

## LOOKING FOR “PSY-TOOLS”

An explorative study on mental health professionals’ viewpoints about clinical competences.

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### Introduction

“Skill” is usually confused both with the term “ability”, which from the Latin “*habilis*” means manageable, referring to a technical function, both with the term “capacity”, the possibility of realizing a performance (Fulcheri, 2005). Here we intend with the term “skill” a union between “to know”, “to know-how” and “to know how to be”. “To know” regards all theories, codified knowledge formulated by communities of experts about a specific topic. “To know-how” regards working methodology, operative aspects oriented by theories critically chosen by the professional as a working berth. “To know-how” includes, therefore, operative and procedural knowledge, practical skills, specific professional experience, problem solving in working practice.

“To know how to be”, consequently, comes from this kind of methodology and, at the same time, it is a premise of it. “To know how to be” regards a working method, oriented by a reflective awareness of its role, its function and aims attainable through its work. “To know how to be” includes, therefore, the ability to understand the context in which it operates, manage interactions with other social actors in the contexts and adopt appropriate behaviours.

So a professional is defined competent if he has theoretical knowledge (“know”), the capacity of applying techniques and instruments to solve problems (“know-how”) and if he has a range of resources and personal attitudes that make his work efficacious. Clearly, what defines “competent” a professional is also his smartness in answering questions and solving problems coming from the contest in which he works. Le Boterf (1995), in fact, states that skills are finalized and contextualized: it’s not possible separating them from the conditions they are used in. For these reasons a skill is “evolutionary” and has always to be refined and improved as a function of changes and requests coming from the working contexts. Concerning this, Battistelli (1995) clarifies how professional competences results from a dynamic articulation of knowledge, abilities, attitudes, self-images, personal reasons and personality characteristics. This dynamic articulation allow individual to understand requests and to execute appropriate professional behaviours to meet the working requirement of organizational context. Increasing one’s competence can develop competency, namely, the ability to complete a certain task. This means that competency requires action and verification of what is achieved by that action. Moreover, the competence movement highlights a reflexive feature of competence: a competent performance is attained through reflexive and critical behaviors, i.e. the ability to understand when, where and how to arrange and move resources.

DOI: 10.23823/jps.v1i1.8

Thinking about professionals of mental health (psychiatrists and psychologists), we can state that all said before can be perfectly applied to their typology of work. Mental health professionals, need not only know up to date specific techniques, but also to have personal skills like for example, the relational ones. These are essential for mental health professionals, whose work mainly consists of therapeutic relationships. For this purpose, an intensive, theoretical as well practical training process is needed (Hatcher R. L., Lassiter K. D., 2007).

Some “core competencies” for mental health professionals have been identified. These *core competencies* (IOM2, 2003), are defined by APA’s (American Psychological Association) “*Guidelines and principles for accreditation of professional programs in professional psychology*”. These skills are: *Competence in patient-centred care, Competence in interdisciplinary teamwork, Competence in Evidence-Based Care, Competence in improving care quality, Competence in Informatics*.

European literature concerning this topic, have identified similar competencies for clinical practice, also suggesting how to develop them in the training programs. In Italy, the work conducted by FIAP<sup>1</sup>-CNSP<sup>2</sup> and approved by FIAP on 9th November 2012 (Francesetti G., 2012), is a valid framework for the psychotherapeutic competences of mental health professionals. The FIAP\_CNSP paper adopts 13 core competencies from the EAP (European Association for Psychotherapy) position. According to national and international literature (Rodolfa E., *et al.*, 2005; Fouad N. A, Hatcher R. L., *et al.*, 2009), the profile of mental health professionals should be congruent to work contexts. Moreover, psychologists and psychiatrists uses in a personal way these core competences. In our knowledge, there are few concerning the self- assessment of these professional skills (Dunning D., 2004; Kaslow N. J. *et al.*, 2007; Esposito G., Freda M. F., Bosco V., 2015). Hence, investigating these issues can have positive effects both on the professionals’ training both on the improvement of care and therapy settings.

Our study investigates which skills psychologists and psychiatrists consider essential for psychotherapeutic practice. Our hypothesis was to test whether psychologists and psychiatrists agree in defining their core competences any congruent or discordant evaluations would let us draw a “real” professional profile of psychologists and psychiatrists in the Italian context. Investigating these aspects would allow us to understand which “work and care styles” characterize these two professional figures. However, this work aims to explore present care contexts and their requests. As previously explained, skills are “in contexts”; so, our study wants to explore various operative contexts in connection with requested skills. This point could become a source from which power up developments and improvements in theoretical and practice training of psychologists and psychiatrists.

