Say, Do, Learn: A Cognitive-Constructivist Psychotherapy Training Model

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We do not teach what we want to; actually, we do not even teach what we know or what we think we know: we can teach only what we are.
Jean Jaurès (1859 – 1914)

Some of the Problems of Specialized Training in Psychotherapy

The Problems of Orthodoxy

The first problem that can arise in creating a project within a specialized psychotherapy training program is what is commonly referred to with the term "orthodoxy", with respect to the proposed clinical model. The problem arises primarily in psychoanalytic contexts in relation to the standard procedure which foresees that the analyst in training undergo preliminary personal analysis. This analysis is not only part of the process of "overcoming one's own neuroses", but also often takes on the meaning of identification with one's own training analyst and with his or her style of conducting the therapeutic process. In this light, the assumption of the role of psychotherapist should therefore be contingent upon the internalization of the working methods used by one's own training analyst, reinforcing the sense of identification with the structure of one's specific professional field. In the context of this sort of training model, therefore, particular attention is paid to technique and to the trainees' capacity to acquire and replicate the same technique even with their future patients, exactly as it was learned during their own analytical relationships.
More in general, however, considering a call to orthodoxy as one of the most important objectives in the training process leads – and has historically led – to both inflexible conformism and intellectual stasis within the school of reference (demonizing innovative initiatives towards possible theoretical developments); this also leads to a way of sharply contrasting one's own model with the ideas and proposals that come from different or competing theoretical approaches.
A possible alternative to orthodoxy cannot be found, in our opinion, within the contexts of *Technical Eclecticism* or *Theoretical Integration*. The first approach, which proposes that one should openly choose techniques from different orientations, easily leads down the slope of methodological approximation as it does not give sufficient consideration to the fact that each single technical element is validated when it is inserted into a uniform project that is guided by an internally-coherent strategy, by homogeneous language, and by a theory that justifies the conceptual choices made. The second approach mentioned can be seen as an "ambitious utopia" that, at least in the proposals formulated until now, ends up doing little more than defining oversimplified models that are often conceptually confused and rarely take into account the complexity of human psychological functioning (Cionini, 1998).
The alternative to these three approaches (orthodoxy, eclecticism and integration) in a training context, in our opinion, is to propose that trainees use a framework of the

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epistemological, theoretical and methodological foundations of psychotherapeutic practice that characterize one's specific clinical model. This framework must be sufficiently "precise" to enable therapeutic action that is consistent with these same presuppositions and, at the same time, consist of "sufficiently broad frames" that allow it to be applied and personalized to the individual, distinctive characteristics of the trainee.
If we start from the presumption that the psychotherapeutic process is essentially a process focused on relationships and on the personal and emotional implications that can be at play within these relationships, then we must provide a general style for the clinical approach that is consistent with the proposed theoretical model. This style can subsequently be personalized to the individual characteristics of the trainee-therapist, and integrated with the needs determined by each therapeutic relationship, in all its unique particularities. This kind of approach can both promote personal creativity in responding to practical problems that arise from practicing psychotherapy, and also bring forth new ideas that, over time, can even lead to theoretical developments of the model itself.
In any case, it is thanks to the gradual decrease in requests for orthodoxy over the past few years that we have been able to witness the slow and gradual abandonment of rigid barriers and stark contrasts (or as some call them, the "religious wars") between psychotherapists of different orientations that made any type of dialogue or interchange extremely difficult. The turmoil and developments that have arisen within all existing orientations, and that have lead to their progressive complexification and flexibilization, and the recognition of the substantial effectiveness of psychotherapy in and of itself (when conducted in an appropriate manner consistent with its specific premises) have lead to a slow and gradual process of relative reciprocal reconciliation, to exchanges and communication that were heretofore unimaginable, and to a substantial reciprocal legitimization, while still maintaining diversity.

The Protagonists in Training

Closely tied to this first problem, it is possible to posit another problem that more directly concerns the ways in which we organize didactics and that can be understood by asking the following questions. Is it better that training be carried out by a plurality of teachers who, although they may share the same macro-clinical model (psychoanalytical, cognitive, systemic, Gestalt etc), have their own, widely different working styles and ways of interpreting this model, leaving trainees the freedom of choosing themselves what feels most appropriate for their own style? Or is it more advisable that a smaller number of teachers present a more unified work method (even with their own unavoidable individual differences) that defines the framework mentioned above, initially encouraging the trainees to "find themselves" within the framework, and then later to assimilate and interpret the framework in relation to their own personal characteristics?
Our choice is to lean heavily in the direction of the second scenario. It is certainly more reassuring for the trainees – and presumably more efficient from a didactic point of view – to offer, in the first phase of the training process, precise indications on how they should behave in their relationships with the other and, then, later help them to interpret and give meaning to their own way of interpreting their professional role. This facilitates the process of developing one's own personal style and fosters creativity, a characteristic that is indispensable for an effective psychotherapist as it helps him or her to more easily deal with new and unpredictable situations within clinical relationships.

On a practical level, the choice between these two options also inevitably leads to a different number of teachers entrusted with the "practical training" of the trainees.
In the first instance, during the four years of training the trainees must come into contact with a high number of teachers, each of whom presents their own particular way of interpreting the theoretical and epistemological principles of the macro-model that characterizes the School. The trainees should be supported by one or two teachers (it is common practice in the schools that follow this model to have co-teachers fill this role) who

will assist them in comparing and coordinating the various methods of conducting the therapeutic process that have been presented.
In the second instance, the "practical training" must be entirely carried out by a smaller number of teachers (no more than two or three) who, by using a more homogeneous clinical approach, can provide an experience with more internal congruence, without however running the risk of excessive monolithicity (as might happen with a single teacher). Co-teachers assigned to follow trainees throughout their practical training in this case take on the role of facilitating the comparison and juxtaposition between the various styles of interpreting the therapeutic role. These styles, while they tend to be homogeneous, are nonetheless distinguished by the inevitable personal differences of the teachers themselves. Even in this case, however, as foreseen by Italian ministerial legislation, it is useful and opportune that therapist-teachers of other orientations also participate in the training process so they can introduce theoretical and epistemological frames of reference that differ from those that characterize the school.

Learning Theory through Experience

Another problem that must be addressed (and that will be discussed in depth later on) is whether or not we should favor "knowing" or "knowing how to do" throughout the sequences of the training process, in relation to constructing "knowing how to be". Once again the question reflects a choice between at least two possible training models. The first model posits the condition of initially offering an exhaustive and well-delineated framework of the theory that represents the basis of the clinical model, emphasizing the implications on a practical level and with regard to the psychotherapeutic relationship. Only after this theory has been fully absorbed by the trainees, when the trainees come to incarnate that theory, should the trainees begin to practice the clinical procedures so they can eventually acquire a therapeutic style that is consistent with the theoretical presuppositions, starting with an analysis of the personal epistemology of the trainees.
The second training model tends to favor "knowing how to do" and "knowing how to be", on the basis of the belief that "knowing" is easily acquired and, most of all, can be easily integrated through action and through reflecting upon one's own actions. In this case, therefore, only a few general and basic presuppositions of the theoretical clinical model are presented in the initial stages for the trainees to begin to experience and learn through their experience. The process of redefining and dissecting theories on technique is only carried out later on, within the context of practical exercises and/or when under supervision, when the trainees are actually faced with the inherent difficulties of their own way of being, through analysis and through discussions on the implicit meanings that emerge from their actions and behavior in relation to others.
Even in this case our preference clearly lies with the second option.

