KEY COMPETENCIES OF THE PSYCHODYNAMIC PSYCHOTHERAPIST AND HOW TO TEACH THEM IN SUPERVISION

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Four of Rodolfa et al.'s (2005) competencies in professional psychology—relationship, self-reflection, assessment-case conceptualization, and intervention—are key for the psychodynamic psychotherapist. Relationship lies at the heart of what is understood to be curative about psychodynamic psychotherapy. Self-reflection implies a complex and highly developed process that includes but goes beyond Rodolfa et al.'s and Kaslow, Dunn, and Smith's (2008) definitions. Competent assessment, diagnosis, and case conceptualization entails making inferences about unconscious processes by observing the client and also one's own experience, and integrating these inferences with theory. Effective psychodynamic intervention is derived from what the psychotherapist has experienced, processed, and conceptualized about the relationship with the client and about the client's internal object world. An extended vignette shows these competencies emerging in a psychotherapist-in-training, facilitated by an intense interaction with a supervisor. Although the supervisory and clinical tasks are different, the supervisor provides a relationship experience that models these same competencies for the supervisee and catalyzes their development in the supervisee.

Keywords: psychodynamic, supervision, relational, competencies

Challenges of This Task

The project of defining core psychotherapeutic competencies, undertaken in this Special Section of *Psychotherapy,* is an important one, although challenging from a psychodynamic perspective. Tuckett (2005) put the problem well in a paper that attempted to remedy the lack of a broadly accepted method of evaluating psychoanalytic candidates. He asked, How does one "develop a transparent frame work based on an empirically supported demonstration of analytic capacity" (p. 31) that is also sensitive enough and subtle enough to satisfy the psychoanalysts who would be called on to apply it? Any such framework "needs to take cognizance of the twin facts that there is more than one way to practice psychoanalysis and that it is necessary for the legitimacy of the field to avoid an 'anything goes'" stance (p. 31). For Tuckett this meant finding "good enough" indicators of competent psychoanalytic practice, indicators that are both broadly defined and well selected that they can even be agreed to by psychoanalysts who work from a variety of different psychoanalytic models.

Tuckett's (2005) solution to this problem is directly relevant to my task. He evaluated a psychoanalyst's functioning in terms of his or her capacity to sustain three linked "lenses" or "frames." He called these the participant-observational, the conceptual, and the interventional frames. These three frames find common ground with four of the competency dimensions recently defined within professional psychology.

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For Tuckett (2005), the participant-observational frame[1] referred to "the way the analyst is with the patient" (p. 37), and emphasized the analyst's capacity to bear and process, rather than act on, the emotional states that the patient evokes within her or him. The capacity to sustain a participant-observational stance is closely related to two foundational competencies in the professional psychology literature. The first is relationship, defined as the "capacity to relate effectively and meaningfully with individuals, groups, and/or communities"[2] (Rodolfa et al., 2005, p. 351). The second is self-reflection, a component of "reflective practice" (Kaslow, Dunn, & Smith, 2008).

For Tuckett (2005), a psychoanalytic psychotherapist's second crucial capacity was the ability to manage what he called the conceptual frame. This frame "concerns the specific ability to conceptualize clinical experience" (p. 41) by identifying the transference and countertransference and the development of an analytic process. This frame is similar to Rodolfa et al.'s (2005) functional competency assessment and diagnosis-case conceptualization, defined as "assessment and diagnosis of problems and issues associated with individuals, groups, and/or organizations" (p. 351).

Tuckett's (2005, p. 43) third frame was the capacity to sustain an interventional frame, that is, to intervene in a way that is consistent with the psychoanalyst's participant-observational stance and his or her conceptualization. This frame corresponds closely to Rodolfa et al.'s (2005) functional competency intervention, defined as "interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations" (p. 351).

