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Doctoral Thesis:

Construction of a workshop protocol on psychotherapeutic competences for the management of complex depression in institutional primary care setting

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DEDICATION

I dedicate this work to all the people looking for a light of hope and wish to find some answers in psychotherapy; to my clinician mentor, Dr Juan Yáñez; and my patients, who have taught me to develop my sensitivity to be a better psychotherapist.

My deepest wish is to contribute to all those colleagues who are on this exciting professional development journey.

In memory of Estercita

OUTLINE

FIGURES OUTLINE

TABLES OUTLINE

Abstract

Background: In Chile, the prevalence of depression is high, constituting one of the main reasons for seeking mental health assistance in institutional settings, but psychologists who are working in primary care report having weak competences for treating depression and unlike in other countries, there is a lack of competence frameworks to equalise the performance of professionals.

Aim: To construct a workshop protocol on psychotherapeutic competences for the management of complex depression aimed at psychologists working in primary care.

Methodology: A mixed sequential exploratory design was employed that comprised two studies: a qualitative one (GT) to explore psychotherapeutic competences from the protagonists' perspective; and another that involved the construction of workshop protocol and its validation with a Delphi methodology.

Results: It is proposed a framework of competences that comprises four domains: knowledge (i.e. knowing about depression and its comorbidities); technical competences (i.e. knowing what to do and adapting techniques); interpersonal competences and attitude (i.e. being welcoming, active, and engaged); and professional and personal competences (i.e. being flexible in the exercise of one's role). Based on these frameworks, it constructed the workshop protocol validated with a consensus ≥80% composed by six modules: 1) theoretical-empirical basis of the protocol; 2) complex depression; 3) objectives, goals, focus, and crisis intervention; 4) suicide risk; 5) therapeutic relationship; 6) social dimension and networks in depression management.

Discussion: It is highlighted the integration of patients, psychologists and experts perspectives to proposed a transtheoretical framework of competences and the challenges to construct a workshop protocol to train them.

Conclusion: a framework of competencies and a workshop protocol to train them are proposed to guarantee more appropriate psychological care of depression in primary health care.

Keywords: psychotherapeutic competencies, expectations, depression, primary care, psychological care

1. INTRODUCTION

Depression affects over 300 million people worldwide (WHO, 2020) and has been forecast to become the second leading cause of disability by 2020 (Mathers & Loncar, 2006). In Chile, 6.2% of the population is affected by a depressive disorder (Minsal, 2018a), surpassing the global prevalence (4.4%; WHO 2017).

As in other countries, depression has been incorporated into the National Mental Health and Psychiatry Plan (PNSM) and into the Explicit Health Care Guarantees. Depression management has been integrated into primary health care (PHC) through a program for the detection, diagnosis, and integral treatment of depression, which combines medical and psychosocial interventions, including psychotherapy (Minsal 2013, 2017a).

Even though the policies implemented are important for guaranteeing the proper management of depression in the Chilean health system, studies conducted in the country had revealed inconsistencies in this plan due to the insufficient training and competences of professionals, all of which hinders its objectives (Alvarado & Rojas, 2011; Minoletti & Zaccaria, 2005; Marín et al., 2016; Bedregal, 2017). Overall, this is one of the critical issues affecting Chile's health care network (MINSAL, 2018b).

This gap between the depression figures in Chile, the need to improve access to quality treatment for those affected, and the necessity to offer training in psychotherapeutic competences to improve depression management were the three main reasons for this doctoral research project. The study sought to devise a training program aimed at psychologists working in PHC, where they are usually called upon to help people from more vulnerable socioeconomic backgrounds (MINSAL, 2017b)

As previously noted, even though the Ministry of Health has issued clinical guidelines for depression treatment that orient treatment plans, it has been observed that professionals tend to disregard these indications (Alvarado & Rojas, 2011). Also, as of this writing, no psychotherapeutic competence training programs have been implemented to match the level of the professionals who enter the health system, unlike in other countries. Abroad, the most noteworthy example is the Improving Access to Psychological Therapies (IAPT) program, NHS, which proposed a framework of competences for certain therapeutic approaches and common mental health disorders (Roth, 2015). Lack of training programs to level the professionals' competences is one of the key reasons why the first part of this thesis was to explore and propose a theoretical model of psychotherapeutic competences to

treat depression that any psychologist could use regardless of their theoretical approach. Then, the second part was to build a training protocol based on these competences.

The training protocol was targeted at psychologists who work in PHC institutions since they represent 92% of the psychologists in the public system (Minoletti, 2014) and deal with over 50% of all instances of mental health attention (Minoletti et al., 2012). Furthermore, this is the level where professionals must "solve" the case of patients with depression (De la Parra et al., 2019; MINSAL, 2017b)

It is worth noting that effective psychotherapeutic treatments for depression and its competences have been developed mainly in high-income countries (HIC) (Cuijpers et al., 2018) (e.g. CBT, Interpersonal Psychodynamic Therapy) and then imported to other parts of the world. Unfortunately, this is often done without culturally adapting foreign psychotherapeutic models or without an exploration of the competences that clinicians need to treat "a specific population, in particular settings", where contextual limitations often make it impossible to offer traditional psychotherapy (LMICs, Kohrt et al., 2015; Kutcher, 2005; Patel et al., 2018; Patel et al., 2011).

This thesis aims to construct a workshop protocol for building psychotherapeutic competences for depression management in primary health care settings (PHC). To achieve this goal, an exploratory, qualitative, and empirical study was conducted whose purpose was to propose a theoretical model of psychotherapeutic competences through four analysis processes: 1. Patients' expectations and needs regarding the treatment; 2. The perspective of the psychologists who work in (non-ideal) institutional settings; 3. The perspective of experts regarding the competences that all psychologists should possess to treat this disease; 4. The integration of these three perspectives into a proposal of a model that reflects the dynamics between the competences domains.

The second study consisted of generating a workshop protocol to train psychotherapeutic competences for the management of complex depression aimed at psychologists working in PHC. To achieve this goal, we formed a team of editors from the research project entitled "Training of competences for the psychotherapy of depressive disorders in institutional primary health care settings", within the framework of the 16th National Competition of Research and Development Projects in Health Care (FONIS, 2019). This team was tasked with producing the modules of the training protocol based on the therapeutic competences yielded by Study 1 (qualitative). In addition, we integrated

evidence provided by the Millennium Institute for Depression and Personality Research (MIDAP) on complex depression and information derived from the model of psychotherapy in institutions in Chile (De la Parra et al. 2018, 2019). The last step in the study consisted of having the protocol evaluated by a panel of expert raters through the Delphi protocol until they reached a level of consensus ≥80% concerning its pedagogical aims and contents.

This doctoral dissertation ends with delivering a product: the Protocol for Training in Psychotherapeutic Competences (PECP-2). This protocol comprises six modules: 1) the theoretical-empirical basis of PECP-2; 2) Complex Depression 3) Treatment goals and objectives, focus and crisis; 4) Suicide risk; 5) Therapeutic Relationship 6) Social dimension of depression and network management.

The protocol was produced as a textbook for future trainees and informed the construction of a b-learning platform adapted to the pandemic context. It should be noted that this training program is being implemented with psychologists from four primary health care centres, and its acceptability will be evaluated shortly in the context of FONIS research. Figure 1 outlines the contents of this doctoral dissertation.

Figure 1. *Dissertation Outline*

Note. The illustration shows an outline of the contents of this thesis. 1) Introduction; 2) Rationale, which presents the empirical and theoretical basis of the thesis; 3) Purpose of the research project; 4) Presentation of Study 1 (qualitative), including method, results, and discussion sections; 5) Presentation of Study 2, focused on the construction of the training protocol and its validation through a Delphi study; 6) Conclusions; 7) Appendixes; 8) References.

2. RATIONALE: THEORETICAL AND EMPIRICAL BACKGROUND TO THE RESEARCH PROBLEM

2.1 DEPRESSION IN CHILE AND ITS MANAGEMENT IN THE HEALTH CARE SYSTEM.

This disorder is one of the country's main health problems. In Chile, 6.2% of the population is affected by a depressive disorder (MINSAL, 2018), surpassing the global prevalence (4.4%; WHO 2017). Depression is the second leading cause of loss of disability-adjusted life years (8.8%) and the top reason in women (MINSAL, 2013; WHO, 2017; Errázuriz et al., 2015).

The prevalence of depression in Chilean women is five times higher than in men (10.1% vs 2.1%) (Hojman et al., 2018), with the rate of severe depressive symptomatology being twice as high in women from lower socioeconomic backgrounds as in higher socioeconomic status ones (Hojman et al., 2018). Furthermore, previous studies have reported an association between low perceived social support and depressive symptoms (Dagnino et al., 2017). Concerning men, no differences in the prevalence of depressive symptoms are observed in connection with income (Hojman et al., 2018). Studies conducted in other countries have also shown that women from more disadvantaged backgrounds are more vulnerable to the disease (Levy & O'Hara, 2010; Patel et al., 2018). Likewise, patients who have experienced early childhood adversity and trauma constitute another group prone to more severe depression symptoms (Vitriol et al., 2017).

Chilean suicide rates increased by 90% between 1990 and 2011, while those of member countries of the Organization for Economic Co-operation and Development (OECD) have gone down by 20% on average (OECD, 2014). Well-known studies (Hidaka 2012; Moyano & Barría, 2006) have shown a link between GDP per capita and depression and suicide risk: wealthier countries tend to display higher depression prevalence.

As a consequence of economic growth community-centric societies to become into individualistic and competitive societies, increasing the prevalence of depression (Kato & Kanba, 2017; Krause et al., 2015; Orchard & Jimenez, 2016; Patel et al. 2018). Furthermore, global growth is not aligned with the subjective and safety needs of human development (PNUD, 1998; 2017). This discrepancy between country-level development and the dispiriting personal reality of Chileans was illustrated by the "social explosion" of October 2019, when people demonstrated against the deep inequalities and social malaise

with slogans such as "It was not depression, we needed social justice" and "No more fluoxetine; more social justice" (Toro, 2020).

A program for the detection, diagnosis and comprehensive treatment of depression was implemented in primary health care (PHC), combining medical and psychosocial interventions and providing a set of Clinical Guidelines for decision-making (Alvarado & Rojas, 2011; MINSAL, 2013, MINSAL, 2017a). Nevertheless, several authors have remarked on a number of inconsistencies in depression management which result from insufficient training and a lack of competences among the professionals in charge of treatment delivery (Acuña et al., 2016; Alvarado & Rojas, 2011; Marín et al., 2016; Minoletti & Zaccaría, 2005). Some of the weaknesses identified in PHC depression treatment were: 1) incorrect diagnoses, which tended to downplay the severity of the disorder; 2) non-application of the treatments included in the Clinical Guidelines (pharmacotherapy, psychotherapy, and psychosocial group interventions); 3) high treatment dropout rates (34.9%) (Alvarado & Rojas, 2011).

Concerning the situation in industrialised countries, only 5 to 40% of patients receive appropriate treatment in primary care settings (Neumeyer-Gromen et al., 2004). Thus, around the world treatments for depression in this setting are often ineffective and unsatisfactory (Barley et al., 2011; Araya et al., 2006).

It is worth pointing out that Chile has a mixed health care system with public and private administrators. In this context, university clinics are a good choice for people who cannot afford private psychotherapy sessions (De la Parra et al., 2018). In institutional settings of this type (PHC and outpatient university clinics), depression is one of the most frequent reasons for seeking help (Minoletti et al., 2012; Minoletti, 2014; De la Parra et al., 2018).

Psychotherapeutic care in institutional settings, especially in primary health care, is often challenging for psychologists due to: 1. The high pressure of care and the inadequate way of scheduling patients - which response to medical scheduling rather than a psychotherapeutic process - impacts negatively on the frequency of sessions, being limited to offering a monthly session or a session every two months (Fisher et al., 2019; De la Parra et al. 2019); 2. A limited duration of sessions, which on average in primary care is 20 minutes and does not consider the time to fill the clinical record (Planella & Martinez, 2018), a standard that is far from the 45-50 minutes recommended in other research

(Bruijniks et al., 2015); 3. The high waiting list is a phenomenon that is recognised as a problem both in public services and university clinics (MINSAL, 2018c; De la Parra et al., 2018). A patient could wait between 48-80 days for their first psychological care if the model of care does not fit the needs of the institutional setting (Planella & Martinez, 2018; De la Parra et al., 2018).

In brief, effective depression management is a priority in Chile, which prompts the need to conduct studies to improve the quality of the treatment received by those who need it most. In this context, this thesis is an effort to enhance the training of primary health care professionals to address the complexities of this disorder more effectively.

2.2 COMPLEX DEPRESSION: WHY DO WE ADOPT THIS TERM AND NOT JUST "DEPRESSION"?

This dissertation employs the term *complex depression* (NICE, 2017) to stress depression is not a one-dimensional phenomenon (Botto et al., 2014). Instead, depression can become more complex due to clinical, demographic, characterological, and attitudinal factors (Delgadillo et al., 2017). Furthermore, depressive disorders are among the most frequent comorbidities in patients with borderline personality disorder (BPD; Leichsenring et al., 2011). This comorbidity is also a consequence of the overlap of symptoms in both disorders, for instance, affectivity alterations (dysregulation) or suicidal ideation (Behn et al., 2018; Köhling et al., 2015; Leichsenring et al., 2011). The notion of "complex depression" is more accurate to the etiological, clinical reality of depression, given the large body of evidence showing that it is not a homogeneous disorder and that its manifestations and intensity result from a person's multiple depressive experiences (Blatt et al., 1982; Fuhr & Shean, 2001; Klein et al., 2011).

From a psychodynamic perspective, the model advanced by Blatt (1974) explains the influence of personality styles on clinical depression symptoms and the many ways in which patients can respond to treatment (Ouimette et al., 1994). Blatt described the "anaclitic" personality style, a type of dependent personality characterised by feelings of helplessness and fragility, fear of abandonment, and the desire to be protected and loved. People with this personality style benefit from support interventions (De la Parra et al., 2017). The "introjective" personality style, on the other hand, is a self-critical personality characterised by intense feelings of inferiority and guilt and the idea that one must strive to compensate for one's failure to meet certain expectations or standards. People with this

personality style are believed to be non-responsive to expressive support therapy or brief interventions (De la Parra et al., 2017).

Concerning self-criticism (or perfectionism), this trait can make depressive symptoms more severe than the dependent style (Hermanto et al., 2016; Chui et al., 2016; Overholser & Dimaggio, 2020). It has also been associated with inadequate response to treatment (Blatt et al. 1995, Chui et al. 2016; Marshall et al. 2008). Self-critical patients can be highly challenging for the therapist's performance. They can generate tensions in the alliance due to their fear of compassion or the tendency to negatively interpret the impossibility of reaching their "high standards" (Hermanto et al., 2016; Overholser & Dimaggio, 2020). Therefore, the therapist must develop personal competences such as patience, persistence, and a "playful attitude" to provoke the patient (Overholser & Dimaggio, 2020).

In Chile, several studies sponsored by the Millennium Institute for Depression and Personality Research (MIDAP) have revealed that depression is a heterogeneous disorder marked by the functioning of the patient's personality structure, depressive experience style, recurrence of the disease, suicide risk, contextual factors, and medical comorbidities, all of which has an impact on treatment response (De la Parra et al., 2021; 2017). These studies have provided evidence for the predictive validity of the Self-Critical (Introjective) and Dependent (Anaclitic) personality styles proposed by Blatt (1974; 2004) regarding patient response to psychotherapeutic treatment. For instance, more self-critical patients (in contrast with more dependent ones) display higher dropout rates and benefit less from psychosocial interventions, attaining less symptomatic change at the end of the process (De la Parra et al., 2017). In addition, self-critical patients display more biological reactivity to stress with a low subjective perception of it, low mentalisation, and a more vulnerable personality structure (De la Parra et al., 2017). Using the OPD-2 system, authors have found that greater personality structure vulnerability correlates with more depressive symptomatology, recurrence of depressive episodes, and poorer quality of life (Dagnino et al., 2017; Crempien et al., 2017).

Regarding suicide risk as such, depression and prior suicide attempts are the most significant predictors of consummated suicide (WHO, 2014). Styles of depressive experience have also been found to be predictors of suicidal behaviour, with self-critical people being more vulnerable to attempt suicide in the face of intrapsychic stressors (the

attempt being an escape), and those with a dependent style responding to interpersonal stressors (as a way of communicating their unhappiness to others) (Fazaa & Steward, 2003). A mediating role of self-critical style has also been observed between anxious and avoidant insecure attachment and suicidal behaviour (Falgares et al., 2017).

Considering the high suicide risk in Chile (noted above), it is relevant for mental health professionals to have the knowledge and competences needed to prevent it. Studies sponsored by MIDAP (e.g. Barros et al., 2020; Morales et al., 2016; Echevarri et al., 2015) have shown that suicidal behaviour is dynamic, that it manifests itself individually, and that it is possible to evaluate states that make individuals vulnerable to suicidal behaviour through the identification of protective and risk factors. Furthermore, these studies have yielded clinical guidelines by recognising variables relevant to each subject's intervention, mainly by assessing feelings of satisfaction/dissatisfaction with oneself and one's life, satisfaction/dissatisfaction with one's achievements, and reasons to live/stay alive if suicidal ideation is present (Barros et al., 2019).

Given this background, it was decided to administer instruments to confirm the interviewees' depression diagnosis, severity, and suicide risk with the MINI International Neuropsychiatric Interview, Spanish version 5.0.0.0 (Sheehan et al., 1998; Ferrando et al., 2000). Also, to evaluate the patients' personality structure integration and depressive style, we administered the Operationalised Psychodynamic Diagnostic (OPD-2) system (OPD Task Force, 2008) and the Personality Styles Questionnaire: Chilean version (Rost & Dagnino, 2011) of the Depression Experience Questionnaire (DEQ, Blatt et al., 1976) respectively.

2.3. PSYCHOTHERAPEUTIC COMPETENCES FOR DEPRESSION TREATMENT IN INSTITUTIONAL SETTINGS: PATIENTS' PERSPECTIVES, PRACTITIONERS' PERSPECTIVES, AND COMPETENCE FRAMEWORKS FROM EXPERTS.

