discriminant validity of these measures. Indeed, in this study, only in the treatment of 3 participants, therapists displayed concurrently competence scores above the mean and adherence scores below it. Similarly, only in the treatment of 16 participants, therapists had concurrently adherence scores above the mean and competence scores below it. Despite of these results, it is well-known from clinical experience that most therapists can be adherent to a treatment model but not necessarily deliver its interventions competently. Thus, it is likely that the restricted variability in this study derived from the fact that the therapists in the REDIT trial were highly trained. Possibly, the study of the discriminant validity between competence and adherence in naturalistic samples where a larger number of therapists concurrently display disparate scores on competence and adherence, could shed light on the relation between these variables.
Another possible explanation for the measures’ lack of discrimination between competence and adherence found in this study, is that although the CPPS-ER has been used as a measure of adherence to psychodynamic and cognitive-behavioural psychotherapeutic techniques (R. E. Goldman et al., 2013), it also does not completely disentangle the constructs of therapist competence and adherence. The CPPS-ER measures the psychodynamic-interpersonal and the cognitive-behavioural items in a 7-point Likert scale, that ranges from “Not at all characteristic” to “Extremely Characteristic” (Hilsenroth et al., 2005). Although the scoring method aims to measure how frequently the different techniques are used, it is implicit in the wording of the items that a degree of skill is required to deliver the interventions. For example, “The therapist links the patient’s current feelings or perceptions to experiences of the past” (Hilsenroth et al., 2005) is an item that presupposes that: (1) the therapist has an adequate understanding of the patient’s feelings in the here-and-now of the session; (2) the therapist properly assessed the patient and developed an understanding of the patient’s history and relationships; and that, (3) the therapist has formulated the patient’s difficulties and is able to skilfully make links in the material and deliver interventions. Therefore, although the CPPS-ER is primarily a measure of adherence, it does not adequately separate therapist competence from adherence. Hence, it is likely that the TCS competence subscale and the PI subscale measure a similar construct: the delivery (adherence) and skill (competence) with which the therapist intervenes according to psychodynamic-interpersonal principles.

An interesting question is whether it is feasible to develop a measure that more clearly differentiates between competence and adherence. Possibly, it would have to be an instrument that only conceptualises competence as the need of the therapist to go off-manual in accordance to the patient changing states in the here-and-now of the session. Within this understanding, a therapist that is flexible by adapting to the patient’s needs, would be described as competent and not adherent to the treatment manual. However, the operationalisation of therapist competence in the use of specific techniques and interventions that belong to a specific therapeutic brand, does not allow for a clear separation between the constructs of therapist competence and adherence. Thus, in every occasion that the therapist competently delivers the
manual interventions, he/she will be highly adherent to is as well. Therefore, the attempt of this study to moderately disentangle therapist competence from adherence, might not be feasible. Indeed, McLeod et al. (2018) have corroborated the high degree of overlap between competence and adherence measures, and have suggested that it might not be possible to distinguish between these variables. As stated by M Hilsenroth (personal communication, September 14, 2016), adherence to technique is only relevant if it benefits patients, and only constitutes an interesting variable inasmuch as it represents a potential mechanisms of change that affects clinical outcomes.

A noticeable result of this study was the low positive correlation found between the competence subscale and the CPPS-ER. It is likely that this finding is related to the fact that the CPPS-ER includes items not only related to PI interventions, but also to CB techniques (Hilsenroth et al., 2005). In fact, an interesting result of this study was the low negative correlation found between the competence subscale and the CB subscale. In the same line, a low positive correlation was found between the incompetence subscale and the CB subscale. One possible understanding for this finding is that a number of cognitive-behavioural interventions might be conceptually opposite to the operationalisation of competence in a brief psychodynamic psychotherapy. For example, the item of the CB subscale “The therapist suggests specific activities or tasks (homework) for the patient to attempt outside of the session” (Hilsenroth et al., 2005) might be understood as an incompetence from a psychodynamic viewpoint, because it entails giving the patient concrete solutions that might seem to overlook the patient’s unconscious realm. Therefore, an indirect correlation between the competence in DIT and CB techniques, was expectable. However, it is interesting that the magnitude of the correlation between the CB subscale and the TCS subscales is only “low”. The latter possibly is associated with the fact that DIT includes a number of techniques that could be considered to be closer to cognitive-behavioural interventions. For example, the DIT manual specifies that, “The most ‘directive’ intervention in DIT is the focus on the IPAF, which will require tracking the focus and actively redirecting the patient to it where necessary” (p. 166, Lemma et al., 2011a). The latter is conceptually close to cognitive-behavioural interventions that require the therapist to be active and directive towards
specific topics of discussion (Hilsenroth et al., 2005). Therefore, although the TCS operationalised competence within a psychodynamic framework, due to the nature of DIT interventions the correlation of the competence subscale with the CB subscale was negative, but only “low” in magnitude.

Other possible explanation for the low negative correlation between the competence subscale and the CB subscale might be related to the concept of “adherence flexibility”. A recent study found that “adherence flexibility”, meaning the use of a limited amount of CB techniques in a psychodynamic therapy-, was related to better treatment outcomes in comparison to not incorporating these interventions in the treatment of depression (Katz et al., 2018). “Adherence flexibility” could be understood as equivalent to competence, as it implies that the therapist does not deliver the manual interventions rigidly, but adapts the interventions to the patient’s needs. Therefore, it could be suggested that finding that the correlation between the TCS competence subscale and the CB subscale was only low and not higher in magnitude, could be related to the fact that the operationalisation of competence in the TCS, encompasses the capacity of the therapist to not be inflexibly adherent to the treatment manual.

The patient complexity rating showed significant correlations with neither the CPPS-ER subscales, nor the TCS subscales. This result suggests that therapist adherence and competence are not related to the patient’s capacity to work psychotherapeutically, nor to his/her receptiveness to the therapist interventions. This finding could be understood in two possible ways. On one hand, it could be suggested that the patient’s clinical complexity does not affect the therapist’s capacity to be adherent/competent to psychotherapeutic techniques. Therefore, the therapist would intervene independently of the clinical presentation of the patient. On the other hand, this finding could suggest that the adherent and competent use of PI techniques does not help the patient to become more trustful and open towards the therapist interventions. However, these results should be considered with caution considering that the patient complexity rating is not a validated measure. Additionally, a better suited methodology, such as multilevel modelling, should be used in order to examine the relationship between competence and patient complexity.
The study of the convergent and discriminant validity of the TCS in reference to the therapeutic alliance was examined through the correlations between the TCS and the WAI-O-S. A moderate positive correlation was found between the competence subscale and the WAI-O-S. In the same line, a moderate negative correlation was found between the incompetence subscale and the WAI-O-S. Concurrently, moderate positive correlations were found between the competence subscale and all the WAI-O-S subscales. Similarly, moderate negative correlations were found between the incompetence subscale and the Task and Goal subscales. These results are in line with the hypothesis of this study which posed that the competencies related to the development of the therapeutic alliance explain partly, but not entirely, the skilfulness of the therapist. These results are relevant because they suggest that the TCS captures different kinds of competencies, the ones related to the psychotherapeutic common factors, as well as the competencies related to the specific ingredients of psychotherapy (Imel & Wampold, 2008; Wampold, 2015). Ackerman and Hilsenroth (2003) identified the attributes and techniques of the therapist that correlate with strong therapeutic alliances. Among the attributes, being honest, trustworthy, experienced, confident, interested, alert, friendly, warm, flexible and open were identified. Important therapist techniques that correlated with stronger alliances included being supportive, being reflective, facilitating emotional expression, being active, providing accurate interpretations, noting past therapy success, and being affirming. Therefore, the literature has confirmed that there are several attributes and techniques related to the development of the alliance, however these attributes and techniques are only part of the exhaustive list of competencies a therapist should display in order to deliver psychodynamic psychotherapy appropriately.

An interesting result of this study was that a low negative correlation was found between the patient complexity rating and the three subscales of the WAI-O-S. This finding suggests that the patient's openness and receptivity towards therapy could be related to the availability of the patient to form a therapeutic alliance with the therapist. Thus, it is possible to suggest that the patient's epistemic trust is fundamental for the development of the therapeutic alliance (Fonagy et al., 2015). However, the low negative correlation found between patient complexity and the three subscales of the WAI-O-S could also
be interpreted in the opposite direction. Therefore, it could be suggested that the therapist’s ability to form a therapeutic alliance with the patient may lower the complexity of the patient’s presentation, by helping the him/her become more open and trustful towards the interventions. Fonagy et al. (2015) have proposed that treating the patient as an agent and helping him/her mentalize, brings about a sense of genuine collaboration through the establishment of an attachment relationship that in turn increases the sense of epistemic trust which allows for a greater openness to social learning. Future research should examine the temporality of the association between patient complexity and the therapeutic alliance, as well as the specific competencies that may allow for the development of epistemic trust.

This study has several limitations. Firstly, and most importantly, the low variability in the scores of the different scales may have hampered the study of the TCS convergent and discriminant validity, particularly in the examination of the constructs of adherence and competence. Possibly, future studies in naturalistic samples would enable a better approximation regarding the ability of the TCS to distinguish between competence and adherence. Additionally, future research should examine the characteristics of the sessions in which therapists display adherence but not competence, in order to achieve a better understanding of the relationship between these variables.

Another important limitation of this study was that only one rater coded the three subscales and therefore, the reliability of the measurements could not be studied. Additionally, the rater did not formally train in the utilization of the scales, but only learned about the use of the CPPS-ER and the WAI-O-S through reading the materials associated with the development of these scales. These issues could increase the probability of random and systematic error in the measurements.

A third important limitation of this study is that the criterion validity of the TCS was not examined. Therefore, as the scores of the TCS were not compared to a “gold standard” measure of therapist competence, it is not possible to establish with certainty that the TCS is in fact measuring therapist competence (Raykov & Marcoulides, 2011). However, there are no instruments in brief-psychodynamic psychotherapy that have been considered as “gold standards” of therapist competency (Barber et al., 2007). Therefore, although
there are obstacles to examine the criterion validity of the TCS, the lack of a comparison with a criterion measure should be taken into consideration when examining the results of this study.

In conclusion, this study examined the convergent and discriminant validity of the TCS. The TCS was not able to distinguish between the concepts of therapist competence and adherence in this sample. However, the low variability of the scores in the sample studied might have hampered the assessment of the ability of the TCS to distinguish between these constructs. Additionally, the feasibility of developing measures that distinguish between competence and adherence was questioned. On the other hand, the TCS captured the competencies of the therapist related to the development of the therapeutic alliance. Future research should aim to study the criterion validity of the TCS in order to contextualise the findings of this study. The results of this study should only be considered as initial estimates of the validity of the TCS. Further studies are needed to achieve more robust conclusions regarding the validity of this newly developed scale.
Chapter 10: Therapist Competence and its Association with Patient's Clinical Outcomes

10.1 Introduction

The aim of the current study was to examine the relationship between therapist competence, as measured with the TCS, and patients’ clinical outcomes in the REDIT trial. This study pertains to the field of psychotherapy process-outcome research, and therefore it is important to describe the relevant literature from which it comes about.

Several “active ingredients” have been hypothesised to be responsible for the clinical improvement of patients receiving psychotherapy. Customarily, the active ingredients of psychotherapy have been grouped into two categories, the common factors and the specific factors (Louis G Castonguay, 1993). The common factors entail the elements shared across the various psychotherapeutic modalities, such as the therapeutic alliance. On the other hand, the specific factors are the ones set out by particular treatment manuals, which are interested in both, the degree to which therapists deliver theory-specific interventions (adherence), as well as the skill with which these interventions are implemented (competence) (Sharpless & Barber, 2009). Therefore, in order to identify the specific “active ingredients” of psychotherapy, process-outcome research has examined the statistical relation between variability ratings of adherence and competence and scores on outcome measures. Thus, understanding which psychotherapeutic components constitute mechanisms of change, by bringing about positive treatment outcomes, allows researchers to modify treatments in order to make them more effective (Kazdin, 2006; C. Webb et al., 2010).

The study of the relationship between adherence and outcome has shown inconsistent results (Miller & Binder, 2002; Perepletchikova & Kazdin, 2005). Indeed, C. Webb et al. (2010) meta-analysis of 36 studies found effect sizes, -in the adherence-outcome and competence-outcome relationship-, not significantly different from zero. However, a second meta-analysis (Zarafonitis-Müller et al., 2014) found a small but significant effect of competence on the patients’ clinical improvements ($r = 0.24$), but no significant effects of adherence
on outcome. Additionally, Crits-Christoph et al. (2013) have indicated that there is evidence that competence in psychodynamic interventions predicts treatment outcomes, at least in psychotherapy for anxiety and depressive disorders. Therefore, the current study aimed to thoroughly study the relationship between therapist competence and outcome in patients receiving DIT, a psychotherapy intended for the treatment of depressive and anxious symptomatology (Lemma et al., 2010).

Although a relationship between therapist competence and outcome has been suggested, research examining this association has had several limitations. Firstly, there have been important conceptual limitations considering that therapist competence has not been distinctly and validly operationalised. Research measures used to assess psychodynamic competence have not been empirically derived, neither validated. Furthermore, studies that have attempted to measure competence mostly rely on subjective ratings (Orlinsky & Howard, 1986), therefore differences between scores and the components of competence have not been adequately operationalised. Additionally, competence measures do not consistently disjoint this construct from the notion of treatment adherence. Adherence may have a very complicated relation with outcome, and failing to separate out adherence may obfuscate any association between competence and outcome. Another conceptual limitation is that most measures of competence only assess limited-domain competencies. Although it is possible that patient improvement may result from competence demonstrated in a single domain, it is more likely that competence demonstrated across multiple domains or as global competence, may be a more consistent predictor of treatment outcomes (Barber et al., 2007). Furthermore, difficulties in conceptualising therapist competence may reflect the complexity of operationalising therapist’s responsiveness, meaning the ability “to do the right thing at the right time, where the right thing varies with shifting client requirements, therapeutic approach and other circumstances” (C. Hill & Castonguay, 2017, p.327). Thus, past operationalisations of competence that only encompass stable characteristics or behaviours of the therapist, are inadequate conceptualisations of competence (Stiles & Horvath, 2017).

Furthermore, research studies that have investigated the relationship between therapist competence and outcome have important methodological
and statistical limitations. Firstly, therapist competence has mainly been studied in RCTs which tend to rely on highly trained therapists. Therefore, the therapists that participate in these studies have a narrow range of competence, which could result in a low variability of competence and/or outcome scores. Hence, the small effect of competence on outcome may reflect the restricted range of competence among RCT’s participating therapists. Moreover, studies examining the association between competence and outcome have not adequately explored the effect of competence at different stages of therapy. Therefore, it is not known whether competence is a proximal or distal predictor of outcome, or whether competence has different associations with outcome at the different stages of therapy (Barber et al., 2007). Another limitation is that separate process-outcome studies have used different conceptualisations of outcome. There are studies that have examined the total amount of change achieved by the patient (i.e., effectiveness), and others that have investigated the rate of patient’s improvement (i.e., efficiency). Considering that these two conceptualisations of outcome could bring about different results, it has been recommended that both of them should be estimated (Barkham et al., 2017). Finally, a fundamental limitation of studies that have explored the association between therapist competence and outcome is the use of unsuitable statistical methods to examine this relationship. Studying the association between competence and outcome entails the analysis of a multilevel data structure, in which sessions are nested in patients, and patients nested in therapists. Research that has failed to use an appropriate statistical methodology, - multilevel modelling-, is unable to adequately examine the effect of competence, disentangling the different sources of variance that contribute to treatment outcomes (Wampold et al., 2017).

The current study aims to examine the association between therapist competence and outcome taking into consideration the conceptual and methodological/statistical limitations of past research studies. In order to address the conceptual limitations mentioned above, the current study assessed therapist competence with the TCS. The TCS is the first measure of therapist competence in psychodynamic psychotherapy research, that has been empirically developed according to expert clinician’s conceptualisations of the construct. Furthermore, the TCS is the first measure of therapist
competence in psychodynamic psychotherapy research whose psychometric features have been supported by a preliminary process of validation. Furthermore, the TCS attempts to conceptualise competence by distinguishing the construct from the notion of treatment adherence, which in past research may have hampered the examination of the association between competence and patient improvement. Additionally, the TCS has included in its operationalisation the notion of therapist responsiveness, which is essential to accurately and appropriately define therapist competence. Moreover, the TCS encompasses multiple-domain competencies and a measure of therapist global competence, two different and complementary conceptualisations of competence which help to better understand the relation between this variable and patient improvement. Furthermore, the TCS encompasses a comprehensive assessment of therapist competence, which includes a large number of items that aim to account for and distinguish between different degrees of competence among therapists, which is of particular relevance in RCTs, where the range of competence among therapists is frequently restricted. Therefore, the TCS allows for studying therapist competence comprehensively, capturing flexibility, contextual responsiveness, nuance, and depth.

Additionally, this study aimed to investigate the relationship between competence and outcome, taking into account several methodological and statistical limitations of past research studies. Therefore, the current study investigated the effect of competence longitudinally, considering treatment outcomes in terms of effectiveness and efficiency. Furthermore, linear and non-linear relations between competence and outcome were explored. Moreover, this study considered the study of third variables that could impact the association between competence and outcome, such as patient complexity. Additionally, this study employed multilevel modelling in order to appropriately study the relationship between therapist competence and outcome, taking into account the hierarchical structure of the data.

The fundamental research question of this study was, is therapist competence, as operationalised by the TCS, associated with the patients’ clinical outcome in DIT? It was hypothesised that there would be a significant association between competence and treatment outcome, and based on the
literature review findings, it was predicted that this relationship would be more relevant in patients with higher symptomatology at baseline. Furthermore, it was predicted that competence would have an effect on outcome scores, as well as an impact in the rate of patient recovery. Additionally, considering the inconsistencies of the literature review findings regarding a positive association between competence and outcome, it was hypothesised that part of the association between competence and outcome would be linear, while other portions of it would have a non-linear relationship. Finally, it was predicted that there would be a significant interaction between therapist competence and patient complexity, being the former of greater importance the more complex the treated patient.

To the best of my knowledge, this is the first study regarding psychodynamic competence and its relationship with treatment outcome, that attempts to overcome fundamental limitations of past research studies on this important field of psychotherapy research.

10.2 Methodology

10.2.1 The REDIT study

The study of the association between therapist competence and outcome was conducted by rating audio-recorded sessions, from the REDIT study, by assessing competence with the TCS. The REDIT study constituted the context in which this study was developed and therefore it is described in detail in the methodology section of this dissertation. In the current study, therapist competence was studied only across the DIT arm of the REDIT trial.

10.2.2 Sample of recordings

Two hundred and eighty-four audio-recorded DIT sessions were coded in order to study therapist competence in the REDIT trial. The audio-recorded sessions were selected following a stratified random procedure (computer-
generated). The stratification aimed to select sessions from the initial, middle and end phase in a 1:3:1 proportion. Thus, a larger number of sessions were selected from the middle phase of therapy, which are considered to be more representative of the therapeutic competencies used in DIT than initial and end phase sessions, which are restricted by the specific therapeutic tasks of these phases. The selected sample was composed of 65 sessions from the initial phase; 169 sessions from the middle phase; and, 50 sessions from the end phase of DIT.

Since a number of patients dropped-out, the final sample for this study included: 4 participants with 1 session rated; 4 participants with 2 sessions rated; 2 participants with 3 sessions rated; 8 participants with 4 sessions rated; 42 participants with 5 sessions rated; and, 4 participants with 6 sessions rated. The selected sample included the 17 therapists that participated in the trials, as well as the total number of participants (n=68).

It is important to mention that in order to standardise the number of assessments, it was decided that 5 time-points would be analysed per participant. Therefore, participants with less than 5 time-points rated with the TCS, were considered as having “missing data” for competence ratings. Conversely, only 5 of a total of 6 time-points were analysed for participants with more than five ratings for competence.

10.2.3 Raters

The author of this dissertation rated all the sampled DIT sessions with the TCS, after studying the inter-rater reliability across 25 DIT sessions.

10.2.4 Measures of therapist competence and outcome

In the current study, therapist competence was assessed with the TCS. The TCS is composed of 2 subscales and 2 global ratings. The first subscale includes 42 core competencies that are grouped according to 17 fundamental aims that a DIT therapist has within a session. The second subscale comprises
38 incompetent attitudes and behaviours that a therapist can display during therapy. Additionally, the TCS includes two global ratings. The first one aims to provide an overall impression of therapist competence in a session. The second overall rating intends to present a general estimation of the patient’s clinical complexity and availability to work psychotherapeutically. The competence subscale and the global competence rating are scored in a 7-point Likert scale (0-6 points, from limited to advanced competence). Likewise, the patient complexity rating is scored in a 6-point Likert scale (1-6 points, from mild to severe complexity). Conversely, the incompetence subscale constitutes a binary scale, according to the presence (1) or absence (0) of the incompetence described.

The initial study of the psychometric features of the TCS was conducted in the previous chapters of this dissertation. According to Generalizability theory, the competence subscale of the TCS presented excellent internal consistency (coefficient = 0.994) and a good level of inter-rater reliability (coefficient = 0.790). Concurrently, in agreement with the Generalizability theory, the incompetence subscale presented a moderate level of internal consistency (coefficient = 0.731) and inter-rater reliability (coefficient = 0.648). The global competence rating presented a good level of inter-rater reliability (ICC= 0.756), and the patient complexity rating displayed a moderate level of inter-rater reliability (ICC = 0.524) across sessions.

Furthermore, the initial study of the convergent and discriminant validity of the TCS was conducted in a previous study of this dissertation. Specifically, this study aimed to evaluate the construct validity of the TCS, and therefore its ability to capture therapist competence, and to separate it from the constructs of treatment adherence and the therapeutic alliance. The ability of the TCS to distinguish between therapist competence and treatment adherence was examined through the study of the correlations between the subscales of the TCS, and the CPPS-ER and its subscales. A high positive correlation was found between the competence subscale and the PI subscale, whilst a high negative correlation characterised the relationship between the incompetence subscale and the PI subscale. This suggested that the construct measured by the TCS overlapped with the construct of treatment adherence in this study. Therefore, within the sample studied, the TCS did not clearly differentiate between
therapist competence and adherence. The study of the convergent and discriminant validity of the TCS in reference to the therapeutic alliance was examined through the correlations between the TCS and the WAI-O-S. A moderate positive correlation was found between the competence subscale and the WAI-O-S. In the same line, a moderate negative correlation was found between the incompetence subscale and the WAI-O-S. These results are in line with the notion that the competencies related to the development of the therapeutic alliance explain partly, but not entirely, the skilfulness of the therapist. This suggested that the TCS captures different kinds of competencies, the ones related to the psychotherapeutic common factors, as well as the competencies related to the specific ingredients of psychotherapy.

The primary outcome of this study were the participants’ symptoms of depression, which were assessed by a research assistants blind to treatment allocation, who rated the 17-item Hamilton Depression Rating Scale (HDRS-17) (Hamilton, 1960). The HDRS-17 is a structured interview that quantifies the severity of depressive symptoms in patients already diagnosed as suffering from a depressive disorder. The psychometric properties of the instrument are good. The HDRS internal consistency ranges between 0.46–0.97, and its interrater reliability (Pearson coefficient) ranges between 0.82-0.98. Additionally, it has shown adequate convergent and discriminant validity (Boateng et al., 2018). The HDRS-17 was rated at baseline, as well as at the 8th (middle of treatment), and 16th (end of treatment) week assessments.

10.2.5 Data analysis

The relationship between therapist competence and clinical outcome was studied using linear multilevel modelling. Multilevel models are appropriate when data is nested, and allow to account for individual change in the presence of missing data (Singer et al., 2003). Considering that the data structure of this study was hierarchical, the models proposed for data analysis consisted of three levels: (1) session, (2) participants and (3) therapists. Thus, a three-level

20 See Appendix T.
hierarchical linear models were used to analyse the longitudinal variation of HDRS-17 scores. Multilevel models disentangle total variation in health outcomes into variance components attributable to each level of analysis. The final statistical model was developed following a number of analyses which will be described in detail below.

Following Leckie (2013), and considering that the aim of the study was to examine the effect of competence at the different levels of the hierarchy on outcome, the first and simpler model analysed included variables that represented competence at the level of the session, participant and therapist. Additionally, in this model both, participants and therapists were treated as random effects. This model (Model 1) was specified as:

\[
y_{jit} = \beta_0 + \beta_1 c_{1jit} + \beta_2 c_{2it} + \beta_3 c_{3t} + \beta_4 \chi + vt + u_{it} + e_{jit}
\]

where \( \beta_0 + \beta_1 c_{1jit} + \beta_2 c_{2it} + \beta_3 c_{3t} + \beta_4 \chi \) is termed the fixed part of the model and \( vt + u_{it} + e_{jit} \) represents the random part of it. The fixed part of the model specifies the overall mean association between HDRS-17 and the competence variables; that is, the association between these variables that occurs in the average therapist. The random part of the model represents how the specific relationships of therapists and patients with outcome, differ from the overall mean relationship. In this model, \( y_{jit} \) represents HDRS-17 throughout treatment for session \( j \) participant \( i \) and therapist \( t \); \( c_{1jit} \) represents competence at the session level with a slope coefficient of \( \beta_1 \); \( c_{2it} \) represents competence at the participant level with a slope coefficient \( \beta_2 \); \( c_{3t} \) represents competence at the therapist level with a slope coefficient \( \beta_3 \); and, \( \chi \) represents time with a slope coefficient of \( \beta_4 \). The random effects of therapist, participant and residual errors are assumed independent of the predictor variables. In this model \( \sigma^2 v \) represents the between-therapist variance, and \( \sigma^2 u \) represents the
within-therapist variance after adjusting for the predictor variables (Leckie, 2013).

The first model proposed examined the mean relationship of competence, at the different levels of analyses, and the associated random effects, with treatment outcome. Thus, this model explored the longitudinal total amount of change in outcome (i.e., effectiveness) achieved by the patient. However, Barkham et al. (2017) suggested the importance of studying process-outcome variables not only considering their effectiveness, but also their efficiency, meaning their effect on the rate of patient’s improvement. Taking this recommendation into account, the second model (Model 2) studied was specified as:

\[
y_{jit} = \beta_0 + \beta_1 c_{jit} + \beta_2 c_{2it} + \beta_3 c_{3t} + \beta_4 c_{1jit}X_{time} + \beta_5 c_{2it}X_{time} \\
+ \beta_6 c_{3t}X_{time} + \beta_7 \chi + \nu t + u_{it} + e_{jit}
\]

where \(\beta_4 c_{1jit}X_{time}, \beta_5 c_{2it}X_{time}, \) and \(\beta_6 c_{3t}X_{time}\) represent the interactions between: competence at the session level and time; competence at the participant level and time; and, competence at the therapist level and time, respectively. The other terms in this model correspond to the same ones explored in the first model.

The third model considered in this study took into account Barber et al. (2007) suggestion that competence might have a quadratic association with treatment outcome, in which low and high levels of competence may predict worse outcomes. Therefore, the third model (Model 3) of this study was specified as:

\[
y_{jit} = \beta_0 + \beta_1 c_{jit} + \beta_2 c_{2it} + \beta_3 c_{3t} + \beta_4 c_{1jit}X_{time} + \beta_5 c_{2it}X_{time} \\
+ \beta_6 c_{3t}X_{time} + \beta_7 c_{1jit}Xc_{1jit} + \beta_8 \chi + \nu t + u_{it} + e_{jit}
\]

where the term \(\beta_7 c_{1jit}Xc_{1jit}\) represents the square of competence at level 1. The other terms in this model correspond to the same ones explored in the second model. It was contemplated that the square of competence at the session level could provide an account of the change of competence in time,
an issue that was considered worthy of attention in order to examine the potential quadratic effect of competence on outcome. However, the square of competence at the level of participant and therapist were not included in this model, considering that these terms would have represented stable parameters across time.

The final model studied took into account the impact of patient complexity on the therapist level of competence. Several research studies have claimed that the level of patient severity influences the activity and effectiveness of therapists (Okiishi et al., 2006; Saxon & Barkham, 2012; Saxon, Ricketts, & Heywood, 2010). Therefore, the fourth model (Model 4) of this study was specified as:

\[
yjit = \beta_0 + \beta_1 cjit + \beta_2 c2it + \beta_3 c3t + \beta_4 c1jitXtime + \beta_5 c2itXtime + \beta_6 c3tXtime + \beta_7 c1jitXc1jit + \beta_8 c3tXpc2it + \beta_9 \chi + vt + uit + ejit
\]

where the term \(\beta_8 c3tXpc2it\) represents the interaction between competence at the therapist level and patient complexity at the participant level. The other terms in this model correspond to the same ones explored in the third model.

This study used a multiple imputation procedure to impute the missing data. In total, 74 HDRS-17 scores out of 340 scores (21.7%) were missing from different time-points (baseline, middle treatment, and end of treatment/5 time-points per patient), which were considered not to be missing at random. Twenty imputations were conducted using the following independent variables in the imputation procedure: time, age, gender, competence (at the session, participant and therapist levels), incompetence (at the session, participant and therapist level), and patient complexity (at the session, participant, and therapist level). Additionally, in order to account for the nested structure of the data, the multiple imputation command included indicator variables for the clusters in the model (Eddings & Marchenko, 2011). Therefore, therapist and participant were included in the imputation model as indicator variables for the
cluster they represented. All the analyses and multiple imputation were conducted using Stata 14.2.

A post hoc power analysis was conducted with MLPowSim applying the appropriate guidelines for hierarchical models (Browne et al., 2009). The estimates for the basic model (Model 1) were calculated using the Z-score method for balanced data. However, considering that this study’s dataset was not balanced, power was estimated employing three number of time-points per therapist and participant. The power of Model 1 was 1 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 1, respectively. The power of Model 1 was 1 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 3, respectively. The power of Model 1 was 1 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 5, respectively. Additionally, power was calculated with different numbers of participants per therapist. The power of Model 1 was 0.986 when the number of therapists, patients by therapists and time-points per patient were 17, 1, and 3, respectively. The power of Model 1 was 1 when the number of therapists, patients by therapists and time-points per patient were 17, 4, and 3, respectively. The power of Model 1 was 1 when the number of therapists, patients by therapists and time-points per patient were 17, 8, and 3, respectively.

Nevertheless, it is important to remark that when the number of therapists was reduced to 16, the model had virtually no power ($b=0.057$). The latter suggests that it is likely that the model had low power, which is difficult to estimate due to the hierarchical and unbalanced nature of the dataset.

10.3 Results

10.3.1 Descriptive Statistics

The mean of competence at the session, participant and therapist level was 3.48, 3.38 and 3.37 points, respectively. On the other hand, the level of
incompetence at the session, participant and therapist level was 0.14, 0.15 and 0.15 points, respectively. The mean of patient complexity at the session, participant and therapist level was 2.23, 2.23, and 2.32 points, respectively. The mean HDRS-17 at baseline, middle of treatment and end of treatment was 18.51, 14.66, and 9.69 points, respectively (Table 10.1).

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Mean</th>
<th>STD</th>
<th>Min</th>
<th>Max</th>
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<td>1.15</td>
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<td>6</td>
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<td>Competence by participant</td>
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<td>Competence by therapist</td>
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<tr>
<td>Incompetence by participant</td>
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<td>0</td>
<td>0.39</td>
</tr>
<tr>
<td>Global Competence by session</td>
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<td>1.17</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Global Competence by participant</td>
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<tr>
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</tr>
<tr>
<td>HDRS-17 mid-treatment</td>
<td>255</td>
<td>14.66</td>
<td>5.80</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>HDRS-17 end of treatment</td>
<td>245</td>
<td>9.69</td>
<td>6.54</td>
<td>0</td>
<td>27</td>
</tr>
</tbody>
</table>

*Note. STD = Standard deviation.*

Competence, incompetence, global competence, and patient complexity had non-normal distributions at the three levels of analysis. The HDRS-17 at baseline, middle of treatment and end of treatment presented a non-normal distribution (Table 10.2)
10.3.2 Multilevel models

As mentioned above, Model 1 (Table 10.3) evaluated the fixed effects on HDRS-17 of competence at the session, participant and therapist level. Additionally, the random effects of therapist and participant were explored. The coefficient of the mean association between HDRS-17 and competence at the therapist level was significant at -3.47. Additionally, time had a significant and negative association with HDRS-17. The mean fixed effects of competence at the session and participant level were not significantly associated with outcome. The ICC for therapist level was minimal, and most remaining variance was attributable to the patient level (67%).
In Model 2 (Table 10.4), the interactions of time with competence at the session, participant, and therapist level, were added to the first model. It was found that there was a trend towards significance in the interaction of competence at the session level and time. This interaction was explored further, suggesting that patients with greater levels of severity at baseline, in terms of HDRS-17, responded faster when they received more competent interventions at the session level. Conversely, patients mildly depressed at baseline, responded in a slower rate, when they received less competent interventions, at the session level (Figure 10.1). Furthermore, Model 2 showed a trend towards significance of the association between the fixed effect of competence at the therapist level, and HDRS-17. The ICC for therapist level was minimal, and most remaining variance was attributable to the patient level (68%).
<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>SE</th>
<th>p</th>
<th>95% CI</th>
<th>ICC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>21.24</td>
<td>2.41</td>
<td>0.000</td>
<td>[16.51, 25.97]</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>-1.44</td>
<td>0.58</td>
<td>0.014</td>
<td>[-2.59, -0.29]</td>
<td></td>
</tr>
<tr>
<td>Competence by session</td>
<td>1.03</td>
<td>0.62</td>
<td>0.094</td>
<td>[-0.17, 2.25]</td>
<td></td>
</tr>
<tr>
<td>Competence by participant</td>
<td>1.37</td>
<td>1.79</td>
<td>0.444</td>
<td>[-2.14, 4.88]</td>
<td></td>
</tr>
<tr>
<td>Competence by therapist</td>
<td>-3.46</td>
<td>1.82</td>
<td>0.058</td>
<td>[-7.05, 0.12]</td>
<td></td>
</tr>
<tr>
<td>Competence by session X</td>
<td>-0.55</td>
<td>0.29</td>
<td>0.059</td>
<td>[-1.12, 0.02]</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competence by participant</td>
<td>0.47</td>
<td>0.53</td>
<td>0.376</td>
<td>[-0.57, 1.52]</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competence by therapist</td>
<td>0.04</td>
<td>0.48</td>
<td>0.925</td>
<td>[-0.91, 1.00]</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Random Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residual</td>
<td>9.79</td>
<td>1.01</td>
<td></td>
<td>[7.99, 12.00]</td>
<td></td>
</tr>
<tr>
<td>Within</td>
<td>21.26</td>
<td>4.31</td>
<td></td>
<td>[14.29, 31.63]</td>
<td>0.68</td>
</tr>
<tr>
<td>Therapist Between</td>
<td>6.35e⁻¹³</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.04e⁻¹⁴</td>
</tr>
</tbody>
</table>

*Note. SE = standard error; CI = confidence interval; ICC = intraclass correlation coefficient. LR test vs linear model: \(\chi^2(2) = 154.65\) Prob >\(\chi^2 = 0.000\)*
Figure 10.1. Prediction of HDRS-17 scores by the fixed effect of the interaction between Competence at the session level and Time

In Model 3 (Table 10.5), the quadratic effect of competence at the session level was explored, in addition to the rest of the parameters examined in Model 2. A quadratic association between competence at the level session and outcome was found, in which, low and high levels of competence predicted a worse HDRS-17 score, and moderate levels of competence were associated with patient improvement (Figure 10.3). Additionally, in this model the interaction of competence at the session level and time was significant (Figure 10.2), as well as the association of the mean effect of competence at the therapist level, and HDRS-17. The ICC for therapist level was minimal, and most remaining variance was attributable to the patient level (68%).
Table 10.5

**Model 3**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>SE</th>
<th>p</th>
<th>95% CI</th>
<th>ICC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Effects</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>25.61</td>
<td>3.18</td>
<td>0.000</td>
<td>[19.36, 31.85]</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>-1.63</td>
<td>0.58</td>
<td>0.005</td>
<td>[-2.78, -0.48]</td>
<td></td>
</tr>
<tr>
<td>Competence by session</td>
<td>-1.50</td>
<td>1.37</td>
<td>0.272</td>
<td>[-4.19, 1.18]</td>
<td></td>
</tr>
<tr>
<td>Competence by participant</td>
<td>1.51</td>
<td>1.78</td>
<td>0.395</td>
<td>[-1.97, 5.00]</td>
<td></td>
</tr>
<tr>
<td>Competence by therapist</td>
<td>-3.82</td>
<td>1.82</td>
<td>0.036</td>
<td>[-7.40, -0.24]</td>
<td></td>
</tr>
<tr>
<td>Competence by session X Time</td>
<td>-0.66</td>
<td>0.29</td>
<td>0.025</td>
<td>[-1.23, -0.08]</td>
<td></td>
</tr>
<tr>
<td>Competence by participant X Time</td>
<td>0.53</td>
<td>0.53</td>
<td>0.314</td>
<td>[-0.50, 1.58]</td>
<td></td>
</tr>
<tr>
<td>Competence by therapist X Time</td>
<td>0.13</td>
<td>0.48</td>
<td>0.788</td>
<td>[-0.82, 1.08]</td>
<td></td>
</tr>
<tr>
<td>Competence by session X Competence by session</td>
<td>0.39</td>
<td>0.19</td>
<td>0.038</td>
<td>[0.02, 0.76]</td>
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</tr>
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</table>

Random Effects

<table>
<thead>
<tr>
<th></th>
<th>Coefficient</th>
<th>SE</th>
<th>p</th>
<th>95% CI</th>
<th>ICC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residual</td>
<td>9.61</td>
<td>1.27</td>
<td></td>
<td>[7.41, 12.47]</td>
<td></td>
</tr>
<tr>
<td>Within</td>
<td>21.01</td>
<td>11.92</td>
<td></td>
<td>[6.91, 63.90]</td>
<td>0.68</td>
</tr>
<tr>
<td>Therapist Between</td>
<td>7.90e^{-16}</td>
<td>2.72e^{-14}</td>
<td>[3.35e^{-16}, 2.258e^{-17}]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note*. SE = standard error; CI = confidence interval; ICC = intraclass correlation coefficient. LR test vs linear model: \( \chi^2(2) = 157.62 \) Prob >\( \chi^2 = 0.000 \)
Figure 10.2. Prediction of HDRS-17 scores by the fixed effect of the interaction between Competence at the session level and Time

Figure 10.3. Prediction of HDRS-17 scores by the fixed effect of squared Competence at the session level

In Model 4 (Table 10.6), the interaction of competence at the therapist level with patient complexity at the participant level, was studied in addition to the rest of the parameters of Model 3. The interaction between competence at
the therapist level and patient complexity at the participant level had a positive and significant association with HDRS-17, which was explored further. It was found that higher competence at the therapist level in the presence of severe patients, -in reference to the patient complexity rating-, predicted lower HDRS-17 scores throughout the therapy. Conversely, low competence at the therapist level in the treatment of patients of low complexity, predicted worse treatment outcomes (Figure 10.4).

Additionally, in Model 4, the findings of Model 3 remained significant. Furthermore, the ICC for therapist level was minimal, and most remaining variance was attributable to the patient level (65%).
Table 10.6
Model 4

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>SE</th>
<th>p</th>
<th>95% CI</th>
<th>ICC</th>
</tr>
</thead>
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<td><strong>Fixed Effects</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>30.22</td>
<td>5.69</td>
<td>0.000</td>
<td>[19.06, 41.39]</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>-1.66</td>
<td>0.58</td>
<td>0.005</td>
<td>[-2.81, -0.51]</td>
<td></td>
</tr>
<tr>
<td>Competence by session</td>
<td>-1.62</td>
<td>1.36</td>
<td>0.233</td>
<td>[-4.30, 1.04]</td>
<td></td>
</tr>
<tr>
<td>Competence by participant</td>
<td>1.36</td>
<td>1.73</td>
<td>0.433</td>
<td>[-2.04, 4.76]</td>
<td></td>
</tr>
<tr>
<td>Competence by therapist</td>
<td>-6.23</td>
<td>2.43</td>
<td>0.010</td>
<td>[-11.01, -1.46]</td>
<td></td>
</tr>
<tr>
<td>Competence by session X Time</td>
<td>-0.68</td>
<td>0.29</td>
<td>0.020</td>
<td>[-1.26, -0.10]</td>
<td></td>
</tr>
<tr>
<td>Competence by participant X</td>
<td>0.55</td>
<td>0.53</td>
<td>0.301</td>
<td>[-0.49, 1.59]</td>
<td></td>
</tr>
<tr>
<td>Competence by therapist X Time</td>
<td>0.14</td>
<td>0.48</td>
<td>0.765</td>
<td>[-0.80, 1.09]</td>
<td></td>
</tr>
<tr>
<td>Competence by session X</td>
<td>0.42</td>
<td>0.18</td>
<td>0.027</td>
<td>[0.04, 0.79]</td>
<td></td>
</tr>
<tr>
<td>Competence by session</td>
<td>-2.36</td>
<td>1.92</td>
<td>0.219</td>
<td>[-6.12, 1.40]</td>
<td></td>
</tr>
<tr>
<td>Patient Complexity by participant</td>
<td>1.29</td>
<td>0.63</td>
<td>0.041</td>
<td>[0.05, 2.52]</td>
<td></td>
</tr>
</tbody>
</table>

**Random Effects**

<table>
<thead>
<tr>
<th></th>
<th>Coefficient</th>
<th>SE</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Residual</td>
<td>9.65</td>
<td>1.00</td>
<td></td>
<td>[7.87, 11.82]</td>
<td></td>
</tr>
<tr>
<td>Within</td>
<td>18.08</td>
<td>3.75</td>
<td></td>
<td>[12.03, 27.16]</td>
<td>0.65</td>
</tr>
<tr>
<td>Therapist Between</td>
<td>4.62e-19</td>
<td></td>
<td></td>
<td></td>
<td>1.66e-20</td>
</tr>
</tbody>
</table>

*Note.* SE = standard error; CI = confidence interval; ICC = intraclass correlation coefficient. LR test vs linear model: $\chi^2(2) = 132.11$ Prob $>\chi^2 = 0.000$
The goodness of fit of the models described was studied with a likelihood ratio test. Only model 4 fitted the dataset significantly better than the other models (Table 10.7).

### Table 10.7

<table>
<thead>
<tr>
<th>Likelihood ratio test</th>
<th>LR chi (2)</th>
<th>Prob&gt;chi²</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1 vs M2</td>
<td>3.71</td>
<td>0.1565</td>
</tr>
<tr>
<td>M2 vs M3</td>
<td>4.28</td>
<td>0.11</td>
</tr>
<tr>
<td>M3 vs M4</td>
<td>7.53</td>
<td>0.0061</td>
</tr>
</tbody>
</table>

10.4 Discussion

The current study examined the association between therapist competence and treatment outcome in the REDIT trial, using the TCS. This is the first study to examine psychodynamic therapist competence with an empirically-derived measure, that evaluates global competence and multiple-
domain competencies comprehensively and reliably, as informed by initial psychometric studies of the measure. Additionally, this is the first study to evaluate the relationship between psychodynamic competence and patient improvement, using different conceptualisations of outcome, -effectiveness and efficiency-, while applying multilevel statistic models for its analysis.

This study identified several important findings regarding the relationship between competence and outcome. Firstly, an interaction between competence at the session level and time was found, indicating that the delivery of higher levels of competence in a psychotherapy session, are associated with a faster rate of patient improvement. The faster rate of improvement was particularly noticeable in patients with higher baseline severity (HDRS-17 scores).

Additionally, the current study found that the fixed effect of competence at the therapist level, had a consistent, positive and significant effect on treatment outcome. Furthermore, a quadratic relationship was found between competence at the session level and HDRS-17, in which higher and lower levels of competence at the session level predicted worse HDRS-17 scores, whilst a moderate degree of competence at the session level was associated with better treatment outcomes. Moreover, in this study, a significant interaction between competence at the therapist level and patient complexity at the participant level was found, suggesting that more competent therapists bring about lower HDRS-17 scores, particularly when treating individuals with higher patient complexity, as defined by the TCS. Conversely, it was found that less competent therapists bring about worse treatment outcomes, especially when treating individuals with higher patient complexity.

The identified interaction between competence at the session level and time, indicated that higher levels of competence in a session are associated with a faster rate of patient improvement, particularly in patients with higher HDRS-17 scores at baseline. Similar findings had been previously suggested by the literature. Barkham et al. (2017) found that therapist effects were a function of initial patient severity in that, the higher the initial patient severity, -measured with the Brief Symptom Inventory (Derogatis & Spencer, 1975), Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), Outcome Questionnaire-45 (M. Lambert et al., 2004), and CORE-OM (Barkham et al., 2001), the greater the therapist effects. In other
words, the higher the initial patient clinical severity, the more it matters which therapist the patient sees and, -in terms of this study findings-, the higher the levels of depression at baseline, the more it matters that the patient receives higher degrees of competence in every session. This finding makes good clinical sense, in terms that as clinical cases become more complex and severe, higher competence will be required in order to deliver an appropriate treatment. However, it is noticeable that Barkham et al. (2017) study referred to therapist effects in terms of effectiveness, meaning the total amount of change in outcome scores, whilst the findings of this study are in reference to therapist efficiency, meaning the rate of patient improvement. Furthermore, (Barkham et al., 2001) did not elucidate which of the therapist attitudes, characteristics, and/or behaviours were associated with their findings, considering that their results were in terms of overall therapist effects. Therefore, the original finding of the current study is that there is a specific association between greater competence at the session level and a higher rate of patient improvement, which is more pronounced when the patient initial clinical severity is higher. This finding, could be understood following Schön (1983) notions of “knowing-in-action” and “procedural knowledge” in reference to the expert therapists’ capacities of implicitly and spontaneously recognising significant patterns, carrying out relevant actions, and making contextual judgements. It is plausible that therapists that can effortlessly and spontaneously appraise clinical situations and deliver, without delay, appropriate and accurate action strategies, do not lose time delivering futile interventions, and therefore provide a continuous and higher level of competence throughout sessions, which is more efficient in bringing about better treatment outcomes.

Moreover, this finding is of particular importance, specifically if relevant psychotherapy research literature is considered. E. M. Anderson and Lambert (2001) research study found that highly distressed outpatients need more sessions to recover than less-disturbed clients, suggesting that patients who are suffering the most, require at least 20 sessions of psychotherapy, -instead of 11-16 sessions-, in order to have a good chance to recover. Therefore, it might be, -as suggested by Svartberg et al. (1996) research and now by this study findings-, that highly competent therapists help severe patients recover at a faster rate than less competent therapists, at the session level.
Nevertheless, the significant interaction between competence at the session level and time should be analysed with caution, considering that it might also be that patients with higher initial severity, respond faster, only because they have “more” to recover from. However, the latter could be argued if we consider that not only participants with higher baseline severity had a faster pace of response, but also patients with lower initial severity responded faster when treated with a higher degree of competence at the session level. Therefore, according to this finding, it would not only be important to treat highly severe patients with a high degree of competence in every session, but to also take into account that patients that are less severe at baseline, also require a high degree of competence at the session level, in order to attain better outcomes at a faster pace.

In addition, this study found a significant and negative fixed effect of competence at the therapist level on HDRS-17 scores throughout treatment, suggesting that more competent therapists bring about better clinical outcomes. Thus, according to the results of this study, competence at the therapist level is associated with treatment effectiveness (total amount of change in outcome measure), and competence at the session level is pivotal to ensure an efficient response to treatment. However, it is noticeable that neither competence at the session level, nor at the participant level had a significant effect on outcome. It is possible that competence did not have an effect on outcome at the session level considering that it might be that differences in the competence between sessions do not have a great impact, if overall, there is a more or less consistently competent therapist. However, this explanation is less suitable to understand the non-significant association between competence at the participant level and patient improvement. Another understanding might be that the sample of participants was not large enough, and did not have enough power to account for an effect of competence on outcome. Nevertheless, all these findings should be prudently studied and be considered only as preliminary results.

It is important to consider the findings mentioned above concurrently with the result of this study that suggested a quadratic relationship between competence at the session level and treatment outcome. This finding indicates that low and high levels of competence at the session level are associated with
worse treatment outcomes, whilst moderate degrees of competence are related to greater patient improvement. Although it is expectable that lower levels of competence would result in worse clinical outcomes, the finding that higher competence in sessions is associated with higher HDRS-17 scores, is not. There are several ways of elucidating this result. Firstly, it may be that competence does not have the same impact on the effectiveness of therapy (i.e., total amount of change) as the one it has in how efficient therapy is (i.e., the extent of change per session over the number of sessions delivered). Thus, - and taking into consideration the other results of this study-, it is possible that competence may be related to quicker patient improvement, but not to the overall amount of change achieved in treatment. Barkham et al. (2017) has suggested, based on Okiishi et al. (2006) research, that this pattern might indicate therapists whose patients respond to therapy promptly but who, on average, drop-out from treatment with little improvement gained. Therefore, the latter could give the false impression that higher competence would result in a lesser amount of change achieved in therapy, whilst it could be truly reflecting that competence might bring about a faster recovery, which in turn leads patients to leave treatment earlier with a lesser amount of total change achieved.

However, it is important to consider other reasons that may underlie the association of higher levels of competence at the session level and worse treatment outcomes, as suggested by the quadratic relationship between competence in the session and outcome. Barber et al. (2007) and Huppert et al. (2001) had previously suggested a quadratic relation between competence and treatment outcome, by indicating that the highest quality in the delivery of interventions may not be what determines better treatment outcomes, but that a moderate level of competence could be more predictive of patient improvement. Literature related to ruptures and repairs of the therapeutic alliance (Eubanks et al., 2018; Muran et al., 2010; Safran et al., 1990; Safran & Muran, 1996; Safran et al., 2011) has suggested that resolving alliance ruptures may entail a more in-depth exploration of what transpires between therapist and patient, as well as an in-depth inspection of the patient’s experience. It is conceivable that more competent therapists, by constantly doing “the right thing”, prevent the occurrence of ruptures in the alliance, and therefore, there
are less opportunities for patient and therapist to experience moments of greater understanding and relational depth, which often take place after episodes of emotional distance and discord. Therefore, there might be an added value, to the customary effectiveness provided by sustained therapist competence, in the experience of repairing a rupture in the collaborative relationship between patient and therapist, and the associated breakthrough it may bring about for the therapeutic process. Thus, moderate levels of competence, at the session level, would bring about the possibility of working through more ruptures to the alliance, and therefore be associated with better treatment outcomes than sustained higher levels of competence in the session. This interpretation of the quadratic relationship between competence at the session level and outcome is in line with the literature that has suggested that the alliance might moderate the relationship between the competence and outcome (Barber et al., 2007; Despland et al., 2009; M. Hendriksen, Peen, Van, Barber, & Dekker, 2014).

Overall, it is important to take into account that the quadratic association of competence in the session and outcome only explained part of the variance in the same statistical model that found a significant linear negative association between competence at the therapist level and HDRS-17 scores. Additionally, in this statistical model, part of the variance was attributed to the interaction between competence at the session level and time mentioned above. Therefore, the interpretation of the quadratic relationship between competence in the session and outcome, should be guided by the consideration that it may only explain part of the overall relationship between competence and outcome, whilst other components of this model may explain other aspects of this general relationship. It may be that third process-outcome variables could explain in which circumstances the relation between competence and outcome appears to be linear, and in which contexts the association between these variables appears as a quadratic one. Therefore, future research should attempt to replicate these preliminary findings and explore them further in order to clarify these associations.

The current study also found a significant interaction between competence at the therapist level and patient complexity at the participant level. The latter suggests that more competent therapists bring about lower HDRS-
17 scores in their patients, particularly when treating individuals with high patient complexity, as defined by the TCS. Conversely, it was found that less competent therapists bring about worse treatment outcomes, especially during the treatment of individuals with higher patient complexity. In the TCS patient complexity was conceptualised in terms of epistemic trust and epistemic vigilance (Fonagy et al., 2017). A participant with low levels of patient complexity was considered to have enough psychological resources to deal with the psychotherapeutic process, and conveyed high levels of epistemic trust, openness and receptiveness to most interventions. Conversely, a participant that scored high in patient complexity, corresponded to one that did not have enough psychological resources to work in therapy, and that showed high levels of epistemic vigilance throughout the session. The effect of patient difficulty on the capacity of the therapist to be competent has not been appropriately studied by the research literature. Although the Assessment of Core CBT Skills scale (Muse et al., 2017) includes an item to assess patient complexity, there are no studies that have explored its impact on therapist competence in CBT. Svartberg and Stiles (1992) research study assessed the effect of therapist competence and of patient-therapist complementarity on predicting change in outpatients suffering from anxiety disorders. Although no association was found between competence and outcome, patient-therapist complementarity ratings predicted patient improvement both alone and over and above competence. Despite the fact that the patient-therapist complementarity rating referred to the general communicational strategy of the therapeutic couple, its role in predicting outcome emphasises the fact that therapists do not act in isolation, but are always affected by the interaction with the patient. Therefore, it is of pivotal importance in process-outcome psychotherapy research, and in particular, in the study of the association between competence and outcome, to explore the role of the patient and his/her psychopathology. Thus, this study’s finding regarding the interaction between patient complexity and therapist competence, -although preliminary-, is of substantial relevance to guide future research in the study of the relation between competence and outcome.

A noticeable finding of this study, was that the random effect of therapists (between-therapist effect) was minimal across the four statistical models
studied. However, when the unconditional three-multilevel model of the data was analysed, the random effect of therapists accounted for 2.8% of the treatment outcome (ICC = 0.028). The literature has been consistent in indicating that therapist effects account for 5% to 8% of the treatment variance (Barkham et al., 2017). On the other hand, psychotherapy research literature has repeatedly suggested that despite the knowledge of the existence of therapist effects, little is known about why some therapists are more effective than others (L. Castonguay & Hill, 2017). Although the variance attributable to therapists in this study might be lower than expected due to the small sample size of therapists, and the fact that data belongs to an RCT (Barkham et al., 2017), it still becomes evident that the predictors studied in the four models, explained a large proportion of the between-therapist variance of the unconditional model. Therefore, it is plausible to suggest that competence, patient complexity and time might be the fundamental predictors that underlie the effects of therapists on outcome.

The current study has several limitations. Firstly, the investigation of the association between competence and outcome was studied using a newly-developed scale, whose psychometric features had only been preliminary assessed. Although the internal consistency and inter-rater reliability of the TCS were explored in this dissertation, its results need to be replicated by examining a higher number of raters and sessions. Additionally, although the convergent and discriminant validity of the TCS were initially explored in this dissertation, the analysis needs to be replicated assessing a higher number of sessions. Additionally, it is important to remark that the face validity, content validity and construct validity of the TCS have not been studied. These issues might have compromised the results of this study, which should be replicated by future research, once the TCS is rigorously validated.

An additional limitation of this study is that although the REDIT study provided the essential data to examine the association of competence and outcome, it was not originally designed as a well-controlled experimental study that aimed to investigate these process-outcome variables. Therefore, the exploration of the relation between competence and outcome in this study employed observational methods (Webb et al., 2010). It has been claimed that in order to increase the reliability of observational studies, three criteria should
be met: covariation between variables; non-spuriousness; and, the temporal precedence of cause before effect (Judd & Kenny, 1981). Although the current study explored the covariation between variables and the temporality of events, the non-spuriousness of the results cannot be demonstrated as the effect of one or more unmeasured third-variables might confound the results. An important third-variable that was not measured in this study was the therapeutic alliance, which in past research has been suggested as a possible moderator of the relation between competence and outcome (Despland et al., 2009; C. Webb et al., 2010).

In addition, this study had several other weaknesses. Firstly, only a sample of sessions of the full data-set was rated in order to increase the feasibility of the study. However, this significantly reduced the sample size at every level of analysis, therefore decreasing the overall power of the study. Additionally, the data had an unbalanced structure, considering that therapists treated different number of participants, that participants attended different number of sessions, and that different number of sessions were rated per participant. The latter may have also reduced the power of the study. Another important limitation is that only one judge coded all the sessions. Moreover, the same judge assessed the same participant and the same therapist in more than one opportunity. Therefore, although inter-rater reliability was initially assessed, the fact that the remaining portion of sessions were only rated by one judge may have biased the ratings. Moreover, the fact that the study of treatment integrity was conducted within an RCT in which both, therapists and patients, are highly selected and therefore not representative of the real-world population of therapists and patients, limits the generalizability of the results. Finally, a fundamental factor that could have limited the results of this study was the conceptualisation of clinical outcome as the HDRS-17. Literature on process-outcome research has suggested that clinical outcomes, other than symptomatic relief, should be employed to investigate the relationship between process variables and patient improvement. It has been suggested that the assessment of outcome should encompass the measure of in-depth outcomes, such as those that are targeted in exploratory or insight-oriented therapies. Additionally, the measure of negative changes, deterioration and drop-out,
should also be studied in order to attain a more accurate understanding of the effect of process variables on outcome (L. Castonguay & Hill, 2017).

Overall, this is the first study to use a comprehensive and empirically-based operationalisation of psychodynamic competence in order to better understand the relationship of this variable and treatment outcome. The employment of this measure, which provided a new operationalisation of competence, allowed to study and attain an enhanced comprehension of the association between therapist competence and outcome, that hitherto had not been possible to achieve. It was found that competence at the therapist level was associated with patient improvement. Additionally, the results indicated that competence at the session level increases the efficiency in bringing about patient improvement, particularly in severely depressed individuals. Furthermore, it was found that moderate degrees of competence, at the session level, provide better outcomes than lower or higher degrees of it. Moreover, it was indicated that competent therapists bring about greater clinical improvement, particularly in patients that display higher levels of epistemic mistrust. Although, these findings only constitute preliminary approximations to the understanding of the association between competence and outcome, they nevertheless represent important points of reference that might guide future research studies on the topic. Finally, it is important to remark that the results of this study improve our current understanding of psychotherapeutic process and change, suggesting that competence may have a relevant role in helping to alleviate the distress suffered by patients experiencing enduring emotional difficulties.
PART III: General Discussion, Study Implications and Final Remarks
General Discussion, Study Implications and Final Remarks

Introduction

This dissertation provided a detailed report of the development and initial validation of the Therapist Competence scale (TCS), an original and empirically-derived measure that aims to comprehensively operationalise therapist competence in DIT. Throughout the literature review and the chapter on Treatment Fidelity and Outcome in the REDIT study, the importance of operationalising competence was elucidated, and the gap regarding an appropriate measure of therapist competence became apparent. Thus, the TCS was developed to fill this gap and to allow for the study of the relation between therapist competence and treatment outcome in DIT. Results from the studies supported the initial reliability and validity of the TCS, and suggested that competence may have an effect on patient improvement in terms of the extent of change achieved in outcome scores (i.e., effectiveness), as well as in terms of change in outcome scores per session over the number of sessions delivered (i.e., efficiency). Additionally, a quadratic relation was found between competence and outcome. These are preliminary results that should be replicated by future research. In the following paragraphs, an overview and review of the implications of the studies of this dissertation will be described in detail.

State and Implications of Current Research to the Study of the Association between Therapist Competence and Outcome

As it was mentioned in the literature review, an inconsistent association has been found in the relation between competence and outcome (Crits-Christoph et al., 2013; Luborsky et al., 1985; Sandell, 1985). The chapter on treatment fidelity and outcome in the REDIT study, aimed to examine the relation between competence and outcome, as well as between adherence and outcome, with the goal of replicating the study of the association between these variables, as
it has customarily been conducted by the research literature. An additional aim of this study was to examine possible factors that could underlie the inconsistency of the association between treatment integrity and outcome, hitherto found in the literature. Based on previous findings of the literature, regarding the study of the association between competence and outcome, and the association between adherence and outcome, and considering the undetermined reliability and validity of the treatment integrity instruments used, it was hypothesised that there would be no significant association between these variables. It was also hypothesised that there would not be a quadratic relation between adherence and outcome, and between competence and outcome, as it had been previously suggested in the literature (Barber et al., 2006; Barber et al., 2007). As it was predicted, no significant association was found between these variables, besides the positive and significant association between adherence at the participant level and outcome in the first two-level model studied. It is important to remark that this latter result was not found when more sophisticated and accurate models (three-level models) were analysed.

Although it might seem evident that technique and the skill with which it is delivered should predict patient recovery, until now the literature has been unable to robustly prove it. This study replicated these results and additionally shed light on a number of conceptual and methodological factors that may underlie the lack of association between treatment fidelity and outcome, which will be described in the following paragraphs.

**Conceptual Factors Related to the Operationalisation of Treatment Fidelity**

Firstly, it is important to study in detail the characteristics of the instruments used in the first study of this dissertation (Chapter 6) to measure competence and adherence in this study, which are representative examples of the customary measures used to examine treatment fidelity in RCTs (Tables 6.1 and 6.2). An in-depth analysis of the items comprised by the adherence scale

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21 Perepletchikova and Kazdin (2005) have argued that RCTs customarily study treatment integrity with new, non-validated measures, developed only for the purpose of conducting the RCT.
 brings about the fact that the attitudes and behaviours they represent, also include elements of therapist competence. For example, the item “the therapist works collaboratively with the patient on formulating and /or discussing the IPAF” entails a skill on the part of the therapist of formulating and co-constructing meaning and the focus of therapy with the patient. Indeed, this involves not only the plain delivery of an intervention, but the ability of the therapist of performing competently. Similar arguments could be made with each of the items of the adherence scale. Therefore, the face validity of the adherence scale is questionable. Furthermore, when analysing the items of the competence scale, it becomes evident how similar, -or even identical- , they are to the adherence items, which is relevant despite them being rated in a different fashion. Indeed, in this study, adherence and competence showed a high correlation. Thus, the ability of these two scales to operationalise and differentiate between the components of treatment integrity is questionable. The validation of treatment fidelity measures is essential in order to determine that the instruments are actually assessing adherence and competence. Thus, assuming that the treatment integrity scales include the characteristics of interest without providing supporting evidence, jeopardises the credibility of its results. Therefore, an important implication of this study is that future research regarding treatment fidelity should conduct a separate assessment of the validity of the adherence and competence measures used, before investigating the association between treatment integrity and outcome (Perepletchikova & Kazdin, 2005). More importantly, it is noticeable that the items of the competence scale predefined the qualities with which each of the interventions should be delivered. Thus, these items pose an essential question regarding the nature of the concept of competence: Is competence a predefined skill with which the therapist delivers each of the interventions of the treatment manual? Or, is competence the ability of the therapist to decide which interventions are employed and to modify the quality of their delivery by taking into account the patient state, traits, phase of therapy, level of understanding, level of distress, and current context, among other issues? Conceptualising competence as a fixed, predetermined way of delivering interventions seems to go against the very essence of what competence is. It is expected that an operationalisation
of competence should include the concept of therapist responsiveness, which refers to the notion that therapists adapt their interventions to the unfolding context of the session, patient’s characteristics and behaviours. Therapists do not deliver predetermined levels of a specified intervention. Instead, therapists intervene in a responsive way, according to the emerging events in therapy (C. A. Webb et al., 2012). Therefore, it is likely that many studies that have attempted to examine competence and its effect on outcome, have failed to truly conceptualise the construct, and thus, have arrived into inaccurate results. Indeed, understanding the complexity and the changing nature of what the concept of competence entails, confirms the great difficulty of operationalising the construct. Subsequently, it is possible that instruments that have hitherto attempted to operationalise competence have not done justice to its convoluted nature, and have given in to define competence as a prearranged set of skills. However, it is pivotal that future research on the association between technique and clinical outcome, includes measures of competence that operationalise the construct considering its complex nature.

Additionally, the examination of the items of the adherence and competence scales questions the necessity of conceptualising each of these constructs, and the need of differentiating between them. Firstly, psychotherapy research literature has indicated the difficulty of operationalising competence without its definition including a measure of treatment adherence in it, considering that it is impossible to deliver a treatment competently without being adherent to it (Barber et al., 2007). On the other hand, it seems unfeasible to define adherence without the concept including a certain degree of skill in the implementation of the interventions. Furthermore, it is reasonable to question the need to determine treatment adherence to a specific manual. The need to verify the delivery of interventions, without taking into account the skill with which they are delivered, is debatable. It could be argued that there is little point in corroborating that a therapist adhered to the manual if there is no information on whether the interventions were delivered competently. Until now, it has been claimed that making separate conceptualisations of adherence and competence allows us to derive into two different understandings regarding the effects of treatment on outcome. On one hand, demonstrating treatment adherence allows to study whether there is an association between the
treatment interventions and clinical outcomes. On the other hand, demonstrating competence allows us to study whether there is an association between the skilful delivery of treatment interventions and clinical outcomes (Perepletchikova & Kazdin, 2005; Perepletchikova et al., 2007). However, it could be argued whether it would be correct to conclude that outcome is associated with treatment if only adherence, and not competence, could be demonstrated. In other words, it would be debatable to conclude that patient improvement was due to the interventions of the manual if these were not delivered competently. Therefore, the need to conceptualise and differentiate between adherence and competence is arguable, considering the difficulties of distinguishing between the two concepts, as well as the fact that an adherent practice, -without it being competent-, would not necessarily allow to make appropriate and applicable conclusions regarding the relevance of a treatment manual. However, it is possible that until now, defining and verifying treatment adherence has been more feasible than operationalising and corroborating therapist competence. Therefore, a fundamental question brought about by this study is whether it is relevant to maintain the current understanding of treatment fidelity, and whether this conceptualisation should be updated according to research developments. Indeed, Truijens et al. (2018) in a recent meta-analysis found that manual adherence does not affect outcome. Conversely, they recommend the study and use of manualised and non-manualised interventions according to each clinical situation. Thus, in other words, this meta-analysis supports the conclusions of this study in that isolated adherence might not be consequential if it does not go along a competent practice.

**Methodological Factors**

Besides the difficulties in relation to the measures of treatment fidelity employed in the first study of this dissertation, and the intrinsic complexity of operationalising therapist competence, there were a number of additional factors that might have underlay the lack of association between the variables examined. An important factor that may have obscured the association between treatment fidelity and outcome is the presence of third variable effects.
that were not considered in the analyses, such as patient’s characteristics (e.g., symptom severity, motivation to change), or relationship factors (e.g., therapeutic alliance). These effects may be related to both, fidelity and outcome, and thereby indirectly account for the observed results. Importantly, the complexity of the patient was not considered in the analysis of the association between adherence, competence, and treatment outcome. It is conceivable that the degree to which the therapist adheres to the manual, and the level of skill in the delivery of interventions varies depending on the difficulty of the treated patient. Furthermore, Svartberg and Stiles (1992) found, that in patients suffering from anxiety disorders, patient-therapist complementarity ratings predicted outcome both alone and over and above therapist competence. Despite the fact that the patient-therapist complementarity rating referred to the general communicational strategy of the therapeutic couple, its role in predicting outcome emphasises the fact that therapists do not act in isolation, but are always affected by the interaction with the patient. Therefore, it is of pivotal importance in process-outcome psychotherapy research, and in particular, in the study of the association between competence and outcome, to explore role of the patient and his/her psychopathology.

Moreover, there is an additional argument that supports the study of third variables in this study. One of the reasons to explain the non-association between treatment fidelity and outcome was a possible ceiling effect of adherence and competence on outcome. Thus, it was indicated that, considering that most scores of adherence and competence were in the higher range-, there could be a level over which higher degrees of treatment fidelity would not have an impact on clinical outcome. This argument makes clinical sense in terms of the experience of treating complex patients who may not recover, despite the therapist displaying high levels of adherence and competence. Therefore, the possibility of a ceiling effect is another element that should be explored by future research in order to examine third variables that could impact the relation between treatment fidelity and outcome.

An additional factor that may have been related to the lack of association between competence, adherence, and outcome in this study, was the conceptualisation of clinical outcome as the HDRS-17 scores. Most studies that have examined the association between treatment fidelity and outcome have
measured clinical outcome only in terms of symptoms (L. Castonguay & Hill, 2017). Therefore, research literature in this topic has not considered the complexity of the change process and the possibility of measuring outcome in reference to other constructs. For example, outcome could be conceptualised in terms of social performance, as well as in terms of intrapsychic functioning using instruments that measure the nature of defences or character structure. These different types of outcome would reflect another layer of complexity of the effects of treatment fidelity. Therefore, it is questionable if symptomatology, and the HDRS-17 scores in this study, is the most accurate conceptualisation of outcome in order to assess the change process in psychotherapy. Future research should explore different operationalisations of clinical outcome and their relation to treatment fidelity, in order to more accurately understand the process-outcome field of psychotherapy.

Furthermore, the literature has found that when the effectiveness of therapists has been investigated across multiple outcome domains (e.g., anxiety, depression, substance use, quality of life, sleep), in naturalistic samples, therapist effects are evident on single outcomes. Thus, some therapists consistently achieve better outcomes in depression reduction, with this same notion holding for other single-outcome domains. Additionally, it has been shown that individual therapists have a differential pattern of performance depending on their patients’ problem domain. For example, some therapist are effective in reducing depression but are ineffective, - or even harmful-, in other domains (Constantino et al., 2017). Although these findings are not in relation to therapist competence, but studied in terms of therapist effects, it is still important to consider them in order to appropriately examine the association between treatment fidelity and outcome. Future research should assess adherence and competence across different domains of outcome and in different populations of patients, in order to examine the differential impact of treatment fidelity in each of the variables studied.

Moreover, psychotherapy research has studied the association between treatment fidelity and outcome under the assumption that patients improve in a linear fashion in time. Although a linear recovery of patients in psychotherapy has been suggested by the literature (Falkenström, Josefsson, Berggren, & Holmqvist, 2016), clinical experience suggests that patients frequently undergo
a process characterised of progress and setbacks, that gradually leads to improvement. Therefore, it may be hypothesised that the lack of an association between treatment fidelity and outcome could be related to the assumption of a linear and gradual recovery on the part of the patients. The process of improvement in time in relation to adherence and competence should be explored further in the literature in order to clarify the relationship between these variables.

In conclusion, in the study of Treatment Fidelity in the REDIT trial revealed several conceptual and methodological factors that limit an appropriate investigation of the associations between adherence, competence and treatment outcome. Understanding these conceptual and methodological limitations, which are representative of the challenges of customary treatment integrity studies, laid the groundwork for the following studies of this dissertation.

Operationalising Therapist Competence Through the Development of the TCS

Following the first study of this dissertation, the development of the TCS aimed to operationalise and assemble a measure of competence that would attempt to overcome some of the conceptual difficulties posed by the literature review on the topic. The scale aimed to be clinically relevant and empirically derived from the qualitative analysis of expert clinicians’ viewpoints on therapist competence in DIT. The research questions of the thematic analysis were: (1) How do expert clinicians define therapist competence?; (2) What do expert clinicians consider to be the core or essential elements of therapist competence?; (3) How do expert clinicians conceptualise the competencies proposed by the Framework of Competence in Psychodynamic/ Psychoanalytic therapy and DIT (Lemma et al., 2008)?; (4) What attitudes and/or behaviours constitute the observable or objective aspects of therapist competence?; (5) What are the specific competencies that a DIT therapist should demonstrate?; and, (6) What is an incompetent attitude or behaviour in a therapist? Considering the exploratory nature of this study, no hypothesis prior to the beginning of the study were made.
The TCS was construed in order to systematically and comprehensively assess therapist competence in DIT. The TCS included 2 subscales and 2 global ratings. The first subscale included 42 core competencies, and the second subscale comprised 38 incompetent attitudes and behaviours that a therapist can display in a DIT session. Additionally, the TCS includes two global ratings. The first one aimed to provide an overall impression of the therapist competence in a session. The second global rating intended to present a general estimation of the patient’s clinical complexity and availability to work psychotherapeutically. The competencies subscale and the global competence rating are scored according to a 7-point Likert scale. The incompetence subscale is rated in a binary fashion, according to whether the described attitude and/or behaviour is present or absent from the session. The patient complexity rating is scored according to a 6-point Likert scale. In order to capture attitude and behaviours that may have low base rates, the entire session was considered the unit of observation for the scale.

Several principles were followed in the development of the TCS. Firstly, the TCS items aimed to describe the therapist competence and incompetence in terms of behavioural and linguistic cues that could be objectively observed by a rater that has an understanding of psychodynamic psychotherapy processes. In order to ensure interrater reliability, coding descriptions and examples for each of the items were included in the scale. The second principle indicated that items should be described in terms of competencies and incompetencies that would be possible to demonstrate when listening to an audio-recorded session. Therefore, only items that were audibly verifiable were kept in the scale. The third principle was that all items should outline a competence/incompetence that could be observed in any session, independently of the phase of therapy. The fourth principle followed in the development of the TCS was the organisation of the items in a hierarchy of competencies. It was thought that structuring the scale using a hierarchy would help operationalise in a better way the different high-order competencies. This arrangement would allow the removal of various redundant items, while maintaining the capacity of the scale to characterise in detail each of the major competencies and incompetencies. Thus, the hierarchical structure would improve the depth and breadth to the scale. The fifth principle that guided the
development of the TCS was that the wording of the items should be theoretically neutral and therefore, to not belong to any specific school of psychoanalysis. This was decided in order for the items to only reflect DIT competencies and psychodynamic/psychoanalytic competencies, without theoretical restrictions. Finally, the sixth principle was to arrange the items in terms of the aims that a therapist has in every DIT session instead of organising them according to domains of competence. The idea underlying this principle was for the scale to be arranged in accordance to clinical objectives rather than as an item checklist.