Goals of the Training Process

The primary goal of specialized training in psychotherapy, taking into account the considerations made in the last paragraph, is therefore that of creating the necessary conditions for trainees to be able to construct their own professional role which is contemporaneously consistent with the epistemological suppositions of the school's therapeutic model and with the trainees' own particular idiosyncrasies. In other words, the trainees are presented with the theoretical and methodological bases so they can "learn to learn" through experience and through a continuous process of exploration and awareness, and thus begin to actively carve out and construct their own professional role.
The reason that it is so important to foster awareness of self and of one's own emotional dynamics is not so much to "heal one's own neuroses" (an objective that is certainly desirable, but not indispensable), but rather to promote sufficient consciousness of one's own cognitive and emotional dimensions, an understanding that enables one to distinguish

self from other within the therapeutic process and relationship. In this sense we are in total agreement with Carli, Grasso and Paniccia (2007) when then affirm that the most important skill for a clinical psychologist to master is the "capacity of recognizing the emotions that are evoked *within a specific relationship* and to use these same emotions to construct hypotheses on that relationship, not to protect oneself against them."
Aside from techniques and/or procedures, we consider the true basis of the training process to be the acquisition of the capacity to construct relationships with others with the objective of *understanding* the sense of what is being told, beyond the possible superficial meanings, and contemporaneously paying attention to the feelings that this brings out in us, using these sensations as instruments for deepening our awareness and understanding of the person who has asked for our help. These feelings, once one has filtered out the aspects that can surreptitiously resonate with one's own personal dynamics, represent one of the most fundamental instruments for understanding and therefore also for therapeutic practice.
Another element that we consider to be essential to effectively taking on the professional role of psychotherapist is related to understanding that, no matter how able or efficient he or she may be, a psychotherapist can only facilitate a process of change that the patient must necessarily carry out autonomously. The clinical psychologist and/or psychotherapist cannot rely on any instrumentation that can *determine* change in others, different from the physician who, through the use of pharmaceuticals (when sufficient and efficient), can generate "change" in the patient's symptoms. What they can do, to borrow a cheerful metaphor from Vittorio Guidano (1991), is to take on the role of a *strategically-oriented perturber,* without knowing, however, exactly how their disturbance will affect the patient's system. We usually tell our trainees that a psychotherapist "is not capable of healing anyone" also because the concept of healing is quite different from that which is used in the rest of the medical field. A psychotherapist should not simply aim towards the goal of reducing a patient's symptoms; if we presume that each symptom has a meaning and a function for the person who displays it, then it would be quite difficult to "solve the problem" simply by reducing the symptoms. In our clinical experience it isn't rare to witness that, even if we have not acted directly on the symptoms, a patient's symptomatology is drastically reduced to the point of disappearance following an initial treatment period, though this does not automatically translate into a disappearance of the patient's distress. Treatment can therefore continue much longer than the symptoms to elaborate the functional significance of the disturbance, which can be present even without the appearance of full-blown symptoms.

The Theory of Technique

Clinical Behavior in the Approach with Others

First and foremost, we believe that it is essential for trainees to enter into a dimension in which they are fully aware (not just cognitively aware) that *any clinical hypothesis, evaluation, observation or explanation is the result of an active and dynamic process of construction* and it should never be taken as a certain, singular, objective or nosographic fact.
For this reason, for example, when teachers present their clinical cases with their own professional interpretations it is important that they not be presented as absolute truths "handed down from the heavens", but rather proposed to the group that should then express their own opinions, impressions, considerations and sensations and possible alternative interpretations. Each single element proposed by the group should be taken into consideration by the teacher who should evaluate its explicative consistency and try to assist the trainees in the process of interpreting the personal methods that may have influenced their reasoning and conclusion.
It is therefore fundamental that the trainees' attention be drawn to the *provisional nature of any clinical interpretation* made during the evolution of a psychotherapeutic process. If it is true that the therapist regards a professional hypothesis, at a certain phase in the therapy, to be the most functional in as much as it allows him or her to proceed with the treatment in

a strategic manner, it is also true that psychotherapy is characterized by the practice of proceeding “hypothesis by hypothesis”, each step of the way, until a hypothesis emerges that seems to best explain and adapt itself to that particular clinical moment and to the new elements that have surfaced in the relationship with the patient-as-system.
The educational message that we want to transmit therefore focuses on the fact that there is never a “single solution” that is static, firm, or final, and that we should instead internalize the necessity of processuality. This is unavoidable as it characterizes each process of change, and it brings centrality, not so much to the definitions, but to the process of active considerations that lead toward *that* clinical construction instead of others, by the criteria of efficiency in treatment.
And thus a training parameter emerges that does not oscillate between the poles of right and wrong or exact and inexact, but rather goes by the criteria of the feasibility and explicative functionality of each professional interpretation.

All of this is closely tied to the trainees’ acquisition of a comprehensive and all-encompassing *capacity to grasp the other in his or her singularity and complexity.* Trainees are therefore brought to professionally construct the person they have before them – through theoretical-clinical constructs – without loosing sight of the fact that no professional interpretation, no matter how conceptually accurate or precise, can ever capture the full complexity of an individual. This process can be activated and constantly enlivened by stimulating the trainees to “see” the person in their entirety, to see them in the context of the world that they live in and the way in which they live, of the language they use, of the body they live in, of how they relate to their own network of significant relationships, etc. This means accompanying trainees in the process of focusing their attention on each single element that can possibly help them to more closely and intimately understand how that person acts and moves within his or her own reality.
The intention is that the trainees will learn to represent the other, or better yet, to “grasp” the other, as a true, flesh and blood protagonist of a story whose evolution has been interrupted, without ever simplifying or reducing the individual to fit into a codified theoretical interpretation. This serves, above all, to prepare them to tackle variegated clinical realities as the people they will encounter over time in their professional practice will invariably be unique and always different from those encountered before them.

We therefore find a reduction of professional interpretation to mere diagnostic labeling to be absolutely inopportune. As a form of static description, we regard strictly-conceived diagnoses to be utterly inadequate to grasp the process in motion, in all its complexity, that each person represents, even those who seem immobilized by their suffering. Following this essential presupposition, we exclude the use of classic nosographic frameworks in professional clinical training.
In particular during the initial phases of training when analyzing clinical cases, we advise trainees to compare the use of medical-psychiatric diagnoses with the use of explicative and functional evaluations; this enables them to directly feel the greater heuristic power and lesser tautological risk of the latter.
Another important training message is the uselessness of conveying any sort of diagnostic communication to the patient who may, sometimes even explicitly, request this; this often occurs as a habit of social behavior, as it is a standard medical-treatment procedure to provide classificatory results, or perhaps to satisfy the desire to give a name to one’s own distress, with the false hope that the name will somehow provide an easy way out of this distress. The important thing is to transmit to the trainees that not communicating any kind of diagnosis is not about a “rule” per se, but about the fact that doing so is not only uselessness, but even worse, it is intrinsically paradoxical as you risk giving the patient a “mixed message” that is inconsistent with the logic that only the patient, accompanied by – but not replaced by – the therapist, can arrive at a personal reading of and thus meaning for his or her own distress.

