The competences required to deliver effective Psychoanalytic/ Psychodynamic Therapy

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The full listing of the psychoanalytic/ psychodynamic competences described in this report is available online at www.ucl.ac.uk/CORE

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Summary

This document identifies the activities associated with the delivery of high-quality psychoanalytic/ psychodynamic therapy and the competences required to achieve this. It describes a model of the relevant competences, and discusses how this should be applied by practitioners, its advantages for clinicians, trainers and commissioners, and the uses to which it can be put.

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[1] Appendix A shows the professional affiliations of members of the ERG

A note on terminology – Psychoanalytic/ Psychodynamic Psychotherapy

Throughout this report we refer to psychoanalytic/ psychodynamic psychotherapy, and do not make any distinction between the two terms. This may be seen as controversial by some practitioners, because it elides any debate about whether therapists who claim one or the other title are intervening in a way which is distinctive.

The decision to adopt this portmanteau term was ratified by the Expert Reference Group, and denotes the fact that the competences listed here have been abstracted from manualised treatment packages that reflect a range of theoretical traditions within applied psychoanalysis. The composition of the members of the ERG also reflected a range of theoretical perspectives and trainings and hence provided an extra layer of scrutiny in this respect.

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Executive summary

The report begins by briefly describing the background to the work on competences for psychological therapies.

It will then outline an evidence-based method for identifying competences, and presents a competence model for psychoanalytic/ psychodynamic therapy. This organises the competences into five domains:

1. **Generic competences** - used in all psychological therapies
2. **Basic psychoanalytic/ psychodynamic competences**
3. **Specific psychoanalytic/ psychodynamic techniques** - the core technical interventions employed in most forms of psychoanalytic/ psychodynamic therapy
4. **Problem-Specific competences/adaptations** - the packages of analytically/dynamically informed interventions for particular problems as well adaptations of a core psychoanalytic/ psychodynamic model
5. **Meta-competences** – overarching, higher-order competences which practitioners need to use to guide the implementation of psychoanalytic/ psychodynamic therapy

The report then describes and comments on the type of competences found in each domain, before presenting a 'map' which shows how all the competences fit together and inter-relate.

Finally the report comments on issues which are relevant to the implementation of the competence framework, and considers some of the organisational issues around its application.

How to use this report

This report describes the model of psychoanalytic/ psychodynamic competences and (based on empirical evidence of efficacy) indicates the various areas of activity that, taken together, represent good clinical practice. The report does not include the detailed descriptions of the competences associated with each of these activities. These can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE). They are available as pdf files, accessed directly or by navigating the map of competences (as represented by Figure 2 in this report).

Background

The Improving Access to Psychological Therapies (IAPT) programme, which was launched in May 2007, provided the backdrop for the first wave of work on the development of competences for the practice of psychological therapies[2]. The IAPT programme has focused to date on delivering CBT for adults with common mental health problems because CBT has the most substantial evidence base supporting its effectiveness in the treatment of depression and anxiety in particular (e.g. NICE, 2004a, 2004b, 2005a, 2005b). Consequently, the first wave of work was concerned to identify the competences needed to deliver good quality CBT. The development of the CBT competence model was specifically developed to be a "prototype" for developing the competences associated with other psychological therapies. The work reported here is based on this model.

National Occupational Standards (NOS): The work undertaken in this report also needs to be seen in the context of the development of National Occupational Standards (NOS), which apply to all staff working in health and social care. There are a number of NOSs which describe standards relevant to mental health workers, downloadable at the Skills for Health website (www.skillsforhealth.org.uk), and the work described in this report will be used to inform the development of standards for psychoanalytic/ psychodynamic therapy.

How the competences were identified

Oversight and peer-review: The work described in this project was overseen by an Expert Reference Group (ERG). This comprised national experts in psychoanalytic/ psychodynamic therapy, selected for their expertise in the development of novel psychoanalytic/ psychodynamic treatments, the evaluation of psychoanalytic/ psychodynamic therapy in formal trials, and the development and delivery of supervision and training models in psychoanalytic/ psychodynamic therapy.

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[2] It is anticipated that when the work is complete there will be competence frameworks for CBT, psychoanalytic/psychodynamic, systemic and humanistic therapies, along with a description of the competences required for supervision of these therapies.

The ERG ensured that the right trials and manuals were identified and that the process of extracting competences was appropriate and systematic. Additional peer review was provided by the researchers and clinicians who had developed the therapies contained in the framework. All this was designed to assure the fidelity of the framework in relation to the therapy it claimed to represent. Overall, this process of open peer-review ensured that the competence lists were subject to a very high level of scrutiny.

Identifying competences by looking at the evidence of what works[3]: This project began by identifying those psychoanalytic/ psychodynamic approaches with the strongest claims for evidence of efficacy, based on the outcome in clinical controlled trials.

Almost invariably the therapy delivered in these trials is based on a manual which describes the treatment model and associated treatment techniques. Treatment manuals are developed by research teams to improve the internal validity of research studies: they explicate the technical principles, strategies and techniques of particular models of therapy. In this sense the manual represents best practice for the fully competent therapist – the things that a therapist *should* be doing in order to demonstrate adherence to the model and to achieve the best outcomes for the client. Because research trials monitor therapist performance (usually by inspecting audio or video recordings) we know that therapists adhered to the manual. This makes it possible to be reasonably confident that if the procedures set out on the manual are followed there should be better outcomes for clients.

Once the decision is taken to focus on the evidence base of clinical trials and their associated manuals, the procedure for identifying competences falls out logically. The first step is to review the outcome literature, which identifies effective therapeutic approaches. Secondly, the manuals associated with these successful approaches are identified. Finally the manuals are examined in order to extract and to collate therapist competences[4]. A major advantage of using the manuals to extract competences is that by using the evidence base to narrow the focus it sets clear limits on debates about what competences should or should not be included.