Following the literature review, the study on fidelity in the REDIT trial, and the expert clinicians’ interview, several aims were set in order to both, include in the scale essential features of competence, as well as to overcome the difficulties of past operationalisations of this construct. In the following paragraphs these aims will be described along with the items that attempted to operationalise the competencies specified by each particular aim. Firstly, it was recognised that an important challenge of operationalising psychodynamic competence entailed putting together an objective definition of the unconscious and subjective processes that underpin the therapist’s attitudes and behaviours within a session. This idea was in line with the literature and with the considerations of Parth and Loeffler-Stastka (2015) who stated that the great challenge of operationalising competence was due to the elusiveness of the Unconscious. Several items in the scale encompassed an awareness on the part of the therapist of unconscious processes. The item most representative of this particular aim was item 9: “The therapist maintains a focus, awareness, and receptivity to the unconscious processes that take place in the session, including the unfolding of the transference and countertransference”. This item included 8 sub-competencies that included specifications of the main competency, including the following: “The therapist is not only attentive to the emotions openly expressed by the patient, but particularly to the patient’s feelings that are not being explicitly expressed, such as anger or envy, and is open to their exploration”; “The therapist conveys an awareness in the unconscious processes in: a) the content, construction, and timing of his/her interventions; b) when he/she decides to not to intervene; c) in his/her affective tone and thought processes during the session; and/or, d) by naming the
contradictions between manifest and latent contents, or by showing to the patient the latent material in a straightforward way". Therefore, it is possible to say that the TCS attempted to capture the unconscious processes that underlie a competent practice, which was indicated to be, -in the literature review-, one of the greatest challenges in the operationalisation of competence.

A second important challenge was for the TCS to capture the responsiveness of the therapist, meaning the ability of the therapist to consistently do the right thing, which may be different at each time, providing each patient with a different, individually tailored treatment (Stiles & Horvath, 2017). As it was indicated in the literature review, therapist responsiveness is an essential element of competence, and in itself is difficult to operationalise considering the changing nature of what it entails. The TCS aimed to capture therapist responsiveness in a number of items, being this notion best represented in item 28: “The therapist adapts the interventions to the individual patient, rather than delivering a generic therapy, in order to achieve the different aims of the psychotherapeutic process. The therapist adapts the interventions to the following patient’s traits: a) character structure; b) defences; c) level of intelligence. The therapist adapts the interventions to the following patient’s states: a) level of arousal; b) capacity to think and tolerate difficult affects; c) level of understanding; d) level of functioning and capacity to cope; e) level of risk; f) current context; g) current difficulties; h) trajectory within therapy; i) state of the therapeutic alliance; and, j) transference and countertransference dynamics”. Thus, the TCS attempted to overcome a well-known difficulty of operationalising competence, -as stated in the literature review-, that entails including in its conceptualisation the notion of therapist responsiveness.

A third aim in the development of the scale was for the TCS to capture the meta-competences defined in the framework of psychodynamic competence (Lemma et al., 2008) in relation to the ability of the therapist of knowing when to intervene and when not to intervene, demonstrating the ability of finding a balance in the delivery of interventions. As stated in the literature review, this is an important domain of competence as it describes procedural rules which enable therapists to deliver the treatment in an informed and coherent fashion (Lemma et al., 2008). Items of the TCS that illustrate these meta-competences are: 1) “The therapist demonstrates a receptive, involved,
yet non-gratifying attitude, a balance between emotional closeness and distance, that maintains the patient’s emotional arousal at an optimal level (not too high so that the patient loses his/her ability to mentalize; not too low so that the session becomes meaningless emotionally)”; 32) “The therapist is able to find a balance between on one hand, delivering the interpretations tentatively, as hypotheses that need to be tested with the patient; and on the other hand, not delivering the interventions in such a tentative way that it seems that he/she does not believe in the therapy that he/she is delivering”; and 41) “The therapist allows the evacuation of raw emotions when, for example, the patient has recently experienced an external traumatic situation. However, when the emotional hyperarousal of the patient is in relation to transferential issues, the therapist attempts to lower the intensity of the emotions by helping the patient mentalize”. Therefore, the TCS took into account the notion of meta-competences described in the framework of psychodynamic competence in its operationalisation of therapist competence (Lemma et al., 2008).

A fourth important aim for the TCS, as indicated by the literature review and the experts’ clinicians interview, was the ability of the therapists to be flexible and to remain open to change their formulation and understandings in relation to the unfolding interaction with the patient. As it was indicated in the literature review, the concept of adaptive flexibility is a fundamental component of competence as it entails the ability of the therapist to intuitively adjust, improvise and reshape the understandings and therapeutic strategies in agreement with the continuous changes of the therapy (Binder, 1999; Holyoak, 1991; Schön, 1983, 1987). This notion was exemplified in item 31: “The therapist builds meaning and understanding by working collaboratively with the patient. The therapist delivers tentative interventions rather than rigid statements, and corrects what he/she is saying after receiving the patient’s manifest and latent feedback”. This item included several sub-competencies, such as: “The therapist remains open to the possibility that his/her interventions are not necessarily accurate or right. The therapist does not have certainty and does not treat his beliefs as facts. Instead, the therapist is flexible and open to change his way of thinking according to what is happening with the patient, modifying his/her interventions according to the patient’s feedback or state of mind”. Thus, it could be argued that the TCS operationalised the ability of the
therapist to be flexible and open, an important notion of competence as indicated by the literature review.

A fifth aim was for the TCS to conceptualise competence comprehensively, including general as well as specific competencies that would specify the skill of the therapist in the delivery of particular interventions. General competencies referred to the ones that are employed in any kind of psychotherapy, such as the fostering of the therapeutic alliance or the ability of the therapist to engage the patient. This type of competency is exemplified in item 21: “The therapist conveys that the therapeutic alliance is a bond with a purpose. The therapist interventions take into consideration the goals of the therapy, that have been collaboratively agreed with the patient-, reminding him/her that the therapist cares, and therefore, enhancing the therapeutic bond”. Additionally, the TCS aimed to indicate the skill with which to deliver particular psychodynamic interventions. An item that represents the specific competencies of the TCS is item 33: “The therapist interventions progress from surface to depth, starting from the issues that are closer to the patient’s consciousness. The therapist titrates the delivery of interventions in order to meet the patient where he/she is at, not threatening his/her psychic equilibrium, and taking into consideration how defended the patient is from conflicting unconscious affects”. Hence, it is possible to suggest that the TCS attempted to operationalise competence comprehensively, including both, generic as well as specific competencies.

The sixth aim involved the inclusion of items that conceptualise therapist incompetence. This entailed an original contribution of the TCS by being the first scale to operationalise therapist incompetence in the psychotherapeutic process. Unlike the competence subscale, the incompetence subscale did not attempt to distinguish between “levels of incompetence”, but assessed whether specific incompetencies were present or absent in a DIT session. It was contemplated that a therapist should not only be considered competent because of the skill demonstrated in a session, but also due to his/her capacity to avoid incurring into incompetent attitudes and behaviours. Thus, the competence and incompetence subscales complement each other, elaborating on the established understanding of therapist competence. Accordingly, for a therapist to be considered competent he/she should demonstrate both, a high
level of skill in the delivery of interventions, as well as the avoidance of incompetent attitudes and behaviours.

The seventh aim was for the TCS to capture not only single-domain competencies but also to involve a global rating of competence. The latter was intended following Barber et al. (2007) emphasis of the importance of assessing these two types of competence and their relation to outcome. They suggested that in order to appropriately examine the association between competence and outcome, not only single-domain competencies should be assessed as it was possible for global competence to be more consistently predictive of outcome. Therefore, the TCS addressed this consideration by including items that assessed single-domain competencies, as well as an item that intended to rate the overall competence of the therapist within a DIT session.

The eighth and final aim was for the TCS to include an evaluation of the difficulty of the patient treated by the therapist. Although the patient complexity rating did not emerge from the thematic analysis, its inclusion in the scale was considered important in order to understand therapist competence and incompetence in context. Indeed, a therapist may be more competent if he/she displays the same level of skill with a complex patient rather than with a less complex one. Additionally, the literature review emphasised the importance of studying third variables in order to examine appropriately the association between competence and outcome. Therefore, a measure of patient complexity was included in the TCS in order to enhance the study of the relation between competence and outcome.

The assessment of therapist competence in DIT requires an understanding of relational dynamics and of how unconscious processes impact verbal and non-verbal communications. The latter has important implications that may hamper the operationalisation of competence in an observational measure. Despite having a sophisticated measure and high-quality audio-recorded sessions, objectively observing the emotional impact of a behaviour, or capturing what is missing from a session, are issues that are difficult to measure. Additionally, the perspectives of the therapist and patient cannot be reliably assessed. Furthermore, the therapist formulation of the case, critical to understand the strategies employed throughout the treatment-, is not an observable process. Thus, although the TCS attempts to operationalise
competence based on observable and objective descriptions, a certain level of subjectivity and inference in the TCS items was unavoidable. Future research should assess the degree of accuracy of the operationalisation of competence in the TCS. Thus, the scores obtained with the TCS should be correlated to other measures of competence, and to instruments that rate flexibility, responsiveness, patient complexity, among others, in order to verify the capacity of the TCS of truly capturing these constructs. Only studying how the TCS works in practice will allow to improve the individual items and the overall operationalisation of competence.

Reliability of the TCS

The reliability study aimed to examine the internal consistency and interrater reliability of the TCS, in order to assess the precision with which it captured therapist competence and incompetence in DIT audio-recorded sessions. This study took into consideration the pitfalls of past studies that had evaluated the reliability of scales exclusively using CTST which only accounts for a single source of error in the measurements. Not considering more than one source of error in the measurements can bring about inaccurate results regarding the reliability of the scale. Thus, this study additionally employed GT in order to appropriately study the precision of the TCS. Several hypotheses were made before the beginning of this study. Considering the similar nature of the items of the competence subscale, it was predicted that they would have a good/high internal consistency and interrater reliability. Concurrently it was hypothesised that the global competence rating would be scored similarly to the single-domain competency items, and that it would have good/high interrater reliability. Taking into account the binary nature of the incompetency items, it was predicted that only a fair/moderate internal consistency and interrater reliability would be found between them. Furthermore, considering the difficulty of capturing the complexity, openness and psychological resources of the patient in a single item, it was hypothesised that the patient complexity score would only have a fair/moderate inter-rater reliability.
In accordance with the CTST, the competence (ICC =0.794) and incompetence (ICC =0.846) subscales, as well as the global competence rating (ICC =0.756) demonstrated a good interrater reliability. The patient complexity rating across sessions displayed a moderate interrater reliability (ICC =0.524). In terms of the individual items, most of the items of the competence subscale demonstrated a moderate/good inter-rater reliability, while only two items had a very poor interrater reliability (item 26 ICC= 0.157; item 32 ICC= 0.355). It was only possible to explore the interrater reliability of 21 items of the incompetence subscale, -which ranged from a slight to an almost perfect interrater agreement-, considering that Cohen’s kappa could not be calculated for items in which either one or both raters scored the item as “absent” in every session.

In reference to GT, the generalizability (0.788) and dependability (0.787) coefficients of the competence subscale, showed good reliability for relative and absolute decisions. Additionally, the competence subscale displayed a good level of interrater reliability (0.790), and an excellent internal consistency (0.994). The major variance component of the scores (47%) was attributable to the therapist competence in a session, -the object of measurement-, which was followed by the interaction between therapist competence in a session and the raters, signifying that competence in a session was rated differently by the two raters. The generalizability (0.806) and dependability (0.775) coefficients of the incompetence subscale, showed good reliability for relative and absolute decisions. Additionally, the incompetence subscale displayed a moderate level of interrater reliability (0.648) and internal consistency (0.731). Most of the variance in the measurement of the incompetence subscale were attributable to the error term, and only 14.8% of the variance was attributable to the object of measurement.

The results of this G study indicate that therapist competence and incompetence can be rated with high degree of relative and absolute reliability; and with a moderate to high level of interrater reliability with the TCS. Furthermore, the variance in the measurement was primarily composed by the true variance of the object of measurement, considering that therapist variability in a session was the larger component of the variance in the competence subscale. The good reliability and interrater reliability, as well as the ability to
measure meaningful therapist-to-therapist variability using the TCS, indicates that it is possible to study competence as a psychotherapy process construct in the context of DIT.

Hitherto, the limited reliability of therapist competence scales has been an issue of concern in the psychotherapy research field. The estimates of interrater reliability for competence measures has been reported as low in the literature, particularly when ratings of few judges are averaged in the estimate (Vallis et al., 1986). Barber et al. (2007) have suggested that the poor interrater reliability of competence measures might be due to several difficulties that include the complexity of operationalising competence, the dissimilar understandings between judges regarding what therapist competence is, as well as the fact that different raters prioritise disparate aspects of the delivery of treatment. The current study obtained an overall good reliability by addressing these difficulties, generating a detailed operationalisation of therapist competence, and training the raters in the understanding of therapist competence provided by the TCS. Firstly, operationalising competence appropriately and describing the items in terms of observable attitudes and behaviours, and providing clinical examples to illustrate them, may have enhanced the interrater reliability of the TCS. Additionally, the different steps of the judges training, -which progressed from arriving to a mutual understanding of the items to a level of greater independence in the ratings-, may also have impacted the degree of interrater reliability achieved in this study. An important factor that may have contributed to the good interrater reliability, could have been the fact that both raters were clinically trained. The specific assessment of competence requires that judges have an in-depth understanding of the clinical process, and that have a practical understanding of what competence means. The latter entails that the assessment of competence should be conducted by “competent” raters. It is conceivable that past research, -regarding the interrater reliability of competence measures-, could have been flawed, considering that it might have been more difficult to bring together raters with a higher level of expertise, which could have also entailed higher costs for the research study. Thus, an important implication for future studies that examine the interrater reliability of competence scales, is that the ratings should be conducted by expert judges.
The competence subscale demonstrated an overall good level of reliability. However, although this subscale had an excellent level of internal consistency, suggesting that the items measure a similar construct, this might also indicate that items may be measuring redundant features of competence. Conceivably, the TCS would benefit from a factor analysis in order to explore the presence of underlying components in the subscale, which would allow to discard redundant items. Additionally, two items of the competence subscale demonstrated a very poor interrater reliability (ICC < 0.5). Item 26 displayed an ICC = 0.157; and item 32 an ICC = 0.355. However, these ICCs did not coincide with the actual scores for these two items, which were similar between the two judges in every session. Considering that the numerator of the ICC formula takes into account the variance between items, this matter was explored. The variance of item 26 was 1.029, and the variance of item 32 was 1.016. The mean variance of the competence subscale items was 1.361. Therefore, it is possible that the lower variance in the scores of items 26 and 32 resulted in a lower ICC, secondary to a higher agreement between raters and a lower variability between the items’ scores. Nevertheless, future research should monitor the interrater reliability of these items in order to assess whether they should be or not removed from the subscale.

In relation to the incompetence subscale, good generalizability and dependability coefficients were found. However, a lower internal consistency of the subscale was evidenced. Additionally, the analysis of the sources of error measurement of this subscale indicated that the error term was the major component of the variance in the ratings. The latter suggests that non-studied facets of the incompetence subscale may have impacted its reliability. Furthermore, these results suggest that the incompetence subscale only has a moderate ability to capture the construct of therapist incompetence. This was also supported by the fact that items 15, 18, 27, and 36 of the incompetence subscale demonstrated only a slight agreement between raters. An important difference between the competence and the incompetence subscales, is that the latter was composed of items that are not expected to be routinely present in every session of psychotherapy. The latter has to do with the nature of incompetent attitudes and behaviours, which are not generally displayed by
average psychotherapists. Therefore, future research should explore the content and operationalisation of the items of the incompetence subscale in order to improve their reliability and practical relevance.

In reference to the patient complexity rating, only a moderate interrater reliability was found. It is expectable that attempting to capture the overall difficulties of the patient and his/her ability to work psychotherapeutically in a single item, could be a matter that is difficult to agree between raters. Considering the importance of including a measure of patient complexity in the scale, future research should explore ways of making the content of this item more reliable.

The study of the reliability of the TCS has several limitations. Firstly, the sample size and the limited number of raters may have impacted the results. Future research should investigate the replicability of the results with a larger sample size of sessions and with a greater number of raters. Secondly, the study of the reliability of the TCS should be replicated in naturalistic samples to assess whether the results are generalizable beyond the context of an RCT.

In conclusion, the results of this study found that the TCS is a reliable measure of therapist competence in terms of internal consistency. Furthermore, the TCS demonstrated a moderate-good level of interrater reliability. Therefore, the TCS overcame a known limitation of other instruments that measure intervention competence, which have generally displayed low levels of interrater reliability (Barber et al., 2007). Thus, the TCS may be a useful tool to measure and study therapist competence as a psychotherapy process variable. However, the results of this study should only be considered as initial estimates of the reliability of the TCS. Further studies are needed for more robust conclusions.

Convergent and Discriminant Validity of the TCS

The aim of this study was to explore the convergent and discriminant validity of the TCS, by examining its ability to distinguish therapist competence in DIT from other relevant constructs. The first aim was to assess the extent to which the TCS could differentiate between therapist competence and treatment
The second aim was to examine the ability of the TCS to distinguish between techniques related to the common factors of psychotherapy (Weinberger, 1993) and specific DIT/Psychodynamic interventions. Prior to the beginning of the study it was hypothesised that the TCS would demonstrate a partial correlation to measures of treatment adherence, considering that adherence is a prerequisite, but not equivalent, to therapist competence. Additionally, it was predicted that the TCS would capture the competences associated with the establishment of a positive therapeutic alliance. Nevertheless, it was predicted that the TCS would only correlate partially to measures of alliance, indicating that therapist competence in DIT goes over and above the techniques related to fostering a good therapeutic alliance with the patient.

As it was mentioned in the literature review, an important challenge in the conceptualisation of therapist competence is operationalising it distinguishing it from the construct of treatment adherence. Thus, an aim of this study was to assess the extent to which the TCS could discriminate between competence and adherence. The latter was examined through the study of the correlations between the subscales of the TCS, and the CPPS-ER and its subscales. A high positive correlation was found between the competence subscale and the PI subscale ($\rho = 0.851; p < 0.01$), whilst a high negative correlation characterised the relationship between the incompetence subscale and the PI subscale ($\rho = -0.810; p < 0.01$). This indicated that the construct measured by the TCS overlapped with the conceptualisation of treatment adherence in this sample. Thus, according to these findings the TCS did not clearly discriminate between therapist competence and adherence. Although a moderate degree of overlap between these two instruments was predicted, due to the impossibility for a therapist to be competent but not adherent to the model of therapy delivered, a high Spearman coefficient between the competence subscale and the PI subscale suggested that the TCS was not able to disentangle competence from adherence in this study. Following this result, the discriminant capacity of the TCS to distinguish between competence and adherence was explored further by comparing the AVE coefficients and the shared variance between these constructs. However, the discriminant validity
of the TCS could not be established despite of accounting for the error in the measurements. It is possible that the low variability in the competence and adherence scores in the studied sample, limited the study of the discriminant validity of the TCS. Thus, it might be that the overall high scores in competence and adherence obtained by the highly trained therapists that participated in the REDIT trial, may have impacted the study of the TCS discriminant validity. Future research should study this issue in naturalistic samples where a larger number of therapists may concurrently display disparate scores on competence and adherence, which could shed light on the discriminant validity of the TCS.

Barber et al. (2007) has suggested that is theoretically possible to distinguish competence from adherence, and that in order for instruments that measure competence to be useful, they should discriminate between these variables. However, instruments that measure these constructs have not been consistently able to discriminate between them (McLeod et al., 2018). The feasibility of developing an instrument that clearly discriminates between competence and outcome is questionable. On one hand instruments that assess adherence, tend to additionally measure the degree of skilfulness in the delivery of interventions, considering that only examining the frequency counts of specific techniques is an inadequate measure of adherence. On the other hand, adherence is an essential prerequisite of competence, as it is impossible to deliver a specific treatment competently without being adherent to it (Barber et al., 2007). Therefore, an important degree of overlap between therapist competence and treatment adherence is expected. Conceivably, only operationalising competence as the need of the therapist to go off-manual in accordance to the patient’s changing needs and states, would allow a clear-cut differentiation from the construct of competence. Thus, only under this operationalisation of competence it would be possible to define a therapist as competent and not adherent, in reference to situations where the patient’s needs require the therapist to intervene in disagreement with what the treatment manual specifies. However, the operationalisation of therapist competence in the use of specific interventions that belong to a specific treatment manual, does not allow for a clear separation between the constructs of competence and adherence. Therefore, in every occasion that the therapist competently delivers the manual interventions, he/she will be highly adherent
to is as well. Therefore, the attempt of this study to moderately disentangle therapist competence from adherence, might not be feasible. Indeed, McLeod et al. (2018) has suggested that it might not be possible to develop measures that clearly distinguish between competence and adherence.

Furthermore, the relevance and the need to define and discriminate between competence and adherence should be analysed in detail. Perepletchikova et al. (2007) have insisted on the need of ensuring treatment fidelity, considering that failing to corroborate it undermines the credibility and internal validity of the outcomes of a study. Thus, adherence to the interventions specified by the manual, as well as ensuring that the interventions were competently delivered, are important factors to establish whether the clinical outcomes were a result of a specific psychotherapeutic treatment. However, it would be possible to question, what is the need of determining a high degree of adherence, if the interventions of a treatment were not delivered competently? Would it be possible to sustain the internal validity of a study if the manual interventions were delivered, but not in a competent manner? Would it still be possible to maintain that treatment outcomes are the result of a specific psychotherapy if its interventions were delivered, but without skill nor consideration for the patients’ needs? It would be possible to suggest that a composite construct that considers both, competence and adherence, would be a more valid measure of both, the internal validity of a study, as well as of how faithful the therapist is to the treatment manual. Additionally, it would be more feasible to operationalise this composite construct than attempting to clearly distinguish between competence and outcome. Future research should examine the necessity of distinguishing between these two notions of treatment fidelity and the implications of developing such composite competence/adherence construct.

The ability of the TCS to capture both, competencies related to the common factors of psychotherapy, as well as competencies related to specific techniques has important implications for psychotherapy research, and therefore, examining this issue was a relevant aim of this study. The study of the convergent and discriminant validity of the TCS in reference to the therapeutic alliance was investigated through the correlations between the TCS and the WAI-O-S. A moderate positive correlation was found between the
competence subscale and the WAI-O-S ($\rho = 0.626; p < 0.01$). Concurrently, a moderate negative correlation was found between the incompetence subscale and the WAI-O-S ($\rho = -0.539; p < 0.01$). All the subscales of the WAI-O-S showed a moderate positive correlation with the competence subscale. Likewise, moderate negative correlations were found between the incompetence subscale and, the Task and Goal subscales. These findings support the hypothesis regarding that the competencies related to the fostering of the therapeutic alliance explain partly, but not entirely, the skilfulness of the therapists. These findings are relevant because they suggest that the TCS captures different kinds of competencies, the ones related to the psychotherapeutic common factors, as well as the competencies related to the specific ingredients of psychotherapy (Imel & Wampold, 2008; Wampold, 2015).

Hitherto, the relevance of each group of techniques to treatment outcome is still a source of controversy (Owen et al., 2013). On one hand, a number of studies have indicated that specific techniques only account for 15% of the clinical outcome variance, half of what is accounted by the common factors of psychotherapy (M. J. Lambert, 1992; M. J. Lambert & Barley, 2001). On the other hand, an increasing number of studies have supported the claim that the use of specific techniques has, in addition to the common factors of psychotherapy, an important effect on clinical outcome (Larry E Beutler et al., 2003). Likewise, Owen et al. (2013) have indicated that “curative” psychotherapeutic factors go beyond the establishment of a good therapeutic alliance. Indeed, it has been suggested that the therapeutic alliance and specific therapist techniques contribute in a similar fashion to the treatment outcome variance (about 10%), and that both are interrelated (Larry E Beutler, 2002). It is likely that until now it may have been easier to establish the role of the common factors of psychotherapy on outcome considering the lesser level of expertise required for their delivery, in comparison to the level of competence required to deliver the specific factors of psychotherapy. Thus, it is incontrovertible that by identifying the competencies associated with the different psychotherapeutic components it will be possible to better determine not only the association between the common factors of psychotherapy and
outcome, but also the association between specific interventions and patient improvement. Therefore, an important implication of the operationalisation of competence in the TCS, and its ability to capture both, the common and specific factors of psychotherapy, is that it may become possible to better study the effect of these different components of psychotherapy on treatment outcomes.

The findings of the study on the convergent and discriminant validity of the TCS only constitute the preliminary results regarding the validity of the scale. Thus, future research should focus on conducting an appropriate process of validation. Firstly, the low variability in the scores of the different scales may have hampered the study of the TCS convergent and discriminant validity, particularly in the examination of the constructs of adherence and competence. Secondly, the study on the convergent and discriminant validity of the TCS should be replicated with a higher number of sessions and raters, considering that an important limitation of this study was that only one judge coded the three scales. Thirdly, the criterion validity of the TCS should be examined in order to compare it to a “gold standard” measure of therapist competence. Although no instrument of psychodynamic competence has been established as a “gold standard”, Perepletchikova and Kazdin (2005) have suggested that a competence measure could be compared with measures of quality provided by clinical supervisors. Additionally, these authors have suggested that the concurrent validity of a competence measure could be examined by assessing its relation with measures of patients’ characteristics, considering that therapist performance may vary as a function of patient difficulty.

In conclusion, this study examined the convergent and discriminant validity of the TCS. The TCS was not able to distinguish between the concepts of therapist competence and adherence in this sample. However, the limited variability in the scores and the feasibility of the matter may have hampered the study of the capacity of the TCS to distinguish between competence and adherence. On the other hand, the TCS captured the competencies of the therapist related to the development of the therapeutic alliance. Future research should focus on conducting a proper process of validation of the TCS considering its promising preliminary results.
The aim of this study was to examine the association between therapist competence, as measured with the TCS, and outcome. The relevance of the study was that it was the first to directly address several conceptual and methodological/statistical limitations of past research studies that had examined the relation between competence and outcome. The conceptual limitations were addressed through the use of the TCS, a newly developed scale, empirically-derived and supported by a preliminary process of validation. As it was mentioned above, the development of the TCS aimed to address the gaps of past research studies by including in its operationalisation global-domain and single-domain competencies; the conceptualisation of unconscious processes; the notion of responsiveness, flexibility and meta-competences; items on incompetence; and a measure of patient complexity. Furthermore, the TCS encompasses a comprehensive assessment of therapist competence, which includes a large number of items that aim to account for and distinguish between different degrees of competence among therapists. Additionally, this study addressed several methodological and statistical limitations of past research studies by investigating the effect of competence longitudinally; considering treatment outcomes in terms of effectiveness and efficiency; examining linear and non-linear relations between competence and outcome; studying how third variables could impact the association between competence and outcome; and, through the use of multilevel statistical models.

The fundamental research question of this study was, is therapist competence, as operationalised by the TCS, associated with the patient’s clinical outcome in DIT? A significant association between competence and outcome was predicted particularly, -based on the literature review-, in patients with higher symptomatology at baseline. Moreover, it was hypothesised that competence would have an effect on outcome scores, as well as an impact in the rate of patient recovery. Furthermore, considering the inconsistencies of the literature review findings regarding a positive association between competence and outcome, it was predicted that part of the association between competence and outcome would be linear, while other portions of it would have a non-linear relationship. Finally, a significant interaction between therapist competence and
patient complexity was hypothesized, being the former of critical importance the more complex the treated patient.

As it was predicted, this study found an association between competence and the rate of patient improvement. As mentioned in the relevant chapter, a significant interaction was found between competence at the session level and time, which indicated that higher levels of competence in a session were associated with a faster rate of recovery, especially in patients with more severe symptomatology (HDRS-17) at baseline. This finding was supported by previous research that had already suggested that therapist effects were more important when the patients’ initial severity was higher (Barkham et al., 2017). Furthermore, in this study, the significant interaction between competence at the session level and time, in association with treatment outcome, was also relevant for patients with lower symptomatology at baseline. Thus, patients with lower symptomatology at baseline also responded faster when treated with higher competence at the session level. Therefore, according to the results of this study, it could be suggested that it is important that every patient is treated with a high level of competence at the session level, particularly patients with higher symptomatology at baseline, in order to promote a more efficient rate of recovery. In other words, the higher the initial patient clinical severity, the more it matters which therapist the patient sees, in terms of his/her ability to be competent at the session level. Thus, an important implication of this finding is the need to focus on therapist competence early during treatment in order to ensure a quicker therapeutic change on the part of the patient. Overall, this finding makes good clinical sense, as it well-known that as clinical cases become more complex and severe, higher competence is required in order to deliver an appropriate treatment. This finding regarding competence and the higher efficiency of the treatment in terms of patient improvement could be interpreted in agreement with the well-known attributes of competent clinicians who are able to implicitly, spontaneously and without delay recognise significant patterns, conduct relevant actions, make contextual judgements, and deliver accurate action strategies (Schön, 1983). Therefore, it is likely that competent therapists do not lose time in delivering futile interventions and are therefore able to provide a continuous and higher level of competence.
throughout sessions, which is more efficient in bringing about better treatment outcomes.

This finding, regarding the higher efficiency of competent therapists in bringing about better treatment outcomes, should be understood in association with the predicted second finding of this study concerning the positive and significant fixed effect of competence at the therapist level and treatment outcome (total amount of change in outcome measure). Thus, according to the results of this study, competence at the therapist level is associated with treatment effectiveness, and competence at the session level is pivotal to ensure an efficient response to treatment. Overall, these findings support the importance of training psychotherapists and ensuring that psychotherapeutic interventions are delivered competently. Hitherto, the importance of psychotherapeutic training and of therapist competence have been questioned (Sandell, 1985; Strupp et al., 1988; Svartberg, 1989; Svartberg & Stiles, 1994). However, the latter was probably in the context of the difficulty of operationalising the outcomes of training and the standards to define a competent psychotherapist. It is possible that the greater clarity regarding the construct of competence achieved in the operationalisation of the TCS, allowed to shed light in the relevance of competence for clinical practice, which may have important implications for the training of future generation of psychotherapists and for setting professional standards of practice.

An important hypothesis of this study was that part of the association between competence and outcome would be linear, while other portions of it would have a non-linear relationship. Indeed, a quadratic relationship between competence at the session level and treatment outcome was found. In accordance to this finding, low and high levels of competence at the session level were associated with worse treatment outcomes, whilst moderate degrees of competence were related to greater patient improvement. Although it is expectable that lower levels of competence result in worse clinical outcomes, the finding that higher competence in sessions is associated with higher HDRS-17 scores, is not. Thus, this last result could be interpreted in different ways. On one hand, considering the interaction between competence and time, and the higher efficiency in patient improvement, it would be possible that therapists whose patients respond to therapy promptly could, on average, drop-
out from treatment with little improvement, as it has been indicated by Barkham et al. (2017). Therefore, the latter could give the false impression that higher competence would result in a lesser amount of change achieved in therapy, whilst it could be truly reflecting that competence might bring about a faster recovery, which in turn leads patients to leave treatment earlier with a lesser amount of total change achieved. On the other hand, and taking into consideration the literature that suggests that alliance might moderate the relation between competence and outcome (Barber et al., 2007; Despland et al., 2009; M. Hendriksen et al., 2014), it is possible that a moderate level of competence represents a point in which there is a balance between there not being too many ruptures in the alliance with the patient, but also entailing enough processes of rupture and repair of the alliance that allow to establish a deeper connection between therapist and patient. Literature related to ruptures and repairs of the therapeutic alliance (Eubanks et al., 2018; Muran et al., 2010; Safran et al., 1990; Safran & Muran, 1996; Safran et al., 2011) has suggested that resolving alliance ruptures may entail a more in-depth exploration of what transpires between therapist and patient, as well as an in-depth exploration of the patient’s experience. It is conceivable that more competent therapists, by constantly doing “the right thing”, prevent the occurrence of ruptures in the alliance, and therefore, there are less opportunities for patient and therapist to experience moments of greater understanding and relational depth, which often take place after episodes of emotional distance and discord. Therefore, there might be an added value, to the customarily effectiveness provided by sustained therapist competence, in the experience of repairing a rupture in the collaborative relationship between patient and therapist, and the associated breakthrough it may bring about for the therapeutic process. Thus, moderate levels of competence, at the session level, would bring about the possibility of working through more ruptures to the alliance, and therefore be associated with better treatment outcomes than sustained higher levels of competence in the session.

However, these two interpretations regarding the quadratic relation between competence at the session level and outcome should be analysed with caution, and future research should explore them further. It is important to consider that the quadratic relation between competence and outcome only
accounted for a portion of the variance in the same statistical model that found
a significant linear negative association between competence at the therapist
level and HDRS-17 scores. Furthermore, in this statistical model, a portion of
the variance was attributed to the interaction between competence at the
session level and outcome. Thus, the interpretation of the quadratic relationship
between competence in the session and outcome, should be guided by the
consideration that it may only elucidate part of the overall relation between
competence and outcome, whilst other components of this model may explain
other aspects of this general relationship. It is likely that third process-outcome
variables could explain in which circumstances the relation between
competence and outcome appears to be linear, and in which contexts the
association between these variables appears as a quadratic one. Further
research is needed to clarify these associations.

As mentioned above, it was predicted that there would be an interaction
between competence and patient complexity. Indeed, a significant interaction
between competence at the therapist level and patient complexity at the
participant level was found. This finding suggests that more competent
therapists bring about lower HDRS-17 scores in their patients, especially when
treating individuals with higher patient complexity, as defined by the TCS.
Conversely, it was found that less competent therapists bring about worse
treatment outcomes, particularly when treating individuals with higher patient
complexity. In the TCS patient complexity was operationalised in terms of
epistemic trust and epistemic vigilance. A participant with a low score in patient
complexity was considered to have enough psychological resources to deal
with the psychotherapeutic process, and conveyed high levels of epistemic
trust, openness and receptiveness to most interventions. Conversely, a
participant that scored high in patient complexity, corresponded to one that did
not have enough psychological resources to work in therapy, and that showed
high levels of epistemic vigilance throughout the session. Therefore,
considering this conceptualisation, the significant interaction found between
competence at the therapist level and patient complexity at the participant level,
is in line with Fonagy et al. (2017) model of psychotherapeutic change. These
authors have proposed that psychopathology is based on an important difficulty
to trust and learn from social experiences. Individuals normally display
epistemic trust as an adaptation that allows them to receive social knowledge. The internalisation of social knowledge involves encoding data as relevant to the recipient and as socially generalizable. In this model of change, learning is stimulated by ostensive cues, displayed by the communicator, which provoke a pedagogic stance in the recipient, priming them to appraise the communicated information as significant. In situations where the individual’s early learning environment is characterised by unreliable communicators (i.e., abusive early environments), the development of epistemic trust is hindered, as it becomes more adaptive to remain vigilant and closed off to social knowledge. Epistemic vigilance often presents as the misattribution of intention and the assumption of malicious motives underlying other people’s behaviours. Furthermore, in a state of epistemic mistrust, the individual cannot receive, internalise and appropriately reapply information. Consequently, the person is unable to modify stable beliefs about the world, which results in a rigid and “hard to reach” personality. A competent therapist, responsible for the treatment of an individual with epistemic mistrust, learns to recognise the patient’s personal narrative and to gradually help them increase their epistemic trust by: establishing a collaboration with the patient; demonstrating that they see the patient’s problems from their perspective; recognising them as agents; and, by conveying an attitude that the patient has things to teach to the therapist. Through these interventions, the therapist provides a model of interaction that acts as an ostensive cue, which increases the patient’s epistemic trust, driving forwards the psychotherapeutic process (Fonagy et al., 2015; Fonagy et al., 2017). The operationalisation of competence outlined by the TCS includes the interventions mentioned above, which are considered essential for the development of epistemic trust, as well as fundamental for the characterisation of a competent therapist. Therefore, this model of psychotherapeutic change is supported by this study’s finding that more competent therapists are able to bring about better outcomes, particularly in participants displaying higher levels of complexity, otherwise denominated, epistemic vigilance.

This study has several limitations which should be taken into account in the examination of the findings. Firstly, a newly developed scale, whose psychometric features have only been preliminary assessed, was employed for the investigation of the relation between competence and outcome. Although
the initial reliability and validity of the TCS have been examined in this dissertation, future research should attempt to replicate these results examining a larger number of sessions and raters. Furthermore, in the future, the TCS should be appropriately validated, and in particular, its construct validity should be studied in order to assess the accuracy and practical-relevance of its operationalisation of competence. Moreover, future research should monitor each of the items of the scale in order to understand which are more representative of competence, as well as to investigate which of the items are more correlated to treatment outcome. This knowledge would enable to systematise which are the relevant competencies that should be included in the training of future psychotherapists, and which competencies are fundamental for the design of specific psychotherapeutic treatments.

Another important limitation of this study is that besides the examination of the level of patient complexity and its impact on the relation between competence and outcome, no other third variables were included in the analyses. Thus, several factors regarding the complexity of the change process, the intertwining of patient and therapist characteristics, and the many mediators and moderators of change were not considered in this study. Future research should address the impact of these variables in the association between competence and outcome. Furthermore, another weakness of this study is that only outcome measures related to the severity of symptoms were included in the analyses (i.e., HDRS-17 scores). The literature has substantiated the need of including outcome measures that assess more in-depth outcomes, such as those targeted in insight-oriented and exploratory psychotherapies with long-term approaches. It might be reductionist to only include outcome measures of symptom relief as they might not represent the complexity of the change process experienced by patients in psychotherapy. Additionally, in the study of the association between competence and outcome it would also be important to include as outcomes the emergence of negative changes and deterioration, considering that is possible that some therapists may be harmful (L. Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010a). Importantly, it would be relevant to assess which competencies have particular effects on specific domains of outcome, which improve the
knowledge of how to develop psychotherapies tailored to the patients’ specific needs and difficulties.

Due to several other limitations regarding the sample size, the selection of partial data from a full data-set, the unbalanced structure of the data and the restricted number of raters the results of this study should be considered with caution and as preliminary findings that could guide future research in the field of therapist competence. Nevertheless, the significance and uniqueness of this study should not be overlooked as it is the first study to use a competence measure which provided a new operationalisation of competence that allowed to study and attain an enhanced comprehension of the association between therapist competence and outcome, that hitherto had not been possible to achieve. Overall, a relation was found between competence and patient improvement, a finding that was aligned with a renowned model of psychotherapeutic change (Fonagy et al., 2015; Fonagy et al., 2017), suggesting that therapist competence may have a relevant role in improving patients’ epistemic trust, which in turn can help alleviate the enduring emotional difficulties experienced by these individuals.

General Implications of the Study

There are several fundamental implications of this study, particularly secondary to the operationalisation of therapist competence and to the better understanding of the association between competence and outcome achieved in this dissertation.

Firstly, a better understanding of the competencies required to deliver specific psychotherapeutic interventions will allow to better understand what are the “active ingredients” of psychotherapy. It is possible that until now, the study of the effects of the specific factors of psychotherapy has been hampered due to the lack of specification regarding the skills required to deliver them. The operationalisation of competence allows to determine whether these specific psychotherapeutic factors were appropriately delivered, and therefore, it becomes possible to study their effects on patient improvement. Understanding the role of specific psychodynamic interventions on outcome will allow to
elucidate the psychotherapeutic mechanisms of change, which would enable to design psychotherapeutic treatments that have a predictable and a positive effect on patients’ mental health.

These ideas are key to understand the potential of competence research for the general psychotherapy field. As mentioned in the literature review, hitherto psychotherapy research has prioritised the study of how specific brands of psychotherapy may be related to patient improvement (M. J. Lambert, 2013), which has led to conclude that different psychotherapeutic modalities have similar treatment outcomes, a phenomenon denominated the “dodo bird verdict” (Luborsky et al., 1975). It is likely that hitherto, the lack of an appropriate operationalisation of therapist competence for the different psychotherapeutic brands, has not allowed to evaluate whether the different treatments under study were delivered with skill. Therefore, it could be possible that the conclusion regarding the similar effectiveness of different types of psychotherapies, is inaccurate. Therefore, competence research opens a new prospect in the field of psychotherapy. Competence research may not only enable to appropriately compare between brands of psychotherapy, but has the potential of identifying the “active ingredients” of psychotherapy and the essential skills that a professional psychotherapist should demonstrate. Furthermore, competence research may enable to identify which particular competencies are more helpful to work with specific patients and with particular diagnoses. Therefore, alongside the study of which is a better psychotherapeutic modality, we might start exploring “what works for whom” by investigating which competences are more successful in specific kinds of individuals and psychopathologies.

Furthermore, competence research may have the potential of shaping the different models of psychotherapy. Until now, research has defined the “common factors” of psychotherapy (Imel & Wampold, 2008), whose association with outcome has probably been easier to study than the one of other psychotherapeutic factors, due to their straightforward operationalisation, measurement and skill required for their delivery. Further study of the association between specific competencies and clinical outcomes might identify particular skills that bring about patient improvement. The latter could imply that different models of psychotherapy, independently of their orientation, should
start including in their delivery these particular skills. Therefore, competence research has the potential of blurring the demarcation lines between psychotherapeutic modalities, leading to a potential unification of the field around not only the already known “common factors”, but also around the essential competencies to deliver any psychotherapy.

Additionally, the TCS operationalisation of competence and its association with patient improvement, provide fundamental knowledge regarding the quality of the delivery of interventions. The latter is essential in order for professionals to agree in what constitutes a competent clinical practice. Hitherto, one of the greatest challenges of psychotherapy education is the lack of agreement in the establishment of true standards of professional competence, which has been particularly more difficult among psychodynamic/psychoanalytic institutions. Likewise the criteria that set the goals of psychodynamic training are also ambiguous (O. F. Kernberg, 2007). Indeed, it has been claimed that there is a need of objective criteria regarding competence in conducting psychodynamic treatment in order to assess the expertise of trainees. Furthermore, it has been claimed that there is a need to appropriately systematise psychodynamic technique and the skill required for its application in order to allow an objective assessment prior to trainees’ graduation (O. Kernberg, 2014). One of the major obstacles for establishing such criteria has been the assumption that each psychodynamic situation entails a unique relationship between two individuals and thus, it is not possible to conduct scientific objective measurements of it. However, it could be argued that if the measures that assess the techniques and the competence with which they are delivered give room to the changing nature of the therapeutic situation within common and established parameters of practice, -as the TCS attempts to achieve through the inclusion of the notions of responsiveness, flexibility and meta-competence-, it is possible to study and assess any psychodynamic encounter. Thus, the operationalisation of competence provided in the TCS advances the establishment of a systematisation of psychodynamic interventions and the skills required for their delivery. This could help lay the foundations of the educational standards, as well as the standards of practice of a professional psychodynamic psychotherapist.
As mentioned in the literature review, psychotherapy research has traditionally maintained that competence is acquired through training and experience, however, this association has been questioned and the importance of training has been disputed (Berman & Norton, 1985; Durlak, 1979; Eells, 2003; Henry, Strupp, et al., 1993; Herman, 1993; Shapiro & Shapiro, 1982a). However, it has been suggested that the lack of evidence related to the identification and development of therapist competence is due to the inadequate operationalisation of the construct (C. E. Hill et al., 2017). Thus, this dissertation's operationalisation of competence may provide the grounds to study the importance of training and experience. Additionally, the operationalisation of competence of the TCS may in the long run help design psychotherapeutic trainings in reference to the acquisition of the skills it operationalises. Therefore, the operationalisation of competence may shape how the next generation of psychotherapists is trained, and the various techniques that should be employed with patients. Thus, ultimately psychotherapy training may be modified in order to align clinical practice with well-recognised beneficial, therapeutic practical elements.

The ultimate aim of psychotherapy practitioners and researchers is to promote treatment success and to avoid harm (L. Castonguay et al., 2010a). Within this context, understanding the variables that explain treatment success should lead to an integration of these variables within the different components of mental health care. Therefore, the understanding provided by dissertation regarding the association between therapist competence and outcome might lead to the refinement of a number of mental health practices if the results are corroborated by future research. Thus, as mentioned above, this may involve the modification of training programmes, but could also involve adapting supervision routines, and standard referral practices in order to maximise patient improvement (Barkham et al., 2017). Thus, the findings of this dissertation may help not only scholars, but also practitioners, supervisors, - and most importantly-, our patients.
Future Research

Throughout the general discussion of the studies of the dissertation, specific future lines of research have been outlined. In this section, general future directions of research will be proposed which can be organised into two groups: 1) future research regarding the improvement of the operationalisation of competence; 2) future research to improve the understanding of the association between competence and outcome.

Regarding research involving the operationalisation of competence, the TCS should undergo an appropriate process of validation, and particularly, its construct validity should be explored. Firstly, the dimensions of competence that emerged from the qualitative analysis of expert clinicians’ interviews should be triangulated, and therefore verified by the practitioners that participated in these interviews. This would allow to check whether the competencies included in the scale, match with the expert clinicians’ viewpoints on competence. Additionally, the TCS should be compared against supervisors’ understandings of competence, in order to assess its construct validity. Moreover, future research should evaluate whether the different conceptualisations included in the TCS, such as responsiveness, metacompetence, and flexibility, are appropriately captured by the scale. Therefore, the convergent validity of the TCS against measures of responsiveness, therapist flexibility, global and single-domain competence, among others, should be explored. Considering that it became evident that the incompetence items were not conceptualised in a way that they could be expected to be present in every psychotherapy session, future research should explore how to better operationalise therapist incompetence in order to improve the practical relevance of the items of this subscale. Additionally, in order to improve the validity and intrarater reliability of the patient complexity rating, future research should examine the convergent validity of this item by comparing it to measures of epistemic trust. Overall, the convergent and discriminant validity of the TCS, as well as the study of the construct validity of the scale, should be conducted with a larger number of therapists and raters, and investigated in naturalistic samples.

Furthermore, the applicability of the TCS should be studied with a larger number of raters in order to explore whether its reliability is replicated when
used by a greater number of judges. The latter could be enhanced by the development of a training manual for the use of the TCS. Moreover, the different items of the TCS should be monitored in terms of their reliability and validity in order assess which items should be kept or removed from the scale. Future research should also consider conducting a factor analysis of the items in order to avoid redundancy. By following these steps, the overall sophistication and the capacity of the TCS to operationalise competence will improve, and therefore, its applicability will be enhanced. If these studies could be conducted, it would then be interesting to evaluate whether the TCS could be used to assess competence in various brief psychodynamic psychotherapies, -other than DIT-, to evaluate whether it appropriately assesses psychodynamic competencies in a range of brief psychodynamic approaches.

Regarding research involving the study of the association between psychodynamic competence and outcome, the first and most important future research assignment is the replication of the findings of the current dissertation, -regarding the relation between these variables-, in a naturalistic sample with a larger number of sessions, patients and therapists. This would allow to clarify whether these dissertations’ results are robust, precise and consistent. Furthermore, it would be relevant to examine the association between competence and outcome in an experimental study, to assess more accurately the relation between these variables. Particularly, it would be interesting to examine whether the findings regarding the effectiveness and efficiency of competence on outcome, -found in this dissertation-, can be replicated under experimental conditions.

Moreover, it is fundamental that future research engages in studying the effects of competence in samples with different kinds of therapists, patients, diagnoses, and psychotherapeutic modalities. The latter would enable to study to what extent the initial findings regarding competence of this study, generalise to other populations, psychopathologies and treatments. Additionally, these studies should involve measures of outcome that involve, -besides changes in symptomatology-, changes in social and intrapsychic functioning, in addition to drop-outs and measures of deleterious effects. This would allow to more comprehensively understand the effects of therapist competence in patients.
Additionally, it should be examined which of the competencies and incompetencies of the TCS are better predictors of outcome. In particular, it should be investigated which competences predict patient improvement in specific domains of outcome. The latter would set the ground to design psychotherapeutic therapies and interventions that are tailored to the patients’ specific needs.

Importantly, the overall relation of competence and outcome should be examined, exploring when the relation is linear and in which contexts the association between these variables follows a non-linear pattern. In order to conduct this line of research, third variables should be included in the analyses. This would enhance the understanding of the complex association between competence and outcome. Furthermore, the interaction between therapist competence and patient complexity should be studied in depth, in order to learn how to tailor skillfully-delivered interventions to patients with different levels of difficulty, in order bring about better outcomes.

Finally, future research should investigate to what extent it is possible to train competency, and which are the best pedagogic resources to enable a therapist to become competent. This field of research, -regarding the training of psychotherapists-, could then be linked to examine the association between training and clinical outcomes.

Although this dissertation achieved its initial aims of operationalising competence in DIT, providing an initial validation of the newly-developed measure, and studying the association between therapist competence and outcome, the studies proposed above are fundamental to move the field of competence research forwards and to elaborate on the generalisability and applicability of the results.

Final Remarks

The current dissertation attempted to fill the gap in psychodynamic psychotherapy research regarding a measure that appropriately operationalises therapist competence in brief psychodynamic psychotherapy, specifically within the DIT model. Thus, the TCS was developed
addressing the conceptual and methodological difficulties that had hampered the development of a suitable instrument to measure psychodynamic therapist competence in previous studies. The TCS conceptualises competence, incompetence, global competence and a measure of patient complexity, providing an original and empirically-derived instrument to psychotherapy research. Throughout this dissertation, the TCS showed promising results in its preliminary study regarding its reliability and validity. Furthermore, the TCS enabled the study of the association between therapist competence and patient improvement. Importantly, it was shown that therapist competence may have a role in the effectiveness and in the rate of patient improvement in DIT. Additionally, it was found that competence might have a linear and a non-linear relation with outcome. Furthermore, it was found that the patients’ level of complexity interacts with the therapist ability to be competent. All these results are preliminary and should be replicated by future research studies. Overall, the TCS and competence research have the potential of contributing to fill a gap in the study of psychotherapeutic processes, by changing the study angle of psychotherapy research, from comparing modalities of psychotherapy, to defining and sophisticating the skills necessary to deliver the “active ingredients” of therapy. Furthermore, competence research has the potential of shaping and unifying the different models of psychotherapy, by identifying the essential competencies that should be delivered by any psychotherapeutic modality. Therefore, competence research has the potential of shaping psychotherapeutic training and professional practice.

It is well-recognised that in order for psychodynamic therapists to conduct competent work with patients, they have to deeply and intensely work with themselves, experiencing strong primitive strivings and their frustration, with complete awareness of both (Fleming, 1961). As Bion (1965) has claimed, both, therapist and patient will prefer “knowing about something to becoming something” (p. 162). However, in psychotherapy, both, therapist and patient, should hope for maturation and growth. Likewise, the knowledge attained in this dissertation should be thought about, worked through, appraised and questioned in order to strive for a truer understanding that would lead us to become better therapists for our patients.
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APPENDICES
**APPENDICES**

**Table of Contents**

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A:</td>
<td>Methodology of the Literature Review</td>
<td>381</td>
</tr>
<tr>
<td>Appendix B:</td>
<td>Assessment of Adherence to Treatment Manuals</td>
<td>383</td>
</tr>
<tr>
<td>Appendix C:</td>
<td>Competencies Associated with the development of the Therapeutic Alliance</td>
<td>384</td>
</tr>
<tr>
<td>Appendix D:</td>
<td>Levels of Therapist Competence according to Killingmo, Varvin, and Strømme (2014)</td>
<td>386</td>
</tr>
<tr>
<td>Appendix E:</td>
<td>Framework of Psychodynamic/Psychoanalytic Competence (Lemma, Roth, &amp; Pilling, 2008)</td>
<td>392</td>
</tr>
<tr>
<td>Appendix F:</td>
<td>Differences in Therapist Competencies Between Brief Psychodynamic Psychotherapy and Long-Term Psychodynamic Psychotherapy</td>
<td>456</td>
</tr>
<tr>
<td>Appendix G:</td>
<td>First version of the semi-structured interview</td>
<td>461</td>
</tr>
<tr>
<td>Appendix H:</td>
<td>Second version of the semi-structured interview</td>
<td>472</td>
</tr>
<tr>
<td>Appendix I:</td>
<td>Final version of the interview</td>
<td>474</td>
</tr>
<tr>
<td>Appendix J:</td>
<td>Semi-structured interview Information Sheet</td>
<td>476</td>
</tr>
<tr>
<td>Appendix K:</td>
<td>Semi-structured interview Consent Form</td>
<td>477</td>
</tr>
<tr>
<td>Appendix L:</td>
<td>Thematic Analysis: Complete version</td>
<td>478</td>
</tr>
<tr>
<td>Appendix M:</td>
<td>First version of the TCS</td>
<td>595</td>
</tr>
</tbody>
</table>
Appendix N:  
Second version of the TCS  

Appendix O:  
Third version of the TCS  

Appendix P:  
Fourth and final version of the TCS  

Appendix Q:  
Generalizability Theory  

Appendix R:  
Comparative Psychotherapy Process Scale – External rater form (CPPS-ER)  

Appendix S:  
Working Alliance Inventory - shortened observer-rated version (WAI-O-S)  

Appendix T:  
Hamilton Rating Scale for Depression (17-items)
Appendix A

Methodology of the Literature Review

A literature review was conducted on March 2016. The search engine used was University College London Library online, which contains the following databases for Psychology Searches: Annual Reviews; APPI Journals; ASSIA Applied Social Sciences Index and Abstracts; British Education Index (EBSCO); CAIRSS for Music; Campbell Collaboration; CINAHL Plus; Cochrane Library; CogNet (MIT Press); COPAC; Dwsonera; EMBASE; EMBASE Classic; ERIC (EBSCO); ERIC (ProQuest); Health and Psychological Instruments (HAPI); HighWire Press; IBSS: International Bibliography of the Social Sciences (ProQuest); IngentaConnect; JISC Journal Archives; Journals@OVID; JSTOR; MEDLINE (Ovid version); Nature Journals; PEP (Psychoanalytic Electronic Publishing); PILOTS: Published International Literature On Traumatic Stress; ProQuest Central; ProQuest Psychology Journals; ProQuest Social Science Journals; PsycARTICLES; PsycBOOKS; PsycCRITIQUES; PsycEXTRA; PsycINFO; PsycTESTS; Pubget; PubMed; Science Citation Index Expanded; ScienceDirect (Elsevier); SCOPUS; University of London Research Library Services; Web of Science Core Collection; and, Wiley online Library. The following keywords were entered in the Advanced Search engine: (1) Competent AND Psychotherapist, which provided 375 results; (2) Therapist AND Competence AND Psychology, which provided 806 results; (3) Therapist AND Competencies AND Psychology, which provided 131 results; (4) and, Psychotherapist AND Effective, which provided 1065 results.

The inclusion criteria were articles or books regarding: (1) adult patients; (2) individual psychotherapy; and, (3) in English. The exclusion criteria were: (1) articles about specific diagnoses or topics of psychotherapy; (2) dissertations; and (3) articles focused in specific issues of competence (i.e., multicultural competence). The inclusion and exclusion criteria were applied to the search results, and the remaining abstracts were assessed and included in the review if they were in agreement with the aim of the literature review. After this step 194 references were included in the literature review.
In a third step, the full texts of these references were assessed. From the remaining results: (1) 5 were excluded because they were not scientific articles; (2) 93 were excluded because they only referred to competence tangentially; and, (3) 68 were excluded because they referred to other treatment modalities different from psychodynamic psychotherapy. Concurrently, important references cited in these articles and books were included. At this point, 188 references were included in the literature review.

An update of the literature search was conducted in November 2018, using the same search engine and keywords. By following the inclusion/exclusion criteria, and adding important references of the articles found, a final number of 220 references were included in the literature review.

Figure A1. Literature Review Methodology
Appendix B
Assessment of Adherence to Treatment Manuals

Regarding adherence to manuals and its relation to treatment outcomes, it has been claimed that the use of manual can be assessed as a whole (yes/no), -in a categorical manner-, or as continuum of adherence level or dimensional way. It is important to indicate that while the two types of assessment are related they are not exactly the same thing (M. Hilsenroth, personal communication, September 14, 2016). A meta-analysis that assessed the use of treatment manuals as a whole, found that fidelity checks were significantly associated with patients’ clinical improvement between the end of treatment and follow-up assessments (Town et al., 2012).
Appendix C
Competencies Associated with the development of the Therapeutic Alliance

The ability to listen actively is often taken for granted by psychotherapists, and becomes overlooked because of the increasing pressure to “do” something for the patient. However, trying to do something without having first understood the situation and who the person of the patient is, is usually problematic. The importance of being receptive and attuned to the patient, which is probably one of the most powerful means to deeply understand, has been underestimated. Furthermore, by listening to the patient the therapist conveys respect and a commitment to work together. In listening to the patient, particularly at the beginning of therapy, the therapist should make open-ended questions and follow the patient’s lead. In this manner, the therapist expresses curiosity and recognises the patient’s capacity to collaborate, which is key for the therapeutic alliance. In the open-ended enquiry, the therapist must find the balance between following the patient’s lead and directing the conversation towards relevant issues, conveying that he/she is not a passive and disengaged therapist. Furthermore, in listening to the patients, the therapist must help them represent their experiences by finding words and descriptions so as to create a common language with the patient, which is also essential for the therapeutic alliance (Binder & Betan, 2012).

Empathy is an essential competency for the establishment of the therapeutic alliance. It is the ability to resonate with the verbal and non-verbal messages of the patient. Empathy is usually misunderstood as simply mirroring back, as “feeling what another feels” (Binder & Betan, 2012, p. 35). However, empathy entails that the therapist suspends his or her own perspective in order to experience for a moment the patient’s way of living and making sense of what occurs around him or her. Moreover, empathy involves putting words into the patient’s experiences, words that might not be available for the patient, so as to give meaning to the patient’s life and experiences (Binder & Betan, 2012). Curiosity is another of the main competencies that contributes to the
establishment of the therapeutic alliance. By showing curiosity towards patients, the therapist conveys a non-judgmental and genuine interest in knowing more about them. Furthermore, throughout the treatment, the therapist should model an attitude of curiosity, encouraging the patient to think about his or her own experiences (Binder & Betan, 2012).

Adjusting to the patients’ relational concerns and needs requires the therapist to be responsive in a way that engages the patient to the therapeutic process. Such responsivity entails that the therapist attends to the patient’s immediate experience in the session. Furthermore, it entails the ability of the therapist to be flexible in the approach to the patient and in addressing the patient’s relational problems, treating them with compassion, understanding and openness. It is crucial that the therapist attends to the patient’s immediate experience in the session in order to make interventions tailored to the patient’s pressing needs. Therefore, the therapist must be in tune with the patient’s feedback, especially, the non-verbal feedback, such as the tone of voice, eye contact, movements and changes of posture. These interpersonal cues are useful to discover whether there is something troubling the patient. However, it is important to take into consideration that for some patients such attention might be felt as intrusive and overwhelming, consequently it would be necessary to negotiate the closeness/distance of the interaction. Thus, a skilled therapist should be flexible to the individual patient and adapt accordingly. For example, with dismissive/avoidant patients the therapist may attempt to slowly and progressively relate to them. On the other hand, anxious/preoccupied patients may need a therapist that tolerates his or her emotional demands and closeness, while also establishing clear boundaries (Binder & Betan, 2012).
Appendix D
Levels of Therapist Competence according to Killingmo et al. (2014)

In reference to strategic thinking, four levels of competence have been defined: (1) strategic thinking, (2) partial strategy, (3) absence of strategy; and, (4) the anti-therapeutic relation. The first category includes the “high” and “low” level of strategic thinking. The partial strategy refers to a therapeutic situation that is characterised by the use of strategic thinking up until a certain moment of the session, in which the therapist steps out of the therapeutic stance. The absence of strategic thinking is distinctive because of the absolute lack of this competence. Finally, the anti-therapeutic relation refers to therapists whose attitudes and/or behaviours are in opposition to the therapeutic aims of dynamic psychotherapy.

Killingmo, Varvin and Strømme (2014) described these different levels of competence through lucid clinical illustrations. In the clinical illustration of the “low” level strategic thinking, the therapist demonstrates her ability to listen and create a therapeutic space by making “m-hm” utterances that co-occur with her ability to listen actively. She displays a soft and calm tone of voice that enables her to contain her patient. Her ability to create a therapeutic space is also enhanced by her considerate manner of asking the patient how he feels in the present or by how different things made him feel in the past. However, the therapist fails to pick up the unconscious aggression of the patient at certain critical points of the session (Killingmo et al., 2014).

In the clinical illustration of “high” level strategic thinking the therapist is capable of making an interpretation that integrates the patient’s two opposing attitudes – knowing and not knowing about her emotional difficulties- picking up accurately the sub-text, the unconscious meanings of the patient’s communications. The therapist does not rush into this formulation she rather meets the patient calmly, not allowing herself to be pressured into the role of a “helper”. The therapist is able to listen in a non-judgmental manner and concurrently to validate and acknowledge the patient’s affects. While listening to the patient, the therapist refrains from reassuring, asking questions or
explaining, and through this allows the patient to have a space in which to express. The therapist is also able to pick up the patient’s expressions that comprise a unique individual meaning, and then use them in mirroring interventions, bringing the level of communication to a deeper level. Furthermore, the therapist’s interventions include an invitation to the patient to examine together the underlying meanings and feelings. This demonstrates to the patient that the therapist does not have all the answers and that therapy entails collaboration. Moreover, the therapist is able to make metaphoric formulations that communicate the subtleties of the patient’s inner experience.

In conclusion, in the “high” level strategic thinking the therapist is capable of creating therapeutic “space” and to pick up the unconscious subtext of the patient’s communications (Killingmo et al., 2014).

In the clinical illustration of partial strategic thinking the therapist is unable of maintaining therapeutic stance throughout the session. The therapist displays strategic thinking by being emotionally close to the patient and intervening accordingly. However, after a certain point, the patient breaks the flow of the dialogue by abruptly talking to herself with no more than clichés. The therapist is incapable to recover the patient from her monotonous repetitions and fails to pick up on the underlying meaning of the communication break and therefore interpret the patient’s resistance. Later in the session, the therapist gives up her role completely, laughing together with the patient and talking to her in a friendly manner. In some way, for emotional or technical reasons, the therapist is unable to maintain a therapeutic stance throughout the session (Killingmo et al., 2014).

In the clinical illustration of absence of strategic thinking the sessions are distinguishable because of their lack of both, associative as well as emotional coherence. The therapist appears to not have a theoretical background based on internalised knowledge from where to make adequate interventions. The therapist is unable to respond accurately either to the content or form of the patient’s communications. The therapist responds to the patient at face value, not encouraging the patient to understand his or her own subjectivity and to reflect on the nuances that may guide the work to unconscious meanings. Moreover, the therapist uses clichés and/or standard everyday comments without giving attention to the patient’s use of language or tone of voice.
Therefore, the sessions are characterised by a lack of affective depth. When making questions, the therapist creates an expectation in the patient that he or she does not meet, activating multiple affects or themes in the patient without expanding or addressing any of them. The dialogue becomes random and without flow, intellectually condescending or resembling more an interview than a therapeutic situation. Furthermore, the therapist turns the session into a social conversation, actively participating in the patient’s life, granting praise, giving advice and taking sides regarding the patient’s problems. Therefore, the therapist loses the chance of reflecting together with the patient by becoming a real object in the patient’s life. At other times, when the patient has a negative transference reaction, the therapist is unable to understand and react properly, giving up the therapeutic role by becoming perplexed and/or passive (Killingmo et al., 2014).

In the anti-therapeutic relation, differently from the “absence of strategy” which does not cause harm, the therapist’s attitudes and behaviours block or distort the therapeutic process in a destructive manner, damaging the patient. In the clinical illustration of an anti-therapeutic relation, the therapist’s mind is fixed in the task of freeing the patient from her feelings of inadequacy and inferiority and therefore throughout the session the therapist attempts to convince the patient that her feelings of devaluation are unfounded. The therapist floods the patient with points of view and advice, taking control of the relationship with the patient impeding her to present herself freely. The patient’s doubts and uncertainties remain unheard. The anti-therapeutic element of this interaction is the fact that the therapist places herself “above” the patient, intensifying the patient’s feelings of inferiority. Thus, the therapist’s interventions have an opposite effect to the one originally intended and probably, repeating a devaluing behaviour that distinguished a frustrating object in the patient’s past. The repetition on the part of the therapist of a destructive pattern from the patient’s past is anti-therapeutic because it hinders the patient from gaining insight, leaving the patient “alone” with his or her problems. In this clinical illustration, where the therapist performs as an “optimistic helper”, suggests that the therapist too has troubles in dealing with feelings of defeat and therefore is an example of how the therapist’s own issues can interfere in the treatment (Killingmo et al., 2014).
In reference to therapist’s emotional and cognitive way of being during the session two main types of attitudes have been described: the professional and the object attitude. The professional attitude is based on what is prescribed by psychoanalytic theory and practice. The object attitude does not have theoretical backing and refers to habitual daily life attitudes on the part of the therapist. Four types of object attitudes and its underlying dynamics have been identified: the “optimist”, the “realist”, the “compassionate” and the “normaliser”. The “optimist” repeatedly ensures the patient that everything will work out fine and encourages the patient to take initiative in the diverse areas of his or her life. The risk of this attitude is that difficult and negative feelings are played down and overlooked while reinforcing positive feelings (Killingmo et al., 2014). The “realist” is the therapist that mainly focuses in the real, external and practical facts without giving much space to the patient’s feelings and unconscious communications. The risk of this attitude is the tendency to give advice and overlook transferential meanings and the patient’s emotions (Killingmo et al., 2014). The “compassionate” therapist is the one that makes empathic interventions and whose tone of voice is motherly and mild when the patient is narrating difficult situations. The risk of this attitude, if its rigidly maintained, is that the therapist’s interventions may be felt by the patient as not genuine and that feelings of irritation and anger on the part of the patient may be overlooked (Killingmo et al., 2014). The “normaliser” is the therapist that reacts to the patient’s feelings and anxieties categorising them as “normal”, understandable and common for what the patient is going through. Through this attitude, the therapist aims to shift the patient’s attention away from his or her emotions, leaving the importance and underlying meanings of the anxiety un-investigated (Killingmo et al., 2014).

It has been suggested that the object attitude adopted by the particular clinician is not arbitrary but comes about from an unconscious identification with the patient. Therefore, on a conscious level, the therapist’s attitude attempts to meet the patient’s needs but, on an unconscious level, it attempts to meet the therapist’s needs due to his/her identification with the patient. Thus, the therapist style throughout the session may be related to his/her defensive functions. However, not all therapists have a specific style, and most of them do not have a consistent pattern of attitudes (Killingmo et al., 2014).
The therapist’s verbal and non-verbal interventions have also been categorized in a number of ways. One of these classifications understands interventions from its psychological meaning and therapeutic potential, categorising them in 4 groups, where the first two represent interventions delivered by competent therapists. The four groups of interventions are: a) interventions that help the patient feel safer; (b) interventions that address the latent content of the patient’s communications; (c) interventions that are futile; (d) interventions that are anti-therapeutic (Killingmo et al., 2014).

The interventions that help the patient feel safer are the ones where the therapist conveys that he or she is present, attentive, listening and interested, leading the patient to open up. These interventions are often non-verbal, including “hmm” sounds and an attuned tone of voice at a proper time. Furthermore, these interventions entail that the therapist is able to stay calm and not become overwhelmed by the patient’s communications (Killingmo et al., 2014).

The interventions that address latent content refer to the introduction, on the part of the therapist, of ideas, feelings or wishes that have hitherto been unconscious for the patient. One of the aims of therapy is for the therapist to be able to make these interventions that bring about a different understanding from the one that is consciously available to the patient. In therapy, the patient’s relational patterns emerge in the transference relationship. In order to make this sort of intervention, the therapist should be attentive to the transference relationship with the patient, which can shed light on the patient’s relational patterns. Firstly, it is necessary that the patient feels understood and safe enough to express his/her struggles. Only then it is possible for the therapist to say something new, adding meaning to the patient’s understanding (Killingmo et al., 2014).

The interventions that are futile are the ones that stop the progress of a therapeutic dialogue. These interventions are usually unrelated to the patient’s material or entail unhelpful questions, clichés, “small talk” or meaningless remarks. Additionally, these interventions involve taking the patient’s communications at face value and not bringing anything new into the conversation. It is essential that the therapist has the conceptual tools to understand the patient’s material and that he/she does not to become
overwhelmed by it. Occasionally, when the therapist is unable to stay away from these interventions, there is a role inversion in the relationship, where the patient senses the inability of the therapist to be in charge of the situation and therefore he/she personalises the role of the therapist (Killingmo et al., 2014).

The anti-therapeutic interventions do not foster the therapeutic process, and are harmful and damaging. The authors’ clinical illustrations of these interventions involved an overly optimistic therapist that signaled to the patient that he/she was the only person who could tackle the patient’s problems, as well as a therapist that did not allow the patient to say what was in his/her mind. Questions such as, “why do you think this is like this?” are demanding and give the patient the feeling that he/she is being tested and must explain himself/herself. The anti-therapeutic component of these examples is that the interventions are in opposition to the goals of therapy. The therapist is unable to accept his/her vulnerabilities and the patient is manipulated into the role of someone that has failed, and whose only salvation could come from following the therapist’s example (Killingmo et al., 2014).
### Appendix E

**Framework of Psychodynamic/Psychoanalytic Competence (Lemma et al., 2008)**

#### GENERIC THERAPEUTIC COMPETENCES

**Knowledge and understanding of mental health problems**

<table>
<thead>
<tr>
<th>Knowledge and understanding of mental health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>During assessment and when carrying out interventions, an ability to draw on knowledge of common mental health problems and their presentation</td>
</tr>
<tr>
<td>An ability to draw on knowledge of the factors associated with the development and maintenance of mental health problems</td>
</tr>
<tr>
<td>An ability to draw on knowledge of the usual pattern of symptoms associated with mental health problems</td>
</tr>
<tr>
<td>An ability to draw on knowledge of the ways in which mental health problems can impact on functioning (e.g. maintaining intimate, family and social relationships, or the capacity to maintain employment and study)</td>
</tr>
<tr>
<td>An ability to draw on knowledge of the impact of impairments in functioning on mental health</td>
</tr>
<tr>
<td>An ability to draw on knowledge of mental health problems to avoid escalating or compounding the client’s condition when their behaviour leads to interpersonal difficulties which are directly attributable to their mental health problem</td>
</tr>
</tbody>
</table>

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1 Reproduced from [https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Psychoanalytic-Psychodynamic-Therapy](https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks/Psychoanalytic-Psychodynamic-Therapy), with permission
Knowledge of, and ability to operate within, professional and ethical guidelines

Knowledge

<table>
<thead>
<tr>
<th>An ability to maintain awareness of national and local codes of practice which apply to all staff involved in the delivery of healthcare, as well as any codes of practice which apply to the therapist as a member of a specific profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to take responsibility for maintaining awareness of legislation relevant to areas of professional practice in which the therapist is engaged (specifically including the Mental Health Act, Mental Capacity Act, Human Rights Act, Data Protection Act)</td>
</tr>
</tbody>
</table>

Application of professional and ethical guidelines

<table>
<thead>
<tr>
<th>An ability to draw on knowledge of relevant codes of professional and ethical conduct and practice in order to apply the general principles embodied in these codes to each piece of work being undertaken, in the areas of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>obtaining informed consent for interventions from clients</td>
</tr>
<tr>
<td>maintaining confidentiality, and knowing the conditions under which confidentiality can be breached</td>
</tr>
<tr>
<td>safeguarding the client’s interests when co-working with other professionals as part of a team, including good practice regarding inter-worker/inter-professional communication</td>
</tr>
<tr>
<td>competence to practice, and maintaining competent practice through appropriate training/professional development</td>
</tr>
<tr>
<td>recognition of the limits of competence and taking action to enhance practice through appropriate training/professional development</td>
</tr>
<tr>
<td>protecting clients from actual or potential harm from professional malpractice by colleagues by instituting action in accordance with national and professional guidance</td>
</tr>
<tr>
<td>maintaining appropriate standards of personal conduct for self:</td>
</tr>
<tr>
<td>a capacity to recognise any potential problems in relation to power and “dual relationships” with clients, and to desist absolutely from any abuses in these areas</td>
</tr>
<tr>
<td>recognising when personal impairment could influence fitness to practice, and taking appropriate action (e.g. seeking personal and professional support and/or desisting from practice)</td>
</tr>
</tbody>
</table>

Ability to work with difference (cultural competence)

<table>
<thead>
<tr>
<th>an ability to maintain an awareness of the potential significance for practice of social and cultural difference, across a range of domains, but including:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ethnicity</td>
</tr>
<tr>
<td>culture</td>
</tr>
<tr>
<td>class</td>
</tr>
<tr>
<td>religion</td>
</tr>
<tr>
<td>gender</td>
</tr>
</tbody>
</table>
For all clients with whom the therapist works, an ability to draw on knowledge of the relevance and potential impact of social and cultural difference on the effectiveness and acceptability of an intervention.