In our training model it is considered essential that trainees grasp the saliency of the way in which the process of gaining awareness of the other occurs through methods that necessarily see *the dimension of comprehension precede that of explanation* (cf. Cionini, 2006). In this perspective, teachers first help the trainees to read what has been observed by listening to their own senses, in all of their tones and nuances, and only later to redefine and outline these observations through professional, explicative language.
This, for example, can be facilitated in the classroom by constantly stimulating the group's active participation in creating an environment that encourages the expression of any personal idea solicited by the clinical case at hand, and also by a new reading "transmitted in clear" of the teacher's own processuality in clinical management. Teaching methods such as these encourage learning that is not focused on acquiring mere factual knowledge, but rather on a gradual internalization of professional constructs.
To avoid having the awareness of others be limited to "seeing the world through their eyes" or "putting yourself in their shoes", we must bring the trainees to be used to following the moments of comprehension with what we define as *awareness through explanation,* or rather the codification and attribution of a pattern of professional constructs that are specifically personalized for each individual, time and time again. This capacity of professional interpretation, necessarily preceded by coming into contact with the essence of the other, is aimed towards creating a construct of articulated individual complexity, that is at the same time concise, and that enables the formulation and initiation of an effectively therapeutic relationship.
To avoid a polarization, or even a crystallization, of the approach with others in the sole dimension of comprehension or explanation (dimensions that are, on their own, inefficient and inappropriate for an approach with others aimed at change), the process of awareness that the trainees put into action must necessarily be collocated within a context of continuous circularity, in which moments of understanding (the capacity to try to "be the other") and moments of explanation (the theoretical and clinical reinterpretation of the other's hypothetical functioning) are alternated (cf. Morin, 1986). This process can be facilitated by bringing that same circularity to formative training moments. For example, after listening to a clinical case, we go straight to "hot" analysis, working on everything this aroused in the trainees so they can learn to see the world as the other does, stepping into his or her shoes and entering into the reality that the other presents and narrates. Only later, with more distance, do we enter into "cold" analysis, in which we try to breakdown and analyze as specifically as possible a whole slew of different elements, codifying them in professional terms and articulating them in possible hierarchical relationships. We always emphasize the fact, however, that professional readings can in no way prescind from what emerged during the initial "hot" analysis if we are to truly respect the cognitive value of others in all of their individuality.

Question Analysis and the Professional Construction of Others

Another essential goal is for the trainees to acquire the capacity to activate in-depth processes of *question analysis*¸ guiding and critically stimulating them towards interpretations that go beyond the more explicit levels used by patients to formulate their requests for help, searching for the more substantial, implicit needs.
Trainees must take possession of a form of approach to symptoms (understood in the broadest sense of the word, as the problem presented) that enables them to ponder the *functionality of the symptom* itself. The presupposition upon which this is based is the conceptualization that each time a symptom manifests itself, bringing with it suffering, it is a "visible" expression of distress that is not, however, limited to the pain that it provokes. The "symptom" should be considered an integral part of that which the person is, a distinctive sign of his or her specific life experiences. Symptomatology is therefore not something that should be eradicated or made to disappear, in as much as it is something that asks to be read, decoded and understood within the specific story of the individual, in the way the individual relates to his or herself and to others. It also plays a role of protective functionality,

though at a high emotional cost, in that it allows the system to maintain functional balance and therefore achieve certain existential goals, perhaps even guaranteeing psycho-physical survival. Understanding the protective function of symptoms enables you to move on to standard clinical practice in which that which was regarded solely and exclusively as the bearer of pain, and therefore something to be eliminated, can be reconceptualized, even by the patient, as something that is extremely functional and even as something to be embraced in all of its considerable meanings.
While discussing cases, whether teachers or trainees are supervising, it is fundamental that the teachers actively lead the group to contemplate the meaning of whatever the patient presents as suffering, symptom, distress, discomfort or problem, and to construct a specific value for its equilibrium from within the patient-as-system.
Another training goal related to question analysis is to put trainees in a condition to be able to decide if there are valid *prerequisites for treatment* and, if so, of what nature (support, counselling, psychotherapy). Beyond the patient's explicit request for a particular type of help, in fact, it is the therapist's specific professional responsibility to "translate", with professional criteria, this request into a proposal for intervention that is best suited for the situation at hand. It should be noted that in our orientation, different from other approaches, we do not believe there are "a priori" situations, symptoms, conditions, problems, or illnesses that can, in and of themselves, directly indicate a specific type of intervention (for example, that we should always indicate counselling when a work-place decision needs to be made). The choice of the specific type of intervention must always be constructed on the basis of a professional reading of the implications that the problem presents in terms of invalidating individual nuclear constructs, or, to return to the example above, in what way and to what degree the work-related problem being presented could invalidate the sense of personal identity. This choice must also, and most importantly, be constructed on the basis of the possibility for movement that is anticipated in the patient-system. This construct should also enable us to determine if our particular psychotherapeutic model is in fact suitable for the problem at hand.
Another message that we usually try to present as essential to our therapists-in-training is related to learning how to recognize which cases they can and cannot personally follow. This capacity clearly cannot be acquired over such a short period of time as four years of school, but only gradually through clinical practice and experience, and through inevitable professional failures and/or drop-outs. The idea is fundamentally that of debunking the myth of therapists as omnipotent beings who can always cure anyone and everyone, and is consistent with the assumption that psychotherapy is not just a profession to be learned, but also something that involves personal dimensions. Therapists should be able to anticipate to what degree these dimensions could potentially involve themselves in role-playing or with the personal problems presented by the patient, and as a result decide whether or not the treatment of that particular person should be entrusted to another colleague.

In our cognitive-constructivist model, the ability to professionally read others is gained through learning how to *construct professional hypotheses that start from the narration of a person's life story.* After the first session of question analysis there are three, sometimes four, *assessment* sessions (cf. Cionini, 1991; 2006) in which the patient and therapist together retrace the existential and relationship experiences that make up the patient's story, in part in chronological order and in part based on their thematic relevance. This compilation is not put together to serve as a case history, but rather to explore situations and developmental passages that are considered to be crucial, consistent with the theoretical presuppositions of the model.
The overall form of the narration that others presents to us, reconstructed through professional language, is the basis upon which we can construct hypotheses of how their system of consciousness functions. Particular attention is therefore always paid to narrative elements and associated professional constructs, not as single elements, but rather as a whole, and also to their interconnections of function and of meaning. The picture that is created should not end up looking like a list of "indicators" but rather a configuration of interrelated meanings. The narrative form that patients use to present their stories to us

should be considered an important and indicative factor, a representation from within the patients' world and of their interpersonal modes(see par. "Teaching How to 'Professionally Construct' the Patient").
These elements, once they are re-elaborated and reinterpreted as a distinct whole through the aid of clinical codifications and constructs, enable the therapist to formulate a preliminary professional hypothesis of the patient's system of consciousness that is customized to the patient's individuality and complexity; they also enable the therapist to define a treatment strategy and thus initiate the true therapeutic process. It is perhaps important to emphasize the fact that this professional construct – in as much as it is hypothetical – is something that, throughout the therapeutic process, must be continuously and actively re-examined, readapted and modified, session by session, as the patient brings, presents, relates and lives new elements that until then were not visible on his or her cognitive horizon.
In training, therefore, the teachers' goal is that of having trainees *learn a way to collect and grasp elements of the other's story without, however, stopping at these elements alone.* While it may seem paradoxical, this is the fundamental criterion that distinguishes the operation of *assessment* from that of anamnesis. We believe that the formulation of an overall framework, that is as comprehensive as possible of complexity, can only come about at the moment in which we seek an "explicative classification" both for all that which is explicitly narrated, and for that which is implicit in the narration or even for that which is absent from the other's story (missing links or narrative jumps). The trainees should therefore be constantly stimulated to try to put together the "pieces" obtained through the *assessment*, relating them and articulating them to one another through a framework of internally-functional relationships, arriving at a global view of the other as a person with possibilities for systemic movement.