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DOI: 10.23823/jps.v1i1.8

## Aims

This study started from literature analysis before explained with the aims of explore and display any difference in conducting a clinical interview, according to specific competences as well as the psychotherapeutic competences in two groups of mental health professionals: psychologists in psychotherapeutic training and physicians in psychiatric training.

Even though there are dimensions of their operative practice crossing the two professional categories, such as in diagnosis and interview management, it seems to emerge differences and specific competences areas. We will try to explore these differences.

Specific aims were:

- Explore theoretical background that guide these mental health professionals' practice;
- Pointing out their peculiarities in conducting a clinical interview and formulating a diagnosis;
- Describe similarities and differences of psychologists and psychiatrists in selecting a number of core competences for the psychotherapeutic practice;
- Highlighting any difference in therapeutic relationship with the patient.

## Methods and instruments

The sample (Tab. 1) is composed of 83 subjects: 27 physicians in psychiatric training and 56 psychologists in psychotherapy training of different theoretical orientations. As regarding gender, the sample is composed of 80.7% women and 19.3% men.

Tab 1  
*socio-demographic characteristics of the sample (N = 83)*

	Psychologists (n = 56) n (%)	Psychiatrists (n = 27) n (%)	Tot (N = 83) n (%)	p
Gender				.097
Male	8(14.3)	8(29.6)	16(19.3)	
Female	48(85.7)	19(70.4)	67(80.7)	
Age				.234
26-30	32(57.1)	16(59.3)	48(57.8)	
30-35	18(32.1)	5(18.5)	23(27.7)	
Over 35	6(10.7)	6(22.2)	12(14.5)	
Specialization				.389
Not finished	51(91.1)	26(96.3)	77(92.8)	
Finished	5(8.9)	1(3.7)	6(7.2)	
Theoretical orientation				.000
Systemic	43(76.8)	-	43(51.8)	
Psychodynamic	3(5.4)	-	3(3.6)	
Cognitive	3(5.4)	-	3(3.6)	
Psychiatric	-	27(100)	27(32.5)	
Others	5(8.9)	-	5(6)	
Other qualifications				.001
Yes	28(50)	3(11.1)	31(37.3)	
No	28(50)	24(88.9)	52(62.7)	
Place of graduation				.056
Campania	46(82.1)	17(63)	63(75.9)	
Extra Campania	10(17.9)	10(37)	20(24.1)	

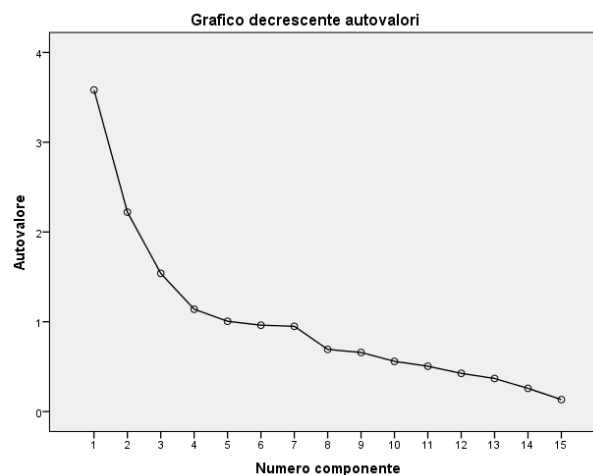
Note. The differences between socio-demographic characteristics were calculated through the  $\chi^2$  test

Subjects have been invited to complete an ad hoc questionnaire to explore skills used in their clinical practice. The questionnaire includes three macro-areas:

1. Personal data and information about academic and post-academic training;
2. A Likert 5- point Scale, composed of 15 items, exploring modes of intervention in clinical interview and diagnosis assessment ;
3. A List of 30 psychotherapeutic competencies borrowed from EAP (European Association for Psychotherapy) and FIAP (Federazione Italiana delle Associazioni di Psicoterapia – Italian Federation of Psychotherapy Associations), between which the subject must choose five of them.

This questionnaire has been submitted in two versions: a paper version and an online one. Data, collected in an excel file, have been subsequently analyzed by mean of an exploratory grid created ad hoc. Using qualitative and quantitative methods and a software for data analysis (SPSS Software - Statistical Package for Social Science) it has been possible to evaluate the answers frequencies.