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[3] An alternative strategy for identifying competences could be to examine what therapists actually do when they carry out a particular therapy, complementing observation with some form of commentary from the therapists in order to identify their intentions as well as their actions. The strength of this method – it is based on what people do when putting their competences into action – is also its weakness. Most psychological therapies set out a theoretical framework which purports to explain human distress, and this framework usually links to a specific set of therapist actions aimed at alleviating the client's problems. In practice these 'pure' forms of therapy are often modified as therapists exercise their judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways which does not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it does make it risky to base conclusions about competence on the work done by practitioners, since this could pick up good, bad and idiosyncratic practice

[4] A detailed account of the methodology and procedures used in this project can be found in Roth and Pilling (2008). Although this paper focuses on the development of the CBT framework the methodological issues it raises are relevant to the present framework).

At present the evidence base for the effectiveness of psychoanalytic/ psychodynamic therapy is not as extensive as that available for the effectiveness of other therapeutic modalities (such as CBT). At least to some degree this reflects a historical position, characterised by a lack of engagement with empirical research among practitioners of this approach. However, there is now an increasing volume of research into the efficacy of psychoanalytic/ psychodynamic therapies and we are very grateful to Andrew Gerber and colleagues at Columbia University who gave us access to the database for a forthcoming systematic review and meta-analysis of psychodynamic therapy with adult clients. This identified 71 randomised trials of psychodynamic interventions (Gernber, 2007, personal communication). We contrasted this list with literature reviews conducted for Roth and Fonagy's review of psychological therapies (Roth and Fonagy 2005), and with the trial and systematic review database held at the Centre for Outcomes, Research and Effectiveness (as part of scoping work for NICE guidance). From the combined lists we identified (in conjunction with the ERG) clinical trials of appropriate quality for inclusion in the framework, and located the manuals used in these studies. To supplement these manuals we also consulted three widely-cited texts which explicate psychodynamic terminology and provide clear descriptions of how these concepts translate into clinical practice (Bateman et al. 2000; Etchegoyen 1999; Greenson (1967); Lemma 2003;, McCullough 2003).

Scope of the work

All the manuals we have drawn on refer to time-limited (though not necessarily 'brief') work, and mostly involve therapy of once (or at most twice) weekly frequency. This means that we have concentrated on the application of psychoanalytic/ psychodynamic interventions as they are provided in the context of publically-funded provision (where more intensive therapy is a scarce resource and once weekly, time limited interventions tends to be the norm).

For the most part the focus of the framework is on the practice of individual therapy with adults. A separate set of additional competences is currently being identified for work with children and adolescents, and this will be forthcoming in due course.

Although some group approaches with good evidence of efficacy are also included, we have not examined the competences associated with the various forms of group analysis or psychotherapy, as developed by for example by Foulkes, or Yalom. While these therapeutic approaches have commonalities with individual therapy, it is not appropriate to see them as if they were individual therapy conducted with more than one person – they are underpinned by coherent and distinct models of group process and behaviour. Because this implies that at least some aspects of the framework would need to be revised to accommodate the differences between individual and group approaches, the ERG agreed that the competences associated with group analysis lay outside the scope of the work.

The competence model for
psychoanalytic/ psychodynamic therapy

Organising the competence lists

Competence lists need to be of practical use. The danger is that they either provide too much structure and hence risk being too rigid or they are too vague to be of use. The aim has been to develop competence lists structured in a way which reflects the practice they describe, set out in a framework that is both understandable (in other words, is easily grasped) and valid (recognisable to practitioners as something which accurately represents the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the way in which competences have been organised into five domains: the components are as follows:

Generic Competences
Generic competences are those employed in any psychological therapy, reflecting the fact that all psychological therapies, including psychoanalytic/ psychodynamic therapy, share some common features. For example, therapists using any accepted theoretical model would be expected to demonstrate an ability to build a trusting relationship with their clients, relating to them in a manner which is warm, encouraging and accepting. Without building a good therapist-client relationship technical interventions are unlikely to succeed. Often referred to as 'common factors' in therapy, it is important that the competences in this domain are not overlooked or treated as an afterthought.

Basic psychoanalytic/ psychodynamic therapy competences
Basic competences establish the structure for psychoanalytic/ psychodynamic therapy interventions, and form the context and structure for the implementation of a range of more specific psychoanalytic/ psychodynamic techniques. For example, psychoanalytic/ psychodynamic therapy prioritises understanding the client's unconscious experience. It is in this context that the vicissitudes of the therapeutic relationship (i.e. the transference) are then explored. While other therapeutic modalities also attend to the therapeutic relationship, what distinguishes the psychoanalytic/psychodynamic approach is this primary focus on the client's *unconscious* experience of the relationship.

Distinguishing "Basic psychoanalytic/ psychodynamic therapy competences" from "Specific psychoanalytic/ psychodynamic therapy techniques"

Figure 1

Outline model for Psychoanalytic/ psychodynamic Therapy competences

Generic Competences in Psychological Therapy

The competences needed to relate to people
and to carry out any form of psychological intervention

Basic psychoanalytic/ psychodynamic therapy competences

Basic psychoanalytic/ psychodynamic competences which are used in most
psychoanalytic/ psychodynamic therapy interventions

**Specific analytic/dynamic
Therapy techniques**

These are specific techniques that
are employed in most
analytic/dynamic interventions

**Problem Specific/specific adaptations
analytic/dynamic therapy skills**

Problem A – the specific analytic/dynamic
Therapy competences needed to deliver
treatment package A

Problem B – the specific analytic/dynamic
Therapy competences needed to deliver a
treatment package B

Adaptation C – the specific analytic/dynamic
Therapy competences needed to deliver an
adaptation of the basic analytic/dynamic model

Metacompetences

Competencies which are used by therapists to work across all these levels
and to adapt psychoanalytic/psychodynamic therapy to the needs of each individual client

There is a fine line between these domains. The distinction between the two is as much pragmatic as conceptual, and is intended to improve the legibility and utility of the model. Essentially, "Basic Competences" are necessary in any analytically/dynamically informed intervention, and provide the backdrop to the more commonly applied techniques – such as working in the transference - that come under the domain of "Specific Techniques". Another way of thinking about the distinction is to see the "Basic Competences" as underpinning any analytically/dynamically informed therapy whereas the use made of the specific techniques is likely to vary more greatly between different psychoanalytic/ psychodynamic models and their application to particular problems. For example, a more exclusive focus on the interpretation of transference is more characteristic of longer term, intensive psychoanalytic/ psychodynamic therapy relative to short-term psychoanalytic/ psychodynamic approaches.