Change

If we start from the assumption that the goal of an individual system of consciousness is the capacity to construct plans for "moving through the world", *psychological suffering can be conceptualized in terms of the capacity of movement being blocked,* accompanied by the feeling of the impossibility of creating subjectively feasible alternatives. Change is in this way understood as the possibility for the system to restart its own process of movement through the creation of new meanings that the subject (blocked in a stereotypical repetition of behaviour, thoughts, emotions) is unable to perceive as possible paths on his or her own cognitive horizon. This construction of new meanings, while taking place in the context of an explorative process carried out together with the therapist, must necessarily originate "from and within" the subject, within his or her own systematic limits and possibilities.
Defined in these terms, the concept of change brings with it the connotation of something new and different that emerges, and that "wasn't there" before, therefore making the psychotherapist's view quite different from that of the medical world, where "curing" requires restoring an organism's conditions to their pre-"illness" state and the resumption of "normal" functioning. At the end of psychotherapeutic treatment, the system should be more complex and articulate than before, enabling the person to foresee a much vaster array of experiences and to maintain greater stability and flexibility in the intrinsic movement as everyday life and reality rolls on.
At the heart of the training model lies the acquisition of the concept of change (and not of "cure"), as a restarting of the system's movement that can only emerge from within the person.
The role of the therapist in reaching the final goal of therapy therefore becomes that of *stimulating and fostering the patient's autonomous reorganization.* The therapist does not provide cures, remedies, advice, solutions, or suggestions, but rather prepares fertile ground on which the other can find the instruments necessary for arriving at his or her own specific answers; instruments such as new ways of approaching listening and self-awareness, to come to understand and explain "oneself through oneself" through various situations experienced over time.

The therapist does not propose specific alternatives, nor practical advice or explanations, as these would be necessarily and exclusively based on criteria that are foreign to the other; the therapist enables patients to let their own answers emerge from within themselves, as these are the only answers that their system of consciousness consider to be effectively practicable.
We emphasize to the trainees that the efficiency of any help given cannot be found in "rescuing" others or in taking others' places, but rather in accompanying others on the path of self-exploration, towards the construction of possible alternatives, offering points of observation and moments of reflection that can be interpreted through one's own constructive potential. The didactic intention is therefore that of bringing trainees to construct a role based on the critical awareness that they cannot find answers to the patients' questions, and therefore that there is no chance that they will be able to heal patients, in the broadest sense of the term (if for "healing" we mean removing suffering, as discussed above).
"Therapeutic action" construed in this way therefore aims not to "do by giving to the other" but rather to "let do, doing with the other".

The Process of Change as a "Threat"

To stimulate and foster a process of exploration that leads towards change, therapists find themselves operating on various levels, often simultaneously, to put into action all of the manoeuvres that they anticipate might promote the other's processes of autonomous reorganization. It is important to always remember, however, that *change –any kind of change – always brings with it a certain amount of "threat" to the system.* Changing means moving away from the present state of affairs, which, while it may be marked by suffering, is nonetheless familiar and habitual and as such in a certain sense even comforting, towards a "new possibility" that in this logic represents the unknown, something presumably never explored until that moment. Things that are new and unknown are, by nature, threatening. In these terms we can say that psychotherapy intrinsically entails a threat, as it is a process aimed, upon explicit request of the patient, at a gradual abandonment of current and known existential territory, towards territories that are yet to be discovered. As an example of the intensity of this transition we would like to quote the words of a patient dealing with his emotional world: "When I was a child the answer to a world, to an unclear reality, was expressed in terms of symptoms, but now it is the world of emotions that is unclear to me… I haven't digested it yet. Now I realize how emotions find me unprotected… Emotions worry me, they are a form of reality that are still unknown to me. I approach emotions like a European who is in the middle of the jungle and hears strange sounds and doesn't understand what they are."
During training we try to emphasize this concept to psychotherapy trainees, focusing on how in any process of change one's interventions must be carefully calibrated in terms of their presumable threat to the equilibrium of the other's system. If the degree of threat is minimal or absent, the result will presumably be a lack of advancement in change. A therapeutic relationship of this kind can seem "pleasant" to a patient who feels looked after and wholly confirmed, but this "coddling" has a significant price, both in terms of lack of movement, and in terms of confirming the danger and/or impossibility of change. Many "unending" psychotherapies are probably due to interactions such as these. At the other end of the spectrum, excessive threat can lead, depending on the characteristics and fragility of the patient, to effects of a different kind, all of which are negative: a reaction of defensive rigidity (which blocks the process for periods short or long, and compromises the relationship), abandoning or dropping out of therapy, or even a worsening of the state of imbalance that can even be manifested by dissociative and/or psychotic episodes.
In didactic terms, this capacity to "calibrate the threat" is not easily learned because it is a complex skill that contemporaneously involves a variety of aspects. These aspects include, but are not limited to: being able to step into another's shoes; creating a picture of one's points of greatest vulnerability (in general and regarding every single moment of the

therapeutic process); being able to anticipate the "disturbing power" (for the system's nuclear dimensions) of each single intervention; and discerning the possibility that the patient will be able to respond to the invalidation that the therapist's intervention could potentially activate, and enter into a void of meaning, from which, subsequently, he or she can build something new. During practical training experiences, it is important to stimulate trainees to reflect on this aspect so they can get used to calibrating their own therapeutic actions in relation to the potential threat that they entail. It is particularly important to focus clearly on this dimension during supervision, inviting trainees to consider the implications of their own interventions and to ask themselves about their possible effects in light of an evaluation of the potential for movement of that specific patient in that specific stage of their therapeutic journey.

The Therapist as a Person: an Instrument for Change

Our view puts understanding before any other type of theoretical or explicative interpretation, and therefore the person behind the therapist is seen to play a crucial role in the process of change.
This is where we enter directly in the discourse of *knowing how to be*. The training goal is that the apprentice-therapists acquire, during their four years of training, a good awareness of self, of the characteristics of their own system of consciousness, and of their own theory of the world. This awareness should enable them to read their own cognitive, affective-emotional and relational processes and to better understand the implications of the involvement of self in the therapeutic process.
Through good personal awareness, future therapists can sharpen their capacity to distinguish self from other, to take distance from their own system of meanings, and to enter into the patient's own system of consciousness; in particular, as we usually tell the trainees, they become capable of *letting themselves be "penetrated" by others* and by their meanings, to understand them in all their specificity.
Another fundamental aspect is *to be able to let oneself enter into a "void of meanings"* without explicative hypotheses; this space and time is essential for coming to understand the other. Trainees are helped to construct these moments as active moments, even in their apparent passivity, and therefore to see them not as indicators of incapacity, inadequacy, or a lack of professionalism, but rather as necessary passages in the process of creating awareness of the other.
Beyond self-awareness, which can be achieved in four years of specialized training, we believe that it is extremely important for trainees to acquire a dimension that we define as *knowing how to change* (Cionini & Ranfagni, in press). This dimension seems relevant to us in a profession in which the fundamental nucleus is the interpersonal relationship itself, because, from a constructivist viewpoint, we cannot assume that therapists, who are first and foremost people themselves, are systems of awareness in movement and that a relationship formed by two persons, even if one is the therapist and the other the patient, is inevitably a source of reciprocal change.
Arriving at this notion will enable future therapists to critically and consciously contend with the limits that might materialize throughout their professional practice, regarding particular moments of a specific therapeutic process, regarding certain procedures, or regarding their own personal way of relating to the theoretical reference model. If they are met with awareness and therefore "lived serenely", these are the moments in which therapists' personal creativity can be put to play, allowing them to review, vary, integrate, adapt or transform aspects (even structural ones) of their way of *knowing, knowing how to do,* and *knowing how to be*, while still staying within the confines of a logic that is internally-consistent with the epistemological suppositions of the reference theory.
By transmitting the training message in this way, the goal is to enable future therapists to avoid staying rigidly devoted to an illusory image of self as if it were an invariable element of the psychotherapeutic process, and to be able to constantly increase their tendency to open themselves up to what emerges as "new" (even in their own subjective dimension) during

their encounters with others, without perceiving this as a threat to maintaining their professionalism.

