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Developing relational competence in psychotherapy training: a qualitative study of trainees' perspectives

Giovanna Trimoldi,[1] Marco Sambin,[2] Pietro Spataro,[1] Giulia Gagliardini,[1] Irene Messina[1]

[1]Universitas Mercatorum, Rome; [2]Centro Psicologia Dinamica, Padua, Italy

Abstract

Relational competence is a key determinant of psychotherapy outcomes, yet its development during training remains insufficiently understood. The present study adopts a qualitative, trainee-centered approach to examine how psychotherapy trainees conceptualize relational competences, evaluate their strengths and limitations, and identify the experiences most influential in their development. Forty-nine trainees from a four-year psychotherapy training program completed a structured interview, and data were analyzed using inductive qualitative content analysis. Findings revealed four main themes: i) the conceptualization of relational competence as a foundational and multidimensional component of clinical practice; ii) a predominantly external, patient-driven *locus* of validation for perceived strengths; iii) the context-dependent and relationally situated nature of perceived limitations; and iv) the central role of experiential learning contexts in fostering relational development. Overall, relational competence emerged as a dynamic and developmental construct, shaped by the integration of personal dispositions, experiential learning, and evolving professional identity. These findings highlight the need for training models that more effectively integrate experiential and reflective components, while supporting the development of more internalized standards of professional competence.

Key words: relational competencies, psychotherapy training, therapeutic relationship, qualitative research.

Correspondence to: Irene Messina, Universitas Mercatorum, Piazza Mattei, 10, 00186 Rome, Italy.
E-mail: irene.messina@unimercatorum.it

Introduction

In psychotherapy research, the quality of the therapeutic relationship has consistently emerged as one of the most robust predictors of treatment outcome across diagnostic categories and theoretical orientations (Constantino *et al.*, 2021; Norcross & Lambert, 2018). This body of evidence suggests that relational skills are not secondary to technical expertise but constitute core mechanisms of therapeutic change. Accordingly, therapists' relational abilities play a key role in the formation of the therapeutic alliance (Heinonen *et al.*, 2014; Nissen-Lie *et al.*, 2010) and predict treatment outcomes (Heinonen & Nissen-Lie, 2020), underscoring the importance of relational competence in effective psychotherapy.

Despite its relevance, relational competence remains less structured, less explicitly operationalized, and more difficult to monitor than technical skills within training programs (Rocco *et al.*, 2019). This challenge is partly inherent to the nature of the construct. While often described in terms of skills, relational competence cannot be fully reduced to standardized abilities. Unlike technical interventions, which can be more readily defined, taught, and evaluated, relational capacities occupy a more ambiguous epistemological space. They may be understood as observable interpersonal skills enacted in clinical performance (Ackerman & Hilsenroth, 2003; Heinonen & Nissen-Lie, 2020), as relatively stable dispositional tendencies shaping therapists' relational stance (Nissen-Lie *et al.*, 2010; Orlinsky *et al.*, 2020; Orlinsky *et al.*, 2024; Rønnestad & Skovholt, 2013), and as reflective capacities grounded in self-awareness and ongoing self-evaluation (Messina *et al.*, 2018; Orlinsky & Rønnestad, 2005). From this perspective, relational competence is not simply possessed but enacted in interaction and retrospectively interpreted through processes of personal and professional meaning-making.

This conceptual complexity also helps explain why the development of relational competence during professional training remains insufficiently understood. Although psychotherapy training research has increasingly focused on how therapists' interpersonal capacities evolve (Orlinsky *et al.*, 2015), evidence suggests that their developmental trajectory is less clear and less robust than that of technical competencies (Dennhag & Ybrandt, 2013), even if some change over time has been observed (Messina *et al.*, 2018). Rather than reflecting a linear accumulation of skills, relational development appears to unfold through qualitative transformations in trainees' self-understanding and professional identity (Rønnestad & Skovholt, 2013). Discrepancies between actual and ideal professional selves further highlight the role of evolving internal standards and aspirations in shaping relational functioning (Tilkidzhieva *et al.*, 2019). The context-dependent, interpretative, and meaning-laden nature of relational competence suggests that its development may be difficult to fully capture through standardized or purely quantitative measures. Qualitative approaches are

therefore particularly suited to exploring how trainees make sense of their relational experiences, how they interpret their own strengths and limitations, and how these meanings evolve within specific training and clinical contexts.