Specific psychoanalytic/ psychodynamic techniques
These are the core technical interventions employed in most applications – the set of commonly applied techniques found to a lesser or greater extent in most forms of psychoanalytic/ psychodynamic therapy. Examples would be the interpretation of transference and using the counter-transference.

Problem-specific competences and specific adaptations
Competence lists in this domain represent "packages" of psychoanalytic/ psychodynamic therapy interventions, as described in treatment manuals. Some of these outline interventions for specific disorders, where there is evidence of benefit for particular problem presentations (e.g. clients with Borderline Personality Disorder). Others are adaptations which are rooted in psychoanalytic ideas, representing a distinctive form of technique

Metacompetences
A common observation is that carrying out a skilled task requires the person to be aware of why and when to do something (and just as important, when not to do it!). This is a critical skill which needs to be recognised in any competence model. Reducing psychological therapy to a series of rote operations would make little sense, because competent practitioners need to be able to implement higher-order links between theory and practice in order to plan and where necessary to adapt therapy to the needs of individual clients. These are referred to as metacompetences in this framework: the procedures used by therapists to guide practice, and operate across all levels of the model. These competences are more abstract than those in other domains because they usually reflect the intentions of the therapist. These can be difficult to observe directly but can be inferred from their actions, and may form an important part of discussions in supervision.

Specifying the competences needed to deliver

psychoanalytic/ psychodynamic therapy

Integrating knowledge, skills and attitudes
A competent clinician brings together knowledge, skills and attitudes. It is this combination which defines competence; without the ability to integrate these areas practice is likely to be poor.

Clinicians need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps the practitioner understand the rationale for applying their skills, to think not just about *how* to implement their skills, but also *why* they are implementing them.

Beyond knowledge and skills, the therapist's attitude and stance to therapy is also critical – not just their attitude to the relationship with the client, but also to the organisation in which therapy is offered, and the many cultural contexts within which the organisation is located (which includes a professional and ethical context, as well as a societal one). All of these need to be held in mind by the therapist, since all have bearing on the capacity to deliver a therapy that is ethical, conforms to professional standards, and which is appropriately adapted to the client's needs and cultural contexts.

The map of Psychoanalytic/ Psychodynamic Therapy competences

Using the map
The map of psychoanalytic/ psychodynamic therapy competences is shown in Figure 2. It organises the competences into the five domains outlined above and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences. The details of these competences are not included in this report; they can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE).

The map shows the ways in which the activities fit together and need to be 'assembled' in order for practice to be proficient. A commentary on these competences follows.

Figure 2
The map of psychoanalytic/ psychodynamic therapy competences

Ability to maintain an analytic attitude

Generic therapeutic competences	Basic analytic/dynamic competences	Specific analytic/dynamic techniques	Problem specific competences/specific adaptations	Metacompetences

Generic therapeutic competences

Knowledge and understanding of mental health problems

Knowledge of, and ability to operate within, professional and ethical guidelines

Knowledge of a model of therapy, and the ability to understand and employ the model in practice

Ability to engage client

Ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world view'

Ability to deal with emotional content of sessions

Ability to manage endings

Ability to undertake generic assessment (relevant history and identifying suitability for intervention)

Ability to make use of supervision

Basic analytic/dynamic competences

Knowledge of basic principles and rationale of analytic/dynamic approaches

Ability to assess the likely suitability of an analytic/dynamic approach

Ability to engage the client in analytic/dynamic therapy

Ability to derive an analytic/ dynamic formulation

Ability to establish and manage the therapeutic frame and boundaries

Ability to work with unconscious communication

> Ability to facilitate the exploration of the unconscious dynamics influencing relationships
>
> Ability to help the client become aware of unexpressed or unconscious feelings

Ability maintain an analytic/dynamic focus

Ability to identify and respond to difficulties in the therapeutic relationship

Ability to work with both the client's internal and external reality

Specific analytic/dynamic techniques

Ability to make dynamic interpretations

Ability to work in the transference

Ability to work with the counter-transference

Ability to recognise and work with defences

Ability to work through the termination phase of therapy

Problem specific competences/specific adaptations

Mentalisation based treatment for Borderline Personality Disorder (Bateman & Fonagy)

Transference Focused Psychotherapy for Borderline Personality Disorder (Clarkin).

Interpersonal Group Psychotherapy for Borderline Personality Disorder (Mazrziali)

Panic Focused Psychodynamic psychotherapy

Supportive-Expressive Therapy

Psychodynamic Interpersonal Therapy

Time limited, interpretive group therapy for pathological bereavement

Metacompetences

Generic metacompetences

Capacity to use clinical judgment when implementing treatment models

Capacity to adapt interventions in response to client feedback

Analytic-specific metacompetences

Ability to make use of the therapeutic relationship as a vehicle for change

Ability to apply the model flexibly in response to the client's individual needs and context

Ability to establish an appropriate balance between interpretative and supportive work

Ability to identify and skillfully apply the most appropriate analytic/dynamic approach

Generic therapeutic competences

Knowledge: Knowledge of mental health problems, of professional and ethical guidelines and of the model of therapy being employed forms a basic underpinning to any intervention, not just to psychoanalytic/ psychodynamic therapy. Being able to draw on and apply this knowledge is critical to the delivery of effective therapy.

The ability to operate within professional and ethical guidelines encompasses a large set of competences, many of which have already been identified and published elsewhere (for example, profession-specific standards, or national standards (such as the Shared Capabilities (Hope, 2004)) and the suites of National Occupational Standards relevant to mental health (available on the Skills for Health website (www.skillsforhealth.org.uk)). Embedded in these frameworks is the notion of "cultural competence", or the ability to work with individuals from a diverse range of backgrounds, a skill which is important to highlight because it can directly influence the perceived relevance (and hence the likely efficacy) of an intervention.

Building a therapeutic alliance: The next set of competences is concerned with the capacity to build and to maintain a therapeutic relationship. Successfully engaging the client and building a positive therapeutic alliance is associated with better outcomes across all therapies. Just as important is the capacity to manage the end of treatment; which can be difficult for clients and for therapists. Because disengaging from therapy is often as significant as engaging with it, this process is an integral part of the 'management' of the therapeutic relationship.