The Therapeutic Relationship

There is an intrinsic connection between good self-awareness and the possibility of using the therapeutic relationship as an essential instrument for change. This is where the dimensions of *knowing how to do* and *knowing how to be* come together and synergetically integrate with one another.
From our point of view, Bowlby's *secure base* metaphor (1988) can be directly applied to the therapeutic relationship. Consistent with this theory, *the therapist*, as a person that patients turn to at particularly difficult moments of their lives, *can be legitimately considered a potential and important attachment figure.* From the onset of the therapeutic relationship, but most of all once the relationship has been stabilized and structured, patients tend to reproduce within the same setting the same processes of attributing meaning – to self and to other – and to live the same emotional nuances that now characterize their relationships with the significant figures in their lives. Analyzing the processes that emerge in the relationship offers unique opportunities to reinterpret, together with the patients, the characteristics of their interpersonal patterns in the precise moment in which they are enacted, and also to analyze the anticipatory constructions that the patients put into effect regarding the therapist, their emotional responses, and their behavior. The sensation of unconditional acceptance and the possibility of receiving "warm" understanding from the therapist can permit the patient to construct those protective feelings that characterize a *secure base* that facilitate the exploration of areas within oneself that are unknown and uncharted, and as such, threatening.
A therapist's "relationship moves" can sometimes aim specifically to demonstrate the transference processes under way and focus patients' attention on them. It is therefore important for trainees to learn how to pay attention to the relational significance of their actions (on a verbal, paraverbal and non-verbal level) and to always ask themselves, in a more or less explicit manner, "in what way will what I am doing affect the relationship?". In this way the trainees can be able to put themselves in the setting in a way that on one hand (and in part) satisfies the patient's relationship requirements, and on the other hand offers the patient opportunities to experiment in a new way, in a protected environment. The setting can therefore become a privileged and secure context for exploring "self-in-relationships" by offering patients opportunities to try to allow themselves feelings that would otherwise be "forbidden"; opportunities that can lead to the invalidation of anticipations that these processes – different from those that the patients usually adopt in their interpersonal relationships – will lead the therapist to criticize, refuse or abandon them (Cionini, 2005). The dynamics of the patient-therapist relationship can sometimes be made explicit and thus become the object of meta-communication, and other times they can be left at an implicit level, without linguistic translation or expressed only through the mediation of metaphorical communications.
Therapists in training must learn to pay attention to their own personal feelings (activated by and within the therapeutic relationship), using the greatest level of awareness possible to determine to what extent whatever happens, and whatever they feel, could be influenced by the typical modes of their own system of consciousness, and to what extent they are influenced by the patients' own fears, difficulties, and systematic relationship strategies. Individual supervision sessions in front of the group are particularly useful for this purpose, as each reference made by the other members of the group and by the teachers, stimulates the trainee at hand to construct different points of view that can be used to observe him or herself during therapeutic interaction.

Errors in Conducting the Therapeutic Process

As in other dimensions of life, even in the therapeutic process mistakes are inevitable in as much as they are intrinsic to human nature.
From our point of view, the approach to possible “errors” on the part of the therapist takes on a particular connotation. The basic assumption is that to regard an error as just “an error” (with the common sense implications that something went wrong that shouldn’t have been done) leads therapists to get mired in a dimension of right/wrong, metaphorically locking themselves into a sort of tribunal where, should a verdict be delivered that condemns the guilty-therapist, no benefit whatsoever is attained for the patient. Vice versa, if the error did not cause any grievous injury to the psycho-physical well-being of the other, nor were any of the fundamental ethical and deontological assumptions violated, then we believe that it should be considered like any other “event” or experience analyzed within the setting, and that, if used correctly, can even herald meaning, transmitting information and awareness of the therapist’s personal dimensions that emerged in a particularly evident way in the context of the dynamics of that specific relationship.
When therapists believe they have committed an error, it is therefore important that they accept it and consider it’s informative value, without dramatizing the situation, but, at the same time, without minimalizing or trivializing it. It is also important that they look within themselves to try to understand to what extent the error could be explained by the intersubjective dimension or, as is often the case, to their own personal problems. Should the latter be true, then therapists must activate a process of self-reflection and consideration (on an individual level, or in the context of a supervision) that enables them to critically elaborate the situation at hand and to continue the therapeutic process, “straightening their aim” for the benefit of the other, and staying on the alert so the same dynamics are not put in act again.
If therapists believe they can construct the “error” in relational terms, they should use the error as an informative source that explains something that is underway in their interaction with the patient, and that can be reinterpreted with meanings that can be utilized for the treatment process itself.
If the error was only detected by the therapist, then the therapist must decide whether or not it would benefit the patient to communicate the occurrence to him or her; vice versa, if the patient was the one to point out the error, then the error must necessarily be analyzed, starting with an explicit acknowledgement of the error by the therapist – presumably through an operation of self-disclosure – that leads to a “four-handed” process of sharing and candid examination of the occurrence and of the effects that it has had on the relationship.
In didactic terms, the goal therefore becomes that of helping trainees to not “deny” their own errors, a response whose probability increases within the context of training as the dimension of learning is often associated with a dimension of evaluation and *assessment*; the trainees are, rather, encouraged to pay close attention to and to emphasize the informative value and the possibility that something that is initially negative and unpleasant can be constructed as an opportunity to widen one’s cognitive awareness of self and of the other.

Training Methodology

The Job of the Therapist

As mentioned above, the training methodology is based on the supposition that the fundamental skills that a therapist must have can be essentially obtained through experiential practical training aimed to promote personal growth, rather than through acquiring specific techniques and theoretically-taught methods. This practical training intends to develop, throughout the entire training process, complex abilities that can enable future therapists to handle the difficulties inherent in the management of the therapeutic process.
The first of these abilities is the capacity to establish authentic dialogue with one’s patients, relating to the other in a manner that favors understanding; this approach requires therapists

to be open and willing to challenge their own preconceptions. As Gadamer contends, acquiring a sensitivity to otherness, understanding the other and opening oneself up to the novelty of the other's story "does not presuppose either objective *neutrality* or oblivion of self, but requires a precise consciousness of one's pre-suppositions and of one's prejudices" (Gadamer, 1960, p. 316). This capacity is manifestly connected to the activation of knowledge belonging to one's own affective-emotional domain, and it therefore requires training that must necessarily pass through an experiential process centered on awareness of self in relation to the other.
Equally important is the capacity to *reflect while acting*; this procedural ability does not necessarily imply a conscious mental process, as it is often carried out through sensations or intuitions, and it enables therapists to modify their own understanding and their own actions in relation to what is happening and to improvise, responding in a pertinent manner to the particularity of the moment and to the situation of the relationship at hand (Safran & Muran, 2000).
A good psychotherapist should also acquire the capacity (again, a procedural capacity and therefore predominantly unconscious) to integrate a set of information coming from different sources: the reference theory, one's own affective-emotional reactions to what occurs in relationships, the patient's explicit and implicit responses and their meanings, and the possible effects of one's own actions within the setting.