I consider relationship, self-reflection, assessment and diagnosis, and intervention—from among the complete list of foundational competencies (reflective practice-self-assessment, scientific knowledge-methods, relationship, ethical-legal standards-policy, individual-cultural diversity, and interdisciplinary systems) and functional competencies (assessment, intervention, consultation, research-evaluation, supervision-teaching, and management-administration) defined by Rodolfa, et al.—to be key for a psychodynamic model of psychotherapy.

For me as a relationally[3] oriented psychoanalyst, primary among these four closely intertwined competencies is relationship. Recent research relating the process of psychodynamic psychotherapy to its outcome shows why prioritizing relationship competency makes good empirical sense. Silverman (2005) for example, in discussing the findings of an American Psychological Association task force on evidence-based practice pointed out that treatment conditions are not in themselves reliable predictors of outcome because the level of relationship skill of the person who is conducting the treatment matters so much:

A pure ingredient (an interpretation, for example) cannot be assumed in psychotherapy because it always exists in the context of the therapeutic relationship . . . [any effort to "manualize" psychotherapist activity] eliminates from consideration the important fact of variability in efficacy of the individual psychotherapists within the same treatment condition. (pp. 308–309)

Similarly, Orlinsky, Grawe, and Parks's (1994) meta-analysis of hundreds of psychotherapy process-outcome studies concluded that a good psychotherapeutic relationship—more than any particular form of intervention—was the strongest predictor of positive outcome.

And yet, it is hard to define exactly what an effective and meaningful psychodynamic psychotherapeutic relationship consists of. Ablon and Jones (2005), summarizing the results of their intensive quantitative study of two cases of psychotherapy, provided evidence for the claim that each "good" psychotherapeutic relationship has its own qualities. They observed, "each analytic pair has a *unique interaction pattern* [emphasis added] linked to treatment progress" (p. 541). Orlinsky et al. (1994) distilled from their meta-analysis a list of relationship qualities, which when perceived in psychotherapists by their clients predicted successful treatment outcome. These included being experienced by the client as "empathic, affirmative, collaborative

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[1] Aspects of this capacity are also variously referred to in the psychoanalytic literature as maintaining an analytic attitude, containing and metabolizing projective identifications, creating a holding environment, and working in the countertransference.

[2] In this paper, for simplicity, I am limiting myself to discussing individual psychodynamic psychotherapy, and not addressing group or family intervention. Of course, I am not addressing work with organizations or communities either.

[3] I use the descriptor "relational" broadly to refer to all psychotherapeutic approaches that emphasize the two-person nature of the psychotherapeutic enterprise and the importance of both interpersonal relationships and internalized object relations in understanding clients and their problems.

and self-congruent (p. 361)." However, Orlinsky et al.'s list cannot answer a question that immediately arises when one looks at the psychotherapeutic dyad from an intersubjective perspective: "What does this psychotherapist need to do with this client before the psychotherapist can be experienced as having these attributes?" In fact, many clients require significant psychotherapeutic work with their negative reactions to their psychotherapist, as well as significant specific adjustments in style from their psychotherapist, before they can experience that person as empathic, affirmative, collaborative and self-congruent, and thus solidify a meaningful working alliance (Bordin, 1979). Given the challenges of speaking in general terms about something as individualized as a relationship-based approach to treatment, I chose to build my discussion around a particular clinical and supervisory vignette, condensed and edited from Frawley-O'Dea and Sarnat *The Supervisory Relationship* (2000, pp. 118–122). In this vignette, taken from the middle of a 12-week supervision of a short term psychodynamic psychotherapy, I show how a trainee begins to develop relationship, self reflection, assessment, and interventional competencies. I also try to show how the supervisory relationship contributes to that process.

Clinical and Supervisory Vignette[4]

Lisa was confident in her skills in crisis intervention but felt unsure of herself as she started seeing clients in brief psychodynamic treatment for the first time. Knowing something about my psychotherapeutic and supervisory approach, her request was for assistance in identifying and using countertransference. During our first five supervisory sessions, however, Lisa seemed to need concrete help in getting started with clients, and my interventions were largely didactic and supportive.