Assessment: The ability to make a generic assessment is crucial if the therapist is to begin understanding the difficulties which concern the client. This is a different activity to the focussed assessment described in the problem-specific competence lists or the assessment specific to the likely suitability of an psychoanalytic/ psychodynamic approach. In contrast a generic assessment is intended to gain an overview of the client's history, their perspectives, their needs and their resources, their motivation for a psychological intervention and (based on the foregoing) a discussion of treatment options.

Assessment also includes an appraisal of any risk to the client or to others. This can be a challenging task, especially if the person undertaking the assessment is a junior or relatively inexperienced member of staff. Bearing this in mind, the ability for workers to know the limits of their competence and when to make use of support and supervision, will be crucial.

Supervision: Making use of supervision is a generic skill which is pertinent to all practitioners at all levels of seniority, because clinical work is demanding and usually requires complex decision making. Supervision allows practitioners to keep their work on track, and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals.

Ability to maintain an analytic attitude

Activities in all domains of psychoanalytic/ psychodynamic therapy competence need to be carried out in the context of an overarching metacompetence: the ability to approach all aspects of the interaction with the client, and of the management of the therapeutic setting, with an "analytic attitude".

The analytic attitude describes the therapist's 'position' or state of mind in relation to the therapeutic task. This stance is characterised by a receptiveness to the client's unconscious communications and to the unfolding of the transference. The therapist's state of mind thus functions as "the keeper of the analytic process" (Calef & Weinschel, 1980).

Nowadays there is no consensually held notion of shared technique (Gabbard & Westen, 2003), such that even definitions of the analytic attitude are subject to variation across different schools of psychoanalysis. Notwithstanding this point, across the manuals we surveyed, there is consensus about the importance of the therapist being as unobtrusive as possible and of retaining a more neutral, relatively anonymous stance towards the client that prioritises reflection and interpretation over action. Such an attitude, of course, is in itself an intervention because clients will react differently, for example, to the therapist's interest in the meaning behind the client's request for advice rather than its provision. The client's reactions to the therapist then become the focus of exploration and provide opportunities for understanding the transference and the client's internal world of relationships. Keeping to an interpretative mode conveys to the client, even if painfully, that difficult states of mind can be reflected upon with another person.

This way of working has contributed to a caricature of the psychoanalytic/ psychodynamic therapist as aloof and unemotional This caricature is common, and while it may true of some individual therapists, it is by no means true of the majority. It is also unhelpful on at least two counts. If psychoanalytic/ psychodynamic therapy were to be implemented in this way it is unlikely that enduring change would result. And as should be clear from the competence framework described in this report, it would not really be psychoanalytic/ psychodynamic therapy. Striving for 'neutrality' and relative anonymity should not result in emotional detachment. The analytic attitude is about a particular way of listening: the therapist empathises with the client's subjective experience while at the same time being curious about its unconscious meaning, rather than trying to solve problems or give advice. Rather than being aloof, the psychoanalytic/ psychodynamic therapist should be actively engaged and emotionally attuned to the client's subjective experience: they are a participant in the therapeutic process and will experience strong feelings in response to the client's communications. However, they also need to be able to stand back from the interaction with the client so as to reflect and comment on it, thereby helping the client gain understanding of how they relate to others.

Psychoanalytic/ psychodynamic work requires the therapist's ability to alternate between the temporary and partial identification of empathy and the return to the position of an observer to the interaction. The therapist therefore requires a well-developed capacity for self-monitoring and self-scrutiny in order to reflect on and modify their responses in the moment.

Basic Psychoanalytic/ psychodynamic Therapy competences

This domain contains a range of activities that are basic in the sense of being fundamental areas of skill; they represent practices that underpin any psychoanalytic/ psychodynamic therapy intervention.

Knowledge of the basic principles of psychoanalytic/ psychodynamic therapies falls into three areas: knowledge of the core principles of psychoanalytic/ psychodynamic therapy, of developmental theory and of a psychoanalytic/ psychodynamic model of the mind.

The **ability to assess the likely suitability of psychoanalytic/ psychodynamic therapy** represents a potential challenge, since we know that pre-therapy client characteristics are not significantly predictive of outcome. Often therapists base their treatment decisions on information gleaned from the 'live' experience of the assessment process and on cumulative practice-based evidence of the indications and contra-indications for the approach. Psychoanalytic/ psychodynamic therapy can be applied to a range of clinical problems, and a key task for any assessment is to identify those ways in which the therapy may need to be applied or adapted to meet the needs of the individual client, as well as taking into account the resources available to the therapist (e.g. access to multidisciplinary support).

The **ability to engage the client** in the therapeutic work is fundamental to any approach. In psychoanalytic/ psychodynamic therapy this is achieved by listening attentively and responding non-judgementally to the client's conscious and unconscious experience. It also requires that early on the therapist provides the client, with an experience of how the therapy works, for example, through maintaining the analytic attitude.

The therapist uses their experience of the client's response to them in order to help identify what adaptations may be necessary to meet the needs of client who may have difficulty engaging with therapy. For example, some clients may have had little, if any, experience of another person helping them to make sense of what they feel, and to begin with the work is often not about uncovering meaning; rather, it is about helping the client to build a relationship within which they can articulate *what* they feel before they can begin to explore *why* they feel in a particular way.

In order to engage, the client needs to have enough information to make an informed decision about their treatment and to feel that the therapist is willing to discuss this

openly with them. It is therefore important that the therapist provides the client with direct information about the approach, including its potential risks.

The client will also require a sense of what the therapy can help them with. An important task at this early stage involves working together with the client to identify and agree therapeutic aims. This is particularly important when working within a time-limited frame, because a focus that is felt to be meaningful to the client is more likely to promote engagement

The **ability to formulate** is fundamental to the practice of psychoanalytic/ psychodynamic therapy. A formulation accounts for the developmental origins of the client's difficulties, the underlying unconscious conflicts, the defences associated with their management and the recurring interpersonal patterns and expectations of others. Clients will have areas where they show a good capacity for functioning as well as areas in which they are vulnerable or have difficulties (i.e. areas of deficit and of conflict), and formulations need to reflect this balance.