2.3.1 THE PERSPECTIVE OF PATIENTS

Cuijpers (2011) has noted that, despite the large number of studies and controlled trials conducted to determine the effectiveness of depression treatment, authors have overlooked the perspective of the depressive patient. In his opinion, "we still do not know very well what having depression means for patients, what they need from treatments and how their problems can be resolved" (Cuijpers, 2011, p.2). This shortcoming of depression research

has been pointed out in other studies (Chevance et al., 2020, Ormet et al., 2019). Approximately only 0.07% of major depression studies include "patient advocacy" (Cuijpers, 2011), even though evidence-based approaches recommend considering patient preferences and expectations in treatment planning (APA, 2006; Mulder et al., 2017).

Given the importance of identifying the patients' needs and expectations regarding their depression treatment, the first specific objective of the Study (qualitative) was to ask them what they expected from psychological care. Our assumption was that their answers would help us to identify psychologist competences and treatment qualities aligned with their expectations and requirements.

In this regard, quantitative and qualitative studies have explored patients' expectations, preferences, and views with respect to what they consider to be important in their treatment. According to data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP), patients' expectations of improvement predict the probability of full recovery (Sotsky et al., 1991; Elkin, 1994) and predict patients' active engagement in therapy, which is also associated with improvement (Meyer et al., 2002). Expectations have been shown to be the best predictors of the therapeutic alliance after the first session (Rizvi et al., 2000) and have a small but significant positive effect size on treatment outcome ($d=.36$, $p<.001$) (Constantino et al., 2018). Also, the generation of hope and positive expectations have been considered a critical factor in many forms of healing (Frank & Frank, 1991).

A qualitative study that explored pre-treatment expectations in a sample of 6 adolescents with depression (aged 15-19 years) identified four important topics in their narratives: being cautiously hopeful, seeing the therapy as a long and difficult process where they have to deal with negative emotions or suppressed memories, considering that the therapy is a chance to understand themselves, and wishing to find the "perfect" therapist for them (Weitkamp et al., 2017).

Van Grieken et al. (2014) interviewed 27 patients who had recovered from MDD to explore their perspectives on the impeding characteristics of professional treatment. The interviewees identified as barriers the lack of clarity and consensus with the professional about the nature of their depression and the aims of the treatment. Many patients reported finding it difficult to voice their disagreements or state that they felt that they were not making any progress. Also, they considered that their treatment "was not personalised" or

complained that they received no explanation of what it consisted of in. Another barrier mentioned by the interviewees was that the relationship with the clinicians was poor, as they did not give them their trust or failed to convey hope.

Regarding the clinicians' attitude, the patients complained that they were always "in a hurry", "did not take them seriously", and lacked "compassion", "humanity", and "proactivity". The patients appreciated clinicians who were "leaders", which involved "being an expert", "choosing a focus", and "guiding them and setting boundaries" (Van Grieken et al., 2014, p. 157). Lastly, the participants were not satisfied with the professionals' limited availability when they needed help due to the long waiting lists or the difficulties they encountered when trying to contact the clinician during and after treatment. The latter point has been identified by other authors as possible barriers that characterise certain institutional settings, preventing patients from getting weekly sessions and being treated by the same therapist, or causing sessions to be too short (de la Parra et al., 2019; Fischer et al., 2019; Koekkoek et al., 2006; Moukaddam et al., 2017; Rojas et al., 2015).

Other studies have revealed that depressed patients had a negative experience because providers do not listen to them, lack empathy, or are only interested in filling out their medical records and provide no guidance for their problems (Johnston et al. 2007), displaying none of the "proactivity" reported by Van Grieken et al. (2014).

A recent qualitative study aimed at identifying patients' views on the quality of depression and anxiety care in Canadian PHC (Ashcroft et al., 2020) reported that the participants (N=40, focus group) appreciated that clinicians were empathetic and compassionate, understood the patient, and belonged to a sociocultural milieu similar to theirs. Having a trust-based relationship with their provider, communicating in a way that aligns with patients' preferences, and being included in shared decision making, were reported as being particularly valuable.

Kan et al. (2020), from the perspective of patients (N=11) and clinicians (N=7), examined relevant outcomes of depression treatment in mental healthcare settings. The patients –whose opinion coincided with that of the clinicians– highlighted goals in the areas of social functioning and interpersonal relationships. Patients with a history of chronic depression stressed that they needed to find "new ways of functioning" (Kan et al., 2020, p.3) that would enable them to navigate the circumstances that they encountered.

They also stressed the importance of preventing relapses and noted that they needed to "accept depression as part of life in order to keep going" (Kan et al., 2020, p.4).

Studies largely based on surveys have collected relevant information about the needs of patients with depression and the aspects that they regard as important for their treatment. According to the 2007 World Survey conducted by the World Health Organization (WHO 2007), which covered 245,404 people in 60 countries, 9.3 to 23% of the respondents with one or more chronic diseases also had depression and had the poorest health indexes in relation to depression alone. In another international survey conducted by Chevance et al. (2020) in 52 countries –which included 1,912 patients with depression as well as informal caregivers (n= 464) and healthcare professionals (n=627) (psychologists, psychiatrists, nurses)– 80 domains were defined that can help researchers to identify the benefits of depression treatment for these three groups, which exhibited significant convergences. These domains included: reduction in self-harm symptoms associated with suicide attempts; reduction in depressive symptoms, mood symptoms, and mental pain (with patients highlighting anxious symptoms); improvement in motivation and reduction in physical symptoms; improvement in biased perceptions of self (e.g. low self-esteem); improvement in functioning (e.g. self-care, daily tasks); and alleviation of social isolation. The latter domain received the most mentions by the patients, followed by improvements in their interpersonal relationships, which they illustrated by noting that "isolation and loneliness are the worst" (Chevance et al., 2020, p.698).

Lastly, after surveying the views of patients and General Practitioners (GPs) on the treatment of recurrent depression, which was answered by 1,010 patients and 200 GPs, Manning & Marr (2003) reported that 65% of the interviewees had discontinued their pharmacotherapy, which might be a cause of the recurrence of the disorder. Although the patients expressed their concerns over relapses, it was observed that they remained untreated or interrupted their treatment. Even so, they noted that they preferred to speak to their GP –rather than to a relative or a psychiatrist– if they had trouble with their treatment. Other studies have also mentioned patients' preferences for being listened to or receiving psychotherapeutic or psychological care over medical treatment. (Johnston et al., 2007; Bosman et al., 2008).

2.3.2 THE PERSPECTIVE OF PRACTITIONERS

The effect of therapists on therapeutic outcomes has been estimated to range from 8 to 17% (Lutz et al., 2007). For instance, Kim et al. (2006), based on data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP), found a 5-10% variance ascribed to therapists (with no variance being associated to the use of either CBT or IPT). Therefore, it is important to consider the therapist variables that can positively or negatively impact patient change. In this regard, Anderson and colleagues (2016) have shown that Facilitative Interpersonal Competences (FIS) (i.e. verbal fluency, emotional expression, persuasiveness, warmth/positive regard, hopefulness, empathy, alliance bond capacity, and alliance-rupture-repair responsiveness) (see Anderson et al., 2015, p.58) can contribute to the client's progress, especially if the process is brief (≤ 8 sessions).

It has been noted that the therapists who achieved the highest effectiveness in depression treatment had a more psychological than biological orientation in their interventions and tended to be psychologists rather than psychiatrists, primarily employing psychotherapy alone (73.8%) and only occasionally (19.6%) combining psychotherapy with medication (Blatt et al., 1996). Likewise, it was observed that the therapeutic attitude adopted by the clinicians regarding the aetiology of depression and its treatment could have an indirect influence on good outcomes if said attitude interacted with the expectations and powers that the patients had regarding their depression and the process (Blatt et al., 1996).

With respect to depression management in routine practice, especially in mental healthcare settings, it should be noted that specialists are less integrated with such contexts, which forces clinicians (who are not experts) to treat more complex patients unaided (Rubenstein et al., 1999). Studies have shown that physicians (GPs) find it hard to diagnose depression, underestimating its severity and considering that their competences are limited (Alvarado & Rojas, 2011; Acuña et al., 2016; Burroughs et al., 2006; Shah & Harris, 1997). This situation, compounded by a negative attitude toward diagnosing depression, results in unsatisfactory clinical performance (Dowrick et al., 2000; Haddad et al., 2011). Therefore, GPs are more likely to act intuitively and often avoid diagnosing depression, as they feel that they cannot offer their patients anything better due to their limited training in therapeutic interventions, short time per session, and the impossibility of

referring them to a psychologist or secondary level care due to long waiting lists, among other aspects (Burroughs et al., 2006; Chew-Graham et al., 2002; Barley et al., 2011).

As for Chilean psychologists, they consider that the most necessary interpersonal competences for doing their job in primary care contexts are empathy, emotional support, communication, and assertiveness (Scharager & Molina, 2007). However, they report being poorly equipped to treat depression (Z <.10) (Bedregal, 2017) (see details in the Research Problem section).

Beyond competence deficits, it has been observed that more years of practice correlate with better therapeutic management of complex patients, better communication, and good, respectful interaction (Edgoose, 2012; Hinchey & Jackson, 2011). In contrast, younger clinicians tend to report frustrations, especially physicians who treat patients with psychosocial issues (Krebs et al., 2006). It has also been observed that patients with personality pathologies or who require additional care from the treatment teams tend to generate negative feelings among clinicians, such as rejection, pessimism, fatigue, and unease, reinforcing their idea that they are dealing with a difficult patient (Fischer et al., 2019; Haas et al., 2005, Koekkoek et al., 2006). In contrast, when therapists receive training in personality disorders with the aim of improving attitudes and service provision, they can develop competences such as empathy and the ability to provide a suitable diagnosis, thus increasing the likelihood of a successful treatment outcome (Beryl & Völlm, 2018; Shanks et al., 2011).

In general, therapists' competences have been explored in research on the integrity and effectiveness of treatment handbooks (Perepletchikova & Kazdin, 2005; Vermilyea et al., 1984; Fairnburn & Cooper, 2011), with few studies examining what practices are considered to be useful in "real-world practice". For this reason, the second specific objective of the qualitative study was to explore the views of psychologists regarding the competences needed to treat depression and complex depression.

2.3.2 COMPETENCES FRAMEWORKS FROM EXPERTS

In the field of psychotherapy, one can find multiple definitions of psychotherapeutic competences, but all of them are theoretical and not empirical. Also, there is no consensus about the methodology for generating these frameworks (Roth, 2015). The definitions and frameworks most relevant to this thesis will be presented below.

In the field of professional psychology practice, competences have been defined as the knowledge, skills, and attitudes –and their integration– needed to provide the community with effective care (Hatcher et al., 2013; Kaslow et al., 2004; McDaniel et al., 2014; McClelland, 1973). Epstein and Hundert (2002) have advanced one of the most comprehensive definitions of professional competence in the medical field. For them, competence is "the habitual and judicious use of knowledge, technical competences, clinical reasoning, emotions, values, and reflections in everyday clinical practice for the benefit of the individual and the community being treated" (Epstein & Hundert, 2002, p.226). According to Kaslow (2004), this definition is also applicable to psychologists.

Anderson and Hill (2017) proposed a contextual model of therapist competences, identifying four domains: 1) technical competences, which refers to the interventions and specific skills described in treatment manuals; 2) relational competences, which refers to interpersonal and emotional communication competences, including empathy, positive regard, warmth, and genuineness; 3) conceptual competences, which refers to the cognitive capacity to understand the patient; 4) cultural competences, which refers to the capacity to understand the patient's sociocultural context.

According to Barber et al. (2007), competences within a psychotherapy context have at least two meanings: global competency and limited-domain competency. The former refers to the broader ability to gain a sense of perspective when conducting the intervention, addressing multiple clinical problems, and being able to help the patient to fulfil his/her objectives. In contrast, limited-domain competences can be understood as a subset of global competence that is solely expressed within the context of a specific intervention or treatment modality (Barber et al., 2007).

A meta-analytic review conducted by Webb et al. (2010) demonstrated that therapist competences have a small, positive, and significant influence on depression treatment outcomes (r=.28), whereas the link between therapist adherence or competences and other disorders is non-significant. A larger effect size was also observed in studies that did not control for therapeutic alliance.

Regarding the specific competences –comparable to limited-domain competences– that have been linked to good patient outcomes, the literature has highlighted, though not exclusively, cognitive and psychodynamic therapeutic approaches (see CBT Kuyken &Tsivrikos, 2009; Branson et al., 2018; Shaw et al., 1999; and psychodynamic BDT,

Barber et al., 1996; Dynamic Gibbons et al., 2016; SET Gibbons et al., 2012). Previous studies have shown that specific skills such as homework therapist ability in CBT (DeRubeis & Feeley, 1990; Ilardi & Craighead, 1994) and expressive ability in BDT (Barber et al., 1996) predicted symptoms reduction.

Roth (2015) and colleagues developed competences frameworks for treating depression and other disorders by an Expert Reference Group (ERG) whose members were selected considering their contribution to research and their expertise in therapist training. This major effort sought to produce a national curriculum of competences within the context of the Improving Access to Psychological Therapies (IAPT) program (Roth, 2015), which has become an example of competence unification for various types of therapies (e.g. CBT, systemic, humanistic, psychodynamic). These ERGs defined 5 domains for each therapeutic approach: 1) generic competences, which are the competences shared by all psychotherapy types based on common factors; 2) basic therapy competence, which are the competences employed in most of the interventions belonging to an approach (e.g. CBT, homework; IPT, ability to identify an interpersonal problems); 3) specific therapy techniques, which are competences associated with higher-intensity techniques (e.g. CBT, Socratic questions; IPT, communication analysis); 4) problem-specific competences, which are the sets of competences for treating a disorder listed in treatment manuals (CBT, behavioral activation, Jacobson or Beck's therapy; IPT for depression, Weissman and colleagues); and 5) metacompetences, which are the competences that therapists must make use of to implement and adapt therapeutic strategies across all levels considering the patient's needs and the time available for treatment (Roth & Pilling, 2007; Lemma et al., 2008; see more at https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks).

Even though well-defined competence frameworks have been produced for treatments proven to be effective in depression management (Roth, 2015; Cuijpers et al., 2019), it must be stressed that most have been developed in high-income countries (HIC) (Cuijpers et al., 2018) and that there is limited evidence about the competences that clinicians need to treat common disorders in other contexts (LMICs, Kohrt et al., 2015; Kutcher, 2005; Patel et al., 2018; Patel et al., 2011). Based on this information, this doctoral research seeks to determine which psychotherapeutic competences are needed to treat one of the disorders that have been most extensively studied in controlled trials and whose treatment outcomes have not been found to differ significantly among major psychotherapy modalities

(Cuijpers et al., 2014; Cuijpers et al., 2008). This study is an attempt to allow clinical psychologists, regardless of their theoretical approach, to incorporate psychotherapeutic competences that are better aligned with real practice and the common elements of psychotherapy (Lambert, 2013; Wampold, 2015), adopting a person-centred perspective (Blatt & Luyten, 2009) and considering the institutional context of health care centres in LMICs (achieving "ecological validity", Bernal et al., 1995).

The following section presents a summary of competence frameworks for professional psychologists working in various institutional settings proposed by experts.

2.3.3.1 COMPETENCE FRAMEWORK FOR PROFESSIONAL PSYCHOLOGISTS WORKING IN INSTITUTIONAL SETTINGS.

Treatments for depression in complex health care services are highly challenging for clinicians due to the high levels of pressure affecting care delivery, administrative burden, insufficient frequency between sessions, a lack of supervision, and a lack of competences or tools to care for difficult patients (Fischer et al., 2019; Haas et al., 2005; Koekkoek et al., 2006). In real-world practice, it is necessary to offer cost-effective services that cover the whole range of user's needs since patients are in different places within the life cycle, hold different beliefs, and belong to specific cultures (McDaniel et al., 2014).

McDaniel et al. (2014) proposed a competence model for psychologists working in primary health care (PHC) centres which comprises six domains: Science (e.g. science related to the biopsychosocial approach), Systems (e.g. leadership/administration interdisciplinary systems, advocacy), Professionalism (e.g. Professional values and attitudes, diversity, ethics, reflective practice/self-assessment/self-care), Relationship (Interprofessionalism, Building and sustaining relationships), Application (Practice management, Assessment, Intervention, Clinical consultation), and Education (Teaching and Supervision). Based on this framework, Bedregal (2017) designed an instrument to evaluate the perceived competences of PHC psychologists and physicians (see results in Research Problem section).

Rodolfa et al. (2005) proposed the Cube Model, with one side containing the *foundational competency domain*, composed of features that form the basis of the psychologist's work (e.g., scientific knowledge, reflective practice, relationships). Another side contains the *functional competency domain,* which comprises features of professional

practice (e.g., assessment, diagnosis, conceptualisation, intervention, supervision). The third side refers to the clinician's professional development (e.g. doctoral education).

Other authors have also defined fundamental and functional competences for working in Academic Health Centers (AHCs; Kaslow et al., 2008). An example of this kind of setting is the Mental Health Unit of the UC-Christus Health Network, one of the centres where patients and therapists were interviewed. In this context, regarding basic competences, psychologists must convey responsiveness to the needs of the patient and his/her family, which requires adapting the treatment to emergent requirements, aligning treatment plans in a way that is acceptable to the patient, his/her family, and the treatment team (among other aspects highlighted in Kaslow et al., 2008). Regarding *functional competences*, one of their key aspects is the ability to collect psychosocial information, knowing how to make a diagnosis, and being able to generate a conceptualisation of each case, which must be clearly conveyed to the patient and other members of the treatment team. Lastly, psychologists must be able to employ the best available evidence to prevent and treat common psychological problems and comorbid medical conditions. In this context, authors have proposed a collaborative treatment plan involving patients and their families to increase motivation and treatment adherence, which constitute the main challenges of routine psychotherapeutic practice (intervention competences) (Kaslow et al., 2008).