In the sixth supervisory week countertransference issues became "hot." Lisa looked distraught as she entered my office and told me that she had begun to feel intensely critical of her psychotherapeutic work. Listening to tapes of her psychotherapy sessions was now excruciating because she was increasingly aware of her incompetence in conducting psychodynamic psychotherapy. Specifically, Lisa worried that she had done damage to one of her clients, a young adult woman who suffered from depression and loneliness. During their most recent session, when Lisa's client had observed that she often pushed people away, Lisa disclosed that she herself had felt pushed away by the client in their first session. Tearfully Lisa reported that her worries about this self disclosure had intensified when she was subsequently "criticized" by another supervisor over another intervention with a different client. Lisa, who herself was in psychotherapy, told me that she felt like "an omnipotent 2-year old who thinks she can destroy

everything," and added that she had been realizing that she had felt too powerful as a child in her family.

I listened sympathetically, neither encouraging her to disclose further nor cutting short this emotional outpouring. I then told her that her anxiety about her power in her new role, and her uncertainties about how to use her power, were understandable, but that it wasn't clear that her actual intervention had been destructive. Lisa agreed and seemed to calm down, but then told me that she had just turned my comment into self-accusation, deciding that I was telling her she was "over-reacting" and "making too big a deal" of her feelings. Lisa added that her reaction reminded her of how her parents had responded to her distress—by shaming her for expressing it. Now, she added, with a note of despair in her voice, she did not feel able to contain her client's upsets, and she worried that it might be years before she worked this problem out in her own psychotherapy. Maybe she wasn't emotionally cut out for this work? I tried again to address Lisa's anxiety, reminding her that she was a beginner trying to learn a difficult job, and this time I added something about my own struggles as a beginning psychotherapist.

Lisa's mood shifted as she now spoke with more self-compassion about how she was expecting so much more of herself than she had when doing crisis work. She said that she did not want to go back, but that this new experience was destabilizing all the same.

I then observed that Lisa had seemed to think she should be able to manage her own and her client's intense anxieties by herself, which was an unrealistic self-expectation at this stage in her training, and perhaps at any stage. Had Lisa thought of calling me during this difficult week? Lisa said that she had wanted to, but thought I might be annoyed with her for "overreacting." "Like your parents?" I asked with a smile, and Lisa agreed with a laugh. She seemed relieved and commented as she left the supervisory meeting that actually she didn't think she was doing so badly in her hours, despite her anxiety.

In the next supervisory meeting, Lisa described how her client had raged at her for abandoning her. Indeed the client had suffered several disappointments, including Lisa's failing to persist in returning her client's between-sessions phone call. Although this client had previously behaved in a dismissive way toward Lisa, no-showing more than once and not returning Lisa's calls, unbeknown to Lisa her client's situation had suddenly changed: She had just been rejected by her lover.

Lisa said that during the hour she had become aware of a new capacity to sit with her client's upset and angry feelings, despite the anxiety that her client's distress and accusations evoked in her. Lisa said she felt she could understand from the inside what her client was feeling and was touched that her client had taken the risk of expressing it to her. Lisa told her client how sorry she was that she hadn't kept trying to reach her, but also told her client that she had actually not "gotten it" that her client really needed something from her. Lisa's client was moved and responded, "I had been pushing you

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[4] Adapted from *The Supervisory Relationship* (pp. 118–122) by M. G. Frawley-O'dea & J. Sarnat, 2000, New York: Guilford. Copyright 2000 by Guilford Publications. Reprinted with permission.

away, hadn't I?" Lisa responded, "I wish I had understood how vulnerable you were making yourself by calling me at that moment. If I had, I would have been more persistent in trying to get back to you." At this the client began sobbing, and said that she now realized this was the kind of reaction she had longed for from her mother. Lisa told me that she had been moved, and that she felt that she was beginning to understand how psychodynamic psychotherapy works.