Where social and cultural difference impacts on the accessibility of intervention, an ability to make appropriate adjustments to the therapy, with the aim of maximising its potential benefit to the client.
Knowledge of a model of therapy, and the ability to understand and employ the model in practice

<table>
<thead>
<tr>
<th>An ability to draw on knowledge of factors common to all therapeutic approaches*:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>supportive factors:</strong></td>
</tr>
<tr>
<td>a positive working relationship between therapist and client</td>
</tr>
<tr>
<td>characterised by warmth, respect, acceptance and empathy, and</td>
</tr>
<tr>
<td>trust the active participation of the client</td>
</tr>
<tr>
<td>therapist expertise</td>
</tr>
<tr>
<td>opportunities for the client to discuss matters of concern and to express their feelings</td>
</tr>
<tr>
<td><strong>learning factors:</strong></td>
</tr>
<tr>
<td>advice</td>
</tr>
<tr>
<td>correctional emotional</td>
</tr>
<tr>
<td>experience feedback</td>
</tr>
<tr>
<td>exploration of internal frame of reference</td>
</tr>
<tr>
<td>changing expectations of personal</td>
</tr>
<tr>
<td><strong>effectiveness assimilation of problematic experiences</strong></td>
</tr>
<tr>
<td><strong>action factors:</strong></td>
</tr>
<tr>
<td>behavioural</td>
</tr>
<tr>
<td>regulation</td>
</tr>
<tr>
<td>cognitive mastery</td>
</tr>
<tr>
<td>encouragement to face fears and to take risks</td>
</tr>
<tr>
<td>reality testing</td>
</tr>
<tr>
<td>experience of successful coping</td>
</tr>
</tbody>
</table>

An ability to draw on knowledge of the principles which underlie the intervention being applied, using this to inform the application of the specific techniques which characterise the model

An ability to draw on knowledge of the principles of the intervention model in order to implement therapy in a manner which is flexible and responsive to client need, but which also ensures that all relevant components are included

### Ability to engage client

<table>
<thead>
<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>While maintaining professional boundaries, an ability to show appropriate</td>
</tr>
<tr>
<td>levels of warmth, concern, confidence and genuineness, matched to client</td>
</tr>
<tr>
<td>need</td>
</tr>
<tr>
<td>An ability to engender trust</td>
</tr>
<tr>
<td>An ability to develop rapport</td>
</tr>
<tr>
<td>An ability to adapt personal style so that it meshes with that of the client</td>
</tr>
<tr>
<td>An ability to recognise the importance of discussion and expression of client’s emotional reactions</td>
</tr>
<tr>
<td>An ability to adjust the level of in-session activity and structuring of the session to the client’s needs</td>
</tr>
<tr>
<td>An ability to convey an appropriate level of confidence and competence</td>
</tr>
<tr>
<td>An ability to avoid negative interpersonal behaviours (such as impatience, aloofness, or insincerity)</td>
</tr>
</tbody>
</table>
Ability to foster and maintain a good therapeutic alliance, and to grasp the client’s perspective and ‘world view’*

Understanding the concept of the therapeutic alliance
An ability to draw on knowledge that the therapeutic alliance is usually seen as having three components:
- the relationship or bond between therapist and client
- consensus between therapist and client regarding the techniques/methods employed in the therapy
- consensus between therapist and client regarding the goals of therapy
An ability to draw on knowledge that all three components contribute to the maintenance of the alliance

Knowledge of therapist factors associated with the alliance
An ability to draw on knowledge of therapist factors which increase the probability of forming a positive alliance:
- being flexible and allowing the client to discuss issues which are important to them
- being respectful
- being warm, friendly and affirming
- being open
- being alert and active
- being able to show honesty through self-reflection
- being trustworthy
Knowledge of therapist factors which reduce the probability of forming a positive alliance:
- being rigid
- being critical
- making inappropriate self-disclosure
- being distant
- being aloof
- being distracted
- making inappropriate use of silence

Capacity to develop the alliance
An ability to listen to the client’s concerns in a manner which is non-judgmental, supportive and sensitive, and which conveys a comfortable attitude when the client describes their experience
An ability to ensure that the client is clear about the rationale for the intervention being offered
An ability to gauge whether the client understands the rationale for the intervention, has questions about it, or is skeptical about the rationale, and to respond to these concerns openly and non-defensively in order to resolve any ambiguities
An ability to help the client express any concerns or doubts they have about
Capacity to grasp the client’s perspective and ‘world view’

An ability to apprehend the ways in which the client characteristically understands themselves and the world around them

An ability to hold the client’s world view in mind throughout the course of therapy and to convey this understanding through interactions with the client, in a manner that allows the client to correct any misapprehensions

An ability to hold the client’s world view in mind, while retaining an independent perspective and guarding against identification with the client

Capacity to maintain the alliance

Capacity to recognise and to address threats to the therapeutic alliance (“alliance ruptures“)

An ability to recognise when strains in the alliance threaten the progress of therapy

An ability to deploy appropriate interventions in response to disagreements about tasks and goals:

- An ability to check that the client is clear about the rationale for treatment and to review this with them and/or clarify any misunderstandings
- An ability to help clients understand the rationale for treatment through using/drawing attention to concrete examples in the session
- An ability to judge when it is best to refocus on tasks and goals which are seen as relevant or manageable by the client (rather than explore factors which are giving rise to disagreement over these factors)

An ability to deploy appropriate interventions in response to strains in the bond between therapist and client:

- An ability for the therapist to give and ask for feedback about what is happening in the here-and-now interaction, in a manner which invites exploration with the client
- An ability for the therapist to acknowledge and accept their responsibility for their contribution to any strains in the alliance
- Where the client recognises and acknowledges that the alliance is under strain, an ability to help the client make links between the rupture and their usual style of relating to others
- An ability to allow the client to assert any negative feelings about the relationship between the therapist and themselves
- An ability to help the client explore any fears they have about expressing negative feelings about the relationship between the therapist and themselves

the therapy and/or the therapist, especially where this relates to mistrust or skepticism

An ability to help the client articulate their goals for the therapy, and to gauge the degree of congruence in the aims of the client and therapist
* Sources:
**Ability to deal with emotional content of session**

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>An ability to facilitate the processing of emotions by the client – to acknowledge and contain emotional levels that are too high (e.g. anger, fear, despair) or too low (e.g. apathy, low motivation)</td>
<td></td>
</tr>
<tr>
<td>An ability to deal effectively with emotional issues that interfere with effective change (e.g. hostility, anxiety, excessive anger, avoidance of strong affect).</td>
<td></td>
</tr>
<tr>
<td>An ability to help the client access differentiate and experience his/her emotions in a way that facilitates change</td>
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</tbody>
</table>
## Ability to manage endings

<table>
<thead>
<tr>
<th>Ability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to signal the ending of the intervention at appropriate</td>
<td>The ability to signal the ending of the intervention at appropriate points during the therapy (e.g. when agreeing the treatment contract, and especially as the intervention draws to close) in a way which acknowledges the potential importance of this transition for the client.</td>
</tr>
<tr>
<td>points during the therapy (e.g. when agreeing the treatment contract,</td>
<td></td>
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<tr>
<td>and especially as the intervention draws to close) in a way which</td>
<td></td>
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<tr>
<td>acknowledges the potential importance of this transition for the client</td>
<td></td>
</tr>
<tr>
<td>An ability to help client discuss their feelings and thoughts about</td>
<td>The ability to help client discuss their feelings and thoughts about endings and any anxieties about managing alone.</td>
</tr>
<tr>
<td>endings and any anxieties about managing alone</td>
<td></td>
</tr>
<tr>
<td>An ability to review the work undertaken together</td>
<td>The ability to review the work undertaken together.</td>
</tr>
<tr>
<td>An ability to say goodbye</td>
<td>The ability to say goodbye.</td>
</tr>
</tbody>
</table>
### Ability to undertake a generic assessment

<table>
<thead>
<tr>
<th>Ability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to obtain a general idea of the nature of the client's problem</td>
<td></td>
</tr>
<tr>
<td>Ability to elicit information regarding psychological problems, diagnosis, past history, present life situation, attitude about and motivation for therapy</td>
<td></td>
</tr>
<tr>
<td>Ability to gain an overview of the client’s current life situation, specific stressors and social support</td>
<td></td>
</tr>
<tr>
<td>Ability to assess the client’s coping mechanisms, stress tolerance, and level of functioning</td>
<td></td>
</tr>
<tr>
<td>Ability to help the client identify/select target symptoms or problems, and to identify which are the most distressing and which the most amenable to intervention</td>
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</tr>
<tr>
<td>Ability to help the client translate vague/abstract complaints into more concrete and discrete problems</td>
<td></td>
</tr>
<tr>
<td>Ability to assess and act on indicators of risk (of harm to self or others) (and the ability to know when to seek advice from others)</td>
<td></td>
</tr>
<tr>
<td>Ability to gauge the extent to which the client can think about themselves psychologically (e.g. their capacity to reflect on their circumstances or to be reasonably objective about themselves)</td>
<td></td>
</tr>
<tr>
<td>Ability to gauge the client’s motivation for a psychological intervention</td>
<td></td>
</tr>
<tr>
<td>Ability to discuss treatment options with the client, making sure that they are aware of the options available to them, and helping them consider which of these options they wish to follow</td>
<td></td>
</tr>
<tr>
<td>Ability to identify when psychological treatment might not be appropriate or the best option, and to discuss with the client (e.g. the client’s difficulties are not primarily psychological, or the client indicates that they do not wish to consider psychological issues) or where the client indicates a clear preference for an alternative approach to their problems (e.g. a clear preference for medication rather than psychological therapy)</td>
<td></td>
</tr>
</tbody>
</table>
Ability to make use of supervision

<table>
<thead>
<tr>
<th>An ability to hold in mind that a primary purpose of supervision and learning is to enhance the quality of the treatment clients receive</th>
</tr>
</thead>
</table>

An ability to work collaboratively with the supervisor

| An ability to work with the supervisor in order to generate an explicit agreement about the parameters of supervision (e.g. setting an agenda, being clear about the respective roles of supervisor and supervisee, the goals of supervision and any contracts which specify these factors) |
| An ability to help the supervisor be aware of your current state of competence and your training needs |
| An ability to present an honest and open account of clinical work undertaken |
| An ability to discuss clinical work with the supervisor as an active and engaged participant, without becoming passive or avoidant, or defensive or aggressive |
| An ability to present clinical material to the supervisor in a focussed manner, selecting the most important and relevant material |

Capacity for self-appraisal and reflection

| An ability to reflect on the supervisor’s feedback and to apply these reflections in future work |
| An ability to be open and realistic about your capabilities and to share this self-appraisal with the supervisor |
| An ability to use feedback from the supervisor in order further to develop the capacity for accurate self-appraisal |

Capacity for active learning

| An ability to act on suggestions regarding relevant reading made by the supervisor, and to incorporate this material into clinical practice |
| An ability to take the initiative in relation to learning, by identifying relevant papers, or books, based on (but independent of) supervisor suggestions, and to incorporate this material into clinical practice |

Capacity to use supervision to reflect on developing personal and professional role

| An ability to use supervision to discuss the personal impact of the work, especially where this reflection is relevant to maintaining the likely effectiveness of clinical work |
| An ability to use supervision to reflect on the impact of clinical work in relation to professional development |

Capacity to reflect on supervision quality

<table>
<thead>
<tr>
<th>An ability to reflect on the quality of supervision as a whole, and (in accordance with national and professional guidelines) to seek advice from others where:</th>
</tr>
</thead>
<tbody>
<tr>
<td>there is concern that supervision is below an acceptable standard</td>
</tr>
</tbody>
</table>
where the supervisor’s recommendations deviate from acceptable practice
where the supervisor’s actions breach national and professional guidance
### BASIC ANALYTIC/DYNAMIC COMPETENCES

**Knowledge of the basic principles and rationale for analytic/dynamic therapy**

#### Knowledge of developmental theory
- An ability to draw on knowledge of the developmental factors that shape an individual’s experience of themselves and others (i.e. the importance of early relationships/attachments).
- An ability to draw on knowledge of the different types of personality organisations (i.e. neurotic, borderline, psychotic).
- An ability to draw on knowledge of the operation of defences throughout development.
- An ability to draw on knowledge of developmental psychopathology.

#### Knowledge of an analytic/dynamic model of the mind
- An ability to draw on knowledge that we have a conscious as well as a dynamically unconscious mental life.
- An ability to draw on knowledge of the different structures of the mind (ego, id, superego) and their contribution to personality development.
- An ability to draw on knowledge of an unconscious inner world of object-relations that:
  - mediates the way people experience themselves and others
  - informs how people act in the external world.
- An ability to draw on knowledge of, and respect for, the importance of the client’s imaginative life (e.g. unconscious fantasies, dreams, metaphors) as a vehicle for understanding their unconscious experience of themselves and others.

#### Knowledge of the core principles of an analytic/dynamic therapeutic approach
- An ability to draw on knowledge of the affective and interpersonal focus of the therapy.
- An ability to draw on knowledge of the rationale for closely tracking the therapeutic process (i.e. attending closely to micro-processes in the therapeutic relationship so as gain a detailed understanding of the client’s internal world of relationships and conflicts).
- An ability to draw on knowledge of the rationale for adopting a primarily receptive (i.e. non directive) stance in relation to the client’s communications so as to facilitate
An ability to draw on knowledge of the importance of maintaining an open mind throughout therapy (avoiding premature closure and tolerating 'not knowing', so as to avoid imposing assumptions about the client’s difficulties or the direction of treatment).

An ability to draw on knowledge that the alleviation of symptoms is not normally regarded as the primary target of the therapy, but is considered to be the outcome of an understanding of their unconscious meaning.
### Ability to undertake an assessment of likely suitability of analytic/dynamic therapy

#### Knowledge

<table>
<thead>
<tr>
<th>An ability to draw on knowledge that pre-therapy client characteristic are not significantly predictive of therapy success:</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to draw on knowledge of factors that may be pertinent to the ways in which an analytic/dynamic approach is applied/needs to be adapted to meet the client’s needs:</td>
</tr>
<tr>
<td>the client’s response to an exploratory approach (e.g. their response to a relative lack of therapist direction, indicators of an interest in reflection)</td>
</tr>
<tr>
<td>the client’s interest in reflecting on how their relationships with others work</td>
</tr>
<tr>
<td>the client’s interest in working with interpersonal and affective themes</td>
</tr>
<tr>
<td>the client’s curiosity about their role in their difficulties</td>
</tr>
<tr>
<td>the risk to the client of connecting with painful feelings and/or memories, which could be difficult for them to manage (e.g. increasing risk to themselves) balanced against the benefits of exploring issues in therapy</td>
</tr>
<tr>
<td>the external resources that could support the client during the therapy</td>
</tr>
<tr>
<td>the therapist’s experience with the client in the session</td>
</tr>
</tbody>
</table>

An ability to draw on practice-based knowledge of the contra-indications for brief and more intensive analytic/dynamic therapy (e.g. risk of exacerbation of problems)

An ability to draw on knowledge of other psychological therapies as the basis for considering more suitable alternatives for the client

#### Application

**Frame for the assessment**

<table>
<thead>
<tr>
<th>An ability to approach the assessment with an analytic attitude so as to observe the client’s interaction with the therapist and evaluate what adaptations may be necessary to support the client’s capacity to work within an analytic frame:</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to balance the need to gather information about the client and their difficulties against the requirement to assess how they manage without therapist imposed direction in the session</td>
</tr>
</tbody>
</table>
An ability to realistically consider, with the client, their capacity to work within an analytic frame in the context of an assessment of potential risk (e.g. increase in self-harming behaviour)

**Listening: content and process**

| An ability to listen both to the content of the client’s narrative while taking into account the way in which they present themselves (e.g. non-verbal communications) |
| An ability for the therapist to identify the emotional impact the client’s presentation: has on them |
| an ability to appraise the potential significance of the therapist’s response to understanding the client’s interpersonal patterns |
### Intervention

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to engage the client’s interest in this therapeutic approach by making interpretations that connect the client’s presenting difficulties/symptoms to their past and current relationships and behaviour.</td>
</tr>
<tr>
<td>An ability to evaluate the client’s readiness and motivation at this point in time to engage with the affective and interpersonal focus of the therapy through relevant questions and interpretations (e.g. a “trial interpretation”).</td>
</tr>
<tr>
<td>An ability to formulate the dominant transference theme(s) that emerge in the assessment so as to gauge how the client responds to a transference focus.</td>
</tr>
<tr>
<td>An ability to help the client reflect on their experience of the assessment by articulating their conscious and unconscious experience of it.</td>
</tr>
</tbody>
</table>

### Ability to identify and take account of external resources available to the client and to the therapist when planning interventions

<table>
<thead>
<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>An ability to inform the therapeutic plan and consider the need for additional resources by exploring the client’s external resources (e.g. sources of support, stability of housing, etc).</td>
</tr>
<tr>
<td>An ability to appraise the appropriateness of the setting in which the therapy will be offered relative to the client’s needs (e.g. for additional support from other professionals).</td>
</tr>
</tbody>
</table>
Ability to engage the client in analytic/dynamic therapy

Ability to develop a therapeutic alliance

<table>
<thead>
<tr>
<th>An ability to respond to the client’s presenting problems in a concerned, non-judgemental manner through:</th>
</tr>
</thead>
<tbody>
<tr>
<td>allowing the client’s narrative about their difficulties to emerge without imposing a structure</td>
</tr>
<tr>
<td>asking clarifying questions so as to understand the client’s perspective without making assumptions</td>
</tr>
<tr>
<td>communicating empathic understanding in response to the client’s conscious and unconscious communications</td>
</tr>
<tr>
<td>respecting the client’s need for defences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An ability to foster the development of a working relationship of trust and rapport through:</th>
</tr>
</thead>
<tbody>
<tr>
<td>containing the client’s level of anxiety by engaging with the client’s conscious and unconscious anxieties about the therapy and the therapist</td>
</tr>
<tr>
<td>tolerating the client’s distress and other feelings in order to remain emotionally attuned to them</td>
</tr>
<tr>
<td>adjusting technique with those clients who are unproductively disturbed by a more passive stance in the early stages of therapy</td>
</tr>
<tr>
<td>communicating the boundaries and frame of the therapy clearly</td>
</tr>
<tr>
<td>providing some brief guidance on the differential expectations of both therapist and client (e.g. to say what comes to mind) so as to orient the client to the particular style of therapy</td>
</tr>
<tr>
<td>assessing which clients may require a strengthening of the supportive aspects of the therapeutic relationship in an explicit manner so as to engage them</td>
</tr>
</tbody>
</table>

Ability to help the client understand the rationale for analytic/dynamic therapy

<table>
<thead>
<tr>
<th>An ability to provide the client with sufficient direct information about the therapy (including its risks and benefits) so as to make consent meaningful</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to use the assessment session(s) to give the client an experience of an analytic/ dynamic approach and the challenges this might present for them, for example through:</td>
</tr>
<tr>
<td>showing interest in, and commenting on, the client’s unconscious communications, especially about the relationship with the therapist</td>
</tr>
<tr>
<td>conveying an understanding of how the client’s presenting symptoms/problems may be connected with unconscious feelings and...</td>
</tr>
<tr>
<td>conflicts</td>
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<tr>
<td>------------------------</td>
</tr>
<tr>
<td>An ability to encourage the client to reflect on their reactions to the proposed therapy and its focus (i.e. primarily on feelings and relationships)</td>
</tr>
</tbody>
</table>
**Ability to identify and agree therapeutic aims**

<table>
<thead>
<tr>
<th>An ability to share a tentative account of how the therapist understands the client’s problems early on in the therapy so as to provide the client with an opportunity to ask questions, clarify and agree therapeutic aims</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to engage the client in articulating the aims for the therapy through:</td>
</tr>
<tr>
<td>enquiring explicitly about what the client hopes to achieve</td>
</tr>
<tr>
<td>communicating understanding that in addition to the stated aims there might be less conscious aims</td>
</tr>
<tr>
<td>communicating understanding of the client’s resources and vulnerabilities in relation to the stated aims</td>
</tr>
<tr>
<td>helping the client to reflect on their expectations of therapy so as to introduce some realism about what might and might not be achievable</td>
</tr>
</tbody>
</table>
# Ability to derive an analytic/dynamic formulation

## Knowledge

An ability to draw on knowledge that a psychodynamic formulation takes into account the respective contribution of:

- relevant developmental deficits (including early traumata)
- unconscious conflicts, including unconscious anxieties and the defences associated with their management (and which may “oppose” change and pose challenges to the therapy)
- recurring interpersonal patterns and expectations of others
- areas of resilience

An ability to draw on knowledge that the formulation will be informed by the therapist’s observations about the quality of:

- the client’s presentation of their narrative
- the client’s relationship with the therapist in the session

An ability to draw on knowledge that formulation is not a “once-and-for-all” process, but requires regular revision in light of client feedback and the therapist’s evolving understanding of the client over time.

## Application

### Ability to derive an analytic/dynamic formulation

An ability to be curious about the client’s subjective experience

An ability to identify recurring interpersonal themes through:

- relevant questions and observations
- reflection on the transference-countertransference themes that emerge in the session

An ability to develop hypotheses about:

- the unconscious meaning of the client’s presenting symptoms
- the significance of the therapist’s emotional response(s) to the client

An ability to bring together information directly provided by the client, as well as the experiential information derived from the here-and-now of the therapeutic interaction, to arrive at a provisional formulation of the client’s difficulties.

### Ability to elaborate and agree the formulation with the client

An ability to work collaboratively with the client to promote a sense of agency and participation in arriving at a formulation that is meaningful to them:

- an ability to communicate in a clear manner the therapist’s understanding of the client’s experience and difficulties
- an ability to engage the client in responding to the therapist’s formulation and
elaborating it or revising it

<table>
<thead>
<tr>
<th>An ability to ascertain the formulation's relevance and/or any threats it poses to the client's equilibrium from their response to it.</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to revise the formulation (and hence the focus of the therapy) in light of new evidence and/or the client's response to the therapy</td>
</tr>
</tbody>
</table>
Ability to establish and manage the therapeutic frame and boundaries

Knowledge

An ability to draw on knowledge that the therapist’s boundaries and those of the therapeutic frame will have an idiosyncratic meaning for the client and that this will inform how the client experiences the frame and any changes to it.

An ability to draw on knowledge that the physical setting of the therapy room is invested with an affective charge that is linked to the relationship with the therapist.

Knowledge that planned and unplanned interruptions in the treatment may impact on the client and that this requires acknowledgement and understanding when it occurs:

- knowledge of the dynamics of separation, loss and mourning as the basis for understanding the client’s subjective experience of breaks during the treatment.

Application

Ability to establish and maintain a consistent therapeutic frame

An ability to establish clear parameters within which the treatment will take place (setting; frequency and length of sessions; use of the couch where applicable; limits of confidentiality; expectations of the client [e.g. that they will say what comes to mind/bring dreams etc]; arrangements/cover over breaks).

An ability to maintain consistency in relation to the agreed parameters and therapeutic stance so as to create a stable and secure setting for the client through:

- maintaining the therapist’s analytic attitude
- being alert to the meaning to the client of any changes to the agreed setting, whether planned or unplanned
- helping the client to explore their experience of any changes
- attending to and interpreting the therapist’s understanding of the client’s experience of separations/discontinuities in the treatment frame

An ability to be receptive to the client’s conscious and unconscious experience of the setting and its boundaries and to help the client to articulate this experience so as to:

- ensure that the client’s agreement to the therapy and its boundaries is rooted in an exploration of their conscious and unconscious feelings and fantasies about the therapy.
identify early transference patterns that will form the basis for eventual interpretations

### Ability to manage deviations from the established therapeutic frame

| An ability to evaluate the meaning of the client’s requests for modifications to the parameters of the therapy as the basis for responding to such requests |
| An ability to help the client explore unverbalised feelings and unconscious conflicts to counter the pressure to act out and so protect the viability of the therapy |
| An ability to maintain (or regain) a reflective stance when managing forms of acting out in relation to the setting (by the client, therapist or both) |
| An ability to set clear limits where necessary (e.g. if the client’s behaviour undermines the viability of the treatment) |
**Ability to manage interruptions in the treatment**

| An ability to prepare the client for planned interruptions (e.g. holiday breaks) in the treatment by helping them explore their conscious and unconscious responses to breaks |
| An ability to assess risk during breaks in the treatment and to make arrangements for additional support when required |
### Ability to work with unconscious communication

#### Knowledge

| An ability to draw on knowledge that a client’s manifest communications may contain a latent meaning |
| An ability to draw on knowledge that the latent content of any communication may at times only become manifest indirectly through the emotional impact the communication has on the therapist |
| Knowledge of the principle that unconscious communication is more likely to emerge in the absence of therapist-imposed structure, and that remaining silent can facilitate this |

#### Application

##### Ability to facilitate unconscious communication

| An ability to allow the emergence of spontaneous communication of feelings, thoughts, fantasies, daydreams or dreams so as to gain access to the client’s imaginative world by: |
| allowing the client to talk without imposing any formal structure or direction in the sessions (e.g. by using questions infrequently) |
| communicating understanding to the client of the internal obstacles to free association |

| An ability to tolerate uncertainty and ambiguity when trying to understand the client’s communications so as to not foreclose exploration through: |
| helping the client explore their feelings about not being understood or helped (e.g. when the therapist does not provide practical advice) |
| understanding and managing the therapist’s own feelings of anxiety about ‘not knowing’ (e.g. about being perceived to be incompetent) |

##### Ability to listen to unconscious communication

| An ability to pay attention to the client’s imaginative life and to use its manifestations (e.g. conscious and unconscious fantasies, dreams, metaphors) to further the understanding of the client, and hence as the basis for a more focused interpretation |
| An ability to note, and reflect upon, the latent meaning conveyed through non-verbal communications (e.g. tone of voice, body posture etc) |
An ability to allow the therapist’s own subjective associations and ideas to form in response to the client's communications
### Ability to respond to unconscious communication

| Ability to prioritise process over content when responding to the client’s communications |
| Ability to consider the potential latent content in the client’s communications by: |
| being curious about what anxieties may lie behind the client’s questions, even if ostensibly ‘sensible’, and drawing the client’s attention to these |
| identifying and helping the client to reflect on unverbalised feelings |
| An ability to consider the possible meaning of the therapist’s own emotional reactions to the client as a basis for an intervention |
| An ability to help the client elaborate on their idiosyncratic use of language/imagery/dreams, with the aim of facilitating the experience and expression of their feelings and states of mind. |

### Ability to tolerate and make judicious use of silence

| Ability to tolerate and allow silence so as to permit the emergence of the client’s uninterrupted flow of associations and communications |
| An ability to resist interpersonal pressure to break silences (e.g. by asking questions) |
| An ability to manage the anxiety evoked in the therapist by silences |
| An ability to communicate to the client an understanding of the anxiety silence can generate, rather than responding directly by filling the silence |
| An ability to monitor the client’s level of anxiety in response to silence, and limit silences if the client’s anxiety risks undermining engagement with the therapy by: |
| interpreting the anxiety |
| increasing the therapist’s level of activity when appropriate |
| An ability to engage the client in exploring the unconscious meaning of silences as they occur in a session: |
| exploring the client’s use of silence in the session |
| exploring the client’s response to the therapist’s use of silence |
### Ability to help the client explore the unconscious dynamics influencing their relationships

#### Knowledge

| An ability to draw on knowledge that the origins of the client’s difficulties will normally lie in their early relational experiences |
| An ability to draw on knowledge that both internal and external forces shape the mind and therefore inform our perception of ourselves in relationships with others |
| An ability to draw on knowledge that unconscious projective and introjective processes underpin the client’s subjective experience of their relationships |

#### Application

**Ability to formulate the client’s internal world of relationships (as the basis for helping them to understand their subjective experiences of relationships)**

| An ability to listen out for recurring interpersonal and affective patterns in the client’s past and current relationships: |
| an ability to identify recurring configurations of ‘self’ and ‘other’ representations |
| an ability to identify areas of omission from the client’s descriptions of their relationships (e.g. a pervasive absence of conflict) |
| An ability to make use of the experience and observation of the client’s ways of relating within the session to inform the understanding of the client’s internal world of relationships |

**Ability to help the client explore their feelings when in a relationship**

| An ability to help the client identify and understand recurring affective patterns in their relationships, particularly by exploring how these play out in the relationship with the therapist |

**Ability to help the client explore the defences mobilised in relationships**

| An ability to help the client identify areas of difficulty in their relationships |
| An ability to help the client understand the unconscious strategies they use to manage areas of difficulty in their relationships |
Ability to help the client become aware of unexpressed or unconscious feelings

Knowledge

| An ability to draw on knowledge that the client may be troubled by feelings and experiences other than those which they consciously report |

Application

Ability to facilitate the expression of unexpressed or unconscious feelings by:

| communicating to the client that their feelings can be tolerated and thought about by the therapist (i.e. through the therapist’s understanding, empathic stance) |
| responding to non-verbal cues by the client and linking these to unexpressed or unconscious feelings |

Ability to engage the client in exploring unexpressed or unconscious feelings

An ability to help the client put into words what they feel, or fear feeling, by:

| enquiring into the subjective meaning of the client’s use of particular words, dreams, fantasies or non-verbal behaviours |
| encouraging the client to stay with a current feeling as it emerges in the session and to articulate what they are experiencing |

An ability to help the client explore internal and interpersonal obstacles to the awareness, and expression, of particular feelings (especially in the context of the relationship with the therapist).
## Ability to maintain an analytic/dynamic focus

### Knowledge

An ability to draw on knowledge that ‘maintaining an analytic focus’ describes two distinct activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>maintaining the primary focus on the exploration of the client’s unconscious experience (i.e. maintaining an analytic attitude)</td>
<td></td>
</tr>
<tr>
<td>remaining focused on a particular theme to the relative exclusion of others for the duration of the therapy (which typically applies to brief therapeutic approaches)</td>
<td></td>
</tr>
</tbody>
</table>

### Application

#### Ability to approach all aspects of the work with an analytic attitude

<table>
<thead>
<tr>
<th>Ability to approach all aspects of the work with an analytic attitude</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to stay focused on:</td>
<td>exploring the client’s unconscious, “internal world” of relationships</td>
</tr>
<tr>
<td></td>
<td>identifying and responding to the transference and countertransference</td>
</tr>
<tr>
<td>An ability to prioritise the focus of the interventions on the here-and-now therapeutic interaction:</td>
<td>an ability to identify when such a focus is not appropriate so as to attend to other material that carries a strong affective charge</td>
</tr>
</tbody>
</table>

#### Ability to “track” a specific dynamic theme/conflict

<table>
<thead>
<tr>
<th>Ability to “track” a specific dynamic theme/conflict</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to relate the content of interventions to the interpersonal and affective themes and unconscious conflicts that the formulation identifies as the focus of the therapy</td>
<td></td>
</tr>
<tr>
<td>An ability to help the client explore themes relevant to the agreed focus through the use of techniques such as clarification, confrontation and interpretation</td>
<td></td>
</tr>
<tr>
<td>An ability to work on the agreed focus by exploring the vicissitudes of the therapeutic relationship:</td>
<td>an ability to help the client identify relevant interpersonal and affective patterns through exploration of interpersonal narratives and (where relevant) their elaboration in the transference</td>
</tr>
<tr>
<td>An ability to help the client identify and explore the meaning of diversions away from the agreed focus (e.g. because it is too painful to address)</td>
<td></td>
</tr>
</tbody>
</table>
## Ability to identify and respond to difficulties in the therapeutic relationship

### Knowledge

| An ability to draw on knowledge that a degree of resistance to the painful nature of exploratory therapy is normal, and to be expected in everyone |
| An ability to draw on knowledge that difficulties in the therapeutic relationship may reflect the operation of the client’s defences |
| An ability to draw on knowledge of the reasons for “negative therapeutic reactions” and “flight into health” |
| An ability to draw on knowledge that enactments are inevitable and require the therapist to work to regain a reflective stance |

### Application

**Ability to engage the client in understanding the meaning of difficulties between themselves and the therapist**

<table>
<thead>
<tr>
<th>An ability to identify therapeutic ruptures or impasses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>an ability to engage with the client in understanding what is felt to have gone wrong in the therapeutic relationship, through:</td>
</tr>
<tr>
<td>conveying to the client that the relationship with the therapist is something they can discuss</td>
</tr>
<tr>
<td>responding non-defensively to the client’s negative experience of the therapeutic work and of the therapist</td>
</tr>
<tr>
<td>helping the client understand the emotional impact of the work, including the impact of the therapist’s interventions (e.g. the client’s experience of empathic failure as an abandonment)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An ability to facilitate the client’s involvement in making sense of the interpersonal behaviours that express opposition to the therapist through:</th>
</tr>
</thead>
<tbody>
<tr>
<td>helping the client understand that the therapeutic relationship (like any relationship) operates at different levels such that positive and uncomfortable/negative feelings towards the therapist can co-exist</td>
</tr>
<tr>
<td>drawing the client’s attention to the feelings they may be trying to avoid</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An ability to recognise the importance of working with the negative transference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>an ability to make use of ruptures or impasses in the therapy as opportunities for expanding the understanding of the client’s subjective experience and of their difficulties</td>
</tr>
</tbody>
</table>
### Ability to reflect on the therapist's contribution to difficulties in the therapeutic relationship

<table>
<thead>
<tr>
<th>Ability</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to engage in self-reflection to clarify the therapist’s possible contribution to</td>
</tr>
<tr>
<td>a difficulty in the therapy and to understand its meaning</td>
</tr>
<tr>
<td>An ability to consider the respective contributions of the therapist and the client to the</td>
</tr>
<tr>
<td>client’s perception of the therapist</td>
</tr>
<tr>
<td>An ability to distinguish between instances when resistance to therapy is a manifestation</td>
</tr>
<tr>
<td>of the client’s difficulties and instances when the client is responding to an accurate</td>
</tr>
<tr>
<td>perception of differences of opinion between themselves and the therapist</td>
</tr>
<tr>
<td>Where the therapist identifies their contribution to a therapeutic impasse, an ability to</td>
</tr>
<tr>
<td>consider the most helpful way of using this awareness to resolve the impasse (e.g. by</td>
</tr>
<tr>
<td>openly acknowledging an error)</td>
</tr>
<tr>
<td>An ability to identify the need for supervision/further personal therapy in order to</td>
</tr>
<tr>
<td>protect the client’s therapy</td>
</tr>
</tbody>
</table>
### Ability to work with the client’s internal and external reality

#### Knowledge

An ability to draw on knowledge that analytic/dynamic approaches privilege the exploration of the client’s internal, unconscious world of experience, but that this is not at the expense of the exploration of, and sensitivity to, the client’s external reality and value systems.

#### Application

**Ability to balance working with the client’s internal and external reality**

<table>
<thead>
<tr>
<th>An ability to attend and respond to the conscious as well as the unconscious meaning of the client’s preoccupations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>an ability to respond sensitively to the client’s current preoccupations and distress</td>
</tr>
<tr>
<td>an ability to evaluate when it is most productive to focus primarily on the client’s external or internal reality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An ability to help the client to make connections between their current, real-life preoccupations and their unconscious internal world of subjective experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to respond openly and respectfully to the client’s conscious and unconscious experience of race, culture, religion, age, gender and sexual orientation:</td>
</tr>
<tr>
<td>an ability to explore for the client the meaning of their cultural, ethnic, socio-economic and religious background as well as their gender and sexuality</td>
</tr>
<tr>
<td>an ability to explore the relationship, if any, between the client’s external context and values and their difficulties</td>
</tr>
</tbody>
</table>

**Ability to work with differences between the therapist and client**

<table>
<thead>
<tr>
<th>An ability to be curious about the meaning and impact of differences in race, culture, age, socio-economic status, religion, gender and sexuality between therapist and client</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to respond openly and sensitively to the client’s experience of difference in the therapeutic relationship</td>
</tr>
<tr>
<td>An ability to explore with the client the unconscious use that may be made of actual differences between therapist and client</td>
</tr>
<tr>
<td>An ability to be aware of, and reflect on, the significance of the therapist’s countertransference in relation to difference(s)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>An ability to critically self-reflect on assumptions, biases and prejudices that may be operating consciously and unconsciously in the therapist with respect to difference(s)</td>
</tr>
</tbody>
</table>
### SPECIFIC ANALYTIC/DYNAMIC TECHNIQUES

#### Ability to make dynamic interpretations

**Knowledge**

<table>
<thead>
<tr>
<th>An ability to draw on knowledge of unconscious processes to help the client become cognisant of aspects of emotional and interpersonal experience that lie outside their immediate awareness, and that are a source of conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to draw on knowledge that the process of interpretation is collaborative, so that the therapist:</td>
</tr>
<tr>
<td>- draws on their experience of the here-and-now relationship with the client</td>
</tr>
<tr>
<td>- relates to their interpretations as hypotheses to be tested with the client</td>
</tr>
<tr>
<td>- makes it clear to the client how they arrived at the interpretation</td>
</tr>
<tr>
<td>- is open to client feedback about the helpfulness or otherwise of an interpretation.</td>
</tr>
<tr>
<td>An ability to draw on knowledge that interpretation is best seen as a process (i.e. based on a series of interventions over time, rather than on a single comment):</td>
</tr>
<tr>
<td>- an ability to draw on knowledge of the use of clarification and confrontation to gradually bring feelings, fantasies and behaviours to the client’s attention and as the basis for eventually making an interpretation</td>
</tr>
<tr>
<td>- an ability to draw on knowledge that interpretations are hypotheses formulated over time and are normally shared with the client gradually</td>
</tr>
<tr>
<td>- an ability to draw on knowledge that the process of interpretation aims not only to capture the client’s conscious and unconscious experience, but also to introduce a new perspective on their experience</td>
</tr>
<tr>
<td>- an ability to draw on knowledge that the work of interpretation is not a once-and-for-all process but requires ‘working through’ to enable the client to gradually apply their understanding of themselves</td>
</tr>
<tr>
<td>An ability to draw on knowledge that the aims of interpreting are manifold:</td>
</tr>
<tr>
<td>- to bring together disparate aspects of the client’s experience</td>
</tr>
<tr>
<td>- to bring unconscious conflicts and fantasies to consciousness</td>
</tr>
<tr>
<td>- to provide the client with an experience of another person who can think about their experience</td>
</tr>
<tr>
<td>- to contain anxiety</td>
</tr>
</tbody>
</table>
## Application

### Focus of interpretation
An ability to maintain the primary focus of interpretations on:

<table>
<thead>
<tr>
<th>dynamically unconscious content</th>
</tr>
</thead>
<tbody>
<tr>
<td>the client’s interpersonal and affective experiences.</td>
</tr>
</tbody>
</table>

An ability to communicate to the client an interpretation that captures multiple levels of meaning (i.e. it goes beyond what the client consciously reports feeling).

### Process of interpretation
An ability to integrate information gathered from various sources (e.g. accounts of external events, relationship with the therapist, countertransference reactions) to arrive at hypotheses regarding unconscious processes.

An ability to help the client to explore and become more aware of painful conflicts by pointing out unacceptable or uncomfortable feelings (that are otherwise managed by being kept out of the client’s conscious awareness).

An ability to draw the client’s attention to communication that is unclear, vague, puzzling or contradictory, with the aim of encouraging the client to elaborate on these elements.

An ability to help the client become aware of incongruent elements in their communication:

- by pointing out and giving meaning to discrepancies and incongruities in what is being communicated through different “channels” (e.g. a contrast between verbal and non-verbal communication)
- by bringing together conscious, pre-conscious and unconscious material that the client may be experiencing separately.

An ability to consider the potential latent content in the client’s communications through:

- being curious about what anxieties may lie behind the client’s questions, even if ostensibly legitimate, and to draw the client’s attention to these
- identifying and pointing out to the client unverbalised affect when it is manifested in the session

An ability to share with the client an interpretation in a manner that is:

- **clear** (i.e. succinct enough for the client to be able to take in what is being said)
- **appropriately timed** a) in relation to an assessment of what the client can bear to think about at any given point and b) relative to the amount of time left in a session (i.e. not introducing new topics that may be unsettling to the client too close to the end of a session)
of appropriate depth (i.e. moving gradually from pre-conscious content to more unconscious content)

*pertinent* to the affective and/or interpersonal focus of the session
### Client's experience of interpretations

<table>
<thead>
<tr>
<th>An ability to assess the client’s capacity to make use of an interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to critically appraise the helpfulness and correctness of an interpretation:</td>
</tr>
<tr>
<td>by listening to the client’s conscious and unconscious response to the interpretation</td>
</tr>
<tr>
<td>by responding non-defensively to the client’s experience of an interpretation (including disagreement with it)</td>
</tr>
<tr>
<td>by incorporating this into an ongoing process of evaluation.</td>
</tr>
</tbody>
</table>
Ability to work in the transference

Knowledge

An ability to draw on knowledge that a transference interpretation makes explicit reference to the client-therapist relationship so as to elucidate and encourage a joint exploration of the client’s deficits and/or conflicts.

An ability to draw on knowledge that working in the transference relies primarily on interpreting the current relationship between therapist and client (i.e. as opposed to interpreting the childhood origins of the client’s current interpersonal patterns).

An ability to draw on knowledge that the transference can take many forms (e.g. positive, idealised, negative, sexualised).

An ability to draw on knowledge of the rationale and features of the analytic setting and stance that encourage the development of the transference.

An ability to draw on knowledge of the emotional impact of transference interpretations on the client so that their use is “titrated” in a manner that reflects the client’s capacity to receive them.

An ability to draw on knowledge that the interpretation of transference is core to an analytic/dynamic approach, but that the therapist also needs to acknowledge and explore other relationships and salient events in the client’s life.

Application

Ability to facilitate the client’s exploration of the therapeutic relationship

An ability to encourage the client to discuss and explore:

- their perceptions of, and feelings about, the therapist
- how they think the therapist may feel or think about them

An ability to accept the client’s view of the therapist so as to allow a particular experience of the client’s self in relationship to the therapist to emerge in the session.

Ability to maintain the focus of exploration on the transference relationship

An ability to help the client explore recurring patterns in their relationship to the therapist.

An ability to help the client make links and draw parallels between their subjective experience with others outside the therapy (past and present) and with the therapist (and vice versa).
An ability to re-establish a focus onto the transference relationship when the client, therapist (or both) are unproductively pulled away from reflecting on the "here-and-now" of the therapeutic relationship.
**Ability to understand and help the client manage the emotional impact on them of the transference relationship**

<table>
<thead>
<tr>
<th>Ability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to help the client understand an increase in their positive or negative feelings towards the therapist that may result from the transference to the therapist</td>
<td></td>
</tr>
<tr>
<td>An ability to address and help the client understand the meaning of erotic feelings they may experience towards the therapist</td>
<td></td>
</tr>
<tr>
<td>An ability to recognise the client’s need to 'test' the relationship with the therapist in the transference and to communicate this understanding to the client</td>
<td></td>
</tr>
</tbody>
</table>

**Ability to respond non-defensively and flexibly to the client’s experience of a transference interpretation**

<table>
<thead>
<tr>
<th>Ability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to evaluate the impact of a transference interpretation at any given point in time in light of:</td>
<td></td>
</tr>
<tr>
<td>the client's conscious and unconscious response to the interpretation (e.g. what associations/understandings follow an interpretation)</td>
<td></td>
</tr>
<tr>
<td>the therapist’s evaluation of the quality of the working alliance following an interpretation (i.e. a strengthening or weakening of the alliance)</td>
<td></td>
</tr>
<tr>
<td>the client’s level of distress following an interpretation</td>
<td></td>
</tr>
<tr>
<td>An ability to be open to the client’s view that the interpretation may be incorrect or badly timed and to respond to this non-defensively</td>
<td></td>
</tr>
</tbody>
</table>

**Ability to use the therapist’s experience of the transference**

<table>
<thead>
<tr>
<th>Ability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to use the therapist’s experience of the transference in order to inform their understanding of:</td>
<td></td>
</tr>
<tr>
<td>the client’s patterns of relating and of their defences</td>
<td></td>
</tr>
<tr>
<td>the client’s capacity to work <em>in</em> the transference (i.e. to make use of transference interpretations)</td>
<td></td>
</tr>
</tbody>
</table>
### Ability to work with the countertransference

### Knowledge

An ability to draw on knowledge that countertransference reactions are variously determined by:

- the therapist’s ordinary emotional response to the client’s predicament
- the therapist’s own transference to the client
- the client’s projections into the therapist

An ability to draw on knowledge that enactments (by the client, therapist or both) are inevitable in the course of treatment and require understanding so as to regain a reflective stance:

- knowledge of the possible sources of countertransference to understand and manage the pull towards immediate action or enactment of particular roles with a client

### Application

**An ability to make use of the therapist’s responsiveness to the client as the basis for interpretation**

An ability to attend to the specific quality of the feelings, thoughts, flow of associations and fantasies that are evoked in the therapist during the exchanges with the client so as to hypothesise about what the client may be expressing indirectly.

An ability to be open to experiencing transitory identifications with the client’s projections (e.g. of particular roles) through:

- allowing the client to view the therapist in a manner incongruent with the therapist’s own self-perception, so as to understand the meaning of this for the client (i.e. not interpreting this prematurely)
- being receptive to the client’s conscious and unconscious needs and wishes in relation to the therapist

An ability to appraise the relevance of the therapist’s own thinking about, and affective responses to, the client and to use this as a basis for an interpretation of what the client may be struggling to articulate explicitly

**An ability to reflect on the therapist’s involvement in the therapeutic process**

An ability for the therapist to reflect on their emotional reactions to the client so as to maintain an “observing distance” from the part of themselves that is involved in the
An ability to recognise erotic feelings towards the client and to think through the meaning and implications for the therapist and for their relationship with the client

An ability for the therapist to critically consider the meaning of their emotional reactions to the client so as to minimise the risk of unsubstantiated speculation or of misattributing to the client feelings that belong to the therapist:

| an ability for the therapist to identify personal need for further therapy/supervision. |
# Ability to recognise and work with defences

## Knowledge

| An ability to draw on knowledge that all individuals deploy defences to manage uncomfortable and painful feelings, states of mind (e.g. the experience of dependency) and forbidden impulses |
| An ability to draw on knowledge that defences have both adaptive and maladaptive functions |
| An ability to draw on knowledge that defences are often unconscious mental processes that distort reality, and that they: |
| may exclude a feeling or thought from consciousness altogether |
| may consciously admit the disturbing feeling /thought but detach it from its emotional significance |
| may substitute one feeling for another |
| may distort or confuse the perception of self and others (thus fundamentally altering perceptions of external and internal reality) |
| An ability to draw on knowledge that any behaviour or feeling may be used defensively and that an important task in analytic/dynamic therapy is to identify the defensive function of a feeling, behavioural pattern or state of mind. |
| An ability to draw on knowledge that the nature of the defences predominantly used by a client will reflect their level of personality functioning (i.e. neurotic, borderline or psychotic) |
| An ability to draw on knowledge that interpretation of the link between anxiety and defence is normally prioritised over the interpretation of content. |

## Application

### Ability to help the client understand why and how they protect themselves from painful feelings/states of mind

<p>| An ability to accept the client’s style of relating and respect the defensive needs that may underlie particular interpersonal styles |
| An ability to help the client explore and become more aware of areas of conflict by drawing attention to feelings/states of mind that seem unacceptable or uncomfortable |
| An ability to help the client explore the meaning of their defensive structures by: |
| empathically pointing out how they may unconsciously protect themselves (e.g. by becoming confused or unable to think) |</p>
<table>
<thead>
<tr>
<th>helping the client understand why they need to protect themselves from the experience of particular feelings /states of mind</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to help the client become more aware of how they manage problematic aspects of their relationships through an exploration of defences as they arise in relation to the therapist and significant others</td>
</tr>
<tr>
<td>An ability to help the client understand the ‘costs’ of the defences used by pointing out their impact on their own capacities and on their relationships</td>
</tr>
</tbody>
</table>
### Ability to manage the anxiety generated by the exploration of defences

| An ability to assess the client’s readiness to explore their defences |
| An ability to be receptive to the client’s anxiety as it manifests in the therapeutic relationship so as to facilitate the client’s reflection on its meaning |
| An ability to contain the client’s experience of anxiety if they feel too exposed |
**METACOMPETENCES**

Capacity to implement treatment models in a flexible but coherent manner

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to implement a model of therapy in a manner which is flexible and</td>
</tr>
<tr>
<td>which is responsive to the issues the client raises, but which also ensures</td>
</tr>
<tr>
<td>that all relevant components of the model are included</td>
</tr>
<tr>
<td>An ability to use clinical judgment in order to balance adherence to a model</td>
</tr>
<tr>
<td>against the need to attend to any relational issues which present themselves</td>
</tr>
<tr>
<td>An ability to maintain adherence to a therapy without inappropriate switching</td>
</tr>
<tr>
<td>between modalities in response to minor difficulties (i.e. difficulties which</td>
</tr>
</tbody>
</table>
### Capacity to adapt interventions in response to client feedback

<table>
<thead>
<tr>
<th>An ability to accommodate issues the client raises explicitly or implicitly, or which become apparent as part of the process of the intervention:</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to respond to, and openly to discuss, <em>explicit</em> feedback from the client which expresses concerns about important aspects of the therapy</td>
</tr>
<tr>
<td>An ability to detect and respond to <em>implicit</em> feedback which indicates that the client has concerns about important aspects of the therapy (e.g. as indicated by non-verbal behaviour, verbal comments or significant shifts in responsiveness)</td>
</tr>
<tr>
<td>An ability to identify when clients have difficulty giving feedback which is &quot;authentic&quot; (e.g. clients who respond in accordance with what they think the therapist wishes to hear, rather than expressing their own view) and discussing this with them</td>
</tr>
<tr>
<td>An ability to be aware of, and respond to, emotional shifts occurring in each session, with the aim of maintaining an optimal level of emotional arousal (i.e. ensuring that the client is neither remote from or overwhelmed by their feelings)</td>
</tr>
</tbody>
</table>
Ability to make use of the therapeutic relationship as a vehicle for change

### Knowledge

An ability to draw on knowledge that the detailed tracking and exploration of the vicissitudes of the therapeutic relationship is the cornerstone of analytic/dynamic technique

### Application

<table>
<thead>
<tr>
<th>An ability to establish and maintain emotional contact with the client</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to prioritise the experiential focus of the here-and-now of the session as the basis for interventions:</td>
</tr>
<tr>
<td>an ability to respond to the current state of the relationship</td>
</tr>
<tr>
<td>An ability to make use of the therapist’s experience with the client to inform the therapy:</td>
</tr>
<tr>
<td>an ability for the therapist to monitor their emotional reactions to the client</td>
</tr>
<tr>
<td>an ability to critically consider the relevance of the therapist’s current experience with the patient as the basis for furthering understanding of the patient</td>
</tr>
<tr>
<td>an ability to self-reflect and where appropriate to identify the need for further personal therapy and/ or supervision (to protect the client from potential harm)</td>
</tr>
<tr>
<td>An ability to identify, and respond appropriately when the client’s experience of close emotional contact with the therapist leads to a deterioration in their functioning</td>
</tr>
</tbody>
</table>
Ability to apply the analytic/dynamic model flexibly in response to the client’s individual needs and context

**Ability to respond flexibly to changes in the client’s presentation**

<table>
<thead>
<tr>
<th>Ability documented</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to monitor the client’s experience of the therapy and their state of mind</td>
<td></td>
</tr>
<tr>
<td>An ability to adapt the model, technique (e.g. interpreting the negative transference), frequency of sessions or setting of the therapy in response to:</td>
<td></td>
</tr>
<tr>
<td>the individual needs of the client (including their level of distress) at a given moment in the session and during particular phases of the therapy</td>
<td></td>
</tr>
<tr>
<td>the quality of the therapeutic alliance</td>
<td></td>
</tr>
<tr>
<td>changes in the client’s external context</td>
<td></td>
</tr>
<tr>
<td>changes in the treatment setting</td>
<td></td>
</tr>
<tr>
<td>An ability to systematically monitor any harmful impact of therapy on the client:</td>
<td></td>
</tr>
<tr>
<td>an ability to identify the need for consultation/supervision if there are indications that the client is at risk</td>
<td></td>
</tr>
<tr>
<td>An ability to monitor and explore the meaning for the client of any adaptations to the originally agreed treatment plan</td>
<td></td>
</tr>
</tbody>
</table>

**Ability to titrate the level of therapist activity in response to the client’s levels of arousal**

<table>
<thead>
<tr>
<th>Ability documented</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to closely monitor the client’s levels of arousal</td>
<td></td>
</tr>
<tr>
<td>An ability to intervene to help the client manage anxiety that would otherwise prevent exploration:</td>
<td></td>
</tr>
<tr>
<td>an ability to help the client understand what may be making them anxious</td>
<td></td>
</tr>
<tr>
<td>an ability to adapt technique flexibly (e.g. by increasing the therapist’s level of activity) so as to respond to unproductive levels of anxiety in the client</td>
<td></td>
</tr>
</tbody>
</table>

**Ability to tailor therapy to the time available**

<table>
<thead>
<tr>
<th>Ability documented</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to identify the adaptations of the core analytic/dynamic model required to work within a specified time frame (e.g. if brief therapy, regular reminders to the client of the time-limited nature of the work)</td>
<td></td>
</tr>
<tr>
<td>An ability to adjust the level of therapist activity relative to the length of treatment (e.g. greater activity if working on a circumscribed focus within a time-limited frame)</td>
<td></td>
</tr>
<tr>
<td>An ability to appraise the risks and benefits for the client of an open-ended or time limited approach</td>
<td></td>
</tr>
</tbody>
</table>
where risks are identified, an ability to establish safe parameters for the therapy (e.g. by organising additional support)
### Ability to establish an appropriate balance between interpretative and supportive work

#### Knowledge

<table>
<thead>
<tr>
<th>An ability to draw on knowledge that while the primary focus in analytic/dynamic psychotherapy is on interpretative techniques, supportive techniques facilitate the development and maintenance of a working alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to draw on knowledge of both interpretative and supportive approaches, their overall objectives and different technical emphases:</td>
</tr>
<tr>
<td>that the aim of interpretative techniques is to engage the client’s curiosity about, and understanding of, their unconscious inner mental life and the ways in which this informs their subjective experience of self and others</td>
</tr>
<tr>
<td>that the aim of supportive techniques is to alleviate the client’s immediate problems by strengthening their resilience (i.e. building “ego strength”) and focusing on conscious experience</td>
</tr>
</tbody>
</table>

#### Application

<table>
<thead>
<tr>
<th>An ability to evaluate and support the client’s ability to manage the demands of interpretative work (both within a given session, and as an overall treatment strategy during particular phases of therapy) by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>continuously monitoring the client’s level of distress</td>
</tr>
<tr>
<td>listening to the client’s conscious and unconscious communication about how they are experiencing the therapy</td>
</tr>
<tr>
<td>communicating to the client an understanding of why they may be finding aspects of the work particularly challenging at certain points</td>
</tr>
<tr>
<td>responding flexibly to the client’s shifting capacity to tolerate an interpretative approach</td>
</tr>
<tr>
<td>regularly reviewing the client’s external systems of support</td>
</tr>
<tr>
<td>An ability to identify when it is appropriate to act on the anxiety generated by the client in the therapist (i.e. not only reflect on its possible meaning) so as to protect the client/others/the therapy</td>
</tr>
<tr>
<td>Where the therapist shifts from an interpretative to a more actively supportive stance, an ability to:</td>
</tr>
<tr>
<td>identify the impact this may have on the therapeutic relationship</td>
</tr>
<tr>
<td>communicate to the client an understanding of the meaning for them of this shift in style</td>
</tr>
</tbody>
</table>
Ability to identify and apply the most appropriate analytic/dynamic intervention

**Knowledge**

| An ability to draw on knowledge of the various analytic/dynamic models and techniques in order to identify the most appropriate intervention for a given |

**Application**

| An ability to apply the chosen model skilfully |
| An ability to consider the length, intensity and format of the treatment (individual, group, family, couple) in light of: |
| developmental factors (e.g. age) |
| the client’s mental state |
| the level of risk |
| the setting in which the therapy will take place |
| the nature of the problem |
This section describes the knowledge and skills required to carry out Dynamic Interpersonal Therapy.

It is not a ‘stand-alone’ description of technique, and should be read as part of the psychoanalytic/ psychodynamic competence framework.

Effective delivery of this approach depends on the integration of this competence list with the knowledge and skills set out in the other domains of the psychoanalytic/ psychodynamic competence framework.


### Knowledge

#### General

An ability to draw on knowledge of the psychological and interpersonal difficulties experienced by clients with a diagnosis of depression

#### Knowledge of the developmental model underpinning the understanding of depression

An ability to draw on knowledge that DIT is grounded in attachment theory (including models of mentalization), object relations theory and interpersonal psychoanalysis

An ability to draw on knowledge of attachment-based and object relational models of depression

#### Knowledge of the aims and focus of treatment

An ability to draw on knowledge that DIT aims to help the client:

- understand the connection between their presenting symptoms and significant difficulties in their relationships, by working with them to identify a core, unconscious, repetitive pattern of relating (and making this the focus of the therapy)
- develop a capacity to mentalise

An ability to draw on knowledge that the primary aim of DIT is to enhance the client’s interpersonal functioning and their capacity to think about and relate, changes in their mood to mental states (conscious and non-conscious)

An ability to draw on knowledge that DIT systematically focuses on:
<table>
<thead>
<tr>
<th>a circumscribed interpersonal and affective focus (IPAF) that is linked with the onset and/or maintenance of symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>the client’s state of mind, rather than their behaviour</td>
</tr>
<tr>
<td>the client’s experience in the here-and-now of the session or recent past, rather than the interpretation of distal events</td>
</tr>
</tbody>
</table>
Knowledge of the treatment strategy

<table>
<thead>
<tr>
<th>An ability to draw on knowledge that the three main phases of the treatment have distinct aims:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>an initial</strong> phase that aims to assess the quality and patterning of relationships, past and present, as the basis for identifying a dominant, recurring, unconscious interpersonal and affective pattern (IPAF) that will become the focus of the therapy</td>
</tr>
<tr>
<td><strong>a middle</strong> phase that focuses on helping the client to elaborate and work on the IPAF</td>
</tr>
<tr>
<td><strong>an ending</strong> phase that focuses on helping the client to reflect on the affective experience of ending and so prepare for ending and plan for the future</td>
</tr>
</tbody>
</table>

An ability to draw on knowledge that DIT makes active use of the client-therapist relationship to explore the IPAF

An ability to draw on knowledge that DIT makes use of expressive, supportive and directive techniques to support the aims of the treatment

Interventions

Therapeutic stance

<table>
<thead>
<tr>
<th>An ability to establish and maintain an involved, empathic relationship with the client:</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability to establish and sustain an active, collaborative stance</td>
</tr>
<tr>
<td>An ability to adopt a ‘not knowing’, curious stance when exploring the client’s mental states, to communicate a genuine attempt to find out about their mental experience</td>
</tr>
</tbody>
</table>

Ability to assess the severity of the client’s depression

An ability to assess the client’s overall functioning to arrive at a diagnosis of depression

An ability to assess level of risk:

An ability to involve relevant professional networks to support the therapy where appropriate

Ability to assess the quality and patterning of the client’s current and past interpersonal functioning and formulate a focus

An ability to generate, clarify and elaborate narratives about relationships

An ability to draw the client’s attention to repetitive patterns in their relationships
An ability to identify one dominant repetitive interpersonal pattern that is connected to the onset/maintenance of the depression and that will become the focus of the therapy (the Interpersonal Affective Focus –IPAF)

An ability actively to reflect on, and make use of, the transference relationship, and the therapist’s countertransference, to arrive at the formulation of the IPAF
**Ability to engage the client in DIT**

An ability to communicate with the client in a direct, transparent manner that invites them to provide feedback on the formulation and process of therapy:

| An ability to respond to requests by the client for clarification in a direct and clear manner that models a self-reflective stance that is open to correction |

An ability to offer a “trial interpretation” in order to:

| make use of client’s response to the interpretation in order to elaborate the evolving formulation |
| assess the client’s capacity to make use of such interventions |

An ability to engage the client in formulating the focus of the work by:

| tentatively sharing an understanding of how their symptoms/problems be connected with presenting may unconscious feelings and interpersonal conflicts. |
| actively soliciting the client’s response to the formulation and engaging reflection on their emotional reaction to it |
| modifying the formulation in line with new understanding developed with the client. |

An ability to introduce the client to the rationale and aims of DIT through the use of ‘live’ material in the session (e.g. by drawing the client’s attention to recurring interpersonal dynamics as they describe themselves and their relationships):

| an ability to personalise the introduction of the model by linking it to the client’s own history, current symptoms and interpersonal experiences |

**Ability to help the client identify their aims for the therapy**

An ability to identify and agree with the client therapeutic goals that are meaningfully connected with the agreed IPAF

An ability to help the client to be realistic about what can be achieved within a brief time frame:

| an ability to respond to any feelings the client has about areas it may not be possible to work on |

**Ability to work to the agreed focus**

An ability to elicit interpersonal narratives and to track the agreed IPAF as it emerges in the narrative(s) as the basis for any interpretation

| an ability to take a stance of curiosity about interpersonal scenarios (e.g. asking questions and clarifications as necessary, to bring into focus an
interpersonal exchange so as to highlight a salient repetitive pattern).

<table>
<thead>
<tr>
<th>An ability to maintain a focus on the agreed IPAF by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>identifying areas of difficulty in the client’s relationships that relate to the IPAF</td>
</tr>
<tr>
<td>understanding the client’s characteristic ways of managing areas of difficulty in their relationships and to point out the ‘cost’ of these strategies</td>
</tr>
<tr>
<td>inviting reflection on the unconscious assumptions behind feelings and thoughts when in a relationship in order to highlight the way these assumptions perpetuate or exacerbate interpersonal difficulties</td>
</tr>
<tr>
<td>drawing the client’s attention to their affective state in the session</td>
</tr>
<tr>
<td>attending to the therapeutic relationship in order to draw the client’s attention to</td>
</tr>
</tbody>
</table>
Ability to focus the content of interventions

<table>
<thead>
<tr>
<th>Ability to focus on the client’s mind, not on their behaviour:</th>
</tr>
</thead>
<tbody>
<tr>
<td>an ability to follow shifts and changes in the client’s understanding of their own and others’ thoughts and feelings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ability to focus on the client’s affects (primarily in relation to the here-and-now of the session and their current circumstances)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ability to focus on current relationships including the relationship with the therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>an ability to focus on current relationships including the relationship with the therapist</td>
</tr>
</tbody>
</table>

Ability to work collaboratively with the client towards an understanding of the transference experience

<table>
<thead>
<tr>
<th>An ability to help the client to be curious about what is happening in the therapeutic relationship</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>An ability to identify and respond to enactments/rupture in the therapeutic relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>an ability to respond non-defensively to the client’s experience of the therapist</td>
</tr>
<tr>
<td>an ability to use clarification and elaboration to elicit a detailed picture of what has transpired between client and therapist</td>
</tr>
<tr>
<td>an ability to monitor countertransference and to work to regain a reflective stance after an enactment</td>
</tr>
<tr>
<td>an ability to acknowledge and explore openly with the client any enactments on the part of the therapist:</td>
</tr>
<tr>
<td>an ability to communicate the therapist’s perspective about the impasse or rupture</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An ability to monitor and engage with the client’s response to an interpretation</th>
</tr>
</thead>
</table>

Ability to support the client’s mentalizing stance in relation to the IPAF

<table>
<thead>
<tr>
<th>An ability to use clarification and elaboration to gather a detailed picture of the feelings associated with a specific behavioural sequence related to the IPAF</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>An ability to help the client make connections between actions and feelings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>An ability to help the client develop curiosity about their motivations</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ability for the therapist to share their perspective so as to help the client to consider an alternative experience of the same event</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>An ability to help the client shift the focus from non-mentalizing interaction with the therapist towards an exploration of current feelings and thoughts (as manifested in the client-therapist interaction, or in recent experiences outside the therapy room)</td>
</tr>
</tbody>
</table>
**Ability to encourage interpersonal change**

An ability to balance helping the client to explore the IPAF and supporting them to make use of their understanding of the IPAF to change current relationship patterns that are linked with the onset and/or maintenance of depression

An ability to monitor and respond to the client’s experience of the therapist’s more active stance

**Ability to integrate routine outcome monitoring into the therapeutic process**

An ability to engage the client in reflecting on their responses to the questionnaires:

- an ability to respond to the client’s use of the questionnaires in the context of the evolving transference relationship

An ability to use and interpret weekly questionnaire data in order to track progress, and to guide any changes to the intervention indicated by this data (e.g. in response to evidence of a deterioration in levels of depression)

**Ability to explore the unconscious and affective experience of ending**

An ability to assess the client’s sensitivity to separation so as to ensure that the meaning of the ending is worked on from the outset

An ability systematically to draw attention to, and explore, the client’s feelings, unconscious fantasies and anxieties about the ending of therapy.

An ability to recognise and respond to indications of regression near the end of treatment (e.g. a symptomatic deterioration) by linking this with the feelings and fantasies associated with endings.

An ability to help the client to review the therapy as a whole (e.g. whether they have achieved their aims):

- an ability to help the client express disappointment where appropriate
- an ability to respond non-defensively to the client’s feedback about the therapy

An ability to compose a ‘goodbye’ letter which reviews the original agreed formulation and progress made in working on the issues identified at the start of therapy:

- an ability to engage the client in responding to and refining the letter
### Appendix F
**Differences in Therapist Competencies Between Brief Psychodynamic Psychotherapy and Long-Term Psychodynamic Psychotherapy**

#### Table 2

*Differences in Therapist Competencies Between Brief Psychodynamic Psychotherapy and Long-Term Psychodynamic Psychotherapy*

<table>
<thead>
<tr>
<th></th>
<th>Brief Psychodynamic Psychotherapy</th>
<th>Long-Term Psychodynamic Psychotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model</strong></td>
<td>Drawing on knowledge about a particular model of brief psychodynamic, applying it to clinical practice (model of understanding of psychopathology, model of treatment strategy)</td>
<td>Drawing on knowledge of the basic psychodynamic theories and their implications for clinical practice, without a particular model of therapy in mind</td>
</tr>
<tr>
<td><strong>Emphasis of Interventions</strong></td>
<td>The main emphasis is to maintain a focus on current significant relationships that demonstrate the activation of the IPAF and its relationship to depression (symptoms)</td>
<td>The main emphasis is to explore and understand the patient’s unconscious through the transference, countertransference, dreams, phantasies, resistance and non-verbal behaviour. There is no attempt to conceptualise one repetitive interpersonal-affective pattern, rather to openly explore and re-formulate throughout the therapy different areas of the patient’s unconscious</td>
</tr>
<tr>
<td></td>
<td>Focusing in and enhancing the patient’s capacity to mentalize, attending to the patient’s capacity to think about and relate changes in their mood to mental states</td>
<td>The patient’s ability to mentalize is needed to deliver therapy, but there are no explicit interventions in order to recover the patient’s capacity to mentalize</td>
</tr>
<tr>
<td></td>
<td>A systematic focus in the patient’s experience</td>
<td></td>
</tr>
</tbody>
</table>
in the here-and-now of the session or recent past, rather than the interpretation of distal events

An ability to actively reflect on and make use of the transference relationship and countertransference to arrive at the formulation and explore the IPAF

An ability to elicit interpersonal narratives and to track the agreed IPAF as it emerges in the narrative(s) as the basis for any interpretation

Ability to explore the unconscious and affective experience of ending

A systematic focus in the patient’s experience in the here-and-now of the session or recent past, attempting to connect it to distal events in the patient’s history

An ability to actively reflect on and make use of the transference relationship and countertransference to explore and understand the patient’s unconscious

Interpersonal narratives are important only if they unlock aspects of the patient’s unconscious dynamics

The ability to explore the unconscious and affective experience of ending is important, but due to the length of the therapy, is less present than in brief psychodynamic psychotherapy

There is no systematic focus of the therapy, particularly in open-ended treatments. Ideally, there should be an open exploration of the different aspects of the patient’s unconscious in relation to the original therapeutic goals

There is no point in the therapy where the therapist’s shares a conceptualised focus or

Therapeutic Focus

A systematic focus and identify one repetitive interpersonal and affective focus (IPAF) that is linked to the onset and/or maintenance of symptoms

Tentatively sharing an understanding of how their presenting symptoms/problems
may be connected with unconscious feelings and interpersonal conflicts

Asking actively the patient’s response to the formulation and engaging reflection on their emotional reaction to it

Modifying the formulation in line with a new understanding developed with the patient. Communicating with the patient in a direct, transparent manner that invites them to provide feedback on the formulation and process of therapy, modelling a self-reflective stance that is open to correction

An ability to work and maintain a focus on the agreed IPAF

Therapeutic Stance

Sustaining an active and collaborative therapeutic stance, while being receptive to the patient’s unconscious communications.

formulation. The therapist shares interpretations with the patient’s which lead to an ever-increasing shared understanding of the patient’s unconscious dynamics

The therapist does not ask directly for feedback from the patient. The therapist waits for the patient’s reactions to interpretations

Although the therapist original formulation changes throughout the therapy, through the interactions with the patient, this process is less explicitly cooperative than in brief psychodynamic psychotherapy

The therapist is not guided by a particular focus, but by the patient’s free associations The therapist retains a more neutral, relatively anonymous stance towards the patient prioritising reflection and interpretation over action. It is a particular way of listening to the patient’s unconscious communications and to the unfolding of transference in order to
Adopting a “not knowing”, curious therapeutic stance when exploring the patient's mental states, to communicate a genuine attempt to find out about their mental experience

Although the therapist should ideally address the patient without preconceptions ("memory and desire"), this is not directly made explicit to the patient.

Does not use directive interventions

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Ability to assess the patient’s psychopathology, level of risk, need of support, and define a therapeutic focus considering the therapeutic time-frame of 16 sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouraging Change and Therapeutic Goals</td>
<td>Ability to encourage interpersonal change</td>
</tr>
<tr>
<td></td>
<td>An ability to identify and agree with the patient therapeutic goals that are meaningfully connected with the agreed IPAF</td>
</tr>
<tr>
<td></td>
<td>The therapist agrees goals with the patient at the beginning of therapy. However, the ultimate goals are pursued not directly but through addressing an intermediate goal: profound personality change or “structural change”, involving growth toward greater differentiation and integration that enhances the patient’s ego strength. It is this intermediate goal that is specifically psychoanalytic and that makes this therapy safeguard the analytic process.</td>
</tr>
<tr>
<td></td>
<td>The therapist does not explicitly encourage change</td>
</tr>
</tbody>
</table>
An ability to help the patient to be realistic about what can be achieved within a brief time frame inevitably long-term. Other intermediate goals are: the resolution of conflict, search for truth, improved capacity to seek out appropriate self-objects, improved relationships as a result of a gain in understanding one’s internal objects, generation of meaning within the therapeutic dialogue, and improved reflective functioning.

Goal are less determined by time, but by the patient’s resilience and structural difficulties.

(De Jonghe et al., 2012; Fonagy, Roth, & Higgitt, 2005; Gabbard, 2010; Lemma et al., 2008; Lemma, Target, & Fonagy, 2011)
Appendix G

First version of the semi-structured interview

Knowledge

1- How should a competent therapist use knowledge (theoretical and practical) with their patients? (What would be an adequate/competent use of knowledge?)

2- How would a competent therapist draw knowledge of developmental theory and use it within a session?

3- How would a competent therapist draw knowledge of the analytic model of the mind and inner world of object relations and use it within a session?

4- What kind of actions/attitudes convey that the therapist has enough theoretical and practical knowledge

5- What is the minimum knowledge a competent therapist should have?

6- What characterises and expert therapist?

7- How do you understand the supportive aspect of therapy and when/how should it be employed?

8- Should the therapist give advice and/or feedback? How/when?

9- What does it mean in practice to track closely the therapeutic process? What does it mean to attend closely to the micro-processes of the therapeutic relationship so as to gain understanding of the patient? Can you give an example?

10- How would you describe a primarily receptive stance that facilitates the elaboration of unconscious communications in relation to the patient?

11- How would a competent therapist maintain an open mind, tolerating uncertainty and “not knowing”? What would an incompetent therapist do instead?