Lastly, authors in Chile proposed a framework for psychotherapeutic care in public health centres (PHC) and university clinics based on adaptive indication (De la Parra et al., 2018; 2019, 2021). The term *adaptive indication* (Thomä & Kächele, 1989) involves adapting techniques to the patient's requirements and context and adjusting interventions throughout the process (De la Parra, 2017) to benefit multiple types of patients with a broad range of psychic and psychosomatic alterations, offering a variety of paths and opportunities for change. This model is built upon two key pillars: 1) knowing about evidence-based interventions (e.g. for depression treatment in public health care centres Cuijper et al., 2019) and 2) knowing the generic contextual model and the common factors of psychotherapy (Orlinsky, 2009; Wampold, 2015). Adaptive indication considers the patient's internal context and the external conditions that must be met for the treatment to be conducted, including institutional factors. Based on the premise of granting adaptive care, brief therapies (8-12 sessions) are recommended because it has been proven that this range makes it possible to attain a higher level of adherence and can increase patient recovery (Orlinksy et al., 2004; De la Parra et al., 2018). Furthermore, the model

emphasises the competences needed to set achievable goals with the patient, focalise, and carry out crisis interventions (De la Parra et al., 2018, 2019, 2021).

Adaptive indication, proposed by Thomä and Kächele (1989), can be likened to the term *responsiveness* (Stiles et al., 1998). Stiles and Horvath (2017) argue that effective therapists have achieved an *appropriate level of responsiveness;* that is, they consistently do the right thing, delivering individualised treatment tailored to each patient (Hatcher, 2015).

2.3.4 RESEARCH PROBLEM: THE NEED TO TRAIN PSYCHOLOGISTS IN COMPETENCES FOR THE PSYCHOTHERAPEUTIC TREATMENT OF DEPRESSION IN CHILE

Given the extensive amount of background information presented about depression as a public health concern in Chile, and considering the importance of being equipped to assess the factors that add complexity to this disorder, we sought to conduct a study aimed at addressing one of the weaknesses of the National Mental Health Plan, which has become one of the critical issues of the health care system: the insufficient training received by professionals to treat depression in public health centres.

One of the weaknesses of the National Depression Program implemented 20 years ago was that it did not include a standardised training program aimed at equipping psychologists to apply the Clinical Guidelines for Depression (MINSAL, 2013, 2017a). In other words, treatment recommendations and guidelines are available, but there is no training stage for psychologists to develop the necessary competences to treat depression in this context.

Bedregal (2017) confirmed the quality deficits affecting the training of psychologists who provide primary health care, observing problems when applying the Guidelines for Clinical Depression Management (MINSAL, 2013), as well as deficits in their perceived competence for depression management. Through an ad-hoc scale (based on the framework proposed by McDaniel et al. 2014, presented above) and using Z-scores, Bedregal and colleagues evaluated the professional competences of physicians and psychologists taking part in the GES program for depression treatment in public health care (FONIS-SM14I0020). The team found that the weakest competence domain for psychologists (n=55 of 72) was Depression Treatment (lower than .10), followed by Sociocultural Approach, Treatment Plan, and Clinical Diagnosis (slightly higher than .20).

The strongest competence was found to be Teamwork (.30), followed by Group Management, Professionalism, Psychologist-Patient Relationship, and Network Management (.40). It should be noted that the most critical competence domains are linked to the clinical-psychotherapeutic management of depression.

In the study by Bedregal and colleagues (FONIS-SM14I0020), the 55 psychologists consulted belonged to 22 different universities (n=55/72), which inevitably prompts the question of whether they are all equally prepared to work in settings as demanding as primary health care. In a prior study, psychologists had already reported the need for university syllabuses to match real-life practice in the health system, noting that undergraduates require stronger training in clinical and community psychology, public policy, and administration (13) (Scharager & Molina, 2007).

The need to develop a general competence curriculum to improve access to psychotherapeutic interventions and their quality has been addressed in developed countries such as the United Kingdom, where, as previously noted, several competence frameworks have been devised as part of the IAPT program (Roth, 2015). In order to cover the training needs of the professionals who are currently part of the depression program in primary health care, this doctoral thesis is aimed at constructing a protocol for training in psychotherapeutic competences that are better aligned with the needs and expectations of depression sufferers, considering the multiple factors that can add complexity to this disorder as well as the professional competences needed to perform well in this context, while also working to build global and common therapeutic competences (Barber et al., 2007, Kohort et al., Anderson et al., 2015; Wampold et al., 2015). All these considerations are expected to result in a protocol that makes sense to all professionals regardless of their therapeutic approach.

3. RESEARCH PROPOSAL

3.1 GENERAL OBJECTIVE

- To construct a workshop protocol on psychotherapeutic competences for the management of complex depression in the institutional primary care setting

3.1.1 *STUDY 1: EXPLORATION AND DESCRIPTION OF PSYCHOTHERAPEUTIC COMPETENCES NEEDED TO TREAT COMPLEX DEPRESSION IN AN INSTITUTIONAL PRIMARY CARE SETTING*

GENERAL AIM.

To explore and describe psychotherapeutic competences from the perspective of patients, psychologists, and experts.

SPECIFIC AIMS.

1. To describe what patients with complex depression need and expect from psychological care

2. To describe the professional qualities of psychologists and their views on the psychotherapeutic competences needed to manage complex depression in institutional settings

3. To describe experts' opinions on the competences necessary to manage complex depressions in the institutional primary care setting

4. To develop an emergent theoretical model of psychotherapeutic competences for treating complex depression from the perspective of patients, therapists, and experts.

GUIDING QUESTIONS OF STUDY 1.

- To address specific objective number 1, which consists in exploring patients' views, the following guiding questions were generated:

What do you expect from the intervention/psychological treatment?

What help do you expect to receive from the psychologist?

What characteristics (competences and attitudes) do you wish to find in your psychologist?

- To address specific objective number 2, which consists in exploring psychotherapists' views, the following guiding questions were generated:

What competences have you developed for tackling the challenges and needs of care in institutional settings?

What strategies have you developed, and what competences have you used to manage complex patients, considering their depressive symptomatology, personality features, adverse living conditions, or other comorbidities in institutional treatment setting?

What do you think about the competences that a psychologist must possess to manage complex depressions in institutional settings?

- To address specific objective number 3, which consists in exploring the opinions of experts, the following guiding questions were generated:

What knowledge, technical and interpersonal competences are needed to manage patients with depression and complex depression? Considering psychosocial factors (personality vulnerabilities, adversity background) and care characteristics in routine primary care settings?

3.1.2 STUDY 2: CONSTRUCTION OF A WORKSHOP PROTOCOL TO DEVELOP PSYCHOTHERAPEUTIC COMPETENCES AND ITS VALIDATION THROUGH THE DELPHI METHOD.

GENERAL OBJECTIVE.

To construct and validate the Workshop Protocol on psychotherapeutic competences for the management of complex depression in the institutional primary care settings.

SPECIFIC AIMS.

1. To construct a preliminary workshop protocol for training in psychotherapeutic competences for depression management in primary health care.

2. To evaluate the level of agreement between the experts regarding the workshop protocol until the highest level of consensus possible is reached (≥ 80%).

3. To construct version 2 of the workshop protocol based on the final validation provided by the Delphi panel.

GUIDING QUESTIONS OF STUDY 2.

- Do the objectives and contents proposed in the workshop protocol to develop psychotherapeutic competences foster the development of knowledge, skills, and attitudes for adequate management of depression in primary care settings?

4. METHODOLOGY

A non-experimental, trans-sectional design with a mixed exploratory sequential (predominantly qualitative) method was used for collecting and analysing data (Creswell & Plano, 2011).

This doctoral thesis comprises two studies: 1. the first study was qualitative and sought to explore and describe the competences necessary to treat depression from the perspective of patients diagnosed with depression. We employed a qualitative approach based on grounded theory (Strauss & Corbin, 2002; Chapman et al., 2015, Flick, 2018) with a constructivist paradigm, which makes it possible to construct knowledge using socially and experientially based realities (Guba & Lincoln, 2002) while also making it possible to develop an empirical understanding of the phenomenon –i.e. psychotherapeutic competences– (Levitt, 2021), describing the characteristics of the object of study from the subjective perspective of the actors of psychological treatments and according to academia (Krause, 1995; Levitt, 2021). Afterwards, we plan to propose a theoretical model of competences integrating all these perspectives. To achieve this goal –developing theoretical insights based on subjective views–, Grounded Theory (Strauss & Corbin, 2002; Chapman et al., 2015; Flick, 2018) is the most suitable choice.

2. The second study was devoted to the construction of the workshop protocol and its validation through the Delphi method. Based on the emergent theoretical model of competences yielded by qualitative study 1, a review of the empirical evidence produced by the Millennium Institute for Depression and Personality Research (MIDAP) regarding depressive experience profiles (self-critical/dependent), personality structure vulnerabilities, and suicide risk, and the Chilean Model of Psychotherapy in Institutions (see De la Parra et al., 2018, 2019, 2021), we constructed a training protocol that was submitted for evaluation by a Delphi panel (Dalkey et al., 1992) in order to attain external consensus regarding its objectives and contents. The Delphi study employed a quantitative methodology to calculate consensus, which was set at ≥ 80% (following the recommendations of studies conducted elsewhere in the world, e.g., Green et al., 1999; Hasson et al., 2000; Williams & Haverkamp, 2010). In addition, we conducted a qualitative content analysis (Cho & Lee, 2014) of the spontaneous suggestions offered by the panel.

5. FIRST QUALITATIVE STUDY: EXPLORATION AND DESCRIPTION OF PSYCHOTHERAPEUTIC COMPETENCES NEEDED TO TREAT COMPLEX DEPRESSION IN AN INSTITUTIONAL PRIMARY CARE SETTING

5.1 THE PRESENT STUDY AND ETHICAL CONSIDERATIONS

The purpose of this study was to explore the psychotherapeutic competencies needed to treat depression (complex depression) in an institutional setting according to patients, psychologists, and experts through a method informed by grounded theory (Corbin & Strauss, 1990) that is suitable for developing theoretical insights based on the perspective of those who take part in the psychotherapeutic process (Chapman et al., 2015). As previously noted, the Grounded Theory is well suited to generating theory based on the views of participants (Creswell & Poth, 2018) while also making it possible to develop new insights through the cumulative study of data, highlighting the subjectivities and the emergent phenomena resulting from data analysis (Glasser & Strauss, 1967; Corbin & Strauss, 1990; Levitt, 2021).

This study adopts a constructivist-interactional perspective that involves a close relationship between data collection and analysis while also requiring researchers to work sensitively and creatively (Strauss & Corbin, 2002). The assumption was that an in-depth exploration of patients' expectations who seek psychological help in institutional contexts could help build therapeutic competencies responsive to their needs and requirements. In addition, the exploration of the perspective of psychologists and experts of diverse orientations, but with academic expertise and experience delivering care in these settings, was expected to clarify which competencies match the profile of the patients and the contextual characteristics of routine practice beyond the specific therapeutic models (limited domain competency).

This research project was approved by the Health Sciences Research Ethics Committee of the Pontificia Universidad Católica de Chile.

5.2 PARTICIPANTS

5.2.1 PATIENTS

They were recruited with purposive sampling for convenience. Inclusion criteria were being over 18 years old, awaiting psychological care in an institutional setting, and being diagnosed with depression disorder. Thirteen women and three men (N=16), between 21

and 58 years old (M=35.82, SD=12.39), all of them self-identified as Chilean (Latin American ethnicity) and from lower-middle socioeconomic strata, were recruited in an outpatient university clinic (N=10) and two primary care facilities (N=6). The MINI International Neuropsychiatric Interview (Ferrando et al., 2000) was administered to verify depression diagnoses. All participants (N=16) met the criteria for major depressive episodes, 8 of whom had recurrent depressive episodes melancholic features. Also, 12 participants met the criteria for suicide risk (7 mild risk, 3 moderate risk, and 2 high risk). In addition, two instruments were administered to assess personality: the Operationalised Psychodynamic Diagnosis Structure Questionnaire (OPD-SQ, Ehrenthal et al., 2012), which showed an intermediate level of integration (M= 2.6; SD= 0.6; range [.83 to 3.44]), and the Depression Experience Questionnaire (DEQ, Blatt et al., 1976; Rost & Dagnino, 2011), which revealed that 6 patients had a dependent style, 6 had a self-critical style, and 4 were left uncategorised (see Table 1).

Table 1. *Patients' Characteristics*

Variable	N	%	M	SD
Gender				
Female	13	81.2		
Male	3	18.8		
Age			35.82	12.39
Previous therapeutic experiences	13	81.2		
PHC and other public institutions	10	62.5		
University-Clinic and other mental health centres	5	31.25		
Depression Diagnosis [1]				
Recurrent Major Depressive Episode	8	50		
Major Depressive Episode with Melancholic features	8	50		
Suicide Risk [1]	12	75		
Mild Risk	7	43.8		

Moderate Risk	3	18.8		
High Risk	2	12.5		
Personality Structural Functioning Diagnosis [2]				
Intermediate level of integration			2.6	0.6
Personality Styles [3]				
Self-critical	6	37.5		
Dependent	6	37.5		
No categorization	4	25		

Note. N=16; [1] MINI, Ferrando et al, 2000; [2] OPD-SQ, Ehrenthal et al., 2012; [3] DEQ, Blatt D'Afflitti, & Quinlan, 1976; Rost & Dagnino, 2011

5.2.2 THERAPISTS-PSYCHOLOGISTS

They were purposively recruited using a snowball strategy, including the maximum possible variety of approaches and work experience in various institutional settings (primary care, university-clinic; hospital). One exclusion criterion was set: only having work experience in private practice. The Development of Psychotherapists Common Core Questionnaire (DPCCQ, Orlinsky et al., 1999; 2005) was administered to collect personal and professional information. The sample consisted of 16 psychologists, 9 women and 7 men, with an average age of 44.19 years (SD=11.9); range [28-68]). Four psychologists were identified with a particular treatment mode: two Cognitive, one Psychodynamic and one Systemic. The others were identified as integrative. Their average work experience was 16.5 years (SD=10.5; range [4-35]). On a response scale from 0 to 5, psychologists reported high confidence in their overall therapeutic competences (M=4.2; SD=0.5), low difficulties in practice (M=1.89; SD=0.9), and the use of constructive coping strategies (M=3.21; SD=0.6). Their treatment goals focused on patients understanding their emotions, motivations, and/or behaviours (N=12), integrating excluded or segregated aspects of their experience (N=10), experiencing a reduction in symptoms (N=7), and improving the quality of interpersonal relationships (N=7) (see Table 2).

Table 2. *Therapists' Characteristics*

Variable	N	%	M	SD
Gender				
Female	9	56.3		
Male	7	43.8		
Age			44.19	11.9
Years of Work Experience			16.5	10.5
Workplaces				
Public institutional setting (PHC, hospitals)	9	56.3		
Private institutional setting	7	43.8		
(University-Clinics; Psicomédica)				
Psychotherapeutic Modalities [1]				
Cognitive	2	12.5		
Psychodynamic	1	6.25		
Systemic	1	6.25		
Integrative	11	68.75		
Qualities of psychotherapists [1]				
High confidence in their current therapeutic skills			4.2	0.5
Low difficulties in practice			1.89	0.9
Use of constructive coping strategies			3.21	0.6

Note. N=16; [1] DPCCQ, Orlinsky et al. 1999; 2005

5.2.3 EXPERTS

They were purposively selected for convenience. To be included in the study, prospective participants had to be professional psychologists or psychiatrists and depression researchers, belong to different theoretical approaches and speak English or Spanish. Eight experts were recruited, four men and four women of various nationalities (one American, two Germans, one Mexican, and four Chileans), with an average age of 53,6 years (SD=12,23; range [39-67]). Their average work experience was 27.25 years

(SD= 8.8; range [16-39]). Three experts self-identified as psychodynamic, while one expert reported being psychodynamic and having EMDR training. The remaining experts subscribed to two or more approaches, preferably problem-solving (N=2), cognitive-behavioural (N=3), motivational interviewing (N=2), and interpersonal (N=1); plus, 4 Latin American experts reported having a community, cultural, and gender perspectives. All experts held academic and management positions in the research and health care fields (See Table 3)

Table 3. *Experts' Characteristics*

Variable	n	%	M	SD
Gender				
Female	4	50		
Male	4	50		
Age			53,6	12,23
Nationality				
American (USA)	1	12,5		
German	2	25		
Mexican	1	12,5		
Chilean	4	50		
Years of Work Experience			27,25	8,8
Psychotherapeutic Modalities [1]				
Psychodynamic	3	37,5		
Psychodynamic and EMDR	1	12,5		
Problem-Solving	2	25		
Cognitive-Behavioural Therapy	3	37,5		
Motivational Interviewing	2	25		
Interpersonal Therapy	1	12,5		

Note. N=8; [1] Five experts reported ascribing to more than one specific approach, and the four Latin American experts said working with a community, cultural and gender approach

5.3 SEMI-STRUCTURED INTERVIEWS

In a directed study of the PhD program, the first author constructed and piloted the three semi-structured interview scripts for patients, psychologists, and experts. These scripts covered common topics aimed at exploring what knowledge, technical competences, interpersonal and personal qualities and attitudes a therapist should have to care for outpatients with depression in institutional settings, especially primary care. Each interview consisted of a body of open-ended questions adapted to each perspective. Some of the questions used were:

- Patients: *What do you hope to achieve with psychologist care? How would you like your psychologist to be?* The latter question explored professional and personal characteristics and attitudes.

- Psychologists: *What competences/attitudes have contributed to your work with patients with depression in this care centre? What strategies have you used? What kinds of competencies do you think psychotherapists should develop to treat depressed patients in these settings?*

- Experts: *What factors are most relevant to consider in managing patients with depression in an institutional setting? What kind of competencies do you think psychotherapists should develop to treat patients with depressive symptoms and complex depression?*

5.4 PROCEDURE AND DATA COLLECTION

The principal investigator and the team of assistants contacted the participants and arranged an appointment to sign the informed consent and conduct the interviews.

The patients were interviewed a couple of hours before they first attended their psychological session at the care centre, where they sought help. During that time, they received an informed consent document and were administered the instruments to verify their depression diagnosis, depressive personality style, and OPD. After a break, the in-depth interview was conducted, which lasted 20 to 30 minutes.

In some cases, the experts were contacted via email, and others were contacted in person. Once they agreed to participate, a date was arranged for the interview, which lasted between 20-30 minutes. Psychologists were contacted in person, by telephone or email, and once they agreed to participate, a visit was scheduled at their place of work for the

interview. This interview lasted between 30 to 40 minutes. They received the DPCCQ (Orlinsky et al. 1999; 2005) on the interview date, and a day was set for collection.