A formulation helps to bridge theory and practice, and helps ensure that therapy is mapped to the needs of the individual client. Because it is usually shared with the client it gives them a chance to conceptualise their own difficulties, and a chance to appraise the degree of fit between the formulation and their own experiences. If the formulation does not feel right to the client it can be discussed and, if appropriate, revised. This process is important because if it makes sense to the client they are more likely to be engaged with therapy.

Establishing and managing the therapeutic frame and boundaries involves a range of activities and interventions, all of which are likely to have meaning for the client. For example, changes to the time of appointments or of the therapy room can be experienced as emotionally charged events for some clients. This is why when changes or deviations occur – and they invariably do – the psychoanalytic/ psychodynamic therapist works with the client to understand the unconscious meaning the deviation has for them and helps the client to link this with the interpersonal dynamics that are being explored in the therapy. Exploration of the client's experience of the frame and of the boundaries of the therapeutic relationship is therefore of value in helping them to understand themselves and their difficulties .

 The **ability to work with unconscious communication** underpins the next two areas of competence, namely facilitating the exploration of unconscious feelings and of the unconscious dynamics influencing relationships. It refers to a particular quality of listening in which the explicit content of the client's communications is considered to be the "tip of an iceberg" of reference and implication. Therapists need to take what the client is telling them at face value, but also to be attuned to meanings which are inherent or implied. In this sense they are listening to several levels of discourse simultaneously, making this a distinctive and sophisticated skill, Of course, communication would fail if the therapist did not attend to the first level of implication of what the client said to them;

an overemphasis on what the client is *not* explicitly saying can undermine the development of a good therapeutic alliance.

The primary means of unconscious communication are the client's narratives, dreams and their free associations (the spontaneous links they make between ideas). The therapist can facilitate unconscious communication by knowing when to allow silence, so that free associations can emerge.

The therapist listens out for recurring affective and interpersonal themes. Listening in this way is not a passive process. It involves actively being with the client, moment-by-moment, and tracking the often subtle changes in their state of mind, this reflects the central importance of the therapist's receptivity to the client's unconscious communications. It also points to the fact that it is impossible to listen without also being in some way personally involved an 'analytic ear' without involving ourselves. The ability to be self-reflective and to identify the need for consultation and supervision (or further personal therapy, where required), are therefore key competences.

The **ability to maintain an analytic focus** refers to two distinct, but related, activities. Firstly, it underlines that psychoanalytic/ psychodynamic therapy's primary, overarching focus is on the exploration of the client's unconscious experience. Essentially this means that all aspects of the work are approached with an analytic attitude. Secondly, it refers to working on a particular dynamic theme or conflict to the relative exclusion of others for the duration of the therapy. This is usually the case in time-limited therapy, where it is essential to negotiate with the client a circumscribed conflict or interpersonal pattern that will provide direction and a boundary for both client and therapist.

Because psychoanalytic/ psychodynamic approaches use the therapeutic relationship as the main vehicle for change, the **ability to identify and manage difficulties in the therapeutic relationship** is an important skill. For example, whether an interpretation is experienced as helpful will be determined, in large part, by the client's dominant experience of the relationship at that particular moment in time.

The therapeutic relationship can suffer the strains of misunderstandings and mis-attunements. The therapist might also need to stand the test of the client's hostility or of their mistrust. Such experiences need to be understood and discussed: the therapist's interest and openness to making sense of these difficulties will set the tone and implicitly model for the client how conflict can be resolved. The therapeutic relationship is strengthened by the experience of difficulties that can be openly discussed and resolved.

It is easier for clients to give voice to negative feelings if they trust that the therapist can tolerate their expression without retaliating or trying to minimise their significance. Responding to such feelings requires that the therapist is able to critically scrutinize their own contribution to any difficulties or impasses in the relationship.

Psychoanalytic/ psychodynamic approaches prioritise the exploration of the client's subjective, unconscious experience, and therapists need the **ability to work with both**

the client's internal and external reality. The internal world is, however, always in a dynamic interaction with the external world. To get as close as possible to the client's experience it is therefore essential to also take into account the external reality of the client's life.

The therapeutic relationship will also be affected by the perceived differences (e.g. of age, culture) and similarities between the client and therapist. These need to be openly and sensitively explored, not only because these perceptions are often rich in meaning, but also because, left unexplored, they can become the source of misunderstandings between client and therapist and can undermine the therapeutic alliance.

Specific Psychoanalytic/ psychodynamic Therapy techniques

This domain includes the main techniques employed by psychoanalytic/ psychodynamic therapists - making dynamic interpretations (particularly of the transference), making use of the counter-transference and working with defences. Not all of these would be employed for any one individual, and different technical emphases would be deployed for different problems.

Ability to make dynamic interpretations: An interpretation puts into words the client's conscious and unconscious experience. Often interpretations serve the function of validating the client's experience; they convey to the client that the therapist has understood their predicament by going one step beyond an acknowledgement of what the client consciously feels. Sometimes an interpretation brings together disparate elements in a way that can be challenging, because it introduces a new perspective on the client's experience. It is important therefore to create the conditions of safety within which the client can tolerate these challenges, which are a necessary part of the therapeutic enterprise.

Interpretations are best seen as hypotheses – they invite the client to consider another perspective, which may or may not fit. This is why an interpretation is usually couched as a tentative statement or question. Although it is a hypothesis, an interpretation can be experienced by the client as an action, that is, as the therapist doing something to the client. For example, an interpretation of unconscious motivations which may lie behind the client's behaviour could be experienced as the therapist making a critical comment; if this was so it would be experienced as unsettling and unhelpful. Knowing when and what to interpret relies on the therapist's ongoing assessment of the client's degree of disturbance and of their shifting states of mind, within a given session and over time.

A good interpretation is often simple, to the point and transparent, that is, it shows the client how the therapist arrived at their particular understanding. This is especially important in the early stages of therapy when the client might be unaccustomed to working with the unconscious and may therefore experience an interpretation as 'plucked

out of the blue' unless it is grounded in the content of what they were talking about in the session. Importantly, this ensures that the therapeutic process is a collaborative one.