Ethics

1- What characterises an ethical practice?
Engagement

1- How would you describe the process of engaging a patient in therapy?
2- How does the competent therapist engender trust?
3- What actions/attitudes of the therapist are essential in the process of developing rapport with the patient?
4- What characterises the process of adapting personal style so that it meshes that of the patient? Can you give an example?
5- How would describe a helpful way to let the patient discuss and express his emotional reactions?
6- What signs from the patient would help the therapist to adjust and structure the session according to his/her needs? Can you give examples?
7- Can you give examples of how the therapist conveys competence and confidence to the patient?
8- How does a competent therapist show respect to the patient?
9- What does it mean in practice to respond to the patient’s problems in a concerned, non-judgmental manner? What would be an incompetent manner of responding to the patient’s problems?
10- How does a competent therapist communicate empathic understanding to the patient’s conscious and unconscious communications?
11- Could you describe the process of how a competent therapist contains a patient?
12- What actions/attitudes impair the therapist’s ability to contain a patient?
13- How would you describe the way competent and incompetent therapists deal with the patient’s distress?
14- How would you define being attuned to the patient’s emotions?
15- How does a competent therapist adjust his/her technique to foster trust and rapport with a passive patient?
16- What is the competent and the incompetent way of communicating the boundaries and frame of therapy?
17- How does the competent therapist recognise which patients may require more supportive interventions in order to engage them?
18-How does the competent therapist provide the patient an experience of an analytic/dynamic approach?
19-How does the competent therapist encourage the patient to reflect on his/her reactions and on the proposed therapeutic focus?

Therapeutic Alliance
1- How would you describe a positive bond with the patient?
2- How would you describe a negative bond with the patient?
3- How does the competent therapist agree with the patient on the tasks of therapy?
4- How does the competent therapist get to an agreement with the patient regarding the goals of therapy?
5- What signs would indicate that the alliance is under threat?
6- What would be a competent and an incompetent approach to address disagreements with the patient regarding tasks and goals of therapy?
7- What would be a competent and an incompetent intervention in response to strains in the bond between therapist and patient?

Factors associated with Therapeutic Alliance?
1- Could you exemplify competent and incompetent ways the therapist can be flexible in therapy? When should the therapist be flexible?
2- Could you exemplify competent and incompetent ways the therapist can be warm, friendly and affirming?
3- Could you exemplify competent and incompetent ways the therapist can be open in therapy?
4- Could you exemplify competent and incompetent ways the therapist can be alert and active in therapy?
5- How would a therapist convey rigidity to a patient?
6- What would you consider an inappropriate self-disclosure?
7- What would be an inappropriate use of silence on the part of the therapist?
8- What is the difference between being critical and confronting with the patient?
9- What characterises the therapist’s ability to listen to the patient sensitively?
10- In grasping the patient’s perspective and “world view”, how would a competent and an incompetent therapist’s approach this issue?
11- What is the appropriate balance between interpretative and supportive work?

Working with the emotional content of the session
1- How would you describe a competent and an incompetent way of approaching the affective world of the patient?
2- What would be a competent way to facilitate the processing of high level emotions (i.e., anger) on the part of the patient?
3- What would be a competent way to facilitate the processing of low level of emotions (i.e., apathy, low motivation) on the part of the patient?
4- How would be a competent way of dealing with emotional issues that interfere with effective change (e.g. hostility, anxiety, excessive anger, avoidance, strong affects)?
5- What actions/attitudes from the therapist help the patient differentiate, acknowledge and experience his /her own emotions in a way that facilitates change?
6- How does the competent therapist establish and maintain emotional contact with the patient?

Managing endings
1- How would you describe a competent and an incompetent way of managing the ending of therapy?
2- How does the competent therapist attune to the patient’s responses to separation/termination?

3- How does the competent therapist prepare the patient for the ending of therapy?

Assessment

1- How does a competent therapist assess the patient’s problems, diagnosis, history, present situation, and risk?

2- How would you describe an incompetent assessment of the patient’s problems, diagnosis, history, present situation and risk?

3- What is an effective way of assessing the client’s coping mechanisms, stress tolerance, resources, and level of functioning?

4- What is an ineffective way of assessing the client’s coping mechanisms, stress tolerance, resources and level of functioning?

5- What guides the competent therapist in deciding which symptoms/problems cause more distress and which the most amenable to intervention?

6- Is it possible to differentiate a competent from an incompetent translation of vague complains into a more discrete problem? How?

7- How does the competent therapist gauge the patients’ ability to think about themselves psychologically?

8- How does the competent therapist explore the patient’s motivation for therapy?

9- How does the competent therapist explore the patient’s suitability for dynamic therapy? How would an incompetent therapist undertake this task?

10- How does the competent therapist adapt his approach to the patient’s needs?

11- What signs would indicate the therapist that a psychodynamic therapy is counter-indicated for a certain patient?

12- Could you give an example of how the competent therapist listens to both, the patient’s verbal and non-verbal communication?
13-What would be an incompetent way of dealing with the emotional impact the patient’s presentation has on the therapist?
14-What would be a competent and an incompetent way of doing a “trial” interpretation”?
15-How does the therapist help the patient reflect on their experience of the assessment? Can you give an example?
16-What signs would guide the therapist to consider the need of additional resources for the patient?

Ability to arrive into an analytic/dynamic formulation
1- How does the competent therapist arrive into an analytic formulation?
2- What characterises the process and outcome of an incompetent analytic formulation?

Ability to maintain an analytic/dynamic focus
1- How does the therapist competently maintain the focus on a particular theme?
2- How does the therapist competently remain focused in the patient's unconscious?
3- How does the therapist recognise when a focus is not appropriate?
4- How does the therapist competently help the patient identify relevant interpersonal and affective patterns?
5- How does the therapist competently help the patient explore the meaning of diversions away from the agreed focus?

Ability to work with unconscious communication and unexpressed feelings
1- How would you describe the ability of a competent therapist to listen, understand and work with the patient’s unconscious communications/latent content?
2- How does the therapist competently facilitate the emergence of unconscious communications?
3- How does the therapist competently deal with uncertainty and ambiguity when trying to understand the patient?

4- How would you describe the ability of a competent therapist to respond to the patient’s unconscious communications?

5- How would you describe a competent use of silence?

6- How does the therapist competently facilitate the expression and awareness of unexpressed feelings?

Relational experiences

1- How does a competent therapist explore and understand the patient’s difficulties in relationships?

2- How does a competent therapist use the early experiences of the patient to understand the dynamics of his/her relationships?

3- How does the competent therapist assess the unconscious projective and introjective processes that underpin the patient’s subjective experiences of his/her relationships?

4- How does the competent therapist distinguish a recurrent interpersonal and affective pattern in the patient’s relationships?

5- How does the competent therapist understand and work through the difficulties in the therapeutic relationship?

6- How does the incompetent therapist deal with the difficulties in the therapeutic relationship?

7- How does the competent therapist deal with “negative therapeutic reactions” and “flight into health”?

8- How does the competent/incompetent therapist elaborate and work through their own contribution to the difficulties in the therapeutic relationship?

9- What does it mean to make use of the therapeutic relationship as a vehicle for change? Does it necessarily entail the interpretation of the transference?

Therapeutic frame and boundaries

1- How does the competent therapist establish the therapeutic frame and boundaries?
2- What are incompetent ways of managing the therapeutic frame and boundaries?
3- How does the competent therapist manage deviations from the established therapeutic frame?
4- What would be an incompetent way of managing the interruptions of treatment?

Work with internal and external reality
1- How does the competent therapist balance the work with the client’s internal and external reality?
2- How does the competent and incompetent therapist respond to the client’s conscious experience?
3- How does the competent therapist work the differences between him/her and the patient?

Interpretations
1- What differentiates a competent from an incompetent therapist in the process of arriving at an interpretation?
2- What is a good and a bad timing to make an interpretation?
3- What does it mean that the process of arriving at an interpretation is collaborative with the patient?
4- What does the competent and incompetent therapist do after delivering an interpretation?
5- How does a competent therapist make an interpretation?
6- How does an incompetent therapist make an interpretation?
7- How does the competent therapist react to the patient’s feedback after an interpretation?
8- How does the incompetent therapist react to the patient’s feedback after an interpretation?
9- How does the therapist approach to possible latent contents of the patient’s communications?
10-How would you tell that an interpretation has the “appropriate depth”?
11-How does the therapist critically appraise the helpfulness and correctness of an interpretation?
Transference

1- How does the competent therapist facilitate the patient's exploration of the therapeutic relationship?
2- How does the competent therapist use the transference in the session?
3- How much focus should the competent therapist give to the “here and now”?
4- What would be an incompetent way of working in the transference?
5- How does the competent therapist make a transference interpretation?
6- How would an incompetent therapist make a transference interpretation?
7- How does the competent therapist facilitate the development of the transference?
8- How can the therapist hinder the development of the transference?
9- How does the therapist “titrate” the patient’s capacity to receive transference interpretations?
10- What is the balance between exploring the transference relationship and other relationships of the patient?
11- How does the therapist explore and arrive into a transference interpretation?
12- How does the competent therapist help the patient understand an increase in their positive or negative feelings towards the therapist?
13- How does the competent and the incompetent therapist react to the patient’s testing of the therapeutic relationship?
14- How should the competent therapist react to the patient’s experiences after receiving a transference interpretation?
15- What uses gives the competent therapist to his/her experience of the transference?

Countertransference

1- How does the competent therapist use the countertransference?
2- How would be an incompetent use of the countertransference?
3- How do the competent and incompetent therapist manage enactments?
Defences

1. How does the therapist understand which defences are used by the patient?
2. How does the therapist comprehend from what the patient is defending from?
3. How does the therapist differentiate adaptive from maladaptive defences?
4. How does the therapist understand which defences should be worked through and which not?
5. How would an incompetent therapist work with the defences?
6. What characterises a competent work with the defences?
7. How does the competent therapist help the patient explore and become more aware of areas of conflict that seem unacceptable or uncomfortable?
8. How does the competent therapist assess the patient’s readiness to explore his/her defences?
9. How does the competent and incompetent therapist work with the patient that feels too exposed?

DIT

1. Give an example of a therapist not involved and non-empathic with the patient
2. Give an example of a therapist being inactive and without sustaining a collaborative stance
3. How does the competent therapist assess the severity of the patient’s depression?
4. What would be an incompetent way of identifying the IPAF?
5. What would be an incompetent way of working with the IPAF?
6. What would be an incompetent way of offering a “trial interpretation”?
7. What is the balance in DIT between focusing in current and past relationships? And between the therapeutic and external relationships?
8. How does the competent therapist work with the IPAF?
9- How should the competent therapist respond to pre-mentalizing modes in the patient?

10-What would be an incompetent way of managing enactments?

11-What would be an incompetent way of managing the countertransference?

12-What techniques from MBT are shared by DIT and which not?

13-How does the competent therapist help the client mentalize in DIT?

14-How does the competent therapist encourage interpersonal change?

15-How would be an incompetent way of encouraging interpersonal change?

16-How much directiveness should the therapist exercise in DIT?

17-How does the competent therapist respond to indications of regression or deterioration near the end of treatment?

18-What is a competent and an incompetent “goodbye” letter?

Analytic attitude

1- How would you describe a receptive, non-directive yet involved attitude? Give examples

2- How would you describe a neutral, non-gratifying, yet concerned stance? Give examples

3- What signs guide the competent therapist to step back from the therapeutic process and reflect?
Appendix H
Second version of the semi-structured interview

1- What do you understand as competence in a psychotherapist?
2- Thinking from your clinical experience, what do you think are the essential components of a therapist competence?
3- In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is being a competent psychotherapist?
4- Thinking clinically of a therapist competence, could you give an example?
5- What do you think are the key qualities a therapist should develop in order to provide Brief Psychodynamic Psychotherapy?
6- What do you think as an incompetent psychotherapist?
7- Could you give an example of an incompetent psychotherapist?
8- In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is engaging the patient?
9- In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is contributing to the creation and maintenance of the Therapeutic Alliance?
10- In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she accurately understands the patient?
11- How would a competent therapist deal with the emotional content of the session?
12- How does a competent therapist arrive into an analytic/dynamic formulation?
13- How does the competent therapist facilitate, listen and respond to the patient’s unconscious communications?
14- How does the therapist competently help the patient become aware of the feelings and the defences mobilised in interpersonal relationships?
15-What differentiates a competent from an incompetent therapist in the process of arriving and making an interpretation?
16-In observing a psychodynamic therapy, what characteristics or behaviours of the therapist would inform you that he/she is competently understanding and using the transference?
17-How does a competent therapist recognise and work competently with the defences?
18-Thinking about the therapeutic stance in DIT, could you give an example?
19-In observing a DIT session, what characteristics or behaviours of the therapist would inform you that he/she is competently arriving at an accurate IPAF by collaborating with the patient?
20-What are the most common pitfalls of a DIT therapist?
21-How does a competent therapist maintain an analytic attitude while working with the premises of a brief psychodynamic psychotherapy?
Appendix I

Final version of the interview

1- What do you understand as competence in a psychotherapist?
2- Thinking from your clinical experience, what do you think are the essential components of therapist competence?
3- In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is being a competent psychotherapist?
4- Thinking clinically of therapist competence, could you give an example?
5- What do you think are the key qualities a therapist should develop in order to provide Brief Psychodynamic Psychotherapy?
6- What do you understand as an incompetent psychotherapist?
7- Could you give an example of an incompetent psychotherapist?
8- In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is engaging the patient?
9- In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is contributing to the creation and maintenance of the therapeutic alliance?
10- In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she accurately understands the patient?
11- How would a competent therapist deal with the emotional content of the session?
12- How does a competent therapist arrive into an analytic/dynamic formulation?
13- How does the competent therapist facilitate, listen and respond to the patient's unconscious communications?
14- How does the therapist competently help the patient become aware of the feelings and the defences mobilised in an interpersonal relationship?
15- What differentiates a competent from an incompetent therapist in the process of arriving and making an interpretation?
16-In observing a psychodynamic session, what characteristics or behaviours of the therapist would inform you that he/she is competently understanding and using the transference?

17-How does a competent therapist recognise and work competently with the defences?
Appendix J

Semi-structured interview Information Sheet

Therapist Competence in Brief Psychodynamic Psychotherapy

Information Sheet

Invitation to participate
You are being invited to take part in a research study that is being conducted by the University College London. Before you decide whether to take part, it is important to understand why the research is being done and what it will involve. Please read the following information carefully. Take your time to decide whether or not you wish to take part. If you are interested in taking part the researcher will go through this information with you and answer any questions. Thank you for reading this.

The purpose of the study
This research project attempts to create a measure that describes the role, behaviours, attitudes and techniques that make a therapist competent in providing Brief Psychodynamic Psychotherapy. In order to develop a measure as close as possible to the current understanding of therapist competence in Brief Psychodynamic Psychotherapy, a literature review and interviews with experts regarding the aforementioned topic will be completed.

Why have I been chosen to take part?
Due to your expertise in Psychodynamic Psychotherapy your opinion regarding clinical competence is highly valuable for this research project. Therefore, we would like to interview you in order to study, compare and analyse your viewpoint.

Do I have to take part?
No, taking part in this study is voluntary. It is up to you to decide whether or not to take part.

What will taking part involve?
Once you provide consent you will be interviewed by the research assistant on the topic of therapist competence in Brief Psychodynamic Psychotherapy. The interview will be audio-recorded and transcribed. Only appointed people at UCL that are part of this research project will have access to the tape and the transcription. Both, the tape and the transcription will be destroyed 6 months after the study finishes.

If you have any questions about the study please contact:

Tamara Ventura  
07522363778  
tamara.ventura.14@ucl.ac.uk  
UCL Psychoanalysis Unit  
1-19 Torrington Place  
London WC1E 7HB
Appendix K
Semi-structured interview Consent Form

Therapist Competence in Brief Psychodynamic Psychotherapy
Consent Form

1. I have read the participant information sheet and have been given a copy to keep. I have been able to ask questions about the project and I understand why the research is being done.

2. I understand that my participation in this study is entirely voluntary and that I will not receive any payment. I am free to withdraw my consent at anytime without giving a reason.

3. I am willing to be interviewed and I understand and agree with the interview being audio-recorded and transcribed.

4. I give permission to the research team to access and study the recording and transcription of my interview.

5. I understand that all information I give will be treated confidentially and will not be used or released in such a way that I could be identified.

6. I have the names and telephone numbers of the research team in case I have any queries in the future.

7. I agree to take part in the study.

…………………………….  …………………………  …………………
Name of participant  Date  Signature

…………………………….  …………………………  …………………
Name of researcher  Date  Signature
Appendix L
Thematic Analysis: Complete version

Competence Definitions

As a response to the first question of the interview, the expert clinicians expressed their opinions on how best to define and understand therapeutic competence. Experts raised the need to separate competence from other overlapping concepts. Therefore, competence was distinguished from treatment adherence and positive clinical outcomes. Treatment adherence was defined as the use and implementation of a treatment model's techniques, while positive clinical outcome was understood as the improvement of the patient’s symptoms. Distinctively, competence was defined as the therapist skill to deliver the treatment manual techniques, which does not necessarily bring about good clinical outcomes.

Customarily, a competent therapist has been conceptualised as someone that brings about positive treatment outcomes in his/her patients. However, experts indicated that understanding competence as equivalent to positive clinical outcomes constitutes a circular definition, where it is impossible to distinguish between both concepts. Experts stated that a competent therapist does not necessarily provide positive treatment outcomes in any given case, because there might be issues related to the patient that affect the outcome. Thus, the clinical outcome may be poor even when the therapist was competent.

A few experts draw a distinction between two types of competence. The first type refers to the exhaustive list of clinical attitudes, behaviours and skills a therapist should be able to demonstrate in relation to a patient. The second type of competence refers to the therapist innate talent to understand and treat patients. This innate competence was supposed to be in relation to the therapist: personality, life experience, experience of being a patient, compassion, and own developmental journey. All these factors would make the therapist better suited to understand and treat patients. Additionally, expert clinicians suggested that therapists that possess an innate kind of competence
have a special sensitivity to understand in depth unconscious communications, and to listen and understand what is happening in the transference. Therefore, the innate competence encompasses the therapist psychic sophistication and his/her capacity to work with depth, both of which allow him/her to have a strong sense of understanding of what is happening to the patient.

Furthermore, a number of expert clinicians related this innate competence to the experience of analysis of the own therapist. This is due to the fact that after being analysed the therapist has a better understanding of his/her own capacity to transfer his/her own object relation patterns onto the analyst. Therefore, they can observe, read and understand the patient’s transference better. In association to this, expert clinicians proposed that how competent a therapist is, is related to how deep and far he/she has gone in his/her own analysis.

A few therapists characterised competence as a concept that refers to two kinds of attributes in a therapist: generic and specific. The generic attributes pertain to the competencies that are common to all modalities of psychotherapy, while the specific attributes are related to delivering a particular treatment manual. Customarily, competence has been defined by general attributes due to the fact that more specific ones are particular to determined psychotherapeutic orientations. Examples of generic attributes refer to competencies such as the capacity to foster a relationship with the patient, to respond in a sensitive way, and the capacity of the therapist to be reasonably well trained and confident in what they are doing. Furthermore, generic competencies are related to the ability of the therapist to understand the patient, drawing from a range of domains of knowledge, as well as the ability to deliver interventions that are focused, safe and tolerable for the patient.

A number of therapists agreed that the paradox of the task of defining competence is that by attempting to offer a general idea of what competence is about and by characterising how the therapist should behave with every patient, the quintessential reality of competence is overlooked. The fundamental aspect of competence is the ability of the therapist to individualise the interventions, knowing how to intervene with each patient at different moments. Competence is about the flexibility in adapting the techniques to a particular patient at a specific time, recognising when and when not to intervene. Therefore, defining
competence as general rules that should be applied with every patient goes against the very essence of what competence is.

Several expert clinicians highlighted the importance of rooting competence in a psychotherapeutic model or framework, emphasising that for an intervention to be a competent one, it has to be framed and to be consistent with a specific treatment model. Nevertheless, competence is not just about being consistent with the model, but is the skillfulness with which the therapist effectively delivers the interventions and techniques derived from a specific treatment model. Expert clinicians emphasised that competence, within the psychodynamic framework, concerns the ability of the therapist to fluently use a conceptualisation of the mind that involves unconscious motivations. Moreover, competence would include the ability of the therapist to comprehend the patient’s material, understanding that his/her personality is structured around the developmental resolution of conflicts.

Several expert clinicians understood competence as the ability of the therapist to see and understand the patient’s material when is “hot” in the here-and-now of the session. Thus, competence would entail the understanding of the underlying associations that exist between the material brought by the patient and his/her external situation, but specifically the link between the material and the unconscious aspects of the transference. A competent therapist not only would be capable of understanding the connections between the patient’s material, external situation and transference quickly, but also would be capable of verbalising these links in a way that the patient can receive them although they are shocking and surprising. Therefore, a competent therapist has an excellent management of language, being able to be clear and economical in his/her interventions, which would always be adapted to the specific time/phase of the patient’s therapy.

Although therapist competence has ordinarily been believed to be an “art”, meaning the result of the therapist unique wisdom, intuition and creativity in connection with the patient, experts also agreed that therapeutic competence is more than an art. Therefore, the therapist should not do “what feels right at the time” if it is not guided by the current scientific understandings of what clinical competence is. Thus, there is objective knowledge and specific rules that define what the therapist should do, or avoid doing, in order to be
A few experts defined competence in reference to the clinical judgment and reflexivity of the therapist. Clinical judgment was described as the therapist capacity to come to an understanding of his/her specific patient at a particular time and to deliver an appropriate intervention, by being able to take time to think, gathering all the information he/she has about the patient, acknowledging his/her observations, and understand all this material in light of theory. However, competence was not understood as the raw and enslaved use of theory. Conversely, competence was defined as the ability to apply theory creatively to understand and treat a patient. Therefore, competence is the ability to adapt the use of theory to a specific patient and not being a slave to it.

Experts suggested that competence also depends on the level of self-knowledge the own therapist has of himself/herself.

Core Competence

The expert clinicians identified 8 themes that describe the essential components of a therapist competence. These themes are: (1) the analytic attitude; (2) issues regarding judgment, flexibility, adaptations, and timing; (3) keeping the patient in mind and treating him/her as an agent; (4) occupying the therapist role; (5) therapists’ tasks and skilfulness in the use of techniques; (6) the therapeutic relationship and alliance; (7) the therapist self-awareness, self-regulation and capacity to think; and (8) the ability of understanding and intervening at multiple levels. In the following section I will describe in detail each of these themes.

(1) The Analytic Attitude

Eleven out of twelve expert clinicians highlighted the importance of the analytic attitude as a core competence of a psychotherapist. Several descriptions were made in reference to this theme. Firstly, the analytic attitude was defined as the capacity of the therapist to maintain awareness, throughout
the session, of the unconscious processes that take place in psychotherapy. Therefore, the therapist is able to keep in mind that the patient’s verbal and non-verbal communications have an unconscious meaning. Several expert clinicians indicated that alongside this attitude, the therapist should be able to attune and be attentive to the broader range of communications of the patient. In relation to this, one expert clinician expressed:

“It’s about attunement to where the patient is at and out of that also comes the capacity to be with, to sit with, to know, to identify, to sometimes name, to explore the affect. If a therapist is clearly expressing in the session with the patient that affect is welcome, and that there is affect there, and that it can be thought about and born by both. That feels to me as a competent therapist at work.”

Another competency related to the analytic attitude is the ability of the therapist to help the patient to have a growing awareness of their own psyche and unconscious, even if this does not promote behavioural changes in them. In relation to this an expert clinician reported:

“The overall aim, I think is to promote independence and health and maturity so that eventually the person leaves and he’s able to rely on his own mind to understand his problems. Facilitating insight for instance with the patient whether it through interpretation or holding or clarification is very important.”

Thus, competent therapists should be able to promote the patients’ interest in their own mind. Promoting self-knowledge and self-understanding is particularly relevant with patients that are distrustful or are not able to receive the therapist’s interventions because they are very defended.

An important issue regarding the analytic attitude is that the therapist should not be judgmental towards the patient communications or difficulties. The therapist should be aware and know their own prejudices without letting them interfere with the psychotherapeutic work. An expert clinician considered that therapists:
“Need to be able to adhere to an inner framework of ethical conduct…in terms of prejudice and personal issues in relation to histories or backgrounds or colour or whatever it might be. They need to make a good enough attempt to have identified their own prejudices, and to be able to sit with, and tolerate them and not let them get in the way of the work.”

A therapist that knows the workings of unconscious processes and is aware of them in the session, also knows that at times it is necessary to hold on to the uncertainty associated with not understanding what is going on in the session with the patient. A therapist can show this uncertainty to his/her patient, conveying that the process of psychotherapy is collaborative one where meaning is constructed between therapist and patient. Regarding this issue an expert clinician said:

“You don't need to come across as the one who knows it all. It's true that I said earlier that there needs to be a gap between therapist and patient and that the therapist needs to be better equipped to help the patient. But, that doesn't mean that the therapist is omniscient and omnipotent or that the therapist knows it all. The therapist can show that that he doesn't know and I may sometimes say, 'I don't understand it yet. I hope that at some point I will. But I don't know. I'm not sure.'”

(2) Balances, Adaptations, When and When Not, Timing

A core competence of a psychodynamic psychotherapist is the ability to be flexible in the delivery of interventions, adapting them to the patient. Therefore, the therapist should be able to both, draw on theoretical knowledge about the therapeutic situation, as well as to be able to use this knowledge flexibly and creatively according to the individual patient. In reference to this issue an expert clinician reported:
“…They’re free to move within the model that they’ve actually understood it and they are not following a tick box thing or just following the patient around the material, but actually that they’re also there, stopping, slowing the person down if they don’t understand, asking the right questions, but then making some links or showing that they have an understanding that’s dynamic, that they are aware of resistance to change, that they are aware of how defensive a person might be so that they can make it more real in the moment.”

There are a several elements that a competent therapist should consider when delivering an intervention. In the opinion of several expert clinicians, a competent therapist should be able to adapt the techniques and interventions according to the character structure and difficulties of the patient.

“…Working with people with borderline personality disorder… I think you'd want to be very careful about working in a way that stimulates their already over-elaborated fantasy life. They will see things very much from their own viewpoint very quickly. If you then pick up a stance where you almost become a blank canvas, it's unhelpful because actually, you're almost throwing oil on the fire or you're making it much, much more intense rather than in a way actually giving them reality parameters that can actually help them orientate themselves to the reality”

Therefore, according to the expert clinicians, a competent therapist adapts the technique to the patient’s level of functioning, level of intelligence, personality, state of the relationship with the therapist, and to the state of the therapeutic alliance on a particular moment. Moreover, the competent therapist considers where the patient is at in the trajectory of therapy. This was explained by one of the expert clinicians in the following way:

“So, to take an example, one of the main techniques would be a capacity to interpret the possible unconscious motivation behind something or the unconscious level of meaning of something that's happening. For example, a way that the patient’s behaving in the session and being able to put that into words in a way that the patient can actually understand and doesn't feel
traumatised by and finds meaningful so they can use it and which is at the right time for that patient”

Thus, in the expert clinicians’ opinion a competent therapist needs to be aware in which phase of the therapy they are in the work with the patient. Interventions are only appropriate when they are guided by the understanding of the times of the patient and the therapeutic process. In relation to this an expert clinician expressed:

“I guess that an overall competence relating to what I’ve just been saying is that the therapist needs to be aware of where they’re in the work and be able to draw that understanding to guide what interventions are appropriate, given the phase of therapy that they’re engaged and at that point of time.”

In the expert clinicians’ viewpoint, competence entails delivering interventions at the right time for the patient.

“For example, if you interpret something in the following session that you only understood after the previous session, that may not work for the patient because they may no longer really be in touch with what it is that you are referring back to. The timing is quite relevant. It has to be close enough that the patient is still in the state of mind that you’re trying to help them understand or at least they can clearly remember it.”

In relation to this theme, several expert clinicians described that a competent therapist is able to recognise when is necessary to be active and when it is better to allow for silences in the session. The therapist should not respond right away to everything the patient says. There should be a certain distance and silences that allow for time to think, observe and make links and be attentive to what is happening in the session for both, the therapist and the patient. Overall, all these subthemes indicate that it is very important that a therapist recognises when and when not to intervene.
“She was quite upset but also grateful to be disagreed with and told she was talking complete non-sense. But if I said that halfway through the story, I think she was still trying her hardest to persuade herself and me that she definitely did think that. And it was really only when she had been listening to herself talking rubbish and trying not to notice it. But when I pointed it out, she knew that was right. And so, the timing in that case was important. She could hear it because a bit of her had already started realising it, without being conscious of that.”

An issue of critical relevance is the ability of the therapist to distinguish as well, when and when not to act, particularly when the patient is at risk. In these situations, the therapist should be able to adapt to the patient’s needs and actively take care of the patient’s risk.

A final point regarding the use of judgment in the delivery of interventions is the ability of the therapist to assess whether sharing the counter-transference or not would be helpful for a particular patient. If the therapist considers that it would be helpful, the delivery of it should always be done with prudence, judgment and only sharing it in an hypothetical way.

“I think one’s got to be judicious about what you share about your internal states. I don’t think one would essentially want someone to be as blunt as say, ‘Well actually you’re actually talking to me, Miss X, and I’m feeling immensely bored. Do you feel you have that effect on other people in your life?’ Even if that might be true, it might also be insensitive, and even offensive and provocative. But, I think if you could find a way of -- so this patient I’m thinking about now is someone who when she used to talk to me, I used to feel immensely stupid. I felt like I couldn’t follow her properly and I didn’t understand her, and I always felt rather puzzled. And, in sort of exploring the experience she has with others, it emerged that she often felt stupid. She felt that actually -- I can’t quite remember how I put it to her then, but it would have been maybe something like, when she talks to me she expects that I should feel rather unable to follow her, or unable to make sense of what she is telling me. It was
introducing a relational experience, and then in a sense to invite the patient in a way to be curious about this, and neither for us to say, “That never happens to me, I don’t know what you’re talking about.” Or indeed as she did to actually start to really explore the fact and it turned out that she’d had a learning disability at school, and she always felt rather inferior that in some way got enacted in the relationship with me. “

(3) Keeping the Patient in Mind, Prioritising their Interests, and Treating them as an Agent

Expert clinicians agreed that a basic competence is the ability to help the patient feel stronger, capable of mentalizing his/her own difficulties, allowing him/her to be an active agent in his/her life. Therefore, a core competence is that the therapist promotes the patient’s independence, not dependence, by facilitating insight and change and capacity to understand his/her own mind.

“I think because it challenged him and it would have been easy to go along with thinking that there was someone blocking him but actually it’s got him to look at what he does in the situation, that keeps this going, rather than being a victim of circumstance. And that whether he can or can’t get a pump, whether the pump is the right thing for him or not, that somehow he doesn’t help himself, he actually makes things worse for himself, and there’s some helplessness and passivity in that position.”

An essential component of treating the patient as an agent, is that the therapists understands that the therapy in itself is a collaborative process of exploration, and entails that both, patient and therapist, develop. Therefore, because is an exploratory process, its open in the sense that the therapist should not have a particular agenda for their patients, but should collaboratively build meaning with them.

“…It’s a process of exploration and development for two people in the room. There is no programme, there is no trajectory that needs to be adhered to…in
terms of going in there with an agenda that needs to be left at the door…What I want to say first and foremost, is not knowing…the therapist fundamentally takes on that they don’t know. They’re hoping that the patient can expand and explore and help them understand”

Several expert clinicians considered that a competent therapist should be able to put the patient first. This means that the therapist should always prioritise what is best in the patient’s interest. For example, at the beginning of therapy the therapist should discuss with the patient the different options of treatment, thinking what is best for the patient, and letting him/her make an informed decision. Therefore, a competent therapist respects the patient, his freedom of choice and interests. Thus, a competent therapist needs to be fair and unbiased to help the patient, which is a crucial component of fostering good therapeutic relationship with patient.

“I think a competent therapist brief or long term actually should be familiar enough with other models of treatment and what the options are for the patient and should discuss with them at the beginning what the possibilities are that might help them. Why they offer the model that they offer, what they think that could do for the patient. They should have the patient’s best interests and freedom of choice in mind and that should be communicated. I think it’s really not competent when a patient goes along and because the therapist has a training in a specific thing… They just say this is what we are going to do and I’ll charge you this much and you come every week or whatever. They don’t really get informed consent from the patient to what it is that they are offering and they don’t recognise that the patient might have other alternatives that might help them more. I think an aspect of being competent is to begin the therapy with an honest discussion with the patient about what the therapist can offer and what else the patient might want to consider. And put the patient’s well-being first… I think that’s all part of making a good contact with the patient from the beginning”

The latter is also an important part of keeping an ethical practice, respecting the patient, the process, the boundaries and confidentiality, all of
which are fundamental for the therapist competence according to the expert clinicians.

Several expert clinicians also considered that a core competence of the therapist is the ability to deliver the interventions in a way that the patient is able to take the therapist’s comments constructively, leading to positive changes in the patient. This only can be done if the therapist has the patient in mind, and remembers his/her precautionary tale, which guides the interventions so they are possible to be received by the patient.

“The ability of the therapist is knowing how to…in terms of the precautionary tale or making use of what we know about the patients’ anxieties about coming into therapy…being able to understand those, and begin to talk about those with patients in a way that’s going to be helpful, and enable them to move forward, and use the help that’s on offer.”

(4) Occupy the Therapist Role

Several expert clinicians expressed that a competent therapist is able to trust in his/her own instincts and to try things out with the patient. Thus, the therapist should not only remain in a safe place within therapy because that does not help or lead the patient anywhere. The competent therapist should not be frightened to test out things with the patient and should be open to learn from the patient’s feedback.

“If they can’t hear it then you know something that you didn't know before, but if you're not willing to take some risks and ask the questions that people are too frightened to talk about or what isn't being said then you stay in very safe territories and it doesn't go anywhere”

“Is courage to make links where there needs to be links. A courage to observe things which might be difficult to observe”
Therefore, in the expert clinicians’ opinion the competent therapist is one that uses his/her role in therapy, not feeling insecure, but having a sense of authority of what the role means. The therapist has to believe in himself/herself and the therapy that is being delivered.

“Is feeling that you have authority, almost so that you can be, because I was listening to someone and she was saying all the right things but in such a tentative way that it didn’t feel like she could really occupy her position as a therapist.”

In the expert clinicians’ viewpoint, there has to be an asymmetry between therapist and patient. In other words, the therapist must be able to offer something to the patient that he/she does not have. Additionally, the therapist should be able to see beyond the surface in order to provide a deeper understanding.

“You are there to try and provide some understanding. You cannot be at the same level as the patient. There needs to be a gap. You need to have some knowledge, some capacity to see beyond the surface, to see something behind that the patient cannot see.”

(5) Therapists’ Tasks and Skilfulness in the Use of Techniques

Expert clinicians expressed that there are generic skills which are the basic components of therapist competence, common to all modalities of psychotherapy. The generic skills include the abilities to: listen attentively, show empathy, engage the patient, and to conduct assessments.

In the expert clinicians’ viewpoint, the therapist engages the patient by making him/her more interested and surprised with the material. In other words, the therapist engages the patient by sharing an understanding of the patient's difficulties that he/she has not seen before. In relation to this issue an expert clinician reported:
“I think one indication [that the patient is engaged with therapy]... is if the patient appears to be more surprised and more interested in the point that's being made. To go back to the example of the man with his long time depressing marriage, if I say something about his relationship with his wife...he's actually so bored with the subject...that there's almost nothing anyone could say that would really surprise him...But what surprises him more and makes him more interested...is the idea that there's a way that he behaves with me and uses the relationship with me that's quite similar to what he describes with her. But he believes that there are completely different relationships...he thinks his wife is really stupid and boring...and he thinks that I'm intelligent and interesting, and basically some of the time he wishes he was married to someone like me rather than someone like her. But he actually treats me, without being conscious of it, in a very similar way, in a contemptuous and degrading way that he has described to treating her but he's not at all conscious of that...But if I can show him in the here and now, that actually some way he's been talking to me or behaving in the session...is just the thing he describes with her...then he's really amazed because he thinks how could I possibly be regarding you in the same way as I regard her because you're the opposite. So, then he takes it on. He takes more ownership of that side of himself because that is constant between these two very different relationships so it must be something about him...if someone was observing...would see that the patient is more engaged and surprised and interested following that. The response of the patient is an important indication of whether it was well aimed. I think keeping the patient interested is very important.”

In the experts' opinion, engaging the patient is related to adding meaning and being attentive to the patient’s communications:

“They are thinking in a way that's different from a patient, they are adding something from the model that they have. They may be interpreting something that was unconscious, then may be disagreeing with something because they simply don't believe it...They may be putting together something the patient hasn't noticed like a pattern, a pattern of lateness or pattern of avoiding a
particular subject or something, but to do that, they need to be paying attention. Showing that they’re paying attention or that they are thinking and adding meaning to what’s going on, and enabling the patient to share in that adding of meaning.”

The expert clinicians concurred in that a core competence of the therapist is the capacity to conduct an assessment of the patient’s difficulties, and to have a formulation of the causes and meanings behind them:

“Psychotherapists and psychologists are trained to really get a good, a really good understanding of the patient’s history. Not that you work with the entire history but you’ve got to have some understanding of their relationships and how they’ve come to have this presentation that they’re sitting in front of you with. What that gives you a sense of about what might occur between you and them in the room, but how that will help you to formulate what’s going on. So, of course formulation is really key”

In the expert clinicians’ opinion, a competent therapist should also have the capacity to assess the suitability of the patient for a particular kind of therapy. Experts expressed that the way a competent therapist specifically assesses the suitability for psychodynamic psychotherapy, is by seeing how a patient makes use of an interpretation. Furthermore, the therapist understands that the patient can work within a psychodynamic framework if the patient is capable of working in an unstructured environment, and if they can tolerate learning difficult things about themselves.

Another important generic skill described by the experts was the capacity of the therapist to manage the patient’s expectations about the therapy. Therefore, the therapist should be able to clarify what can and cannot be achieved in therapy, and whether the treatment model proposed is the appropriate one for that specific patient.

“Managing expectations, being clear on what’s possible and I think the other thing is really important is that the responsibility for change always rests with the patient. I’m not going to make the change for him, I don’t have a magic wand
and I don't want to be omnipotent in a relationship, so I always really do make sure that's clear...what would he want to be doing differently and then coming once a week for 50 minutes isn't going to change everything in his life, he'd have to be doing other things, is that something he's willing to do. It's assessing motivation, yes.”

The competent therapist, should also maintain his/her motivation and should enjoy working with their patients.

“It's hard work and it's not often enjoyable but you need to retain some capacity to want to do it. This, in a way, it's kind of intangible thing. Good therapists do this work because of who they are not because of what they do. I don't want to sound too preposterous in a sense, it's a vocation in that sense.”

A competent therapist should be able to challenge his/her patient, and to use humour in a therapeutic way.

“An analyst who I know who does quite lots of psychotherapy as well. I know quite well, is very good at using not interpretations really but ironic comments that are almost sarcastic and humorous and they're little asides like the patient might say something like, ‘I never do this, I can’t bare it when people behave like that and that's something I would never let myself do’, and the analyst might say something like, ‘Except when you do’. Implicitly disagreeing with the patient but in a playful way, and the patient could be shocked that they could ever be like that.”

Several expert clinicians agreed in that therapists should be able to make short, clear, economical interventions, that might not be completely explained, but that nevertheless work when there is a relationship and an understanding with the patient. The patient can understand what the therapist is saying without him/her having to explain everything in detail:

“…economical, I think that’s another aspect of competence that somebody can say something in a pithy way. Something like, ‘Of course that’s about us’ or ‘except when you don’t’. These are very short and they’re not really fully
explained but they work when there’s a good enough understanding with the patient, that the patient can fill in what you’re saying without you having you to have to make speech about it. I think being able to make quick, brief, interesting and surprising, maybe quite amusing”

The expert clinicians also emphasised the importance of skilfully delivering other interventions, besides the general ones. Among the specific psychodynamic competencies, several experts indicated the relevance of the maintenance of the frame and boundaries of therapy.

“The ability to maintain the frame. In that, I refer to several things. One is the physical frame which I think is important. There is stability in the place, the time, the frequency. That gives a sense of safety to the patient…the stance of keeping your own stuff private and not really breaking that boundary of the fact that you are meeting to discuss the patient's problems you are not meeting to discuss the therapist’s problem. Boundaries are very important…privacy, reliability…the fact that if you take the commitment to see a patient you have to take on bold. That you have to be reliable, you have to be on time, you have to finish on time…is very important in order to provide a sense of constancy.”

Another psychodynamic skill is the ability to deliver interpretations, and adapting them in accordance to the patient’s response to it

“…capacity to interpret and be able to carry out an interpretation. For instance, be able to observe what reaction a patient caused on interpretation because that is also informative. Sometimes it's informative of the patient's defences so the patient cannot take your interpretation right now.”

Several expert clinicians highlighted the importance of helping the patient mentalize, as an essential psychodynamic skill a therapist should have.

“I believe just to be important in therapy, is how to help the patient to mentalize because that is what I believe we’re trying to do. For me, a competence would be making interventions that support a mentalizing process…I would say the
whole mark of a psychoanalytic way of working is that you do try to introduce challenges where you can…All that you are doing to pursue with it is to get the patient into a more mentalizing state”

Finally, the expert clinicians highlighted the skill of the therapist to work through the end phase of therapy with the patient.

“The example that comes to mind is someone I was supervising who was working with a male patient towards the end of their dynamic interpersonal therapy, so they were in the goodbye phases. He came in…saying that he’d had a lot of difficulties with a plumbing company…they made a mess of the work. He was a bit better off doing it himself, and then he was rather suspicious of them as a reputable company. What was skilful…is that the therapist was able to understand…how difficult it was and how he felt about it. But, at the same time, she was able to quite skilfully elaborate that experience into things that resonated more generally with his relationships…And, then able to move into talking about that in relation to where they were in the therapy…it was a way of linking through from the very… immediate into something that had to do more broadly with his relationship and his attachment style, and his way of relating, and how he felt about relying on people, to…then actually being able to look at where he was in this therapy, what that meant for him.”

(6) The Therapeutic Relationship and Alliance

The expert clinicians concurred in that an essential therapist competence is the ability to form a therapeutic alliance with the patient, a relationship of trust where the patient and the therapist feel safe to explore difficult contents.

“I think what is really absolutely crucial is whether the person can sit with you and how to really form a good enough, trustworthy relationship that the person can work with you so that some learning can happen.”
Therefore, in the expert clinicians’ viewpoint a competent therapist is able to foster and maintain a relationship with the patient, which generates enough trust and awareness of what the therapist is trying to do, that the patient can tolerate being challenged in what they like to think about themselves.

“She [patient] was quite upset but also grateful to be disagreed with and told she was talking complete non-sense…She could hear it because a bit of her had already started realising it, without being conscious of that…But of course it matters that she’s been seeing me for a few years now…and she trusts me and she also knows that she’s got a lot of help…I think if that had happened the second time I saw her, she probably would have just not have come back. So, it’s become possible to say much more and to challenge her a lot more than I could have done near the beginning of the therapy…to be able to create and maintain a relationship in which those things are possible. So, trust and understanding become possible”

Thus, experts indicated that a core competence is the ability to create an environment of safety where the patient feels able to speak freely. This enables the patient to share and disclose personal information of a sensitive nature because he/she already know that the therapist will be empathic, interested and attentive, all of which are foundation blocks of competence.

“There needs to be some practical disclosure in terms of basic therapeutic frame. If the therapist is basically expressing that there’s a space in which this process can happen, and this space is safe in terms of times, and configuration all those can create boundary things that contributes to it very much so, I think the frame is crucial. There is the relational aspect and that comes about through offering an open, responsive, inquisitive, helpful…space…to make the patient feel safer than they usually do.”
It is important that the therapist fosters a normal human relationship that has boundaries, which are essential for understanding and delivering interventions within the psychotherapeutic process.

“To create and maintain a relationship in which those things are possible...so trust and understanding become possible. And that I think is not just to do with delivering your technique within the theory. It’s also to do with being-- having a setting, a personal setting in which you treat the patient with courtesy and interest, and you remember what they’ve told you before. And you’re reliable, so don’t cancel appointments all the time. And also, that has a human-- definitely a human warmth about it. I think to me, therapists are more competent if they are able to create a normal human relationship within clear boundaries. I don’t think it is as competent when a therapist is-- behaves in a very stiff and formal, almost cold way, a rigid way with a patient. I think that’s less competent because I think it makes it harder for the patient to form an attachment relationship with a therapist. The therapist is not accessible, emotionally accessible for them. So, I think creating that context of the relationship is just as important as the other things.”

Additionally, expert clinicians expressed that an important component of fostering and maintaining the alliance with the patient is the ability of the therapist to explain and collaboratively agree with the patient on the tasks and goals of the therapy.

(7) The Therapist Self-Awareness, Self-Regulation and Capacity to Think

Most expert clinicians indicated that a core competence of the therapist is his/her self-awareness, meaning the realisation of his/her own feelings and thoughts, and the ability to articulate those in a meaningful way in order to understand what the patient is bringing to the relationship with him/her. This competence includes also the ability of the therapist to think, after an enactment, how the patient’s mind impacted the therapist one. Additionally, it includes the therapist awareness of his/her own blind spots, meaning that the
therapist is able to differentiate when what he/she is feeling belongs to the patient and when what he/she is feeling belongs to his/her own personality.

“After a few sessions of this particular person working with this patient, it was thought in supervision, perhaps quite unhelpfully, to stop a psycho-dynamic…this particular patient went off, and did this and received absolutely no benefit from this changing the care plan, was to come back into psycho-dynamic work- brief psycho-dynamic work, and express really difficult feelings about feeling rejected and abandoned by the therapist in this plan of basically sending them off and then coming back…what transpired as the work progressed is that it was disclosed that he had been adopted and all of a sudden, the penny dropped for the therapist and the supervisor and so far, as we had completely enacted it…The handing over, and what came out of that, and what was needed to be done, was the therapist, in a very skilful and helpful way to this patient, holding…to the enactment, and to use that as a springboard to access a configuration that was so fundamental to this patient in their way of experiencing themselves, in relationship to other people…out of that came a therapist’s bit of work…it was conveyed that although, as a service, unconsciously we’d slipped up and we’d done the very thing that was least wanted, that out of that, some sense could be made and some meaning could be found that would help this person become more able to envisage, and to know what they do in the world…You can't be the perfect therapist to the patient all the time, but what the therapist has done is that they've really displayed a capacity to metabolise, and sit with, and basically unpick…a projective identification that has allowed learning on both parts. For me, to go back to the original question, if a therapist is displaying competence, there are two people in the room changing, and that’s the crucial thing. That this part of oneself that the therapist offers will always be being modified, and that’s crucial for me. That two people are working.”

Thus, in the experts’ opinion an important competence is the capacity of the therapist to contain his/her own anxieties and feelings and not to enact them, understanding why he/she is feeling in a certain way.
“They need to be able to sit in a room with somebody else…and tolerate feelings of anxiety…Not in an overbearing sense but they need to offer a part of themselves that can be utilised by somebody else and not everyone has that capacity, I don't think. They need to be able to tolerate very difficult feelings.”

Several expert clinicians highlighted that the competent therapist will be able to think in the room with the patient, meaning that the therapist will be able to be open to the patient’s influence while at the same time draw on theoretical knowledge to understand what the patient is communicating. Therefore, the competent therapist should be able to retain the capacity to think, to see, and to experience new things together in the session with the patient. Only a therapist that is capable to think in the room with the patient will be able to understand what the patient is communicating or enacting in a unique, individual and creative way, and intervening accordingly.

“That you don't have to know the answers…we're being curious and not knowing…that you can really think with someone to make sense and to try and get some coherence about what might be going on for them. You need to be willing to be lost and overwhelmed and to feel that you can trust that you will come out the other end, and that you can still retain a capacity to think”

Most expert clinicians considered that in order to able to think, the therapist should tolerate ambiguity and uncertainty, so there is space to explore and understand.

“I think a competent therapist is someone I think who most probably can manage with a certain level of ambiguity, with uncertainty, he can tolerate some uncertainty…a colleague who you feel he’s immensely solid with patients. He’s not too frightened; he’s not out of touch either. He’s not naïve or grandiose, but you feel actually that if people come and tell him things that are quite difficult or unpleasant, or scary or whatever, he takes it in his stride. I think it’s …someone who feels that they’ve had life experience, handling complexity in some way. You can manage complex feelings, or you can hear things that you’re not so easily shocked.”
The expert clinicians coincided in that in order to be self-aware of his/her own blind spots, and to be able to think in the session, the therapist should have his/her own experience of being in psychotherapy. Furthermore, it is important that the therapist has had his/her own therapy to have a sense that it is helpful, and to convey this to the patient. Additionally, the therapist’s own therapy would help him/her have a better understanding of unconscious dynamics and relationships.

“I think you need to be analysed yourself so that you’re not unaware of your own contribution to the situation, because I think if you feel fully aware of your own issues, you can be there in a much more open and genuine way to have proper encounter with someone”

Furthermore, expert clinicians considered that it was essential for the therapist self-awareness and capacity to think, that he/she would be able to make use of supervision. Therefore, the competent therapist should be able to bring to supervision the right content and describe what is happening in the transference with the patient, being able to receive and think about what the supervisor suggests. This has to do with the ability of the therapist to check their own practice, making use of supervision and new knowledge. Supervision, knowledge, peers and the organisation the therapist works at, help to contain the therapist in the psychotherapeutic job.

“‘Are you able to use supervision?’ So that…you can bring in a different kind of meta-perspective so that the exchange between the patient and the therapist can be looked into. Basically, what I’m saying is what happens in the room but also the capacity for you to really take it outside therapy and be able to look at it and learn”

For the latter, it is essential that the therapist is humble and knows that every patient is different. Therefore, the therapist should know that there is always something to learn from every individual, and every session.
Most expert clinicians coincided in that a competent therapist is able to intervene in multiple levels. Therefore, by being attuned to the patient, the therapist can understand the patient’s internal state, external relationships and transference situation. The therapist holds an understanding of the patient in mind that they can sensitively share in the session, expanding the patient’s understanding of the implications and consequences of their difficulties.

“They’re both incredibly competent therapists, and they both have a remarkable capacity to be, not in a gooey or sentimental way to be empathic whilst retaining a dignified position in relation to the client. So that they do what we call marked mirroring so they’re able to show that they know how the patient feels, and that they’re always able to present an understanding of what the client is saying. That actually expands the clients horizon in a certain way, but their understanding is in line with where they’re trying to take the client to…She’s able to respond to the increased depression that the client is feeling, and then be sympathetic with the struggle that the person has with self-esteem…and link that to the situation in the therapy where…they feel that the therapy should have done better, but they also feel humiliated that they haven’t done any better for the therapist and link that to their internal relational-affective pattern that the person is working on”.

Most expert clinicians conceptualised the competence of intervening at multiple levels as encompassing three steps. The first step is the ability of the therapist to understand the unconscious meanings of the patient’s communications. The second step is the ability of the therapist to understand the implications of the unconscious meanings of the patient’s communications to the therapeutic relationship in the here-and-now of the session. The last step is the ability of the therapist to intervene competently in accordance with these understandings.
“My thinking about it is usually the client is outlining a state of affairs, a situation, something that they are presented with in their life and the therapist has an understanding of it so they need to, first of all, understand the communication then appraise it to come to what does this-- and I'm using the term meaning here quite specifically-, what does this mean in terms of the multi-layered nature of human communication. What does this communication mean or imply in terms of the client’s life outside of the therapy, the situation that they're in, the way they are looking at that situation, and then, what does it imply about the situation in the therapy, why are they saying it now and what does it mean in terms of the current situation for the client in the consulting room? Taken that together, how does my supervisee respond to that? People tend to fall, sometimes, at the first hurdle”

“Then that leads in to a capacity to utilise any transference activation which requires in the part of the therapist to skilfully bring in to the patients a potentially new and quite challenging level of experience which needs to be held in that as if realm. That if the therapist can help the patient see that what is occurring in the therapy is a manifestation of some fundamental way of, it's object relating, and that that becomes alive in the therapy, and that the therapists can bear that, and can make sense of it, and can digest it and can contain and utilize it, that feels like a competent therapist to me.”

Most expert clinicians highlighted that the ability of understanding the patient’s communications and intervening accordingly at multiple levels requires an understanding of what is taking place in the here-and-now with the patient. The latter entails the ability of the therapist to understand relational dynamics.

“If then a therapist can make sense of links, reflect on potentially what's happening in the room, take it out to other domains within the patient’s life, historical context developmental stuff and is beginning to help the patient map their inner world, that feels like a competent therapist to me from a psychodynamic perspective…. When I get the sense that the therapist is able to follow the material, is able to understand what is going on in the session.”
Several expert clinicians indicated that the therapist's interventions are competent when they are delivered in a genuine way, creating a subjective experience that feels immense to the patient, because something he/she was unaware of, becomes verbalised. The latter produces a “click” experience in the patient who is able to then understand something different or with another depth. When this takes place, there is usually an observable change in the patient: of tempo, of emotions, or of the usual behaviour in the session. This can bring about new material or allow that old material is elaborated in a different way.

“I think the patient feels that some things about their experience has been acknowledged, recognised…something that they’ve been unaware of, or perhaps haven’t quite put together in that way before stands out in a sense…you get to the deepening of effective authenticity, where someone can actually express something in a more genuine way, be it sadness or be it rage, that they’re a bit more emotionally, their head and heart are a bit more connected…you can often see or hear when something actually clicks into place a bit, and you actually feel this, something deepening in a way, something is being grappled with and explored…sometimes you will see or hear, sometimes it is about a change in the tempo of speech…if I found a way of talking to him in a way that made sense to him or kind of got hold of how he was feeling, or what he might be anxious about…he would just settle a bit, and you’d feel that he would almost, sometimes you’d see him sit back in his chair. He’s always on the edge of his seat, sort of sit back…relax. Think a bit more…being more receptive in a way…you can see then what then patients will go on and talk about. I think they…may often bring something new material or they’ll elaborate older material in a new way. The experience where you can listen to a patient telling you something that they’ve told you before, but they’re saying it in a way that’s sort of different and that…You see things in a different way. It’s not just about patients, but I think, having insight. It’s about the therapist starting to, ‘Ah, so it’s a bit more like that in a way,’ or that sort of thing.”
The interview of expert clinicians included several questions about specific competencies that had been outlined by Lemma et al. (2008) in the Framework of Psychodynamic Competence. The underlying idea was to comprehend how expert clinicians would understand in practice the competencies outlined by this framework. The specific psychodynamic competencies that the expert clinicians referred to in the interview were: (1) accurately understanding the patient; (2) therapeutic alliance; (3) arriving at a dynamic formulation; (4) assessment and using trial interpretations; (5) use of the countertransference; (6) management of defences; (7) management of the emotional content of the session; (8) empathy; (9) working through the end of therapy; (10) engaging the patient; (11) understanding the patient’s interpersonal feelings and defences; (12) interpretations; (13) use of supportive vs expressive interventions; (14) mentalizing; (15) risk assessment; (16) titrating interventions; (17) understanding and using the transference; and, (18) facilitating, responding and understanding unconscious communications.

(1) Accurately Understanding the Patient

a) Patient’s Reactions

Expert clinicians conveyed that it is easy to misjudge whether the therapist is accurately understanding the patient or not when supervising, listening or observing a session. Often the therapist may say something clever that the patient is unable to understand. Therefore, experts emphasised that the best indicator that the therapist accurately understands the patient, are the patient’s reactions to the therapist’s interventions.

“Sometimes it’s impossible to judge and I find it quite hard but often you get misled because the therapist seems to be very insightful and intuitive and you are impressed by how well they understand the patient…‘ That was clever’ but actually from the patient’s point of view, complete waste of time. They didn’t
understand it, they thought the therapist was being so…How the patient responds is really quite important"

Most expert clinicians coincided in that it is possible to say that the therapist accurately understands the patient if, after an intervention, the patient changes his/her behaviour. Therefore, when the patient feels accurately understood, he/she may become silent, or could change the rhythm in the affects or in the thought processes of the session. Additionally, the patient may often start making more connections and bringing about new contents. Thus, the patient may become more trusting, disclosing or remembering relevant material, which is usually associated with an important emotional reaction. This change in the patient’s behaviour does not need to happen right after the therapist intervention, it can also occur a few sessions later.

“Where someone can feel understood, and that can either give them pause in a helpful way, or make them think about something. Or they could introduce something where I see things a bit differently…they make links, might bring new material…in a way shares something or shows you something about themselves, they make themselves a bit more vulnerable. They perhaps are a bit more disclosing or trusting in some way.”

“Or sometimes it's not just the immediate response the patient has to the interpretation for instance. But is also important to see the session as a whole because, many times you may say something and the patient may not react. But then when you get to the end of the session…you actually see that there has been a reference to what the therapist said”

Most expert clinicians indicated that it is possible to say that the therapist accurately understands the patient when after an intervention the patient not only agrees with the therapist, but also elaborates further the contents of the intervention. Additionally, another sign that the therapist understands the patient, is the ownership, -on the part of the patient-, of the idea conveyed by the therapist.
“Usually if you're on the right track the patient gives you a sort of confirming and personal narrative, or will say something that validates or gives you a new piece of information that you didn't know about before that gives you another deeper level of understanding”

“And the patient's reaction either is expanding, elaborating or I'm thinking maybe he might be touched emotionally… and then say something that makes it clear that they're thinking about it a different way from the form and they've really been taken aback by the point that you made. And it then becomes productive, they can see things in a way that makes more sense to them.”

The expert clinicians also indicated that, when the therapist misunderstands the patient, he/she may react by displaying: distress, aggression, compliance towards the therapist, as well as by breaking the alliance. Additionally, an intervention that is wrong in its content or time may lead the patient to close down or stop mentalizing in the context of the session.

“If you're not understanding or if you're getting it wrong…and if it's abrasive or attacking…I think patients can very quickly, and very adeptly let you know, that they're not being understood, in all sorts of ways…You get all sorts of reactions. You get bristling, you get confusion, you get irritation, aggression. You get distress. You get compliance, and you get patients trying to make it better. Trying to save the therapist, trying to educate them. You get all sorts of things. But there's a break, there's an energetic break, there's a fracture in something…Yes, and there's a break in the way of two people relating, and all of a sudden, you may be stuck in a slightly awkward bit, and no one quite knows what's happened…Breaks in mentalizing, on both parties, or whatever it might be.”

b) Therapist Attitudes and Behaviours

Most expert clinicians indicated that in order to accurately understand, the therapist gets alongside with the patient’s experience and feelings. Accurately
understanding the patient means to provide them the experience of being understood in a deep and meaningful way, not just telling them what they already know, but also saying something new. The experience of being understood involves a therapist that gets alongside with the patient, which is quite profound and immensely moving for both individuals.

“The experience of being understood…for me it was always about facing a patient with something they hadn’t known before…Something new that was a bit outside of their awareness and that you were not just telling them what they know. But, actually I do think that the experience of being understood I think is quite profound. When someone really understands you and understands your view, and understands your predicament and your situation that can be immensely moving in a way…the first thing you do is get alongside someone...Actually, you’re not offering any solutions or messages when you see anything profound, but you’re saying, ‘Actually, I understand that when you come to see me and you sit in a room with me and we talk, it’s an excruciating experience, and it’s really difficult for you. We could try and work out why that is.’ I think that can really make a difference.”

Expert clinicians indicated that it is possible to say that a therapist accurately understands the patient if he/she is following the patient’s unconscious communications, seeing the depth of the material rather than the surface of it. An indication of this, is that the therapist acknowledges and names the contradictions in the material between the manifest and latent contents, or shows the latent material in a straightforward way to the patient.

“It would be about whether the therapist is able to track unconscious communications. That’s what accurate understanding is. It’s not sticking to the surface communication of the patient but going behind it to see what else maybe being communicated unconsciously either through verbal or non-verbal channels so that that would be what I’d been looking for...That the therapist interventions would go beyond the manifest content of what the patient has said. The therapist might say ‘I know you've just said to me that actually you've had quite a good week but in fact I experience you very differently in the room
today…You look very tensed. You can't even look at me.’ That would be, to me, an indication that the therapist is trying to really get to an accurate understanding because there is a disjunction between the surface communication and what…the therapists observes in the patient’s nonverbal behaviour…”

Expert clinicians conveyed that it is possible to say that the therapist accurately understands the patient when his/her interventions make sense from what has been happening in the therapy, meaning that the interventions are based on enough evidence

“Does this interpretation or this intervention by the therapist make sense to me based on what the patient has been describing? There isn't a question of whether you agree with what the therapist said. You'll say that's accurate if you think they're right. That judgment will be made on essentially whether the therapist has the evidence in the material for what they said about it.”

Expert clinicians concurred in that the timing of the interventions is a pivotal issue when assessing whether the therapist accurately understands the patient. Therefore, the competent therapist should have the ability to adapt his/her interventions to where the patient is at in the therapy, meaning the state of the patient at a particular time in the session. Thus, interventions should be delivered only if they are also accurately timed for the patient.

“Accuracy cannot, to my mind, be determined on the spot because you could be absolutely accurate about what you're picking up but the patient is not ready…to listen to it…But depending on how you defined accurate. Let's say that I say something to the patient and two sessions later, it turns out it was absolutely right. But in the moment the patient says ‘No, I don't feel that. I felt absolutely fine.’ I think the intervention that has…to go with what the patient can bear to hear that will become the accurate intervention. So, there is an accurate intervention but it's not timely at but it will be revealed to be accurate two sessions later. But if the patient doesn't, can't make use of that intervention then the accurate intervention is to stay with where the patient desires.”
Expert clinicians highlighted that a competent therapist always remains open to the fact that his/her interventions are not necessarily accurate and right. Therefore, the therapist is flexible and open to change his way of thinking according to what is happening with the patient. The therapist does not have certainty and does not treat his beliefs as facts; he/she is rather flexible about them.

“I would never make an interpretation thinking I'm 100% right. I mean I just think that that position, in fact, we talk about competence is the position of an incompetent therapist to have absolute certainty that what you think is right. I can't see how the good therapy can come out of that. For me, that is a very important issue. I would always be open to the fact I may have got it wrong but what I'm trying to model is that.... May not be your thought you're telling me it doesn't make sense to you, let's just park it... Instead, the patient picks it up two sessions later then we revisit it again at that point. I've got to be prepared and that's part of the competence in the therapist to actually be flexible in relation to my own beliefs and not treat them as facts.”

Therefore, several experts concurred in that a component of understanding the patient accurately, is asking him/her for feedback meaning, asking the patient whether what the therapist is saying makes sense to him/her or not. Even if the patient agrees with what the therapist says but there is a feeling in the counter-transference that he/she does not, this can also be checked out with the patient asking for further feedback.

“Working in a more transparent and collaborative way...the therapist is offering their own interpretation of something...but then a degree of checking out with a patient, whether that feels right. Stopping the patient, “Can we just stop for a minute?” So, you said X, Y, and Z, and actually what I heard when you said that was this and that. Is that right? Have I got the picture right? Is that how it feels for you?”
However, the therapist should not only listen to the patient’s feedback in order to decide the accuracy of the interventions, because some patients may accept every interpretation the therapist makes and this should be questioned. The therapist counter-transference plays an important part in assessing whether the interventions are accurate in content and well timed. In this sense, even if the patient accepts every interpretation as truth, the therapist may feel that beyond the patient’s words, he/she feels removed or distant. In order to judge whether the interventions are accurate, the therapist has to follow the patient and the atmosphere within the session, and not only the manifest material.

“Because a competent therapist will sense that it is false either by the counter-transference, so, for instance, oh the patient is telling me he’s saying, ‘Oh this is great or this is’ But you feel the patient is removed, is distant. You don’t feel you are connected. Your counter transference is quite important”

Finally, expert clinicians concluded that it does not matter much whether what the therapist is saying to the patient is truth or not, because at times they may say something true but that it is wrongly timed for the patient, not useful or unclear to them. The important issue is whether what the therapist says makes sense to the patient, is well timed, useful and clear. Thus, in order to assess whether the interventions are accurate (and not truthful) it is essential to observe the patient’s reactions to them.

(2) Therapeutic Alliance

a) Therapist Attitudes

Expert clinicians described several attitudes that a competent therapist should demonstrate in order to foster and maintain the therapeutic alliance with the patient. Firstly, a therapist contributes to the creation of the therapeutic alliance by having a “not knowing” stance, conveying that he/she does not have all the answers. Therefore, the therapist is curious and interested in what the
patient has to say. Secondly, it is essential for the alliance and the process that the therapist has confidence in the therapy. This confidence comes partly from the therapist’s own experience of having had therapy in the past.

“On the therapist part, a confidence that I think fundamentally comes from their own experience of having had this work done healthily with them, and then becoming able to do that with other people… Their own analysis of their own therapy which is showing them that this actually does help. I think somebody who’s not had that experience from their own personal psychotherapy or psychoanalysis. First, they may not really believe that it is helpful or that it could be helpful… I think it’s very helpful when the therapist has the confidence and the belief, the knowledge actually, that this way of having an understanding of the more unconscious signs of life and relationships is interesting and important and helpful, and can actually really transform somebody’s life…if they actually believe that and believe that they have seen it and experienced it when a psychotherapist handles a patient, then I think that communicates a lot to a patient. I think the therapist who doesn’t really believe it, that also communicates itself, and that leads to a much weaker therapeutic alliance.”

Thirdly, a competent therapist contributes to the creation of the therapeutic alliance by conveying his/her humanity, by being humble, recognising his/her own struggles. Additionally, the therapist fosters and maintains the alliance by surviving to the patient’s attacks, by persevering, by being there for the patient consistently trying to understand and work something out. By conveying this tenacity to the patient, they convey that they feel close to them.

“I think surviving…Actually, week in, week out you are there, you are listening, you are trying to make sense. I think patients can tell -- not patients, people…the fact that you’re trying to work something out with someone, the fact that you’re trying to understand, the fact that you’re trying to sort of make sense of it, a bit of tenacity on your part, I think all can count towards someone feeling this person close”
Finally, the use of humour on the part of the therapist contributes to the creation and maintenance of the therapeutic alliance because it gives a sense of the spontaneity of the relationship.

b) Therapist Curiosity, Attunement and Reparation

Expert clinicians expressed that a competent therapist helps create and maintain the therapeutic alliance by showing interest and curiosity on the patient. This is done by keeping the patient in mind, by following the verbal and non-verbal cues, by remembering what the patient has said in the past, and by holding the patient in mind. Therefore, the therapist forms a relationship based on understanding and attunement. Not only the therapist attunement is important, but also the fact that this is acknowledged by the patient, who can feel that the therapist is interested on him/her.

“Just on a very basic therapeutic level reflecting, and mirroring, and naming, and expressing that you have heard, and now bearing witness to somebody’s painful affect and that’s okay. ‘It’s all right for you to express these feelings here, I’m aware that you gave me the impression previously that you don’t let these feelings out and you work very hard not to show them to any one and I’m struck that they’re here today.’ That conveys a capacity and willingness to be with the person. Lots of it is about keep calm, calling innate achievement.”

In order to create and maintain the alliance the competent therapist is open and modifies his/her interventions according to the patient’s feedback or state of mind. Therefore, the therapist delivers tentative interventions rather than rigid statements, showing that he/she is attuned with the patient’s emotional state.

“When you give an interpretation, you’re pushing the defences. I think that then you’re looking at, have you pushed the defences too much and whether there’s capacity for you to walk with those defences…or whether you think that you have made…a link and the patient can’t really get there. You’d be gauging it
accordingly. Your interventions, after yourself delivering it or really sharing it, would be informed by the response. I think there is a cycle.”

Most expert clinicians agreed that is pivotal for the competent therapist to have the skill of repairing ruptures in the alliance. The therapist creates and maintains the therapeutic alliance by showing to the patient that he/she is on his/her side trying to help, especially when the alliance is broken. This is conveyed by showing interest and curiosity on the patient. The tone of voice is important. When there are ruptures in the relationship the patient’s experience has to be acknowledged and validated by the therapist in order to repair the alliance.

“You would certainly not deny their experience of you in the moment…you may say, what I said and the tone and that’s really important. ‘Thank you for bringing it into my attention because that wasn’t my intention, but I can see that that’s how you experienced it. Perhaps we really need to think about what happened, what was it that I said that made you feel that I was being so critical of you.’ And, you may say, ‘Well, perhaps I did come across very critically, and that’s interesting because I wonder what it was.’ You’d be curious about yourself as well as them…You may say, ‘Look, I completely misunderstood that,’ and really you may have to do that to get the person back on site.”

c) Therapist Mindful of the Patient’s Way of Relating

Expert clinicians indicated that in order to create and maintain the therapeutic alliance the therapist must have the transference in mind, not necessarily to communicate it to the patient, but to use it to understand and address what happens in the session. Additionally, at times, when the transference is verbalised, it might help the patient feel understood and therefore trust in the therapist, promoting the alliance.

“I think that it’s important for the therapist to keep the transference in mind. Not that the transference needs to be interpreted in every session, but perhaps at
times when things are not going very well, maybe it's important that the therapist keeps the transference in mind because there may be a negative therapeutic reaction that may affect the therapeutic alliance and therefore you need to address it.”

Understanding the transference and the relational patterns of the patient may help the therapist see the difficulties he/she may have in forming a relationship of trust, which is essential knowledge in order to foster the therapeutic alliance. In this sense, the therapist should be aware that anything the patient brings to the session about other relationships may indicate a relational pattern that may also become expressed in the relationship with the therapist.

“I suppose keeping on thinking about it in your mind, so listening to the material and thinking, ‘Does this have implications for the transference?’ If they’re talking about a very punitive boss, you’d have to think, ‘Do they feel like I’m punitive?’”

d) Therapist’s Tasks

Experts suggested that the therapeutic alliance is an explicit or implicit agreement between patient and therapist that it is worthwhile to try to understand the unconscious motivations related to the difficulties of the patient. Therefore, the therapist should make meaningful connections, expanding the conscious boundaries of the patient and recognising his/her relational patterns.

“I suppose in an agreement or an assumption between the two people that it is worthwhile to try to understand things more, and that there’s a loss of mental life and lived life which we don’t really understand and we’re not in control of, and where we may be unaware of some of our important motives and that we would benefit from being more aware of them. Either implied or explicit agreement, but this is a useful thing to do.”

“About making connections, making meaningful connections between say their relationship with the therapist and something outside, making connections
between something that's being talked about now and something that's been talked about before, maybe a pattern that they've recognised previously. Pushing out the boundaries of what's conscious. The connections would not just be between things that are already completely conscious. That will distinguish it to some extent from other kinds of therapy.”

Several expert clinicians agreed that it is essential for the creation and maintenance of the therapeutic alliance that the therapist keeps the frame and boundaries of the therapy, while at the same time being compassionate towards the patient.

“There needs to be some…basic therapeutic frame. If the therapist is basically expressing that there’s a space in which this process can happen, and this space is safe in terms of times, and configuration all those can create boundaries…that contributes to it very much so, I think the frame is crucial. There is the relational aspect and that comes about through offering an open, responsive, inquisitive, helpful starts in which space is allowed often to make the patient feel safer than they usually do…I’m thinking of sitting with patients who are crying and you make a small gesture of pushing a box of tissues towards them in this kind of teleological way of responding to somebody that an action imparts some form of message.”

Expert clinicians conveyed that in order to maintain the alliance the therapist’s interventions should always consider the goals of the therapy, reminding constantly to the patient the purpose of coming to treatment. By focusing on the goals of treatment across the interventions, the therapist conveys to the patient that he/she cares, which enhances the bond with the patient. Therefore, the therapist creates a bond with a purpose.

“That's like a lighthouse that you always aim to head towards. Whatever you say is said to maintain the therapeutic alliance, so that the patient will see the purpose of them coming to see you…All the time you have to remind them why it is that they're coming to see you and in what way that's helpful for you and
for them…You care, you create a bond but you create a bond for a purpose. It’s not called an alliance it’s called therapeutic alliance.”

e) Therapist Treats the Patient as an Agent

Expert clinicians indicated that in order to create and maintain the therapeutic alliance the patient must be treated by the therapist as an active participant of the psychotherapeutic process by, for example, collaboratively agreeing with the patient on the therapeutic goals

(3) Arriving at a Dynamic Formulation

a) Sources

Expert clinicians indicated that in order to arrive into a dynamic formulation the therapist must gather information about the patient from different sources and then integrate this knowledge. The therapist should know about the patient symptoms, family, other relationships dynamics, and the history of the patient.

“I think data is at the heart of a good formulation and data from various sources, first of all the integration of a range of key elements. Symptoms is a key part of that, understanding whether someone is depressed whether they're anxious, the context in which those feelings have arisen. I think being able to explore and understand relationship history is important and get a sense of someone's current relationships”

“A good formulation will be able to link these three areas, the past, the present and the relationship in the room. That will give the patient…sense of continuity, that he's able to understand”
Therefore, in order to arrive into a dynamic formulation, the therapist must understand the developmental history and experiences of the patient, as well as the use of defences at different stages.