Key Foundational and Functional Competencies for Psychodynamic Psychotherapy

In this vignette, Lisa participates with her client in an enactment: The client misses sessions and treats Lisa as if she is not important to her, and Lisa reacts by failing to persist in returning her client's latest call. After her supervisor responds to Lisa's feelings of guilt, self doubt, and anxiety, Lisa displays new relationship, self-reflection, assessment, and intervention competencies. In what follows, I offer a formulation of how the supervisory process may have contributed to the emergence of psychotherapeutic competence in Lisa. First we need to define what each of these competencies involves for a psychodynamic psychotherapist.

Salient Foundational Competencies

The simultaneous emergence of the foundational competencies relationship and self-reflection is illustrated here. From a psychodynamic perspective, Lisa is learning to maintain a participant-observational frame (Tuckett, 2005). The two competencies are difficult to disentangle from one another, but for the purposes of this paper, I will try to describe each separately.

Psychodynamic psychotherapy, like all psychotherapeutic approaches, demands relationship competencies such as creating an alliance, titrating client anxiety, and facilitating client attachment. However, because a psychodynamic psychotherapist views the relationship as the crucible of psychotherapeutic change, not just as a preliminary to effective intervention, relationship competency implies developing relationship skills that go beyond these capacities. In the example, Lisa becomes immersed within and then begins to transform the subtle, multilayered, coconstructed, conscious, and unconscious patterns of anxiety, defense, and enactment that emerge in their relationship. She develops the capacity to maintain emotional contact with her

client although under the pressure of intensely difficult feelings. Lisa is thus able to engage with her client in a new way when her client becomes open to doing so. They then create together an alternative to the dismissive attachment pattern that this client had probably repeated in many relationships, and that was very likely connected to her presenting problems of loneliness and depression. Before Lisa could participate in the psychotherapeutic relationship in this new way, she needed to accept her failure to persist in calling back her client. Her ability to do so may have been facilitated by her interaction with a supervisor who helped her to mitigate her self criticism.

I believe that this example shows what a complex and highly developed process the term *self-reflection* implies for a psychodynamic psychotherapist. Rodolfa et al. (2005) defined *reflective practice-self-assessment* as "practice conducted within the boundaries of competencies, commitment to lifelong learning, engagement with scholarship, critical thinking, and a commitment to the development of the profession" (p. 351). From a psychodynamic perspective, however, self-reflection competence, requires a highly developed capacity to bear, observe, think about, and make psychotherapeutic use of one's own emotional, bodily, and fantasy experiences when in interaction with a client. In this vignette, Lisa needed to tolerate difficult affects in the psychotherapeutic and supervisory relationships, including feelings of anger, destructiveness, guilt, need, and dependence, in both herself and her client. She also needed to tolerate awareness of how both she and her client defended against vulnerability. Catalyzed by interaction with her supervisor, Lisa is here developing competence in establishing internal and relational feedback loops that lead, over time, to significant changes in functioning. Continually finding, losing, and then refinding the capacity for participant observation is a challenge that indeed requires a commitment to lifelong learning.

Kaslow et al.'s (2008) further break down of reflective practice-self-assessment into the components of self-reflection and self-care is also relevant here. The fact that Lisa brought her distress to her supervisor means that she is also developing self-care competency. It is apparent in the vignette that without supervisory assistance Lisa might have remained anxious and depressed and therefore might have been handicapped in

working effectively with this client and possibly with others. Self-care competence includes eventually developing the capacity to honor and feel compassion for ones own needs/feelings/ emotions even when consultation is not immediately available.

Salient Functional Competencies

The two functional competencies that are most salient for dynamic psychotherapy, assessment-diagnosis-case conceptualization and intervention, are also salient, of course, for other forms of psychotherapy. However, within a psychodynamic model, these terms imply very particular activities.