A further issue concerns how relational development is supported within training programs. Existing research has mainly examined helpful training experiences from the perspective of program directors. Large-scale surveys of psychotherapy training programs worldwide have documented the widespread use of experiential learning, supervision, case discussions, and reflective practices, pointing to a shared "common core" of training approaches despite organizational and theoretical diversity (Orlinsky *et al.*, 2024). Similarly, qualitative interviews with program directors have emphasized the role of experiential learning opportunities, supervision and intervision, self-awareness-oriented training models, and the quality of trainer-trainee relationships in fostering professional development (Messina & Trimoldi, 2024). Evidence from practicing therapists offers partially converging indications, with studies showing that practice-related interpersonal experiences are perceived as among the most influential for professional growth (Lorentzen *et al.*, 2011). However, the perspective of trainees remains largely underexplored, with only a few small-scale quantitative studies addressing this issue. For example, a pilot study by Zhang *et al.* (2022) suggests that direct clinical experience with patients may be perceived as particularly meaningful for professional development. Moreover, existing quantitative approaches provide limited access to the subjective processes through which trainees interpret and integrate these experiences. A qualitative, trainee-centered perspective may therefore contribute to addressing this gap by capturing the experiential and meaning-making dimensions of relational competence development that are not easily accessible through quantitative measures.

Accordingly, the present study adopts a qualitative, trainee-centered design to explore how relational competence is conceptualized, enacted, and developed within psychotherapy training. Specifically, it investigates how trainees construct the meaning of relational competence, how they position themselves with respect to perceived strengths and limitations, how they deliberately engage and use the therapeutic relationship in clinical practice, and which training experiences they identify as most influential in shaping their relational development.

Methods

Participants

Participants were recruited from a private psychotherapy institute offering a four-year training program officially recognized by the Italian Ministry of University and Research. The training is grounded in a psychodynamic orientation, specifically transactional analysis (Berne, 1961). All trainees enrolled in the program at the time of the study were invited to participate (n=80); of these, 49 responded (38 females and 11 males), representing all four levels of the training *curriculum* and constituting the final sample. In the final sample, trainees were distributed across training levels as follows: 11 in the first year, 15 in the second year, 11 in the third year, and 12 in the fourth year. Ethical standards were upheld by informing participants about the aims of the study and ensuring the confidentiality of their contributions. Written informed consent was obtained from all participants prior to participation in the study.

Researchers

The research team consisted of a full professor of dynamic psychology with expertise in psychotherapy training research and a theoretical background in transactional analysis; an early-career researcher who was directly involved in data collection; and an associate professor and a researcher who contributed an external perspective, drawing on different theoretical orientations. Finally, the training director was not directly involved in data collection or analysis.

Data collection

Participant recruitment and data collection proceeded until content saturation was achieved, defined as the point at which no novel codes or themes emerged from further data analysis (Hennink & Kaiser, 2022). Saturation was operationalized through an iterative process of concurrent data collection and analysis, whereby recruitment was discontinued once successive analyses yielded no new codes or themes. As saturation was reached during the data collection process, no follow-up reminders were sent to trainees who had not responded to the initial invitation.

Structured interview

Participants responded to a set of six open-ended questions designed to explore their understanding and experience of relational skills in clinical practice. The questions addressed the following domains: i) definition of relational competencies; ii) clinical strengths, encompassing both general professional strengths and relational strengths illustrated through clinical examples; iii) professional and relational limitations, including general areas of difficulty and specific relational challenges supported by clinical illustrations; iv) formative training experiences contributing to the development of relational skills (see Table 1 for the full list of original questions). While this format enabled the collection of data from a relatively large sample, it may have influenced not only the depth and spontaneity of responses, but also the type of material produced, potentially favouring more structured and reflective accounts over more immediate or interactionally grounded perspectives.

Table 1. Structured interview.

Domains	Questions
Relational skills	In your training or practice as a psychotherapist, what do relational skills mean to you?
Relational strength	Regarding the ability to relate to the patient, what do you consider to be your main strength as a psychotherapist? In your experience, how does this relational strength manifest?
Relational difficulty	Regarding the ability to relate to the patient, what do you think is your main limitation or difficulty? In your experience, how does relational difficulty manifest?
Relational skills training	In your training experience so far, which experiences have been most useful for improving your relational skills?

Data analyses

The core objective of the data analysis was to move from raw narrative descriptions to a structured conceptualization of how trainees perceive and enact relational competence. All qualitative data were processed using NVivo software to ensure systematic coding and organizational rigor. To address the research objectives, a conventional approach (Hsieh & Shannon, 2005) of qualitative content analysis was employed to systematically transform a large amount of textual data into a highly organized and concise summary of key results; this inductive method is particularly appropriate as it allows categories and named themes to flow directly from the data text rather than being imposed through a pre-existing coding scheme.