“Based on the developmental history so you have to have an understanding of early childhood experiences and linking that with theories around development, and I suppose the impact it's had on psychic development or defences and so on.”

Additionally, it is essential to arrive into a dynamic formulation that the therapist gathers information of how it is to be with that particular patient in the room, understanding how they relate to the therapist, how they reply to questions and situations, and how they elaborate their object relationships.

“I am a dynamically, orientated practitioner, so I’m always a believer that it’s in the space in the room, that the most information is available. It will happen out there and you can note it out there, but you're not going to experientially understand it, to the same extent. If you can establish the beginnings of a picture of representations…objects, relations, types of interpersonal relating, all of that stuff, in the room. I think, that is significantly a better place for people to formulate…”

Thus, in order to arrive into a dynamic formulation of the patient the therapist must understand the meaning behind the patient’s communications, which define the conflict of the patient.

“That’s how they arrive at it. I’m listening to my patient talking about this argument they had, I listened to that, I gave him my mind…how do I understand what they’re saying in terms of their fear of dependency? Maybe they think they walked out but maybe they’re going through this argument with the person after they broke up because they wanted to bring a balance in the situation, but they wouldn’t be abandoned because at least,…it was under their control…They created a conflict situation where they were almost going to keep away from the other and then it was going to break the relationship and they’re desperately
sad about that because it was a relationship that they wanted but, at the other level, they're relieved because even more than being afraid of being alone is they're afraid of being so dependent on somebody else that they lose their sense of identity.”

Among the patient’s communications, the cautionary tale is a very good source to arrive at a dynamic formulation.

“I think quite early on in the-- I mean from the moment, in fact, the patient walks in the room, I'm listening or you listen to what someone is bringing. I’m thinking a patient who-- I mean, she comes into my mind. She came in and the first thing she told me was that she’s just been walking. It was a day of a very strong wind and she had been walking at the train station and she had seen a little girl who she felt was almost been blown away by the wind. That’s the kind of thing I’d listen to.”

Finally, expert clinicians concurred in that the countertransference is an essential source to arrive into a dynamic formulation of the patient.

“They need to be able to reflect on their own responses, reactions, reflections and employ a capacity to unpick and unravel those responses and reflections, and what potentially of theirs and what aren’t, which is a very difficult skill for all of us.”

b) Systematisation

Expert clinicians indicated that in order to arrive into a dynamic formulation of the patient the competent therapist tries to make sense of the entire life of the patient in terms of a psychoanalytic understanding.

“First of all, by having an awareness of the theoretical model because that will inform the formulation.”
Expert clinicians would expect that a competent therapist attempts to understand what is the basic conflict of the patient in order to arrive into a dynamic formulation. They conceptualised the basic conflict as something the patient desires and that he/she is afraid of at the same time.

“Basically, the way my mind works, because I'm a fairly classical psychoanalyst, I look for a conflict. I look for why does that something is a good idea and a terrible idea at the same time. So, how do I get somebody's frightened of dependency, how do I get to that-- because they keep on describing their need for a close relationship but what they're describing is a whole season of failed relationships...So, I come to my hypothesis that whilst at the same time they're needing desperately to have a good close relationship, there's something about this close relationship that they find scary and I got to figure out what is that scary about it and then as I get to know them, they have this fierce independence.”

Specifically, in DIT, arriving into a dynamic formulation involves formulating the IPAF which includes identifying what is the patient’s self-representation, other-representation, and which are the most important affects and defences utilised. In order to formulate the IPAF, it is important to understand what is the patient’s main anxiety in interpersonal relationships. Therefore, expert clinicians agreed that a relevant competence is the ability of the therapist to recognise and articulate the IPAF, after listening to the manifest and latent content of the sessions. This formulation should be shared with the patient and constructed collaboratively

“Use the IPAF and you offer the client a very brief straightforward, if you can, summary, for want of a better word, you're offering them a framework in which to think about how their symptoms may have manifest as a result of the experiences they've had. And so, you would be offering them a very tentative description of how they see other people, I'm thinking of DIT now. How they experience themselves in relation to other people and how as a result of that relating their symptoms may have come about, for example, depression or anxiety and checking with them if that sounds like a working model”
Finally, in order to arrive into a dynamic formulation, the competent therapist should know the patient's defence mechanisms.

“Again, the defences…Thinking of what’s recurring for them, some of the defences, of course, that they’ve employed to manage that. But what’s being avoided underneath, and what’s being avoided, is clearly what’s troubling them.”

c) Process and Delivery

Expert clinicians indicated that a competent therapist arrives at an analytic/dynamic formulation working collaboratively with the patient. Therefore, a competent therapist shares his/her dynamic formulation with the patient not as a sure thing, but expressing doubt, as an hypothesis, waiting to hear the response of the patient to co-construct the formulation collaboratively.

“I think…it's important to be clear but at the same time to express doubt or that this is a way of thinking about it. So, this is more the way it is expressed rather than having to arrive at it. But I think the way to arrive at it is to see a pattern that seems to have a meaning which throws light on the things that are being talked about or have gone wrong, but that you don't know for sure whether that's right. So, the way I tend to express things to patients when I'm making interpretation is in terms of, ‘It makes me think maybe this’ or ‘I wonder whether this might be the cause’, or even 'I know this is not going to be welcome to you. I think we should think about whether...’... I don’t say ‘you are’ or ‘you hate me’...If I had that thought that that was an important thing I would say something like, 'I get the feeling that you hate the fact that I'm not under your control.' It’s a matter of style really, but to me it’s important to acknowledge that you don't know for sure what’s in the patient’s head and you're not the expert about them. You may be able to know more than them and help them but you don't in the end know everything about them. And you're interested in their contribution to understanding it better. It's not like a close statement, it's always
a statement that involves more...and a response wanting to know what they think.”

Expert clinicians expressed that the competent way of delivering a dynamic formulation is when the therapist is able to link the patient’s past history to something that happened in the session that the patient was able to express. By linking it to the material of the session, the therapist makes the formulation more understandable and interesting to the patient.

“Again just thinking of a client with dyslexia...When it was diagnosed her parents responded to it in a way, they were very indifferent and so she experienced herself as damaged...and that led to her feeling ashamed and we could see together formulation was that her current relationships seemed to be based on the fact that she perceived herself as inadequate and that she would expect the other person to see her as inadequate and that was where the shame was being manifest...picked up something that was going on in the session and related it to the past and to her own symptoms in the external world...linking something that happened in the session...to make the formulation so it made sense to her.”

Finally, experts suggested that it is important that the dynamic formulation is delivered to the patient in a way that does not undermine the therapeutic relationship.

(4) Assessment and Using Trial Interpretations

Some expert clinicians suggested the use of a trial interpretation during the patient’s assessment as a technique that could enlighten the therapist about the eligibility of the patient for psychodynamic psychotherapy. If the patient responds to a trial interpretation by being open and available to think about him/herself, it is possible that the patient is suitable for psychodynamic therapy. If not maybe other psychotherapeutic options should be considered by the therapist for that specific patient.
“I think it's also looking at whether a patient's, if you're assessing for psychodynamic therapy, it's also assessing whether a patient can work, is a patient able to work in a more exploratory way, how do they make use of an interpretation when you give that, and the degree to which a patient can work in an unstructured therapeutic environment versus a more structured therapy like CBT, and the degree to which someone can tolerate learning painful things about themselves, and tolerate that amount of distress, and the degree to which they can think about that and reflect on that, versus acting out and escalating in these behaviours and all.”

(5) Use of the Countertransference

A few expert clinicians indicated that the competent use of countertransference is not usually evident by observing a session, but that this might be assessed in supervision.

“It's very difficult because you can infer that from observing a session where, to go back to the example of my supervisee who ends up having a text exchange with this patient and actually in the supervisee's own life she was going through a divorce which is what this patient is going through. I can infer, well, maybe the fact that she's going through a lot of trauma in relation to her own divorce leads her to over-identify with the patient and this leads to the slippage because she herself is very needy. But you can't-- I could only know if that was right by checking it with the supervisee outside of the session. I don't know how you could operationalise that in the session.”

(6) Management of Defences

a) Assessment

Expert clinicians agreed on the importance of assessing the defences and indicated that a competent therapist learns about the patient’s defences by
exploring how he/she has reacted to difficult situations in the past. The competent therapist should assess the areas where the patient is more likely to be defended against. There are clues of what the patient may be defending himself/herself of. Usually there is a sense of history because defences become entrenched at a time in development where there were particular pressures on that person.

“It's about having information about the client’s history. What's going on in their life, their early life, attachments, abandonments, and how that person has navigated their way through crisis or through general life events. How have they responded to life events? How are they responding to the narrative when life events are being discussed?”

“There are also clues to what is being defended against so they're very helpful suggestions as to where to dig so to speak. Somebody is very defended in a particular area than slightly the -- something interesting. It gives you some sense of a history sometimes because of the more defence we have become very entrenched at a time that there were particular pressures on that personal, things that were overwhelming for them. That may make the history more alive in a way.”

Expert clinicians indicated that it is better when the therapist can rely in an assessment of defences that were displayed in an interaction with the therapist in the session. Then it is easier to stop, and assess them together with the patient.

“I think it's tracking what's going on in the room. So, the patient said, ‘Okey-dokey’. It's being aware that there's something about the phrase 'okey-dokey' that's an odd use of the phrase for that particular communication. Being able to notice it in the room, track it enough, being aware that there's something a bit odd about it, and again, having both the courage and the curiosity to stop and question it. To be aware that there’s something which is stopping something--which I guess that is the nature of the defence.”
b) Delivery and Challenge

Most expert clinicians agreed in that a competent therapist should be respectful of the patient’s defences, understanding the reasons behind them. Therefore, the therapist is respectful of both, the defences and the difficulties that originally led to them. Anytime the therapist approaches the defences, he/she must maintain a respectful attitude. This is particularly important in brief work, where the therapist should not aim to disarm the defences.

“First of all, by respecting that people need to have defences and that…originally was a good reason for them being there so you don't just wade in and try and get rid of them.”

Thus, according to all the expert clinicians, a competent therapist recognises and works with the defences by acknowledging the struggle that they mean for the patient.

“Well, defences have to be respected. I have a very clear view of that. You approach a person’s material from the perspective of the ego…which means that you are sympathetic about them struggling with something. Because all the time it’s not that something is anger or hatred or whatever, it’s them struggling with anger, so you, ‘I know how much you do not want to be angry. I think it’s that all your life holding things there because you’re struggling so hard.”

Several experts suggested that one way of working with the patient’s defences is not necessarily by challenging them but by showing the patient the cost of using them.

“It was possible to really do it from a point of view…looking "at what cost." It’s really trying to get under it and I’m not going to dismantle his defences because it's brief work, but getting him to see that actually he stops himself getting what he really wants and also getting him to see that sometimes asking for help is not such a burden which is part of his apathy, he feels like he's a worthless burden. It may give the other person a valuable experience. He’s very helpful
to his girlfriend so he could think about how he feels about being a helper, and also what he thought she felt about him helping her, he said he hadn't ever asked her. So, he might go and think about that with her. But then maybe by asking someone for help, is quite a gift for them not just a burden. We were trying to look at it in all different ways and across all different relationships, and making all those links then so it was a very intense session actually.”

Expert clinicians expressed that the patient’s defences can only be challenged when there is enough trust and a solid relationship with the therapist. The competent therapist challenges the defences with sympathetic interest, never blaming the patient or in an aggressive way. The therapist should show compassion towards the patient while challenging the defences, which is important for the patient to feel safe.

“I'd always try to take the position of a sympathetic interest in why that's the case rather than a blaming…I think that's the style thing that I have where it's very, very rare for me to speak to a patient in a way that suggests that they are just bad or that I can't imagine how they got to be so nasty or whatever. Before I say something about even quite a maybe very aggressive way of behaving, I would wait until I've got some sort of sympathy with it before I talk to them about it.”

Expert clinicians also concurred in that a competent therapist only challenges the defences when the patient has the resources, the capacity and/or external support to cope with the feelings underneath the defence.

“It depends on a patient’s capacity to work with the underlying feelings that you're going to be able to assess. Do they have the capacity? Do they have enough support outside? Do they have resources that they can rely on? All of those things have to be checked and put in place before you do any of that. I think that probably sounds competent. He needs to do that. And that the patient has enough trust in the therapeutic frame and in you, that when you're starting to peel it away, that they are still held.”
Expert clinicians indicated that it is important to take into consideration the length of the therapy when thinking how to address and work with the patient’s defences. In psychodynamic psychotherapy, and specially in DIT, defences should not be addressed at the initial phases of the therapy. Defences should only be addressed at a moment when the therapist thinks the patient can tolerate thinking about them. On the other hand, in long term psychoanalysis, the therapist has more freedom to challenge the defences because, -seeing the patient 5 times a week-, allows him/her to provide more support to the patient. Therefore, how to intervene with defences has to take into consideration the frame of therapy.

“The issue of whether the modality of analytic work is important because with a five times weekly analysis you might be more inclined to feel you can push the patient but you see them the next day whereas if it was a once weekly patient, you might think that it is incompetent to push something right at the end of the session. Again, you need to have the context of the therapy, of the mode of therapy to assess the appropriateness of the intervention within an analytic context”

(7) Management of the Emotional Content of the Session

a) Affect Regulation

Several expert clinicians stated that a competent therapist deals with the emotional content of the session by helping the patient regulate their emotions in order to be able to think about them instead of being overwhelmed by them. The competent therapist must attempt to help patients experience a range of affective states of varying intensities in tolerable limits. Therefore, when the patient becomes easily overwhelmed by emotions the therapist should attempt to bring down the intensity of the affective state, whereas when patients are disconnected from their emotional states the therapist should attempt to bring affects to their attention.
“I think by trying to keep it within useful limits. So, if there's a patient who's extremely distressed or extremely depressed, or in any extreme affect stage, it’s difficult to work with them in a talking therapy because they basically can't concentrate or have much of a dialog. So, in that case, one would have to try to moderate that state, bring them down to something like a more normal level of stress or excitement or misery or whatever the affect is. Assuming it's within a workable limit, they are not completely unemotional and more overwhelmed with emotion…Managing their emotions, I think it's a matter of acknowledging them, trying to help keep them to a level that is bearable. Making sense of them, being able to help the patient to understand more than they did at the beginning about why they feel this way, and including perhaps something that's really surprising to them.”

Therefore, a competent therapist deals with the emotional content of the session by helping the patient mentalize their emotions instead of getting overwhelmed by them. Only by mentalizing the emotional states, it becomes possible for the patient to think about them, moving towards a positive direction.

“I would go back to mentalizing techniques to try to de-arouse the patient, so I certainly wouldn’t be making interpretations. I’d be trying to align myself with their experience of feeling very angry and how difficult that must make it to be in the room with me, trying to understand what made them angry, whether it was something that I said or hadn't said. Not using any interpretative stance to hide behind.”

“You would help them to identify the affect and to mark it, and to be able to process it. So, I think that’s what I would call really appropriately managing affect. That you modulate it as it is needed, and then help the patient to link up with that in order for them to really have some understanding of what's going on. So that they can really take it out there and work with it. Because I think that is important, that whatever you're doing is really helping them to change things outside therapy”
A few expert clinicians indicated that a competent therapist would allow the evacuation of raw emotions when the patient has recently experienced an external traumatic situation. However, when the emotional hyperarousal of the patient is related to the transference, the therapist should attempt to lower the intensity of the emotions by using mentalizing techniques.

“I suppose if you have a patient who has just come from a very arousing incident whether it’s an argument with someone or they have been at a funeral and there is something quite disturbing and traumatic that has happened, I can imagine that I might be more inclined to give them space to just evacuate what it is that they feel. Whereas if a patient…for example, who comes to the session and then lets a lot of anger towards me, it’s very much located in the transference let’s say, I think there I might be more inclined to try to de-arouse them a bit but then to make sense. Because I think that that’s more workable than something that’s coming from outside that is very pressing and very traumatic that might actually need to be worked through instead of just telling the story as it were.”

b) Containment

Expert clinicians stated that once the patient presents emotions that are within a workable limit, the competent therapist should attune to the patient’s feelings. In other words, the therapist is observant and attentive to the patient’s emotions but is careful to not share himself/herself the feeling with the patient. Furthermore, the therapist is attentive to feelings that are not being expressed such as anger or envy, and is open to their exploration.

“I understand empathy as meaning basically sharing a feeling with a person. So, if somebody is extremely sad that you feel very sad as well. That does of course happen but…somebody who is simply very empathic isn't enough use to the patient. For some people, it's very comforting to go and be very sad and feel that the other person is sad because you are sad. And that is sometimes very important, but I think it isn't really psychotherapy, unless in addition to knowing that your therapist is aware of your state, your emotional state, you
also feel that they are still able to think about it and to help you gain some further… connections between that and other things that have been going on that might have been talked about”

Expert clinicians also expressed that a competent therapist should be able to sit with the feelings of the patient without disposing of them, particularly with patients for whom it is difficult to be in touch with their own emotions.

“It's about attunement to where the patient is at and out of that also comes the capacity to be with, to sit with, to know, to identify, to sometimes name, to explore the affect. If a therapist is clearly expressing in the session with the patient that affect is welcome, and that there is affect there, and that it can be thought about and born by both. That feels to me as a competent therapist at work.”

Therefore, one of the most important tasks of the therapist, from the expert clinicians’ viewpoint, is the ability to name and “digest” the emotional experiences of the patients for them.

“A therapist can understand what's going on and, perhaps, in terms of their internal capacity to digest and make sense of it. That they can then find a metaphor that conveys to the patient, in a way that the patient can understand, by using an analogy or a metaphor or some bit of language which locks it into something that can be understood in an easy and palatable way, but relates directly to the experience. That, in my mind, really displays to patients – and when I see therapists working in that way, that symbolic way, that there is something happening between the two people. I think that can be very meaningful for patients to know that they're being understood. That for me, certainly, maintains the therapeutic encounter.”

An expert clinician indicated, in relation to the latter, that an important function of the competent therapist is to help the patient to come to terms with difficult experiences and emotions, assisting them in the process of grief.
“I think we’re talking about people being able to effect change in some way. I see that therapy is about helping people to- partly also to come to terms with something. I think is more than just change but actually being able to come to terms with something, to mourn something, be able to let go of something.”

Expert clinicians stated that in dealing with the emotional content of the session the most important thing is that the therapist is able to maintain his/her ability to think and imagine. The therapist must maintain his/her imagination alive to what else might be going on in the session, rather than only staying with what is being openly shown by the patient.

“But they above all, the therapist need to try to be aware of and to imagine. So, I think one of the ways of dealing with emotional sessions as a therapist…to keep one’s mind and imagination alive to what else might be going on other than what is being openly shown. So, the therapist is all the time trying to guess what more there is. Managing their emotions, I think it’s a matter of acknowledging them, trying to help keep them to a level that is bearable. Making sense of them, being able to help the patient to understand more than they did at the beginning about why they feel this way, and including perhaps something that’s really surprising to them. But sometimes, just adding more context or something so that it has more meaning to them.”

Expert clinicians agreed in that an essential component of dealing with the emotional content of the session is the processing of the countertransference by the therapist. A competent therapist should be able to be aware of and work through his/her counter-transferential feelings between the sessions, so that they do not become enacted with the patient. Additionally, the therapist should be able to differentiate which of these feelings are the patients’ and which belong to the therapist’s own blind spots.

“It would be a question of reflecting on what emotions were aroused in the therapist counter-transferentially and that therefore some reflection on whether this is information about what the patient is experiencing or whether it reflects the therapist own blind spots…I guess I have a slight anxiety about how
counter-transference can sometimes be misused to lay the patient's door. All the feelings that are experienced by the therapist and sometimes I think those feelings just belong to the therapist, so that is a danger of the slippery slope of counter-transference that it's always, but it's a patient projecting into me and sometimes I think it's just the therapist or something is projected into the therapist but the therapist elaborates it in line to their own sort of unresolved issues.”

Therefore, a competent therapist offers his/her own mental apparatus, a part of himself/herself, to deal with the emotions of the patient. Thus, something in the therapist changes in the psychotherapeutic process together with the patient, through containing, understanding and digesting the patient's feelings.

“I think, a competent therapist has to have a predisposition to offer themselves or part of themselves to be the receptacle of it. To contain it. To think about it. To try and make sense of it. What they then do with that, is a very complex question. Where does that inner level of emotional affect, then go in a therapist who's offered themselves to contain it? Does it pass out again? Does it reside? Does it silt the therapist up? Does it get expressed in supervision? Does it come out in parallel process? ...I think there is some change in both people, but a competent therapist is willing to do that.”

Expert clinicians indicated that at times the emotional content of the session can be very difficult to tolerate for the therapist because of his/her own limitations or life circumstances. In these situations, the competent therapist should be able to rely and look for help in supervision, with his/her colleagues and within the health system.

“In terms of dealing with the emotional content I think it's about being aware of your own limitations and also utilising what's available to help you manage the content because it can be horrific, at times. It can be very demanding, it can feel enormous. It's about utilising supervision, increasing supervision if you have to and depending on what context you're working in, it may be that you have other types of supervision, you may have group and peer supervision as
well as individual. You may have a line manager as well that you talk to and you share your concerns with so that your containment of the client is contained within the context of the organization.”

(8) Empathy

a) Being Sensitive but not Sentimental

Expert clinicians emphasised the importance of empathy, understanding it as a sensitive attitude towards the patient. However, expert clinicians highlighted that a competent way of being empathic towards the patient is not doing it in an overly sentimental/emotional way. The therapist should be empathic while retaining a dignified position in relation to the client.

“They're both incredibly competent therapists, and they both have a remarkable capacity to be, not in a gooey or sentimental way to be empathic whilst retaining a dignified position in relation to the client”

b) Being Sensitive While Bringing the Patient to Understand

Expert clinicians concurred in that the competent way of being empathic is not only by being sensitive towards the patient, but also by trying to take the patient into a deeper understanding of the implications of what is happening to them

“But it seems that there’s a sequence of being supportive and then being really empathetic. Validating what the patient is feeling, and then connecting to trying to interpret when that is there.”

(9) Working through the End of Therapy
a) Length Psychotherapy

Expert clinicians agreed that how the competent therapist works through the end of therapy depends on the length of the psychotherapy. Therefore, working through the ending phase will be different in open-ended and in brief models of psychotherapy.

“With any therapy, but again, within DIT, because the therapist needs to have to help the patient to manage the ending phases of therapy, and within a brief therapy that maybe, again, you got less time to do it… maybe more intense things that get triggered from a patient, and depending on the attachment history or the person…”

b) Unconscious Phantasies

Working through the end of therapy involves interpreting the unconscious fantasies that are mobilised by endings

“Of course, when you're moving towards the ending, how much of the work is happening because of the attachment and the loss? And this is where the theoretical orientation will come in. As I certainly want more of that conscious and the unconscious, what's the unconscious fantasy about what's happening?”

(10) Engaging the Patient

a) Interest and Understanding the Patient's Unique Experience

Expert clinicians indicated that a competent therapist engages the patients by making them feel understood. The therapist is someone that understands and contains the patient's anxieties and difficulties without being judgmental.
Therefore, the therapist does not become the object the patient is afraid from, the one that would criticise him/her.

“The engagement is when a patient feels understood. I think the formulation is so important. If the patient feels you've understood, how come they've got this presentation? Why, now in their life? They're pretty much on-board really. They see you as someone who can contain their anxieties, difficulties. They feel they can take those risks that you're not judgmental, that you're not going to be the object that they're frightened of. That kind of engagement, I think if they're able to take those risks to explore things a bit more.”

Expert clinicians agreed in that a competent therapist engages the patient by understanding their unique individual experience, not closing the understanding to soon, not concretising it, but exploring the underlying meaning of the patient’s experience, making individual and unique connections for the patient, attuning to what they are feeling and validating it.

“It was such a strong identification of this-- she did everything for this child but the mother was neglectful. That was just the opening of well you've been neglected too, so let’s talk about that. You could have just talked about manage the anxiety, looked at when does it get worse? When is it better? What are you doing to look after yourself in terms of your sleep, your diet, exercise? You could do it that way, or you try and look at what are the feelings underneath the anxiety. If they understand where you're coming from, and understand what depression, anxiety, these manifestations are of then they've-- if they feel they trust your knowledge base, where you’re coming from”

Expert clinicians highlighted that a therapist engages the patient when the therapist shows interest by following the verbal and non-verbal communications of the patient and sharing this understanding with him/her. It is particularly relevant to engage the patient when the therapist is able to pick up from the communications what is more urgent in the immediate situation of the patient and be able to work with that.
“If a person is very highly aroused and in that time of aroused state, you’re giving a long interpretation, you would see that you’re not engaging with the patient. I think you’re more preoccupied with what you think needs to be said rather than where the patient is at. Your attention to where the patient is at, at the moment”

Expert clinicians expressed that in order to engage the patient, from a psychodynamic perspective, it is necessary to formulate the transference and countertransference, sharing this understanding with the patient, in order to bring to light those dynamics that might get in the way of engagement.

“From analytical point of view, engagement already requires a competence in formulating what’s going on transferentially, counter-transferentially and then translating that into a capacity to make interpretations that bring to light those dynamics that might get in the way of engagement, for example, a patient who develops a very paranoid reaction to a therapist upon meeting them. The therapist capacity to formulate why that may be happening and finding a way of sharing that understanding with the patient already constitutes a core competence around engagement. In other words, I’m saying that to facilitate engagement, you already have to be able to work with transference, counter-transferences… such competencies are very closely connected.”

Expert clinicians stated that in order to engage the patient it is necessary to understand the patient’s defences. Formulating the patient’s defences will help understand why a patient might not want to engage with therapy, and will guide the titration of the interventions.

“Equally, you can say that around engagement you have to have an understanding of defences, why might a patient not want to engage…and therefore, competence, I suppose, in trying to assess what I think a patient can bear to hear and therefore finding a way of titrating my interventions to meet the patient where they’re at.”
b) Patient’s Signs of Engagement

Expert clinicians concurred in that an indicator that the therapist has engaged the patient is the manner the patient responds to the therapist communications verbally and non-verbally. An engaged patient elaborates or is attentive to what the therapist is saying. The patient remembers material of previous sessions. Furthermore, the patient’s posture tells that he/she is in the room with the therapist, and his/her tone of voice shows an affect that changes according to what is happening in the session.

“I suppose expressions of reaction by the patient seeming to be interested enough to produce some further material and to react or respond to what they think therapists does or says, that the patient comes to the sessions with a sense of expectation and the patient remembers things that have been said in previous sessions as well…The therapist and the work of the therapist is part of their life that they actually think about. Tone of voice, because quite important.”

Another way of observing whether the patient is engaged in the therapy is evaluating whether they are changing a bit the way they relate to others, are they showing more vulnerability? Are they exposing themselves more?

“You can see if they feel very engaged because of what they’re transferring to their relationships outside, so you’re checking that. Are they trusting other relationships? Are they giving themselves expose-- not exposing but showing some of the vulnerability, or showing more of themselves? That’s what you keep a check on too I think.”

Expert clinicians agreed in that an engaged patient will elaborate what the therapist says, and/or will have emotional responses to him/her, as well as even conveying disagreement with the therapist. All these responses indicate that the patient is engaged if the patient conveys that he/she is interested in what the therapist is saying.
“I would want to say I think that it’s not just that he says, “Oh, you’ve really understood me, yes.” And deepening network. I think engagement can also come with, you say something that actually provokes a patient and they go, “How dare you say that to me? You always go on about my father, for God’s sake.” That’s an engaged patient. You might have some work to do around it, but you’re actually in something. It feels as though two people are talking to each other and trying to work something out.”

c) Techniques Associated with the Alliance

All the attitudes and behaviours that contribute to engaging the patient in therapy, contribute as well to the development of the therapeutic alliance. The latter includes following the patient, respecting him/her, giving appropriate and timed interventions, showing that the therapist holds the patient in mind, among others. The therapist engages the patient by creating and maintaining a relationship with the patient. The latter entails that the therapist shows interest, kindness, remembers and refers back to what the patient has said. Additionally, the therapist tone of voice should interplay, almost in a dance, with how the patient is expressing himself/herself, conveying that the therapist is concerned and influenced by what the patient says.

Furthermore, competently engaging the patient involves repairing the ruptures in the alliance, considering how the patient is experiencing the therapeutic relationship, aligning with them in order to bring them back to the room with the therapist.

Additionally, at the beginning of therapy, the therapist engages the patient by explaining what the therapy is about, its setting, as well as the kind of communication that takes place between therapist and patient.

(11) Understanding the Patient’s Interpersonal Feelings and Defences

a) Techniques
Expert clinicians agreed that the most important technique for understanding the patient's feelings and defences mobilised in interpersonal situations is conducting a polite enquiry to elicit information.

“I think through inquiry, through I think being interested and curious about that experience. It could start off very thin, ‘I went to a night club with my friend and I got fed up at the bar and I went home early and I had an early night and thought 'sod it, I'm not going to see my friend again'.’ One's got to be curious about, ‘What happened? Sounds like that wasn't the evening you were planning. What happened?’ You're wanting I think to get some detail, perhaps in a way and starting to get perspective on different aspects, ‘Why would your friend have done this? What happened? How did it feel? How does it feel telling me now?’”

Important techniques that could be used in this enquiry are clarification, confrontation and interpretation. Furthermore, a number of therapists coincided in that helping the patient mentalize the different perspectives in an interpersonal conflict is an essential competency in order to explore the interpersonal feelings and defences mobilised in relationships.

“I suppose mentalization comes into my mind, at this point. If somebody who goes out to into the world and experiences thoughts of being a victim, and every time they get cut up in the post office queue, that their mind is flooded with these non-mentalized experiences and thoughts, that the world is out to get them. Deploying basic mentalization techniques and rewinding, pausing, opening up, exploring what's going on in the mind. I think this is specifically in relation to non-mentalized states and defences and very entrenched, unhelpful, cognitive frameworks, that people take up. It's very useful to be able to have those skills to wander with the patient, if there isn't any possibility that there’s a mental alternative appraisal, at that point”

“To think about it from the other person's perspective. For example, a patient who comes in and recounts an argument they've had with their partner and they are simply recounting it and saying how terrible he was. And they said this and
they did that. And ask them to think about what it felt like at the time. You might actually start to get them to unpack what was going on, and think about what was going on underneath their partner’s accusation”

Several therapists emphasised the importance of helping the patient explore unconscious feelings that may emerge in interpersonal situations, in order to understand the conflict and defences that are being mobilised in a set of specific circumstances.

“But, it is sort of I think having a lot of experience then gives you an idea of how people might respond, or what isn't happening so that you can also then say, ‘Well most people would be really angry in that situation, but you don't seem to be angry. Where do you think your anger goes?’” There might be ways of tackling avoidance that aren’t too threatening, and that don’t push it into someone”

b) Delivery and Working Through

Expert clinicians coincided in that the therapist can help the patient work through the defences and feelings mobilised in interpersonal situations, by using a series of competencies. Firstly, the therapist should deliver his/her understanding of the patient’s interpersonal conflicts by both, describing the contradictions in the patient’s account, as well as by helping the patient solve the apparent contradictions in the story. Therefore, a competent therapist draws the patient’s attention to the contradictions in their narrative, trying to understand alongside with them the affects and defences, and the different perspectives in a particular interpersonal situation.

“They’ll tell you enough for you to identify the contradictions, but things just don’t add up and then you draw their attention to the contradiction and you ask them what their understanding of the contraction is and you then work with them, alongside them, trying to resolve the contradictions and it starts to make sense and you add the unconscious bit or the non-conscious bit to the figuring out of
about-- to make their life as much of a puzzle...Identify the contradiction and then share the puzzle and make it a puzzle for them. Then we're working together to solve the puzzle.”

A number of expert clinicians agreed in that the overall aim of working through the affects and defences mobilised in interpersonal situations is in order to deactivate the patient’s affective-relational pathological pattern (IPAF in DIT).

“There was a client who came along because she felt she was being exploited by her partner...It became clear that, yes, she was clearly allowing herself to be exploited financially, emotionally, in terms of her time. But somehow, she was unable to leave this person...The way she saw it, she was doing everything she possibly could do to make him love her and I was very confused but her friends were saying, ‘Leave him, he’s terrible, he’s abusive. He swears at you and he calls you names. He’s terrible.’ But she would keep trying, and trying, and trying. In time, I was able to relate what was going on with her current partner to what was going on in her life growing up...when her sibling was born. At that point, all the attention naturally went to her sibling and she was beefed. From that point on...was trying very hard to get mom to like her. As she started recounting this, ‘Goodness, yes. I used to ask mom if I could do the shopping for her and I used to clean without her asking.” And she started to recount what she had done as a child to try to please mom, it’s as if she had this eureka moment and she suddenly realised what she was repeating.”

Several expert clinicians expressed that the first step in the exploration of the feelings and defences mobilised in interpersonal relationships is to make the patient feel understood. Only after this it is possible to explore other perspectives of the interpersonal situation.

“Once you can help the patient to feel that you’ve understood their experience, to see if they are accepted to engaging in what might have been going on for the other person. That would be the cycle in my mind.”
Additionally, a number of expert clinicians suggested that a competent therapist should be aware of how much affect the patient can tolerate and acknowledge in reference to a specific situation. Thus, the competent therapist should titrate his/her interventions taking into consideration how defended the patient is.

“In terms of feelings, affect, it would be a question of seeing how much affect they could tolerate. Can they be present, for example, in their vulnerability but not overwhelmed by it? Talk about the things, enabling, and see what they do with them. If they are massively guarded, then, again, it’s a question of monitoring how much you can probe”

One expert clinician emphasised that during the exploration of an interpersonal situation, a moment might come when the therapist feels ready to build up and deliver his/her understanding to the patient. However, the therapist must be willing to be surprised considering that new pieces of information can emerge that may change the therapist formulation. Therefore, the therapist should be flexible enough to add the new information to the understanding he/she has made of the interpersonal situation of the patient.

(12) Interpretations

a) Elements to consider before making an interpretation

The majority of expert clinicians agreed in that in order to deliver competent interpretations it is necessary for the therapist to have an understanding of both the patient’s transference/countertransference dynamics, as well as the patient’s defences.

“Someone I was supervising was working with a male patient towards the end of their dynamic interpersonal therapy, so they were in the goodbye phases. He came in, in one of these later stages, one of the later sessions saying that he’d had a lot of difficulties with a plumbing company, and he had brought these plumbers in, and they in a way made a mess of the work. He was a bit better
off doing it himself, and then he was rather suspicious of them as a reputable company. What was skilful about the way the therapist is that the therapist was able to deal with the situation. So, actually what that experiences was like for him and what in a way, how difficult it was and how he felt about it. But, at the same time, she was able to quite skilfully elaborate that experience into things that resonated more generally with his relationships. He didn’t feel he could depend on people. He was often suspicious about what their intended motivation was, what their intentions were. Partly he was beginning to fear that he didn’t really want to ever need anyone because he always felt let down, and it was better off he could do things on his own. And, then able to move into talking about that in relation to where they were in the therapy, and that actually what had his experience been”

A number of therapists expressed that the competent therapist knows which kind of interpretation to make at a specific time, either interpret the transference or the patient’s external situation. In order to know this, the therapist is guided by what the patient is more interested in at a specific point of the therapy.

“I think that a competent therapist will be able to draw on different aspects like -- well, that may be more for formulation like the past and the present. Because when you are on day-to-day therapy, you will not always link everything. Maybe that the more competent therapist will pick the atmosphere of the point at that specific moment, what is relevant at the moment to interpret.”

A number of expert clinicians considered that transference interpretations have a much more powerful, lasting and memorable impact on the patient, because they are delivered at the same time that a particular situation is taking place within the therapy. However, although expert clinicians favoured transference interpretations over other kinds of interpretations, they also agreed in that the therapist must make a judgement about whether to take something up in the transference or whether to focus on something the patient is concerned about in his/her outside world. Expert clinicians considered that a
A competent therapist is able to deliver both kinds of interpretations and have the judgment of which type to deliver at a specific time.

“I think one indication that it’s a good judgment is if the patient appears to be more surprised and more interested in the point that’s being made. To go back to the example of the man with his long time depressing marriage, if I say something about his relationship with his wife and what he unconsciously has invested in that, he’s actually so bored with the subject. He’s been complaining to everyone including his wife for so long that there’s almost nothing anyone could say that would really-- he’s surprised by the idea that he gets anything out of it. But what surprises him more and makes him more interested and very in fact very interested is the idea that there’s a way that he behaves with me and uses the relationship with me that’s quite similar to what he describes with her. But he believes that there are completely different relationships.”

A number of experts expressed that competent therapists, differently from incompetent ones, do not always feel the pressure to deliver interpretations, they only do it when it is the right intervention. Expert clinicians considered that a competent therapist should have a range of interventions he/she is able to deliver, and that before interpreting, the therapist should always have in mind the patient, the possible consequences of the intervention, and the timing.

“I think also competent therapists have a range of interventions at their disposal, they don’t just think of interpreting to interpret, so that you can use clarification or inquiry or questioning. I think having a range of tools in the box I think can encourage you to be less rigid and less forceful. I think rushing to interpretations I think often incompetent therapists will rush to the first thing a patient says, you’ll jump on and make an interpretation…I think most really competent therapists most probably weigh up options in their own mind, they think through the consequences also of giving an interpretation, what the impact might be, the timing of an interpretation, what that interpretation will be in the service of, what you’re trying to do in a way…”
The competent therapist should also consider whether it is sensitive to deliver a specific intervention to a patient at a specific time.

“I was delivering a seminar and going through a case synopsis of a client who came to the session complaining that she's bereaved of her father. Very difficult death, sudden, horrific and she came to the session and the therapist mentioned the fact that she’s been referred because of this bereavement but the client totally glossed over it and said, ‘You know, actually, I’m just angry all the time. I've just had my car parking space stolen. I was gearing up to get into the car parking space and someone stole it.’ Students said, ‘You could interpret her car parking space-- you could interpret things get taken away from her like her car parking space and her dad.’ Although that student was on the right track of, yes, we could interpret that things seem to get taken from her or she can't seem to hold on to things, things that are rightfully hers get taken away. It was clumsy because comparing her father to a car parking space somehow didn’t feel…right for the patient”

b) Process of delivering an interpretation

Almost all expert clinicians agreed in that a competent way of delivering interpretations is by arriving at them slowly and alongside the patient, holding the patient’s hand as they arrive at it, saying the interpretation for the patient but with the patient.

“I think that a competent therapist arrives at their interpretation through a process of gradually testing out many hypotheses with the patient, so that by the time the interpretation comes, the patient can almost see how the therapist has arrived at it, and they’re illustrating how they arrived at the interpretation”

Several expert clinicians coincided in that a competent interpretation is based on enough information and evidence that has already been discussed with the patient.
“Well, I think, again I think it’s about having enough, you need to have enough evidence really in order to make an interpretation, and indeed like that with the patient, yes there needs to be enough evidence if you’re sort of roughly on the right track.”

A number of expert clinicians considered that there is a specific sequence that helps deliver interpretations in a competent manner. In order to make a competent interpretation the therapist must first do supportive interventions, validating the patient's feelings. Only when the patient feels safe enough it is possible for the therapist to make links and deliver interpretations.

“But it seems that there's a sequence of being supportive and then being really empathetic. Validating what the patient is feeling, and then connecting to trying to interpret when that is there.”

A number of expert clinicians expressed that a competent therapist delivers interpretations in constructive, -not punitive-, way towards the patient. Additionally, a competent therapist delivers the interpretations as hypotheses that need to be tested together with the patient, because the therapist understands that some elements are not necessarily the patient’s projections, but belong to his/her own difficulties.

“This is bringing to mind this for me, does that make any sense? Is that a part of your experience? Because you have to be quite careful when you get into that. Is it your stuff or is it the patient’s stuff?.’’

It is especially important to deliver interpretations as hypotheses, in a tentative way, because this invites the patient to co-create together with the therapist the meanings in the therapeutic process.

“All of these will be said in a tentative way so that the patient feels there's a collaborative effort to understand their mind. A competent therapist is the person who provides some evidence for how they understand the patient’s
mind, presents it tentatively and actively tries to engage the patient in helping them to understand how accurate or not, that picture of their pattern is.”

A few expert clinicians expressed that a competent therapist only makes an interpretation if it has a purpose, and that this is especially important in brief psychodynamic psychotherapy.

“I think in brief work, it would also be known why you’re making an interpretation, for what purpose. So, not a gratuitous interpretation and certainly if you don't know why, do it as a curious question rather than a statement of knowledge, I would say. It's terrible that this even comes to my mind but doing it because you're wanting to help the patient with what they’ve come for help with rather than because you want to be clever and, in a way, create something powerful”

A number of expert clinicians agreed in that a competent therapist delivers interpretations in a language that belongs to the patient, using the words and thinking the patient uses. Therefore, the therapist emulates the patient’s language when delivering an interpretation

“…Trying to find the words that the patient would use…she is really good at that. Find the language that the patient would use and put-- the way they would construe that, that's not just words, it's their thinking, she's able to emulate. She's thinking like the patient in the room. Which is really quite…an art to be able to…”

(13) Use of Supportive vs Expressive Interventions

Expert clinicians considered that a competent therapist must know when to prioritise supportive interventions over expressive ones. Supportive interventions should be favoured when the therapist senses that the patient is feeling fragile and/or overwhelmed. However, expert clinicians expressed that the therapist must not collude staying with the patient only in their comfort zone
by not asking difficult questions or not delivering interpretations. In order to do the latter sensitively the therapist should prepare the patient with phrases like “this might sound difficult to hear but…”

“I might actually sometimes say to people, ‘this might sound difficult to hear’, so I might anticipate that it might difficult and say that or say ‘this might feel quite challenging but I’m curious about this and what does that mean.’ Sometimes I think if you’re not confident to take it up there’s a collusion that can go on, where people don’t want to talk about it and they’re also desperate talk about this, they can. Then if you’re not willing to ask the questions like what happened in the abuse or what went on, then people get a sense that you don’t really want to know it’s very painful you don’t, they can't do that to you.”

(14) Mentalizing

Most participant considered helping the patient mentalize a primary/basic competence every therapist should have. Participants agreed in that helping the patient recover his/her ability to mentalize should take place before the therapist delivers any other intervention to the patient.

“But that’s kind almost more fundamental than the transference in a sense because sometimes the transference, interpretation might facilitate a mentalizing process, but there might be times when it wouldn’t do that, actually inhibit a mentalizing process.”

Furthermore, expert clinicians coincided that a competent therapist should know which interventions support mentalizing and which interventions might hinder mentalization processes. The competent therapist should be able to implement appropriately the interventions that promote mentalizing. Working with the defences, transference and other interventions should be guided by the priority of helping the patient mentalize
“It’s understanding the competencies as a knowledge component to that, understanding what supports mentalizing, what inhibits it, and then a capacity to implement those interventions, which then drawn on working with defences with the transferences and so on…Well I think …certainly… all that you are doing to pursue with it is to get the patient into a more mentalizing state…”

(15) Risk Assessment

A number of expert clinicians expressed that an important competence is the capacity of the therapist to assess whether the patient is at risk, especially when he/she is too fragile, does not have enough external support, and expresses hints of suicidal ideation or self-harm.

“Let’s say that somebody is presenting with a high level of risk, and if I’m sitting there as the therapist trying to just get on with my session six or session four…I think, probably, that would be quite a major error. What I would really expect is that the person or even if it’s myself, that the technique and the model is part and I think what you’re looking at is what’s going to really keep the person safe.”

(16) Titrating Interventions

Several expert clinicians recognised that there are some models of psychodynamic psychotherapy that consider as an important competence to challenge defences early in the therapeutic process, while other models believe that it is necessary to first formulate the defences and later decide whether it is possible to address them or not. A number of expert clinicians considered that a competent therapist must titrate the delivery of his/her interventions. According to expert clinicians the right timing to make a specific intervention is guided by clinical intuition and experience, which makes this issue hard to operationalise.
“I suppose, clinical intuition of a particular patient which I accept is a very difficult term to operationalise what that means, but I suppose I'm guided partly by prior experience of what I’ve learned without the patient about timing.”

Expert clinicians expressed that in order to titrate interventions, meeting the patient where he/she is at, it is necessary to know what are the specific and most frequently used defences of the patient. In order to titrate the delivery of interventions, it is necessary that the intervention itself addresses the specific need of the patient to protect him/herself from a particular issue that would threat his/her psychic equilibrium.

“I am primarily guided, I suppose, by my evolving formulation of how the patient functions. For example, if I'm picking up that a patient has very strong narcissistic defences that keep them together. I'm obviously going to be very mindful that the intervention I make has to address that need to protect themselves against a particular view of themselves that would be too threatening to their psychic equilibrium.”

(17) Understanding and Using the Transference

a) Recognise the Transference to Understand the Patient

Most expert clinicians agreed in that an important competency is the ability of the therapist to find unconscious meanings relevant to the patient in reference to the transference relationship to the therapist. The competent therapist has in mind that there might be relevant unconscious meanings particularly when the patient is avoiding a topic or a transference issue is kept away from the discussion with the therapist. Therefore, a competent therapist must be attentive to both, to what the patient is saying as well as to what he/she is not saying.
“I suppose it's being able to bring awareness to what might be going on in the therapeutic relationship that links with material they're bringing. Sometimes what's going on in the relationship needs thinking about because it's about the here-and-now in our relationship. Someone who told me had a patient asked her to turn the recording off, you would want to know what's that about. What's the anxiety, why has it happened now? Was it something that she'd said, or is there something the person wants to disclose that they don't want to put on the recording? And you'd need to work in the relationship to understand the communication rather than going along with it or rectifying something or saying, ‘No, I can't,’ and being quite authoritative.”

Most expert clinicians considered that a competent therapist understands and uses the transference, knowing that anything the patient says in the therapy reflects in some way what is happening in the therapeutic relationship. Additionally, a competent therapist understands that anything the patient says in the therapy has an impact in the therapeutic relationship. Therefore, in order to understand and use the transference the therapist must be open to the relationship with the patient, putting him/herself out there and not feel the relationship with the patient as something neutral or distant.

“I suppose keeping on thinking about it in your mind, so listening to the material and thinking, ‘Does this have implications for the transference?’ If they're talking about a very punitive boss, you’d have to think, ‘Do they feel like I’m punitive?’”

“A good therapist puts themselves out there. The relationship is never too far away. This is about therapy, it's about a relationship, whatever the patient says reflects in some way the relationship that impacts on the relationship”

The majority of expert clinicians expressed that a competent therapist understands and uses the transference knowing that anything the patient says in the therapy is a reflection of the total transference situation with the therapist.

“That row is an event that occurred, that they're reflecting on that you want to understand, the context that the row occurred. You also want to understand
what it means for them to be talking about that row, what they think about that row now they're reflecting on it with you, but you also want to understand what it has meant to them to talk about that row...how your views of them might have been impacted on them talking about that row. All these are the different layers of understanding that event of them to-- and you can easily get lost in any one of them and the transference, to me, and in this I totally agree with Betty Joseph, is the totality of that.”

Expert clinicians coincided in that in the specific case of DIT a competent way of using the transference is by understanding what the patient is saying not only in terms of the relationship with the therapist but also linking it to the patient's IPAF.

“In the short term, if in a transference something is absolutely applicable to their recurring issue and it’s linked to their goal about what they want, then absolutely you got to use it.”

b) Therapeutic Uses of Transference

A number of expert clinicians considered that a competent use of the transference does not necessarily involve interpreting it. Other alternative of competently understanding and using the transference in therapy is describing the transference situation and linking it to separate issues, relevant to the patient, that might challenge his/her beliefs about him/herself.

“They might say something like, I think that in a number of important relationships you end up feeling that people don't really have time for you and maybe sometimes even feel that with me. They are not really focusing on the transference but they’re including it in what they’re talking about.”
Expert clinicians suggested that an important competency related to working with the transference is the ability of the therapist to be attentive and understand the use the patient is making of the transference interpretations.

“It would be how they made the interpretation and whether they’re receptive to the patient’s experience of the interpretation track the use that patient makes of the interpretation. For example, you have patients who love transference interpretations but not because they’re actually making use of the pattern they are highlighting but because they are gratified by the apparent intimacy that it sort of presents them with. They like you saying you feel this towards them because in that moment they are responding to feeling very fused with you. This is all about us, you’re very interested in me, we have a relationship and actually what you’ve actually said doesn’t make any difference. If it was that kind of patient what I be looking for in a competent therapist is someone who said, ‘At one level you are responding to my interpretation but I get the impression that actually what you’re responding to is not what I’ve said, but the fact that every time we talk about what’s going on between us you go into this fantasy of us as a couple, where you feel safe and everything is good and actually your mind stops working at that point.’ That for me would be an example of a competent therapist who doesn’t just stop at making the transference interpretation but looks at how the patient uses it.”

Expert clinicians said that at times a competent therapist may be understanding and using the transference competently but this is not visible in the session, but only in supervision.

“They’re using their formulation of the transference to guide how they’re intervening but they’re not interpreting the transference to the patient. That would be more apparent to me as a supervisor…”

Several expert clinicians considered that a competent therapist is able to recognise and deliver his/her understanding of the transference in a sensitive and challenging way to the patient. In DIT, a competent therapist will recognise the transference situation by relating it to the patient’s IPAF. Additionally, the
therapist will deliver this understanding of the patient’s relationships in a sensitive way, and will challenge the patient’s related behaviour in the outside world.

“But I think from a DIT point of view as well, you’re wanting in a sense to in some way facilitate someone also getting into the world and experimenting a bit, with behaviours that they might feel inhibited to do. You’re not just keeping within the space of the mind and mental phenomenon and effort. You’re actually saying, “What if you want to go to a party tomorrow and talk to people what would happen?” And almost in a sense trying to in a way create a different trajectory so they actually have a real-life experience”

Therefore, according to the expert clinicians’ viewpoint, a competent therapist is the one who leads the patient to test something new, to try out, and experiment something spontaneous in the therapeutic relationship.

“Yes, that he was boring and didn’t have anything to offer. So, in a way we experimented a bit in the middle phase of him just having a go, just being a bit spontaneous with me, saying whatever was on his mind or that him starting the session rather than me asking him more and more questions. So, in that way using the relationship with me as a way of testing something out”

c) Differentiating the Transference from the Real Relationship with the Patient

A number of expert clinicians referred that an essential competency is the capacity of the therapist to differentiate the issues that belong to the transference relationship with the patient from the ones that belong to the real relationship with him/her.

“I think the concept of transference, you would have to see if the person understands what transference is. And that you would see that they would understand that in a sense the transference is in a sense a representation of
an earlier relationship and feelings and attitudes and inferred characteristics and qualities. But you’d also have to understand that there are times when you might actually behave in a particular way that will provoke the patient's…That’s actually the patient responding to you or you doing something that they haven’t liked or haven’t appreciated or been provoked by or upset by. But, that’s a different matter. I think being able to be clear about also that there’s a real relationship as well as a transferential relationship, being able to tell the difference.”

(18) Facilitating, Listening and Responding to Unconscious Communications.

a) Facilitating Unconscious Communications

Several expert clinicians agreed in that the frame and boundaries of the therapy are essential to create an environment of safety for the patient, which is in itself pivotal to facilitate the emergence of unconscious communications from the patient.

“Are they attending to details such as when appointments happen, at what time? Are they regular or are they the same time each week? If they’re not, is that thought about if it’s brought up at all in the sessions. Being mindful of and careful about those details. Looking out for them is potential insights into what might be going on in a client's inner world so that that can be brought out and thought about and used therapeutically with the client.”

A number of expert clinicians considered that a competent therapist facilitates the patient’s unconscious communications by promoting free association from the patient and by not having an agenda in mind for the therapeutic process. Additionally, the therapist can competently facilitate unconscious communications from the patient by listening to him/her and making links with free-floating attention.
“Well, I think, going back to the old school theory, free association is key. Non-agenderised way of working is key. You don’t know until the patient brings it, so, it’s about listening, it’s about hunches, it’s about intuition, it’s about linking, it’s about those things”

Expert clinicians referred that, by definition, the more a session is structured the less facilitation there is for the emergence of the patient’s unconscious communications. Therefore, the competent therapist has to find a balance between the required structure to deliver therapy and the necessary space in order to facilitate the patient’s unconscious communications. Expert clinicians suggested that this balance is maintained by keeping the frame and boundaries of therapy, which are essential to structure the sessions. However, other issues could be left unstructured to facilitate the emergence of unconscious communications from the patient.

“I suppose an important competence, which becomes particularly present in a brief therapy, is the therapist’s capacity to manage the need for structure with the need to allow an emerging quality to the exchange. If I saw a therapist who talked 10 to the dozen constantly, I’d be quite concerned, and that will seem to me to not be someone who is working psycho-dynamically. You’ve got to allow some silences, some pauses for the elaboration of content.”

Therefore, less structured therapies facilitate more the emergence of unconscious communications. Thus, this is more likely to occur in long term psychodynamic psychotherapy, rather than in brief psychotherapeutic processes, such as CBT or DIT.

b) Listening to Unconscious Communications

The majority of expert clinicians suggested that in order to listen and understand the patient’s unconscious communications it is essential for the therapist to have a psychotherapeutic model in mind, so as to use it to tune into and get to know what the patient is communicating. Within the psychodynamic
model of the mind, the therapist should be attentive to all verbal as well as non-verbal communications, and particularly attentive to the issues the patient might be avoiding and keeping away from the discussion. Therefore, a competent therapist should be constantly attentive to what the patient is saying and not saying.

“I think there’s something about being, I think there is a way of I suppose being able to consider, I think having a knowledge of an unconscious, knowing something about the way the unconscious works, knowing something about defence mechanisms, knowing something about transference and counter-transference things like manifest content, latent material, those things position you in a particular way to listen to material and to understand unconscious communication. I think it’s most probably an area that is different from competence but around skill, that’s where you see very particularly skilled therapists working because it can very easily be rather crassly handled or ignored or overlooked and that’s really where experience really shines through”

Thus, an important issue is the non-verbal communications from the patient to get to understand unconscious meanings. The competent therapist is attentive and picks up what the patient's body leaks by its gestures or posture, as well as by the emotional atmosphere of the session.

“I suppose, going back to Freud, the body always leaks all sorts of things. With some patients, you have to go much more by the emotional atmosphere that is created, the away that they embody themselves and how they relate to the physical setting of the room that you meet them in. All that might give you many more clues to what is going on than what they are verbally saying”

Several expert clinicians referred that a way the therapist can be guided on the patient's unconscious affects, is by looking where in the narrative the feelings seem to be guarded, defended or cut-off.

“He talked about his father, but again it felt like when he talked about him it was very cut off, and it felt very defended and very guarded. I felt that he had lost
touch with the anger and rage with his father, and it seemed to be expressing itself elsewhere.”

Additionally, expert clinicians considered that in order to listen and understand the patient’s unconscious communications the therapist must be more attentive to how the patient communicates than to what he/she is saying. Therefore, the competent therapist should be more observant of the form and process of the patient’s communications rather than the content.

“I think I have been referring to this throughout. I think that the unconscious communications are more to do with the how than the what. It’s not so much what the patient is saying but how the patient says it. For instance, we trained in psychological therapy, we observe, say, the behaviour of the patients. Verbal behaviour like he’s talking very fast. How is he talking? He’s talking very fast. He’s talking very low. He’s shouting. The way he talks. The physical behaviour. The way he’s sitting in the chair. Did he arrive late?”

Most expert clinicians referred that a fundamental way the therapist listens and understands the patient’s unconscious communications is by being attentive to his/her own countertransference.

“They need to be able to reflect on their own responses, reactions, reflections and employ a capacity to unpick and unravel those responses and reflections, and what potentially of theirs and what aren’t, which is a very difficult skill for all of us.”

Another road to learning from the patient’s unconscious meanings is by knowing that the patient’s symptoms may be a manifestation of an unconscious conflict. Additionally, the competent therapist would be attentive to the patient’s slips and dreams as another manifestation of their unconscious processes.

c) Responding to Unconscious Communications
Several expert clinicians considered that a competent way of responding to the patient's unconscious communications is by progressing from surface to depth, starting from the issues that are closer to consciousness. Therefore, a competent therapist will bring something up in therapy when he/she senses that the patient is almost conscious of it.

“If it's going to be useful to you it's going to be useful because it's fairly close to consciousness. So, I don't believe in things from the deep unconscious being valuable. What I go for are things that are almost conscious already and then you make more progress but I'm definitely…come surface to depth”

The therapist facilitates the patient’s unconscious communications by mentioning elements that are left out of the communication, letting the patient know that his/her feelings are understandable, and that it is possible to share them in therapy. Additionally, the therapist facilitates, listens and responds to the patient’s unconscious communications by putting into words the latent meaning of the session. The way of putting the unconscious content into words is never with certainty, but always tentatively, leaving space to think together with the patient.

A competent therapist may respond to the patient’s unconscious communications by linking what is happening in the present or in the session, to the patient’s past experiences.

Finally, a competent therapist responds to unconscious communications when the patient is open to receive the therapist's interventions.

Incompetence

The interview of expert clinicians included a number of questions about what constitutes therapist’s incompetence. The underlying idea was to comprehend how expert clinicians understand therapist incompetence in clinical practice. In the interview, expert clinicians referred to therapist incompetence in reference to the following topics: a) Definitions: Differentiating Incompetence from
Incompetent; b) Enactments, Concrete Interventions, and Not Thinking; c) Inability to Foster the Therapeutic Alliance; d) Not Adapting the Interventions to the Patient/Context and Not Considering the Consequences of Interventions; e) Lacking Basic Skills to Intervene; and the, f) Therapist Mental Health Issues.

a) Definitions: Differentiating Incompetence from Incompetent

A number of expert clinicians emphasised that it is important to differentiate a therapist that is incompetent in a specific area and/or at a specific moment but that in the overall is able to help the patient, from a therapist that is negligent or even damaging towards the patient who can be denominated as incompetent.

“I'm just worried about the word incompetence because it's an odd word because actually, in many ways often there may be some incompetence but overall the patients still receive something. In some ways, to be damaging you have to be really incompetent. I'm not sure that, I mean, to be damaging, I think sometimes somebody can be not helpful and a patient might say, 'Well, I didn't really feel like I got a lot out of it but it's not damaging.'”

b) Enactments, Concrete Interventions, and Not Thinking

Several expert clinicians considered that an important incompetence is the therapist inability to think, mentalize, and explore the different possible perspectives of what the patient is bringing to the session. Therefore, the therapist can easily become concrete in his/her interventions and/or get trapped in enactments.

“I have had to work with one person particularly I thought who could not A, understand, and then B, see the enactment, acknowledge it, and in anyway try to understand what was going on, and it was like bashing your head against the wall with this person, and interestingly, they preceded to enact and enacted
with me… In supervision. Got very angry with me. The whole thing was about getting angry with a patient in terms of what was said, had felt very under attack. Reacted badly, got into a very adversarial kind of way of relating in a session. Was incredibly defensive about what had gone on and couldn't, wouldn't, didn't want to go-- don't know what it was about-- just couldn't go there and this was also picked up by her training organization.”

Therefore, an incompetent therapist is one that cannot understand and think about what the patient communicating and cannot understand enactments. Thus, the therapy can easily become stuck.

“Occasionally if I get really frustrated listening to a recording it's because something is being missed, or a therapist is like hammering a point, or they go over the transference in such a pejorative way, and I think the ways of opening things up which are easier for people to hear and sometimes something very critical gets enacted and the therapist just keeps going for it and going for it that's not really helpful… I suppose when you're listening to it and you think ‘this isn't going anywhere, it's going in circles, or it's a very elusive quality, or it sounds like you're in a pretend mode or there's no feeling in the room, or it's very intellectualized maybe.’ I suppose sometimes there's very little linking going on to the material.”

Thus, expert clinicians agreed that an incompetent therapist is one that in unable to pick up the unconscious communications of the patient which might lead to collusion. The latter is particularly likely to happen when the therapist does not pick up the negative transference and/or difficult feelings from the patient such as his/her aggression.

“An example of that is somebody who doesn't take it up when the patient is consistently very late for their sessions, which I'll take to be a communication from the patient, but because that therapist, and this is something I supervised, is always under huge pressure. They're actually quite pleased if a patient is late because they can make a phone call or do their email or something. So, in supervision I will say I really know she was 10 minutes late, and the next time
she was maybe 15 minutes late and then she was 25 minutes late the next session, but they never seem to say anything to the patient about that. In supervision, you can find out that they were really relieved, the more time they had which they hadn't expected, the better really. So, they were quite pleased when the patient’s late. I think that would be an example of incompetence; that they are both missing something that needs to be understood…There’s a failure to pick up and address something which should be being understood and give more meaning and simply for the patient to also to have a chance to say what she or he might have in mind when they don’t bother to come on time. It’s a missed opportunity to understand something and to do something about it. It’s also a collusion so that the therapist allows the patient to, or encourage this freely the patient not to use their sessions, not to use them fully”

Hence, expert clinicians considered that a therapist is incompetent when he/she cannot see the layers of meaning in the patient's material, therefore getting stuck in a concrete level of communications which prevents the patient from thinking.

“To give you an example…a therapist who the patient sort of texts her and she replies through texting in a very non-thoughtful manner, but in a sense, starts to engage with the patient in a text exchange, that would lead me to worry about what's happening. Particularly, if the therapist has no reflection that there’ll be something potentially problematic. This therapist presented it to me as saying he was in a crisis…and I kept on saying about what might it also mean. There was an incapacity to imagine that that behaviour could have layers of meaning and impact on the way that patient and therapist relate. It's sticking to a very concrete level. The patient…responded back engaging in a text exchange…opposed to thinking…there was a sense that the therapist’s mind was closed down to thinking about other potential meanings.”

Expert clinicians concurred in that a therapist may lose the ability to think and trust his/her own judgment when he/she is overwhelmed with the patient, becoming overly anxious or afraid of the effect of their interventions on the
patient. They are particularly afraid that the patient may disapprove or become angry at an intervention.

“Sometimes its anxiety based, that a person worries that if they say something they'll offend the patient, or they'll provoke the patient, or they'll make the patient angry or the patient will get too distressed. I think sometimes it can just be that they don’t trust their judgment, or that it’s on the sharper end of the dynamics where somebody might be relating to you in a way that’s undermining or provocative.”

In relation to the idea of incompetence being associated with delivering concrete interventions, expert clinicians expressed that an incompetent way of using and understanding the transference is when the patient brings an event to the therapy and the therapist takes it as a direct and concrete example of what is happening in the therapeutic relationship. For example, a therapist may say to his patient “you are telling me about this row with your friend because you want to have a row with me”.

Expert clinicians referred that another way of being concrete and not being able to think together with the patient, is when the therapist quickly reassures the patient, acting fast and superficially, without thinking and/or without gathering enough information to understand.

Additionally, expert clinicians considered that giving the patient advice, homework and/or direct answers to their questions is an incompetent way of intervening because leads to a mode of relationship that although might be comfortable for the patient, it does not allow him/her to think nor work psychologically.

“And, she was telling him to go and have a glass of wine with his partner and talk about this. It was not analytic work, and she being a nurse, and she was a group analyst, and I just thought, ‘Well, there’s no analytic attitude here,’ so I couldn’t pass the case. He liked her and he felt helped, but it wasn’t DIT, it wasn’t analytic work. It was more like supportive counselling.”
“For me the key seems to be and then that might be things that would be proscribed that would make you think the therapist is not working…like giving advice and giving the patient homework and getting stuck in in a sort of mode of relating that is very easy on the patients…that would make me think this person is not sort of working psychologically…not actually trying to elaborate the transference…but they’re getting very direct answers.”

Thus, in expert clinicians’ opinion an incompetent therapist is the one that becomes concrete by giving fast, specific and manic solutions to his/her patients.

All of the above, exemplify a therapist that is incompetent because he/she closes a topic too soon a topic, narrowing it down without really exploring or understanding it together with the patient. Consequently, the patient cannot understand what is happening to him/her and therefore, an aspect of him/her becomes split-off.

“I could probably only answer that by giving an example. I’m thinking of, perhaps, a supervisee of mine who would immediately jump to offering an explanation to a client about their symptoms which I wouldn’t consider a psychodynamic approach because it closes down any exploration of what those symptoms might mean to the client.”

An expert clinician considered that a therapist that is frequently colloquial with the patient is incompetent, because this behaviour and attitude does not allow therapy to occur.

“If having a small talk which some therapists may do it at the beginning. I agree with that because…it’s very fair but some therapists will start maybe if the patient comes in , ‘Did you have a nice weekend? Yes, very nice and you?’ Some therapists will do that, but then will move to the therapeutic stance of having some distance of observing and giving something back of interpreting. I felt that this therapist all she did throughout the whole session was to have a chit-chat with the patient. But chit-chat that absolutely made my hair stand”
Expert clinicians considered that it is incompetent when a therapist delivers an intervention without taking into consideration: the context, the timing, and the effects of the intervention on the therapy and the patient. Thus, this would be an inappropriate and not-adapted intervention which can potentially lead to an enactment.

“After a few sessions of this particular person working with this patient, it was thought in supervision…to stop a psychodynamic intervention or press pause on it, and then for him to be offered something else…as an alternative intervention…what transpired after this particular patient went off, and did this and received absolutely no benefit from this changing the care plan, was to come back into psychodynamic work…and express really difficult feelings about feeling rejected and abandoned by the therapist in this plan of basically sending them off and then coming back. This was early on in the work and we knew a little bit about this patient’s early developmental life, but what transpired as the work progressed is that it was disclosed that he had been adopted and all of a sudden, the penny dropped for the therapist and the supervisor and so far, as we had completely enacted it”

In the expert clinicians’ viewpoint, an incompetent therapist is the one that is unaware that he/she is doing harm or simply not doing anything helpful, but without realising the effect of his/her behaviours and attitudes on the patient.

“I think that making transference interpretations when the patient is not receptive to them could be very damaging to a patient. I think it's a very powerful intervention. That could be very damaging. Not being able to monitor your own counter transference in terms of your own blindspots might need you to make interventions that are gratifying to you as an analyst, but not helpful to the patient and can lead to serious enactments at times particularly of a sexual nature. Those would be sort of areas of very gross incompetence.”

c) Inability to Foster the Therapeutic Alliance
Expert clinicians expressed that a cold, rigid, and stiff therapist is less competent because it makes it harder for the patient to form an attachment relationship with him/her.

“I think to me, therapists are more competent if they are able to create a normal human relationship within clear boundaries. I don't think is as competent when a therapist is-- behaves in a very stiff and formal, almost cold way, a rigid way with a patient. I think that's less competent because I think it makes it harder for the patient to form an attachment relationship with a therapist. The therapist is not accessible, emotionally accessible for them. So, I think creating that context of the relationship is just as important as the other things.”

Therefore, in expert clinicians’ opinion an incompetent therapist is the one that cannot maintain an alliance with the patient.

“I think somebody who is so reserved or awkward or high-bound by their theoretical framework that they can't relate on a human level to a patient is to my mind not a very competent therapist. Because they're not going to make a warm and trusting relationship...”

Additionally, expert clinicians coincided that an incompetent therapist often forget important information about the patient. Thus, it becomes difficult for the therapist to elaborate on the patient’s material because he/she is not retaining the patient in mind.

“Even if the person's just been talking about an interaction with James for example, the therapist two minutes later won't be able to remember the name of the person or will get it wrong. And you can hear the patient in different sessions feeling depressed and detaching...because it's quite hurtful because someone wasn't really listening or that interested...I think being able to keep in mind what's being described and build it up into a picture and make that clear to the patient is a competent thing, and not being able to retain the picture of the patient which you can make clear to them is a sign of incompetence”
Several expert clinicians considered incompetent when there are prolonged silences in the session, signalling a disconnection between therapist and patient, and that the therapist has not properly engaged the patient with therapy.

“You think that psychoanalytic work is being silent, and neutral and not saying anything. Actually, that is often I think quite unhelpful… I’d rather someone is engaging with the person, and trying to understand something, and trying to work it out, and thereby rather than creating almost a void into which the patient can very quickly either feel that they’re on their own, and that they don’t have support and involvement from the person they’re seeing for that help. Or indeed start to become paranoid and anxious”

In relation to this last point, expert clinicians expressed that often a sign of a therapist being incompetent is that the patient becomes less interested and less connected to the therapist and the therapy.

Expert clinicians indicated that an incompetent therapist is one that does not listen to the patient. Not listening to the patient could mean just not hearing as well as not listening to the different layers of meaning in what the patient is conveying to the therapist.

d) Not Adapting Interventions to the Patient/Context and Not Considering the Consequences of Interventions

Expert clinicians considered that incompetence is when the patient gets worse in the course of treatment and the therapist is unaware of it and/or unable to address that with the patient. Often the latter happens when the therapist stops thinking and delivers the treatment manual automatically, not learning from the individual patient nor adapting the interventions to that specific patient.

“Incompetent is somebody who, the operation was highly successful, unfortunately, the patient died. You see what I mean? Who deliver the treatment but actually the patient gets worse, it's not that. To me, incompetent doesn't
mean that they're good off manual, they can be on manual but actually the therapy is going to hell in a hell basket and they're not able to address that.”

Therefore, an incompetent therapist is the one who imposes their own model of therapy in a dogmatic way, without considering the patient. Thus, in expert clinicians’ opinion an important incompetence is the inability of the therapist to prioritise the patient’s interests before their own. Incompetent therapists are biased and unfair, which may harm the patient.

“I think a competent therapist brief or long term actually should be familiar enough with other models of treatment and what the options are for the patient and should discuss with them at the beginning what the possibilities are that might help them. Why they offer the model that they offer, what they think that could do for the patient. They should have the patient’s best interests and freedom of choice in mind and that should be communicated”

Expert clinicians expressed that an incompetent therapist will deliver interpretations driven more by their own ideas or in an automatic/mechanistic way, rather than being driven by the patient’s needs at a specific time. Thus, an incompetent therapist delivers interpretations not thinking about the patient, nor adapting the interpretations to the therapeutic context. Conversely, the therapist delivers interpretations that are mainly self-gratifying.

“The incompetent therapist arrives at interpretation before the patient has said anything. They already know what they're going to say because in supervision last week, that's what their supervisor said that they should say, so they're going to say it whatever happens. Basically, to translate to that-- The incompetent therapists, they're driven by their own ideas more than by what they hear from the patient”

Expert clinicians considered that an incompetent way of dealing with the patient’s defences is treating them disrespectfully, not understanding the underlying struggle they entail for the patient. Therefore, it is incompetent to point out the defences to the patient not considering the consequences this
might have. Furthermore, it is incompetent to challenge a defence too soon because it may leave the patient feeling exposed, which may also result in a rupture in the therapeutic alliance.

“The other area of incompetence would be that you challenge it too quickly so that the patient's very fragile ego feels completely exposed and raw and you leave them with nothing. How you operationalise that is tricky because sometimes you don’t notice that until the patient comes back the next session. For example, I remember years ago when I was still myself rather inexperienced I had a patient who was obviously quite, she was in the NHS. A very disturbed patient and I can’t remember what the interpretation was. Something about her mother. It was almost the end of the session, like 10 minutes before the end I made it, the patient left and I could see that she was really quite stirred by what had happened. The next week she said that on the way home she had been incontinent on the bus. Then I was able to recover my error as it were and acknowledge that had I sort of pushed something into her mind that was too much and she couldn't hold herself together. I had sort of completely taken away her skin as it were and that actually helped to recover the rupture.”

Thus, in the expert clinicians’ opinion it is incompetent to overlook the patient’s coping mechanisms and to not understand their distress as a signal of how much they are struggling with their difficulties. The latter is essential for the patient to feel understood and supported. Therefore, an incompetent therapist would mainly focus on the patient’s problems overlooking their defences and coping mechanisms, and blame the patient’s difficulties for the lack of progress in therapy. Expert clinicians coincided that is greatly incompetent when a therapist blames the patient for their own incompetence.

“It's someone who just would present the person, exaggerate the patient's difficulties and say this was a very disturbed person and putting all the problems of the therapy with the individual. He'll always say, ‘Oh God, this is a terribly difficult case’, they…all the time blame the patient and the patient's difficulties for the lack of progress…It was very clear from supervision that actually the
problem was that they didn’t really understand the person at all…Just massively misunderstood and...patient actually dropped out, then I told the therapist. I said, ‘Look, this is not going to go very well because all the time you’re being very sympathetic but you’re implicitly blaming the person.’ Blaming them, saying how terrible their childhood was, and how difficult it is for them and all that, which is fine but you’re not focusing on how hard they are struggling in order to control their anger... And they’re distressed by that, but actually when you’re not focusing on how much they’re trying not to kill the person all the time…To me, probably the worst thing is that people blame the patient for their own incompetence. That's probably the worst crime that you can commit in my book.”

Expert clinicians considered incompetent when the therapist interventions do not show sensitivity to the patient’s situations and difficulties.