Assessment considers the whole person of the client, beyond specific symptoms, and includes his or her conscious and unconscious conflicts, internalized relational patterns, interpersonal patterns, and defenses. Conceptualization means formulating an understanding of the client that is based not only on the client's actions, affects, avoidances, self-reports and history; but also on the affective, fantasy, and somatic responses that are evoked within the psychotherapist. All of this material is integrated into a coherent-as-possible and ever-evolving formulation, with the help of psychodynamic concepts. Conceptualization both contributes to and is a product of an analytic frame of mind, and to be affective, must be more than just a coherent narrative. It must also have a ring of truth and emotional immediacy (Tuckett, 2005).

One might assume that intervention from a psychodynamic point of view means primarily interpretation. From a relational perspective, however, the distinction between interpretation and relationship participation is understood to be an arbitrary one, and insight and change are understood to result from both. How one conducts the psychotherapeutic relationship—the nuance of what one says and does with the client, and how and when one says and does it—always has interpretive implications, and all interpretations are equally understood to be actions taken in the relationship. Ablon and Jones (2005), referencing a 1993 report by Fonagy, Moran, Edgcumbe, Kennedy, & Target, commented on this intertwining of the two in discussing the results of their study of psychotherapy process and outcome. They said,

> insight and relationship have complementary roles, since psychological knowledge of the self can develop only in the context of a relationship within which the psychotherapist endeavors to understand the mind of the patient through the medium of their interaction. (Ablon & Jones, 2005, p. 564–565)

How one intervenes—that is, how one participates in the relationship and how one interprets unconscious material—springs directly from the clinician's working conceptualization. Ideally, he or she intervenes only after becoming able to bear the transference/ countertransference situation, and avoids reacting directly out of it. Sometimes silence is the intervention of choice. The inversion of a familiar saying comes to mind: "Don't just *do* something. *Sit* there!" "Sitting there" implies, again, the self-reflective capacity to move from reactivity to thinking, formulation, and creating a thoughtful and well-metabolized intervention. In theory, if a psychotherapist is in an analytic frame of mind, an intervention will tend to be well-timed and useful to the client because it will arise naturally from the psychotherapist's unconscious link to the client.

Tuckett (2005) offered a list of general criteria for evaluating a psychoanalyst's capacity to intervene. These are criteria that he believed would be agreed to by psychoanalytic practitioners of most persuasions. They are: balancing affect and intellectual illumination, appropriateness of timing and appropriate emotional level, whether the intervention furthers the analytic process, whether it addresses the here-and-now of the transference, and whether it elaborates unconscious relationships within the patient's mind (p. 43). Notably, each of these criteria includes relationship competence elements, and it is a list that I can indeed endorse. I might merely add that "addressing the here and now of the transference" should be broadly defined to include the kind of intervention Lisa made in her second hour. There she spoke from within the transference/ countertransference situation ("Lisa told her client . . . that she had actually not 'gotten it' that her client really needed something from her") rather than making interpretations about it (something such as "You were defending yourself by acting as if you didn't need anything from me and so what you needed was not clear").

In the vignette, Lisa is struggling with the appropriate use of self-disclosure as a psychodynamic intervention. Despite Lisa's anxiety about the destructiveness of her initial countertransfer-

ence disclosure, after reflecting on that anxiety in supervision, Lisa made a second countertransference disclosure in the next clinical hour. When Lisa told her client about her regret at having failed to call back, she expressed her feelings in an authentic manner that was well-timed and dosed, and she succeeded in reaching her client emotionally. The helpfulness of this intervention was confirmed when the client tearfully observed that she was having the kind of experience with Lisa that she wished that she had had with her mother. The client here developed a new insight: She came in touch with her disappointment in her mother, something that she had apparently been, until then, unable to know about.