The interviews were conducted before the pandemic, face to face with all participants, except for one expert whose interview was conducted via Skype. All interviews were audio-recorded and transcribed in their entirety using Mergenthaler Norms (Mergenthaler & Gril, 1996)

A preliminary analysis was conducted for each perspective while the interviews were underway to make decisions regarding the theoretical sampling process.

First, a team of three coders, a master's student in clinical psychology and two doctoral students in psychotherapy at the Pontificia Universidad Cátolica de Chile, was formed. The principal investigator audited the coding and presented the results to two academics who acted as independent supervisors.

Then, a second coding team was tasked with the analysis of the hermeneutic units of psychologists and experts. The team was composed of two Bachelors of Psychology from the Universidad de Chile, and the principal researcher audited the codifications. This team also included one supervising academic.

The last stage of selective coding was performed by the principal researcher, one coder from the second team and one supervisor from the first team. Also, consultations were held with two qualitative researchers external to the project who served as independent advisors.

5.5 DATA ANALYSIS

The unit of analysis was composed of 40 interviews in total (patient interviews=16; therapist interviews=16; expert interviews=8). We worked sequentially with three hermeneutic units starting with the analysis of patient interviews, followed by psychologist interviews, and then expert interviews. The analysis was carried out in an iterative process of open, axial, and selective coding (Corbin & Strauss, 1990; Chapman et al., 2015) supported by Atlas Ti v8.

Open coding: This step consisted in the textual analysis of each interview in which units of meaning and conceptual indicators of competencies emerged, leading to definitions of

the competence categories and their primary codes, extracted from the "raw" data (Bonilla-García & López-Suárez, 2016).

Axial coding: The primary codes were organized into categories through an inductive, deductive, and comparative process and by constantly contrasting the concepts developed with the reporting of explicit and implicit competencies derived from the narratives told by the interviewees. Competences were grouped into four domains: knowledge (know-what), technical competences (know how to do), interpersonal competences and attitude (know-how to interact, readiness to act), professional and personal therapist competences (skills to perform like a professional, considering personal qualities)

Selective coding: The most relevant categories were selected according to the objectives set, and considering the point of theoretical saturation, at which no new properties and dimensions emerge in core categories, explaining much of the variability (Corbin & Strauss, 1990). Using a theoretical discriminating sampling procedure (Titscher et al., 2000), the categories emerging from each perspective (patients, psychologists, and experts) were compared to maximize the relationships among the saturated categories and visualize those that were underdeveloped, synthetizing and integrating the categories-per perspectives- in the proposal of its respective phenomenon, to later incorporate the three views in a new organization of psychotherapeutic competences.

5.5.1 INTEGRITY AND FIDELITY OF QUALITATIVE ANALYSES

Three strategies were employed to control any possible interpretation biases: triangulation and consensus, stability check, and the nomenclature of frequencies derived from the Consensual Qualitative Research method (Hill et al., 2005; Hill & Knox, 2021).

The researchers' impressions of the data analysis and interpretation were triangulated in order to reach a consensus through intersubjective agreement (Altimir et al., 2017; Hill y Knox, 2021). Triangulations were also carried out with external researchers, with a constant comparison between domains, emergent categories, and core ideas (Hill & Knox, 2021). Also, to correctly interpret data that were not clear enough to be coded, some of the interviewees were contacted to clarify the content of what they had stated.

The stability check (Hill et al., 2005), which took place after the analysis phase, consisted of taking a transcribed interview of each perspective (before the selective coding phase) to ensure that the domains and categories analysed matched the data provided

interviews. The coding of these cases resulted in no substantial changes in terms of the emergence of new categories or the frequencies allocated (e.g. “general”, “typical”) to the existing categories.

We adopted the nomenclature advanced by Hill et al. (2005) and Hill and Knox (2021) to report the frequency of each category to perform a more faithful comparison of the significant contents that emerged from each of the three perspectives, striving not to overestimate contents that might have been too idiosyncratic.

“General” refers to categories that appeared in all participants or all except for 1 (15-16 for patients and therapists; 7-8 for experts); “Typical” refers to categories that appear in more than half the participants (9-14 for patients and therapists; 5-6 for experts); “Variant” is for categories that appear in half the participants or fewer (6-8 for patients and therapists; 2-4 for experts); and “Rare” is for categories that appear in 2 or 3 participants in large samples (n=16) (Hill & Knox, 2021).

5.6 RESULTS

5.6.1 THE PERSPECTIVE OF PATIENTS WITH DEPRESSION: NEEDS AND EXPECTATIONS REGARDING THEIR FUTURE PSYCHOLOGICAL TREATMENT AND THEIR PSYCHOLOGIST

A summary of the phenomenon of patient expectations is proposed and presented in Figure 2.

Expectations from psychological treatment were grouped into three major categories: regarding **the treatment, regarding the psychologist, and regarding the change**. Patients expect the therapy **“to not be just going there to talk and talk”,** and that “**Should it last as long as it takes to feel better**”. They expect to be treated by **a “professional” with helping vocation who actually takes part in the session (active)** and who is also **welcoming and engaged (receptive)** in terms of the relationship established. This professional is expected to help the patient **“to move forward”** by enabling him/her **to understand or find out in-depth why I have this problem/depression** (which in some cases also involved understanding him/herself better), **developing resources/prevent crises and manage/improve mood and self-esteem.**

In addition, through the analyses, other topics emerged: **Facilitating factors for having expectations from psychological care and hindering factors to achieving what one expects from psychological care.** Facilitating factors included a **preference for psychological treatment** (over medical or pharmacological treatment), **the need to share one's problems/unburden oneself with a professional**, and **to have hope and faith in moving forward**.

On the other hand, narrated experiences of prior psychotherapeutic treatment revealed the presence of **hindering factors to the achievement of one's expectations**, such as **institutional limitations** to offer a satisfactory therapeutic process and a **therapist who was unhelpful and unwelcoming.**

5.6.1.1 EXPECTATIONS REGARDING THE TREATMENT: "NOT JUST GOING THERE TO TALK, AND THAT IT LASTS LONG ENOUGH FOR ME TO FEEL BETTER".

Typically, the patients expected the therapy to go beyond talking so that they can get the feeling that an effort is being made to help them to understand what they are going through. Patient 8, a young woman who had several treatment experiences (in private practice and a university clinic), when asked about her expectations of how psychologists could help her with her depression, answered considering her dissatisfaction with her past therapies when she felt that just talking was meaningless:

> "More than just talking and having conversations… **maybe there's something that can help me to educate**, or maybe not that… **the thing is, I used to talk and talk to my previous psychologist, but she gave me nothing in return** [...] Sometimes just having a clear idea, like 'what's the point of this thing you're asking me?' That's good because **you go there, you talk and talk… and you don't know why you have no idea how that's helping you."** (Patient 8)

Most of the patients hoped that it should last "as long as it takes to feel better" regarding treatment duration**"**. The case of Patient 7 –who had sought help at three different institutions, including primary care– is illustrative in this regard. On this occasion, she expected to take part in a process that should last as long as it needs to be to enable her to feel better:

> "Here, they said I was going to have one session per week. So, I hope it will last for a while! **As long as it's necessary for me to feel better.** When I can say to myself, 'I don't need to talk to you anymore', I'm leaving (*laughs*)". (Patient 7)

Nevertheless, some patients stated their preference for brief processes (less than six months) since longer durations might be exhausting. This is noted by Patient 3 – "no more than six months or people get bored" –; alternatively, it could be difficult to stay in treatment due to external factors (e.g. money issues, problems with getting permission from work) (variant). In contrast, other patients preferred a longer treatment (around one year or more) (variant), arguing that it takes time to establish a trust-based relationship with the professional.

5.6.1.2. EXPECTATIONS REGARDING THE PSYCHOLOGIST: "A PROFESSIONAL WITH HELPING VOCATION, WHO TAKES AN ACTIVE PART, AND WHO IS WELCOMING AND ENGAGED".

Typically, patients expected the psychologist to be a professional with a helping vocation, highlighting characteristics such as being responsible with the scheduled sessions ("not cancelling sessions without warning") and respecting their duration (not closing them before the set time) (variant). Other respondents mentioned that the psychologist should be up to date in terms of knowledge (variant).

In response to the question "What characteristics, attitudes should a psychologist have for you?" Patient 5 responded by referring to having a vocation as a professional:

> "**Desire to...to help people** [...] because there are some who study this because they think they are going to earn money...and that shows when one comes to therapy session...**there are attitudes that one says...'like.... Why did he study this?',** it's like he doesn't have a vocation...**it's vocation that I think a psychologist should have**." (Patient 5)

In addition, the patients expected the psychologist to intervene during the sessions. The patients stressed the importance of knowing how to listen, remembering what topics were previously covered (typical). Patient 9 stated that listening and remembering are therapeutic actions that can help the therapist to appear to take an active part in the therapeutic relationship:

> "I want the psychologist to listen to me...**to listen actively**, I feel it's too important because I feel like **I notice it in the details that...later on**, like **in the other sessions, he remembers and is clear about the things I said.**" (Patient 9)

The patients typically stated their desire for the therapist to be active searching for a solution to their problems, offering advice and guidance. This is pointed out by Patient 14, a man who was about to receive psychological care for the first time:

> "More than support, **I want him to advise me**, not so much on how to take decisions, but to tell me, **'Look, you need to deal with this problem, and you need to do so in this way.'**" (Patient 14)

Other patients expected the psychologist to help them to see things from new perspectives (variant). For instance, Patient 15 wanted: "[…] So that's what I like, for the psychologist to let me know things from another point of view."

Typically, patients expected the therapist to conduct interactive tasks, including questionnaires, homework, surveys, or other activities to allow them to understand/discover more about themselves or their problem. This hope is voiced by Patient 9, a young woman who had received psychotherapeutic treatment at several institutions, including primary care:

> "I'd like something more… **I don't know if the word is play-based**, but, for instance, that **through certain exercises or a game**… obviously something related to what's happening to me, **we could draw conclusions**, for example. **Maybe I could do a survey on something, and based on that, we, like… have a discussion, 'look, you're saying this… so… why did you answer this?'** That sort of stuff, I think that can help you to **discover yourself and, like… discovering tools.**" (Patient, 9)

This excerpt also shows how the patient illustrates the therapist's voice, taking advantage of the "activity" to draw conclusions. This therapist action of ensuring that the patient would walk out of the office with a significant insight, based on a conversation or activity, was typically expected by the patients, as exemplified by another excerpt from the interview with Patient 6:

> "**If the psychologist can** make me… um… discover something new… and **go home with an idea**… with something in my head… **with clear insight**, even if it's a new question… if the psychologist manages that in a session, I think… that's going to result in something important!" (Patient 6)

The ability to ask questions that enable them to gain a better understanding of what is happening to them and discover what happened to them (linked to their change expectations) was also pointed out by some patients (variant), as was illustrated:

> That's it, I'd like him to **ask questions that allow me to… detect what the problem is, questions that are, like, the right questions, because… I don't know how to ask myself those questions**. And, when he asks me those questions, **maybe I… could solve or discover what happened in my life** […]" (Patient 6)

As for the interaction style of the therapist, in general, the patients stress that he/she should be welcoming. Typically, the patients appreciated closeness and warmth in the therapist, even stating that they expected him/her to be like their "partner" (Patient 15). Likewise, the therapist was expected to be cordial, likeable (variant), and inspire trust and safety (typical). Also, some patients felt that it was important for the professional to have a non-critical attitude (variant), knowing how to look others in the eye that was a sign of this trust. In the words of Patient 1: "I don't want him to raise an eyebrow if I say something outrageous". Some of the core ideas of what it means to be welcoming (receptive function of the therapist) are illustrated by another patient in this excerpt:

> "I'd like him to be **cordial**… like, that **you can feel that she's welcoming you… or that he's welcoming you** […] **she should be likeable, she should know how to earn your trust** […] **she should welcome you cordially, so you feel safe** with the person you're discussing your problems with." (Patient 3)

Patients expected to see an engaged professional (typical), that is, one who was involved at a more affective level, being able to empathize and understand their sorrow ("putting themselves in their shoes") (typical) and showing their emotional attunement with them (variant). These categories are illustrated by the following excerpt:

> "**He should learn to understand the patient, put himself in the patient's shoes, feel what she's feeling**. That's like the main difference between a good and a bad psychologist… **he should be engaged to the patient and understand her.**" (Patient 7)

It is also desirable for the therapist to show interest and concern for the patient (typical), as reflected in the following quote: "[What attitude is important for you to see in the psychologist?] Interest. The interest in wanting to know how I feel, how I am doing." (Patient 13).

5.6.1.3. CHANGE EXPECTATIONS: "TO MOVE FORWARD: TO UNDERSTAND OR DISCOVER WHY I HAVE THIS PROBLEM/DEPRESSION, DEVELOP RESOURCES, AND MANAGE/IMPROVE MOOD AND SELF-ESTEEM".

The patients' expectations included wanting to move forward (general), understanding, or discovering aspects of themselves or their problem/depression (typical), developing resources (typical), and learning to manage their mood (negative emotions) and their self-esteem (typical).

Understanding themselves and understanding or find out in-depth "why I have a problem/depression" were typically mentioned by the patients. Patient 10, an adult woman who had been treated only pharmacologically during 15 years in primary care, expressed this expectation from the psychological help that she was about to receive at the university clinic:

> "I want the psychologist **to find out why I have this depression and this anguish that I don't know how to define.** I want the psychologist to look into me until I know **why I have this misfortune.**" (Patient 10)

Other expected achievements included developing more personal resources and preventing crises. The patients typically expressed this regarding having "weapons" and "strategies" to deal with critical situations. Patient 1, a woman who was again seeking help at a university clinic due to a new depressive episode (see more details about her case in Item V), expressed this desire to obtain more resources to cope with potential losses:

> "**I want to move forward… discover weapons in me in case something similar happens to me, or something different**. For example, I lost my mom four years ago… I'm going to lose my dad due to the law of life, or

> maybe I'll go first… I'm going to lose him at some point. So, **I need weapons** to cope when I experience losses, failures, to deal with all the negative things in life". (Patient 1)

Regarding symptoms, the patients typically manifested their need to know how to manage and improve their mood and negative emotions. This can be illustrated with an excerpt of the interview with Patient 7: "I'd like to try to **control my emotions**, like… like… like **if I'm crying, try to soothe myself so the crisis will go away sooner**". Also, learning to regulate their self-esteem was another expectation that emerged because the patients typically reported that being too self-critical or accepting "humiliations" or "being unappreciated" affected their self-esteem, which they wanted to improve. This is noted by Patient 9: "I sort of feel that I'm really self-critical and **have low self-esteem**. I'd really like to **love myself a little more**".

5.6.1.4. FACILITATING FACTORS FOR HAVING EXPECTATIONS FROM PSYCHOLOGICAL CARE.

Underlying the patients' expectations concerning psychological care, it found some categories that typically facilitated the appearance of positive expectations. These included: **Preference for psychological over medical treatments** (typical); **The need to share one's problems/unburden oneself with a professional** (typical); and **to have hope and faith in moving forward** (typical).

Regarding the preference for psychological care, it quotes Patient 10, who, as previously noted, had never been referred to a psychologist for her depression, which probably predisposed her against medical care:

> "Look... um… I've never seen a psychologist, but **I prefer a psychologist to a psychiatrist**, because, I mean, I don't really understand what depression is like, but… um… **you're [the psychologists] going to listen to me and advise me, and the psychiatrist will just give me some pills. And I don't want that.**" (Patient 10)

The patients typically exhibited a positive attitude toward discussing their problems with the psychologist because their issues could not always be shared with a friend, being intimate subjects that they could not disclose to someone in their circle, or which required more specialized listening. This is illustrated by Patient 4, an adult woman with prior

experiences in clinics: “You need to go to therapy, **talk to someone who doesn’t know you**, **talk to a professional”.**

Frequently, despite their depression, the patients felt hopeful that they would move forward. This “faith” is often expressed with optimism regarding the initiation of therapy, as expressed by Patient 3: “I come with so much faith! **I have so much faith** that I really... that... **I'm going to move forward.**”

It should be noted that not all patients were so optimistic before starting their psychological treatment. This was the case of Patient 14, an adult man who was deeply affected by his life with his partner, who suffered from alcoholism and bipolarity. His partner’s health caused him to experience high levels of stress, hopelessness, and sadness. Even more so, while taking part in this interview, he exhibited active suicidal ideation. Nevertheless, he felt that taking part in this study and being treated by a psychologist after his participation were chances to find a way out of his problem:

> “**I’m hopeful that I’ll pull through and feel normal, I mean… live a happier life, without so many problems**… I think if you’re doing this, it’s because you’re professionals, I mean, if one of you doesn’t have a solution, you can ask a colleague, **and that’s how one can manage to leave this behind**” (Patient 14).

5.6.1.5. *HINDERING FACTORS TO ACHIEVING WHAT ONE EXPECTS FROM PSYCHOLOGICAL TREATMENT.*

Most of the patients included in this sample (13 of 16) had prior treatment experiences. Based on some of these cases (typical), we identified two factors that might prevent patients from achieving what they expected from psychological care.

The first concerned the institutional limitations (variant) making it difficult to offer a help process due to restrictions on treatment duration (limited number of sessions), referrals for patients to be treated at other health institutions due to their complexity or a lack of depression specialists in primary care (variant), or simply because patients were scheduled to see other professionals, as the continuity of the process with single psychology was not guaranteed (variant).

The second factor consisted in dissatisfaction with the therapist (typical) because he/she was unhelpful to solve their problems or treat their depression or was not welcoming

enough toward the patient and failed to inspire the trust that he/she needed to share his/her issues.

To exemplify these factors, we will present an excerpt from the interview with Patient 2, an adult woman who reported having experienced many "low points" in her life. She had had several psychotherapeutic experiences in private therapist offices and primary care, complaining that she had received multiple diagnoses but that therapists had been unable to "treat" her depression. She illustrates what it means to go from one health institution to another health institution looking for a treatment suited to her problems, since she answered the question "Why are you seeking care here (outpatient university clinic)?" by saying:

> "**Because the primary care psychologist didn't know how to treat me**, **so she referred me to another place.** However, **I couldn't stay in treatment in this second place** [secondary health care**] because it offered a limited number of sessions, and I got all of them**. That's why I'm here. [Interviewer: "How did you feel about being referred somewhere else for the first time?"] **I got frustrated because she** [the psychologist from primary care] **couldn't help me with anything**; I wasted my time with her".