“You need to respond to the story with an indication that you understand the implication of this story, for the client. You show some bit of sensitivity. You don’t say, ‘Well, you’re well out of that relationship. Because I didn’t think that he was good for you anyway.’ But they’re able to appreciate the complexity of the feelings that the person is coming with. Responding sensitively would be somebody who is able to say, ‘This is a very difficult experience. I can see it’s a very troubling thing that happened to you. I think I need to hear more about it though, I’m not entirely sure what it means to you and why you feel such complex feelings about this man. How did he leave you feeling?’ And then the person is able to communicate the complexity of the experience without you having jumped down their throat.”

A number of expert clinicians considered incompetent a therapist that is irresponsible because he/she does not consider the potential effects the interventions may have on the patient.

“Because they’re stupid. I use the term stupid with a specific meaning. They don’t understand the patient, they say the wrong thing, they’re insensitive, they
undermine the patient, they are self-centred, they're narcissistic, they care more about their self-esteem”

Expert clinicians coincided in that an incompetent therapist is an unethical one, someone who is abusive, or exploitative of the patient or neglectful. Furthermore, a therapist that has power struggles with the patient was considered highly incompetent and unethical by the experts. All of these situations are not only unhelpful for the patient but also damaging to him/her.

“I think sometimes some people misuse their position of authority or power or misuse this particularly through transference interpretations and go for it in a way that sometimes it sounds, as I'd listen to, it felt maddening for a patient.”

Furthermore, expert clinicians considered that an incompetent therapist is one that overwhelms the patient, by for example, making them sad or angry instead of helping them to mentalize and verbalise their emotions.

“Experiencing a feeling in the therapy session, that they can narrate, that they can comment on, that's good. Experiencing a feeling and being overwhelmed by it, is bad. Them shouting is bad, them being able to say I'm really cheesed off, I'm really angry, is good.”

e) Lacking Basic Skills to Intervene

Several expert clinicians agreed in that it is incompetent when the therapist does not have a model of therapeutic principles in mind and uses interventions from different models that are incoherent between themselves.

“If they're training in a particular model and they go off without knowing that they've gone off-model. Or they've got a whole lot of exploration and not knowing why. How it links to your model, your theory or how you bring it back into what it's to do with. Not being mindful of what's being done. I would say they are not very competent.”
Expert clinicians coincided in that it is incompetent when the therapist does not keep the frame or boundaries of psychodynamic work.

“People who can't hold the frame. People who can't when session's overrun- I had one person who let me listen to a recording that began with her eating a chocolate in the session. I don’t know how that happened that she had a mouthful of chocolate, and she went to get the patient, and then it overran by 25 minutes, and she gave a lot of advice.”

Expert clinicians also considered incompetent a therapist that cannot deliver the interventions in an appropriate timing for the patient and the therapy. This includes therapists that are slow in making connections in the patient’s material, or therapists that do not think of possible meanings until way after the moment the patient could have been helped by them.

Expert clinicians considered incompetent a therapist that cannot express him/herself clearly. For example, therapists that are ambiguous in what they say, or therapists that speak for so long that the patient forgets where they started. Additionally, therapists that speak in an overly theoretical way that prevents the patient from understanding.

Furthermore, expert clinicians considered incompetent a therapist that intervenes without having gathered enough information that would allow him/her to understand the patient’s situation.

“Now, I want to be sure that the therapist gathered enough information about what the client is saying in order to be in a half-way reasonable position to meaningfully comment on that rather than comment on somebody else's quarrel. Say if they say something like, ‘God, you had a terrible quarrel? I had the worst quarrel with my partner yesterday.' That wouldn't be…It's an indication of competence so that they have acquired some understanding of the nature of the quarrel that were able to extract information from the person…I have no idea what happened with that person and so getting a sense of story is to me always very significant, therapy is about narratives and if you don't get a story…”
Expert clinicians considered incompetent a therapist that is unable to promote psychic change through engaging the patient.

“…Not able to engage the patient and is not able to promote change, psychic change…”

Expert clinicians referred that incompetent therapists tend at times to not allow for silences with the patient, without leaving space and time to think in the session. On the other hand, incompetent therapists tend to become too silent without helping the patient communicate.

“I think that’s why I talked of silence. I find many times in inexperienced therapists the two extremes. Either the therapist that responds to everything the person says. Really doesn’t take the space or the time to do what I call, take the patient in. Just observe. What is the patient coming with? For this you need space. You need time. You need to be a bit removed so that you can observe, not interact all the time. On the other hand, I find other inexperienced therapists that they may sit in silence all session long, practically all session. Then at the end, we say, so today you come feeling very depressed and sad. That irritates me quite a lot because I feel it’s a disservice to the patient. The patient knows that he’s depressed.”

Therefore, expert clinicians considered an incompetence when the therapist is unable to engage the patient by often remaining silent by not knowing what to say to the patient. Furthermore, expert clinicians considered incompetent a therapist that misunderstands the patient, saying wrong things to them, and leaving the patient alone and/or perplexed.

“…Making an interpretation where there’s not enough sort of evidence from the patient’s material, so that’s going to make sense to the patient. So, it would rather leave them feeling that you misunderstood, because he’d said something which just sounds absolutely crazy and doesn’t not make sense, or it leaves them feeling very enraged, or very anxious.”
Expert clinicians agreed in that an incompetent therapist is the one that gives the patient a destructive view of themselves which might lead the patient to feelings of self-hatred and depression instead of wanting to make positive changes in their lives.

“But the difference between a competent and incompetent therapist doing that same thing I think is if you-- It's competent if you can communicate that in a way that the patient can actually both understand and use to change positively and in the way that they would want to be more like. Its destructive if it simply makes the patients feel more hopeless or more self-hatred.”

Expert clinicians agreed in that a therapist is incompetent if he/she knows the theory about psychotherapy but is unable to apply it in practice, lacking the necessary skills to treat patients.

“I think of some trainings, counselling psychology training particularly, in which we do interviews for positions of honorary therapists and…people come in and they're dropping authors names, and they're dropping clinical concepts and they're dropping a new, in a gentle way, just inquire one level further, and they absolutely just stop. They just can't go anywhere other than the language of it.”

Expert clinicians considered an incompetence when a therapist does not continue learning and developing professionally.

“One who doesn't keep themselves abreast of continued professional development. Looking at reading the research, reading generally, looking at developments within the field.”

f) Therapist Mental Health Issues.
Expert clinicians referred that therapists that blame their patients for their own difficulties are highly incompetent. These therapists tend to only focus in the patient’s difficulties, projecting the bad onto the patient and blaming the lack of progress to the patient’s problems.

“It was very clear from supervision that actually the problem was that they didn't really understand the person at all and the person wasn't-- I didn't find the person being difficult. Just massively misunderstood and I found that patient actually dropped out, then I told the therapist…”

Expert clinicians expressed that narcissistic, self-centred therapists, or therapists that cannot take in criticisms, are unable to maintain the alliance with the patient, and are therefore incompetent.

“In a simple sense, I think they were emotionally immature. I think they were therapeutically immature. They conveyed to me a predisposition for quite primitive relating. Could not tolerate difficult feelings inside of themselves and wanted to remove them at any cost. That doesn't make a competent therapist.”

“One of the things that I think contributes to incompetence is certainty. People who really feel they know things and that they're there to impart that to their patients I think they can be incompetent, because actually it lacks a degree of questioning of oneself. Rigidity of ideas, if you just think things are always this, or always that, a kind of more binary position. Most probably if someone has some kind of impediment to learning or impairment to learning, which I think can have its roots in lots of things...He was now looking for supervision for his cases. I just felt that he was so immensely competitive with me, that he couldn't really learn. When he presented it was always presenting me the work to just show how good he was…”

Therefore, in the expert clinicians’ opinion, an incompetent therapist is one that is not self-aware, does not have insight of the effect of his/her actions, is not aware of his/her own blindspots and the way they might interfere with the
therapy. Furthermore, incompetent therapists do not adapt their interventions in accordance to the patient’s feedback.

“Who is incompetent…someone who… certainly a lack of self-awareness would likely contribute to -- if you're unaware about where some of your blindspots are, or if you’re perhaps less reflective…You can say something to someone and not only be focused on what you're saying, and what you're conveying, and how relevant and meaningful it is to what you're trying to in a way explore. Actually, you're gauging whether that actually, you're, ‘Did I get that right?’ It's not always just onward and upward, but actually perhaps to think did I miss something, how's the person responding to it, has that helped in a way, or are we a bit clear about something or have I muddied the waters? If you lack that capacity to engage in that, you can just perpetuate stuff…”

Expert clinicians conveyed that it is also incompetent a therapist that says the wrong things, particularly because he/she is talking mainly about things that interest only them and that are not beneficial for the patient.

“It's terrible that this even comes to my mind but doing it because you're wanting to help the patient with what they've come for help with rather than because you want to be clever and, in a way, create something powerful”

Observable Competencies

Expert clinicians described a series of observable competencies meaning, competencies that may be specified and distinguished when listening and/or observing a psychodynamic session. Below each one of these observable competencies are described and illustrated with examples provided by the expert clinicians.

Expert clinicians coincided in that an observable competence is the therapist’s capacity to identify, name, explore and articulate the patient’s feelings.
“It’s about attunement to where the patient is at and out of that also comes the capacity to be with, to sit with, to know, to identify, to sometimes name, to explore the affect. If a therapist is clearly expressing in the session with the patient that affect is welcome, and that there is affect there, and that it can be thought about and born by both. That feels to me as a competent therapist at work.”

Expert clinicians regarded as an observable competency when the therapist not only reflects back to the patient what he/she is feeling but also expands the patient’s understanding of their own feelings and thoughts.

“She’s able to, first of all, respond to the increased depression that the client is feeling, and then be sympathetic with the struggle that the person has with self-esteem and feeling that they’re not doing any better than they should, and link that to the situation in the therapy where they’re both saying that they feel that the therapy should have done better, but they also feel humiliated that they haven’t done any better for the therapist and link that to the IPAF that the person is working on in relation to having to prove themselves and feeling all the time that they have to prove themselves and how difficult that is. Do you see what I mean? And then she’s going to be able within that kind of a video of four or five minutes be able to bring all that together.”

Expert clinicians referred that an observable competency is the ability of the therapist to focus on relational and affective dynamics as well as on the patterns that unfold in the therapeutic relationship, as opposed to focusing on cognitive functioning.

“What was skilful about the way the therapist is that the therapist was able (a) to deal with the situation. So, actually what that experience was like for him and what in a way, how difficult it was and how he felt about it. But, at the same time, she was able to quite skilfully elaborate that experience into things that resonated more generally with his relationships. He didn’t feel he could depend on people. He was often suspicious about what their intended motivation was, what their intentions were. Partly he was beginning to fear that he didn’t really
want to ever need anyone because he always felt let down, and it was better off he could do things on his own. And, then able to move into talking about that in relation to where they were in the therapy”

Therefore, expert clinicians considered an observable competence the ability of the therapist to elicit and explore the patient’s interpersonal relationships, analysing them together with the patient from every angle.

“Elicit by direct questioning. I guess making links with material that they might be bringing from their own history to a most recent symptom, helping the patient to see that, or using patience. Asking patients to describe situations and getting examples from the patient’s life, and offering an interpretation of a more unconscious material.”

Expert clinicians considered an observable competency the capacity of the therapist to attain a balance between what the patient is interested in talking about in the session and what the therapist considers to be important to address in the context of the therapeutic process.

“But also, this, I think, sort of balancing what she wants to get from that first is what the patient might bring in the beginning of the sessions. So, she will deliver the question as it forms, and then starting with what the patient brings. But then very cleverly manages to keep the patient on, and I think keep them both on task, really, in the session, and not let it meander too much, and very much making reference to the IPAF, very much bringing the formulation in and helping the patient see that, too.”

Expert clinicians considered an observable competence the ability of the therapist to show curiosity towards the patient, particularly to the patient’s communications related to psychic contents rather than to the communications that are only focused on behaviours.
“…Have a curious stance again, an awareness that you're looking at a patient's mind not only behaviour. The questions that are being asked…I would know that I was looking at a more psychodynamic approach, if there was less focus on behaviour…but more interest on how does this person make sense of things? What affect does it evoke? What is in their mind? What are they experiencing about something? I suppose in that would be an awareness of the things that the patient doesn't know in their minds”

A relevant observable competency according to expert clinicians is the ability of the therapist to engage the patient in the therapeutic process. This competency can be observed if there is an alive interchange between therapist and patient. The therapist makes questions that encourage the patient to bring material and there is space for the patient to talk about what concerns him/her.

“For instance…if a person is very highly aroused and in that time of aroused state, you're giving a long interpretation, you would see that you're not engaging with the patient. I think you're more preoccupied with what you think needs to be said rather than where the patient is at. Your attention…to where the patient is at, at the moment, so that I'm engaging…If that's not there, what I am going to do to bring it back as much as possible.”

Expert clinicians referred that an observable competency is the ability of the therapist to gather enough information about the patient in order to understand and comment in a meaningful way about the patient's communications.

“They're free to move within the model that they've actually understood it and they are not following a tick box thing or just following the patient around the material, but actually that they're also there, stopping, slowing the person down if they don't understand, asking the right questions, but then making some links or showing that they have an understanding that's dynamic, that they are aware of resistance to change, that they are aware of how defensive a person might be so that they can make it more real in the moment.”
Another observable competency according to expert clinicians is the ability of the therapist to show empathy and sensitivity in relation to how the patient is feeling when delivering an intervention.

“The tone of voice, the what's said and the development over time of the material between the two people in a session shows that the therapist is paying attention, thinking, saying things that are not just repeating back what the patient said. And therefore, that they're further again contributing to a lively important process that matters to both of them. It's partly expressed in tone of voices, partly expressed in closeness of attention.”

An observable competency is the ability of the therapist to make links between what the patient is saying about his/her external relationships or events and what is happening in the session regarding the therapeutic relationship.

“She's able to, first of all, respond to the increased depression that the client is feeling, and then be sympathetic with the struggle that the person has with self-esteem and feeling that they're not doing any better than they should, and link that to the situation in the therapy where they're both saying that they feel that the therapy should have done better, but they also feel humiliated that they haven't done any better for the therapist and link that to the IPAF that the person is working on in relation to having to prove themselves and feeling all the time that they have to prove themselves and how difficult that is.”

According to expert clinicians an essential observable competency is the skill of the therapist to intervene at multiple levels. The first level is the ability of the therapist to respond to the patient’s current situation with empathy and sensitivity. The second level is the ability of the therapist to intervene conveying an understanding of the implications of the situation to the patient in their external world. The third level is the ability of the therapist to link the patient’s current situation, to the relationship with the therapist and to the main
unconscious fantasies of the patient in order to understand and deliver an
original and helpful intervention.

“He’s been complaining to everyone including his wife for so long that there’s
almost nothing anyone could say that would really-- he’s surprised by the idea
that he gets anything out of it. But what surprises him more and makes him
more interested and very in fact very interested is the idea that there’s a way
that he behaves with me and uses the relationship with me that’s quite similar
to what he describes with her. But he believes that there are completely
different relationships.”

Expert clinicians regarded as an observable competency the ability of
the DIT therapist to intervene being mindful of the IPAF, fitting the interventions
according to the affective patterns agreed with the patient.

“I think because it challenged him and it would have been easy to go along with
thinking that there was someone blocking him but actually it’s got him to look at
what he does in the situation, that keeps this going rather than being a victim
of circumstance. And that whether he can or can’t get a pump, whether the
pump is the right thing for him or not, that somehow, he doesn’t help himself,
he actually makes things worse for himself, and there’s some helplessness and
passivity in that position.”

Therefore, being mindful of the IPAF means that the therapist is
understanding and intervening linking the story the patient brings to therapy to
his/her interpersonal affective pattern.

Another observable competency described by the expert clinicians is the
ability of the therapist to be attentive to what the patient communicates. What
is observable of this ability is that the therapist self-corrects what he/she is
saying after having feedback from the patient.

“Patient A comes into the room and starts talking. The therapist says, ‘I think
you’re very angry with you mother. It sounds like a very difficult experience.’
The patient says, ‘No, I wasn’t. It wasn’t about my mother.’ You go, ‘No. I think
it really was about your mother.’ It’s maybe the lack of or the absence of competence or losing one’s way a bit. Actually, someone who can listen and take feedback, and adjust, and shift their position rather going down a trek or a tunnel where they’ve got an idea and then they just keep running with it and taking the patient back. And, you see this emerging divergence between where the patient’s experience and sense of meaning and the therapist's meaning making if you will.”

A crucial observable competency described by the expert clinicians is marked mirroring, an ability in which the therapist conveys and shows to the patient, mainly through non-verbal/intrinsic, communication, that they are able to know how the patient is feeling at any point, indicating that they are all the time throughout the session able to present an understanding of what the patient is saying.

“They’re both incredibly competent therapists, and they both have a remarkable capacity to be, not in a gooey or sentimental way to be empathic whilst retaining a dignified position in relation to the client. So that they do what we call mark mirroring so they’re able to show that they know how the patient feels, and that they’re always able to present an understanding of what the client is saying.”

Expert clinicians expressed that the ability of the therapist to help the patient mentalize the different perspectives of a particular interpersonal situation is an observable competency. This means that the therapist helps the patient explore the different viewpoints of the people involved in a specific interaction.

“You want someone who can talk to you about relationships. ‘I was at work and had an argument with my colleague.’ And, that there would be a way of exploring that. Having techniques that actually help you explore -- it sounds like, and you could move from the feeling through to the sense-making. In a way drawing on affect and drawing on cognition by -- if it's reflecting how they felt, what they'd left the person with -- Then, in a way thinking through about the dynamics of the relationship. I think importantly a therapist you can visit a
perspective taking. A theoretical construct would be around mentalization… being able to explore. What do you think the other person thought, or why do you think they behaved -- trying to ask you in a way, have someone explore and work with someone around the perception and experience of the self, of being the other, and try to make sense of it”

According to expert clinicians an observable competency is when the therapist is able to frame his/her interventions within a psychodynamic understanding. This is expressed in the way the therapist pays attention to the material, how they formulate, and how they understand what is being said. This all means that the interventions will make reference to something unconscious to the patient.

“To have a clear-- for it to be clear to the observer that the therapist does have some framework for thinking about what the patient is bringing. That's expressed in things like what they pay attention to in the material, how they formulate what they're saying, and how they understand what's being said. And in terms of a psycho-dynamic psychotherapy as well as that, so as well as engagement and having a framework, that the interventions will make reference to something that's not entirely conscious for the patient. So, if I imagine somebody who has the other components but who only ever talks to the patient about what they're fully conscious of, I would have thought that that's not going to be psycho-dynamic psychotherapy.”

Therefore, it is possible to assess whether a therapist is being competent if he/she tracks the conscious communications of the patient looking for potential unconscious latent content, and interpreting the latter. The interpretation of the unconscious content could be through a trial interpretations, extra-transferential or transference interpretations.

“Why it is that he chose and has stayed with a partner that he consciously really dislikes, finds very annoying, and very un-rewarding. Why did he choose this person? And why is he being with her for 35 years. Everyday thinking, ‘I hate her.’ ‘I'm so bored with this relationship.' But there are things that are
nevertheless keeping it important for him and something he wants to be part of and that can be understood from his descriptions of the interactions that they have and the interactions that he has in the relationship with me and by drawing parallels between those two and suggesting things that he hasn't been aware of, for example that she absorbs his sadistic impulses in a way that he needs somebody to do and that she allows herself to be humiliated. There's a complex reason why that is necessary for him but hasn't been conscious of that side of himself or getting that from her but once that was discussed, particularly once it was pointed out that he tried to do something similar to that with me. His attitude to that relationship and the way in which he's able to live in that relationship showed quite a lot of shifts over time.”

DIT Competencies

In the semi-structured interview, the expert clinicians were asked to describe the competencies they considered essential to deliver Dynamic Interpersonal Therapy (DIT). The specific DIT competencies that the expert clinicians referred to in the interview were: a) Activity and Visibility; b) Assessing whether the patient can work in DIT; c) Collaborative Process; d) Creativity and Playfulness; e) Directive to Focus; f) Elicit Interpersonal Narratives; g) Expectations for Change; h) General Exploration, Focus in Recent Events; i) Interpretation; j) Positive Attitudes towards DIT; k) Quickness; l) Stick to Model and Phases; and, m) Transference. Additionally, expert clinicians described specific attitudes and behaviours that they considered incompetent in DIT.

a) Activity and Visibility

Expert clinicians referred that in order to competently provide DIT, the therapist must maintain an active stance during the session with a specific purpose in mind.
“Clarity of thinking. I think they really need to have clarity of thinking. Clarity of thinking, quick thinking, an active stance, purpose”

Expert clinicians agreed that a competent DIT therapist has to be visible and communicative to the patient and not behave like a “blank screen”. They have to be willing to inform the patient considerably while at the same time know when they should listen to the patient, giving him/her space.

“To be communicative with the patients, so basically feedback quite a lot to the patient about what you’re hearing, what you’re thinking about it, asking them whether that makes sense to them, whether they disagree. I think quite a lot of two-way communication is important and particularly in a briefer model.”

b) Assessing whether the patient can work in DIT

Expert clinicians considered that a competent DIT therapist will assess whether the patient can work within a brief model. For example, if the patient has a history of trauma and ruptures, brief therapy might not be the appropriate therapy for him/her.

“Good assessment skills because they need to be able to spot the things that would hinder short-term dynamic therapy. If somebody presents who is not psychologically minded as such, a longer-term therapy, or a group therapy better, could potentially help to develop psychological mindedness. Whereas a short brief intervention isn’t necessarily going to do that.”

c) Collaborative Process

Expert clinicians considered that an essential competence to deliver DIT is the ability of the therapist to formulate and to share this formulation with the patient in order to elaborate it collaboratively and agree on it as the focus of
work. It is not something the therapist develops on his/her own mind alone, it is rather something that the patient feels his/her own as well.

“You have to have the capacity to share that formulation with the patient and to engage the patient collaboratively in formulating it and agreeing to working to that particular formulation. It's not just something that you develop in your mind. You have to actually have the capacity to develop it with the patients, that the patient has ownership of the formulation. You have to have the capacity once formulated to stick to it because it's very common that… then they worked to complete a different focus. That's very important.”

Additionally, expert clinicians considered that a competent DIT therapist will consider as essential the patient's feedback to his/her interventions. The therapist will check how the patient is experiencing, using and not using the interventions, and reviewing how the patient is feeling as the therapy goes along

“I think if there is a link which is emerging in your mind, and you think this does have a relevance. Because you’ve got a formulation then you would give it to the patient. It’s the patient’s response which will tell you whether the patient is ready or not… When you give an interpretation, you’re pushing the defences. I think that then you’re looking at, have you pushed the defence too much and whether there’s capacity for you to walk with those defences and your exploring the defences, or whether you think that you have made too far a link and the patient can’t really get there. You’d be gauging it accordingly. Your interventions, after yourself delivering it or really sharing it, would be informed by the response. I think there is a cycle.”

d) Creativity and Playfulness

Expert clinicians considered that in order to competently provide DIT, the therapist must be creative and playful in relation to what they are trying to achieve with the patient.
e) Directive to Focus

Expert clinicians referred that an important challenge and competence for working in DIT is the ability of the therapist to be directive and focused in the work while retaining an analytic attitude, meaning not becoming too cognitive or losing sight of the patient’s unconscious. In other words, the therapist must be directive while tuned to the unconscious communications, evolving transference and the capacity to interpret.

“I think that for a brief therapy, the therapist has to be on the driving seat all the time. The therapist has to have in mind, ‘Okay, we are in the first phase. I need to hear about his childhood. I need to hear about the significant relationships. I need to ask her a lot of examples.’ Many times, what you find is that the patient comes in a state with the story of what happened yesterday with her husband or whatever. The therapist is carried away by the story and then doesn't fulfil the task of what he needs to find out in this stage.”

Expert clinicians considered that in order to competently provide DIT, the therapist must be elastic instead of flexible. This means, that the therapist can allow him/herself to deviate or stretch from the agreed therapeutic focus but going back to it. This means that the therapist is able to go off-track of the therapeutic focus but never completely or permanently.

“There's a distinction I like between elasticity and flexibility. You don't want to be too flexible but you want to be elastic so that you can stretch like a rubber but actually, you don't snap, you don't stretch so much but you go back. You can allow yourself to go off-track, allow yourself to be pushed off-track but not completely…To have elasticity without being flexible.”

Expert clinicians considered that in order to competently provide DIT, which is a time-limited therapy, the therapist must not get lost in the past history of the patient but prioritise working on the agreed focus. The therapy has to be organised, focused, in accordance to the phase, while still emotionally
engaging for the patient. The therapist must be persistent and hold his/her vision of the patient across the interventions.

“I have an analogy in my mind of this short-term intensive physical training that people do versus this long meandering bike ride. It needs to be punchy, it needs to be—let's use a DIT term—pithy, and focused, and there is not much psychic breathing space. There's no luxury of sitting back and seeing what might emerge.”

According to expert clinicians an important competence of the DIT therapist is the ability to link back what the patient is saying to the IPAF in order to maintain the focus and purpose of the therapy.

“The DIT philosophy would be, in a sense, you mirror something back. You sketch something back. You noticed, with the patient, that there is a configuration. But at that point in the work, this should not really come as a surprise. It's right there for the patient anyway.”

Expert clinicians considered that a competent DIT therapist would not make an interpretation at a certain point if it is difficult to connect to the IPAF the material the patient has brought to the session.

“I think brief work— I don't think this is a complete answer though because your focus may be developed through something, but I think if you're in the middle of the work and you can't think of how somebody's communication links to the focus, you'll probably be advised not to make an interpretation until you can figure it out”

f) Elicit Interpersonal Narratives

Expert clinicians coincided that an essential competence in DIT is the ability of the therapist to elicit interpersonal narratives.
“Certainly, within a DIT model, if you are working particularly in the initial phase, for example, the degree to which the therapist can facilitate the history, but particularly eliciting interpersonal narrative from the patient, and the stories, again in the way in which the therapist allows those stories to unfold in a way that is containing. I guess it’s about containment to the degree to which the therapist can manage. But certainly, within DIT, the therapist would need to be able to elicit interpersonal material and start to begin to help the patient make those links, and they would need to understand and take a detailed history of the symptom and how to encourage the patient to talk about that.”

g) Expectations for Change

Expert clinicians expressed that a competent DIT therapist will explore and agree together with the patient the need for further psychotherapy after finishing the current one.

“For the patient to know that actually if something keeps re-occurring, then they also have a sense that they will have to go somewhere else for longer term. So, preparing them for that.”

Expert clinicians considered that a competent DIT therapist gets the patient to understand more about him/herself. Therefore, the therapist helps the patient to have more insight and to feel understood. This is the most important goal of DIT because not every patient will be able to make behavioural changes during the short course of the therapy.

“I think what you’re doing a lot of the time in brief therapy is that they have a really good understanding of their issues and why they happen, and then you can make some small changes. I think if we don’t get to have a good enough understanding, then I don’t know if we can move beyond that really.”
Therefore, expert clinicians agreed that the competent DIT therapist has to manage the patient's expectations of what it is possible to achieve in a time-limited psychotherapy.

“It’s working with the patients and their expectations in the brief model. This is all that we are going to be able to do. Is it acceptable? Even though they might not find it satisfactory. You have to keep talking about that too”

h) General Exploration, Focus in Recent Events

Expert clinicians considered that the competent DIT therapist, does a general exploration in order to formulate the patient difficulties but focuses in what has been more recent for the patient. The most important issues for DIT are recent experiences and the here-and-now of the session.

“When I supervise or think of my brief psychodynamic work is being less tempted to work in the past and more tempted to work in the present even though you're informed by the past. The most useful work is actually done in therapy, in the room, in the transference and then making links to the past but not necessarily focusing everything in the past.”

i) Interpretation

Because DIT is a Brief Psychodynamic Psychotherapy, expert clinicians coincided in that it should provide mainly supportive rather than expressive interventions. Delivering too many interpretations entails the risk of the therapy becoming stuck, which is particularly difficult in short-term therapy. However, although DIT is primarily a supportive psychotherapy, there must be a balance where the therapist titrates when he/she can be more challenging by delivering interpretations.
“Actually, a treatment I suppose can break down or can get stuck… It’s a balance I think between being supportive but also being a little-like knowing when you could be a bit challenging and sometimes that’s taking things out and titrating that and then knowing when to pull back or how to acknowledge if something felt very uncomfortable.”

j) Positive Attitudes towards DIT

Expert clinicians agreed in that in order to competently provide DIT, the therapist must consistently convey and instil hope regarding the patient’s change, explicitly expressing enthusiasm about the psychotherapeutic process.

“Persistence, also in terms of hope, being able to convey and instil the potential for change, for things being different, and enthusiasm about the process”

Expert clinicians considered essential that the therapist believes in the value of brief therapy, and does not consider it a bad alternative to long term therapy.

“I think that it’s really important that the therapist believes in the value of brief therapy. It’s just a killer if they think it’s a terrible alternative to long term therapy. I think they have to be really positive, genuinely positive about brief therapy.”

Expert clinicians agreed in that considering the short length of the work, the therapist must be able to trust in the process and tolerate uncertainty.
k) Quickness

Expert clinicians considered that an essential competence to provide DIT is the ability of the therapist to think clearly and quickly within the session.

“I think clarity and activity… a capacity to move fairly quickly, to make connections quite quickly”

Expert clinicians referred that a competent DIT therapist has to quickly find the focus of therapy and should be open enough to share it with the patient.

“I think getting to a focus isn't something everyone can do. It's a bit like being a detective and trying to put something together. You have to feel as well, willing to have a go and have a start. It's not perfect it's a starting point. You have to be willing to show the person what you're thinking on the spot.”

Expert clinicians expressed that in DIT it is essential that the therapist is able to quickly form a relationship of trust and openness with the patient. This means that in a few minutes the therapist should convey that he/she is credible, respectful, interesting, and trustworthy.

“They have to make a good connection with all sorts of different people which means being the kind of person who seems to be respectful, credible, interesting, knowledgeable. In other words, the qualities that I've said are aspects of competence like having a model, and having boundaries and so on, all of those need to be evident to the patient quickly. The first time somebody meets the therapist, they need to be getting the impression that this is someone who within a few minutes, that this is somebody who they could trust and they could get something from”
I) Stick to Model and Phases

Expert clinicians considered that a competent DIT therapist has to stick to the therapeutic model and to the tasks that need to be achieved in each phase of the therapy. Furthermore, experts conveyed that in DIT it is particularly important for the therapist to work together with the patient through the ending phase of the treatment.

“With any therapy, but again, with in DIT, because the therapist needs to help the patient to manage the ending phases of therapy, and within a brief therapy that maybe, again, you got less time to do it and maybe more intense things that get triggered from a patient, and depending on the attachment history…”

m) Transference

Because DIT is a brief psychotherapy there is less time to explore the transference relationship, and also a greater risk for the therapy to become stuck when reviewing the transference with the patient. Therefore, expert clinicians considered that a competent DIT therapist deals with the transference by acknowledging it but then reassuring the patient that the feelings associated with the transference are not what the therapist feels in reality and therefore, it is not equivalent to the real relationship.

“Certainly, in relation to say dynamic interpersonal therapy, I think one can…transference with some patients and you can actually explore -- you feel that I'm an intimidating figure, or you come here you feel anxious around me. They had a father who was particularly stern or strict. And, then they experience you in that way, and you could, in certain patients, you could in a way leave that as an open question. Or say, ‘Well, I'm not a persecuting person, I'm actually very benign.’ But, actually when you come here, you immediately feel I'm going to punish you or I'm going to criticise you. I think in dynamic interpersonal therapy, where the work is brief and focused, you might actually be wanting to almost in a sense nullify transference. Which is, I think when I said that to you,
you thought that I was being critical, I'm not. I'm not being critical...Actually one might want to nullify the transference, and almost in a sense detach oneself from a transferential dimension to the relationship...partly because I think of the DIT approach...to be supportive. I think it's largely a treatment that is attempting to support someone with some of the difficulties that they present within some of their recurring relational patterns that often is out of their awareness...Maybe in the middle phase, you'd perhaps be a bit more exploratory... of that. I think you can get I think caught into -- you can be in a way distracted from the focus of the therapeutic endeavour..."

Expert clinicians considered that a competent DIT therapist should, early in the course of the therapy, understand the transference and its implications to the psychotherapeutic process. Thus, the therapist should be able to name these implications and be aware of them with the patient, so that they do not interfere with therapy.

“That being aware of what the transference implications are...the material that the person's bringing so not just thinking about content but I guess what it might mean...it really was possible that I thought 'she might to come into this situation not being sure whether I was safe, what authority would she find’ so naming that can help with thinking, that's the anxiety she is bringing and I'm not going to re-assure her but I know about it and we can name it and it's there to think about.”

n) Incompetence in DIT

Expert clinicians considered that a frequent incompetence of DIT therapists is that they become too concrete and do not pay attention to the counter-transference and/or to enactments. Therefore, an important incompetence of DIT therapist is losing sight of the unconscious realm of the patient and the therapy.
“And I think one of the two things which can happen is that in brief therapy people can really forget about working with the countertransference and holding onto the unconscious enactment. And it can become quite concrete and then, the main flavour of psychodynamic work which is about the unconscious can get lost. I think this particular model brings that challenge”

Expert clinicians coincided in that an incompetent DIT therapist is the one that does not carry out the tasks of each phase of the treatment manual.

Furthermore, expert clinicians considered incompetent a DIT therapist that is unable to quickly create a relationship of trust with the patient.

Finally, expert clinicians considered incompetent a DIT therapist that does not have a focus for the therapy.

“Probably for a brief piece of work, I don’t think that applies for all psychotherapy by any means but it would probably be an incompetence not to at any point think about what your formulation and your focus is.”
Appendix M
First version of the TCS

Assessment of Competence in Dynamic Interpersonal Therapy

**Not Applicable:** The feature described is not present in the session, therefore it is not possible to assess (Score = 0)

**Limited:** Therapist demonstrates an inappropriate performance which is likely to have negative therapeutic consequences (Score = 1)

**Basic:** Therapist’s performance is somewhat appropriate with some degree of skill evident. However, there are some problems or inconsistencies in the therapist’s performance (Score = 2)

**Advanced:** Therapist consistently demonstrates a high level of skill with only very few and very minor problems (Score = 3)
1. The therapist maintains an awareness and is receptive, throughout the session, to the unconscious processes that take place in himself/herself and in the patient, including the unfolding of the transference. The therapist conveys this awareness in: a) the content, construction, and timing of his/her interventions; b) when he/she decides to not to intervene; c) in his/her affective tone and thought processes during the session; and/or, d) by naming the contradictions between manifest and latent contents, or by showing to the patient the latent material in a straightforward way.

2. The therapist is constantly attuned to the patient. The therapist is attentive to the broader range of the patient’s communications, following the patient’s mental states closely, and conveying a capacity to be with, know, identify, name and contain the patient’s unconscious thoughts and affects.

3. The therapist is particularly interested in the patient’s mental states rather than in the patient’s behaviours and external events

4. The therapist helps the patient have a growing awareness of his/her own unconscious mental processes, promoting the patient’s independence, health, insight and capacity to think.

5. The therapist has an implicit or explicit agreement with the patient that it is worthwhile to try to understand the unconscious motivations related to the patient’s difficulties. Therefore, the therapist makes meaningful connections, expanding the conscious boundaries of the patient.

6. The therapist tolerates the uncertainty and ambiguity that is associated with not understanding what is happening in the session with the patient. The therapist is capable of showing this uncertainty to the patient, conveying the importance of thinking, and the fact that psychotherapy is a collaborative process, where meaning is co-constructed between therapist and patient.

7. The therapist fluently uses a conceptualisation of the mind that involves unconscious motivations and the understanding of the personality structure around the developmental resolution of conflicts.

8. The therapist is able to facilitate the development of the transference relationship through a: a) receptive, non-directive, yet involved attitude; and, b) neutral, non-gratifying, yet concerned stance.
1. The therapist helps the patient become interested in his/her own mind, promoting self-knowledge and self-awareness, particularly in the areas in which the patient is more defended or distrustful.
2. The therapist actively helps the patients to become more open to thinking about themselves and to receive/trust the therapist interventions and new understandings.
The therapist does not passively wait until the patient is able to receive the interventions. Instead, the therapist actively helps the patient get into a state of mind in which they can doubt their own story, becoming interested and considering other perspectives around it.
3. The therapist is able to deliver the interventions in a way that the patient is able to receive them. Therefore, the therapist intervenes in a constructive way, giving the patient a positive view of himself/herself, and verbalising the interventions in a way that the patient can receive them although they might be shocking and/or surprising.
4. The therapist conveys the ability to do marked mirroring.
The therapist conveys, mainly through non-verbal communications, that he/she knows how the patient is feeling at any point of the session, which helps the patient to modulate his/her affective states. The therapist mirrors the patient’s emotions in an “as-if” or pretend mode, meaning that he/she does not get overwhelmed by the affective state but can represent/verbalise it for the patient.
5. The therapist delivers interventions that are: a) personally relevant for the patient; b) can be taken by the patient with a sense of ownership; and/or, c) in keeping with the patient’s intentions and interests.
6. The therapist uses ostensive cues, to alert the patient that what is about to be communicated is relevant to them. The ostensive cues mainly include non-verbal signs such as eye contact, turn taking, and the use of a special tone of voice (“motherese”)
7. The therapist gives a special kind of attention to the patient and treats him/her as an agent. The therapist helps the patient feel independent, stronger, capable of mentalizing, and as an active agent responsible for his/her own life and mind.
8. The therapist understands the therapy as a collaborative process of exploration and development for patient and therapist. Therefore, the therapist adopts a “not-knowing” stance, and does not have an agenda.
9. Before delivering interventions, the therapist makes the patient feel listened and understood, conveying that he/she has in mind the patient’s mind.
Thus, before delivering an intervention, the therapist is able to see and verbalise the patient’s concerns and request for change through the eyes of the patient.

10. The therapist prioritises the patient and what is best in his/her interest.
The therapist treats the patient with respect, considering his/her freedom of choice.

Domain 3 - Issues Regarding Judgment, Flexibility, Adaptations and Timing

1. The therapist shows the ability of individualising the interventions, - rather than delivering a generic therapy-, knowing how to intervene with different patients at different moments.
   a) The therapist adapts the interventions to the individual patient, moving freely within the therapeutic model, taking into account the patient’s: i) level of arousal; ii) understanding; iii) character structure and defences; iv) level of functioning; v) level of intelligence; vi) level of risk; vii) capacity to cope; and, viii) the state of the therapeutic alliance.
   b) The therapist adapts the interventions to the specific moment of therapy, moving freely within the therapeutic model, taking into account the: i) patient’s timing; ii) patient’s current context; iii) phase of therapy; and iv) trajectory within the therapy.

2. The therapist applies a specific theory and therapeutic model; however, he/she is not enslaved to these. The therapist is able to apply theory creatively and be aware when is necessary to deviate his/her interventions from the treatment manual.

3. The therapist uses the principles of the intervention model adapted to the patient’s needs, but also ensuring that all relevant components are being included

4. The therapist has the sensitivity to recognise when and when not to intervene

5. The therapist is able to see, understand, and intervene when the patient’s material is “hot” in the here-and-now of the session.
The therapist understands the connections between the patient’s material, external situation and transference quickly, and adapt his/her interventions accordingly

6. The therapist delivers tentative interventions rather than rigid statements, and self-corrects what he/she is saying after having feedback from the patient
The therapist remains open to the possibility that his/her interventions are not necessarily accurate or right. The therapist does not have certainty and does not treat his beliefs as facts. Instead, the therapist is flexible and open to change his way of thinking according to what is happening with the patient, modifying his/her interventions according to the patient’s feedback or state of mind.

7. The therapist titrates the delivery of interventions in order to meet the patient where he/she is at, not threatening his/her psychic equilibrium.
The therapist delivers interventions that address the specific need of the patient of protection from a particular view of himself/herself
8. The therapist is able to attain a balance between what the patient is interested in talking about in the session and what the therapist considers to be important to address in the context of the therapeutic process. 
9. The therapist knows when to prioritise supportive interventions over expressive ones and vice versa, finding a balance between the two. The therapist favours the delivery of supportive interventions when the patient is fragile and/or emotionally overwhelmed. However, the therapist does not collude with the patient by only staying in the patient’s comfort zone. Therefore, the therapist is able to reach a balance for the specific patient between supportive and expressive interventions.

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**Domain 4 - Therapist Use of Generic Skills and Techniques**

1. The therapist is able to listen to the patient attentively
2. The therapist conveys genuine interest, curiosity, concern, and sensitivity towards the patient
3. The therapist is able to genuinely convey hope to patient
4. The therapist believes in the therapy he/she is delivering
5. The therapist is motivated and committed to psychotherapeutic work and to working with his/her patients
6. The therapist keeps an ethical practice (obtaining informed consent, maintaining confidentiality, safeguarding the patient’s interests, maintaining competent practice, protecting clients from potential harm, maintaining appropriate standards of personal conduct)
7. The therapist has an excellent management of language and is able to make short, clear, and economical interventions
8. The therapist is able to make an assessment of the patient
9. The therapist is able to assess the patient’s suitability for psychodynamic psychotherapy
10. The therapist is capable of assessing the patient’s level of risk, and modify his/her interventions accordingly
11. The therapist is able to draw on knowledge of mental health problems and their consequences in order to help and understand the patient
12. The therapist helps the patient recover his/her ability to mentalize. The therapist prioritises this task before delivering any other intervention to the patient
13. The therapist is able to use of humour in a therapeutic way.
14. The therapist has the courage to talk about difficult issues, make challenging links, and ask the questions that need to be asked in order to help the patient.

The therapist does not remain in a safe place. Instead, the therapist trusts his/her own instincts and is able to try new things out with the patient.
15. The therapist understands what his/her role means and believes in the therapy that he/she is delivering. Therefore, the therapist does not say things in such a tentative way that it feels he/she is not occupying his/her position as a therapist.
16. There is a gap, an asymmetry in the relationship between therapist and patient
17. The therapist is able to manage the patient's expectations of therapy. The therapist clarifies to patient what can be achieved, and what not, within the timeframe of therapy, and considers the patient's need for further therapy after finishing the current one. Additionally, the therapist conveys that ultimately change comes if the patient is motivated and committed to work towards it
18. The therapist prepares the patient for planned interruptions in the treatment by helping them explore their conscious and unconscious responses to breaks
19. The therapist is able to work through end phase of therapy. This involves signalling the ending, discussing the feelings/thoughts and the unconscious fantasies that are mobilised. Additionally, the therapist reviews the work undertaken and is capable of saying goodbye to the patient

Domain 5- Fostering and Maintaining the Therapeutic Alliance

1. The therapist is able to foster a therapeutic alliance with the patient, a relationship of trust in an environment of safety, where the patient feels secure to speak freely, explore difficult contents, and disclose personal information of a sensitive nature
2. The therapist is able to foster a normal and human relationship with boundaries. The therapist is not stiff, formal, rigid or cold with the patient. Instead, the therapist is emotionally accessible to the patient in a setting that has clear boundaries which aim is to protect the patient and the therapeutic process.
3. The therapist conveys that he/she keeps the patient in mind and is attuned to him/her. The therapist, remembers what the patient has said in the past, and reflects, mirrors, and names what he/she has heard. The therapist bears witness the patient’s painful affects in a compassionate way, conveying a willingness to create a relationship with the patient
4. The therapist survives the patient’s attacks, by persevering, by being there for the patient consistently trying to understand the material and work something out. The therapist tenacity and constancy conveys to the patient that the therapist feels close to him/her
5. The therapist conveys that he/she keeps the patient’s relational patterns in mind in order to be aware of the patient’s difficulties in forming a relationship of trust. The therapist understands that this is essential knowledge in order to foster the therapeutic alliance.
6. The therapist explains and agrees collaboratively with the patient on the techniques/methods, tasks, and goals of therapy
7. The therapist ensures that the patient is clear about the rationale for the intervention offered
8. The therapist interventions take into consideration the goals of the therapy, reminding constantly to the patient that he/she cares, which enhances the bond between therapist and patient. The therapist conveys that the therapeutic alliance is a bond with a purpose.

9. The therapist keeps the frame and boundaries of the therapy. The therapist conveys that the therapeutic alliance is a bond with a purpose.

10. The therapist is able to repair ruptures in the alliance by: a) accepting his/her responsibility for his/her contribution to any strains in the alliance, allowing the patient to assert any negative feelings about the therapeutic relationship; b) conveying to the patient that he/she is on his/her side, acknowledging and validating the patient’s experience; and, c) engaging the patient in understanding the meaning of the difficulties between himself/herself and the therapist, making use of ruptures as opportunities for expanding the patient’s understanding of their subjective experiences.

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Domain 6- Therapist’s Self-Awareness, Self-Regulations, and Capacity to Think

1. The therapist conveys that he/she is self-aware, realizes his/her own feelings and thoughts and articulates those in a meaningful way in order to understand what the patient is bringing and the relationship with him/her

2. The therapist is able to think in the room with the patient

3. The therapist conveys that he/she is aware of his/her own blind spots, and therefore, is able to differentiate when what he/she is feeling belongs to the patient and when what he/she is feelings belongs to his/her own personality

4. The therapist conveys the ability to self-regulate and contain his/her own anxieties and feelings, in a way that they do not interfere in his/her work with the patient

5. The therapist conveys the ability to think about enactments, and how the patient’s mind impacted the therapist’s one.

The therapist is able to maintain/regain a reflective stance when managing forms of acting out in relation to the setting

6. The therapist is well-developed, he/she is able to: a) tolerate uncertainty; b) not to be easily frightened by the patient’s communications and at the same time to not to be out of touch; c) tolerate and handle complex and unpleasant feelings and situations; d) be humble, open to learn, understanding that every patient is different; e) convey that he/she is psychically sophisticated and that has a life experience that allows him/her to work in depth with the patient; f) be compassionate and reflexive; and, g) be sensitive to work in depth with unconscious communications
1. The therapist understands the multiple levels of the patient’s communications
The therapist understands the patient's internal state, external relationships, transference situation, and the links between them. The therapist holds this understanding of the patient in mind, that he/she can sensitively share in the session.

2. The therapist demonstrates the following abilities: a) understand the patient’s communications; b) understand the implications of the unconscious meanings of the patient’s communications to the therapeutic relationship in the here-and-now of the session; and, c) competently intervene in accordance with these understandings.

3. The therapist is able to intervene at multiple levels.
In the first level, the therapist is able to respond to the patient’s current situation with empathy and sensitivity. In the second level, the therapist is able to intervene conveying an understanding of the implications and consequences of the situation to the patient in their external world. In the third level the therapist is able to link the patient’s current situation, to the relationship with the therapist and to the main unconscious phantasies, expanding the patient’s understanding, by sensitively delivering an original and helpful intervention that addresses the implications and consequences of the patient’s difficulties.

4. The therapist interventions, that address different levels of depth, create a subjective experience that feels immense to the patient, because something he/she was unaware of becomes verbalised.
The patient goes through a “click” experience by becoming able to understand something differently or with another depth
1. The therapist is able to engender trust and develop rapport with the patient
2. The therapist is able to make the patient interested and surprised with the material, by sharing an understanding of the patient’s difficulties that he/she has not seen before
3. The therapist is able to add meaning to the patient’s communications
4. The therapist helps the patient feel understood by containing the patient’s anxieties and difficulties without being judgmental. Therefore, the therapist does not behave as a critical object of whom the patient is afraid of. On the contrary, the therapist delivers a formulation to the patient in which he/she feels understood, accepted and safe
5. The therapist understands the uniqueness of the patient’s experience, and neither closes its understanding to soon, nor concretises it. Instead, the therapist explores the underlying meanings of the patient’s experience, making individual and unique connections, attuning to what he/she is feeling and validating it
6. The therapist is able to pick up what is more urgent in the immediate situation for the patient in order to work with that in the session
7. The therapist engages the patient getting him/her to be responsive to the therapist’s verbal and non-verbal communications.
   The therapist gets the patient to: a) be attentive to the therapist communications; b) elaborate the therapist communications; c) remember material from previous sessions; d) convey changes in his/ her affective tone (for example, through tone of voice, posture); and, e) be in the route of making changes in the way they relate to others.
8. The therapist adapts his/her personal style so that it meshes with that of the patient, and his/her tone of voice interplays in a dance with the patient’s communications.
   The therapist responds to the patient in a way and tone of voice that show concern and influence by what the patient has said, aligning himself/herself with the patient and bringing him/her back to the room with therapist.
9. The therapist is aware that the patient’s defences might prevent him/her of engaging with therapy. The therapist is able to address and deal effectively with these issues together with the patient in the session when they occur
10. The therapist engages the patient in an alive interchange
1. The therapist demonstrates a good understanding of the patient’s history, relationships, and how he/she has come to have the current clinical presentation.

2. The therapist arrives into a dynamic formulation by gathering and integrating information about the patient from different sources.

3. The therapist arrives into a dynamic formulation taking into consideration the developmental history and past experiences of the patient, as well as the use of defences at different life stages.

4. In order to arrive into a dynamic formulation, the therapist gives considerable importance to how it is to be with that particular patient in the room.

The therapist considers essential to understand how the patient relates to the therapist, how the patient replies to questions and different situations, and how the patient elaborates their object relationships.

5. The therapist considers the cautionary tale and/or his/her countertransference as essential sources to formulate the patient’s difficulties.

6. In order to arrive into a dynamic formulation, the therapist systematises the information of all the sources mentioned above, in light of the psychodynamic theoretical model, aiming to conceptualise what is the patient’s basic conflict.

7. The therapist arrives at an analytic/dynamic formulation by working collaboratively with the patient.

The therapist shares his/her dynamic formulation with the patient not as a sure thing, but expressing it tentatively, as a hypothesis, waiting to hear the patient’s response to it in order to co-construct the formulation collaboratively.

8. The therapist delivers the dynamic formulation when it is possible to link it to something that happened in the session.

Therefore, the therapist makes the formulation more understandable, alive and interesting by making a link to the material of the session.
1. The therapist accurately understands the patient, bringing about an observable change in the patient’s: a) tempo or rhythm; b) emotions or affective tone; c) usual behaviour in the session; d) material, therefore the patient can bring about new material or allow for old material to be elaborated in a different way; e) thought processes and ability to make links; f) capacity to trust; g) memories; or, h) ownership of the idea conveyed by the therapist.

2. The therapist, in order to accurately understand, gets alongside with the patient’s experience and feelings. The therapist provides the patient with the experience of being understood in a deep and meaningful way, expanding the understanding and saying something new, which is immensely moving for both individuals.

3. The therapist interventions make sense from what has been happening in the therapy.

The interventions are based on enough evidence provided by the patient.

4. The therapist makes accurate interventions meaning that both, the interventions’ content as well as their timing is appropriate for the patient.

5. The therapist asks the patient for feedback, asking whether what he/she has said makes sense to the patient or not. The therapist is not only attentive to the patient’s verbal and manifest feedback, but also to the feedback provided by the patient’s unconscious communications, including the therapist countertransference.
1. The therapist deals with the emotional content of the session by helping the patient regulate his/her emotions in order to be able to think about them instead of feeling overwhelmed.
2. The therapist helps the patient experience a range of affective states of varying intensities, in tolerable limits. Therefore, with patients that become easily overwhelmed, the therapist attempts to bring down the intensity of the affective state by helping the patient mentalize their emotions; whereas, with patients that are disconnected from his/her emotional states, the therapist attempts to bring affects to their attention.
3. The therapist allows the evacuation of raw emotions when the patient has recently experienced an external traumatic situation. However, when the emotional hyperarousal of the patient is in relation to transferential issues, the therapist attempts to lower the intensity of the emotions by helping the patient mentalize.
4. The therapist attunes to the patient’s feelings but does not overly empathise with them. The therapist attentively observes the patient’s emotions, without sharing himself/herself these feelings with the patient. The therapist is able to retain his/her ability to think and help the patient make sense of his/her emotions.
5. The therapist is not only attentive to the emotions openly expressed by the patient, but particularly to the patient’s feelings that are not being explicitly expressed, such as anger or envy, and is open to their exploration.
6. The therapist is able to sit with the feelings of the patient without disposing of them. The therapist is able to be attuned, identify, name, explore, and articulate the patient’s emotions. In this way, the therapist conveys that affect is welcomed and that can be thought about and born by both.
7. The therapist is able to name and contain (“digest”) the emotional experiences of the patient. The therapist is able to find examples, metaphors or analogies (symbolic work) to understand and contain the patient’s experience, making links that are understandable and palatable for the patient.
8. The therapist helps the patient to come to terms with difficult experiences and emotions, assisting him/her in the process of grief.
9. The therapist deals with the emotional content of the session by retaining his/her ability to think and imagine. The therapist remains open to what else might be going on in the session, apart from what is being openly shown by the patient. Therefore, the therapist is able to add meaning and make new links in the material.
1. In order to understand the patient's feelings and defences mobilised in interpersonal situations, the therapist carries out a polite enquiry to elicit relevant information, using techniques such as clarification, confrontation and interpretation.

2. The therapist helps the patient mentalize the different perspectives in an interpersonal conflict. In order to do this the therapist describes the contradictions in the patient's account, only to then help the patient solve the apparent contradictions in the story. The therapist draws the patient's attention to the contradictions in their narrative, analysing the situation from every angle, and trying to understand the affects and defences aroused.

3. The therapist delivers his/her understanding of an interpersonal situation by following a particular sequence. The first step is to make the patient feel understood. Only after this the therapist can explore the other people's perspectives involved in the interpersonal situation.

4. The therapist helps the patient explore the unconscious feelings that may emerge in interpersonal situations.

5. The therapist titrates his/her interventions taking into consideration how defended the patient is from conflicting and unconscious affects. The therapist is aware of how much affect the patient can tolerate and takes it into consideration when exploring interpersonal situations.

6. The therapist helps the patient become aware of his/her repeated interpersonal pattern of relating, with its affects and defences, that causes the patient difficulties, in order to deactivate it.
1. The therapist promotes the patient’s free association and does not have an agenda in mind for the therapeutic process, therefore facilitating the patient’s unconscious communications.
2. The therapist is able to find a balance between the required structure to deliver therapy and the necessary space in order to facilitate the patient’s unconscious communications. The therapist maintains this balance by keeping the frame and boundaries of therapy, leaving other issues unstructured in order to facilitate the emergence of the patient’s unconscious communications.
3. The therapist listens to the patient and makes links with a free-floating attention.
4. The therapist has a psychotherapeutic model in mind, which he/she uses to tune into and understand the patient’s communications.
5. The therapist is attentive to all the patient’s verbal and non-verbal communications, particularly to the issues the patient might be avoiding and keeping away from the discussion. The therapist is attentive to what the patient is saying and not saying.
6. The therapist is aware where in the patient’s narrative the feelings seem to be guarded, defended, or cut-off, and uses this knowledge as a guide to the patient’s unconscious affects. The therapist sensitively brings about these feelings, that have been left out, allowing the patient to experience and share them in therapy.
7. The therapist gives more importance to “how” the patient communicates than to the content of “what” he/she is saying. Therefore, the therapist prioritises the form and process of the patient’s communications rather than the content in order to understand the unconscious communications.
8. The therapist is attentive to his/her countertransference, and to the patient’s dreams and slips.
9. The therapist facilitates and responds to the patient’s unconscious communications by putting into words the latent meaning of the session. The therapist never expresses the unconscious contents with certainty, but always tentatively, hypothetically, leaving space to think together with the patient.
10. The therapist responds to the patient’s unconscious communications by progressing from surface to depth, starting from the issues that are closer to the patient’s consciousness. The therapist brings something up in therapy when he/she senses that the patient is almost conscious of it.
11. The therapist responds to unconscious communications when the patient is open to receive them.
1. The therapist delivers an interpretation conveying an understanding of both, the patient’s transference/countertransference dynamics, as well as the patient’s defences.
2. The therapist delivers interpretations by arriving at them slowly and alongside with the patient, holding the patient’s hand as they arrive at it, saying the interpretation for the patient but with the patient.
3. The therapist bases his/her interpretations on enough information and evidence that has already been discussed with the patient.
4. The therapist understands which kind of interpretation is more appropriate to deliver at a specific time of the session: either interpret the transference or the patient’s external situation.
   The therapist is guided by what is more relevant and interesting for the patient at a specific point of the session.
5. The therapist delivers interpretations in a way that feel constructive and not punitive to the patient.
6. The therapist delivers the interpretations as hypotheses that need to be tested together with the patient. The therapist delivers interpretations tentatively, inviting the patient to co-create with the therapist the meanings in the therapeutic process.
7. The therapist only delivers interpretations that are focused or have a purpose.
   Thus, the interpretations are pertinent to the affective interpersonal focus of therapy.
8. The therapist interpretations are clear and succinct enough for the patient to be able to take them in.
9. The therapist interpretations are appropriately timed, in relation to an assessment of what the patient can bear to think and in relation to the amount of time left in a session.
10. The therapist interpretations are of appropriate depth, moving from preconscious to more unconscious contents.
11. The therapist delivers interpretations in a language that belongs to the patient, using the words and thoughts the patient employs. The therapist emulates the patient’s language when delivering an interpretation.
12. The therapist follows a specific sequence when delivering interpretations to the patient. Before delivering an interpretation, the therapist makes supportive interventions, validating the patient’s feelings. Only when the patient feels safe enough, the therapist makes new links and delivers interpretations.
13. After delivering an interpretation, the therapist adapts the following interventions to the patient’s reaction to it.
1. The therapist is able to recognise the transference situation. The therapist learns about the patient by exploring and thinking about the unconscious meanings related to the transference relationship.

2. In order to understand and use the transference, the therapist is open to the relationship with the patient, exposing himself/herself to it, letting himself/herself become affected by it, without feeling the relationship with the patient as something neutral or distant.

3. The therapist is aware that anything the patient says in the therapy is a reflection of the total transference situation with the therapist. The therapist is aware that anything the patient says in therapy reflects in some way what is happening in the therapeutic relationship.

4. The therapist understands that anything the patient says in the session has an impact in the therapeutic relationship.

5. The therapist conveys the ability to use the transference in at least one of the following ways:
   a) The therapist is able to understand and use the transference, linking it to the patient’s IPAF
   b) The therapist is able to competently deliver transference interpretations
   c) The therapist uses the transference by describing the transference situation, without interpreting it, and linking it to a separate issue relevant to the patient that might challenge his/her beliefs about him/herself. The therapist does not focus on the transference, but uses it to explore other areas

6. The therapist delivers his/her understanding of the transference in a sensitive and at the same time challenging way to the patient.

7. The therapist focuses in the relational and affective dynamics and patterns that unfold in the therapeutic relationship, rather than focusing on the patient’s cognitive functioning. The therapist’s interventions resonate with the patient’s affects and are not a theoretical/cognitive explanation about the patient’s difficulties that sounds detached from what the patient is feeling or experiencing with the therapist in the session.

8. The therapist leads the patient to experiment something new, to try out something spontaneous in the therapeutic relationship.

9. The therapist is attentive and understands how the patient is using the transference interpretations, either constructively or not, addressing this with the patient.
1. The therapist understands the patient’s defences by exploring and having in mind how the patient has reacted to difficult situations in the past.

The therapist understands that often the defences are associated with the difficulties in the patient’s history, because defences become entrenched at a time in development where there were particular pressures for that individual.

2. The therapist assesses the defences in the interaction with the patient in the session.

3. The therapist is respectful of the patient’s defences, and understands the reasons behind them. Therefore, the therapist is respectful of both, the defences and the difficulties that originally led to them.

This understanding is particularly important in brief work, where the therapist should not aim to disarm the defences.

4. The therapist recognises and works with the defences by acknowledging the struggle that they mean for the patient.

5. The therapist works with the defences by showing the patient the cost of using them, without necessarily challenging the patient to change them.

6. The therapist only challenges the defences when there is enough trust and a solid relationship with the therapist. Additionally, the therapist only challenges the defences when the patient has the resources, the capacity and/or external support to cope with the feelings underneath the defence.

7. When the therapist challenges the defences he/she does it with sympathetic interest and compassion, never in an aggressive way, or blaming the patient.
IPAF and Focusing Interventions
1. The therapist is able to formulate and articulate the IPAF, which includes identifying what is the patient’s self-representation, other-representation, and which are the most important affects and defences employed by the patient
2. The therapist intervenes being mindful of the IPAF, fitting the interventions according to the affective-relational pattern agreed with the patient as the focus of therapy.  
3. The therapist understands and links the material the patient brings to therapy to the IPAF in order to maintain the focus and purpose of therapy

Activity and Visibility
1. The therapist maintains an active stance and clarity of thinking during the session with a specific purpose in mind
2. The therapist is visible and communicative to the patient and does not adopt a “blank screen” attitude towards the patient
3. The therapist finds a balance between giving information (i.e., giving and asking for feedback), and listening and giving space to the patient.

Collaborative Process
1. The therapist formulates the focus of therapy and shares it with the patient in order to elaborate it together and agree on it. The focus of therapy is not something the therapist develops on his/her own, it is rather something that it is built collaboratively with the patient
2. The therapist considers the patient’s feedback an essential therapeutic tool. The therapist takes into account the patient’s feedback for both, formulating the focus of therapy, as well as to adapt his/her interventions to the individual patient at each moment.

Directive to Focus
1. The therapist is able to be directive and focused in the work while retaining an analytic attitude meaning, not becoming too cognitive or losing sight of the patient’s unconscious. Thus, the therapist is directive while tuned into the unconscious communications, evolving transference, and countertransference.
2. The therapist is elastic instead of flexible, meaning that he/she allows himself/herself to deviate from the agreed therapeutic focus but going back to it. Therefore, the therapist is able to go off-track of the therapeutic focus but never completely or permanently.
3. The therapist prioritises working on the agreed focus rather than exploring the patient’s past history.
4. The therapist does a general exploration in order to formulate the patient difficulties but focuses in what has been more recent and relevant for the patient and in the here-and-now of the session
5. The therapist explicitly helps the patient identify the goals for therapy that are meaningfully connected to the IPAF
6. The therapist explicitly encourages interpersonal change

**Eliciting Interpersonal Narratives**
1. The therapist elicits interpersonal narratives

**Quickness**
1. The therapist has clarity of thinking and is able to think quickly within the session
2. The therapist quickly finds the focus of therapy and is open to share it with the patient
3. The therapist is able to quickly form a relationship of trust and openness with the patient. This means that the therapist is able to show, in a few minutes, that he/she is credible, respectful, interesting, giving the impression of someone the patient can trust

**Sticking to the Model and Phases**
1. The therapist sticks to the therapeutic model and to the tasks that need to be achieved in each phase of the therapy.
2. The therapist organises each session in accordance to the therapeutic focus and phase. Therefore, the therapist is persistent and holds his/her vision of the patient across the interventions

**Outcome Measures**
1. The therapist is able to incorporate measures to guide therapy and monitor outcomes

**Transference**
1. The therapist deals with the transference by acknowledging it, but then reassuring the patient that what he/she is experiencing in the transference is not what the therapist feels, and therefore is not equivalent to the real relationship
2. The therapist links what is happening in the transference relationship to the IPAF
The feature described is present in the session  
(Score = 1)

The feature described is not present in the session  
(Score = 0)

**Enactments, Concrete Interventions, and Not Thinking**

1. The therapist is unable to explore, see, understand and/or think the different possible perspectives and meanings underlying the material the patient brings to the session.
2. The therapist is unable to handle and/or understand his/her own countertransference and/or his/her participation in the interaction with the patient.
3. The therapist gets easily trapped in enactments with the patient and/or cannot understand/think about them; thus, the therapy becomes easily stuck.
4. The therapist does not understand and/or is unable to think about what the patient is communicating; thus, the therapy becomes easily stuck.
5. The therapist is unable to pick up the unconscious communications, particularly the negative transference and/or the patient’s difficult feelings (i.e., aggression), leading to a collusion between therapist and patient.
6. The therapist gets stuck in a concrete level of communication, which prevents the patient from thinking, because the therapist cannot see the layers of meaning in the patient’s material.
7. The therapist loses his/her ability to think and trust his/her own judgment by becoming overwhelmed, overly anxious or afraid of the effect of his/her interventions have on the patient. The therapist may be particularly afraid that the patient may disapprove or become angry at an intervention.
8. The therapist takes the narratives of the patient as direct and concrete examples of what is happening in the therapeutic relationship. For example, a therapist may say to his/her patient “you are telling me about this row with your friend because you want to have a row with me”.
9. The therapist quickly reassures the patient, acting fast and superficially, without thinking and/or without gathering enough information to understand and intervene. Therefore, the therapist closes topics too soon, narrowing them down without really exploring or understanding them together with the patient.
10. The therapist gives the patient advice, homework and/or direct answers to their questions. Therefore, the therapist fosters a relationship that might be comfortable for the patient but that does not allow him/her to think, or work psychologically. Therefore, the therapist interventions are concrete by giving fast, specific and material solutions to his/her patients.

11. The therapist frequently communicates in a colloquial way with the patient.

12. The therapist is unaware that he/she is doing harm or simply not doing anything helpful for the patient. Therefore, the therapist does not realise the effects of his/her behaviours and attitudes on the patient.

Inability to Foster the Therapeutic Alliance
1. The therapist is not emotionally accessible to the patient, he/she is either cold, rigid, insensitive, disconnected, and/or stiff, making it hard for the patient to form a relationship of trust with him/her.
2. The therapist conveys negative interpersonal behaviours such as impatience, aloofness, insincerity, or aggressiveness.
3. The therapist often forgets important information about the patient and/or does not keep the patient in mind. Thus, it becomes difficult for the therapist to elaborate on the patient’s material.
4. The therapist allows for prolonged silences in the session.
5. As a consequence of the therapist behaviours, the patient becomes less interested and less connected to the therapist and the therapy.
6. The therapist does not listen to the patient. This entails both, a therapist that does not listen to what the patient says, as well as the therapist that does not listen to the different layers of meaning in what the patient is communicating.

Not Adapting Interventions to the Patient/Context and Not Considering the Consequences of Interventions
1. The therapist delivers interventions without adapting them or considering: the context, the timing, and/or the effects of it on the therapy and/or on the patient.
2. The therapist is unaware of and/or unable to address with the patient that he/she is getting worse in the course of treatment.
3. The therapist is unable to think with the patient and delivers the treatment manual automatically and/or in a dogmatic way, not learning from the individual patient nor adapting the interventions to that specific patient.
4. The therapist is unable to prioritise the patient’s interests before his/her own. The therapist does not put the patient first. Instead, the therapist is biased and unfair, prioritising his/her own interests instead of the patient’s.
5. The therapist makes interpretations driven more by his/her own ideas, or in an automatic/mechanistic way, rather than being driven by what the patient needs at a specific time. Thus, the therapist delivers...
interpretations not thinking about the patient, nor adapting them to the therapeutic context.

6. The therapist treats the patient’s defences disrespectfully, not understanding the underlying struggle that they represent for the patient. The therapist points out the defences, or challenges them too soon in the therapy, without thinking of the consequences that this might have, leaving the patient feeling exposed which might lead to ruptures in the alliance.

7. The therapist overlooks the patient’s coping mechanisms and/or does not understand the patient’s distress as a sign of how much they are struggling with their difficulties. The therapist does not help the patient feel understood and supported. On the contrary, the therapist mainly focuses on the patient’s problems, overlooking their defences and coping mechanisms.

8. The therapist interventions do not show sensitivity to the complexity of the patient’s situations and difficulties.

9. The therapist is irresponsible because he/she does not consider the potential effects the interventions may have on the patient.

10. The therapist behaves in an unethical way. The therapist harms the patient by being abusive, or exploitative of the patient or neglectful. Furthermore, the therapist is unethical by engaging in power struggles with the patient.

11. The therapist overwhelms the patient, for example making them sad or angry instead of helping them mentalize their emotions.

Lacking Basic Skills to Intervene

1. The therapist does not have a model of therapeutic principles in mind and/or uses interventions from different models that are incoherent between them.

2. The therapist does not keep the frame or boundaries of psychodynamic work.

3. The therapist is either too slow in making links in the patient’s material or does not think of possible meanings until way after the moment the patient could really have been helped by them.

4. The therapist does not express him/herself clearly. This includes therapists that are ambiguous in what they say or that speak for so long that the patient forgets where they started at. Additionally, this includes therapists that speak in an overly theoretical way that prevents the patient from understanding.

5. The therapist intervenes without having gathered enough information that would allow him/her to understand the patient’s situation.

6. The therapist is unable of engaging the patient and promoting psychic change.

7. The therapist does not allow for silences to occur, without leaving space and time to think in the session.

8. The therapist becomes too silent without helping the patient communicate or to engage in therapy.

9. The therapist misunderstands the patient and says wrong things to them, leaving the patient alone and/or perplexed.
10. The therapist gives the patient a destructive view of themselves

**Therapist Mental Health Issues**
1. The therapist blames the patient for his/her own difficulties or incompetence.
2. The therapist tends to only focus in the patient’s difficulties, projecting the bad onto the patient and blaming the patient for the lack of progress in therapy.
3. The therapist is narcissistic, self-centred, or cannot take in criticisms.
4. The therapist is unable to maintain an alliance with the patient.
5. The therapist does not have self-awareness, does not have insight of the effect of his/her actions, does not know of his/her own blind spots and their impact on the therapy.
6. The therapist says wrong things to the patient, particularly because he/she is mainly talking about things that interest only him/her and are not beneficial for the patient.

**Not accurately understanding the patient**
1. The therapist does not understand the patient, causing a break in the therapeutic process. As a consequence, the patient may show distress, aggressiveness, compliance, bristling, confusion, irritation, or may react breaking the alliance with the therapist, or trying to save/educate the therapist. Additionally, the patient may close down or stop mentalizing when an intervention is wrong in its content or in its timing.

**Incompetence in DIT**
1. The therapist becomes too concrete and/or cognitive, losing sight of the unconscious realm.
2. The therapist does not carry out the tasks of each phase of the treatment manual.
3. The therapist is unable to quickly create a relationship of trust with the patient.
4. The therapist does not have a focus for the therapy.
### Global Competence Rating

- **Limited:** Therapist demonstrates a significant absence of skill or an inappropriate performance which is likely to have negative consequences (Score = 1)

- **Basic:** Therapist’s performance is somewhat appropriate with some degree of skill evident. However, there are some problems and/or inconsistencies in his/her performance (Score = 2)

- **Advanced:** Therapist consistently demonstrates a high level of skill with only very few and very minor problems (Score = 3)

### Patient Complexity Rating (Level of Epistemic Trust)

- **Severe.** Low level of epistemic trust, with difficulties to receive the therapist’s interventions

- **Moderate.** Moderate level of epistemic trust. The patient receives some of the therapist’s interventions but remains closed to others

- **Mild.** Patient has high level of epistemic trust. The patient is open to receive most of the therapist’s interventions
Appendix N
Second version of the TCS

COMPETENCE

Aim 1: To Create Psychic Space, a Space where it is Possible to Think Together with the Patient

1. The therapist demonstrates a receptive, involved, yet non-gratifying attitude, a balance between emotional closeness and distance, that maintains the patient’s emotional arousal at an optimal level (not too high so that the patient loses his/her ability to mentalize; not too low so that the session becomes meaningless emotionally)

For example, the therapist attunes to the patient’s feelings but does not overly empathise with them. The therapist attentively observes and describes the patient’s emotions, without reacting or sharing them. The therapist is able to retain the ability to think and help the patient make sense of his/her emotions.

Competencies included:
   a) The therapist is visible and communicative to the patient and does not adopt a “blank screen” attitude towards the patient
   b) There is a gap, an asymmetry in the relationship between therapist and patient

2. The therapist is able to find a balance between the required structure to deliver therapy and the necessary space that facilitates the patient’s unconscious communications. The therapist maintains the session’s structure by adhering to the treatment model, directing the interventions towards an agreed focus, and by maintaining the frame and boundaries of therapy. Concurrently, the therapist creates space by promoting the patient’s free association and by not having an agenda in mind for the therapeutic process.

For example, the therapist is able to balance the silences in the session. On one hand, the therapist does not become too silent because this would hinder the patient’s communications and engagement; and, on the other hand, the therapist allows for silences to occur in order to create space and time to think within the session.

Competencies included:
   a) The therapist maintains an active stance and clarity of thinking during the session with a specific purpose in mind
   b) The therapist finds a balance between giving information (i.e., giving feedback), and listening and giving space to the patient

Aim 2: Containment, Making the Patient Feel Understood
1. The therapist is constantly attuned to the patient. The therapist is attentive to the broader range of the patient’s communications, following the patient’s mental states closely, and conveying a capacity to be with, know, identify, name and contain the patient’s unconscious thoughts and affects.

For example, a well-timed and accurate transference interpretation can be a substantial expression of the patient’s attunement, as it conveys to the patient that he/she has been heard at various level, not only in reference to what has happened in the past, but also in reference of what is happening in the session.