In particular, on Likert Scale it has been conducted a tentative factorial analysis. This diagram shows the presence of four principal factors:



56.55% of total variance is explained by the extraction of four factors. The third factor doesn't saturate any item, so a new extraction of three factors has been made. It can explain 48.95% of variance.

**Matrix of components\***

	Component			
	1	2	3	4
Q1_1	.371	.193	.433	.469
Q1_2	.558	-.015	.366	-.148
Q1_3	.048	.173	.486	.643
Q1_4	.650	-.029	.297	-.001
Q1_5	.205	.697	.059	-.155
Q1_6	.325	.588	.264	-.376
Q1_7	.465	-.514	.190	-.053
Q1_8	.668	-.353	.236	-.174
Q1_9	.661	.005	-.485	.189
Q1_10	.737	.001	-.497	.143
Q1_11	.632	.145	-.255	.151
Q1_12	.547	-.343	-.174	-.155
Q1_13	.300	.595	-.268	.170
Q1_14	.086	.644	.023	-.286
Q1_15	.348	-.158	.280	-.270

Extraction method: principal components analysis.  
\* 4 extracts components

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The factorial analysis hasn't put in evidence the prevalence of significant factors. For this reason, a descriptive analysis has been conducted calculating the differences percentage in two samples.

Also for the skills' list, a contingency table has been realized through the "chi square" and percentages in the two subsamples.

### Results and conclusions

The data analysis leads to some preliminary comments, which open the way to new questions. It highlights similarities and differences between two professional categories. Interesting data have been collected both through the Likert scale and the list of competencies.

The analysis of the Likert Scale (Tab.2), highlighted that both professional categories attribute poor weight to a DSM or ICD nosographic diagnosis. This datum was expected for psychologists but not for psychiatrists as their medical training emphasizes the role of diagnosis, also between recognized diagnostic and statistic manuals. Conversely, our research seems to show a common orientation of both groups to consider the value of clinical practice, which is more patient-oriented instead of psychopathology-oriented. This evidence is confirmed by the analysis of the list of competencies that shows a higher attention to the relational skills for both professional categories.

Another significant datum resulting from the Likert scales analysis, is the role of emotional resonances in clinical interviews. The answers to this item (Q13) highlight a particular interest only by psychologists. This peculiarity could descend from the different aims of clinical interview.

As the primary aim of psychiatric interview is the assessment of patient's signs and symptoms to formulate a diagnosis and formulate a therapeutic program (Davies, 1997), the emotional resonances can be an obstacle for the interview.

Tab 2

*Differences between Psychologists and Psychiatrists in the questionnaire replies*

	Psychologists Medium (DS)	Psychiatrists Medium (DS)	95% Confidence interval for the difference between Medium	T
Q1	3.48(.99)	3.44(.93)	-.41, .49	.16
Q2	4.25(.83)	4.33(.83)	-.47, .30	-.42
Q3	2.77(.87)	2.63(.83)	-.26, .54	.68
Q4	3.96(.80)	4.19(.39)	-.54, .10	-1.34
Q5	4.21(.86)	4.11(.84)	-.29, .50	.51
Q6	3.39(1.02)	3.44(.75)	-.49, .38	-.23
Q7	2.68(1.04)	2.78(.84)	-.55, .36	-.42
Q8	3.79(1.00)	4.48(.58)	-1.11, .28	-3.33
Q9	4.52(.66)	4.33(.73)	-.13, .50	1.15
Q10	4.52(.63)	4.44(.57)	-.21, .36	.50
Q11	4.23(.66)	4.11(.64)	-.18, .42	.79
Q12	3.29(1.18)	3.63(.92)	-.86, .17	-1.32
Q13	4.71(.53)	3.78(.93)	-.61, 1.25	5.82***
Q14	3.75(.97)	3.41(1.18)	-.14, .83	1.39
Q15	3.53(.97)	3.44(.89)	-.36, .51	.33

\*p &lt; .05; \*\*p &lt; .01; \*\*\*p &lt; .001

As regards the list of competencies that both professional categories believe essential in a clinic interview (Tab.3), *chi square* analysis highlights significant data.

“To build a therapeutic alliance” (C9), “Re-build family history and social relationships” (C24), “Build an empathic relationship with the patient”(C2) are indicated by most of the sample as fundamental skills. We hypothesize that for both groups, building an empathic relationship and a strong therapeutic alliance is a priority to reach clinical goals. “C24” seems to be important for both groups in order to collect symptoms’ history, find patient’s resources as well as investigate the relational factors that influence the therapy.