Ability to work with transference and counter-transference: Psychoanalytic/ psychodynamic therapy is a relational therapy that focuses on helping the client to understand the dynamic factors (e.g. unconscious feelings and fantasies) that shape their behaviour. It is through addressing these factors, and not simply the experiences that have contributed to them, that therapeutic change is thought to occur.

The main focus for interpretation is the client's recurring interpersonal and affective patterns as they manifest themselves in the transference relationship. These interpretations are often referred to as 'here-and-now' or transference. Although they can refer to figures from the client's past, the primary focus in on the relationship with the therapist as it unfolds in the consulting room. This means that the therapist's focus is usually on the formulation and interpretation of the client's *current* experience of themselves in relationship with other people.

A transference interpretation makes explicit reference to the client-therapist relationship and is intended to elucidate and encourage an exploration of the client's conflicts as they are manifest in the relationship. Although the emphasis is not on the client's past, work in the transference can cast light on this.

Understanding the transference is informed by the therapist's ability to consider the meaning and relevance of their counter-transference, that is, of their emotional reactions to the client. This will involve monitoring their own contribution to the interaction because the quality of the relationship that evolves between the therapist and the client is determined by unconscious forces operating in both. This therefore requires a well-honed capacity to self-monitor and to identify the therapist's own contribution to enactments.

Ability to work with defences: All psychoanalytic/ psychodynamic approaches aim to identify the nature of the client's anxiety and how they manage this. This will involve the therapist establishing whether the defences are directed internally (to ward off awareness of threatening thoughts and feelings) or externally (for example, avoiding intimacy with others). Often they may serve both functions.

A key task for the therapist is to identify how defences manifest themselves in the client's communications and ways of relating to the therapist and other people. Because defences exist for a good reason the therapist approaches them sensitively, with due respect for the client's need for the defences, mindful, too, of the possibility of colluding with them.

In the therapeutic situation defences often manifest themselves as resistances, that is, as a kind of 'opposition' to the therapy. Working with resistance therefore involves helping the client to think about the different, and often conflicting, motivations that lie beneath their wish to seek help.

Ability to work through the termination phase of therapy: Finishing therapy in a planned manner is important not only because clients (and often therapists) may have strong feelings about ending, but also because this allows for discussion of how the client will manage on their own and what further help, if any, they might need. This process is aided by ensuring that the likely schedule for sessions is signalled from the outset, and ensuring that there is explicit discussion towards the end of therapy about the conscious and unconscious meaning of the ending for the client.

Each client reacts to termination differently but, generally speaking, ending therapy elicits feelings of loss and often mobilises anxiety about separation. These feelings are not always expressed directly and one of the therapist's tasks is to help the client to articulate their feelings about ending, and to closely monitor and respond to their experience to minimize the likelihood of premature endings or other "enactments".

Problem specific competences/ specific adaptations of psychoanalytic/ psychodynamic therapy

This domain contains competence lists for three exemplar interventions for Borderline Personality Disorder, for Panic Disorder, and for specific adaptations of psychoanalytic/ psychodynamic Therapy interventions: Supportive-Expressive Therapy (SE), Psychodynamic Interpersonal Therapy (PI) and Time Limited Interpretive Group Therapy for Pathological Bereavement. It is worth noting that this list does not include some approaches which have been influential, but which are not described in a text that could be described as manualised, or been directly tested in a research trial. A good example would be David Malan's contribution to thinking about short-term treatments (e.g Malan and Della Selva (2006).

The lists in this domain are intended to read as a coherent description of the critical elements of (and pathways through) each intervention. Working through the list should identify the elements which, taken together, constitute the treatment "package" and hence best practice. By intent the problem-specific lists include some repetition of basic or specific psychoanalytic/ psychodynamic therapy competences, partly because this makes them easier to digest, and partly because some interventions modify standard psychoanalytic/ psychodynamic Therapy techniques in order to apply them to a particular disorder. Nonetheless, it should be clear that the effective delivery of problem-specific interventions will always rest on a range of generic, basic, specific and meta-competences.

In relation to Borderline Personality Disorder there are competence lists for two approaches. This reflects the fact that within psychoanalytic/ psychodynamic therapy there can be differences in the way this disorder is conceptualised, and hence in the emphasis placed on different aspects of intervention. As there is evidence for the effectiveness of both approaches, it is for the therapist (perhaps in conjunction with the client), to decide which intervention to select.

Metacompetences

Therapy cannot be delivered in a 'cook-book' manner; by analogy, following a recipe is helpful, but it doesn't necessarily make for a good cook. This domain describes some of the procedural rules (e.g. Bennett-Levy, 2005) which enable therapists to implement therapy in a coherent and informed manner.

Technical flexibility - the ability to respond to the individual needs of a client at a given moment in time - is an important hallmark of competent therapists. The interaction of a particular therapist and a particular client also produces dynamics unique to that therapeutic relationship, resulting in context-dependent challenges for the therapist. In other words, in psychotherapy the problems to be addressed can present differently at different times, the contextual meanings of the therapist and the client's actions change and the therapist is engaged in a highly charged relationship that needs to be managed. What is required therefore are a range of techniques, complex interpersonal skills under the guidance of very sophisticated mental activities.

On the whole these are more abstract competences than are described elsewhere, and as a result there is less direct evidence for their importance. Nonetheless, there is clear expert consensus that metacompetences are relevant to effective practice. Most of the list has been extracted from manuals, with some based more on expert consensus[5] and some on research-based evidence (for example, "an ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise", or "an ability to implement models flexibly, balancing adherence to a model against the need to attend to any relational issues which present themselves").

The lists are divided into two areas. Generic Metacompetences are common to all therapies, and broadly reflect the ability to implement an intervention in a manner which is flexible and responsive. Psychoanalytic/psychodynamic therapy-specific metacompetences apply to the implementation of therapy in a manner which is consonant with its philosophy, as well as the way in which specific techniques are applied. As is the case in other parts of the model, this division is pragmatically useful, but it is the case that many of the competences described as ' Therapy -specific' could easily be adapted and apply to other interventions or techniques.

Implementing the competence framework

A number of issues are relevant to the practical application of the competence framework.