The analysis involved a systematic transition from manifest content (direct descriptions) to latent content (interpretative abstraction), and it followed a systematic progression from initial immersion to the extraction of high-order meanings. Following the conventional approach to qualitative content analysis (Hsieh & Shannon, 2005), the analysis involved three recursive phases. First, open coding was conducted to identify meaningful units of text, which were labelled with data-driven codes closely reflecting participants' language. Second, codes were compared and grouped into categories within each question, based on conceptual similarities and patterns across responses. Third, these categories were further examined across questions and iteratively integrated into broader conceptual research domains that captured higher-level thematic structures (Table 2).

Table 2. Summary of qualitative domains, codes, and frequencies.

Domain	Code number	Code	Frequency
1. Conceptualization of relational skills	1.1	Foundations/relational competence	17
	1.2	Synchrony and reciprocity	8
	1.3	Empathy	7
	1.4	Active listening	7
	1.5	Contact	6
	1.6	Awareness	6
	1.7	Non-judgment	5
	1.8	Presence/being with	5
	1.9	Communication	4
	1.10	Support	3
	1.11	Creating space/giving time	3
	1.12	Genuine interest	3
	1.13	Building the relationship	3
	1.14	Constant work/process	2
	1.15	Self-other distinction	2
	1.16	Welcoming/acceptance	2
	1.17	Discomfort/unease	1
2. Developmental drivers	2.1	Supervision	13
	2.2	Internship	9
	2.3	Group simulations	8
	2.4	Individual therapy/acceptance	7
	2.5	Clinical practice	7
	2.6	Simulations (general)	7
	2.7	Specific experiences	5
	2.8	Group psychotherapy	4
	2.9	Tutor	4
	2.10	Total experience	2
	2.11	Peer feedback	2
	2.12	Intervision	2
	2.13	Nonverbal communication	1
	2.14	Modeling	1
	2.15	Practice + theory	1
	2.16	Techniques	1
	2.17	Theory	1
3. Clinical strengths	3.1	Patient validation	16
	3.2	Welcoming communication	10
	3.3	Giving time	10
	3.4	Welcoming (basic)	5
	3.4	Moments of difficulty	2
	3.5	Synchrony and reciprocity	1
	3.6	Diagnosis	1
	3.7	Intuition	1
4. Relational difficulties	4.1	Patient complexity	15
	4.2	Time management	12
	4.3	Welcoming communication	5
	4.4	Empathy difficulties	4
	4.5	Lack of validation	4
	4.6	Specific requests	1

To ensure methodological integrity, analysis continued until saturation was confirmed, signifying that no novel codes or themes could be derived from additional data review (Hennink & Kaiser, 2022). Interpretive reliability was enhanced through a consensus-based procedure involving all authors (Hill *et al.*, 2005).

Results

Relational competencies in trainees' perspectives

Participants' accounts reflected a plurality of definitions of relational competences. The analysis revealed a core theme concerning the recognition of relational competences as a *foundational substrate* of clinical practice [1.1] (n=17/49, 34.7%). Participants described these competences as "the basic structure upon which any type of therapeutic relationship is built" and as "fundamental and foundational to the profession". Within this framework, trainees conceptualized the therapeutic relationship as a vital element that shapes technique and renders it effective, suggesting that, in the absence of such relational foundations, clinical work lacks a stable base.

Beyond this overarching theme, several specific relational competences were identified. The most frequently reported were *synchrony and reciprocity* [1.2] (n=8/49, 16.3%), *empathy* [1.3] (n=7/49, 14.3%), and *active listening* [1.4] (n=7/49, 14.3%). Other relevant dimensions included *contact* [1.5] (n=6/49, 12.2%) and *awareness* [1.6] (n=6/49, 12.2%), alongside *non-judgment* [1.7] (n=5/49, 10.2%). Notably, relational competencies were not described solely as therapist attributes, but also as experiential and process-oriented states, such as *being with* the patient [1.8] (n=4/49, 8.2%) or expressing *welcoming communication* [1.9] (n=4/49, 8.2%). Additional elements, including *support* [1.10], *creating space* [1.11], *genuine interest* [1.12], and *building the relationship* [1.13] (each n=3/49, 6.1%), further highlight the multifaceted and dynamic nature of relational engagement. Overall, these findings suggest that trainees conceptualize relational competences as both dispositional and enacted processes, grounded in an internally oriented, mindful stance and expressed through moment-to-moment clinical interaction.