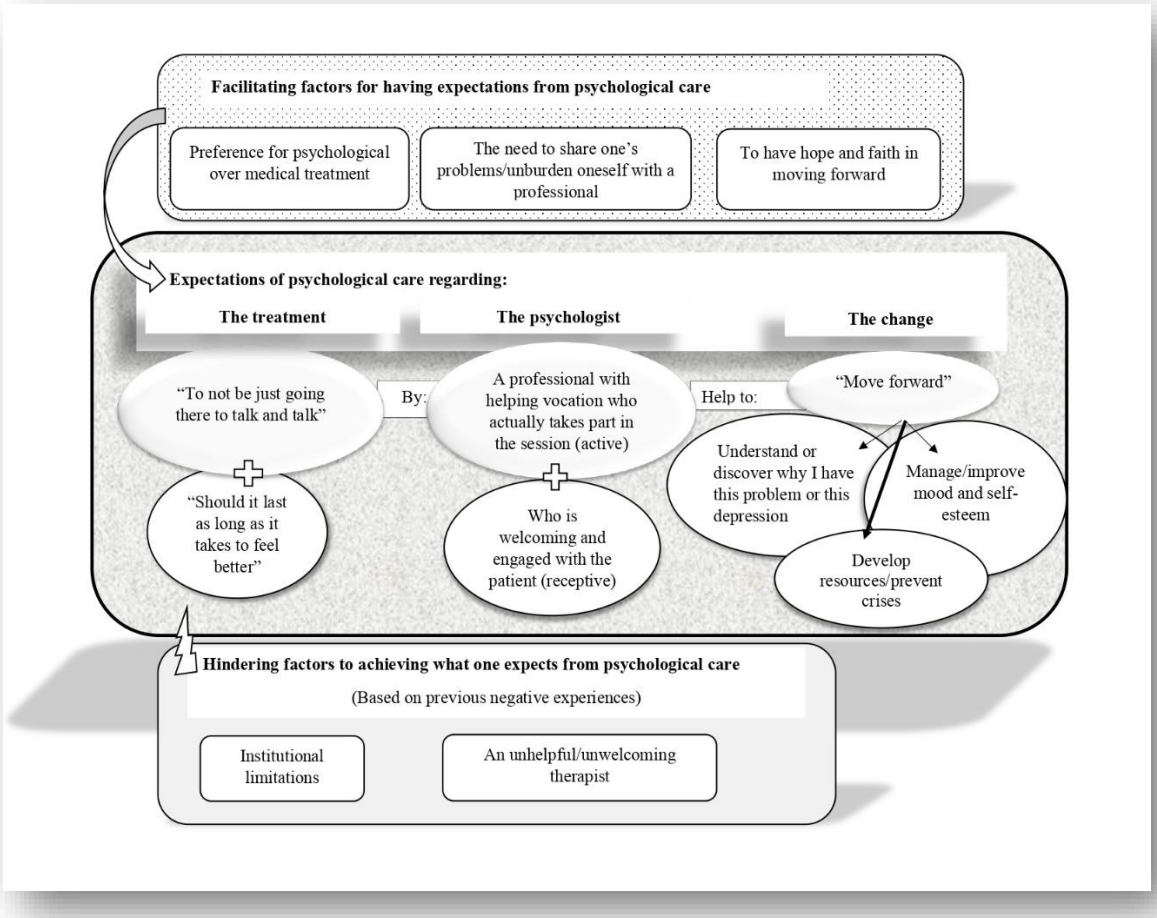
Although institutional limitations can determine the type of help offered, the experience of Patient 2 highlights the importance of identifying which competences are needed to meet the requirements of these patients. To do so, it is relevant to explore the perspective of the psychologists who work in these settings and have developed such competences there in a hands-on manner.

In brief, the phenomenon of treatment expectations observed in figure 2 reveals that patients expect to receive a meaningful therapy that should last long enough to feel better. Professionals with a vocation must deliver the therapy to help others and who should be active to intervene (e.g. "giving me something in every session", "listening to and remembering what we've talked about", "a therapy that does not just talk", "a play-based approach"), and also should be welcoming and engaged (e.g. warmth, no criticism, "putting him/herself in your shoes", "showing interest in what I'm going through"). A professional who helps to "move forward" and attain a change that involves understanding and acquiring tools to prevent crises and regulate his/her mood and self-esteem. Positive expectations are facilitated by preferring psychological treatments to pharmacological

ones, needing to share one's problems, and having hope and faith in moving forward. In contrast, positive expectations are hindered by factors such as limitations of institutional settings to offer a psychotherapeutic process to treat depression and due to unhelpful and unwelcoming therapists.

Figure 2.

Proposal of an emerging phenomenon of patients' expectations



Note. The chart shows the facilitators and obstacles of expectations at the edges and the expectations of treatment, psychologist and change in the middle. They expect treatment not to be just going there to talk and talk and that it lasts as long as it takes to feel better; with a professional who has a helping vocation, who intervenes, and at the same time is welcoming and engaged; who can help the patient to move forward, by discover why I have this problem; developing personal resources; and help to improve mood and self-esteem. Facilitators of these expectations include preference for psychological over medical treatment, the need to share one's problem with a professional, and to have hope

and faith in moving forward. Both institutional limitations and an unhelpful and unwelcoming therapist are obstacles to meet their expectations.

5.6.2 PSYCHOLOGISTS' PERSPECTIVE ON THE PSYCHOTHERAPEUTIC COMPETENCES NECESSARY FOR TREATING PATIENTS WITH DEPRESSION IN INSTITUTIONAL SETTINGS

The professionals reported the competences that they have found useful for treating patients with depression and complex depression in their workplaces.

Figure 3 shows a tentative model of the factors that lead to the therapist feeling able to help a patient with depression. In the professionals' experience, it was important to possess a knowledge background from which to understand the human being that they could use to understand depressive symptoms (typical). For some, their therapeutic approach helped them to adopt a more patient-centred perspective. This is noted by Therapist 15, a professional with some ten years of experience in primary care:

> "It would be great for everyone **to have a basic philosophy to ground their view of human beings** so that it's clear to them. Adopt a perspective to inform their treatments. **I understand the patient's experience from a constructivist-cognitive perspective. This has been really useful for me to focus on the patient.**" (Therapist 15)

For many therapists, this background facilitates their understanding of the depression phenomenon ("where depression comes from"), which according to some (variant), enabled them to help patients to understand their functioning and their depression, which is in line with patients' expectations. Therapist 15 illustrates these core ideas:

> "As I was telling you, I try to give patients clear explanations, and when I see patients who have enough resources, I try to implement an intervention that will help them to reflect on **what caused them to be depressed, what factors of their lives, what elements of their lives and their knowledge about the world made them depressed.**" (Therapist 15)

Also, the therapists typically highlighted the importance of being active during the interventions, as noted by Therapist 4, "daring to intervene, to say more", and generally manifested that it was necessary to be engaged when offering help. This involvement is pointed out by Therapist 3: "What makes the difference between a good and a bad

psychologist **is commitment**, which is found in your desire to help**, committing to the patient by being empathetic and generating a good bond**".

Nevertheless, some professionals pointed out that they were not always able to adopt this active and committed attitude due to personal factors that might hinder it. In this regard, they frequently mentioned (typical) having a good level of "self-knowledge" of their limitations when treating a patient and knowing when their ability to tackle a case was insufficient. This phenomenon is illustrated by Therapist 11, who treated patients in a small primary care institution located in a rural area, and narrated her users' difficulties and her frequent realization that the help that she could offer was limited:

> "**I think it's really important for you to know your limitations and know when you can help and when you can't, and when you can harm your patient even though you're trying to help** […] I think you need to know your limitations, know when you can't help, **acknowledge when you are emotionally overburdened when treating a patient and refer him to a colleague**. I think that's really important". (Therapist 11)

Some therapists (variant) even mentioned that their own psychotherapy was useful for knowing themselves better allowed them to be more understanding of their patients.

It was also observed that most of the professionals criticized therapists who were not flexible in their practice or became inflexible in their theoretical preferences, which prevented them from offering help in a way that met patients' needs. In general, the competence "being flexible in one's professional practice" emerged from the interviews. This is pointed out by Therapist 6, who had worked for more than 30 years in the outpatient units of a psychiatric hospital:

> "**being totally flexible** in the care that we provide, which stands in contrast with what you're taught, at university for instance, where you're taught a lot of rules […] but there are rules you learn, um… or which are still taught in public institutions actually, you need to make them less absolute, more flexible… the same is true of this **attachment to technique… you often need to be more open and utilize a variety of techniques**". (Therapist 6)

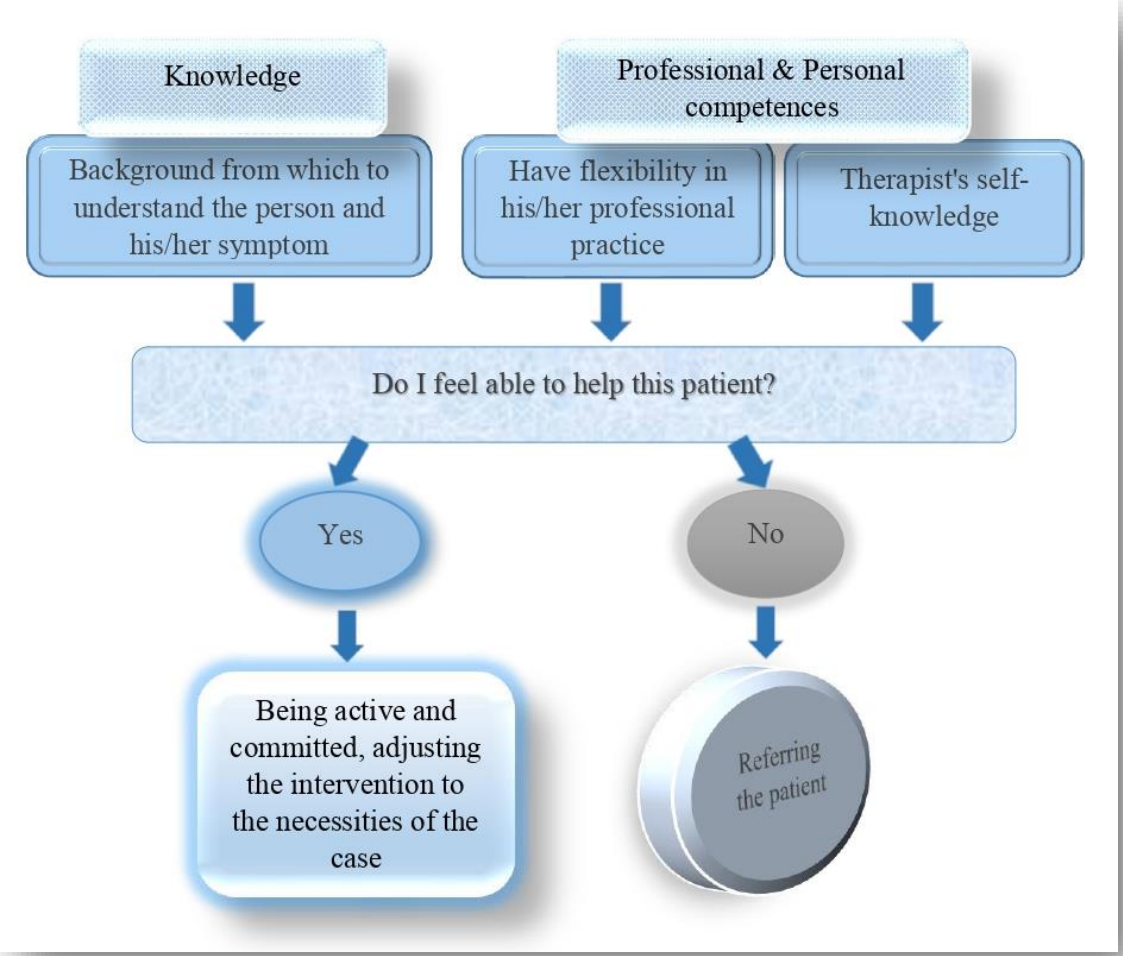
In the same vein, Therapist 3 also refers to the need to be flexible enough to incorporate multiple clinical strategies, adapting to the needs of each patient: "**Being flexible in the**

strategies you use… like using everything at your disposal… **not sticking to one technique, one theory**, and seeing **what works and what doesn't in each case**". Again, if the therapists do not feel able to help the patient, they must refer him/her, as pointed out by Therapist 8: "**and… if you lack tools, competences**, or time, you must **refer** your patient".

In addition, many of the technical and professional competences coincided with those highlighted by the experts, for instance: knowing the health system, adapting the techniques used, knowing how to perform time-limited diagnoses and interventions, having the motivation to work in these settings, tolerating frustration, and having teamwork experience (See quotations in appendix A). In addition, convergences were found concerning interpersonal skills, such as being welcoming and engaged to the patients' expectations regarding their future psychologist (see coincidences in point IV). Below, the specific contributions derived from the professionals' views will be presented through the illustration of a phenomenon.

In brief, the psychologists stated that they need the knowledge background to understand depression in a better way, which will enable them to help patients to explain the underlying reasons for their depression. This approach is in line with the patients' changes expectations. Furthermore, as long as there are no personal interferences and if the therapists are flexible enough to adapt to the needs of each case, they will be able to intervene actively and engagingly, which is also aligned with the patients' expectations. However, if the professional considers that he/she is not able to help the patient-due to personal limitations or a lack of flexibility to adapt the intervention to the patients' needs-, a professional should refer the patient.

Figure 3. *Proposal of an emerging theoretical model of competences highlighted from the therapists' perspective to care or to refer patients*



Note. Having knowledge from which to understand the human being and his/her symptom, having flexibility in their professional practice and self-knowledge regarding their capacities and limitations as a therapist, this set of competencies enables therapists to answer, "Do I feel able to help this patient?" If the answer is Yes, they can be active and engaged with the patient, adjusting the intervention to the necessities of the case. If the answer is No, it is better to refer the patient.

5.6.3 EXPERTS' PERSPECTIVE ON THE PSYCHOTHERAPEUTIC COMPETENCES NEEDED TO TREAT PATIENTS WITH COMPLEX DEPRESSION IN INSTITUTIONAL SETTINGS

Figure 4 summarizes the most relevant competences in the experts' discourse. Their distinctive contributions referred to knowledge (clinical training/education), knowledge about depression, knowing which comorbidities ("trauma", "personality disorders", "medical comorbidities") and social determinants ("poverty", "gender inequality") can co-occur with or underlie the disorder (general).

Expert 5, who is a vastly experienced clinician and depression researcher within the context of primary care, spoke about the importance of receiving clinical training based on these topics:

> "I think they first need to receive clinical training on **what depression is**. Second, **they need clinical training on the comorbidities of depression, and I don't only mean personality disorders, but also chronic and acute diseases** […] In primary care, I think it's very important to consider social determinants and all the psychosocial problems that affect people with depression in these contexts… **they are very grateful when professionals take those factors into account to help them, don't they?**" (Expert 5)

The experts also contributed by shedding light on how to manage criticism and negative views of themselves (or their environment) that patients with depression exhibit (typical), often referring to the self-critical or perfectionist style and noting the difficulties that depressed patients with more dependent personality styles could encounter. Expert 1, a senior researcher with extensive experience training psychotherapists in depression management within the context of a university clinic, points out that technical knowledge is necessary for addressing patients' criticism or perfectionism. Like other experts, he stressed the relevance of learning to detect the interpersonal strategies that emerge from criticism mechanisms, being cautious and not challenging the contents of this negative view –which is what therapists might intuitively choose to do– as this could be counterproductive:

> "So, my prayer, is if you feel helpless with the patient, **realize if it has to do with this self-critical perfectionism of the patient,** which makes you

> helpless as a therapist**. And then don't try to argue because you know that this is not everything**, because you see that this is a gifted patient, who has a wonderful family and whatever… But you won't ever tell this to your patient, **but you will talk with your patient: "what happened just now that comes to your mind this idea of 'I'm just worthless?' What happened?"** (Expert 1)

Thus, the expert focuses the session on "the mechanism of self-criticism", which can be addressed within the therapeutic relationship, and not on "the contents" of the patient's negative or perfectionist perspective.

Also, it is easier for some experts to establish a bond with depressive patients who exhibit a more dependent profile (in contrast with those with a more critical profile). In these cases, achieving separation is the most difficult part; therefore, the bond itself can be used to prompt change, but this requires a therapist who is willing to let this happen, as noted by Expert 3:

> "**Dependent patients seem to be treated more frequently because they have a very strong motivation to establish relationships** and be liked, **so treatments become easier,** and it is also easier for them to change to a certain degree. And so what I want, of course, is **for them to experience that they can rely on themselves more and to realize that they are not as dependent as they think, so they have to experience agency and separation, and some therapists don't like that.**" (Expert 3)

According to this expert, the therapist must be attuned to the patient and willing for him/her to become more autonomous. The personal work that the therapist can perform in the supervision (which was generally mentioned by the experts, which typically converges with the therapists' views) can help to self-identify the obstacles that the professionals might be placing.