Framework of the Training Process

Consistent with what has been affirmed above, the very first months of training are mainly dedicated to the presentation of the epistemological presuppositions of the clinical model and of the fundamental principles that characterize the reference theory and technique theory.
This first phase quickly leads into the start of practical training, which can be subdivided into three moments that are partially distinct, but often overlapping, and aim for the following objectives:
a) question comprehension and professional construction of the characteristics of the patient's cognitive-emotional functioning (assessment);
b) conducting the therapeutic process through conversational procedures, "working on emotions" methods and the management of transference dynamics;
c) supervising psychotherapies carried out by the trainees (starting in the third year of training).
Other specific moments are also dedicated to trainees' experiences during their practical training and to the analysis of the dynamics of the training-group, a particular setting in which trainees not only learn, but also activate processes of personal change; the extent of this change is significantly conditioned by the level of reciprocal trust that is built within the group, which can allow the trainees to trust and rely upon one another and to explore problematic aspects of self. In the third and fourth years of training, trainees must also do individual work with an outside (non-faculty) therapist for a minimum of 20 hours.
In the first two phases of practical training (assessment and conducting the therapeutic process) the didactics are organized with the same logic and with the same methodological framework, while respecting the diversity of the specific content.
We begin with a succinct description of the method used for the specific procedure at hand; the same procedure is then demonstrated in practice by reading transcriptions and/or listening to tapes of sessions conducted by one of the course teachers. The next step is for the teacher to do a "live" demonstration of this same working method in a session with a trainee who plays the patient, dealing with a personal matter suggested by the trainee. This is followed by trainees' "real-life" experiences (meaning not simulated) where the trainees alternate in the role of therapist and patient, focusing on the personal issues of the trainee-patient.
The observations of an expert therapist (one of the group's teachers) in a real-life situation of psychotherapy cannot replace the personal and direct experience of the trainees, but they

help, in an initial phase of the learning process, to see what psychotherapeutic work truly consists of. Trainees are invited to ask themselves why the teacher acted in a certain way at critical moments of the session, in an attempt to reconstruct the teacher's emotional and thought processes. The teachers can also try to reconstruct and illustrate the "logic" they used to act in a certain way in that specific moment, with that specific patient. For this purpose it is useful to consider both sessions that are conducted "successfully", that flow easily, that can exemplify the way to carry out a specific procedure, and sessions in which the teacher-therapist encountered greater difficulty and had to alternate moments of clarity with moments of uncertainty and confusion, and also (at a later stage in the training process) sessions in which the teacher-therapist may have erred, to varying degrees, in carrying out a series of therapeutic actions. It is important for trainees to consider their teachers to be skilled, expert therapists, but, contemporaneously, to not idealize them by considering them "perfect". By understanding that even expert therapists can make evaluative and practical mistakes (as they will inevitably do), trainees can on one hand reduce their own anxiety to be perfectionists (which clearly increases the probability of reaching an impasse and/or making a mistake) and on the other hand learn in concrete terms how errors can become (when recognized and analyzed in their relationship dynamic) important opportunities to better understand self, the other, and the contribution that each person makes to the therapeutic relationship. When a teacher works "as a therapist" with a trainee "patient" in front of the rest of the group, though in a situation like this the explorative process will be more limited because of the particular characteristics of the setting, the advantages are also the following:

- enabling the trainee to directly experience the impact that a particular way of conducting the therapeutic interaction can have on the patient;
- experiencing the situation of trust that typically belongs to a "successful" therapeutic relationship;
- initiating a course of personal awareness that aims to increase awareness of the characteristics of one's own cognitive and affective-emotional processes.

In the next phase in which both roles (patient and therapist) are played by two trainees, further considerations to be added are those of offering the person in the role of the therapist the opportunity to have a direct experience in a protected situation in which he or she can, in every moment (if necessary) count on the "technical" assistance and support of the group and of the teacher.

Let us now consider how this general methodological framework is actualized in the various phases and moments of the training process.

Teaching how to "Professionally Construct" the Patient

Teachers should lay the necessary foundations by describing the strategies and methods for conducting the first session and compiling the patient's life story (see the paragraph on the Theory of Technique), and illustrating the criteria for the transcription of these first sessions, as well as the methods to be used for codifying them in terms of discourse analysis, utilizing the categories of an AAI (*Adult Attachment Interview*) (Crittenden, 1999) and of the "dominant cognitive-emotional patterns" (Cionini & Provvedi, 2002; Cionini, 2006). Once this has been accomplished, the teachers should provide the group with an *assessment*, both in audio and written form, of the first question-analysis session and of the successive life-story sessions that they carried out with one of their own patients.

By listening to this *assessment* and being encouraged by the teachers to freely express their own feelings and reflections, the trainees can thus move immediately into the dimension in which understanding and comprehension must necessarily precede any attempt at explanation in the cognitive process of getting to know the other. Only after this first step dedicated solely to comprehension can the teachers move on to initiate a more analytical and detailed study of the written transcripts, focusing on the criteria used to conduct the session and on the therapist's way of framing questions. Over the space of a week, each trainee must work on these transcripts on their own, focusing on the codifying criteria that

are characteristic of the method. At the next meeting, the trainees, subdivided into different groups, compare their codifications and their constructions of meaning so they can try to better understand the patients' *person* and their way of relating to their own experiences, and thus to construct an explanation of the sense and function of the problem (and of the symptomatology) that the patients' presented in their request for help. The professional interpretations proposed by the various subgroups are then shared and discussed with the others and with the teacher, so they can critically examine and compare their findings, together with those of the teacher who assisted the patient in question.

The goal of the entire *assessment* process is to get used to feeling and thinking "through the eyes of the other", considering the other in their entirety and complexity, to try to construct a rough draft of the other's cognitive-emotional functioning modes and to grasp, as much as is possible, the meanings that the patient attributes to events, the patient's intentionality, and the objectives that guide the patient's actions in relation to him or herself and to his or her significant others. Beyond an initial comprehension of the patients' person and of their problems, we believe that assuming the role of "careful listener" is actually necessary at every single moment of the therapeutic process, as the process of constructing and reconstructing the other comes to an end only at the termination of the psychotherapy.

Following this first stage of training, this same type of work is continuously carried out throughout the four-year training period, initially using the trainees' personal assessments through the procedure of working in couples (see below), and then later, starting in the third year, using the assessments of patients brought in supervision by each trainee.