Another significant datum concerns the C20 item (“Promote conflicts’ resolution”) neglected by the entire sample. We assume that this competence is considered not cogent with the aims of a psychotherapeutic process.

Some data, C3 (“Manage changing processes”) and C4 (“manage moments of therapeutic impasse”), highlight the emphasis given by psychologists to the different steps of a therapeutic process. On the contrary, “Evaluate the necessity of a pharmacotherapy”(C29) is important only for psychiatry trainees.

A statistically significant difference emerges in C1 (“Communicate clearly with the patient”), that shows a higher value by psychologists. This datum can be partly explained by the composition of the psychologists’ group, which is mostly composed of trainees in systemic- relational psychotherapy. The theoretical orientation of systemic training gives, in fact, much importance to the role of communication (Watzlawick et al.,1971).

DOI: 10.23823/jps.v1i1.8

At last, another significant element regards the C8 item (“Evaluate of patient’s motivation and eligibility to therapy”) selected by 30% of the sample and mostly by psychologists (37.5% vs 15% of physicians). We suppose that psychologists, more often than psychiatrists, think that the patient’s personal motivation to a therapeutic process is a prerequisite for building a therapeutic alliance.

Tab 3  
*Differences Between Psychologists and Psychiatrists in the selection of skills*

	Psychologists Medium (DS)	Psychiatrists Medium (DS)	95% Confidence interval for the difference between Medium	T
C1	0.55 (.50)	0.33 (.48)	-.01, .45	1.90*
C2	0.50 (.50)	0.59 (.50)	-.33, .14	-.78
C3	0.18 (.39)	0.00 (.00)	.03, .33	2.39**
C4	0.18 (.39)	0.00 (.00)	.03, .33	2.39***
C5	0.04 (.19)	0.04 (.19)	-.09, .09	-.03
C6	0.09 (.29)	0.04 (.19)	-.07, .17	.85
C7	0.14 (.35)	0.41 (.50)	-.45, .07	-2.78***
C8	0.36 (.48)	0.15 (.36)	.00, .42	1.99***
C9	0.70 (.46)	0.89 (.32)	-.39, .01	-1.94***
C10	0.18 (.39)	0.19 (.40)	-.19, .17	-.072
C11	0.04 (.19)	0.00 (.00)	-.04, .11	.99*
C12	0.25 (.44)	0.15 (.36)	-.09, .29	1.05*
C13	0.16 (.37)	0.15 (.36)	-.16, .18	0.15
C14	0.05 (.23)	0.07 (.27)	-.13, .09	-.36
C15	0.11 (.31)	0.04 (.19)	-.06, .20	1.07*
C16	0.04 (.19)	0.04 (.19)	-.09, .09	-.03
C17	0.02 (.13)	0.00 (.00)	-.03, .07	0.69
C18	0.16 (.37)	0.19 (.40)	-.20, .15	-.28
C19	0.00 (.00)	0.07 (.27)	-.14, .00	-2.09***
C20	0.00 (.00)	0.00 (.00)		
C21	0.11 (.31)	0.19 (.40)	-.24, .08	-.98
C22	0.05 (.23)	0.07 (.27)	-.13, .09	-.36
C23	0.16 (.37)	0.00 (.00)	-.02, .30	2.25***
C24	0.38 (.49)	0.56 (.51)	-.42, .05	-1.56
C25	0.09 (.29)	0.11 (.32)	-.16, .12	-.31
C26	0.02 (.13)	0.04 (.19)	-.09, .05	-.52
C27	0.50 (.50)	0.37 (.49)	-.10, .36	1.10
C28	0.04 (.19)	0.00 (.00)	-.04, .11	0.99*
C29	0.00 (.00)	0.30 (.46)	-.42, .17	-4.80***
C30	0.04 (.19)	0.00 (.00)	-.04, .11	0.99*

\*p < .05; \*\*p < .01; \*\*\*p < .001

In conclusion, this study contributes to focus theoretical as well clinical features that distinguish the theoretical roots and the managing of the clinical interview as well as the therapeutic process by –mental health professionals psychologists in psychotherapeutic training and physicians in psychiatric training.