Competencies included:
- a) The therapist is able to listen to the patient attentively
- b) The therapist conveys genuine interest, curiosity, concern, and sensitivity towards the patient
- c) The therapist is able to sit with the feelings of the patient without disposing of them. The therapist is able to be attuned, identify, name, explore, and articulate the patient’s emotions. In this way, the therapist conveys that affect is welcomed and that can be thought about and born by both.
- d) The therapist shows the ability to do marked mirroring. The therapist conveys, mainly through non-verbal communications, that he/she knows how the patient is feeling at any point of the session, which helps the patient to modulate his/her affective states. The therapist mirrors the patient’s emotions in an “as-if” or pretend mode, meaning that he/she does not get overwhelmed by the affective state but can represent/verbalize it for the patient

2. The therapist is able to contain the emotional experiences of the patient. The therapist understands the uniqueness of the patient’s feelings and experiences, without closing their understanding too soon, or making concrete interventions. Instead, the therapist explores and finds examples, metaphors, or analogies (symbolic work) to understand and contain the patient’s experience, making unique links that are understandable for the patient. The therapist’s interventions create a subjective experience that feels immense to the patient, because something he/she was unaware of becomes verbalised.

Competencies included:
- a) The therapist helps the patient feel understood by containing the patient’s anxieties and difficulties without being judgmental. Therefore, the therapist does not behave as a critical object of whom the patient is afraid of. On the contrary, the therapist delivers a formulation to the patient in which he/she feels understood, accepted and safe
- b) The therapist, in order to accurately understand, get alongside with the patient’s experience and feelings. The therapist provides the patient with the experience of being understood in a deep and
meaningful way, expanding the understanding and saying something new, which is immensely moving for both individuals.

c) The therapist makes the patient go through a “click” experience by becoming able to understand something differently or with another depth

Aim 3: Help the Patient to Think for Himself/Herself (Patient Understands Himself/Herself)

1. The therapist promotes the patient’s capacity to think. The therapist helps the patient become interested in his/her own mind and to have a growing capacity to independently think about his/her own unconscious mental processes.

For example, the therapist gets alongside the patient when exploring a difficult topic but does not give him/her all the answers. Instead, the therapist asks questions and comments in a way that prompts the patient to think, verbalize and reach on his/her own significant meanings and unconscious affects

Aim 4: To Foster the Patient’s Epistemic Trust

1. The therapist uses ostensive cues to alert the patient that the intervention that is about to be delivered is important to him/her. Then, the therapist delivers interventions that are personally relevant for the patient and that are in harmony with his/her intentions and interests, in a sense that can be taken by the patient with a sense of ownership.

For example, with a patient that in the first few sessions asks many practical questions, driven by anxiety, the therapist may adopt a special, calming and maternal tone of voice and say: “Perhaps beginning psychotherapy can make you feel anxious because it might be frightening and painful to face difficult issues about yourself. Asking me a lot of questions is maybe a way of letting me know that you are worried of where this process may lead you to”

Competencies included:

a) The therapist uses ostensive cues to alert the patient that what is about to be communicated is relevant to them. The ostensive cues mainly include non-verbal signs such as eye contact, turn taking, and the use of a special tone of voice (“motherese”)

b) The therapist helps the patient trust and be open

c) Before delivering an intervention, the therapist is able to see and verbalise the patient’s concerns and request for change through the eyes of the patient

d) Before delivering interventions, the therapist makes the patient feel listened and understood, conveying that he/she has in mind the patient’s mind
2. The therapist treats the patient as an agent. The therapist intervenes in a constructive way, giving the patient a positive view of himself/herself. Additionally, the therapist does not have an agenda and understands therapy as a collaborative process, where the patient has an active involvement. Hence, the therapist allows the patient to be an active agent, responsible for his/her own life and mind, independent, and capable to cope.

Competencies included:
a) The therapist verbalises the interventions in a way that the patient can receive them although they might be shocking and/or surprising
b) The therapist delivers interpretations in a way that feel constructive and not punitive to the patient
c) The therapist adopts a “not-knowing” stance, and does not have an agenda
d) The therapist is genuine

3. The therapist actively helps the patient to receive/trust the therapist interventions and new understandings. The therapist does not passively wait until the patient is able to receive the interventions. Instead, the therapist actively helps the patient get into a state of mind in which they can doubt their own story, becoming interested, and considering alternative perspectives around it

For example, a patient reports the therapist that he has stopped attending a course because he felt criticised by the tutor when he asked the patient where he had been after a few weeks the patient had been absent. The therapist may make comments such as “Take me through what happened”; “Not so quickly. Can you go slowly there and tell me what was in your mind at the time”; “Just to be clear, you felt that your tutor was criticising you about your lack of attendance”; “Looking back, do you think that what he said could have been meant in any other way?”; “Have there been other times when you felt he didn’t like you?”

Aim 5: To Centre the Psychotherapeutic Work around the Unconscious Processes

1. The therapist maintains a focus, awareness, and receptivity to the unconscious processes that take place in the session, including the unfolding of the transference and countertransference.

Competencies included:
a) The therapist conveys an awareness in the unconscious processes in: a) the content, construction, and timing of his/her interventions; b) when he/she decides to not to intervene; c) in his/her affective tone and thought processes during the session; and/or, d) by naming the contradictions between manifest and latent contents, or by showing to the patient the latent material in a straightforward way.
b) The therapist is particularly interested in the patient’s mental states rather than in the patient’s behaviours and external events.

c) The therapist fluently uses a conceptualisation of the mind that involves unconscious motivations and the understanding of the personality structure around the developmental resolution of conflicts.

d) The therapist has a psychotherapeutic model in mind, which he/she uses to tune into and understand the patient’s communications.

e) The therapist is not only attentive to the emotions openly expressed by the patient, but particularly to the patient’s feelings that are not being explicitly expressed, such as anger or envy, and is open to their exploration.

f) The therapist is attentive to all the patient’s verbal and non-verbal communications, particularly to the issues the patient might be avoiding and keeping away from the discussion. The therapist is attentive to what the patient is saying and not saying.

g) The therapist is aware where in the patient’s narrative the feelings seem to be guarded, defended, or cut-off, and uses this knowledge as a guide to the patient’s unconscious affects. The therapist sensitively brings about these feelings, that have been left out, allowing the patient to experience and share them in therapy.

h) The therapist gives more importance to “how” the patient communicates than to the content of “what” he/she is saying. Therefore, the therapist prioritises the form and process of the patient’s communications rather than the content in order to understand the unconscious communications.

2. The therapist is able to retain an analytic attitude. Therefore, the therapist’s interventions are neither cognitive, nor theoretical. On the contrary, the therapist does not lose sight of the patient’s unconscious and the interventions resonate with the affective tone of the here-and-now of the session.

For example, the therapist may link the patient’s IPAF to the patient’s interpersonal narratives in a didactical way, instructing the patient about the different components of the IPAF, without connecting it to the emotions or the unconscious processes in the here-and-now of the session. In this case, the therapist would be doing something in an incompetent way because he/she would not be retaining an analytic attitude. The therapist would fulfil this competency by linking the IPAF to the unconscious communications of the session and by focusing on the affective dimension of the IPAF that is activated in a given relationship.

Competencies included:

a) The therapist is directive while tuned into the unconscious communications, evolving transference, and countertransference.

Aim 6: The Therapist is Able to Think About Himself/Herself and in the Room with the Patient
1. The therapist conveys that he/she is aware of himself/herself, realises his/her own feelings and thoughts, and articulates those in a meaningful way in order to understand the patient's material and the relationship with him/her.

2. The therapist is able to self-regulate his/her own anxieties and feelings in a way that they do not interfere with his/her work with the patient. However, when enactments take place, the therapist is able to think how the patient's mind impacted his/hers. Therefore, the therapist is able to regain a reflective stance when managing forms of acting out.

Example: A patient had a highly ambivalent relationship with her mother from whom she asked for help only to then rebuff anything she might suggest. In a session, the therapist found himself giving advice to the patient, after she complained about difficulties in making friends. The patient reacted strongly to this intervention, saying that the therapist wanted her to make friends at all costs so that he could discharge his duties in relation to her. The therapist described to the patient how it had appeared between them a similar scenario to the one the patient had described with the mother. The therapist acknowledged that he had indeed given advice and that this mirrored the patient's view of her mother as someone who responded anxiously to her problems.

Competencies included:
   a) The therapist conveys that he/she is aware of his/her own blind spots, and therefore, is able to differentiate when what he/she is feeling belongs to the patient and when what he/she is feeling belongs to his/her own personality.

3. The therapist is able to think in the room with the patient. The therapist remains open to what else might be going on in the session, apart from what is being openly shown by the patient. Therefore, the therapist is able to add meaning and make new links in the material.

4. The therapist is well developed, he/she is able to: a) tolerate uncertainty; b) tolerate and handle complex and unpleasant feelings and situations; c) be humble, open to learn, understanding that every patient is different; d) be compassionate, reflexive and sensitive to work in depth with unconscious communications.

Aim 7: Promoting Psychic and Behavioural Change

1. The therapist explicitly encourages change in the way the patient relates to others. The therapist explores together with the patient alternative ways of relating to others, motivating the patient to try something spontaneous and new in his/her relationships (including the relationship with the therapist).
For example, the therapist explores together with the patient the success or failure of the patient’s attempts at change, to have a better understanding of the affective and interpersonal processes that inhibit change. The therapist helps the patient anticipate what may prove difficult, as a way of supporting change.

Competencies included:

a) The therapist explicitly helps the patient identify the goals for therapy that are meaningfully connected to the IPAF

b) The therapist leads the patient to experiment something new, to try something spontaneous, in the therapeutic relationship

2. The therapist organises each session in accordance to the therapeutic focus and to the tasks that need to be achieved in each phase of therapy. Therefore, the therapist is persistent and holds his/her vision of the patient across interventions.

Competencies included:

a) The therapist sticks to the therapeutic model and to the tasks of each phase of therapy

Aim 8: Help the Patient Grieve

1. The therapist helps the patient come to terms with loses, endings, difficult experiences and emotions, assisting him/her in the process of grief.

For example, the therapist is able to work through the end phase of therapy. This involves signalling the ending, and discussing the feelings/thoughts and the unconscious fantasies mobilised. The therapist helps the patient to see him/her as a whole object with imperfections that are frustrating, without this overshadowing the qualities that will be missed. The therapist helps the patient accept the separateness and the pain that this can give rise to. Additionally, the therapist reviews the work undertaken, helping the patient take in he/she has received in the therapy. Working through this loss promotes internalisation of the therapeutic relationship and the analytic process.

Aim 9: To Create an Environment of Safety

1. The therapist fosters an environment of safety where the patient feels secure to speak freely, explore difficult contents, and disclose personal information of a sensitive nature. The therapist creates an environment of safety by maintaining the frame and boundaries of therapy, fostering trust, and by prioritising the patient and what is best in his/her interest.

Competencies included:
a) The therapist prioritises the patient and what is best in his/her interest. The therapist treats the patient with respect, considering his/her freedom of choice.
b) The therapist keeps an ethical practice (obtaining informed consent; maintaining confidentiality; safeguarding the patient’s interests; maintaining a competent practice; protecting the patient from potential harm; maintaining appropriate standards of personal conduct).
c) The therapist keeps the frame and boundaries of therapy.

2. The therapist perseveres and is consistently there for the patient trying to understand the material and puzzle out his/her difficulties. The therapist is there for the patient even when he/she is the target of the patient’s negative transference. The therapist survives the patient’s attacks, tenaciously trying to understand what has taken place, conveying to the patient that he/she cares for him/her.

Competencies included:
a) The therapist keeps the frame and boundaries of therapy. The therapist maintains consistency in relation to the agreed parameters of therapy, and is receptive to the patient’s conscious and unconscious experience of them.

Aim 10: To Foster and Maintain the Therapeutic Alliance, a Relationship of Trust that Enables Psychotherapeutic Work

1. The therapist is able to foster a normal and human relationship with boundaries. The therapist is not stiff, formal, rigid or cold with the patient. Instead, the therapist is warm, compassionate and spontaneous, and conveys that he/she keeps the patient in mind, by remembering what the patient has said in the past, and by reflecting and mirroring the patient’s painful affects. The therapist is emotionally accessible to the patient in a setting that has clear boundaries which aim is to protect the patient and the therapeutic process.

Competencies included:
a) The therapist is able to engender trust and develop rapport with the patient.
b) The therapist bears witness the patient’s painful affects in a compassionate way, conveying a willingness to create a relationship with the patient.
c) The therapist is able to use humour in a therapeutic way.

2. The therapist conveys that the therapeutic alliance is a bond with a purpose. The therapist interventions take into consideration the goals of the therapy, that have been collaboratively agreed with the patient, reminding him/her that the therapist cares, and therefore, enhancing the therapeutic bond.
Competencies included:

a) The therapist explains and agrees collaboratively with the patient on the techniques/methods, tasks and goals of therapy

Aim 11: To Engage the Patient with Therapy

1. The therapist engages the patient in an alive interchange, making him/her interested and surprised with the material by sharing an understanding of the patient’s difficulties that he/she had not seen before

2. The therapist is able to pick up what is more urgent in the immediate situation for the patient in order to work with that in the session

3. The therapist adapts his/her personal style so that it meshes with that of the patient. The therapist responds to the patient in a way and a tone of voice that show concern and influence by what the patient has said, aligning himself/herself with the patient and bringing him/her back to the room with the therapist

Aim 12: Promoting Mentalizing

1. The therapist’s interventions stimulate the patient’s capacity to mentalize experiences of self and others. The therapist conveys the capacity to represent both, his/her own internal states as well as the ones of the patient. The therapist focuses on these internal states, sustaining this in the face of constant challenges by the patient.

Competencies included:

a) The therapist helps the patient recover his/her ability to mentalize. The therapist prioritises this task before delivering any other intervention to the patient

2. The therapist assesses the patient’s mentalizing level, and adapts his/her interventions to help the patient recover his/her mentalizing capacity.

   a) If the patient is in pretend mode the therapist intervenes by shifting the topic to areas of higher emotional arousal and greater vitality.

   b) If the patient is in psychic equivalence mode, the therapist intervenes by stopping and rewinding to the moment mentalizing was lost. The therapist then explores the incident step-by-step, focusing on the patient’s affects

3. The therapist models constructive mentalizing by (at least one of the following):

   a) Posing appropriate questions designed to promote exploration of the patient’s and others mental states, motives and affects, starting from a not-knowing stance
b) Checking out his/her understanding of the patient’s state of mind and to what extent this corresponds with the patient’s understanding. Then he/she lets his/her own understanding be influenced by the patient’s understanding and openly admits to any misunderstanding whenever they occur.

**Aim 13: To Have in Mind the Patient’s Traits and States of Mind**

1. The therapist adapts the interventions to the individual patient, rather than delivering a generic therapy, in order to achieve the different aims of the psychotherapeutic process.

   The therapist adapts the interventions to the following patient’s traits: a) character structure; b) defences; c) level of intelligence.

   The therapist adapts the interventions to the following patient’s states: a) level of arousal; b) capacity to think and tolerate difficult affects; c) level of understanding; d) level of functioning and capacity to cope; e) level of risk; f) current context; g) current difficulties; h) trajectory within therapy; i) state of the therapeutic alliance; and, j) transference and countertransference dynamics

   **Competencies included:**
   a) The therapist makes accurate interventions meaning that both, the interventions’ content as well as their timing is appropriate for the patient
   b) The therapist has the sensitivity to recognise when and when not to intervene
   c) The therapist is able to see, understand, and intervene when the patient’s material is “hot” in the here-and-now of the session.
   d) The therapist understands the connections between the patient’s material, external situation and transference quickly, and adapt his/her interventions accordingly
   e) The therapist delivers an interpretation conveying an understanding of both, the patient’s transference/countertransference dynamics, as well as the patient’s defences
   f) The therapist understands which kind of interpretation is more appropriate to deliver at a specific time of the session: either interpret the transference or the patient’s external situation. The therapist is guided by what is more relevant and interesting for the patient at a specific point of the session
   g) The therapist conveys that he/she keeps the patient’s relational patterns in mind in order to be aware of the patient’s difficulties in forming a relationship of trust. The therapist understands that this is essential knowledge in order to foster the therapeutic alliance
   h) The therapist is aware that the patient’s defences might prevent him/her of engaging with therapy. The therapist is able to address and deal effectively with these issues together with the patient in the session when they occur
i) The therapist is able to attain a balance between what the patient is interested in talking about in the session and what the therapist considers to be important to address in the context of the therapeutic process.

2. The therapist is able to find a balance in the use of the therapeutic model. The therapist uses the principles of the intervention model adapting them to the patient’s needs, but also ensuring that all relevant components are being included.

Competencies included:
- The therapist applies a specific theory and a therapeutic model; however, he/she is not enslaved to these. The therapist is able to apply theory creatively and be aware when necessary to deviate his/her interventions from the treatment manual.

3. The therapist only delivers interventions that are focused or have a purpose. However, the therapist is able to deviate from the therapeutic focus when the patient needs it. In these cases, the therapist is elastic rather than flexible, meaning that he/she allows himself/herself to deviate from the agreed therapeutic focus to go back to it later. Therefore, the therapist is able to go off-track of the therapeutic focus but never completely or permanently.

Example: The patient starts the session referring that his father has recently passed away. The therapist gives space and is able to “be” with the patient when he narrates the events and practical issues the patient has had to deal with on the last few days. The therapist is then able to explore the feelings of sadness, abandonment and of being left out that this situation has aroused, containing the patient. Finally, the therapist is able to link the patient’s affects and narrated events to the patient’s IPAF.

Competencies included:
- The therapist delivers interpretations that are pertinent to the affective interpersonal focus of therapy.
- The therapist has clarity of thinking and is able to think quickly within the session.
- The therapist quickly finds the focus of therapy and is open to share it with the patient.

4. The therapist delivers clear and succinct interventions in a language that belongs to the patient, so that it is easier for him/her to understand them and take them in.

Competencies included:
- The therapist has an excellent management of language. The therapist interpretations are clear, economical and succinct enough for the patient to be able to take them in.
- The therapist emulates the patient’s language when delivering interventions.
5. The therapist builds meaning and understanding by working collaboratively with the patient. The therapist delivers tentative interventions rather than rigid statements, and corrects what he/she is saying after receiving the patient’s manifest and latent feedback.

For example, the therapist would not use statements such as, “What you really feel is…”; “I think what you are really telling me is…”; “I think your expectations are distorted”; “What you meant is…”. On the contrary, the therapist interventions would be more similar to the following one: “I have been wondering whether it has been hard for you to tell me how you feel about cancelling your session a few weeks ago…”

Competencies included:
a) The therapist remains open to the possibility that his/her interventions are not necessarily accurate or right. The therapist does not have certainty and does not treat his beliefs as facts. Instead, the therapist is flexible and open to change his way of thinking according to what is happening with the patient, modifying his/her interventions according to the patient’s feedback or state of mind.
b) The therapist arrives at an analytic/dynamic formulation by working collaboratively with the patient.
c) The therapist shares his/her dynamic formulation with the patient not as a sure thing, but expressing it tentatively, as a hypothesis, waiting to hear the patient’s response to it in order to co-construct the formulation collaboratively.
d) The therapist asks the patient for feedback, asking whether what he/she has said makes sense to the patient or not. The therapist is not only attentive to the patient’s verbal and manifest feedback, but also to the feedback provided by the patient’s unconscious communications, including the therapist countertransference.
e) After delivering an interpretation, the therapist adapts the following interventions to the patient’s reaction to it.

6. The therapist is able to find a balance between on one hand, delivering the interpretations tentatively, as hypotheses that need to be tested with the patient; and on the other hand, not delivering the interventions in such a tentative way that it seems that he/she does not believe in the therapy that he/she is delivering.

Competencies included:
a) The therapist delivers the interpretations as hypotheses that need to be tested together with the patient. The therapist delivers interpretations tentatively, inviting the patient to co-create with the therapist the meanings in the therapeutic process.
b) The therapist understands what his/her role means and believes in the therapy that he/she is delivering. Therefore, the therapist does not say things in such a tentative way that it feels he/she is not occupying his/her position as a therapist.
7. The therapist interventions progress from surface to depth, starting from the issues that are closer to the patient's consciousness. The therapist titrates the delivery of interventions in order to meet the patient where he/she is at, not threatening his/her psychic equilibrium, and taking into consideration how defended the patient is from conflicting unconscious affects.

For example, if the patient suppresses tears in a session, the therapist may begin by noting this before moving on to wondering about why she may need to do this. Thus, the therapist is prudent in first taking up the defence, before exploring or commenting that which is being defended against.

Competencies included:

a) The therapist delivers interpretations by arriving at them slowly and alongside with the patient, holding the patient’s hand as they arrive at it, saying the interpretation for the patient but with the patient
b) The therapist brings something up in therapy when he/she senses that the patient is almost conscious of it

8. The therapist delivers interpretations following a specific sequence. Firstly, the therapist makes supportive interventions, validating the patient’s feelings, making him/her feel understood, and strengthening the therapeutic alliance. Only when the patient feels safe enough, it is possible for the therapist to interpret and make new links.

Competencies included:

a) The therapist knows when to prioritise supportive interventions over expressive ones and vice versa, finding a balance between the two. The therapist favours the delivery of supportive interventions when the patient is fragile and/or emotionally overwhelmed. However, the therapist does not collude with the patient by only staying in the patient's comfort zone. Therefore, the therapist is able to reach a balance for the specific patient between supportive and expressive interventions
b) The therapist delivers his/her understanding of an interpersonal situation by following a particular sequence. The first step is to make the patient feel understood. Only after this the therapist can explore
the other people’s perspectives involved in the interpersonal situation.

9. The therapist is able to genuinely convey hope to the patient

Competencies included:
   a) The therapist believes in the therapy he/she is delivering
   b) The therapist is motivated and committed to psychotherapeutic work and to working with his/her patients

Aim 14: Promote and Expand the Patient’s Self-Knowledge and Self-Awareness

1. The therapist is able to understand and intervene at multiple levels.

The therapist understands the patient’s communications in their conscious and unconscious level, and their implications to both, the patient’s difficulties as well as to the transference situation. Therefore, the therapist understands the links between the patient’s internal state and unconscious fantasies, external relationships, and transference situation, and is capable of intervening by conveying this understanding to the patient. The therapist expands the patient’s understanding by sensitively delivering an original and helpful intervention.

Example: A patient, in one of the last sessions of DIT, brings to the session that he has had many difficulties with a plumbing company and that we would have preferred to do the job on his own. The therapist is able to explore the situation, conveying an in depth understanding of the anxieties that the situation might have brought about in the patient. Then the therapist is able to link this situation to the patient’s IPAF, commenting how in this situation again the patient is left out feeling that he is on his own, that he cannot rely on anyone, not even when he asks for help. Finally, the therapist is able to link these feelings to the situation in the transference and phase of therapy, conveying to the patient that she understands that he might be feeling that she is also leaving him alone, that from now on he will have to do the job on his own, leaving him frustrated and ambivalent after he has asked her for help.

Competencies included:
   a) The therapist has an implicit or explicit agreement with the patient that it is worthwhile to try to understand the unconscious motivations related to the patient’s difficulties. Therefore, the therapist makes meaningful connections, expanding the conscious boundaries of the patient
   b) The therapist is able to add meaning to the patient’s communications
   c) The therapist facilitates and responds to the patient’s unconscious communications by putting into words the latent meaning of the session
d) The therapist has the courage to talk about difficult issues, make challenging links, and ask the questions that need to be asked in order to help the patient. The therapist does not remain in a safe place. Instead, the therapist trusts his/her own instincts and is able to try new things out with the patient.

e) The therapist understands the patient’s internal state, external relationship, transference situation, and the links between them. The therapist holds this understanding of the patient in mind, that he/she can sensitively share in the session.

f) The therapist demonstrates the following abilities: a) understand the patient’s communications; b) understand the implication of the unconscious meanings of the patient's communications to the therapeutic relationship in the here-and-now of the session; and, c) competently intervene in accordance with these understandings.

g) The therapist demonstrates a good understanding of the patient’s history, relationships, and how he/she has come to have the current clinical presentation.

h) The therapist arrives into a dynamic formulation by gathering and integrating information about the patient from different sources.

i) The therapist arrives into a dynamic formulation taking into consideration the developmental history and past experiences of the patient, as well as the use of defences at different life stages.

j) The therapist is able to draw on knowledge of mental health problems and their consequences in order to help and understand the patient.

k) In order to arrive into a dynamic formulation, the therapist systematises the information of all the sources, in light of the psychodynamic theoretical model, aiming to conceptualise what is the patient’s basic conflict.

Aim 15: Promote and Expand the Patient’s Knowledge and Awareness of His/Her Relational Patterns

1. The therapist helps the patient mentalize the different perspectives in an interpersonal conflict. In order to do this the therapist describes the contradictions in the patient’s account, only to then help the patient solve the apparent contradictions in the story. Thus, the therapist analyses together with the patient the situation from every angle, and trying to understand the affects and defences aroused in the patient.

Competencies included:

a) In order to understand the patient’s feelings and defences mobilised in interpersonal situations, the therapist carries out a polite enquiry to elicit relevant information, using techniques such as clarification, confrontation, and interpretation.

b) The therapist helps the patient explore the unconscious feelings that may emerge in interpersonal situations.

c) The therapist elicits interpersonal narratives.
2. The therapist is able to formulate and articulate the IPAF, which includes identifying what is the patient’s self-representation, other representation, and which are the most important affects and defences employed by the patient. The therapist understands and links the material the patient brings to therapy to the IPAF in order to maintain the therapeutic focus

Competencies included:

a) The therapist helps the patient become aware of his/her repeated interpersonal patterns of relating, with its affects and defences, that causes the patient difficulties, in order to deactivate it.

b) The therapist prioritises working on the agreed focus rather than exploring the patient’s history

c) The therapist intervenes being mindful of the IPAF, fitting the interventions according to the affective, relational pattern agreed with the patient as the focus of therapy

3. The therapist is able to recognise what is happening in the transference with the patient and is able to use this understanding in at least one of the following ways:

a) Helping the patient make links and draw parallels between the transference and the IPAF. The therapist describes the transference —without interpreting it—, challenging the patient’s beliefs about his/her relational patterns. Thus, the therapist does not focus on the transference, but uses it to explore other areas.

b) Delivering transference interpretations, allowing the patient to work in the transference, and understanding how the patient is using the transference interpretations

For example, the therapist may say: “I think it would be helpful if we pause to think about what has been happening between us, because it seems to me that you are feeling rather hopeless about whether coming to therapy can be of any help to you, and your anxiety seems to be getting worse, and yet you are not communicating this directly to me. Instead I feel you withdrawing. We know how difficult it is for you to feel that you are on your own with a problem and that the other person cannot help you with it. This often leaves you feeling sad and angry, but instead of expressing what you feel you shut down communication. This is similar to what happens with your husband when you get into a conflict with him, just as you were describing earlier in the session”

Competencies included:

a) The therapist is able to recognise the transference situation. The therapist learns about the patient by exploring and thinking about the unconscious meanings related to the transference relationship

b) In order to arrive into a dynamic formulation, the therapist gives considerable importance to how it is to be with that particular patient in the room. The therapist considers essential to understand how the
The patient relates to the therapist, how the patient replies to questions and different situations, and how the patient elaborates their object relationships.

c) The therapist considers the cautionary tale and/or his/her countertransference as essential sources to formulate the patient's difficulties.

d) The therapist delivers the dynamic formulation when it is possible to link it to something that happened in the session. Therefore, the therapist makes the formulation more understandable, alive and interesting by making a link to the material of the session.

e) In order to understand and use the transference, the therapist is open to the relationship with the patient, exposing himself/herself to it, letting himself/herself become affected by it, without feeling the relationship with the patient as something neutral or distant.

f) The therapist is aware that anything the patient says in the therapy is a reflection of the total transference situation with the therapist. The therapist is aware that anything the patient says in therapy reflects in some way what is happening in the therapeutic relationship.

g) The therapist understands that anything the patient says in the session has an impact in the therapeutic relationship.

h) The therapist does a general exploration in order to formulate the patient difficulties but focuses in what has been more recent and relevant for the patient and in the here-and-now of the session.

i) The therapist links what is happening in the transference relationship to the IPAF.

j) The therapist delivers his/her understanding of the transference in a sensitive and at the same time challenging way to the patient.

k) The therapist is attentive and understands how the patient is using transference interpretations, either constructively or not, addressing this with the patient.

Aim 16: To Help the Patient Self-Regulate Emotions

1. The therapist helps the patient experience a range of affective states of varying intensities, in tolerable limits. Therefore, with patients that become easily overwhelmed, the therapist attempts to bring down the intensity of the affective state by helping the patient mentalize their emotions; whereas, with patients that are disconnected from his/her emotional states, the therapist attempts to bring affects to their attention.

Competencies included:

a) The therapist deals with the emotional content of the session by helping the patient regulate his/her emotions in order to be able to think about them instead of feeling overwhelmed.

2. The therapist allows the evacuation of raw emotions when the patient has recently experienced an external traumatic situation. However, when the emotional hyperarousal of the patient is in relation to
transfertential issues, the therapist attempts to lower the intensity of the emotions by helping the patient mentalize

Example:
Patient: You don’t care about me. For you I am just work and even as work I am boring and unimportant
Therapist: I am not sure what I have done but I must have done something, perhaps in the last few minutes or before, that makes you so convinced of that. Do you have any idea what I might have done?
Patient: I saw you looking at your watch
Therapist: You might be right, I do recall looking at my watch. Perhaps the way you are feeling at the moment it is inconceivable that there could be another explanation for me looking at my watch rather than finding you a burden

Competencies included:
a) The therapist is able to repair ruptures in the alliance by: a) accepting his/her responsibility for his/her contribution to any strains in the relationships, allowing the patient to assert any negative feelings about the therapeutic relationship; b) conveying to the patient that he/she is on his/her side, acknowledging and validating the patient’s experience; and, c) engaging the patient in understanding the meaning of the difficulties between himself/herself and the therapist, making use of ruptures as opportunities for expanding the patient’s understanding of their subjective experiences

Aim 17: Managing the Patient’s Defences

1. The therapist is respectful of the patient’s defences, and understands the reasons behind them. The therapist works with the defences by acknowledging the struggle and the costs that they mean for the patient.

Example: “It seems that when you expect someone to criticise you, you become overly compliant and then it becomes difficult for you to think. Maybe being compliant in the past helped you to protect yourself from your parents, but today it is not allowing you to have relationships where you can be yourself and express what you feel…”

Competencies included:
a) The therapist understands the patient’s defences by exploring and having in mind how the patient has reacted to difficult situations in the past. The therapist understands that often the defences are associated with the difficulties in the patient’s history, because defences become entrenched at a time in development where there were particular pressures for that individual
b) The therapist assesses the defences in the interaction with the patient in the session
c) The therapist is respectful of the defences. This is particularly important in brief psychotherapy where the therapist should not aim to disarm the defences.
d) The therapist works with the defences by showing the patient the cost of using them, without necessarily challenging the patient to change them.
e) When the therapist works with/challenges the defences, he/she does it with sympathetic interest and compassion, never in an aggressive way, or blaming the patient.

2. The therapist only challenges the defences when there is enough trust and a solid therapeutic relationship. Additionally, the therapist only challenges the defences, when the patient has the resources, the capacity, and the external support to cope with the feelings underneath the defence.

Example: “It seems that since I brought up the ending a few weeks ago, you have found it very hard to arrive on time. I am wondering if my reminder felt like me pushing you away. We know from the work we have been doing that when you feel this way in your relationships you withdraw and can actually start to do the rejecting. I think that this may be what has happened here: you come late and I am the one waiting here and the one who is left out”

INCOMPETENCE

Enactments, Concrete Interventions, and Not Thinking
1. The therapist is unable to explore, see, understand and/or think the different possible perspectives, meanings and links underlying the material the patient brings to the session.
2. The therapist is unable to pick up the unconscious communications, particularly the negative transference and/or the patient’s difficult feelings (i.e., aggression), leading to a collusion between therapist and patient.
3. The therapist gets stuck in a concrete level of communication, which prevents the patient from thinking.
   For example: giving advice, direct answers, or homework to the patient. Or focusing the interventions in anything but mental states.
4. The therapist quickly reassures the patient, delivering fast and superficial interventions, without thinking and/or without gathering enough information to understand. Therefore, the therapist closes topics too soon, narrowing them down without really exploring or understanding them together with the patient.
5. The therapist takes the narratives of the patient as direct and concrete examples of what is happening in the therapeutic relationship.
   For example, a therapist may say to his/her patient “you are telling me about this row with your friend because you want to have a row with me”
6. The therapist is unable to handle and/or understand his/her own countertransference and/or his/her participation in the interaction with the patient.
7. The therapist loses his/her ability to think and trust his/her own judgment by becoming overwhelmed, overly anxious or afraid of the effect of his/her interventions on the patient. The therapist may be particularly afraid that the patient may disapprove or become angry at an intervention
8. The therapist gets easily trapped in enactments with the patient and/or cannot understand/think about them; thus, the therapy becomes easily stuck

Inability to Foster the Therapeutic Alliance
1. The therapist is not emotionally accessible to the patient, he/she is either cold, rigid, insensitive, disconnected, and/or stiff, making it hard for the patient to form a relationship of trust with him/her
2. The therapist conveys negative interpersonal behaviours such as impatience, insincerity, or aggressiveness
3. The therapist often forgets important information about the patient and/or does not keep the patient in mind. Thus, it becomes difficult for the therapist to elaborate on the patient’s material.
4. The therapist does not listen to the patient

Not Adapting Interventions to the Patient/Context and Not Considering the Consequences of Interventions
1. The therapist delivers interventions without adapting them or considering: the context, the timing, and/or the effects of it on the therapy and/or on the patient.
2. The therapist is enslaved to the treatment manual, not learning from the individual patient, and not adapting the interventions to that specific patient
3. The therapist makes interpretations driven more by his/her own ideas, than by the patient’s needs at a specific time. Thus, the therapist delivers interpretations not thinking about the patient, nor adapting them to the therapeutic context
4. The therapist does not help the patient feel understood and supported. The therapist interventions do not show sensitivity to the complexity of the patient’s difficulties. The therapist does not understand the patient’s distress as a sign of how much they are struggling
5. The therapist treats the patient’s defences disrespectfully, not understanding the underlying struggle that they represent for the patient. The therapist points out the defences, or challenges them too soon in the therapy, without thinking of the consequences that this might have, threatening the patient’s psychic balance
6. The therapist is irresponsible because he/she does not consider the potential effects the attitudes, behaviours, and interventions may have on the patient. This includes therapists that are unaware that they are doing harm or simply not doing anything helpful for the patient.
7. The therapist is unaware of and/or unable to address important or difficult issues with the patient. For example, the therapist is unable to address with the patient that he/she is getting worse in the course of treatment.
8. The therapist overwhelms the patient by for example intensifying his/her feelings of sadness and anger instead of helping him/her mentalize his/her emotions.
9. The therapist is unable to prioritise the patient’s interests before his/her own. The therapist does not put the patient first. Instead, the therapist is biased and unfair, prioritising his/her own interests instead of the patient’s.
10. The therapist behaves in an unethical way. The therapist harms the patient by being abusive, or exploitative of the patient or neglectful. Furthermore, the therapist is unethical by engaging in power struggles with the patient.

Lacking Basic Skills to Intervene
1. The therapist does not have a model of therapeutic principles in mind and/or uses interventions from different models that are incoherent between them.
2. The therapist does not keep the frame or boundaries of therapy.
3. The therapist does not express him/herself clearly. This includes therapists that are ambiguous in what they say or that speak for so long that the patient forgets where they started at. Additionally, this includes therapists that speak in an overly theoretical way that prevents the patient from understanding.
4. The therapist intervenes without having gathered enough information that would allow him/her to understand the patient’s situation.
5. The therapist is unable of engaging the patient and promoting psychic change.
6. The therapist becomes too silent without helping the patient communicate or to engage in therapy.
7. The therapist does not allow for silences to occur, without leaving space and time to think in the session.

Therapist Mental Health Issues
1. The therapist blames the patient for his/her own difficulties or incompetence.
2. The therapist tends to focus on the patient’s difficulties, projecting the “bad” onto the patient, and blaming the lack of progress in therapy on the patient’s problems. Therefore, the therapist gives the patient a destructive view of himself/herself.
3. The therapist is narcissistic, self-centred, or cannot take in criticisms.
4. The therapist is unable to maintain an alliance with the patient.
5. The therapist does not have self-awareness. The therapist does not have insight of how his/her actions and/or his/her blind spots impact the therapy and the patient.
6. The therapist says wrong things to the patient, particularly because he/she is talking mainly about things that interest only him/her and are not beneficial for the patient.

**Not accurately understanding the patient**
1. The therapist does not understand the patient, causing a break in the therapeutic process. As a consequence, the patient may show distress, aggressiveness, compliance, bristling, confusion, irritation, or may react breaking the alliance with the therapist, or trying to save/educate the therapist. Additionally, the patient may close down or stop mentalizing when an intervention is wrong in its content or in its timing.

**Incompetence in DIT**
1. The therapist’s interventions becomes too cognitive, theoretical or concrete that lose sight of the unconscious realm and of the patient’s affects in the here-and now.
2. The therapist is not able to maintain the therapeutic focus across interventions
Appendix O
Third version of the TCS

DIT Therapist Competence Scale

General Guidelines

The DIT Therapist Competence Scale (DTCS) aims to provide a summative feedback about a therapist’s competence within an observed treatment session. The scale assesses the general, psychoanalytic/psychodynamic, and DIT specific competencies required to appropriately deliver DIT to adults experiencing depressive and anxious symptomatology.

The DTCS includes four subscales that separately assess the therapist’s core competencies, incompetence, global competence, and the patient’s complexity.

The core competencies subscale is organized in accordance to aims the therapist attempts to achieve within a treatment session. The subscale intends to assess sessions at any phase of the treatment and so it does not include skills which, although important, do not occur in most active treatment sessions. The items are rated with a numerical score in order to provide a more detailed feedback as to the therapist’s specific areas of strength and weakness.

The incompetence subscale assesses therapist’s performance in reference to seven domains of incompetence. The items are rated as present or absent within the treatment session.

The global competence subscale aims to reflect the assessor’s overall impression of the therapist’s competence in the session as a whole, and is rated using a generic seven-point scale.

The patient’s complexity subscale was incorporated to the measure in order to understand the context within which the therapist’s performance is evaluated so it can be taken into account when reviewing the ratings of the other subscales.

How to rate the DTCS?

Core Competencies Subscale
Each of the 17 therapeutic aims is broken down into one to nine items, each of which is scored on a seven-point scale. The overarching definitions of the scale are as follows:

Limited: The feature described is either not present in the session and/or it is not possible to assess (Score = 0)
**Basic:** The therapist demonstrates a significant absence of skill or an inappropriate performance which is likely to have negative therapeutic consequences (Score = 1-2)

**Good:** The therapist’s performance is appropriate with an evident degree of skill. However, the therapist either demonstrates the competency in a limited way, restricted to a specific aspect of the competency or to particular moments of the session; or, there are problems or inconsistencies in the therapist’s performance of the specific competency (Score = 3-4)

**Advanced:** The therapist consistently demonstrates a high level of skill with only few and minor problems. The therapist demonstrates the ability to carry out the competency in a range of ways and in moments of varying complexity during the session. The therapist demonstrates breadth and depth in the performance of the competency. (Score = 5-6)

Incompetence Subscale
Each of the seven domains of incompetence is broken down into 2 to 10 items, which are rated as present (Score = 1) or absent (Score = 0) in the session.

Global Competence Subscale
The therapist global competence is rated according to the generic seven-point scale outlined above.

Patient Complexity Subscale
The patient complexity is rated according to a 6-point scale (mild, moderate and severe) that takes into account both the difficulties of the patient, as well as his/her receptivity and openness (epistemic trust) to therapy and the therapist.
Core Competencies Subscale

Aim 1: To Create Psychic Space, a Space where it is Possible to Think Together with the Patient

1. The therapist demonstrates a receptive, involved, yet non-gratifying attitude, a balance between emotional closeness and distance, that maintains the patient’s emotional arousal at an optimal level (not too high so that the patient loses his/her ability to mentalize; not too low so that the session becomes meaningless emotionally)

For example, the therapist attunes to the patient’s feelings but does not overly empathise with them. The therapist attentively observes and describes the patient’s emotions, without reacting or sharing them. The therapist is able to retain the ability to think and help the patient make sense of his/her emotions.

Competencies included:
- a) The therapist is visible and communicative to the patient and does not adopt a “blank screen” attitude towards the patient
- b) There is a gap, an asymmetry in the relationship between therapist and patient

2. The therapist is able to find a balance between the required structure to deliver therapy and the necessary space that facilitates the patient’s unconscious communications. The therapist maintains the session’s structure by adhering to the treatment model, directing the interventions towards an agreed focus, and by maintaining the frame and boundaries of therapy. Concurrently, the therapist creates space by promoting the patient’s free association and by not having an agenda in mind for the therapeutic process.

For example, the therapist is able to balance the silences in the session. On one hand, the therapist does not become too silent because this would hinder the patient’s communications and engagement; and, on the other hand, the therapist allows for silences to occur in order to create space and time to think within the session.

Competencies included:
- a) The therapist maintains an active stance and clarity of thinking during the session with a specific purpose in mind
- b) The therapist finds a balance between giving information (i.e., giving feedback), and listening and giving space to the patient

Aim 2: Containment, Making the Patient Feel Understood

3. The therapist is constantly attuned to the patient. The therapist is attentive to the broader range of the patient’s communications, following the patient’s mental states closely, and conveying a capacity to be with,
know, identify, name and contain the patient’s unconscious thoughts and affects.

For example, a well-timed and accurate transference interpretation can be a substantial expression of the patient’s attunement, as it conveys to the patient that he/she has been heard at various level, not only in reference to what has happened in the past, but also in reference of what is happening in the session.

Competencies included:

a) The therapist is able to listen to the patient attentively
b) The therapist conveys genuine interest, curiosity, concern, and sensitivity towards the patient
c) The therapist is able to sit with the feelings of the patient without disposing of them. The therapist is able to be attuned, identify, name, explore, and articulate the patient’s emotions. In this way, the therapist conveys that affect is welcomed and that can be thought about and born by both.
d) The therapist shows the ability to do marked mirroring. The therapist conveys, mainly through non-verbal communications, that he/she knows how the patient is feeling at any point of the session, which helps the patient to modulate his/her affective states. The therapist mirrors the patient’s emotions in an “as-if” or pretend mode, meaning that he/she does not get overwhelmed by the affective state but can represent/verbalize it for the patient
4. The therapist is able to contain the emotional experiences of the patient. The therapist understands the uniqueness of the patient’s feelings and experiences, without closing their understanding too soon, or making concrete interventions. Instead, the therapist explores and finds examples, metaphors, or analogies (symbolic work) to understand and contain the patient’s experience, making unique links that are understandable for the patient. The therapist’s interventions create a subjective experience that feels immense to the patient, because something he/she was unaware of becomes verbalised.

Competencies included:

a) The therapist helps the patient feel understood by containing the patient’s anxieties and difficulties without being judgmental. Therefore, the therapist does not behave as a critical object of whom the patient is afraid of. On the contrary, the therapist delivers a formulation to the patient in which he/she feels understood, accepted and safe
b) The therapist, in order to accurately understand, get alongside with the patient’s experience and feelings. The therapist provides the patient with the experience of being understood in a deep and meaningful way, expanding the understanding and saying something new, which is immensely moving for both individuals.
c) The therapist makes the patient go through a “click” experience by becoming able to understand something differently or with another depth
Aim 3: Help the Patient to Think for Himself/Herself (Patient Understands Himself/Herself)

5. The therapist promotes the patient’s capacity to think. The therapist helps the patient to become interested in his/her own mind and to have a growing capacity to independently think about his/her own unconscious mental processes.

For example, the therapist gets alongside the patient when exploring a difficult topic but does not give him/her all the answers. Instead, the therapist asks questions and comments in a way that prompts the patient to think, verbalize and reach on his/her own significant meanings and unconscious affects.

Aim 4: To Foster the Patient’s Epistemic Trust

6. The therapist uses ostensive cues to alert the patient that the intervention that is about to be delivered is important to him/her. Then, the therapist delivers interventions that are personally relevant for the patient and that are in harmony with his/her intentions and interests, in a sense that can be taken by the patient with a sense of ownership.

For example, with a patient that in the first few sessions asks many practical questions, driven by anxiety, the therapist may adopt a special, calming and maternal tone of voice and say: “Perhaps beginning psychotherapy can make you feel anxious because it might be frightening and painful to face difficult issues about yourself. Asking me a lot of questions is maybe a way of letting me know that you are worried of where this process may lead you to”

Competencies included:
a) The therapist uses ostensive cues to alert the patient that what is about to be communicated is relevant to them. The ostensive cues mainly include non-verbal signs such as eye contact, turn taking, and the use of a special tone of voice (“motherese”)
b) The therapist helps the patient trust and be open
c) Before delivering an intervention, the therapist is able to see and verbalise the patient’s concerns and request for change through the eyes of the patient
d) Before delivering interventions, the therapist makes the patient feel listened and understood, conveying that he/she has in mind the patient’s mind

7. The therapist treats the patient as an agent. The therapist intervenes in a constructive way, giving the patient a positive view of himself/herself. Additionally, the therapist does not have an agenda and understands therapy as a collaborative process, where the patient has an active involvement. Hence, the therapist allows the patient to be an active agent, responsible for his/her own life and mind, independent, and capable to cope.
Competencies included:
a) The therapist verbalises the interventions in a way that the patient can receive them although they might be shocking and/or surprising
b) The therapist delivers interpretations in a way that feel constructive and not punitive to the patient
c) The therapist adopts a “not-knowing” stance, and does not have an agenda
d) The therapist is genuine

8. The therapist actively helps the patient to receive/trust the therapist interventions and new understandings. The therapist does not passively wait until the patient is able to receive the interventions. Instead, the therapist actively helps the patient get into a state of mind in which they can doubt their own story, becoming interested, and considering alternative perspectives around it

For example, a patient reports the therapist that he has stopped attending a course because he felt criticised by the tutor when he asked the patient where he had been after a few weeks the patient had been absent. The therapist may make comments such as “Take me through what happened”; “Not so quickly. Can you go slowly there and tell me what was in your mind at the time”; “Just to be clear, you felt that your tutor was criticising you about your lack of attendance”; “Looking back, do you think that what he said could have been meant in any other way?”; “Have there been other times when you felt he didn’t like you?”

Aim 5: To Centre the Psychotherapeutic Work around the Unconscious Processes

9. The therapist maintains a focus, awareness, and receptivity to the unconscious processes that take place in the session, including the unfolding of the transference and countertransference.

Competencies included:
a) The therapist conveys an awareness in the unconscious processes in:
a) the content, construction, and timing of his/her interventions; b) when he/she decides to not to intervene; c) in his/her affective tone and thought processes during the session; and/or, d) by naming the contradictions between manifest and latent contents, or by showing to the patient the latent material in a straightforward way.
b) The therapist is particularly interested in the patient’s mental states rather than in the patient’s behaviours and external events
c) The therapist fluently uses a conceptualisation of the mind that involves unconscious motivations and the understanding of the personality structure around the developmental resolution of conflicts
d) The therapist has a psychotherapeutic model in mind, which he/she uses to tune into and understand the patient’s communications.
e) The therapist is not only attentive to the emotions openly expressed by the patient, but particularly to the patient’s feelings that are not being explicitly expressed, such as anger or envy, and is open to their exploration.
f) The therapist is attentive to all the patient’s verbal and non-verbal communications, particularly to the issues the patient might be avoiding and keeping away from the discussion. The therapist is attentive to what the patient is saying and not saying.
g) The therapist is aware where in the patient’s narrative the feelings seem to be guarded, defended, or cut-off, and uses this knowledge as a guide to the patient’s unconscious affects. The therapist sensitively brings about these feelings, that have been left out, allowing the patient to experience and share them in therapy.
h) The therapist gives more importance to “how” the patient communicates than to the content of “what” he/she is saying. Therefore, the therapist prioritises the form and process of the patient’s communications rather than the content in order to understand the unconscious communications.

10. The therapist is able to retain an analytic attitude. Therefore, the therapist’s interventions are neither cognitive, nor theoretical. On the contrary, the therapist does not lose sight of the patient’s unconscious and the interventions resonate with the affective tone of the here-and-now of the session.

For example, the therapist may link the patient’s IPAF to the patient’s interpersonal narratives in a didactical way, instructing the patient about the different components of the IPAF, without connecting it to the emotions or the unconscious processes in the here-and-now of the session. In this case, the therapist would be doing something in an incompetent way because he/she would not be retaining an analytic attitude. The therapist would fulfil this competency by linking the IPAF to the unconscious communications of the session and by focusing on the affective dimension of the IPAF that is activated in a given relationship.

Competencies included:
a) The therapist is directive while tuned into the unconscious communications, evolving transference, and countertransference.

Aim 6: The Therapist is Able to Think About Himself/Herself and in the Room with the Patient

11. The therapist conveys that he/she is aware of himself/herself, realises his/her own feelings and thoughts, and articulates those in a meaningful way in order to understand the patient’s material and the relationship with him/her.
12. The therapist is able to self-regulate his/her own anxieties and feelings in a way that they do not interfere with his/her work with the patient. However, when enactments take place, the therapist is able to think how
the patient’s mind impacted his/hers. Therefore, the therapist is able to regain a reflective stance when managing forms of acting out.

Example: A patient had a highly ambivalent relationship with her mother from whom she asked for help only to then rebuff anything she might suggest. In a session, the therapist found himself giving advice to the patient, after she complained about difficulties in making friends. The patient reacted strongly to this intervention, saying that the therapist wanted her to make friends at all costs so that he could discharge his duties in relation to her. The therapist described to the patient how it had appeared between them a similar scenario to the one the patient had described with the mother. The therapist acknowledged that he had indeed given advice and that this mirrored the patient’s view of her mother as someone who responded anxiously to her problems.

Competencies included:
a) The therapist conveys that he/she is aware of his/her own blind spots, and therefore, is able to differentiate when what he/she is feeling belongs to the patient and when what he/she is feeling belongs to his/her own personality.
13. The therapist is able to think in the room with the patient. The therapist remains open to what else might be going on in the session, apart from what is being openly shown by the patient. Therefore, the therapist is able to add meaning and make new links in the material.
14. The therapist is well developed, he/she is able to: a) tolerate uncertainty; b) tolerate and handle complex and unpleasant feelings and situations; c) be humble, open to learn, understanding that every patient is different; d) be compassionate, reflexive and sensitive to work in depth with unconscious communications.

Aim 7: Promoting Psychic and Behavioural Change

15. The therapist explicitly encourages change in the way the patient relates to others. The therapist explores together with the patient alternative ways of relating to others, motivating the patient to try something spontaneous and new in his/her relationships (including the relationship with the therapist).

For example, the therapist explores together with the patient the success or failure of the patient’s attempts at change, to have a better understanding of the affective and interpersonal processes that inhibit change. The therapist helps the patient anticipate what may prove difficult, as a way of supporting change.

Competencies included:
a) The therapist explicitly helps the patient identify the goals for therapy that are meaningfully connected to the IPAF.
b) The therapist leads the patient to experiment something new, to try something spontaneous, in the therapeutic relationship.
16. The therapist organises each session in accordance to the therapeutic focus and to the tasks that need to be achieved in each phase of therapy. Therefore, the therapist is persistent and holds his/her vision of the patient across interventions

Competencies included:

a) The therapist sticks to the therapeutic model and to the tasks of each phase of therapy

Aim 8: Help the Patient Grieve

17. The therapist helps the patient come to terms with loses, endings, difficult experiences and emotions, assisting him/her in the process of grief.

For example, the therapist is able to work through the end phase of therapy. This involves signalling the ending, and discussing the feelings/thoughts and the unconscious fantasises mobilised. The therapist helps the patient to see him/her as a whole object with imperfections that are frustrating, without this overshadowing the qualities that will be missed. The therapist helps the patient accept the separateness and the pain that this can give rise to. Additionally, the therapist reviews the work undertaken, helping the patient take in he/she has received in the therapy. Working through this loss promotes internalisation of the therapeutic relationship and the analytic process.

Aim 9: To Create an Environment of Safety

18. The therapist fosters an environment of safety where the patient feels secure to speak freely, explore difficult contents, and disclose personal information of a sensitive nature. The therapist creates an environment of safety by maintaining the frame and boundaries of therapy, fostering trust, and by prioritising the patient and what is best in his/her interest.

Competencies included:

a) The therapist prioritises the patient and what is best in his/her interest. The therapist treats the patient with respect, considering his/her freedom of choice
b) The therapist keeps an ethical practice (obtaining informed consent; maintaining confidentiality; safeguarding the patient’s interests; maintaining a competent practice; protecting the patient from potential harm; maintaining appropriate standards of personal conduct)
c) The therapist keeps the frame and boundaries of therapy

19. The therapist perseveres and is consistently there for the patient trying to understand the material and puzzle out his/her difficulties. The therapist is there for the patient even when he/she is the target of the patient’s negative transference. The therapist survives the patient’s attacks,
tenaciously trying to understand what has taken place, conveying to the patient that he/she cares for him/her.

Competencies included:
a) The therapist keeps the frame and boundaries of therapy. The therapist maintains consistency in relation to the agreed parameters of therapy, and is receptive to the patient’s conscious and unconscious experience of them

Aim 10: To Foster and Maintain the Therapeutic Alliance, a Relationship of Trust that Enables Psychotherapeutic Work

20. The therapist is able to foster a normal and human relationship with boundaries. The therapist is not stiff, formal, rigid or cold with the patient. Instead, the therapist is warm, compassionate and spontaneous, and conveys that he/she keeps the patient in mind, by remembering what the patient has said in the past, and by reflecting and mirroring the patient’s painful affects. The therapist is emotionally accessible to the patient in a setting that has clear boundaries which aim is to protect the patient and the therapeutic process.

Competencies included:
a) The therapist is able to engender trust and develop rapport with the patient
b) The therapist bears witness the patient’s painful affects in a compassionate way, conveying a willingness to create a relationship with the patient.
c) The therapist is able to use humour in a therapeutic way

21. The therapist conveys that the therapeutic alliance is a bond with a purpose. The therapist interventions take into consideration the goals of the therapy, -that have been collaboratively agreed with the patient-, reminding him/her that the therapist cares, and therefore, enhancing the therapeutic bond.

Competencies included:
a) The therapist explains and agrees collaboratively with the patient on the techniques/methods, tasks and goals of therapy

Aim 11: To Engage the Patient with Therapy

22. The therapist engages the patient in an alive interchange, making him/her interested and surprised with the material by sharing an understanding of the patient’s difficulties that he/she had not seen before
23. The therapist is able to pick up what is more urgent in the immediate situation for the patient in order to work with that in the session
24. The therapist adapts his/her personal style so that it meshes with that of the patient. The therapist responds to the patient in a way and a tone of voice that show concern and influence by what the patient has said,
aligning himself/herself with the patient and bringing him/her back to the room with the therapist.

**Aim 12: Promoting Mentalizing**

25. The therapist’s interventions stimulate the patient’s capacity to mentalize experiences of self and others. The therapist conveys the capacity to represent both, his/her own internal states as well as the ones of the patient. The therapist focuses on these internal states, sustaining this in the face of constant challenges by the patient.

Competencies included:

- a) The therapist helps the patient recover his/her ability to mentalize. The therapist prioritises this task before delivering any other intervention to the patient.

26. The therapist assesses the patient’s mentalizing level, and adapts his/her interventions to help the patient recover his/her mentalizing capacity.

- a) If the patient is in pretend mode the therapist intervenes by shifting the topic to areas of higher emotional arousal and greater vitality.
- b) If the patient is in psychic equivalence mode, the therapist intervenes by stopping and rewinding to the moment mentalizing was lost. The therapist then explores the incident step-by-step, focusing on the patient’s affects.

27. The therapist models constructive mentalizing by (at least one of the following):

- a) Posing appropriate questions designed to promote exploration of the patient’s and others mental states, motives and affects, starting from a not-knowing stance.
- b) Checking out his/her understanding of the patient’s state of mind and to what extent this corresponds with the patient’s understanding. Then he/she lets his/her own understanding be influenced by the patient’s understanding and openly admits to any misunderstanding whenever they occur.

**Aim 13: To Have in Mind the Patient’s Traits and States of Mind**

28. The therapist adapts the interventions to the individual patient, rather than delivering a generic therapy, in order to achieve the different aims of the psychotherapeutic process.

The therapist adapts the interventions to the following patient’s traits: a) character structure; b) defences; c) level of intelligence.

The therapist adapts the interventions to the following patient’s states: a) level of arousal; b) capacity to think and tolerate difficult affects; c) level...
of understanding; d) level of functioning and capacity to cope; e) level of risk; f) current context; g) current difficulties; h) trajectory within therapy; i) state of the therapeutic alliance; and, j) transference and countertransference dynamics

Competencies included:
a) The therapist makes accurate interventions meaning that both, the interventions' content as well as their timing is appropriate for the patient
b) The therapist has the sensitivity to recognise when and when not to intervene
c) The therapist is able to see, understand, and intervene when the patient’s material is “hot” in the here-and-now of the session.
d) The therapist understands the connections between the patient’s material, external situation and transference quickly, and adapt his/her interventions accordingly
e) The therapist delivers an interpretation conveying an understanding of both, the patient’s transference/countertransference dynamics, as well as the patient’s defences
f) The therapist understands which kind of interpretation is more appropriate to deliver at a specific time of the session: either interpret the transference or the patient’s external situation. The therapist is guided by what is more relevant and interesting for the patient at a specific point of the session
g) The therapist conveys that he/she keeps the patient’s relational patterns in mind in order to be aware of the patient’s difficulties in forming a relationship of trust. The therapist understands that this is essential knowledge in order to foster the therapeutic alliance
h) The therapist is aware that the patient’s defences might prevent him/her of engaging with therapy. The therapist is able to address and deal effectively with these issues together with the patient in the session when they occur
i) The therapist is able to attain a balance between what the patient is interested in talking about in the session and what the therapist considers to be important to address in the context of the therapeutic process.

29. The therapist is able to find a balance in the use of the therapeutic model. The therapist uses the principles of the intervention model adapting them to the patient’s needs, but also ensuring that all relevant components are being included

Competencies included:
a) The therapist applies a specific theory and a therapeutic model; however, he/she is not enslaved to these. The therapist is able to apply theory creatively and be aware when is necessary to deviate his/her interventions from the treatment manual
b) The therapist only delivers interventions that are focused or have a purpose. However, the therapist is able to deviate from the therapeutic focus when the patient needs it. In these cases, the therapist is elastic rather than flexible, meaning that he/she allows himself/herself to deviate from the agreed therapeutic focus to go back to it later. Therefore, the
therapist is able to go off-track of the therapeutic focus but never completely or permanently.

Example: The patient starts the session referring that his father has recently passed away. The therapist gives space and is able to “be” with the patient when he narrates the events and practical issues the patient has had to deal with on the last few days. The therapist is then able to explore the feelings of sadness, abandonment and of being left out that this situation has aroused, containing the patient. Finally, the therapist is able to link the patient’s affects and narrated events to the patient’s IPAF.

Competencies included:
a) The therapist delivers interpretations that are pertinent to the affective interpersonal focus of therapy
b) The therapist has clarity of thinking and is able to think quickly within the session
c) The therapist quickly finds the focus of therapy and is open to share it with the patient
31. The therapist delivers clear and succinct interventions in a language that belongs to the patient, so that it is easier for him/her to understand them and take them in

Competencies included:
a) The therapist has an excellent management of language. The therapist interpretations are clear, economical and succinct enough for the patient to be able to take them in
b) The therapist emulates the patient’s language when delivering interventions
32. The therapist builds meaning and understanding by working collaboratively with the patient. The therapist delivers tentative interventions rather than rigid statements, and corrects what he/she is saying after receiving the patient’s manifest and latent feedback

For example, the therapist would not use statements such as, “What you really feel is…”; “I think what you are really telling me is…”; “I think your expectations are distorted”; “What you meant is…”. On the contrary, the therapist interventions would be more similar to the following one: “I have been wondering whether it has been hard for you to tell me how you feel about cancelling your session a few weeks ago…”

Competencies included:
a) The therapist remains open to the possibility that his/her interventions are not necessarily accurate or right. The therapist does not have certainty and does not treat his beliefs as facts. Instead, the therapist is flexible and open to change his way of thinking according to what is happening with the patient, modifying his/her interventions according to the patient’s feedback or state of mind.
b) The therapist arrives at an analytic/dynamic formulation by working collaboratively with the patient.
c) The therapist shares his/her dynamic formulation with the patient not as a sure thing, but expressing it tentatively, as a hypothesis, waiting to hear the patient’s response to it in order to co-construct the formulation collaboratively.

d) The therapist asks the patient for feedback, asking whether what he/she has said makes sense to the patient or not. The therapist is not only attentive to the patient’s verbal and manifest feedback, but also to the feedback provided by the patient’s unconscious communications, including the therapist countertransference.

e) After delivering an interpretation, the therapist adapts the following interventions to the patient’s reaction to it:

33. The therapist is able to find a balance between on one hand, delivering the interpretations tentatively, as hypotheses that need to be tested with the patient; and on the other hand, not delivering the interventions in such a tentative way that it seems that he/she does not believe in the therapy that he/she is delivering.

Competencies included:

a) The therapist delivers the interpretations as hypotheses that need to be tested together with the patient. The therapist delivers interpretations tentatively, inviting the patient to co-create with the therapist the meanings in the therapeutic process.

b) The therapist understands what his/her role means and believes in the therapy that he/she is delivering. Therefore, the therapist does not say things in such a tentative way that it feels he/she is not occupying his/her position as a therapist.

34. The therapist interventions progress from surface to depth, starting from the issues that are closer to the patient’s consciousness. The therapist titrates the delivery of interventions in order to meet the patient where he/she is at, not threatening his/her psychic equilibrium, and taking into consideration how defended the patient is from conflicting unconscious affects.

For example, if the patient suppresses tears in a session, the therapist may begin by noting this before moving on to wondering about why she may need to do this. Thus, the therapist is prudent in first taking up the defence, before exploring or commenting that which is being defended against.

Competencies included:

a) The therapist delivers interpretations by arriving at them slowly and alongside with the patient, holding the patient’s hand as they arrive at it, saying the interpretation for the patient but with the patient.

b) The therapist brings something up in therapy when he/she senses that the patient is almost conscious of it.

c) The therapist interpretations are of appropriate depth, moving from preconscious to more unconscious contents.

d) The therapist responds to unconscious communications when the patient is open to receive them.
e) The therapist delivers interventions that address the specific need of the patient of protection from a particular view of himself/herself
f) The therapist is aware of how much affect the patient can tolerate and takes it into consideration when exploring interpersonal situations
g) The therapist interpretations are appropriately timed, in relation to an assessment of what the patient can bear to think and in relation to the amount of time left in a session

35. The therapist delivers interpretations following a specific sequence. Firstly, the therapist makes supportive interventions, validating the patient’s feelings, making him/her feel understood, and strengthening the therapeutic alliance. Only when the patient feels safe enough, it is possible for the therapist to interpret and make new links.

Competencies included:
a) The therapist knows when to prioritise supportive interventions over expressive ones and vice versa, finding a balance between the two. The therapist favours the delivery of supportive interventions when the patient is fragile and/or emotionally overwhelmed. However, the therapist does not collude with the patient by only staying in the patient’s comfort zone. Therefore, the therapist is able to reach a balance for the specific patient between supportive and expressive interventions
b) The therapist delivers his/her understanding of an interpersonal situation by following a particular sequence. The first step is to make the patient feel understood. Only after this the therapist can explore the other people’s perspectives involved in the interpersonal situation.

36. The therapist is able to genuinely convey hope to the patient

Competencies included:
a) The therapist believes in the therapy he/she is delivering
b) The therapist is motivated and committed to psychotherapeutic work and to working with his/her patients

Aim 14: Promote and Expand the Patient’s Self-Knowledge and Self-Awareness

37. The therapist is able to understand and intervene at multiple levels.

The therapist understands the patient’s communications in their conscious and unconscious level, and their implications to both, the patient’s difficulties as well as to the transference situation. Therefore, the therapist understands the links between the patient’s internal state and unconscious fantasies, external relationships, and transference situation, and is capable of intervening by conveying this understanding to the patient. The therapist expands the patient’s understanding by sensitively delivering an original and helpful intervention

Example: A patient, in one of the last sessions of DIT, brings to the session that he has had many difficulties with a plumbing company and that we would have preferred to do the job on his own. The therapist is
able to explore the situation, conveying an in depth understanding of the anxieties that the situation might have brought about in the patient. Then the therapist is able to link this situation to the patient’s IPAF, commenting how in this situation again the patient is left out feeling that he is on his own, that he cannot rely on anyone, not even when he asks for help. Finally, the therapist is able to link these feelings to the situation in the transference and phase of therapy, conveying to the patient that she understands that he might be feeling that she is also leaving him alone, that from now on he will have to do the job on his own, leaving him frustrated and ambivalent after he has asked her for help.

Competencies included:
a) The therapist has an implicit or explicit agreement with the patient that it is worthwhile to try to understand the unconscious motivations related to the patient’s difficulties. Therefore, the therapist makes meaningful connections, expanding the conscious boundaries of the patient
b) The therapist is able to add meaning to the patient’s communications
c) The therapist facilitates and responds to the patient’s unconscious communications by putting into words the latent meaning of the session
d) The therapist has the courage to talk about difficult issues, make challenging links, and ask the questions that need to be asked in order to help the patient. The therapist does not remain in a safe place. Instead, the therapist trusts his/her own instincts and is able to try new things out with the patient.
e) The therapist understands the patient’s internal state, external relationship, transference situation, and the links between them. The therapist holds this understanding of the patient in mind, that he/she can sensitively share in the session.
f) The therapist demonstrates the following abilities: a) understand the patient’s communications; b) understand the implication of the unconscious meanings of the patient’s communications to the therapeutic relationship in the here-and-now of the session; and, c) competently intervene in accordance with these understandings
g) The therapist demonstrates a good understanding of the patient’s history, relationships, and how he/she has come to have the current clinical presentation
h) The therapist arrives into a dynamic formulation by gathering and integrating information about the patient from different sources
i) The therapist arrives into a dynamic formulation taking into consideration the developmental history and past experiences of the patient, as well as the use of defences at different life stages
j) The therapist is able to draw on knowledge of mental health problems and their consequences in order to help and understand the patient
k) In order to arrive into a dynamic formulation, the therapist systematises the information of all the sources, in light of the psychodynamic theoretical model, aiming to conceptualise what is the patient’s basic conflict
Aim 15: Promote and Expand the Patient’s Knowledge and Awareness of His/Her Relational Patterns

38. The therapist helps the patient mentalize the different perspectives in an interpersonal conflict. In order to do this the therapist describes the contradictions in the patient’s account, only to then help the patient solve the apparent contradictions in the story. Thus, the therapist analyses together with the patient the situation from every angle, and trying to understand the affects and defences aroused in the patient.

Competencies included:
- a) In order to understand the patient’s feelings and defences mobilised in interpersonal situations, the therapist carries out a polite enquiry to elicit relevant information, using techniques such as clarification, confrontation, and interpretation.
- b) The therapist helps the patient explore the unconscious feelings that may emerge in interpersonal situations.
- c) The therapist elicits interpersonal narratives.

39. The therapist is able to formulate and articulate the IPAF, which includes identifying what is the patient’s self-representation, other representation, and which are the most important affects and defences employed by the patient. The therapist understands and links the material the patient brings to therapy to the IPAF in order to maintain the therapeutic focus.

Competencies included:
- a) The therapist helps the patient become aware of his/her repeated interpersonal patterns of relating, with its affects and defences, that causes the patient difficulties, in order to deactivate it.
- b) The therapist prioritises working on the agreed focus rather than exploring the patient’s history.
- c) The therapist intervenes being mindful of the IPAF, fitting the interventions according to the affective, relational pattern agreed with the patient as the focus of therapy.

40. The therapist is able to recognise what is happening in the transference with the patient and is able to use this understanding in at least one of the following ways:

- a) Helping the patient make links and draw parallels between the transference and the IPAF. The therapist describes the transference – without interpreting it, challenging the patient’s beliefs about his/her relational patterns. Thus, the therapist does not focus on the transference, but uses it to explore other areas.

- b) Delivering transference interpretations, allowing the patient to work in the transference, and understanding how the patient is using the transference interpretations.

For example, the therapist may say: “I think it would be helpful if we pause to think about what has been happening between us, because it seems to
me that you are feeling rather hopeless about whether coming to therapy can be of any help to you, and your anxiety seems to be getting worse, and yet you are not communicating this directly to me. Instead I feel you withdrawing. We know how difficult it is for you to feel that you are on your own with a problem and that the other person cannot help you with it. This often leaves you feeling sad and angry, but instead of expressing what you feel you shut down communication. This is similar to what happens with your husband when you get into a conflict with him, just as you were describing earlier in the session”

Competencies included:
a) The therapist is able to recognise the transference situation. The therapist learns about the patient by exploring and thinking about the unconscious meanings related to the transference relationship
b) In order to arrive into a dynamic formulation, the therapist gives considerable importance to how it is to be with that particular patient in the room. The therapist considers essential to understand how the patient relates to the therapist, how the patient replies to questions and different situations, and how the patient elaborates their object relationships
c) The therapist considers the cautionary tale and/or his/her countertransference as essential sources to formulate the patient’s difficulties
d) The therapist delivers the dynamic formulation when it is possible to link it to something that happened in the session. Therefore, the therapist makes the formulation more understandable, alive and interesting by making a link to the material of the session
f) In order to understand and use the transference, the therapist is open to the relationship with the patient, exposing himself/herself to it, letting himself/herself become affected by it, without feeling the relationship with the patient as something neutral or distant.
g) The therapist is aware that anything the patient says in the therapy is a reflection of the total transference situation with the therapist. The therapist is aware that anything the patient says in therapy reflects in some way what is happening in the therapeutic relationship.
h) The therapist understands that anything the patient says in the session has an impact in the therapeutic relationship.
i) The therapist does a general exploration in order to formulate the patient difficulties but focuses in what has been more recent and relevant for the patient and in the here-and-now of the session
j) The therapist links what is happening in the transference relationship to the IPAF
k) The therapist delivers his/her understanding of the transference in a sensitive and at the same time challenging way to the patient
l) The therapist is attentive and understands how the patient is using transference interpretations, either constructively or not, addressing this with the patient
Aim 16: To Help the Patient Self-Regulate Emotions

41. The therapist helps the patient experience a range of affective states of varying intensities, in tolerable limits. Therefore, with patients that become easily overwhelmed, the therapist attempts to bring down the intensity of the affective state by helping the patient mentalize their emotions; whereas, with patients that are disconnected from his/her emotional states, the therapist attempts to bring affects to their attention.

Competencies included:

a) The therapist deals with the emotional content of the session by helping the patient regulate his/her emotions in order to be able to think about them instead of feeling overwhelmed

42. The therapist allows the evacuation of raw emotions when the patient has recently experienced an external traumatic situation. However, when the emotional hyperarousal of the patient is in relation to transferential issues, the therapist attempts to lower the intensity of the emotions by helping the patient mentalize

Example:

Patient: You don’t care about me. For you I am just work and even as work I am boring and unimportant

Therapist: I am not sure what I have done but I must have done something, perhaps in the last few minutes or before, that makes you so convinced of that. Do you have any idea what I might have done?

Patient: I saw you looking at your watch

Therapist: You might be right, I do recall looking at my watch. Perhaps the way you are feeling at the moment it is inconceivable that there could be another explanation for me looking at my watch rather than finding you a burden

Competencies included:

a) The therapist is able to repair ruptures in the alliance by: a) accepting his/her responsibility for his/her contribution to any strains in the relationships, allowing the patient to assert any negative feelings about the therapeutic relationship; b) conveying to the patient that he/she is on his/her side, acknowledging and validating the patient’s experience; and, c) engaging the patient in understanding the meaning of the difficulties between himself/herself and the therapist, making use of ruptures as opportunities for expanding the patient’s understanding of their subjective experiences

Aim 17: Managing the Patient’s Defences

43. The therapist is respectful of the patient’s defences, and understands the reasons behind them. The therapist works with the defences by acknowledging the struggle and the costs that they mean for the patient.
Example: “It seems that when you expect someone to criticise you, you become overly compliant and then it becomes difficult for you to think. Maybe being compliant in the past helped you to protect yourself from your parents, but today it is not allowing you to have relationships where you can be yourself and express what you feel…”

Competencies included:

a) The therapist understands the patient’s defences by exploring and having in mind how the patient has reacted to difficult situations in the past. The therapist understands that often the defences are associated with the difficulties in the patient’s history, because defences become entrenched at a time in development where there were particular pressures for that individual

b) The therapist assesses the defences in the interaction with the patient in the session

c) The therapist is respectful of the defences. This is particularly important in brief psychotherapy where the therapist should not aim to disarm the defences

d) The therapist works with the defences by showing the patient the cost of using them, without necessarily challenging the patient to change them

e) When the therapist works with/challenges the defences, he/she does it with sympathetic interest and compassion, never in an aggressive way, or blaming the patient

Example: “It seems that since I brought up the ending a few weeks ago, you have found it very hard to arrive on time. I am wondering if my reminder felt like me pushing you away. We know from the work we have been doing that when you feel this way in your relationships you withdraw and can actually start to do the rejecting. I think that this may be what has happened here: you come late and I am the one waiting here and the one who is left out”

Incompetence Subscale

Enactments, Concrete Interventions, and Not Thinking

1. The therapist is unable to explore, see, understand and/or think the different possible perspectives, meanings and links underlying the material the patient brings to the session.