Do clinicians need to do everything specified in a competence list? Most of the competence lists are based on manuals, which are "packages" of techniques. Some of these techniques may be critical to outcome, but others may be less relevant, or on occasions irrelevant. Based on research evidence we know that the "package" works, but

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[5] Through discussion and review of metacompetences by the Expert Reference Group

we are less certain about which components actually make for change, and exactly by what process.

It needs to be accepted that the competences which emerge from a manual could represent both "wheat and chaff": as a set of practices they stand a good chance of achieving their purpose, but at this stage there is little empirical evidence which can be used to sift effective from potentially ineffective strategies. This means that competence lists derived from manuals may include therapeutic *cul de sacs* as well as critical elements.

Does this mean that clinicians can use their judgment to decide which elements of an intervention to include and which to ignore? This would be a risky strategy, especially if this meant that major elements or aspects of an intervention were not offered – in effect clinicians would be making a conscious decision to deviate from the evidence that the package works. Equally, manuals cannot be treated as a set of rigid prescriptions, all of which have to be treated as necessary and all of which must be applied. Indeed most of the competence lists for problem-specific interventions include an important metacompetence – the ability to introduce and implement the components of a programme in a manner which is flexible and which is responsive to the issues the client raises, but which also ensures that all relevant components are included. Clearly this involves using informed clinical judgment, rather than opinion.

Are some competences more critical than others? For many years researchers have tried to identify links between specific therapist actions and outcome. Broadly speaking better outcomes follow when therapists adhere to a model and deliver it competently (Roth and Pilling, in preparation), but this observation really applies to the model as a whole rather than its specific elements.

Given the relative paucity of research on psychoanalytic/ psychodynamic therapy there is only very limited evidence on which to base judgments about the value of specific activities, and comment on the relative value of competences may well be premature.

The impact of treatment formats on clinical effectiveness: The competence lists in this report set out what a therapist should do, but do not comment on the way in which therapy is organised and delivered – for example, the duration of each session, how sessions are spaced or whether the therapy is time-limited or longer term. Although such considerations will undoubtedly shape the clinical work that can be undertaken, the consensus of the ERG was that these variations do not necessarily have implications for the skills that therapists deploy.

Treatment formats are sometimes identified in manuals and research protocols, with the schedule constructed so as to match to clinical need and the rationale for the intervention. All the manuals we reviewed delivered therapy once or twice weekly therapy, with sessions of 45-50 minutes duration (thereby closely reflecting standard practice). Some of the 'packages', such as Mentalisation Based Treatment for BPD (Bateman & Fonagy,

2006), also specify the provision of groups alongside the individual therapy. Information about the ways in which therapies are best implemented is usually found in clinical guidelines, such as those produced by NICE

The contribution of training and supervision to clinical outcomes: Elkin (1999) highlighted the fact that when evidence-based therapies are 'transported' into routine settings, there is often considerable variation in the extent to which training and supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (in preparation)) reviewed the training and ongoing supervision associated with the delivery of therapy in the exemplar trials which contributed to this report. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seems reasonable to suppose that these elements make their contribution to headline figures for efficacy - a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems which help to ensure the delivery of competent and effective practice. This means that claims to be implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

Applying the competence framework

This section sets out the various uses to which the psychoanalytic/ psychodynamic therapy competence framework can be put, and describes the methods by which these may be achieved. Where appropriate it makes suggestions for how relevant work in the area may be developed

Commissioning: The psychoanalytic/ psychodynamic therapy framework can contribute to the effective use of health care resources by enabling commissioners to specify the appropriate levels and range of psychoanalytic/ psychodynamic therapy for identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences which is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and development of psychological therapy services: The framework represents a set of evidence-based competences, and aims to describe best practice - the activities that individuals and teams should follow to deliver evidence-based treatments.

Although further work is required on the utility and associated method of measurement – they will enable:

- the identification of the key competences required by a practitioner to deliver psychoanalytic/ psychodynamic interventions
- the identification of the range of competences that a service or team would need to meet the needs of an identified population
- the likely training and supervision competences of those managing the service

This level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to that of the research trials on which claims for efficacy rest. In this way it could help to ensure that evidence based interventions are likely to be provided in a competent and effective manner

Clinical governance: Effective monitoring of the quality of services provided is essential if clients are to be assured optimum benefit. Monitoring the quality and outcomes of psychological therapies is a key clinical governance activity; the framework will allow providers to ensure that:

- Psychoanalytic/ psychodynamic therapy is provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of therapist performance
- Clinical Governance systems in Trusts meet their requirement for service monitoring from the HCC and other similar bodies

Supervision: The psychoanalytic/ psychodynamic therapy competence framework potentially provides a useful tool to improve the quality of supervision by helping supervisors to focus on a set of competences which are known to be associated with the delivery of effective treatments. Used in conjunction with the supervision competence framework (available online at www.ucl.ac.uk/CORE/) it can:

- provide a structure which helps to identify the key components of effective practice in psychoanalytic/ psychodynamic therapy
- help in the process of to identification and remediation of sub-optimal performance

Supervision commonly has two (linked) aims – to improve the performance of practitioners and to improve outcomes for clients. The psychoanalytic/psychodynamic framework could achieve these aims through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

Training: Effective training is vital to ensuring increased access to well-delivered psychological therapies. The framework will support this by:

- providing a clear set of competencies which can guide and refine the structure and curriculum of training programmes (including pre and post-qualification professional trainings as well as the training offered by independent organisations)
- providing a system for the evaluation of the outcome of training programmes

Registration: The registration of psychotherapists and counsellors is a key objective for the Department of Health. Although a clear set of competences associated with the key activities of these professionals groups may well contribute to the process of establishing a register, one caution is that it represents only one aspect of a broad set of requirements for a formal registration system.

Research: The competence framework can contribute to the field of psychological therapy research in a number of areas; these include the development and refinement of appropriate psychometric measures of therapist competence, the further exploration of the relationship between therapy process and outcome and the evaluation of training programmes and supervision systems.

Concluding comments

This report describes a model which identifies the activities which characterise effective psychoanalytic/ psychodynamic therapy interventions, and locates them in a "map" of competences.