At the end of this preliminary stage, therapist-patient partnerships are created within the training group to give each trainee the opportunity to directly experience, in both roles, the procedure of compiling and evaluating life stories that is used in therapy for clinical evaluations. Each session is carried out in a room that is audio-visually linked to the classroom. The group can thus follow the live session as it develops and the trainee-therapists can receive, when they ask or when it seems necessary, indications on how to proceed with possible moments of difficulty in conducting the session. As a guarantee to all, we set the rule that the trainee-therapists can ask to interrupt the session at any point, without having to provide explicit reasons, if they do not want to go into detail about personal issues that they do not feel comfortable sharing in a (group) setting such as this. This rule also makes the trainee-therapists feel much more free to ask whatever questions seem appropriate, without erecting self-limitations connected to the fear of being overly invasive. All of these sessions are also recorded on audio and videotape.

Upon returning to the classroom, we begin by analyzing the direct experiences of the two participants in interpreting each role. We linger in particular on the emotions evoked by the situation and on the way that each person perceived the relationship with the other. Following feedback on this aspect from the other classmates and teachers, we begin to discuss the methodological aspects and make connections between the methods used by the therapist in conducting the session and in playing the role, and the emotions experienced by each person in the relationship. If necessary, after analyzing specific aspects of paraverbal and non-verbal behavior at the moments of greatest emotional charge, we can reanalyze parts of the session on video in the classroom.

The trainee-therapists are then asked to prepare a complete transcription of the session tapes over the coming weeks and (without the presence of the trainee-patient) propose and discuss with the other members of the group (who have, in the meantime, received the transcription and done the same work) their hypotheses of professional codification and construction of the other. The same procedure is carried out following the second and third life-story sessions.

When all the trainees have completed this stage, each trainee presents to a subgroup (usually consisting of four people) his or her own hypotheses of professional interpretation of the cognitive-emotional functioning modes of his or her colleague-patient. Each subgroup then prepares a written report on the professional constructions of their own "patients" that is presented to the teachers for eventual suggestions/corrections/integrations.

At the end of this process, every trainee receives a written report about themselves and, immediately after reading it, they meet one by one with their colleague-therapist in the room

linked audio-visually to the classroom, to together analyze the emotional response elicited by the construction that they have been presented with, and to further discuss the aspects that they would like to reconsider. Back in the classroom, the teacher and co-teacher then present the trainees with their own reflections on the particular difficulties – regarding some of the aspects of their cognitive-emotional characteristics – that they might encounter in managing their professional role; it is worthwhile focusing on the particular relationships that the trainees might need to pay special attention to, and even to the types of patients that the trainees should carefully evaluate, at least in the beginning, to determine how adequate/inadequate it would be to take them on as their own patients.

Practical Training for Conducting Psychotherapies

As mentioned above, the methodological framework utilized for this phase of training (which starts at the second half of the first year) is similar to the one used before. For each work mode we begin by offering indications as to the methodological criteria to be used, listening to recordings of sessions conducted by teachers, and observing the teacher at work with one of the group members. This is followed by repeated moments dedicated to practice in which each trainee can try to put into practice the procedure(s) at hand with a fellow classmate who has offered to provide "personal material".
During the final months of the first year, we begin training on conversational procedures managed in a maieutic manner (Cionini, 1991). Towards the end of the second year we introduce methods of "working on emotions" (Cionini, 1994).
The sessions that involve two trainees (in their respective roles) are carried out in a studio that is connected to the classroom with audio-visual equipment. The analysis of the session is carried out immediately afterwards, focusing our attention on the same elements described in the previous paragraph.
We will sometimes resort to "simulations" carried out directly in the classroom in which one of the teachers plays the role of the patient (simulating a true case), while the trainees take turns at playing the role of the therapist. This context permits us to interrupt the session at each "change of therapist" and, together with the rest of the group, take a break to reconstruct and evaluate what lead the trainee-therapist to act as he or she did, in relation to that which he or she felt/thought, with the objective of explaining the tacit processes that are otherwise difficult to analyze and understand.
Even throughout this stage in training, the fundamental goal of the process is focused not only on "technical" training, but also on augmenting one's acquisition of behavior that facilitates understanding the other and deepening one's awareness of self. We always emphasize the importance of being able to become increasingly aware of the feelings, thoughts, and fantasies that reach the threshold of our consciousness while we are working with patients, and to use them as a source of information about what is happening in the interaction. Particular attention is therefore paid to relationship: the relationship between the trainee-therapist the trainee-patient, the relationships between colleagues within the group (monitoring the atmosphere), and the relationships between teachers and trainees. It is also for this reason that it is important that when trainees play the role of "patient" they feel they have the right to say "no", and to establish their own personal limits in exploring a personally-relevant theme in a setting such as training. To help trainees feel safe to explore personal aspects in front of their classmates and teachers, we emphasize the importance of continuously monitoring their comfort level in exploring self, and of assuming the responsibility for immediately interrupting the process should they not feel like going any further. For this same reason we also dedicate other training moments to the group and the dynamics that develop within the group (see paragraph "Other Training Activities").
We look to these experiential moments to be able to discuss, in their specifics, the theoretical concepts related to the criteria of constructing and consolidating the therapeutic alliance and those related to the rules and opportunities offered by different setting configurations that, in our view, can be managed – at least in some aspects – in a flexible manner (Cionini & Ranfagni, 2009).

Throughout the four-year training period, various meetings are also dedicated to specific themes such as working with couples, sexuological therapy, conducting counseling, child therapy, etc.

Supervision

Supervision begins in the third year. Trainees are asked to make audio recordings of each session; the *assessment* sessions must also be transcribed and codified. During the first supervision, following the life-story compilation, the trainee-therapists must prepare a written report that elaborates on their understanding of the patient and the patient's problem, and on the professional construction of the patient's cognitive-emotional characteristics. By rereading and discussing the report with the rest of the group, the group can evaluate the internal consistency of the professional construction, to what extent this construction reflects a comprehensive vision of the person who has asked for help. This is useful for delineating, at least initially, the goals and strategies of the therapy, and for determining which behavior will presumably be the most effective in constructing a good therapeutic relationship.
Supervision is one of the most important moments in the entire training process because it represents an opportunity to once again address the "technical" themes that were presented in the previous stages of training, starting with specific problematic situations directly experienced by the trainee and the group as a whole. It is also for this reason that we emphasize how important it is that the trainees themselves indicate the theme/problem that they want to bring to supervision. If we don't have any questions, then any answers given will be void of meaning; it is a particularly problematic situation when trainees choose to present themselves as competent figures and demonstrate what they are capable of doing, rather than their own difficulties in managing relationship dynamics with the other.
In practical terms supervision can be carried out by basing it on the following:
- a verbal/written report of the sessions conducted after the previous supervision;
- listening to part of a session that the trainee identifies as having been particularly problematic in terms of its conduction and/or the emotional impact activated by the relationship with the other and by his or her problems.
The goal we aim for is not necessarily an evaluation of the technical accuracy of the actions taken when conducting the sessions, but more an analysis of the difficulties encountered that are related to the trainees' own personal dimensions. For this reason, rather than suggest specific intervention modes that the supervisor considers more efficient, the trainees are helped to autonomously seek their own solutions to the problems at hand, finding these solutions in an analysis of their own personal reactions to what transpired in their relationships with the patient. An appropriate technical suggestions for a specific session can be utterly useless and inapplicable to the next session. Exploring self and focusing attention on one's own experience in the relationship with the other, so this can be used as the basis for the intervention, is therefore the primary focus of the supervision process.
When we listen to the recording of a session it is a good idea to pause at the moments of greatest difficulty for the trainee-therapists and ask them to try to reconstruct the emotions they felt, as a way of helping them to access their own *unformulated experience* or *unknown thought* (Safran & Muran, 2000). For this same purpose it is useful to ask the other members of the group to express their own emotional reactions, presenting them to the therapist as further food for thought.
Once the problem has been delineated, the process of supervision can take on new forms.
One form is that of asking the trainees to play the role of their patients, in a simulated context, while the other trainee or teacher plays the role of therapist. Putting oneself in the patient's shoes and, contemporaneously, experiencing one of the possible routes around an obstacle, can help the trainees both to develop greater empathetic understanding of the patient's own experience and to come in closer contact with the meaning of their own difficulties.