2. The therapist is unable to pick up the unconscious communications, particularly the negative transference and/or the patient’s difficult
feelings (i.e., aggression), leading to a collusion between therapist and patient
3. The therapist gets stuck in a concrete level of communication, which prevents the patient from thinking
   For example: giving advice, direct answers, or homework to the patient. Or focusing the interventions in anything but mental states.
4. The therapist quickly reassures the patient, delivering fast and superficial interventions, without thinking, and/or without gathering enough information to understand. Therefore, the therapist closes topics too soon, narrowing them down without really exploring or understanding them together with the patient.
5. The therapist takes the narratives of the patient as direct and concrete examples of what is happening in the therapeutic relationship.
   For example, a therapist may say to his/her patient “you are telling me about this row with your friend because you want to have a row with me”
6. The therapist is unable to handle and/or understand his/her own countertransference and/or his/her participation in the interaction with the patient.
7. The therapist loses his/her ability to think and trust his/her own judgment by becoming overwhelmed, overly anxious, or afraid of the effect of his/her interventions on the patient. The therapist may be particularly afraid that the patient may disapprove or become angry at an intervention.
8. The therapist gets easily trapped in enactments with the patient and/or cannot understand/think about them; thus, the therapy becomes easily stuck.

Inability to Foster the Therapeutic Alliance

9. The therapist is not emotionally accessible to the patient, he/she is either cold, rigid, insensitive, disconnected, and/or stiff, making it hard for the patient to form a relationship of trust with him/her
10. The therapist conveys negative interpersonal behaviours such as impatience, insincerity, or aggressiveness.
11. The therapist often forgets important information about the patient and/or does not keep the patient in mind. Thus, it becomes difficult for the therapist to elaborate on the patient’s material.
12. The therapist does not listen to the patient.

Not Adapting Interventions to the Patient/Context and Not Considering the Consequences of Interventions

13. The therapist delivers interventions without adapting them or considering: the context, the timing, and/or the effects of it on the therapy and/or on the patient.
14. The therapist is enslaved to the treatment manual, not learning from the individual patient, and not adapting the interventions to that specific patient.
15. The therapist makes interpretations driven more by his/her own ideas, than by the patient’s needs at a specific time. Thus, the therapist delivers interpretations not thinking about the patient, nor adapting them to the therapeutic context.

16. The therapist does not help the patient feel understood and supported. The therapist interventions do not show sensitivity to the complexity of the patient’s difficulties. The therapist does not understand the patient’s distress as a sign of how much they are struggling.

17. The therapist treats the patient’s defences disrespectfully, not understanding the underlying struggle that they represent for the patient. The therapist points out the defences, or challenges them too soon in the therapy, without thinking of the consequences that this might have, threatening the patient’s psychic balance.

18. The therapist is irresponsible because he/she does not consider the potential effects the attitudes, behaviours, and interventions may have on the patient. This includes therapists that are unaware that they are doing harm or simply not doing anything helpful for the patient.

19. The therapist is unaware of and/or unable to address important or difficult issues with the patient. For example, the therapist is unable to address with the patient that he/she is getting worse in the course of treatment.

20. The therapist overwhelms the patient by for example intensifying his/her feelings of sadness and anger instead of helping him/her mentalize his/her emotions.

21. The therapist is unable to prioritise the patient’s interests before his/her own. The therapist does not put the patient first. Instead, the therapist is biased and unfair, prioritising his/her own interests instead of the patient’s.

22. The therapist behaves in an unethical way. The therapist harms the patient by being abusive, or exploitative of the patient or neglectful. Furthermore, the therapist is unethical by engaging in power struggles with the patient.

Lacking Basic Skills to Intervene

23. The therapist does not have a model of therapeutic principles in mind and/or uses interventions from different models that are incoherent between them.

24. The therapist does not keep the frame or boundaries of therapy.

25. The therapist does not express him/herself clearly. This includes therapists that are ambiguous in what they say or that speak for so long that the patient forgets where they started at. Additionally, this includes therapists that speak in an overly theoretical way that prevents the patient from understanding.

26. The therapist intervenes without having gathered enough information that would allow him/her to understand the patient’s situation.
27. The therapist is unable of engaging the patient and promoting psychic change.
28. The therapist becomes too silent without helping the patient communicate or to engage in therapy
29. The therapist does not allow for silences to occur, without leaving space and time to think in the session.

Therapist Mental Health Issues

30. The therapist blames the patient for his/her own difficulties or incompetence.
31. The therapist tends to focus on the patient’s difficulties, projecting the “bad” onto the patient, and blaming the lack of progress in therapy on the patient’s problems. Therefore, the therapist gives the patient a destructive view of himself/herself
32. The therapist is narcissistic, self-centred, or cannot take in criticisms
33. The therapist is unable to maintain an alliance with the patient
34. The therapist does not have self-awareness. The therapist does not have insight of how his/her actions and/or his/her blind spots impact the therapy and the patient.
35. The therapist says wrong things to the patient, particularly because he/she is talking mainly about things that interest only him/her and are not beneficial for the patient.

Not accurately understanding the patient

36. The therapist does not understand the patient, causing a break in the therapeutic process. As a consequence, the patient may show distress, aggressiveness, compliance, bristling, confusion, irritation, or may react breaking the alliance with the therapist, or trying to save/educate the therapist. Additionally, the patient may close down or stop mentalizing when an intervention is wrong in its content or in its timing.

Incompetence in DIT

37. The therapist’s interventions becomes too cognitive, theoretical or concrete that lose sight of the unconscious realm and of the patient’s affects in the here-and now.
38. The therapist is not able to maintain the therapeutic focus across interventions
Global Competence Subscale

**Limited:** The feature described is either not present in the session and/or it is not possible to assess (Score = 0)

**Basic:** The therapist demonstrates a significant absence of skill or an inappropriate performance which is likely to have negative therapeutic consequences (Score = 1-2)

**Good:** The therapist’s performance is appropriate with an evident degree of skill. However, the therapist either demonstrates the competency in a limited way, restricted to a specific aspect of the competency or to particular moments of the session; or, there are problems or inconsistencies in the therapist’s performance of the specific competency (Score = 3-4)

**Advanced:** The therapist consistently demonstrates a high level of skill with only few and minor problems. The therapist demonstrates the ability to carry out the competency in a range of ways and in moments of varying complexity during the session. The therapist demonstrates breadth and depth in the performance of the competency. (Score = 5-6)

Patient Complexity Subscale

**Mild.** The patient appears to be very straightforward to work with. The patient is motivated and engaged with the therapy. The patient has enough psychological resources to deal with the therapeutic process. The patient has high level of (epistemic) trust, he/she is open and receptive to most of the therapist’s interventions (Score = 1-2)

**Moderate.** The patient is at times challenging to work with. The patient may be ambivalent towards therapy. The patient has some psychological resources to deal with the therapeutic process. The patient has a moderate level of (epistemic) trust, he/ she receives some of the therapist’s interventions but remains closed to others (Score = 3-4)
Severe. The patient appears to be challenging to work with. The patient may be unmotivated or disengaged from therapy. The patient appears not to have the necessary psychological resources to deal with the therapeutic process. The patient has a high level of (epistemic) vigilance, and has difficulties to hear and listen to the therapist's interventions (Score = 5-6)
Appendix P  
Fourth and final version of the TCS

DIT Therapist Competence Scale

General Guidelines

The Therapist Competence Scale (TCS) aims to provide a summative feedback about a therapist’s competence within an observed treatment session. The scale assesses the general, psychoanalytic/psychodynamic, and DIT specific competencies required to appropriately deliver DIT to adults experiencing depressive and anxious symptomatology.

The TCS includes four subscales that separately assess the therapist's core competencies, incompetence, global competence, and the patient's complexity.  
The core competencies subscale is organized in accordance to aims the therapist attempts to achieve within a treatment session. The subscale intends to assess sessions at any phase of the treatment and so it does not include skills which, although important, do not occur in most active treatment sessions. The items are rated with a numerical score in order to provide a more detailed feedback as to the therapist's specific areas of strength and weakness.  
The incompetence subscale assesses therapist's performance in reference to seven domains of incompetence. The items are rated as present or absent within the treatment session. 
The global competence subscale aims to reflect the assessor's overall impression of the therapist’s competence in the session as a whole, and is rated using a generic seven-point scale.  
The patient’s complexity subscale was incorporated to the measure in order to understand the context within which the therapist’s performance is evaluated so it can be taken into account when reviewing the ratings of the other subscales.

How to rate the TCS?

Core Competencies Subscale  
Each of the 17 therapeutic aims is broken down into one to nine items, each of which is scored on a seven-point scale. The overarching definitions of the scale are as follows:

**Limited**: The feature described is either not present in the session and/or it is not possible to assess (Score = 0)

**Basic**: The therapist demonstrates a significant absence of skill or an inappropriate performance which is likely to have negative therapeutic consequences (Score = 1-2)
**Good:** The therapist’s performance is appropriate with an evident degree of skill. However, the therapist either demonstrates the competency in a limited way, restricted to a specific aspect of the competency or to particular moments of the session; or, there are problems or inconsistencies in the therapist’s performance of the specific competency (Score = 3-4)

**Advanced:** The therapist consistently demonstrates a high level of skill with only few and minor problems. The therapist demonstrates the ability to carry out the competency in a range of ways and in moments of varying complexity during the session. The therapist demonstrates breadth and depth in the performance of the competency. (Score = 5-6)

Incompetence Subscale
Each of the seven domains of incompetence is broken down into 2 to 10 items, which are rated as present (Score = 1) or absent (Score = 0) in the session. Consider rating as present if the therapist demonstrates the incompetence for most of the time in the session, or if the incompetence is a prominent aspect of the session.

Global Competence Subscale
The therapist global competence is rated according to the generic seven-point scale outlined above.

Patient Complexity Subscale
The patient complexity is rated according to a 6-point scale (mild, moderate and severe) that takes into account both the difficulties of the patient, as well as his/her receptivity and openness (epistemic trust) to therapy and the therapist.
Core Competencies Subscale

Aim 1: To Create Psychic Space, a Space where it is Possible to Think Together with the Patient

1. The therapist demonstrates a receptive, involved, yet non-gratifying attitude, a balance between emotional closeness and distance, that maintains the patient’s emotional arousal at an optimal level (not too high so that the patient loses his/her ability to mentalize; not too low so that the session becomes meaningless emotionally)

For example, the therapist attunes to the patient’s feelings but does not overly empathise with them. The therapist attentively observes and describes the patient’s emotions, without reacting or sharing them. The therapist is able to retain the ability to think and help the patient make sense of his/her emotions.

Competencies included:
- a) The therapist is visible and communicative to the patient and does not adopt a “blank screen” attitude towards the patient
- b) There is a gap, an asymmetry in the relationship between therapist and patient

2. The therapist is able to find a balance between the required structure to deliver therapy and the necessary space that facilitates the patient’s unconscious communications. The therapist maintains the session’s structure by adhering to the treatment model, directing the interventions towards an agreed focus, and by maintaining the frame and boundaries of therapy. Concurrently, the therapist creates space by promoting the patient’s free association and by not having an agenda in mind for the therapeutic process.

For example, the therapist is able to balance the silences in the session. On one hand, the therapist does not become too silent because this would hinder the patient’s communications and engagement; and, on the other hand, the therapist allows for silences to occur in order to create space and time to think within the session.

Competencies included:
- a) The therapist maintains an active stance and clarity of thinking during the session with a specific purpose in mind
- b) The therapist finds a balance between giving information (i.e., giving feedback), and listening and giving space to the patient

Aim 2: Containment, Making the Patient Feel Understood

3. The therapist is attuned to the patient. The therapist is attentive to the broader range of the patient’s communications, following the patient’s
mental states closely, and conveying a capacity to be with, know, identify, name the patient’s unconscious thoughts and affects.

Competencies included:

a) The therapist is able to listen to the patient attentively
b) The therapist conveys genuine interest, curiosity, concern, and sensitivity towards the patient

c) The therapist is able to sit with the feelings of the patient without disposing of them. The therapist is able to be attuned, identify, name, explore, and articulate the patient’s emotions. In this way, the therapist conveys that affect is welcomed and that can be thought about and born by both.

d) The therapist shows the ability to do marked mirroring. The therapist conveys, mainly through non-verbal communications, that he/she knows how the patient is feeling at any point of the session, which helps the patient to modulate his/her affective states. The therapist mirrors the patient’s emotions in an “as-if” or pretend mode, meaning that he/she does not get overwhelmed by the affective state but can represent/verbalize it for the patient.

4. The therapist is able to contain the emotional experiences of the patient. The therapist understands the uniqueness of the patient’s feelings and experiences, without closing their understanding too soon, or making concrete interventions. Instead, the therapist explores and finds examples, metaphors, or analogies (symbolic work) to understand and contain the patient’s experience, making unique links that are understandable for the patient. The therapist’s interventions create a subjective experience that feels immense to the patient, because something he/she was unaware of becomes verbalised.

For example, a well-timed and accurate transference interpretation can be a substantial expression of the therapist’s containment, as it conveys to the patient that he/she has been heard at various level, not only in reference to what has happened in the past, but also in reference of what is happening in the session, making the patient feel understood in a unique way.

Competencies included:

a) The therapist helps the patient feel understood by containing the patient’s anxieties and difficulties without being judgmental. Therefore, the therapist does not behave as a critical object of whom the patient is afraid of. On the contrary, the therapist delivers a formulation to the patient in which he/she feels understood, accepted and safe

b) The therapist, in order to accurately understand, get alongside with the patient’s experience and feelings. The therapist provides the patient with the experience of being understood in a deep and meaningful way, expanding the understanding and saying something new, which is immensely moving for both individuals.

c) The therapist makes the patient go through a “click” experience by becoming able to understand something differently or with another depth
Aim 3: Help the Patient to Think for Himself/Herself (Patient Understands Himself/Herself)

5. The therapist promotes the patient’s capacity to think. The therapist helps the patient become interested in his/her own mind and to have a growing capacity to independently think about his/her own unconscious mental processes.

For example, the therapist gets alongside the patient when exploring a difficult topic but does not give him/her all the answers. Instead, the therapist asks questions and comments in a way that prompts the patient to think, verbalize and reach on his/her own significant meanings and unconscious affects

Aim 4: To Foster the Patient’s Epistemic Trust

6. The therapist uses ostensive cues to alert the patient that the intervention that is about to be delivered is important to him/her. Then, the therapist delivers an intervention whose content is personally relevant for the patient and that is in harmony with his/her intentions and interests, in a sense that can be taken by the patient with a sense of ownership.

For example, with a patient that in the first few sessions asks many practical questions, driven by anxiety, the therapist may adopt a special, calming and maternal tone of voice and say: “Perhaps beginning psychotherapy can make you feel anxious because it might be frightening and painful to face difficult issues about yourself. Asking me a lot of questions is maybe a way of letting me know that you are worried of where this process may lead you to”

Competencies included:
a) The therapist uses ostensive cues to alert the patient that what is about to be communicated is relevant to them. The ostensive cues mainly include non-verbal signs such as eye contact, turn taking, and the use of a special tone of voice (“motherese”)
b) The therapist helps the patient trust and be open
c) Before delivering an intervention, the therapist is able to see and verbalise the patient’s concerns and request for change through the eyes of the patient
d) Before delivering interventions, the therapist makes the patient feel listened and understood, conveying that he/she has in mind the patient’s mind

7. The therapist treats the patient as an agent. The therapist intervenes in a constructive way, giving the patient a positive view of himself/herself. Additionally, the therapist does not have an agenda and understands therapy as a collaborative process, where the patient has an active involvement. Hence, the therapist allows the patient to be an active agent,
responsible for his/her own life and mind, independent, and capable to cope.

Competencies included:
a) The therapist verbalises the interventions in a way that the patient can receive them although they might be shocking and/or surprising
b) The therapist delivers interpretations in a way that feel constructive and not punitive to the patient
c) The therapist adopts a “not-knowing” stance, and does not have an agenda
d) The therapist is genuine

8. The therapist actively helps the patient to receive/trust the therapist interventions and new understandings. The therapist does not passively wait until the patient is able to receive the interventions. Instead, the therapist actively helps the patient get into a state of mind in which they can doubt their own story, becoming interested, and considering alternative perspectives around it

For example, a patient reports the therapist that he has stopped attending a course because he felt criticised by the tutor when he asked the patient where he had been after a few weeks the patient had been absent. The therapist may make comments such as “Take me through what happened”; “Not so quickly. Can you go slowly there and tell me what was in your mind at the time”; “Just to be clear, you felt that your tutor was criticising you about your lack of attendance”; “Looking back, do you think that what he said could have been meant in any other way?”; “Have there been other times when you felt he didn’t like you?”

Aim 5: To Centre the Psychotherapeutic Work around the Unconscious Processes

9. The therapist maintains a focus, awareness, and receptivity to the unconscious processes that take place in the session, including the unfolding of the transference and countertransference.

Competencies included:
a) The therapist conveys an awareness in the unconscious processes in: a) the content, construction, and timing of his/her interventions; b) when he/she decides to not to intervene; c) in his/her affective tone and thought processes during the session; and/or, d) by naming the contradictions between manifest and latent contents, or by showing to the patient the latent material in a straightforward way.
b) The therapist is particularly interested in the patient’s mental states rather than in the patient’s behaviours and external events
c) The therapist fluently uses a conceptualisation of the mind that involves unconscious motivations and the understanding of the personality structure around the developmental resolution of conflicts
d) The therapist has a psychotherapeutic model in mind, which he/she uses to tune into and understand the patient’s communications.

e) The therapist is not only attentive to the emotions openly expressed by the patient, but particularly to the patient’s feelings that are not being explicitly expressed, such as anger or envy, and is open to their exploration.

f) The therapist is attentive to all the patient’s verbal and non-verbal communications, particularly to the issues the patient might be avoiding and keeping away from the discussion. The therapist is attentive to what the patient is saying and not saying.

g) The therapist is aware where in the patient’s narrative the feelings seem to be guarded, defended, or cut-off, and uses this knowledge as a guide to the patient’s unconscious affects. The therapist sensitively brings about these feelings, that have been left out, allowing the patient to experience and share them in therapy.

h) The therapist gives more importance to “how” the patient communicates than to the content of “what” he/she is saying. Therefore, the therapist prioritises the form and process of the patient’s communications rather than the content in order to understand the unconscious communications.

10. The therapist is able to retain an analytic attitude. Therefore, the therapist’s interventions are neither cognitive, nor theoretical. On the contrary, the therapist does not lose sight of the patient’s unconscious and the interventions resonate with the affective tone of the here-and-now of the session.

For example, the therapist may link the patient’s IPAF to the patient’s interpersonal narratives in a didactical way, instructing the patient about the different components of the IPAF, without connecting it to the emotions or the unconscious processes in the here-and-now of the session. In this case, the therapist would be doing something in an incompetent way because he/she would not be retaining an analytic attitude. The therapist would fulfil this competency by linking the IPAF to the unconscious communications of the session and by focusing on the affective dimension of the IPAF that is activated in a given relationship.

Competencies included:

a) The therapist is directive while tuned into the unconscious communications, evolving transference, and countertransference.

Aim 6: The Therapist is Able to Think About Himself/Herself and in the Room with the Patient

11. The therapist conveys that he/she is aware of the emotional impact of the patient’s communications, realising his/her own feelings and thoughts, and using them in a meaningful way in order to understand the patient’s material and the relationship with him/her.

12. The therapist is able to self-regulate his/her own anxieties and feelings in a way that they do not interfere with his/her work with the patient.
However, when enactments take place, the therapist is able to think how the patient’s mind impacted his/hers. Therefore, the therapist is able to regain a reflective stance when managing forms of acting out.

Example: A patient had a highly ambivalent relationship with her mother from whom she asked for help only to then rebuff anything she might suggest. In a session, the therapist found himself giving advice to the patient, after she complained about difficulties in making friends. The patient reacted strongly to this intervention, saying that the therapist wanted her to make friends at all costs so that he could discharge his duties in relation to her. The therapist described to the patient how it had appeared between them a similar scenario to the one the patient had described with the mother. The therapist acknowledged that he had indeed given advice and that this mirrored the patient’s view of her mother as someone who responded anxiously to her problems.

Competencies included:

a) The therapist conveys that he/she is aware of his/her own blind spots, and therefore, is able to differentiate when what he/she is feeling belongs to the patient and when what he/she is feeling belongs to his/her own personality.

13. The therapist is able to think in the room with the patient. The therapist remains open to what else might be going on in the session, apart from what is being openly shown by the patient. Therefore, the therapist is able to add meaning and make new links in the material.

14. The therapist is well developed, he/she is able to: a) tolerate uncertainty; b) tolerate and handle complex and unpleasant feelings and situations; c) be humble, open to learn, understanding that every patient is different; d) be compassionate, reflexive and sensitive to work in depth with unconscious communications.

Aim 7: Promoting Psychic and Behavioural Change

15. The therapist explicitly encourages change in the way the patient relates to others. The therapist explores together with the patient alternative ways of relating to others, motivating the patient to try something spontaneous and new in his/her relationships (including the relationship with the therapist).

For example, the therapist explores together with the patient the success or failure of the patient’s attempts at change, to have a better understanding of the affective and interpersonal processes that inhibit change. The therapist helps the patient anticipate what may prove difficult, as a way of supporting change.

Competencies included:

a) The therapist explicitly helps the patient identify the goals for therapy that are meaningfully connected to the IPAF.
b) The therapist leads the patient to experiment something new, to try something spontaneous, in the therapeutic relationship.

16. The therapist organises each session in accordance to the therapeutic focus (IPAF) and to the tasks that need to be achieved in each phase of therapy. Therefore, the therapist is persistent and holds his/her vision (IPAF) of the patient across interventions.

Competencies included:
a) The therapist sticks to the therapeutic model and to the tasks of each phase of therapy.

Aim 8: Help the Patient Grieve

17. The therapist helps the patient come to terms with loses, endings, difficult experiences and emotions, assisting him/her in the process of grief.

For example, the therapist is able to work through the end phase of therapy. This involves signalling the ending, and discussing the feelings/thoughts and the unconscious fantasies mobilised. The therapist helps the patient to see him/her as a whole object with imperfections that are frustrating, without this overshadowing the qualities that will be missed. The therapist helps the patient accept the separateness and the pain that this can give rise to. Additionally, the therapist reviews the work undertaken, helping the patient take in he/she has received in the therapy. Working through this loss promotes internalisation of the therapeutic relationship and the analytic process.

Aim 9: To Create an Environment of Safety

18. The therapist fosters an environment of safety where the patient feels secure to speak freely, explore difficult contents, and disclose personal information of a sensitive nature. The therapist creates an environment of safety by maintaining the frame and boundaries of therapy, fostering trust, and by prioritising the patient and what is best in his/her interest.

Competencies included:
a) The therapist prioritises the patient and what is best in his/her interest. The therapist treats the patient with respect, considering his/her freedom of choice.
b) The therapist keeps an ethical practice (obtaining informed consent; maintaining confidentiality; safeguarding the patient’s interests; maintaining a competent practice; protecting the patient from potential harm; maintaining appropriate standards of personal conduct).
c) The therapist keeps the frame and boundaries of therapy.

19. The therapist perseveres and is consistently trying to understand the patient’s material and to puzzle out his/her difficulties. The therapist is there for the patient even when he/she is the target of the patient’s
negative transference. The therapist survives the patient’s attacks, tenaciously trying to understand what has taken place, conveying to the patient that he/she cares for him/her.

Competencies included:
a) The therapist keeps the frame and boundaries of therapy. The therapist maintains consistency in relation to the agreed parameters of therapy, and is receptive to the patient’s conscious and unconscious experience of them.

Aim 10: To Foster and Maintain the Therapeutic Alliance, a Relationship of Trust that Enables Psychotherapeutic Work

20. The therapist is able to foster a normal and human relationship with boundaries. The therapist is not stiff, formal, rigid or cold with the patient. Instead, the therapist is warm, compassionate and spontaneous, and conveys that he/she keeps the patient in mind, by remembering what the patient has said in the past, and by reflecting and mirroring the patient’s painful affects. The therapist is emotionally accessible to the patient in a setting that has clear boundaries which aim is to protect the patient and the therapeutic process.

Competencies included:
a) The therapist is able to engender trust and develop rapport with the patient
b) The therapist bears witness the patient’s painful affects in a compassionate way, conveying a willingness to create a relationship with the patient.
c) The therapist is able to use humour in a therapeutic way

21. The therapist conveys that the therapeutic alliance is a bond with a purpose. The therapist interventions take into consideration the goals of the therapy, that have been collaboratively agreed with the patient, reminding him/her that the therapist cares, and therefore, enhancing the therapeutic bond.

Competencies included:
a) The therapist explains and agrees collaboratively with the patient on the techniques/methods, tasks and goals of therapy

Aim 11: To Engage the Patient with Therapy

22. The therapist engages the patient in an alive interchange, making him/her interested and surprised with the material by sharing an understanding of the patient’s difficulties that he/she had not seen before
23. The therapist is able to pick up what is more urgent in the immediate situation for the patient in order to work with that in the session
24. The therapist adapts his/her personal style so that it meshes with that of the patient. The therapist responds to the patient in a way and a tone
of voice that show influence by what the patient has said, aligning himself/herself with the patient and bringing him/her back to the room with the therapist.

Aim 12: Promoting Mentalizing

25. The therapist maintains a focus in the patient’s internal states, sustaining this despite the challenges posed by the patient.

26. The therapist assesses the patient’s mentalizing level, and adapts his/her interventions to help the patient recover his/her mentalizing capacity.

   a) If the patient is in pretend mode the therapist intervenes by shifting the topic to areas of higher emotional arousal and greater vitality.
   b) If the patient is in psychic equivalence mode, the therapist intervenes by stopping and rewinding to the moment mentalizing was lost. The therapist then explores the incident step-by-step, focusing on the patient’s affects.

Competencies included:
   a) The therapist helps the patient recover his/her ability to mentalize. The therapist prioritises this task before delivering any other intervention to the patient.
   b) Checking out his/her understanding of the patient’s state of mind and to what extent this corresponds with the patient’s understanding. Then he/she lets his/her own understanding be influenced by the patient’s understanding and openly admits to any misunderstanding whenever they occur.

Aim 13: To Have in Mind the Patient’s Traits and States of Mind

28. The therapist adapts the interventions to the individual patient, rather than delivering a generic therapy, in order to achieve the different aims of the psychotherapeutic process.

The therapist adapts the interventions to the following patient’s traits: a) character structure; b) defences; c) level of intelligence.

The therapist adapts the interventions to the following patient’s states: a) level of arousal; b) capacity to think and tolerate difficult affects; c) level of understanding; d) level of functioning and capacity to cope; e) level of
risk; f) current context; g) current difficulties; h) trajectory within therapy; i) state of the therapeutic alliance; and, j) transference and countertransference dynamics

Competencies included:

a) The therapist makes accurate interventions meaning that both, the interventions’ content as well as their timing is appropriate for the patient
b) The therapist has the sensitivity to recognise when and when not to intervene
c) The therapist is able to see, understand, and intervene when the patient’s material is “hot” in the here-and-now of the session.
d) The therapist understands the connections between the patient’s material, external situation and transference quickly, and adapt his/her interventions accordingly
e) The therapist delivers an interpretation conveying an understanding of both, the patient’s transference/countertransference dynamics, as well as the patient’s defences
f) The therapist understands which kind of interpretation is more appropriate to deliver at a specific time of the session: either interpret the transference or the patient’s external situation. The therapist is guided by what is more relevant and interesting for the patient at a specific point of the session
g) The therapist conveys that he/she keeps the patient’s relational patterns in mind in order to be aware of the patient’s difficulties in forming a relationship of trust. The therapist understands that this is essential knowledge in order to foster the therapeutic alliance
h) The therapist is aware that the patient’s defences might prevent him/her of engaging with therapy. The therapist is able to address and deal effectively with these issues together with the patient in the session when they occur
i) The therapist is able to attain a balance between what the patient is interested in talking about in the session and what the therapist considers to be important to address in the context of the therapeutic process.

29. The therapist only delivers interventions that are focused or have a purpose. However, the therapist is able to deviate from the therapeutic focus when the patient needs it. In these cases, the therapist is elastic rather than flexible, meaning that he/she allows himself/herself to deviate from the IPAF to go back to it later. Therefore, the therapist is able to go off-track of the therapeutic focus but never completely or permanently.

Example: The patient starts the session referring that his father has recently passed away. The therapist gives space and is able to “be” with the patient when he narrates the events and practical issues the patient has had to deal with on the last few days. The therapist is then able to explore the feelings of sadness, abandonment and of being left out that this situation has aroused, containing the patient. Finally, the therapist is able to link the patient’s affects and narrated events to the patient’s IPAF.

Competencies included:
a) The therapist delivers interpretations that are pertinent to the affective interpersonal focus of therapy
b) The therapist has clarity of thinking and is able to think quickly within the session
c) The therapist quickly finds the focus of therapy and is open to share it with the patient
30. The therapist delivers short and clear interventions, in a language that belongs to the patient, so that it is easier for him/her to understand them and take them in

Competencies included:
a) The therapist has an excellent management of language. The therapist interpretations are clear, economical and succinct enough for the patient to be able to take them in
b) The therapist emulates the patient’s language when delivering interventions
31. The therapist builds meaning and understanding by working collaboratively with the patient. The therapist delivers tentative interventions rather than rigid statements, and corrects what he/she is saying after receiving the patient’s manifest and latent feedback

For example, the therapist would not use statements such as, “What you really feel is…”; “I think what you are really telling me is…”; “I think your expectations are distorted”; “What you meant is…”. On the contrary, the therapist interventions would be more similar to the following one: “I have been wondering whether it has been hard for you to tell me how you feel about cancelling your session a few weeks ago…”

Competencies included:
a) The therapist remains open to the possibility that his/her interventions are not necessarily accurate or right. The therapist does not have certainty and does not treat his beliefs as facts. Instead, the therapist is flexible and open to change his way of thinking according to what is happening with the patient, modifying his/her interventions according to the patient’s feedback or state of mind.
b) The therapist arrives at an analytic/dynamic formulation by working collaboratively with the patient.
c) The therapist shares his/her dynamic formulation with the patient not as a sure thing, but expressing it tentatively, as a hypothesis, waiting to hear the patient’s response to it in order to co-construct the formulation collaboratively
d) The therapist asks the patient for feedback, asking whether what he/she has said makes sense to the patient or not. The therapist is not only attentive to the patient’s verbal and manifest feedback, but also to the feedback provided by the patient’s unconscious communications, including the therapist countertransference
e) After delivering an interpretation, the therapist adapts the following interventions to the patient’s reaction to it
32. The therapist is able to find a balance between on one hand, delivering the interpretations tentatively, as hypotheses that need to be tested with
the patient; and on the other hand, not delivering the interventions in such a tentative way that it seems that he/she does not believe in the therapy that he/she is delivering.

Competencies included:
a) The therapist delivers the interpretations as hypotheses that need to be tested together with the patient. The therapist delivers interpretations tentatively, inviting the patient to co-create with the therapist the meanings in the therapeutic process
b) The therapist understands what his/her role means and believes in the therapy that he/she is delivering. Therefore, the therapist does not say things in such a tentative way that it feels he/she is not occupying his/her position as a therapist.

33. The therapist interventions progress from surface to depth, starting from the issues that are closer to the patient’s consciousness. The therapist titrates the delivery of interventions in order to meet the patient where he/she is at, not threatening his/her psychic equilibrium, and taking into consideration how defended the patient is from conflicting unconscious affects.

For example, if the patient suppresses tears in a session, the therapist may begin by noting this before moving on to wondering about why she may need to do this. Thus, the therapist is prudent in first taking up the defence, before exploring or commenting that which is being defended against.

Competencies included:
a) The therapist delivers interpretations by arriving at them slowly and alongside with the patient, holding the patient’s hand as they arrive at it, saying the interpretation for the patient but with the patient
b) The therapist brings something up in therapy when he/she senses that the patient is almost conscious of it
c) The therapist interpretations are of appropriate depth, moving from preconscious to more unconscious contents.
d) The therapist responds to unconscious communications when the patient is open to receive them
e) The therapist delivers interventions that address the specific need of the patient of protection from a particular view of himself/herself
f) The therapist is aware of how much affect the patient can tolerate and takes it into consideration when exploring interpersonal situations
g) The therapist interpretations are appropriately timed, in relation to an assessment of what the patient can bear to think and in relation to the amount of time left in a session

34. The therapist delivers interpretations following a specific sequence. Firstly, the therapist makes supportive interventions, validating the patient’s feelings, making him/her feel understood, and strengthening the therapeutic alliance. Only when the patient feels safe enough, it is possible for the therapist to interpret and make new links.

Competencies included:
a) The therapist knows when to prioritise supportive interventions over expressive ones and vice versa, finding a balance between the two. The therapist favours the delivery of supportive interventions when the patient is fragile and/or emotionally overwhelmed. However, the therapist does not collude with the patient by only staying in the patient’s comfort zone. Therefore, the therapist is able to reach a balance for the specific patient between supportive and expressive interventions.
b) The therapist delivers his/her understanding of an interpersonal situation by following a particular sequence. The first step is to make the patient feel understood. Only after this the therapist can explore the other people’s perspectives involved in the interpersonal situation.

35. The therapist is able to genuinely convey hope to the patient.

Competencies included:
a) The therapist believes in the therapy he/she is delivering
b) The therapist is motivated and committed to psychotherapeutic work and to working with his/her patients

Aim 14: Promote and Expand the Patient’s Self-Knowledge and Self-Awareness

36. The therapist is able to understand and intervene at multiple levels.

The therapist understands the patient’s communications in their conscious and unconscious level, and their implications to both, the patient’s difficulties as well as to the transference situation. Therefore, the therapist understands the links between the patient’s internal state and unconscious fantasies, external relationships, and transference situation, and is capable of intervening by conveying this understanding to the patient. The therapist expands the patient’s understanding by sensitively delivering an original and helpful intervention.

Example: A patient, in one of the last sessions of DIT, brings to the session that he has had many difficulties with a plumbing company and that he would have preferred to do the job on his own. The therapist is able to explore the situation, conveying an in depth understanding of the anxieties that the situation might have brought about in the patient. Then the therapist is able to link this situation to the patient’s IPAF, commenting how in this situation again the patient is left out feeling that he is on his own, that he cannot rely on anyone, not even when he asks for help. Finally, the therapist is able to link these feelings to the situation in the transference and phase of therapy, conveying to the patient that she understands that he might be feeling that she is also leaving him alone, that from now on he will have to do the job on his own, leaving him frustrated and ambivalent after he has asked her for help.

Competencies included:
a) The therapist has an implicit or explicit agreement with the patient that it is worthwhile to try to understand the unconscious motivations related
to the patient’s difficulties. Therefore, the therapist makes meaningful connections, expanding the conscious boundaries of the patient.
b) The therapist is able to add meaning to the patient’s communications.
c) The therapist facilitates and responds to the patient’s unconscious communications by putting into words the latent meaning of the session.
d) The therapist has the courage to talk about difficult issues, make challenging links, and ask the questions that need to be asked in order to help the patient. The therapist does not remain in a safe place. Instead, the therapist trusts his/her own instincts and is able to try new things out with the patient.
e) The therapist understands the patient’s internal state, external relationship, transference situation, and the links between them. The therapist holds this understanding of the patient in mind, that he/she can sensitively share in the session.
f) The therapist demonstrates the following abilities: a) understand the patient’s communications; b) understand the implication of the unconscious meanings of the patient’s communications to the therapeutic relationship in the here-and-now of the session; and, c) competently intervene in accordance with these understandings.
g) The therapist demonstrates a good understanding of the patient’s history, relationships, and how he/she has come to have the current clinical presentation.
h) The therapist arrives into a dynamic formulation by gathering and integrating information about the patient from different sources.
i) The therapist arrives into a dynamic formulation taking into consideration the developmental history and past experiences of the patient, as well as the use of defences at different life stages.
j) The therapist is able to draw on knowledge of mental health problems and their consequences in order to help and understand the patient.
k) In order to arrive into a dynamic formulation, the therapist systematises the information of all the sources, in light of the psychodynamic theoretical model, aiming to conceptualise what is the patient’s basic conflict.

Aim 15: Promote and Expand the Patient’s Knowledge and Awareness of His/Her Relational Patterns

37. The therapist helps the patient mentalize the different perspectives in an interpersonal conflict. In order to do this the therapist describes the contradictions in the patient’s account, only to then help the patient solve the apparent contradictions in the story. Thus, the therapist analyses together with the patient the situation from every angle, and trying to understand the affects and defences aroused in the patient.

Competencies included:
a) In order to understand the patient’s feelings and defences mobilised in interpersonal situations, the therapist carries out a polite enquiry to elicit relevant information, using techniques such as clarification, confrontation, and interpretation.
b) The therapist helps the patient explore the unconscious feelings that may emerge in interpersonal situations
c) The therapist elicits interpersonal narratives

38. The therapist is able to formulate and/or verbalise the IPAF, which includes identifying what is the patient’s self-representation, other representation, and which are the most important affects and defences employed by the patient. The therapist understands and links the material the patient brings to therapy to the IPAF in order to maintain the therapeutic focus

Competencies included:
a) The therapist helps the patient become aware of his/her repeated interpersonal patterns of relating, with its affects and defences, that causes the patient difficulties, in order to deactivate it.
b) The therapist prioritises working on the agreed focus rather than exploring the patient’s history
c) The therapist intervenes being mindful of the IPAF, fitting the interventions according to the affective, relational pattern agreed with the patient as the focus of therapy

39. The therapist is able to recognise what is happening in the transference with the patient and is able to use this understanding in at least one of the following ways:

a) Helping the patient make links and draw parallels between the transference and the IPAF. The therapist describes the transference – without interpreting it-, challenging the patient’s beliefs about his/her relational patterns. Thus, the therapist does not focus on the transference, but uses it to explore other areas.

b) Delivering transference interpretations, allowing the patient to work in the transference, and understanding how the patient is using the transference interpretations

For example, the therapist may say: “I think it would be helpful if we pause to think about what has been happening between us, because it seems to me that you are feeling rather hopeless about whether coming to therapy can be of any help to you, and your anxiety seems to be getting worse, and yet you are not communicating this directly to me. Instead I feel you withdrawing. We know how difficult it is for you to feel that you are on your own with a problem and that the other person cannot help you with it. This often leaves you feeling sad an angry, but instead of expressing what you feel you shut down communication. This is similar to what happens with your husband when you get into a conflict with him, just as you were describing earlier in the session”

Competencies included:
a) The therapist is able to recognise the transference situation. The therapist learns about the patient by exploring and thinking about the unconscious meanings related to the transference relationship
b) In order to arrive into a dynamic formulation, the therapist gives considerable importance to how it is to be with that particular patient in the room. The therapist considers essential to understand how the patient relates to the therapist, how the patient replies to questions and different situations, and how the patient elaborates their object relationships.
c) The therapist considers the cautionary tale and/or his/her countertransference as essential sources to formulate the patient's difficulties.
d) The therapist delivers the dynamic formulation when it is possible to link it to something that happened in the session. Therefore, the therapist makes the formulation more understandable, alive and interesting by making a link to the material of the session.
f) In order to understand and use the transference, the therapist is open to the relationship with the patient, exposing himself/herself to it, letting himself/herself become affected by it, without feeling the relationship with the patient as something neutral or distant.
g) The therapist is aware that anything the patient says in the therapy is a reflection of the total transference situation with the therapist. The therapist is aware that anything the patient says in therapy reflects in some way what is happening in the therapeutic relationship.
h) The therapist understands that anything the patient says in the session has an impact in the therapeutic relationship.
i) The therapist does a general exploration in order to formulate the patient difficulties but focuses in what has been more recent and relevant for the patient and in the here-and-now of the session.
j) The therapist links what is happening in the transference relationship to the IPAF.
k) The therapist delivers his/her understanding of the transference in a sensitive and at the same time challenging way to the patient.
l) The therapist is attentive and understands how the patient is using transference interpretations, either constructively or not, addressing this with the patient.

Aim 16: To Help the Patient Self-Regulate Emotions

40. The therapist helps the patient experience a range of affective states of varying intensities, in tolerable limits. Therefore, with patients that become easily overwhelmed, the therapist attempts to bring down the intensity of the affective state by helping the patient mentalize their emotions; whereas, with patients that are disconnected from his/her emotional states, the therapist attempts to bring affects to their attention.

Competencies included:
a) The therapist deals with the emotional content of the session by helping the patient regulate his/her emotions in order to be able to think about them instead of feeling overwhelmed.

41. The therapist allows the evacuation of raw emotions when, for example, the patient has recently experienced an external traumatic situation. However, when the emotional hyperarousal of the patient is in
relation to transferential issues, the therapist attempts to lower the intensity of the emotions by helping the patient mentalize

Example:
Patient: You don’t care about me. For you I am just work and even as work I am boring and unimportant
Therapist: I am not sure what I have done but I must have done something, perhaps in the last few minutes or before, that makes you so convinced of that. Do you have any idea what I might have done?
Patient: I saw you looking at your watch
Therapist: You might be right, I do recall looking at my watch. Perhaps the way you are feeling at the moment it is inconceivable that there could be another explanation for me looking at my watch rather than finding you a burden

Competencies included:
a) The therapist is able to repair ruptures in the alliance by: a) accepting his/her responsibility for his/her contribution to any strains in the relationships, allowing the patient to assert any negative feelings about the therapeutic relationship; b) conveying to the patient that he/she is on his/her side, acknowledging and validating the patient’s experience; and, c) engaging the patient in understanding the meaning of the difficulties between himself/herself and the therapist, making use of ruptures as opportunities for expanding the patient’s understanding of their subjective experiences

Aim 17: Managing the Patient’s Defences

42. The therapist is respectful of the patient’s defences, and understands the reasons behind them. The therapist works with the defences by naming the defence and its costs for the patient. Additionally, the therapist works with the defences by acknowledging and understanding the struggle that leads the patient to feel the need to defend himself/herself.

Example: “It seems that when you expect someone to criticise you, you become overly compliant and then it becomes difficult for you to think. Maybe being compliant in the past helped you to protect yourself from your parents, but today it is not allowing you to have relationships where you can be yourself and express what you feel…”

Competencies included:
a) The therapist understands the patient’s defences by exploring and having in mind how the patient has reacted to difficult situations in the past. The therapist understands that often the defences are associated with the difficulties in the patient’s history, because defences become entrenched at a time in development where there were particular pressures for that individual
b) The therapist assesses the defences in the interaction with the patient in the session
c) The therapist is respectful of the defences. This is particularly important in brief psychotherapy where the therapist should not aim to disarm the defences
d) The therapist works with the defences by showing the patient the cost of using them, without necessarily challenging the patient to change them
e) When the therapist works with/challenges the defences, he/she does it with sympathetic interest and compassion, never in an aggressive way, or blaming the patient

Incompetence Subscale

Enactments, Concrete Interventions, and Not Thinking

1. The therapist is unable to explore, see, understand and/or think the different possible perspectives, meanings and links underlying the material the patient brings to the session.
2. The therapist is unable to pick up the unconscious communications, particularly the negative transference and/or the patient’s difficult feelings (i.e., aggression), leading to a collusion between therapist and patient
3. The therapist gets stuck in a concrete level of communication, which prevents the patient from thinking
   For example: giving advice, direct answers, or homework to the patient. Or focusing the interventions in anything but mental states.
4. The therapist quickly reassures the patient, delivering fast and superficial interventions, without thinking and/or without gathering enough information to understand. Therefore, the therapist closes topics too soon, narrowing them down without really exploring or understanding them together with the patient.
5. The therapist takes the narratives of the patient as direct and concrete examples of what is happening in the therapeutic relationship.
   For example, a therapist may say to his/her patient “you are telling me about this row with your friend because you want to have a row with me”
6. When an enactment takes place, the therapist is unable to handle and/or understand his/her own countertransference and/or his/her participation in the interaction with the patient.
7. The therapist loses his/her ability to think and trust his/her own judgment by becoming overwhelmed, overly anxious or afraid of the effect of his/her interventions on the patient. The therapist may be particularly afraid that the patient may disapprove or become angry at an intervention
8. The therapist gets easily trapped in enactments with the patient and/or cannot understand/think about them; thus, the therapy becomes easily stuck
Inability to Foster the Therapeutic Alliance

9. The therapist is not emotionally accessible to the patient, he/she is either cold, rigid, insensitive, disconnected, and/or stiff, making it hard for the patient to form a relationship of trust with him/her
10. The therapist conveys negative interpersonal behaviours such as impatience, insincerity, or aggressiveness
11. The therapist often forgets important information about the patient and/or does not keep the patient in mind. Thus, it becomes difficult for the therapist to elaborate on the patient’s material.
12. The therapist does not listen to the patient

Not Adapting Interventions to the Patient/Context and Not Considering the Consequences of Interventions

13. The therapist delivers interventions without adapting them or considering: the context, the timing, and/or the effects of it on the therapy and/or on the patient.
14. The therapist is enslaved to the treatment manual, not learning from the individual patient, and not adapting the interventions to that specific patient
15. The therapist makes interventions driven more by his/her own ideas, than by what is happening in the session with the patient. Thus, the therapist delivers interventions not thinking about the patient, nor adapting them to the therapeutic context
16. The therapist does not help the patient feel understood and supported. The therapist interventions do not show sensitivity to the complexity of the patient’s difficulties. The therapist does not understand the patient’s distress as a sign of how much they are struggling
17. The therapist treats the patient’s defences disrespectfully, not understanding the underlying struggle that leads the patient to feel the need to defend himself/herself. The therapist points out the defences, or challenges them too soon in the therapy, without thinking of the consequences that this might have, threatening the patient’s psychic balance
18. The therapist is irresponsible because he/she does not consider the potential effects the attitudes, behaviours, and interventions may have on the patient. This includes therapists that are unaware that they are doing harm or simply not doing anything helpful for the patient.
19. The therapist is unaware of and/or unable to address important or difficult issues with the patient. For example, the therapist is unable to address with the patient that he/she is getting worse in the course of treatment.
20. The therapist overwhelms the patient by for example intensifying his/her feelings of sadness and anger instead of helping him/her mentalize his/her emotions
21. The therapist is unable to prioritise the patient’s interests before his/her own. The therapist does not put the patient first. Instead, the therapist is biased and unfair, prioritising his/her own interests instead of the patient’s.

22. The therapist behaves in an unethical way. The therapist harms the patient by being abusive, or exploitative of the patient or neglectful. Furthermore, the therapist is unethical by engaging in power struggles with the patient.

**Lacking Basic Skills to Intervene**

23. The therapist does not have a model of therapeutic principles in mind and/or uses interventions from different models that are incoherent between them.

24. The therapist does not keep the frame or boundaries of therapy.

25. The therapist does not express him/herself clearly. This includes therapists that are ambiguous in what they say or that speak for so long that the patient forgets where they started at. Additionally, this includes therapists that speak in an overly theoretical way that prevents the patient from understanding.

26. The therapist intervenes without having gathered enough information that would allow him/her to understand the patient’s situation.

27. The therapist is unable of engaging the patient and promoting psychic change.

28. The therapist becomes too silent without helping the patient communicate or to engage in therapy.

29. The therapist does not allow for silences to occur, without leaving space and time to think in the session.

**Therapist Mental Health Issues**

30. The therapist blames the patient for his/her own difficulties or incompetence.

31. The therapist tends to focus on the patient’s difficulties, projecting the “bad” onto the patient, and blaming the lack of progress in therapy on the patient’s problems. Therefore, the therapist gives the patient a destructive view of himself/herself.

32. The therapist is narcissistic, self-centred, or cannot take in criticisms.

33. The therapist is unable to maintain an alliance with the patient.

34. The therapist does not have self-awareness. The therapist does not have insight of how his/her actions and/or his/her blind spots impact the therapy and the patient.

35. The therapist says wrong things to the patient, particularly because he/she is talking mainly about things that interest only him/her and are not beneficial for the patient.

**Not accurately understanding the patient**
36. The therapist does not understand the patient, causing a break in the therapeutic process.

Incompetence in DIT

37. The therapist's interventions becomes too cognitive, theoretical or concrete that lose sight of the unconscious realm and of the patient's affects in the here-and now.
38. The therapist is not able to maintain the therapeutic focus across interventions

Global Competence Subscale

**Limited:** The feature described is either not present in the session and/or it is not possible to assess (Score = 0)

**Basic:** The therapist demonstrates a significant absence of skill or an inappropriate performance which is likely to have negative therapeutic consequences (Score = 1-2)

**Good:** The therapist’s performance is appropriate with an evident degree of skill. However, the therapist either demonstrates the competency in a limited way, restricted to a specific aspect of the competency or to particular moments of the session; or, there are problems or inconsistencies in the therapist’s performance of the specific competency (Score = 3-4)

**Advanced:** The therapist consistently demonstrates a high level of skill with only few and minor problems. The therapist demonstrates the ability to carry out the competency in a range of ways and in moments of varying complexity during the session. The therapist demonstrates breadth and depth in the performance of the competency. (Score = 5-6)
Patient Complexity Subscale

**Mild.** The patient appears to be very straightforward to work with. The patient is motivated and engaged with the therapy. The patient has enough psychological resources to deal with the therapeutic process. The patient has high level of (epistemic) trust, he/she is open and receptive to most of the therapist's interventions (Score = 1-2)

**Moderate.** The patient is at times challenging to work with. The patient may be ambivalent towards therapy. The patient has some psychological resources to deal with the therapeutic process. The patient has a moderate level of (epistemic) trust, he/ she receives some of the therapist's interventions but remains closed to others (Score = 3-4)

**Severe.** The patient appears to be challenging to work with. The patient may be unmotivated or disengaged from therapy. The patient appears not to have the necessary psychological resources to deal with the therapeutic process. The patient has a high level of (epistemic) vigilance, and has difficulties to hear and listen to the therapist's interventions (Score = 5-6)
Appendix Q
Generalizability Theory

The GT (Shavelson & Webb, 1991) provides a theoretical framework to evaluate the reliability of scores in a more flexible way than the CTST (Cronbach, Gleser, Nanda, & Rajaratnam, 1972; Shavelson, Webb, & Rowley, 1989). GT identifies the multiple sources of error variation in the measurements, and allows for the estimation and isolation of the different variance components (Shavelson & Webb, 1991). GT provides an extensive theoretical framework and statistical methodology to study the consistencies and inconsistencies observed in the scores of measured objects (Brennan, 2003).

GT relies on the analysis of variance (ANOVA) model to partition the total variance into variance components that belong to different sources (Fan & Sun, 2014). However, GT only uses ANOVA to estimate the variance components in measurements, but does not use this methodology for hypothesis testing. Based on the estimation of the variance components, GT derives generalizability and dependability coefficients which are essential to understand in depth the reliability of measurements (Brennan, 2003).

One unique characteristic of GT is that it conceptualises two types of studies and universes. A G study entails the collection of data from a universe of admissible observations that is defined by several factors or facets determined by the researcher. The results of a G study usually consist on a set of estimated random effect variance components for the measurements, derived from the universe of admissible observations (Brennan, 2003). The second type of study, derived from GT, is the Decision (D) study. The D study examines how the generalizability coefficients would change in different circumstances, using the information of the G study in order to inform a decision in a different universe. Thus, a D study uses the information provided by the G study to plan the best possible application of the measurement to a specific purpose, minimising error and maximising reliability. Hence, in a D study the researcher redefines the universe to which he/she aims to generalize the results to (Webb, Shavelson, & Haertel, 2006).
There are several concepts that are essential to understand GT. Firstly, the object of measurement or facet of differentiation should be distinguished as the phenomenon of interest for the study. The estimated variance component of the facet of differentiation constitutes therefore, the true variance of the phenomenon/subject under study (Brennan, 2001; Shavelson & Webb, 1991; Shavelson et al., 1989).

GT also identifies the facets of generalization. Cronbach et al. (1972) described that the “true” score of the object of measurement cannot be observed but could only be approximated by averaging the scores across all observations. GT deals with this difficulty by defining a finite “universe” of observations, according to all the possible levels of the “facets” the researcher is interested in. For example, the contribution to the observed scores given by all the levels of raters and occasions, could be estimated by defining the “universe” of observations according to these facets. Accordingly, the universe score in GT is the mean score of the phenomenon under study, across all levels of all the facets in this specified finite universe (Bloch & Norman, 2012). Thus, the universe score, -a concept analogous to the true score in CTST-, is an idealised measurement that must be estimated through the average of observed scores, which are obtained randomly from a specified universe (Vanleeuwen, 1997).

The facets that define the universe of observations are called facets of generalization, considering that these are the facets that the researcher is interested in for the generalization of the results. Thus, a change in language is implicit to the use of GT; instead of being interested in what is the interrater reliability, GT studies to what extent is it possible to generalise the results across raters. This change in understanding can be applied to any other facet under study (Bloch & Norman, 2012). It is important to notice that the generalizability coefficient of a G study with only one facet is equivalent to the ICC, considering that it only defines a single source of error (Fan & Sun, 2014). However, GT allows for the definition of various facets that are likely to become sources of error in a specific measurement.

Additionally, GT distinguishes between random and fixed facets of generalization. GT considers as random facets all the facets that are of interest for generalization to another random level. The facets that the researcher is not
interested in generalizing are designated as “fixed facets of generalization”. Fundamentally, fixed facets contribute to the variance of interest (true variance) and the random facets contribute to the error variance. Evidently, the fixed facets replicate the conditions of the original study, while the random facets represent a sample of a “universe” of possible conditions (Bloch & Norman, 2012).

Furthermore, GT distinguishes *stratification facets*, which are facets that are not of interest for generalization, but account for the different strata or nesting in the data. For example, a study that defines items and raters as facets, and in which all raters score all items for every object of measurement, the design of the study is considered to be *crossed*. However, if only some raters score a selection of the items, while other raters score another selection of the items, the design of the study is considered to be *nested*. This distinction in the design is a relevant aspect of G studies, considering that all crossed facets interact, which in itself brings about another source of measurement error. On the contrary, nested facets do not interact, which can be explained in reference to the previous example. If only some raters scored a selection of the items, it is not possible to conclude that there is an effect of raters in items, -or vice versa-, considering that not all items were scored by all raters (Bloch & Norman, 2012).

A G study provides an estimation of the different variance components which reflect the magnitude of error that results from generalizing from an individual score to a universe score (Shavelson & Webb, 1991). The estimated variance components are essential to calculate the generalizability coefficient. See Table 1 for possible G coefficients and their interpretations.
<table>
<thead>
<tr>
<th>Object of measurement</th>
<th>Fixed Facets of generalization</th>
<th>Random Facets of generalization</th>
<th>Question</th>
<th>Classical Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person</td>
<td>Day, Item</td>
<td>Rater</td>
<td>To what extent can I generalize from one rater to another?</td>
<td>Inter-rater reliability</td>
</tr>
<tr>
<td>Person</td>
<td>Day, Rater</td>
<td>Item</td>
<td>To what extent can I generalize from one item to another?</td>
<td>Internal Consistency</td>
</tr>
<tr>
<td>Person</td>
<td>Rater, Item</td>
<td>Day</td>
<td>To what extent can I generalize from one day to another?</td>
<td>Test-retest reliability</td>
</tr>
<tr>
<td>Person</td>
<td>Day</td>
<td>Rater, Item</td>
<td>To what extent can I generalize from one rater on one item to another rater/item?</td>
<td></td>
</tr>
<tr>
<td>Person</td>
<td>Item</td>
<td>Day, Rater</td>
<td>To what extent can I generalize from one rater and day to another?</td>
<td></td>
</tr>
<tr>
<td>Person</td>
<td>Rater</td>
<td>Day, Item</td>
<td>To what extent can I generalize from the same rater on one item and day to another?</td>
<td></td>
</tr>
<tr>
<td>Person</td>
<td>Day, Item, Rater</td>
<td></td>
<td>To what extent can I generalize across all</td>
<td></td>
</tr>
</tbody>
</table>
facets to a comparable overall test?

Note. Adapted from Bloch and Norman (2012)

The estimation of the variance components is based on the theoretical composition of the mean squares for each source of error (also called “Expected Mean Square”). The estimation of the variance components can be carried out with different approaches, such as ANOVA, maximum likelihood estimation, or other provided by the different statistical software. The variance components serve as the basis for calculating generalizability coefficients (Fan & Sun, 2014). In the current study, which considers sessions (s) as the object of measurement; and raters (r) and items (i) as facets of generalization, the formula for the total observed score variance estimated using the expected mean squares in a random-effects ANOVA is:

$$\sigma^2(XSIR) = \sigma^2(s) + \sigma^2(i) + \sigma^2(r) + \sigma^2(si) + \sigma^2(sr) + \sigma^2(ir) + \sigma^2(sir)$$

(4)

(Brennan, 2003; Fan & Sun, 2014)

The expected score for an individual over the facets in the universe of generalization is called “universe score”. However, considering that the sample size of the current study (D study) is limited, the variance components are obtained by dividing the G study variance components by the study sample sizes. Thus, for the current study the estimated random effects variance components are:

$$\sigma^2(s) \quad \sigma^2(i) \quad \sigma^2(r) \quad \sigma^2(si) \quad \sigma^2(sr) \quad \sigma^2(ir) \quad \sigma^2(sir,e)$$

\( \frac{\text{ni}}{ni} \quad \frac{\text{nr}}{nr} \quad \frac{\text{ni}}{ni} \quad \frac{\text{nr}}{nr} \quad \frac{\text{ninr}}{ninr} \quad \frac{\text{ninr}}{ninr} \)

(5)

(Brennan, 2003; Fan & Sun, 2014)
Generalizability coefficients have two components. The first one, $\tau$ (tau), consists of all the variance components (main effects and interactions) related to the object of measurement and the fixed facets of the study. The second component, -the “error term”-, called either $\Delta$ (DELTA) or $\delta$ (delta), includes the main effects and interactions ($\Delta$) or only the interactions ($\delta$) of the facets of generalization and the object of measurement. The terms $\Delta$ and $\delta$ refer to the absolute or relative error coefficients, respectively. If the researcher is interested in interpreting a score in relation to all other scores in the study, the main effects (variance given by each single facet) of the facets of generalization are unimportant, considering that main effects will have the same impact in all scores (i.e., all scores will be equally higher or lower). Therefore, when the researcher is interested in relative decisions, the main effects of the generalizability facets should be omitted from the error term. Concurrently, in the calculation of relative decisions, the error term should include the variance that results from the interaction between facets of generalization and the object of measurement, since these have a differential effect in the phenomenon under study (i.e., the interaction between individuals and items indicates that the item effect is not consistent for all respondents). However, it is important to notice that the interactions between the facets of generalization that do not include the object of measurement should not be part of the error term of a relative decision, considering that these kinds of interactions would affect all the subjects under study in an equivalent way. Conversely, if the researcher is interested in absolute scores, then main (systematic) effects, as well as the interactions between facets, should be included in the error term. Thus, the term $\Delta$ represents the absolute error, and $\delta$ represents the relative error. Therefore, for each facet of differentiation and each facet of generalization there are two possible generalizability coefficients, one related to an absolute decision ($\tau/(\tau+\Delta)$), and another to a relative decision study ($\tau/(\tau+\delta)$) (Bloch & Norman, 2012).

In the current study where session (s) is the object of measurement, the universe score variance for the random model is:

$$\sigma^2(\tau) = \sigma^2(s)$$
Concurrently, the generalizability coefficient for a relative decision involving the object of measurement session (s) in the current study design is:

$$E_{p^2} = \frac{\sigma^2(\tau)}{\sigma^2(\tau) + \sigma^2(\delta)} = \frac{\sigma^2(s)}{\sigma^2(s) + (\frac{\sigma^2(si)}{ni} + \frac{\sigma^2(sr)}{nr} + \frac{\sigma^2(sir,e)}{ninr})}$$

(Brennan, 2003; Fan & Sun, 2014)

The formula for the dependability coefficient for an absolute decision involving the same facets is:

$$\phi = \frac{\sigma^2(\tau)}{\sigma^2(\tau) + \sigma^2(\Delta)} = \frac{\sigma^2(s)}{\sigma^2(s) + (\frac{\sigma^2(i)}{ni} + \frac{\sigma^2(r)}{nr} + \frac{\sigma^2(si)}{ni} + \frac{\sigma^2(sr)}{nr} + \frac{\sigma^2(ir)}{ninr} + \frac{\sigma^2(sir,e)}{ninr})}$$

(Brennan, 2003; Fan & Sun, 2014)

The formulas displayed consider all the facets of generalization as random. However, GT also allows to fix a facet, which results in a restricted universe of generalization compared to the universe of generalization of the random model. For mixed-models the preferable option is to employ multivariate GT. However, it is also possible to use simplified univariate procedures, which can be applied to a mixed-models study provided that: (1) the G study estimated variance components are for a random model; (2) each
facet in the D study is either random or fixed; and that (3) the design is balanced, meaning that there is no missing data and if a facet is nested, the number of levels of the nested facet is a constant. It is noticeable that for an analysis to be meaningful, there must be at least one random facet, considering that if all facets are fixed, no generalization is involved and all the error variance, by definition, would be zero (Brennan, 2003; Fan & Sun, 2014).

In the current study, simplified univariate procedures were employed to perform a mixed-model analysis, particularly to study the random effects of raters and items (See Table 2) (Brennan, 2003; Fan & Sun, 2014).

Table 2

<table>
<thead>
<tr>
<th></th>
<th>I, R Random</th>
<th>I Fixed</th>
<th>R Fixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\sigma^2(s)$</td>
<td>$\tau$</td>
<td>$\tau$</td>
<td>$\tau$</td>
</tr>
<tr>
<td>$\sigma^2(i) = \sigma^2(i)/ni$</td>
<td>$\Delta$</td>
<td></td>
<td>$\Delta$</td>
</tr>
<tr>
<td>$\sigma^2(r) = \sigma^2(r)/nr$</td>
<td>$\Delta$</td>
<td>$\Delta$</td>
<td></td>
</tr>
<tr>
<td>$\sigma^2(si) = \sigma^2(si)/ni$</td>
<td>$\Delta, \delta$</td>
<td>$\tau$</td>
<td>$\Delta, \delta$</td>
</tr>
<tr>
<td>$\sigma^2(sr) = \sigma^2(sr)/nr$</td>
<td>$\Delta, \delta$</td>
<td></td>
<td>$\tau$</td>
</tr>
<tr>
<td>$\sigma^2(ir) = \sigma^2(ir)/ninr$</td>
<td>$\Delta$</td>
<td>$\Delta$</td>
<td></td>
</tr>
<tr>
<td>$\sigma^2(sir) = \sigma^2(sir)$</td>
<td>$\Delta, \delta$</td>
<td>$\Delta, \delta$</td>
<td>$\Delta, \delta$</td>
</tr>
</tbody>
</table>

/\ninr

*Note.* Adapted from Brennan (2003). S= session; I = item; R= rater.

Therefore, in the current study with a S x I x R design, when I is considered a fixed facet, the generalizability and dependability coefficients, respectively, are:

$$E_{p^2} = \frac{\sigma^2(s) + \frac{\sigma^2(si)}{ni}}{\sigma^2(s) + \left(\frac{\sigma^2(si)}{ni} + \frac{\sigma^2(sr)}{nr} + \frac{\sigma^2(sir, e)}{ninr}\right)}$$
It is important to notice that the denominator of the dependability coefficient does not include the main effect for items.

In order to study the standardized interrater reliability, in which there is a correlation between the scores assigned by two raters to the same items, it is necessary to compute a generalizability coefficient that fixes the item facet. Therefore, in the current study, with a S x I x R design, equation (9) will be used to compute the generalizability coefficients of the inter-rater reliability.

In the current study with a S x I x R design, when R is considered a fixed facet, the generalizability and dependability coefficients, respectively, are:

$$E_p^2 \quad = \quad \frac{\sigma^2(s) + \frac{\sigma^2(sri)}{ni} + \frac{\sigma^2(sr)}{nr}}{\sigma^2(s) + \frac{\sigma^2(sir)}{ni} + \frac{\sigma^2(sri)}{nr} + \frac{\sigma^2(sir,e)}{ninr}}$$

(11)

$$\varphi \quad = \quad \frac{\sigma^2(s) + \frac{\sigma^2(sr)}{nr}}{\sigma^2(s) + \frac{\sigma^2(sir)}{ni} + \frac{\sigma^2(sri)}{nr} + \frac{\sigma^2(sir,e)}{ninr}}$$

(12)

(Webb et al., 2006)
In order to study the internal consistency between the items, scored by the same raters, it is necessary to compute a generalizability coefficient that fixes the rater facet. Therefore, in the current study, with a S x I x R design, equation (11) will be used to compute the internal consistency generalizability coefficient (Bloch & Norman, 2012).
Appendix R
Comparative Psychotherapy Process Scale – External rater form (CPPS-ER)

Instructions. Using the scale provided below, please rate how characteristic each statement was of the therapy session. For each item, please write the scale rating number on the blank line provided.

<table>
<thead>
<tr>
<th>Scale Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all Characteristic</td>
</tr>
<tr>
<td>1</td>
<td>Somewhat Characteristic</td>
</tr>
<tr>
<td>2</td>
<td>Characteristic</td>
</tr>
<tr>
<td>3</td>
<td>Extremely Characteristic</td>
</tr>
</tbody>
</table>

1. The therapist encourages the exploration of feelings regarded by the patient as uncomfortable (e.g. anger, envy, excitement, sadness, or happiness). ___

2. The therapist gives explicit advice or direct suggestions to the patient. ___

3. The therapist actively initiates the topics of discussion and therapeutic activities. ___

4. The therapist links the patient’s current feelings or perceptions to experiences of the past. ___

5. The therapist focuses attention on similarities among the patient’s relationships repeated over time, settings, or people. ___

6. The therapist focuses discussion on the patient’s irrational or illogical belief systems. ___

7. The therapist focuses discussion on the relationship between the therapist and patient. ___

8. The therapist encourages the patient to experience and express feelings in the session. ___

9. The therapist suggests specific activities or tasks (homework) for the patient to attempt outside of session. ___

10. The therapist addresses the patient’s avoidance of important topics and shifts in mood. ___

11. The therapist explains the rationale behind his or her technique or approach to treatment. ___

12. The therapist focuses discussion on the patient’s future life situations. ___

13. The therapist suggests alternative ways to understand experiences or events not previously recognized by the patient. ___

14. The therapist identifies recurrent patterns in patient’s actions, feelings and experiences. ___

15. The therapist provides the patient with information and facts about his or her current symptoms, disorder, or treatment. ___
16. The therapist allows the patient to initiate the discussion of significant issues, events, and experiences.

17. The therapist explicitly suggests that the patient practice behaviour(s) learned in therapy between sessions.

18. The therapist teaches the patient specific techniques for coping with symptoms.

19. The therapist encourages discussion of patient’s wishes, fantasies, dreams, or early childhood memories (positive or negative).

20. The therapist interacts with the patient in a teacher-like (didactic) manner.
Appendix S

Working Alliance Inventory - shortened observer-rated version (WAI-O-S)

Instructions. Below, there are 12 sentences that describe some of the different ways a therapist/client dyad may interact in therapy. If a statement describes the way you always (consistently) perceive the dyad, circle the number 6; if it never applies to the dyad, circle the number 0. Use the numbers in between to describe the variations between these extremes. PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

1. There is agreement about the steps taken to help improve the client's situation. _____
2. There is agreement about the usefulness of the current activity in therapy (i.e., the client is seeing new ways to look at his/her problem). _____
3. There is a mutual liking between the client and therapist. _____
4. There are doubts or a lack of understanding about what participants are trying to accomplish in therapy. _____
5. The client feels confident in the therapist's ability to help the client. _____
6. The client and therapist are working on mutually agreed upon goals. _____
7. The client feels that the therapist appreciates him/her as a person. _____
8. There is agreement on what is important for the client to work on. _____
9. There is mutual trust between the client and therapist. _____
10. The client and therapist have different ideas about what the client's real problems are. _____
11. The client and therapist have established a good understanding of the changes that would be good for the client. _____
12. The client believes that the way they are working with his/her problem is correct. _____
Appendix T
Hamilton Rating Scale for Depression (17-items)

Instructions: For each item select the “cue” which best characterises the patient during the past week.
Citation: Hamilton M: A rating scale for depression. Journal of Neurology, Neurosurgery and Psychiatry 23:56-62, 1960

1. Depressed Mood (sadness, hopeless, helpless, worthless)
0 Absent
1 These feeling states indicated only on questioning
2 These feeling states spontaneously reported verbally
3 Communicates feeling states nonverbally, i.e., through facial expression, posture, voice and tendency to weep
4 Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and nonverbal communication

2. Feelings of Guilt
0 Absent
1 Self-reproach, feels he has let people down
2 Ideas of guilt or rumination over past errors or sinful deeds
3 Present illness is a punishment. Delusions of guilt
4 Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

3. Suicide
0 Absent
1 Feels life is not worth living
2 Wishes he were dead or any thoughts of possible death to self
3 Suicide ideas or gesture
4 Attempts at suicide (any serious attempt rates 4)

4. Insomnia - Early
0 No difficulty falling asleep
1 Complains of occasional difficulty falling asleep i.e., more than an hour
2 Complains of nightly difficulty falling asleep

5. Insomnia - Middle
0 No difficulty
1 Patient complains of being restless and disturbed during the night
2 Waking during the night – any getting out of bed rates 2 (except for purposes of voiding)

6. Insomnia - Late
0 No difficulty
1 Waking in early hours of the morning but goes back to sleep
2 Unable to fall asleep again if gets out of bed

7. Work and Activities
0 No difficulty
1 Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
2 Loss of interest in activity; hobbies or work – either directly reported by patient, or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)
3 Decrease in actual time spent in activities or decrease in productivity. In hospital, rate 3 if patient does not spend at least three hours a day in activities (hospital job or hobbies) exclusive of ward chores.
4 Stopped working because of present illness. In hospital, rate 4 if patient engages in no activities except ward chores, or if patient fails to perform ward chores unassisted.

8. Retardation
(slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
0 Normal speech and thought
1 Slight retardation at interview
2 Obvious retardation at interview
3 Interview difficult
4 Complete stupor

9. Agitation
0 None
1 “Playing with” hand, hair, etc.
2 Hand-wringing, nail-biting, biting of lips

10. Anxiety - Psychic
0 No difficulty
1 Subjective tension and irritability
2 Worrying about minor matters
3 Apprehensive attitude apparent in face or speech
4 Fears expressed without questioning

11. Anxiety - Somatic
0 Absent Physiological concomitants of anxiety such as:
1 Mild Gastrointestinal - dry mouth, wind, indigestion,
2 Moderate diarrhea, cramps, belching
3 Severe Cardiovascular – palpitations, headaches
4 Incapacitating Respiratory - hyperventilation, sighing
   Urinary frequency
   Sweating

12. Somatic Symptoms - Gastrointestinal
0 None
1 Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
2 Difficulty eating without staff urging. Requests or requires laxatives or medications for bowels or medication for G.I. symptoms.

13. Somatic Symptoms - General
0 None
1 Heaviness in limbs, back or head, backaches, headache, muscle aches, loss of energy and fatigability
2 Any clear-cut symptom rates 2

14. Genital Symptoms
0 Absent 0 Not ascertained
1 Mild Symptoms such as: loss of libido,
2 Severe menstrual disturbances

15. Hypochondriasis
0 Not present
1 Self-absorption (bodily)
2 Preoccupation with health
3 Frequent complaints, requests for help, etc.
4 Hypochondriacal delusions
16. Loss of Weight

A. When Rating by History:
0 No weight loss
1 Probable weight loss associated with present illness
2 Definite (according to patient) weight loss

B. On Weekly Ratings by Ward Psychiatrist, When Actual Changes are Measured:
0 Less than 1 lb. weight loss in week
1 Greater than 1 lb. weight loss in week
2 Greater than 2 lb. weight loss in week

17. Insight

0 Acknowledges being depressed and ill
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

Total Score:_____________________
Patient Name:________________________________________________________
______ Date:_____________________