As supervision and psychotherapy progressed, I would want Lisa to learn to reflect on what led her to make a particular intervention, why a particular intervention worked or did not, and how her intervention's impact might be understood in theoretical terms. However, I would hope that developing such conceptual competence would not interfere with her demonstrated capacity to make intuitive unconscious links to her clients and thus to make well timed and dosed disclosures.

Teaching Psychotherapy Competencies in Supervision

The vignette and commentary in the previous sections have already illustrated a good deal about my supervision approach. The first several weeks of this supervision had been primarily didactic in tone. In the presented supervisory hour, however, my interventions with Lisa rested heavily on my clinical understanding and my application of clinical technique in the service of teaching and learning.[5] First, I provided emotional containment to Lisa—listening, processing my emotional reactions internally, and responding to her distress with an analytic attitude, thus exercising clinical relationship, self-reflection, and conceptualization competencies. I was working to create a supervisory relationship into which Lisa could safely bring intense affective states, and where we could do psychological work with those states. Creating this kind of supervisory environment is essential to supporting the development of a supervisee's capacity to bear the emotional intensity of the psychotherapeutic relationship and to learn from that experience.

I also intervened to help Lisa with her tendency toward self-attack. I first attempted to normalize her struggles. When that did not suffice, I told a story about my own.[6] Finally, I connected Lisa's fears of how I would react to what she had just told me about her childhood experience, asking, "Like your parents?" Here I clarified an aspect of her negative transference to me because I thought that Lisa's projection of her internalized parents' judgmental feelings on to me was threatening her feeling of safety in our relationship (assessment-case conceptualization), and required active challenge. Rather than merely reassuring her, I made a kind of interpretation. In so doing, I invited her to self-reflect. I did not, however, invite her to elaborate further on the historical origins of her concerns, or her relationship with her parents, or her fantasies about me, keeping my focus on the here-and-now impediments to our supervisory alliance and on helping her with her client. By staying with the supervisory task, I believe that despite the clinical nature of some of my interventions, I honored the teach/treat boundary, modeling ethical-legal competency, another foundational competency that is of universal importance for clinicians.

In the second clinical hour, Lisa showed a capacity to bear her client's negative affect while staying empathically connected to her. She developed this competence without having received any explicit supervisory coaching, but rather as a response to my bearing and helping her to process her own affects. In my experience, supervising in a way that offers to the supervisee the qualities one is trying to teach is a powerful intervention that contributes to the development of psychotherapeutic competency.

I often use experiences in supervision to teach clinical theory, but only after the crisis has passed and the supervisee's anxiety has diminished (relationship and assessment-case-conceptualization competencies). In this case we might discuss such concepts as unconscious transference/countertransference enactment, resistance, defense, parallel process, holding, and

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[5] See Frawley-O'Dea and Sarnat (2000) for a discussion of the complexities of the ethical use of clinical thinking and intervention in the service of teaching.

[6] In my view, the indications for supervisor anonymity are often different than for a psychotherapist. See Frawley-O'Dea and Sarnat (2000) for a discussion of supervisor disclosure.

Bion's (1962) concept of container/contained. We would discuss each concept as it came alive in our shared experience. By integrating theory with experience in supervision, my hope is that my supervisee will feel that theorizing can provide containment in the midst of turbulent relational events, rather than being a primarily intellectual activity.

In my approach to teaching conceptualization I draw on a variety of psychoanalytic theories, treating them as lenses through which the same experience may be understood differently. I also try to offer a range of intervention possibilities, rather than teaching technique as received wisdom. When I suggest possible interventions as I listen to an hour, I point out that such interventions are based on who I am and how I work (self-reflection). I acknowledge that I cannot know the client as intimately as my supervisee does (case formulation), and that because I am not in the room with them, I cannot know as well as the supervisee does what words would fit best (intervention).