Patient-driven validation of clinical strengths

The most frequently reported perceived strengths were *receptive stance* and *validation processes* [3.1] (n=16/49, 32.6%) and respecting the patient's change process, reflected in *giving time* [3.3] (n=10/49, 20.4%). Beyond the specific strengths identified, thematic analysis revealed a core theme whereby the *locus* of validation for clinical strengths was predominantly external and patient-driven [3.1]. Trainees described experiencing a sense of competence not through theoretical mastery or supervisory feedback, but through direct patient responses, thereby positioning clinical interactions as the primary source of validation for their skills. This pattern of patient-driven validation was reported in 16 cases (n=16/49, 32.7%). Illustrative examples include: "A patient, who had previous negative experiences with other therapists, appreciated my delicacy" and "A patient told me that, for the first time, they felt completely unjudged while discussing their extramarital relationship".

Relational target-specific locus of limitations

Marked variability emerged in trainees' accounts of limitations in their relational competencies. One limitation was reported with notably higher frequency, namely difficulties in respecting the timing of the patient's *change process* [4.2] (n=12/49, 24.5%).

Beyond these specific limitations, the analysis revealed a core pattern, conceptualized as a relational target-specific *locus* of weakness. In contrast to strengths, which were typically described as stable personal qualities, limitations were not framed as enduring individual deficits. Rather, they were articulated as context-dependent challenges emerging in relation to specific *patient complexity* or clinical situations [4.1]. For instance, one trainee noted: "With the specific patient group of adolescents, I struggle with the relationship because I feel too involved and maternal". Another reported: "I find it difficult to remain grounded in the face of attacks on me and the therapeutic setting from patients with certain narcissistic personality types". Taken together, these findings suggest that limitations are primarily experienced as situational and relationally embedded, rather than as stable intrapersonal deficits.

Experiences supporting the development of relational skills

The findings underscore the centrality of experiential training components, which were reported as substantially more influential than theoretical instruction in the development of relational skills. Clinical *supervision* [2.1] emerged as the most frequently reported driver (n=13/49, 26.5%), followed by hands-on experience during *internships* [2.2] (n=9/49, 18.4%) and *group simulations* [2.3] (n=8/49, 16.3%). *Personal psychotherapy* [2.4] was also identified as an important component (n=7/49, 14.3%), pointing to the importance of working through the therapist's own relational patterns in shaping professional development. Within these contexts, the focus appeared to shift from technical mastery to internal self-reflection. As one trainee explained: "Working on personal experiences and countertransference was fundamental in refining my capacity for deep listening, emotional presence, and the management of relational complexity".

In contrast, traditional academic components such as *theory* [2.17] (n=1/49, 2.0%) and *techniques* [2.16] (n=1/49, 2.0%) were only marginally mentioned. Overall, trainees conveyed a shared understanding that relational competencies are primarily "learned by doing" and "refined through supervision", rather than acquired through theoretical instruction alone. Within this framework, *internships* [2.2] were often described as the first context in which trainees encounter the concrete impact of their clinical presence. One participant highlighted this transition from theoretical learning to the responsibility of practice: "During an undergraduate internship in a community for psychotic patients, my supervisor explained the impact that my every single behavior or word could have on the patients and taught me how to relate to them effectively". This process of "effective relating" was further described as being deepened within reflective spaces such as supervision and personal work.

Discussion

The present study aimed to explore how psychotherapy trainees conceptualize relational competences, how they position themselves in terms of strengths and limitations, and which training experiences they perceive as most influential in their development. Overall, the findings portray relational competence as a dynamic, context-sensitive, and experientially grounded construct.

First, trainees consistently described relational competences as foundational to clinical practice, rather than as ancillary skills. This view aligns with a substantial body of psychotherapy research emphasizing the central role of relational factors in therapeutic effectiveness (Constantino *et al.*, 2021; Norcross & Lambert, 2018), indicating convergence between trainees' perspectives and the broader scientific literature. Such alignment may partly reflect the influence of training *curricula* and exposure to research evidence. Notably, participants did not frame relational competencies as discrete techniques or observable behaviors, but as encompassing both dispositional qualities and their enactment within the therapeutic encounter. This perspective is consistent with approaches that conceptualize therapeutic expertise as the capacity to flexibly adapt interventions to the evolving needs of the client and the interaction, highlighting the role of context-sensitive judgment (Hatcher, 2015; Kramer & Stiles, 2015).