In addition, the experts generally highlighted the ability to regulate self-esteem, which converged with the patients' expectation to improve their self-esteem (typical). From the perspective of the experts, two lines of work emerged for the regulation of self-esteem: helping patients to make their achievements and progress visible, and secondly, using the therapeutic relationship to work on the hypersensitivity that they may have in the

interpersonal sphere, as stated by Expert 8, who works in therapist training and research on the treatment of difficult patients:

> "**Someone who is more hypersensitive** tends to quickly **deregulate in terms of his/her self-esteem when he/she feels some rejection or feels more invisible in interpersonal relationships**. It is important to be attentive to how this [relational pattern] **is replicated in the relationship here and now in therapy** so that it can be alluded to, and to be able to work on that sensitivity and use a magnifying glass to examine it [...]" (Expert 8)

Considering the difficulties that can affect the bond established with depressive patients, especially in connection with intense negative feelings derived from criticism, or the "frustration" or "hopelessness" that can be transmitted to the therapists' mood, some experts mentioned that it is necessary to possess skills to deal with alliance ruptures (variant). One such skill is meta-communication, which enables the therapist to express his/her internal states constructively, making the patient feel that they are part of a dyad. This phenomenon is illustrated by Expert 3, who is also vastly experienced in depression and personality research and the therapist training field:

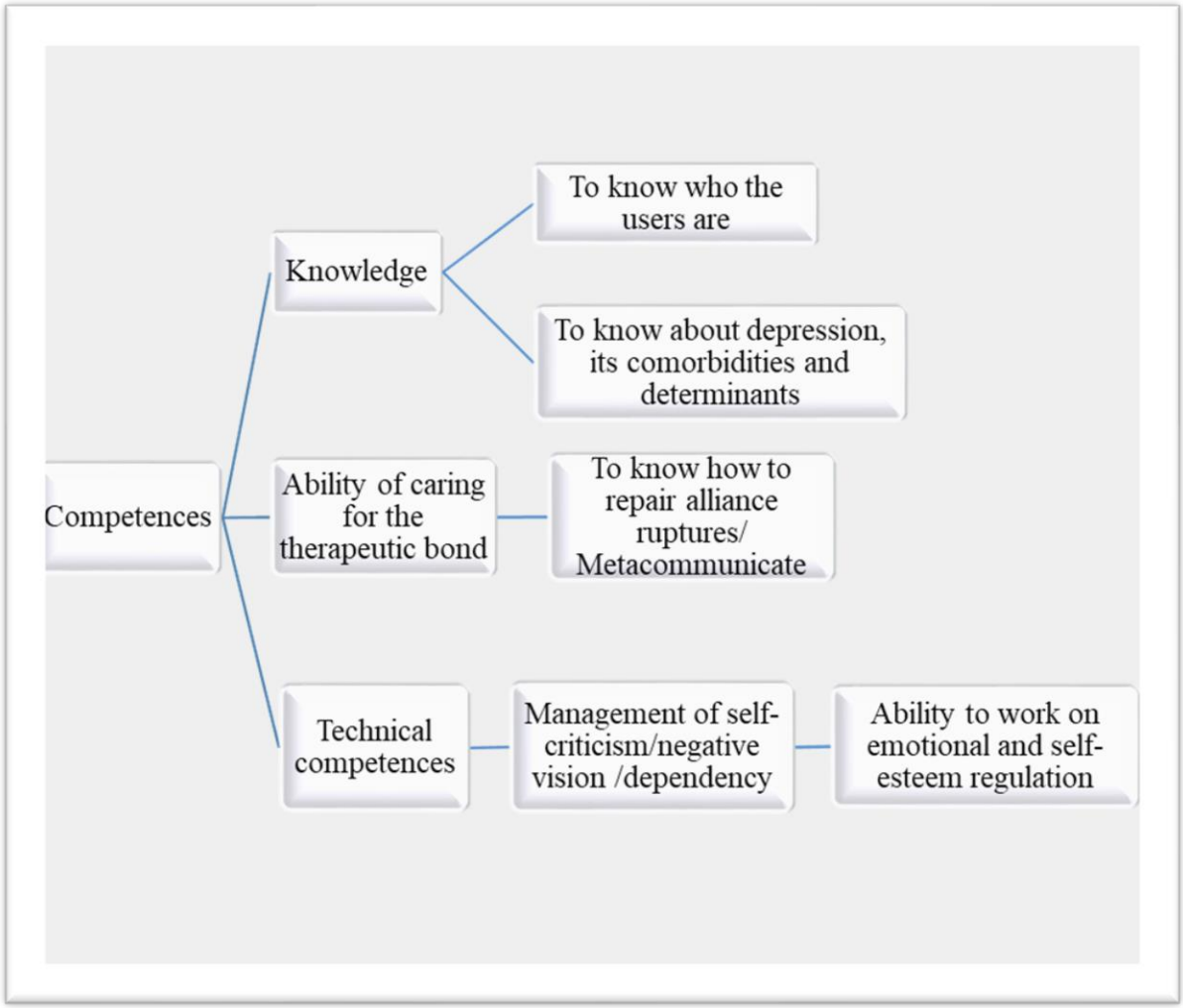
> "So, you know, 'I'm getting the feeling that I've upset you. I'm also not sure how to fix it. And I really would like to, but I'm not sure how. What are your thoughts?' So that is just sort of **sharing with the patient that you are in a dyad**. It's a relationship, and you're both sharing it. **To me, metacommunication is a meta competency** that all therapists should possess regardless of whether they're doing therapy A, therapy B, or therapy C." (Expert 3)

Finally, the experts stressed the need for future professionals joining primary care to have previous experience with the consulting population in these facilities. They suggested that future therapists should have contact with communities at an undergraduate level so that in the future, they would have more mastery of how to operate and how to adapt their interventions to their patients' sociocultural context. This background is related to the psychotherapeutic competencies of cultural competence, interpersonal skills to generate a therapeutic bond, and being flexible to adapt the technique to the requirements of the patients. Expert 7, who is greatly experienced in depression research focused on women living in vulnerable contexts, illustrates these core ideas:

> "**You need to know who these people are**, **know their reality** […] Here [in Latin America] **the bond starts the moment you spend time with them**. That's why I'm telling you to **get practical experience**, ask psychologists to go to the community, ask them to collect data, examine what they observed and learned from their practical experience, **how they felt about communicating there**. **I feel that they [professionals] need this immersion in the social context…** they need to listen more, learn more, **and then translate what they know as therapists into the social condition of the patients.**" (Expert 7)

In summary, the competences mentioned by the participating experts refer to knowledge derived from experience (to know who are the users, to know what is their living context) and skills oriented toward treating aspects of depression as such and managing the emergence of these contents in the therapeutic relationship: depression and its comorbidities, criticism, negative perspectives, dependency, and dysregulation of self-esteem, including the ability to manage alliance ruptures through meta-communication.

Figure 4. *A synthesis of the most relevant therapeutic competences from experts' perspective*



Note. The diagram shows the contribution from the experts' perspective to the therapeutic competences. They highlighted knowing who the users are and knowing about depression, its comorbidities, and determinants at the level of knowledge. At the level of skills to caring for the therapeutic bond, the knowledge of how to repair the ruptures of the alliance, using metacommunication, emerged. At the level of technical competences, the skills to manage self-criticism, negative vision and dependency stood out, and these were associated with the ability to work on emotional and self-esteem regulation.

5.6.4 A TENTATIVE MODEL OF THE COMPETENCES NECESSARY TO MANAGE COMPLEX DEPRESSION BASED ON THE SUBJECTIVE PERSPECTIVES OF PATIENTS, PSYCHOTHERAPISTS, AND EXPERTS

Figure 5 presents a proposal of the dynamics between competences domains that contribute to building and caring for a bond to treat depression, based on the integration of the patients, psychologist and experts perspectives. This model illustrates the convergences of the four competence domains analysed.

- Knowledge and technical competence are related through the need to possess a theoretical background for knowing which interventions to implement and how to adapt techniques to patients' needs and the treatment context ((1) in figure 5).

- Technical competences, interpersonal competences, and a patient-oriented attitude are linked through the ability to be active in the therapeutic relationship when intervening ((2) in figure 5).

- Interpersonal competences and patient-oriented attitudes are linked to the therapist's professional and personal competence by demonstrating his/her engagement to the patient ((3) in figure 5).

- Professional skills and knowledge are related to being flexible since possessing that skill requires openness in terms of role paradigms and a broad background of knowledge about the discipline and the context in which the therapist operates ((4) in figure 5).

- Lastly, the competences (in their respective domains) mentioned above contribute to the core competence of build and caring for a therapeutic bond in which the patient can find a new interpersonal experience ((5) in figure 5).

(1) Knowing what to do and adapting techniques

With respect to knowledge, therapists' and experts' views mostly coincided regarding knowledge about the model and system of treatment in public health (typical for therapists and experts), such as "knowing the procedures, the networks of the public system" (Therapist 7) and "understanding what primary care is" (Expert 7). While therapists stressed the importance of possessing a theoretical background regarding human beings which could be used to "explain the depressive symptom" (typical), experts emphasized the need to know the people who used these services (general), "having spent time with them", "having a practical experience" (Expert 5, Expert 6), and knowing about

depression, its comorbidities, and its determinants (general), which was associated with knowing how to make a therapeutically relevant diagnosis (general for experts and typical for therapists). A quote by Expert 1 illustrated these core ideas:

> "You should know about positive and negative predictive factors... this is **diagnostic knowledge** because it guides you in your therapies, you get an impression of how much you can stress the patient, how much you can demand from the patient because you have to be demanding sometimes but not too much. Of course, **you have to have an idea of what depression is and what it is not; you have to know about comorbidities." (Expert 1)**

Knowing how to diagnose depression "distinguishing its mixtures" or identifying when one is dealing with a "genuine depression" (Therapist 8) and when it is necessary to shift the focus from depression to emotional dysregulation" (e.g. Therapist 2, 3, 8), converges with the need of some patients to receive the right diagnosis, a "hypothesis" of what is happening to them, "what is wrong with me" (Patient 8).

This set of knowledge provides professionals with a conceptual repertoire to know which approach to adopt and what to do while also adapting the technique or intervention to the patient's needs (expectations) and goals. Therapists and experts generally mentioned this competence of adapting techniques.

An extensive theoretical background prevents therapists from adhering blindly or dogmatically to what they think "must be done with patients" (Therapist 3). Also, this knowledge is useful for offering a therapy suited to the patient, as illustrated by Therapist 2, who has worked in outpatient university-clinic for several years:

> "**The intervention must make sense to the person**. For example, some people need to understand and are very willing to delve into their inner world and engage in introspection, but others that approach is not useful to other people, and they tell you, no, 'I need tips, I want more practical tools to deal with these problems'. So, in those cases, **I think you need to adapt your technique** […]" (Therapist 2)

There was also a general interest among therapists and experts in adapting to the patients' sociocultural reality. For instance, Therapist 16 pointed out: **"**I can't talk about well-being with a patient if she can't pay her electric bill or has no food to eat that day.

How can I talk to her about spiritual development?". Expert 4 emphasized that: "it is necessary to understand that the patient comes to the session with a culture" and that therapists must strive to avoid adopting "a position of cultural superiority", considering, for instance, the treatment of patients with depression and a history of childhood trauma, but which had not been signified as "trauma" despite displaying the relevant symptoms due to the social-cultural context. In this regard, the expert noted that therapists required "a great deal of sensitivity" to intervene and adapt the intervention to the patient's reality.

With respect to knowledge about more specific interventions, therapists and experts converged on knowing how to perform time-limited or brief interventions, which were typically mentioned by both therapists and experts groups, with therapists highlighting psychoeducation more (typical for therapists, variant for experts) and experts mentioning support interventions (distinguishing them from counselling, typical). Concerning having a background in specific interventions, some therapists noted the interventions belonging to the cognitive-behavioural model (variant), while some experts mentioned the importance of knowing about interpersonal theory (variant) (see quotations in appendix A).

(2) Being active

However, in light of our findings, it is not enough to know about interventions, as the therapist must be "active during the session", which involves a "forward-leaning" therapeutic attitude (a concept derived from the interview with the Therapist 3, see below). In patients, this active attitude was not explicitly mentioned, but it emerged as the expectation that their therapist would help them "to draw something significant from the session" (typical); also, they expected that the set of interventions carried out by their future psychologist would require a therapist who would participate actively, "remembering what they had worked on in previous sessions" (Patient 1), "listening actively" (Patient 9), saying "'look, you have this problem… and you can solve it in this way...'" (Patient 6), among other expectations.

The psychologists typically mentioned being active, while the experts mentioned this in a general manner. Therapist 3 had extensive experience in outpatient units and stated that having an "active attitude" means: "not coasting, thinking you have all the time in the world to collect information, no! You need to be active, ask questions, understand, and intervene". In other words, she felt that it was necessary to take advantage of each meeting

with the patient because outpatient treatment means that the person cannot be guaranteed to have another session with her.

Expert 8 spoke about having an active "but not reactive" attitude, noting that: "It has been seen and proven worldwide that in patients with personality pathology [complex depressions] **a fluid, energetic, active attitude works**". This active therapeutic attitude, to be aligned with the patient's need to be welcomed (general) and listened to (typical), requires relevant interpersonal qualities to preserve the therapist's receptive function and avoid premature actions, as Therapist 9 advises: "Trying to welcome the patient, listening to her first without rushing to intervene, before validating her feelings".

(3) Being engaged

To ensure that the therapist is able to be engaged with the patient (typically mentioned by patients and experts, and generally mentioned by therapists), the therapist requires other interpersonal skills, such as being empathetic (typically mentioned by patients and experts and by some therapists). Therapists are also expected to exhibit "a genuine interest" (Therapist 4) in the patient, which should facilitate the adoption of an engaged therapeutic attitude. Furthermore, patients state that they can notice when the professional is interested in their issues or "attuned to their suffering" (Patient 1).

The therapist also requires personal skills, typically mentioned by the patients through the idea that "he/she must have a helping vocation", which is connected to the notion that "he/she must be interested in helping or understanding the patient, find a solution" (as noted by Patients 5, 13, and 14, among others), and that he/she must be a responsible professional, which involved "not missing any appointments, not being distracted by other things" (Patient 6). These qualities also demonstrate the therapist's commitment and interest in his/her patient.

Likewise, Therapist 5 regards personal and professional skills as part of the notion of commitment:

> "I think a good psychologist is someone who, to begin with, **has a strong engagement to what he/she is doing,** to the profession, to others, because that leads you to study, reflect, do personal work… it leads you to everything that's important." (Therapist 5)

Lastly, therapists and experts agreed on the personal and professional competences of using supervision and self-care strategies since their contributions can help therapists cultivate this commitment to patients. This situation is noted by Expert 6: "It is also necessary to include self-care elements because we all know that when a professional is emotionally exhausted, he/she is less empathetic".

(4) Being flexible

The category "being flexible in one's professional practice" was generally mentioned by therapists and experts. Both groups agreed on the importance of being flexible in "one's adherence to one's model" (experts) and "not becoming rigid within one's theoretical framework" (therapists). But the professionals also referred to the ability to be flexible in treating all types of people and all kinds of demands and knowing when to take distance about "neutrality" taught in university ("the fantasy of neutrality", mentioned by Therapist 12). This skill also requires background knowledge about the treatment setting, the health system, and experience with the target population. These points were alluded to by Therapist 6, who stated that, in these settings, "it was necessary to become quite flexible", "relativize certain rules" taught in university to show himself as a more genuine person, closer to the users.

In this regard, background knowledge allows professionals to open up to the possibility of being flexible regarding their role as clinicians (leaving the classical therapeutic frame) and incorporating new strategies beyond what they have learned in their training as a "private practice therapist". Thus, a therapist who is aware of the context and living situation of his/her users is able to deconstruct his/her "dogmas" and become more flexible to adapt to his/her patients' needs, establishing a closer bond with patients and also –at a more specific level– developing a larger repertoire regarding the functioning of other clinical tools which might differ from their therapeutic model of choice. Therapist 12 stated some of these core ideas:

> "In terms of competence… **the flexibility to**… considering that in this context **you often have to leave your therapist role, in contrast to what you do in your private practice**, that is, in terms of frame… **Here, it needs to be more flexible to allow you to incorporate other characters in the psychotherapeutic process**, like the patient's family, partner, child… also, **that flexibility to snap out of that 'fantasy of neutrality'**, which is rather

> irrelevant to what you need to do here so that change allows you to establish a **more genuine contact with the person**". (Therapist 12)

Expert 4, who is a vastly experienced clinician, researcher, and therapist trainer in public health institutions, points out that it is necessary to change therapists' relationship with treatment manuals, enabling them to become more flexible as a way of delivering the care that patients need considering their perspective and context:

> "I think **we need to change our point of view regarding the use of these rigid psychotherapeutic models**. For instance, **scheduling weekly sessions over an eight-month period… many patients don't need that!** […] I have patients who tell me, 'Doctor, I don't have time to come to therapy, I need to go to work'. And I answer, 'go to work, because if you feel fine when you're working….' Do you see what I mean**?** I think we need flexible therapeutic indications**. Being flexible**, that is, **ask what patients need to be asked**, **indicate what patients need… that's my point**." (Expert 4)

(5) To build and caring for a (therapeutic) bond

Finally, the four domains – knowledge, technical competences, interpersonal-attitude competences, professional and personal competences – as a whole contribute to the therapists' ability to build and care for a bond through the bridging categories: knowing what to do and adapting one's technique, being active, being engaged, and being flexible in one's professional practice.

From the patients' perspective, this bond allows them to feel "unique", important to the therapist, and consider that the therapist is actively present in the helping relationship by sharing his opinion, remembering, paying attention, being tuned, etc. This view is illustrated by the interview with Patient 1, an adult woman with several prior experiences of psychotherapeutic treatments in different mental health care who was again seeking help at an outpatient university clinic due to a "new depression". Throughout the interview, Patient 1 describes how she would like her new therapist to be, pointing out the therapist's technical and interpersonal skills to generate and caring the bond between them, as she stated:

> "Maybe it would be desirable… for instance, there should be a way for the professional to **remember more than just through a patient record or a chart**… **what the patient is going through. 'Oh, so you're dealing with this'** 'You came because of this', 'you've made some progress… do you remember?' **It would be really important: 'remember that you told me this the last time?' You'd immediately see that the other person is connected with the present moment…** it's hard because there are so many patients… **but it's important for one to feel like… you're the only one**. **It's not about egocentrism**; the thing is, **one needs help**. I know everyone comes here looking for the same thing, but **it would be great for them** [the psychologists] … **to have the ability to be fully engaged to the patient, more than all the other professionals** […]". (Patient 1)

This interview extract shows how important it is for patients with depression to feel part of a (therapeutic) bond, in which the therapist is active and engaged with the patient, says something to them (technical competences), shows an interest in caring and makes them feel unique (interpersonal competences). Nevertheless, mainly due to the high demand for care in primary care facilities, it is often difficult to bear in mind the needs of patients all the time. This fact can trigger a complex situation for both the patient and the therapist, as experts suggested. In this regard, Expert 2, a clinician with vast experience in psychotherapy research and therapist trainer, offered pointers on how to address the challenging treatment expectations conveyed by Patient 1, his view illustrated in the quote:

> "So, if a patient feels like **you have not remembered enough or they are not special enough,** I think **it's really important to acknowledge that it must be terribly painful to them** […] So at least you're not trying to come up with an excuse and say 'well, I see eight patients a day. So how could I remember everything?' or 'my job is very difficult'…Do you know? I think we can tend to have impulses to be defensive, **but if we can be validating instead, I think that's really important**." (Expert 2)

In this way, Expert 2 introduces a skill necessary to constructively address patients' care needs, which, as noted in the quotes above, can be highly demanding for therapists. This skill is the ability to manage the intense negative feelings that emerge in the therapeutic relationship (therapists and experts typically mentioned this, and some of them called it

countertransference); it prevents the bond from being strained by an impulsive reaction of the therapist and instead validates the affective needs and expectations of care of the patients.