The work has been guided by two overarching principles. Firstly, it stays close to the evidence-base, meaning that an intervention carried out in line with the competences described in the model should be close to best practice, and therefore likely to result in better outcomes for clients. Secondly, it aims to have utility for those who use it, clustering competences in a manner that reflects the way interventions are actually delivered and hence facilitates their use in routine practice.

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring, or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a cook-book. Delivering effective therapy involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Therapists of all persuasions need to operate using clinical judgment in combination with their technical skills, interweaving technique with a consistent regard for the relationship between themselves and their clients.

Setting out competences in a way which clarifies the activities associated with a skilled and effective practitioner should prove useful for workers in all parts of the care system. The more stringent test is whether it results in more effective interventions and better outcomes for clients.

References

Bateman, A. & Fonagy, P. (2006) <u>Mentalisation Based Treatment</u>. London: Routledge

Bateman, A. Brown, D. and Pedder, J. (2000) *introduction to psychotherapy: An outline of psychodynamic principles and practice* (3rd edition) London: Routledge

Bennett-Levy, J. (2005) Therapist Skills: A Cognitive Model of their Acquisition and Refinement <u>Behavioural and Cognitive Psychotherapy</u>, 34, 57–78

Department of Health (2007) <u>Commissioning a brighter future: Improving Access to Psychological Therapies</u> London: Department of Health

Calef, V. & Weinschel, E. (1980) The analyst as the conscience of the analysis. <u>International Review of Psychoanalysis</u> 7 279-290.

Etchegoyen, R.H. (1999) *The fudamentals of psychoanalytic technique(revised edition)* London: Karnac Books

Elkin, I (1999) A major dilemma in psychotherapy outcome research: Disentangling therapists from therapies <u>Clinical Psychology: Science and Practice</u> 6 10-32

Gabbard, G, & Westen, D. (2003) Rethinking therapeutic action. <u>International Journal of Psychoanalysis</u> 84 823-841.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis. Vol. I*. New York: International Universities Press

Hope, R. (2004) *The Ten Essential Shared Capabilities - A Framework for the whole of the Mental Health Workforce* London: Department of Health

Malan, D.& Della Selva, P C. (2006) *Lives Transformed: How Psychodynamic Psychotherapy Works* London: Karnac Books

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., and Hurley, C. (2003). *Treating Affect Phobia: A Manual for Short Term Dynamic Psychotherapy*, New York, NY: Guilford Press.

NICE (2004a) Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care (http://guidance.nice.org.uk/CG22/guidance/pdf/English)

NICE (2004b) Depression: management of depression in primary and secondary care - NICE guidance (http://guidance.nice.org.uk/CG23/guidance/pdf/English)

NICE (2005a) Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder (http://guidance.nice.org.uk/CG31/guidance/pdf/English)

NICE (2005b) Management of post-traumatic stress disorder in adults in primary, secondary and community care (http://guidance.nice.org.uk/CG26/guidance/pdf/English)

Roth, A.D., and Pilling, S. (2008). Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. Behavioural and Cognitive Psychotherapy 36 129-147

Roth A.D. and Pilling, S. (in preparation, b) The impact of adherence and competence on outcome in CBT and in psychological therapies

Roth, A.D., Pilling S., and Turner, J. (in preparation) Therapist training and supervision in CBT in major trials for depression and anxiety

Roth, A.D. and Fonagy, P. (2005) What works for whom: A critical review of psychotherapy research New York: Guilford Press

Turpin,.G., Hope, R.,Duffy,R., Fossey,M., Seward,J. (in press) Improving access to psychological therapies: implications for the mental health workforce Journal of Mental Health Workforce Development

Appendix A

Membership of the ERG

Professor Anthony Bateman (Chair)   Barnet, Enfield and Haringey NHS Trust and UCL
Dr JoAnne Carlyle   Private practice
Dr Lorna Champion   Royal Edinburgh Hospital &
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Professor Else Guthrie   University of Manchester
Professor Gillian Hardy   University of Sheffield
Ms Louise Lyon   Trust Clinical Director -Tavistock and Portman
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Dr Christopher Mace   Royal College of Psychiatrists
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Dr Frank Margison   Manchester Mental Health and Social Care Trust
Dr David Mathews   Skills for Health
Professor Sue Wheeler   University of Leicester (University of Leicester and
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Appendix B – List of manuals

Bateman, A. & Fonagy, P. (2006) *Mentalisation-based treatment for Borderline Personality Disorder*. London: OUP

Book, H. (1998) *How to practice Brief Psychodynamic Psychotherapy: the CCRT method*. Washington: APA

Clarkin, J., Yeomans, F. and Kernberg, O. (2006) *Psychotherapy for Borderline personality: Focusing on object relations*. Washington: APP.

Guthrie, E. and Margison, F. *Psychodynamic Interpersonal Therapy: An evidence base* (Unpublished manuscript)

Hobson, R. (1985) *Forms of feeling*. London: Tavistock Publications

Leichsenring, F.; Beutel, M.; Leibing, E. (2007) Psychodynamic psychotherapy for social phobia: a treatment manual based on SE therapy. *Bulletin of the Menninger Clinic*, 71(1): 56-83

Luborsky, L. (1984) *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment*. New York: Basic Books

Marziali, E. and Munroe-Blum, H. (1994) *Interpersonal Group Psychotherapy for Borderline Personality Disorder*. New York: Basic Books

Milrod, B., Busch, F. Cooper, A.; Shapiro, T. (1997) *Manual of Panic-Focused Psychodynamic Psychotherapy*. American Psychiatric Press Inc Washington DC and London

Osimo, F. (2003) *Experiential Short-term Dynamic Psychotherapy*. Bloomington, IN: First Books

Piper, W., McCallum, M. Joyce, A. (1995) *Manual for time limited, short term, interpretative group therapy for patients experiencing pathological bereavement.* (Unpublished manuscript).

Piper, W., McCallum, M. Joyce, A. et al (1995) *Manual for individual interpretative therapy*. Unpublished manuscript.

Shapiro, D. & Firth, J. *Exploratory Therapy Manual for the Sheffield Psychotherapy project* (Unpublished)