In other cases it can be more useful, after having analyzed and discussed the problem at hand, to ask another two members of the group to volunteer to interpret the roles of therapist and patient; the trainee in supervision thus witnesses a simulation of the session and can better recognize, by observing from the outside, the dimensions and meaning of the situation of "impasse" that he or she encountered.
The difficulties that trainees come across in their first psychotherapeutic experiences are frequently related to the fact that the problems presented by the patients arouse in them, more or less consciously, important emotional responses related to the perception of similarities to some of the personal themes. In these cases the scenario put to play in the therapeutic relationship can also resurface during supervision. When this happens, an opportunity presents itself to recreate the conditions in which the trainees in supervision can directly experience – even within the supervision relationship – the same difficulties that they encountered with the patient. The supervisors, without necessarily explaining what they are doing, but directly acting within their relationship with the trainees, can guide the interaction in such a way as to lead the trainees to "emotionally" come into contact with the personal dimensions that are blocking the therapeutic process, enabling them to feel these reactivated sensations in the here-and-now of the supervision and explore their various dimensions, and eventually to lead the trainees to directly and "emotionally" experience an alternative way of dealing with the problem through work on "their problem". In these role-plays, the trainee-therapists become patients and the supervisors become therapists. The process is thus enlivened by a series of quick and direct exchanges between the trainee-therapist-patient in supervision and the other members of the group, and can be re-elaborated at a later point both on an individual level and in the larger group setting. At an even later point in time, the experiences of the trainee and of the group, though marked by different degrees of involvement, can be reread and theorized in professional language.

Other Training Activities

Other training activities are also carried out, though more infrequently, that are worth mention because they have an equally important function within the entire project. They are: supervision during apprenticeship, analysis of the relationship dynamics within the training group, a weekend retreat in a residential setting (usually in the summer), and the so-called "individual cognitive analysis".
The apprenticeship is usually the context in which trainees have their first experiences with clinical or psychotherapeutic interviews/consultation in a "real" environment (not protected as the school environment was), in which they try to put into practice all that they have learned up to that point regarding knowing, knowing how to do, and knowing how to be. The activities carried out during the apprenticeship vary greatly from one place to another; some places entrust the apprentice-therapists with patients much too early (sometimes even in the first year), while others have difficulty assigning them patients for therapy even at much later stages. This is why trainees are asked to provide us with feedback on the experiences that have in each context, both regarding the types of activities they do, and regarding their relationships with the institutional tutors; in this way we can create a kind of database of the apprenticeship structures that future trainees can refer to when choosing where to apply for apprenticeship. When the trainees carry out veritable psychotherapies within their apprenticeship (in the third and fourth years), they are supervised using the modalities described in the previous section. For a few days each year, a co-teacher usually conducts analysis of the apprenticeship experiences using methods that are, though more superficial as the sessions are not as lengthy, similar to those utilized for the supervision of real psychotherapies. Particular attention is paid to the impact that these first experiences have on the trainees, focusing on their emotional reactions in their relationship with the user.
Twice a year we consider it essential to dedicate an entire day to the activity of analyzing the dynamics of the training group regarding both the interpersonal relationships that have formed within the group and the implications of the training experience on a personal level. On these occasions both teachers and co-teachers involved in all aspects of the training are

present. Encouraging every member of the group to present their point of view, we begin by asking the trainees to give their feedback on their training experiences up until that point, analyzing their difficulties and sharing their possible criticisms, proposals and/or requests regarding the organizational methods of teaching. This type of request is different and much broader than the request to provide anonymous written evaluations on closed-question questionnaires (used for the issuance of "quality certifications") of all of the teachers involved in each step of the theoretical and practical training; in this case we ask much more direct involvement from the trainees, starting from the subjectivity of their own training experience. The "second round" of questions are much more personal, dealing with the interpersonal relationships that the trainees perceive to be living both with their colleagues within the group and with the teachers of their practical training. Each group builds over time their own "group structure" that tends to change and evolve to differing degrees. As mentioned above, for the type of work that is carried out that requires the trainees to individually put themselves "on the line", it is essential that the group setting be lived not just as a relational context in which the trainees can more or less comfortably expose themselves, but as a context that is capable of providing technical, but most of all emotional, support in the moments of greatest personal difficulty. We thus consider both the individual problems that each person identifies in their relationships with other colleagues and/or teachers, and the comprehensive dynamic configuration of the group up until that point, in light of the possible formation of subgroups that are in some degree of explicit or implicit conflict with one another, as well as the situation of marginalization of some individuals. Throughout the training process, there are typically moments of overall crisis for the group that usually correspond to the commencement of new educational activities that bring to the surface difficulties in assuming the role of therapist that have not yet been addressed. The teachers also clearly participate, in this case "as persons", putting themselves on the line and expressing their personal perceptions of the group, as members of the group themselves, and even at times (when they consider it useful to the training experience) expressing their feelings regarding the relational configuration of the group and particular relationships with some of its members. The group atmosphere is usually significantly, and positively, altered by these moments that frequently develop within the context of decidedly strong expressed emotionality.

Once a year, during the summer, we usually hold a weekend school retreat (usually in the countryside) during which we hold lessons, but even we live, eat, and sleep together for three days. This change in setting stimulates types of communication and interpersonal exchanges that are wholly different from those brought to play in our usual encounters. Like with every change in setting, as can happen in psychotherapy, if planned (cf. Cionini & Ranfagni, 2009), the interaction modalities between trainees and between trainees and teachers change almost automatically. One of the three days of the retreat is usually dedicated to the activities mentioned in the previous paragraph, carried out with the presence of all of the teachers that participate in the practical training of the group.

And to conclude we would like to touch on what we call "individual cognitive analysis". A minimum of 20 hours of this type of analysis are carried out during the third, or preferably, the fourth year of training by an "expert" psychotherapist of the same orientation but not one of the group's teachers. The goal is to provide an opportunity to analyze one's own personal problems in managing the therapeutic relationship in a setting that facilities greater "opening" and therefore with a greater possibility of delving deeper than when the same is done within the group. In most cases, in fact, trainees perceive the need to initiate a process of individual psychotherapy during their years of training. In these cases the 20-hours are considered a part of this experience. Other times, however, when this initiative has not been spontaneously instigated by the trainee, these hours represent an opportunity to initiate a process of more in-depth examination of self that, in most cases, does not stop after 20 hours but automatically transforms itself into a longer individual experience. There are truly very few cases in which the trainee does not perceive this kind of need. We do believe, however, that it is much more useful and advantageous when a psychotherapy is initiated if and when the trainees themselves construct their own use/need for it, rather than when it is presented as an obligatory requirement. A psychotherapy undertaken "because you have to"

will most likely lead to much more modest results. Considering that, in our experience, almost every single trainee eventually chooses to initiate a psychotherapy at some point in the training, it is therefore preferable to let them take personal initiative on this matter, even if there is may happen that some will limit themselves to a brief experience of just 20 hours.

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