The above is exemplified by Therapist 8, who has spent many years working in public and private institutions and has trained primary care therapists after implementing the depression program in Chile. He pointed out that in the context of primary care and in working in other mental health institutions - where there is a large waiting list - one cannot miss the opportunity to help. In this sense, one must be a "bond generator", but not just any bond. From his perspective, this bond requires the therapist to be active and show interest in helping the patient solve conflicts, often displaying a strong emotional commitment to the patient in intervention. As he stated:

> "Here, you must be… um… **an active generator of bonds**. That is the basic thing, **but not the traditional bond**. I remember cases where the tension mounted and mounted, and the patient might just slam the door on his/her way out… and initially, I allowed him/her to leave… but then I learned I shouldn't, so when I noticed that the patient was on that path, I'd say **'no, no, you know what? Don't go; I don't need you to leave like this, angry. Why? Because we're repeating your pattern and I want to help you, so I'm going to… stop arguing with you'**. So, that's why **you need to take care of the bond**". (Therapist 8)

The ability to build and care for the bond also includes the ability to be humble. In general, therapists highlighted this quality, and experts typically pointed to it. According to the interviewees, being humble makes it easier for therapists to recognise their mistakes, as Expert 2 notes:

> "So, I think **one way that you build a relationship** is that **you're willing to be humble**, so you're **willing to admit** when you've said something that's a **mistake**, or you've said **something that may hurt somebody**, or you've said something insulting". (Expert 2)

The ability to be humble is closely related to metacommunication, as proposed by some experts. In this way, humility generates a therapist's disposition of "non-omnipotence" (Expert 4) towards patients. On the contrary, it demonstrates a disposition of respect and non-judgement when dealing with the patient. Humility would also make it possible to

recognise when the expected match with patients is not taking place, as Therapist 16 pointed out:

> "I think **you have to be super humble**, and super ethical too, to understand that if you are not linked, it is not that you are bad, nor that the other is bad; it is that we are human beings, and we are different, and there are things that link us and things that do not link us […]" (Therapist 16)

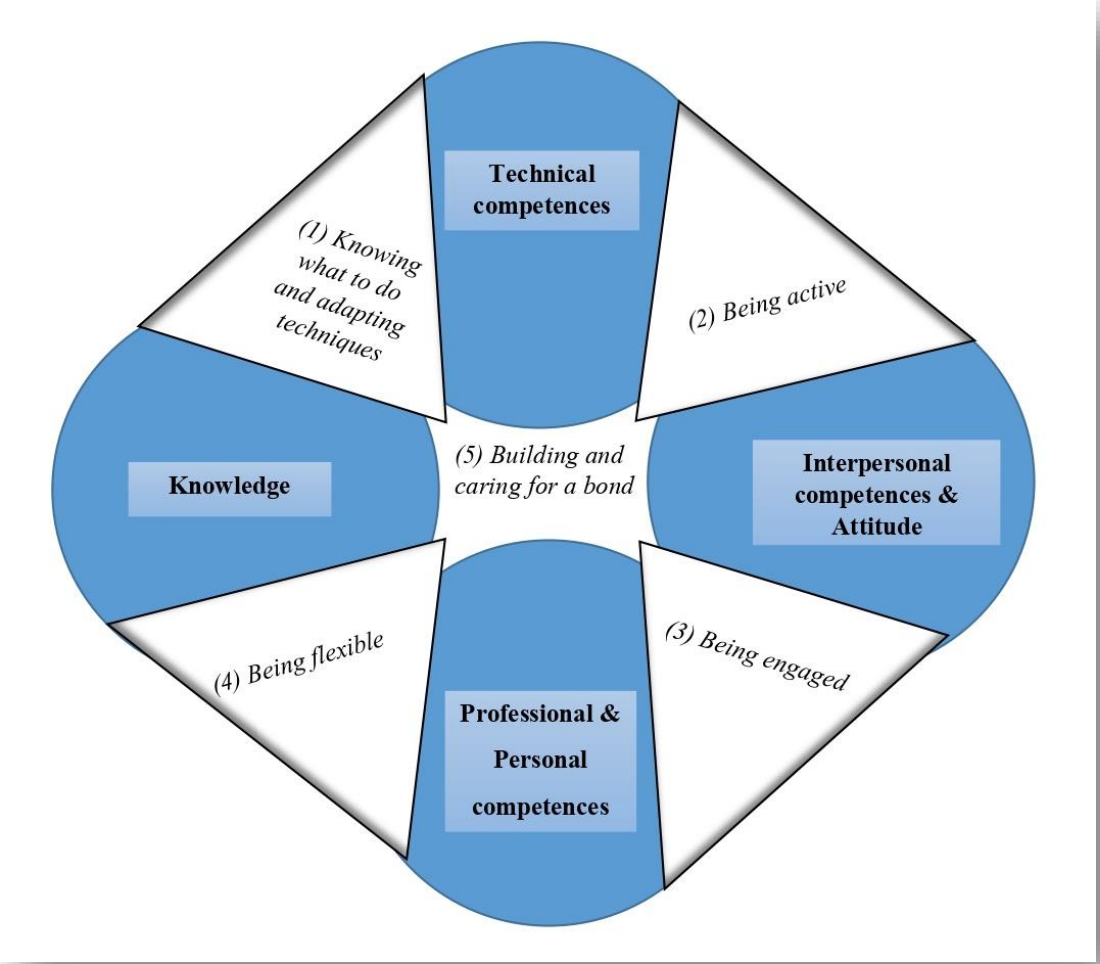
Humility makes it easier for the therapist to recognise the limitations of the bond and "to take a step to the side" (Therapist 16) to find another professional who can better help that patient (see full quote in appendix A). It was observed that this interpersonal competence is associated with the domain of professional and personal competences, through the ability to be flexible, to have personal knowledge, and to know when to refer.

In brief, considering the emergent competence model, the psychologist's ability to build a bond and take care of it by using skills belonging to the four domains presented – knowledge, technical competence, interpersonal-attitude competences, and professional personal competences - could set the conditions to meet the expectations of psychological care of patients. Having knowledge of the health system and who the users are, together with being flexible in their professional role, contributes to knowing what to do and adapting the intervention to the patients' socio-cultural context, which helps build the bond. In addition, the bridging categories of knowing what to do and adapting the technique, being active, being committed and being flexible contribute to generating a bond that fits the helping needs (e.g., developing resources in oneself and understand why I have depression), and the relational needs of the patients (e.g., the therapist showing interest in what is happening to me).

In the light of the findings, it is proposed that bonding, its building and caring (e.g., metacommunication or repairing tensions when appropriate) becomes an interpersonal experience that can be new for a depressed patient, in terms of finally finding a space where he/she can experience a welcome for him/herself and his/her suffering, as pointed out by Expert 2:

> "The idea of being happy or content or no longer depressed is so foreign and probably so threatening. […] I think we can create a new interpersonal experience, one that somebody else can internalize and say, 'oh! I can be in a relationship where I'm allowed to say what I need, and it's ok'". (Expert 2)

Figure 5. *A proposal of the dynamics between competences domains that contribute to building and caring for a bond, based on the integration of the patients, psychologist and experts perspectives*



Note. The chart shows the dynamics between the domains of competences (▪) and some "bridging" competences (△) between the respective domains that contribute to the ability to building and caring for a bond (core category). (1) Between knowledge and technical skills is the ability to know what to do and adjust the technique to the needs and requirements of the patients. (2) Between technical and interpersonal competences-attitude, there is being active to intervene and interact with the patient. (3) Between interpersonal and professional competences, there is being engaged in the helping relationship. (4) Professional-personal competences and knowledge include having flexibility in professional practice to offer help that is sensitive to the needs of the case.

5.7 DISCUSSION

This first study aimed to explore the psychotherapeutic competences needed to manage depression in institutional settings, especially in primary care, from the perspective of patients, psychologists, and experts in the field.

Competence frameworks have focused on describing the competences that clinicians require to perform well and guaranteeing the quality of the care delivered to the community (Hatcher et al., 2013; Kaslow et al., 2004; McDaniel et al., 2014); however, expert professionals have largely developed these frameworks (e.g. Roth, 2015; Rodolfa et al., 2005, Kaslow, Dunn, & Smith; 2008) without taking into account the views of patients (despite being aimed at ensuring that they receive better care). Therefore, one of the main contributions of this study consisted of developing a competence model that integrated patients' views on what they would like to find in their future psychological treatment and their therapist. This perspective shed further light on how therapists can be responsive to patients' needs (Stiles & Horvath, 2017).

We begin this section with a discussion of findings presented from patients' perspectives, followed by a reflection on the theoretical model proposed upon the basis of the integration of the three perspectives.

Patients generally expect positive changes from psychological care. They refer to them as "moving forward", which involved knowing themselves better and discovering why they have depression and improving their mood and self-esteem and developing resources/preventing crises. These achievement expectations align with prior research on the qualities of treatment that patients with depression expect or appreciate (Weitkamp et al., 2017; Kan et al., 2020; Chevance et al., 2020).

One of the facilitating factors for developing positive expectations was to prefer psychological care over medical treatment, which is in line with the preferences of primary care users (Cuijpers et al., 2019; Prins et al., 2009; Van Schaik et al., 2004; Johnston et al., 2007). Although some patients had had negative psychological treatment experiences due to institutional limitations or unwelcoming therapists ("Hindering factors to achieving expectations"), all of them expected to improve after the current process, which is a good starting point to ensure successful treatment (Constantino et al., 2018; Meyer et al., 2002). This hopeful approach contrasts with the patients' hopeless attitude before starting the therapy that has been reported in the literature (Beck et al., 2012; Weitkamp et al., 2017).

Therapists must be prepared to deal with the mood swings of patients and adequately reward the hope that they place in psychological help (Beck et al., 2012; Frank & Frank, 1991). Being responsive to patients' trust and showing hope (Van Grieken et al., 2014) appear to be important therapist skills.

The positive impact of patients' willingness to discuss their problems with a professional and placing more trust on psychological than medical treatment confirms how relevant it is for the therapist's attitude regarding the management of the disorder to be consistent with the patient's views on the aetiology of his/her depression and how to treat it (Blatt et al., 1996; OPD-2 Task Force, 2008). In turn, the provision of first-line psychological treatment can improve the effectiveness of pharmacological treatment and adherence to it, which can help prevent relapses due to the discontinuity of the pharmacological treatment (Ormel et al., 2019; Manning & Marr, 2003).

The patients' willingness to go to therapy "for as long as it takes to feel better" highlights their desire for extended treatment and more frequent sessions. These expectations make sense if we consider that most patients had previous treatment experience (13 of 16 interviewees). Also, some of them had received unsatisfactory treatment in primary care facilities and later went to university clinics to find more specialized care (5 of 10 interviewees). Furthermore, this desire and willingness to stay in therapy until they recover from their depression was confirmed by our patients recruited in primary care institutions (N=6). Our sample revealed that institutional barriers to offering psychological treatment in primary care could make it more difficult to meet patients' care expectations, which has been reported in the literature (Van Grieken et al., 2014; de la Parra et al., 2019; Fischer et al., 2019, Koekkoek et al., 2006; Moukaddam et al., 2017; Rojas et al., 2015).

Regarding patients' expectations of their future psychologist, it can be said that our observations match those reported by Weitkamp et al. (2017), as they hoped to get "a therapist who is perfect for them". When the patients voiced their expectation that the treatment would not be "just talking and talking", they are asking to get a structured treatment that addresses their needs, which was reflected by the types of interventions that they expected to see the psychologist implement: "give me an opinion", "remember what we worked on", "ensure that I can take something from the session", "identify the problem and tell me how to solve it". Without explicitly stating it, they were asking for an active

therapist who possessed the professional competences needed to make sure that they could draw something meaningful from the session. In this regard, in the study conducted by Van Grieken et al. (2014), the participants reported that a non-proactive therapist was an obstacle. It is worth noting that the therapists interviewed in our study also highlighted this professional competence.

Also, patients described interpersonal competences that they deemed important for constructing a therapeutic bond, such as welcoming, warm, likeable, inspiring trust, showing interest, being empathetic, being engaged to the patient, and not being critical. Some of these qualities, such as empathy and positive regard, have been classed as "common therapist skills" (Anderson et al., 2015) or "contextual model factors" (Wampold, 2015) and have been highlighted or desired by patients in other studies (Weitkamp et al., 2017, Van Grieken et al., 2014; Ashcroft et al., 2020). This emphasis by patients on a patient-oriented attitude may be reflecting a deep desire for the therapist to keep them in mind and offer a helping relationship informed by a person-centred rather than a disorder-centred approach, thus allowing them to experience a corrective emotional experience (Gunderson & Links, 2014).

Based on the main contributions made by the patients, psychologists, and experts who took part in the present study, it has proposed a model of psychotherapeutic competency for depression treatment composed of knowledge, technical competences, interpersonal competences-attitude, and professional and personal competences. These domains are connected through bridging categories for building and caring for a therapeutic bond: knowing what to do and adapting one's techniques, being active, being engaged, and being flexible.

For knowing what to do and adapting one's technique, it should be noted that therapists and experts were mostly in agreement, although each group highlighted different knowledge backgrounds (e.g. therapists stressed the importance of having a more philosophical, "understanding" conception of the patient, while experts stated that it was necessary to know about depression and its comorbidities). Both groups deemed it necessary that the therapist be able to adapt his/her intervention to the patient's needs, cultural context, and aims. Interestingly, this view is comparable to the model of adaptive indication (Thomä & Kächele, 1989), appropriate responsiveness *(*Stiles & Horvath, 2017), and the intervention-level competences listed by Kaslow et al. (2009) and McDaniel et al.

(2014) regarding the need to have the "best possible evidence" to decide on an intervention. Having a theoretical background in multiple therapeutic modes affords flexibility regarding one's adherence to one's model, which has a positive effect on outcomes and the alliance (Wampold, 2015; Owen & Hilsenroth, 2014).

At a technical level, the proposed model could differ more from other competence frameworks present in treatment manuals since they tend to focus on specific ingredients needed to treat depression (See Wampold, 2015, Barber et al., 2007, Webb et al., 2010, De Rubeis & Feelley, 1990). Although some therapists and experts mentioned specific interventions (e.g. cognitive behavioural, interpersonal, motivational interviewing), the three perspectives yielded interventions that met patients' care expectations and could be implemented by therapists with different approaches. These include: using interactive or play-based instruments/tasks in the session that foster self-knowledge or insight, asking the patient useful and interesting questions, helping the patient to understand him/herself or understand why he/she is depressed, providing new perspectives and helping patients to see things differently, helping the patient to manage his/her criticism and negative views of him/herself, aiding him/her in self-esteem regulation, and guiding him/her in problem-solving. All these interventions meet the patients' expectation "to move forward" and are therapeutic actions that the people interviewed in other studies appreciate (Grieken et al., 2014; Johnston et al. 2007; Kan et al., 2020; Chevance et al., 2020).

For their part, the experts contributed with specificities that point to the core complexities of the disorder, such as possessing skills to deal with negative points of view or criticism in depressed patients, self-esteem deregulation, and repairing alliance ruptures. Experts typically noted that it is necessary to contribute to the patient's understanding of his/her symptoms and state, "giving these depressive contents some room to present themselves" and help him/her to understand when these interpersonal strategies appear. In this regard, they stated that therapists should be cautious when addressing "the content of the criticism". Instead, the experts asserted that validating the patient's emotional state is a good way of dealing with these contents since it may result from feeling disappointed in the therapist. This focus on the personal-interpersonal functioning of the depressed patient has been reported as an expectation of patients in other studies (Kan et al., 2020; Chevance et al., 2020) and matches the approach used with patients who exhibit a more self-critical or perfectionist style, which requires the development of personal skills such as patience and persistence, as well as caution regarding the challenges that these patients may pose

(Hermanto et al., 2016; Fazaa & Page, 2003; Overholser & Dimaggio, 2020; Behn et al., 2018).

As observed in the Results section, it is not enough to know what to do; rather, according to the therapists and experts, it is necessary to adopt an active attitude when intervening. More specifically, the therapists described this attitude as "forward-leaning", directly aimed at helping the patient, being bold and taking risks. The experts spoke about the knowledge to repair alliance ruptures and use Metacommunication (Safran & Muran, 2000), which requires this active attitude. Although the patients did not explicitly mention this attitude, they reported several interventions that they would like to see, indicating a desire for therapists to play a more active role in the helping relationship (discussed above). This attitude also appears to impact the strengthening of the therapeutic bond due to the satisfaction that patients derive from "taking home something significant from the session". It is worth pointing out that, in the study conducted by Van Grieken et al. (2014), the patients reported that the absence of this proactive attitude hindered the treatment.

Depression is an individual emotional response to feelings of loss or the failure to achieve the desired state (Luyten & Blatt, 2012). In this context, an "engaged therapist" can provide the patient with emotional support, potentially filling the emotional void resulting from the loss or lack of significant figures. Furthermore, the active disposition of the therapist in achieving the changes that patients are not able to achieve on their own can be curative in itself by instilling hope, as noted by the patients interviewed. Therapists and experts also noted that commitment made the therapist "a good professional", with this quality being closely related to exhibiting genuine interest in the patient and striving to ensure that he/she would move forward. From the perspective of the contextual model, this has a positive impact on outcomes (Wampold, 2015) and is also valued by patients worldwide (Johnston et al., 2007; Weitkamp et al., 2017; Ashcroft et al., 2020).

The concept of flexibility was used to mean a variety of things. First, some participants referred to "not being dogmatic" with one's therapeutic model. Second, other participants used the term to refer to being flexible enough to treat all the diverse users who seek treatment in institutional settings, a competence found in the models advanced by McDaniel et al. (2014) and Kaslow et al. (2009). Third, other participants saw flexibility in terms of the interpersonal and professional skills needed to offer a bond, pointing out that "neutrality in the relationship" was not well suited to the type of users they served. In the

therapists' experience, they became more and more flexible compared to what they had learned in university to establish a "more genuine" relationship with patients. This experience is consistent with the evidence showing that professionals develop their ability to work in primary care settings in a gradual manner (Minolleti & Zaccaria, 2005) and that undergraduate programs do not prepare them for real treatment settings (where there are no therapist's couches) (De la Parra et al. 2018; Scharager & Molina, 2007).