Nevertheless, our study is limited by some bias. First, the psychologists’ sample is mainly composed of systemic trainees, it should be more homogeneous as regard the psychotherapeutic models. Secondly, the ad hoc Likert Scale is not validated, bestowing validity only to the descriptive analysis. Finally, our competences list, is only borrowed by the EAP and FIAP position papers whereas the specific literature embraces other points of view on this specific issue. Further studies are needed to explore the topics here investigated.

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DOI: 10.23823/jps.v1i1.8

Appendix 1



Instructions for completing the questionnaire

*Dear colleague, we are conducting a research that explores the basic skills that the mental health professionals consider essential for conducting clinical interview with the patient.*

*We encourage you to answer the following anonymous questionnaire.  
Thanks for collaboration!*

Registry Datas

Age: \_\_\_\_\_

Sex:      F      M

Training Datas

Degree:

Psychology     

Physician     

University of Degree: \_\_\_\_\_

Degree Course : (ex: "Degree in...") \_\_\_\_\_

Master degree:

No

In progress

Psychotherapy: 1°    2°    3°    4°

Name of Master Degree School: \_\_\_\_\_

Psychiatric: 1°    2°    3°    4°    5°

Master yet obtained

Ear of degree: \_\_\_\_\_

Other specializations obtained post lauream: \_\_\_\_\_

Questionnaire

*On a scale from 1 to 5 say your agreement with these items:*

- 1. Strongly disagree    2. Slightly agree    3. Indifferent    4. Strongly agree    5. Total agree

DOI: 10.23823/jps.v1i1.8

- 1) The description of patient's symptoms conditions my conduction of clinic interview 1 2 3 4 5
- 2) Exploring symptom's story (debut, course, recurrences, therapeutic treatments, recoveries) is essential for diagnosis 1 2 3 4 5
- 3) In conducting clinic interview is necessary to focus on patient's past 1 2 3 4 5
- 4) Evaluate the patient's cognitive abilities(wakefulness,orientation in time and space, cognitive functions) is essential for diagnosis 1 2 3 4 5
- 5) It's necessary to observate patient's nonverbal behaviour (posture, gestures, look) to make the diagnosis 1 2 3 4 5
- 6) Physical aspect, clothing and attitude to the interlocutor must condition the diagnosi's formulation 1 2 3 4 5
- 7) It's fundamental to formulate a nosographic diagnosis of the patient according to DSM or ICD 1 2 3 4 5
- 8) It'essential to collect information about patient's general health state 1 2 3 4 5
- 9) It's always necessary to explore familiar relationships in a clinical interview 1 2 3 4 5
- 10) It's necessary to explore patient's current social relationships in a clinical interview 1 2 3 4 5
- 11) It's necessary to consider patient's opinion about his sympotms 1 2 3 4 5
- 12) It's necessary to join with the patient my own diagnostic evaluation 1 2 3 4 5
- 13) It's necessary to consider my emotional resonances during the interview 1 2 3 4 5
- 14) Clinical interview's context (public or private) conditions the clinical interview 1 2 3 4 5
- 15) This questionnaire describes core competencies to conduct a clinical interview 1 2 3 4 5

*Here are listed 30 professional competencies about therapeutic process borrowed from criteria recognized by EAP (European Association for Psychotherapy) and FIAP (Federazione Italiana delle Associazioni di Psicoterapia). You're asked to*

DOI: 10.23823/jps.v1i1.8

*choose 5 competencies (marking with an "x") you think are essential for the therapeutic practice.*

- Communicate clearly to the patient
- Build an empathic relationship with the patient
- Manage changing processes
- Manage therapeutic moments of empassé
- Evaluate the drop out
- Use psychodiagnostic instruments
- Recognize signs and symptoms of mental illness in the patient
- Evaluate patient's motivation and idoneity to the therapy
- Build a therapeutic alliance
- Facilitate emotions'expressivity and elaboration
- Take note and/or register interviews
- Operate according to ethical and deontological principles
- Considerate patient's culture and values
- Know how to sign a therapeutic contract
- Evaluate patient's defensive mechanisms
- Maintain a therapeutic neutrality
- Use interpretations
- Consider tranfert and controtransfert
- Give advice, tips and information to the patient
- Promote conflict resolution
- Promote insight in the patient
- Work through patient's dreams and fantasies
- Formulate a relational diagnosis
- Re-build patient's familiar story and social relationships
- Identify recurrent relational styles
- Identify recurrent cognitive patterns
- Recognize and evaluate patient's resources
- Explore attachment styles
- Evaluate the necessity of a pharmacotherapy
- Evaluate the opportunity to send the patient to another therapist or another type of therapy