A second key finding concerns the *locus* of validation for clinical strengths. While trainees' descriptions of their competencies – particularly in terms of openness, active listening, emotional attunement, and communication – are broadly consistent with previous research (Hill *et al.*, 2013; Joo *et al.*, 2005; Messina *et al.*, 2018), the present results indicate that such evaluations are frequently grounded in patients' responses. Patient feedback thus appears to function not only as an indicator of outcome, but also as an experiential basis for self-evaluation. Although the extent to which these perceptions correspond to actual competence remains to be clarified, the findings suggest that early professional confidence is closely tied to relational feedback emerging within clinical interactions. This reliance on patient responses may reflect a developmental stage in which internal standards of competence are still consolidating, leading trainees to draw more heavily on external sources to evaluate their effectiveness (Mathieson *et al.*, 2009).

Third, trainees' perceived limitations were primarily described as context-dependent and relationally situated, rather than as stable personal deficits. Difficulties were often associated with specific patient groups or clinical situations, supporting the view that relational functioning is inherently interactional and co-constructed. This perspective can be considered in relation to research on therapist effectiveness, showing that therapist performance displays a degree of consistency across contexts (Nissen-Lie *et al.*, 2016), while differences between more and less effective therapists become particularly evident when working with more complex or high-risk patients (Saxon & Barkham, 2012). These findings suggest that trainees' perceptions of their limitations reflect a situated, experience-near understanding of clinical work, in which difficulties are primarily attributed to specific relational configurations. This, in turn, underscores the importance of supporting trainees in developing the flexibility required to work effectively across diverse patient populations.

Taken together, the findings concerning the sources of self-evaluation and the contextual nature of perceived limitations point to the role of these processes in the construction of professional identity. Trainees' tendency to ground their evaluations in patient feedback, combined with the experience of limitations as context-dependent, suggests that their sense of competence develops through the interpretation of relational experiences. These results underscore the importance of explicitly supporting identity development within training. Reflection on clinical experiences – particularly those involving patient responses and perceived difficulties – should be treated as a core process through which trainees construct their professional self-understanding. Encouraging trainees to critically examine how they interpret their effectiveness, recognize potential biases, and integrate multiple sources of feedback may foster more coherent and context-sensitive professional identities. These processes may also have implications for clinically relevant outcomes, such as treatment engagement, the management of alliance strain, and premature termination, particularly when relational difficulties are not effectively addressed (Oasi *et al.*, 2024).

The findings concerning the sources of self-evaluation of strengths and limitations also have implications for research on therapist development. Given that much of the literature relies on self-reported measures (Messina *et al.*, 2019; Orlinsky *et al.*, 2015), these results help to clarify how such evaluations may be shaped, suggesting that they are often grounded in specific relational experiences with patients. Greater attention to the processes underlying self-assessment may support a more accurate interpretation of self-report findings and contribute to a more nuanced understanding of relational competence.

Finally, the present study extends previous findings on psychotherapy training by providing complementary evidence from trainees' perspectives. In line with research based on trainers (Messina & Trimoldi, 2024; Orlinsky *et al.*, 2024) and practicing therapists (Lorentzen *et al.*, 2011), experiential and reflective components emerged as central to the development of relational competencies. Clinical supervision, internships, and personal psychotherapy were consistently identified as the most influential learning contexts, whereas formal theoretical instruction appeared comparatively less salient. This convergence across perspectives reinforces the importance of experiential and reflective processes and supports the need to maintain and strengthen practice-based components within training programs.

Despite its contributions, the present study has several limitations. The sample was drawn from a single training institute, which may limit the generalizability of the findings across different training contexts and theoretical orientations. In addition, the use of a structured written interview, while allowing the inclusion of a relatively large qualitative sample, may have constrained the depth and spontaneity of participants' responses compared to in-depth interviews. Finally, the findings rely on self-reported accounts, which reflect trainees' subjective perceptions rather than direct observations of clinical practice. Future research could adopt longitudinal designs to examine how conceptualizations of relational competence evolve over time, as well as comparative studies across training models and cultural contexts. Integrating qualitative accounts with observational or process-based measures may further enhance understanding of how relational competences are enacted in clinical practice.

Conclusions

The present study highlights how relational competence is understood by trainees as a dynamic, context-sensitive, and experientially grounded process. The findings suggest that both competence and self-evaluation are shaped through ongoing engagement with clinical experiences, particularly those involving patient interactions. These results support the value of training approaches that combine experiential learning with structured opportunities for reflection in order to foster the development of both relational skills and a coherent professional identity.

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