One other form of intervention that is crucial to my way of supervising deserves mention here, although it does not arise in this vignette: The supervisor's explicit acknowledgment of her own unconscious contribution to the supervisory relationship (Sarnat, 1992). Here again the medium is the message as the supervisor's willingness to be known as a participant as well as an observer demonstrates something about how to be a participant observer in the psychotherapeutic situation. In this vignette we do not take up my unconscious participation in the here-and-now of our supervisory relationship, nor do I disclose any of my immediate reactions to my supervisee. This was a moment of crisis, and at such a moment I prioritize helping the supervisee to work with the client. I also do not want to interfere with an idealization of me when my supervisee is anxious and needs to think of me as "the one who knows" to reduce her anxiety (assessment-case conceptualization). Although I do, therefore, sometimes let idealization stand, I try to stay silently in touch (self-reflection) with my human limitations and the reality that I have my own anxieties and defenses (Slochower, 2009). Unless a supervisor can do so, supervisees are at risk for being made to feel that they are the sole source of difficulties that emerge in the supervisory relationship. Shame and anxiety will then prevent them from bringing in the problems with which they most need and want their supervisor's help.

However at some point in most of my supervisory relationships I find it helpful and even necessary to process my unconscious participation with my supervisee. These moments can be opportunities to model another competency that is important, in my view, in both a psychodynamic psychotherapist and supervisor. That is, to receive negative feedback without responding either defensively or with self-attack, and to accept one's human frailties (self-reflection). One may then, one hopes, find oneself in a position to use the experience for the benefit of the client or supervisee, as well as for oneself.

Conclusions

Drawing on Tuckett's (2005) work on assessing competency in psychoanalytic candidates, I selected four of Rodolfa et al.'s (2005) competencies in professional psychology as key for the psychodynamic psychotherapist. I tried to show through an extended vignette how these four—relationship, self-reflection, assessment-case conceptualization, and intervention—emerge in a psychotherapist-in-training, and how the emergence of competence is facilitated in relationship with a psychodynamic supervisor. Although the supervisory and clinical tasks are different, the supervisor demonstrates competencies in supervising that are closely related to those she is striving to develop in her supervisee.

References

ABLON, S., & JONES, E. (2005). On analytic process. *Journal of the American Psychoanalytic Association, 53,* 541–568.

BION, W. (1962). A theory of thinking. In *Second Thoughts,* pp. 110–19. Northvale, NJ: Aronson, 1993.

BORDIN, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapay: Theory Research and Practice, 16,* 252–260.

FRAWLEY-O'DEA, M. G., & SARNAT, J. (2000). *The supervisory relationship: A contemporary psychodynamic approach.* New York, NY: Guilford Press.

KASLOW, N., DUNN, S., & SMITH, C. (2008). Competencies for psychologists in academic health centers. *Journal of Clinical Psychology Medical Settings, 15,* 18–27.

ORLINSKY, D., GRAWE, K., & PARKS, B. (1994). Process and outcome in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 270–376, 4th ed.). New York, NY: Wiley.

RODOLFA, E., BENT, R., EISMAN, E., NELSON, P., REHM, L., & RITCHIE, P. (2005). A cube model for competency development: Implications for psychology educators

and regulators. *Professional Psychology: Research and Practice, 36,* 347–354.

SARNAT, J. (1992). Supervision in relationship: Resolving the teach-treat controversy in psychoanalytic supervision. *Psychoanalytic Psychology, 9,* 387–403.

SILVERMAN, D. (2005). What works in psychotherapy and how do we know? What evidence-based practice has to offer. *Psychoanalytic Psychology, 22,* 306–312.

SLOCHOWER, J. (2009, March). *Colliding idealizations in psychoanalysis: With some thoughts about Winnicott and his patients.* Paper presented at the Psychoanalytic Institute of Northern California, San Francisco.

TUCKETT, D. (2005). Does anything go? Toward a framework for the more transparent assessment of psychoanalytic competence. *International Journal of Psychoanalysis, 86,* 31–49.