Finally, the different findings of this study made it possible to propose a set of competences that are strongly oriented to establishing a therapeutic bond focused on the needs and expectations of patients with depression, considering the features of institutional settings. In addition, they are in line with the model of common factors (Lambert, 2013; Wampold, 2015), highlighting the therapist's flexibility to adapt his/her techniques and actions to the contextual and linkage requirements, which is comparable to the competence of assimilative integration (Boswell et al., 2010); therefore, these competence domains can be incorporated into routine practice regardless of the therapist's preferred therapeutic modality.

It is worth noting that the theoretical model proposed here is centred on the ability to building and caring for a therapeutic bond, with its "active ingredient" appearing to meet the expectation to receive help from "a therapist who is active, welcoming, and engaged to the patient". These components are part of Empirically Supported Relationships ESRs (e.g., therapist-offered alliance, real relationship, repairing alliance ruptures; Norcross & Lambert, 2011; 2018) and –according to Anderson et al. (2015) – could be regarded as "Common Therapist Skills".

6. STUDY 2: CONSTRUCTION OF A WORKSHOP PROTOCOL TO DEVELOP PSYCHOTHERAPEUTIC COMPETENCES AND ITS VALIDATION THROUGH THE DELPHI METHOD.

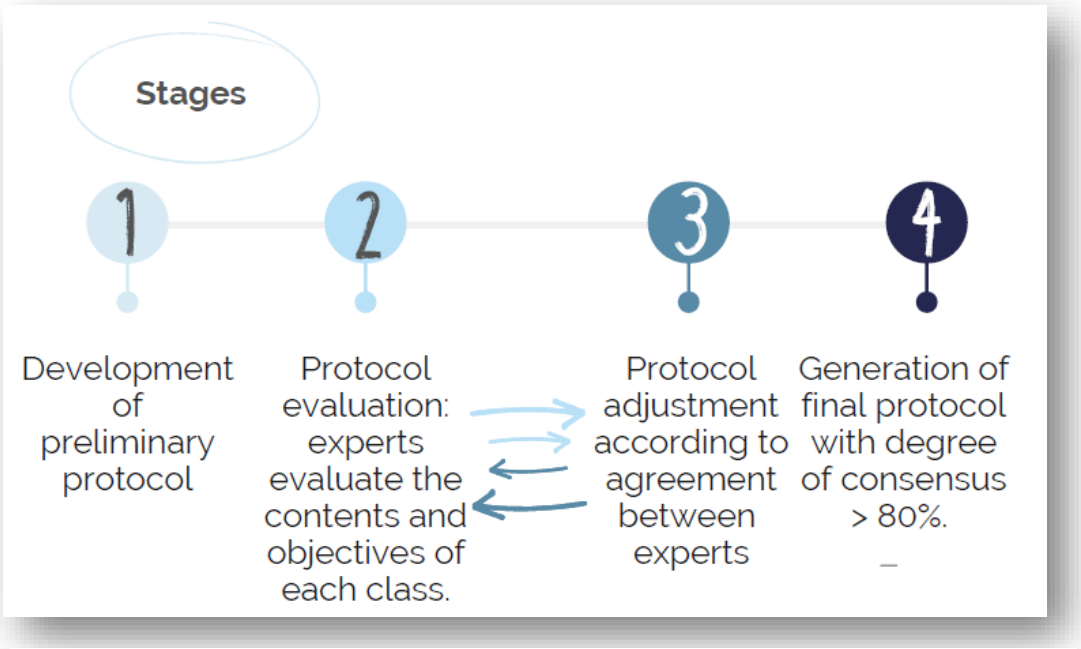
The second study of this doctoral thesis was incorporated as the first stage of the research, "Training of competencies for the psychotherapy of depressive disorders in institutional contexts of primary care", in the framework of the XVI National Competition for Research and Development Projects in Health 2019 FONIS. This FONIS research seeks to implement and evaluate the acceptability of the final product of this dissertation, the workshop protocol.

As shown in Figure 6, Study 2 has four stages: 1. Development of preliminary workshop protocol (PECP-1)[1]; 2. Assessment through the Delphi method of the contents of the PECP-1; 3. Protocol adjustment according to agreement between experts; 4. Generation of final protocol (PECP-2)[2].

[1] In the original language the acronym "PECP" was used to indicate “Protocolo de Entrenamiento en Competencias Psicoterapéuticas” whose English translation is: "Psychotherapeutic Competence Training Protocol". PECP-1 refers to the preliminary protocol.

[2] PECP-2 refers to the version resulting from the Delphi validation

Figure 6. *Stages of Study 2*



Note. Once the preliminary protocol is written (1), it undergoes evaluation and adjustment based on the level of agreement of the Delphi panel, until 80% consensus is reached, generating the final protocol (2, 3 and 4).

6.1 DEVELOPMENT OF PRELIMINARY WORKSHOP PROTOCOL (PECP-1)

6.1.1 PROCEDURE

A team of editors was formed with the FONIS researchers to propose and draft a training protocol based on: The psychotherapeutic competencies that emerged from patients, psychologists and experts (results of study 1); 2. The review of empirical evidence from the Millennium Institute for Research on Depression and Personality (MIDAP) regarding profiles of depressive experience (self-critical-dependent), vulnerabilities of personality structure and suicidal risk, and the Chilean (empirical) experience of the brief psychotherapy model in institutional contexts (see De la Parra et al., 2018a; De la Parra et al. 2018b; De la Parra et al. 2021). The systematisation was carried out through the exhaustive review of the material and the consensus of the editorial team's (Altimir et al., 2017; Hill and Knox, 2021).

Based on the three axes of contents outlined above, a training comprising six modules was proposed. Researchers from outside the project were invited to contribute their

expertise to writing some of the modules and classes (e.g. early adversity enquiry, DBT model skills, crisis focus-intervention, therapeutic relationship, and suicide).

A responsible author was assigned to each module, which was free to convene a team to develop the proposed topic. Each author was sent instructions on how to write their respective module and was offered a set of ad-hoc competencies to develop it. The authors were free to use this set of competencies as they saw fit.

Each module of the training protocol had two classes, which were proposed to take place over two weeks, with trainees spending an estimated 2.5 hours per week. Given the pandemic context, asynchronous online training was proposed for the six modules. Once this stage was completed, a synchronous session was held to resolve any concerns regarding the contents, supervise cases, go deeper into topics that were of interest during the training course, and provide self-care strategies (more details regarding the platform and synchronous session in Annex 3). The preliminary PECP-1 protocol will be described below.

6.1.2 PRELIMINARY WORKSHOP PROTOCOL (PECP-1) STRUCTURE: MODULE CONTENTS AND COMPETENCES

Module I: Theoretical-empirical basis of the PECP-1 model. It covered the theoretical-empirical basis of the model, including adaptive indication, common factors and the desirable competences for professionals from phase 1 of this doctoral research. The competences that served as inputs were: introduction to technical competences (from evidence-based models and patient-rated interventions); interpersonal competences (based on patients' expectations of therapeutic bonding and common factors of therapy); flexibility and adaptive indication (adapting treatment to emerging needs); knowledge of the functioning and reality of care; willingness and appreciation for the work being done there; knowledge of depression and its comorbidities; ability to psychoeducation about the depressive disorder and its complexities; knowledge of patients' expectations of psychological help.

Module II: Complex Depression. It was wholly devoted to complex depression, addressing personality dysfunctions, self-critical and dependent functioning, and aspects of trauma. The core competencies were: to know how to make a therapeutically oriented diagnosis to treat depression and its comorbidities (mainly personality disorder and trauma), being able to identify vulnerabilities of structural functioning in patients with

personality disorders; to distinguish focuses of attention, aimed at strengthening structural functions of the personality; to help the patient to understand aspects of self-related to the depressive picture (e.g. emotional dysregulation, regulation of self-esteem); to have an attitude towards the patient's depressive state (e.g. emotional dysregulation, regulation of self-esteem); to be able to identify the vulnerabilities of the structural functioning in patients with depressive disorders; have an active and interested attitude in therapeutic dialogue to probe adverse childhood experiences; have a background in specific brief models for dealing with resistant symptoms of depression, emotional dysregulation and problem solving (specific competences from cognitive models and general psychiatric management).

Module III: Therapeutic relationship. It focused on the therapeutic relationship, laying out how the patient's context and the therapist's work setting influence the latter's emotional functioning. The core competences were the interpersonal competences to offer a therapeutic bond and to have the interpersonal and technical skills to take care of it. Such as showing interest in the user, reminding him/her of what was worked on in previous sessions, welcoming, warm, and recognising humbly one's own mistakes to therapeutic impasses. To know how to identify ruptures in the alliance and know how to metacommunication to repair the relationship, clarify expectations with the patient, and learn to manage transference-countertransference. In addition, the skills of working with and relying on the team are promoted, and the ability to seek help, such as peer supervision, and to use self-care strategies in the context of care as far as possible.

Module IV: Brief therapy, goals, focus, and crisis. It was devoted to brief therapies, structure-focused therapy, and crisis interventions. The core competence was to know how to deal with high-pressure care settings through agreement with treatment objectives and goals, knowing how to focus and manage crises intervention. In addition, this module incorporated other competencies such as: tolerating frustration, teamwork skills, and developing an engaged and active stance to intervene.

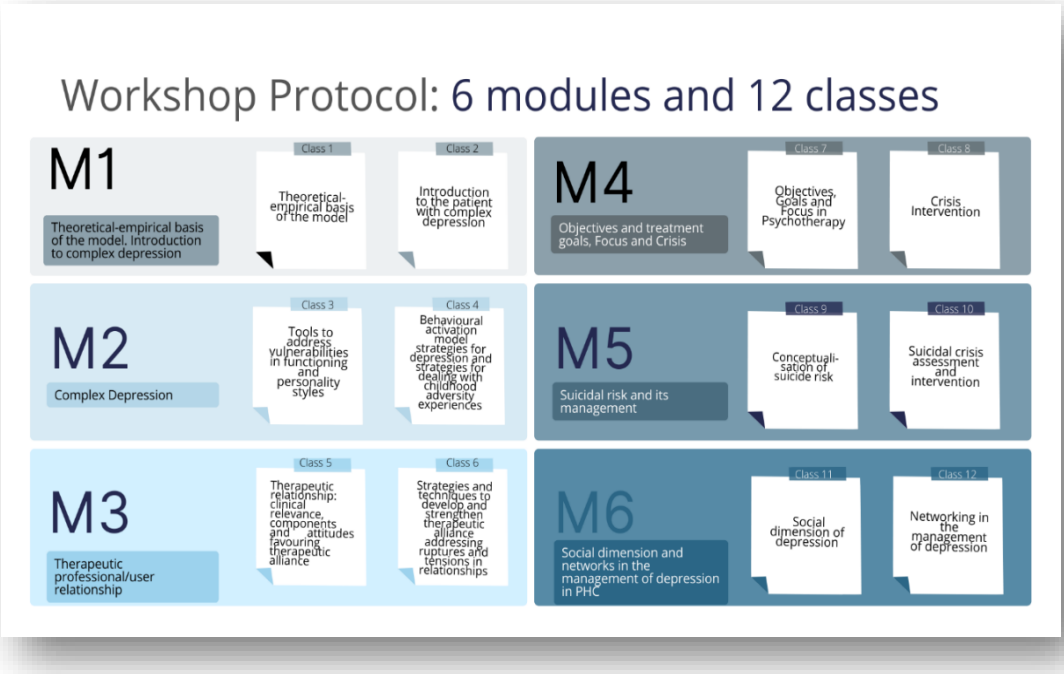
Module V: Suicide risk and its management. This module highlighted the knowledge and technical competences (handling of enquiry and assessment tools) to manage suicidal risk and its evolution. And the interpersonal skills of an engaged therapist, which implies being emotionally attuned to the client, having empathy, promoting hope and validating suffering (not the idea of dying). In addition to being welcoming, active and non-

judgmental (non-judgmental) listening. The competences of the therapist's person were also addressed, related to having a good "self-awareness" of their internal emotional states, knowledge of their capacities and limitations, and tolerance to frustration related to fears that the complexity of the suicide risk may provoke.

Module VI: Psychosocial aspects of depression and networking. It was discussed culturally informed psychotherapy and therapists' community-related competences, such as patients' community involvement and network activation. The theoretical background of this module was based on knowledge regarding the public health system, the functioning of primary health care, its networks, and who its users are, teamwork to address psychosocial determinants of depression and to activate support networks. Socio-cultural competence was the pillar of this module, which facilitates a comprehensive mastery and approach to depression from a social perspective, knowing how to identify psychosocial risk factors that influence depressive symptomatology, developing the sensitivity to adapt treatments considering the social determinants in the manifestation of the disorder.

Figure 7 summarises the structure of PECP-1 with its modules and their respective classes.

Figure 7. *Outline of preliminary workshop protocol (PEPC-1)*



The modules sequence, some pedagogical objectives and the organisation of some contents (but not the proposed competences) were slightly changed according to the suggestions coming from the Delphi panel (see below).

6.2 VALIDATION OF THE PRELIMINARY WORKSHOP PROTOCOL USING THE DELPHI METHOD

6.2.1 INTRODUCTION TO DELPHI METHOD

The Delphi method is a systematic process aimed at gathering information and judgement from a group of experts on a particular topic. It is a valuable method for building consensus among a group of people who have expertise on a given topic (Dalkey et al., 1972). Participants are selected according to their knowledge of the topic under investigation, also referred to as a panel of knowledgeable individuals or experts (McKenna, 1994; Shariff, 2015; Skulmoski et al., 2007). The diversity of participants - rather than the number of participants (Rowe & Wright, 2001) - is optimal for maximising diverse views on the topic to be evaluated (Powell, 2003). Through iterative rounds -2 or 3 rounds is ideal- (García & Suárez, 2013), the information to be evaluated is submitted to the experts, and the consensus of the panel is sought through a series of data collection and analysis techniques interspersed with feedback, for which a structured survey is generally used. It should be noted that there is no contact between them throughout the process (Dalkey et al., 1972; McKenna, 1994; Hasson et al., 2000). The evaluation ends when a certain percentage of agreement is reached, a consensus greater than the range of 70-80% is considered adequate to end the process (Green et al., 1999; Hasson et al., 2000; Williams & Haverkamp, 2010).

The Delphi method has been used in various researches in diverse fields of knowledge, including health professional competency assessment and psychotherapeutic competences (Montero et al., 2007; Von Treuer & Reynolds, 2017; Dois et al., 2018; Williams & Haverkamp, 2010).

6.2.2 PARTICIPANTS: INCLUSION CRITERIA AND RECRUITMENT

A panel of judges was formed with 7 participants, three women, three men, and another gender. With an average age of 49.2 years (SD= 14.9), four were psychologists and two psychiatrists, all Chilean. The panel had experience working as academic professionals and managerial positions in mental health programmes and/or research in public mental health, primary care, and depression (see table 4).

The inclusion criteria were: Psychologists or psychiatrists with proven national experience in the academic area, depression clinic, and psychotherapist training for the care of patients with depression in institutional settings were personally contacted. Given the specificity of

the inclusion criteria and considering the accessibility criterion, a minimum sample start of 5 experts was proposed. Finally, a panel of N=7 was formed. In this regard, a small number of experts could be unaffected by the effectiveness of the assessment and have no more advantage than a larger panel size (Rowe & Wright, 2001).

The sampling technique was non-probabilistic, purposive, and snowball sampling, typically used for this type of study (Habibi et al., 2014).

Table 4. *Experts' Characteristics of Delphi Study (n=7)*

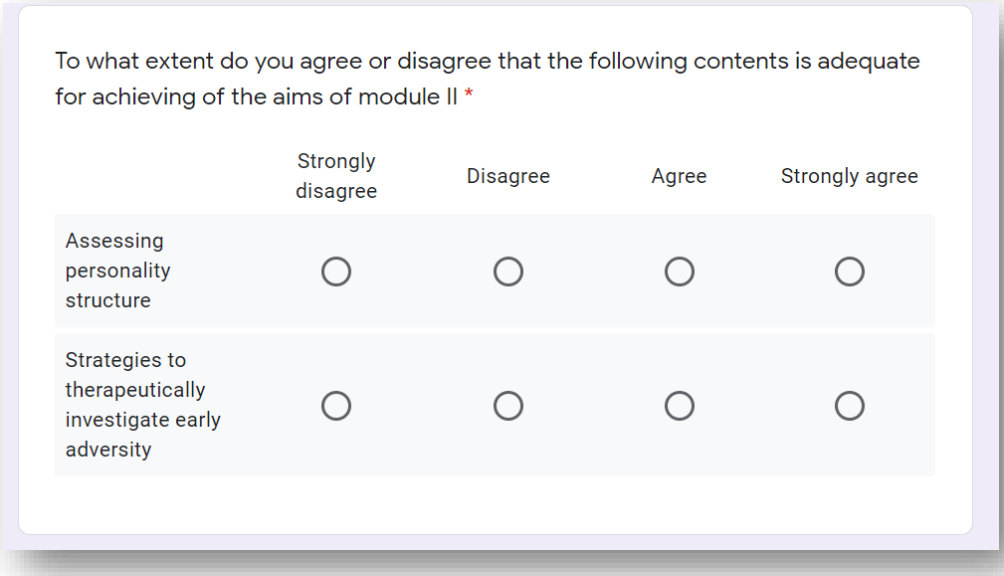
Variable	N	%	M	SD
Age			49,2	14,9
Gender				
Female	3	42,9		
Male	3	42,9		
Other	1	14,3		
Profession				
Psychiatrist	2	28,6		
Psychologist	4	57,1		
Experience (>5 yrs)				
Depression Research	4	57,1		
Public Mental Health	5	71,5		
PHC	3	42,9		

6.2.3 INSTRUMENTS

A survey was constructed ad-hoc to evaluate the specific objectives and contents of workshop protocol with a Likert scale, with responses containing a four-point scale: strongly disagree (1), disagree (2), agree (3), and strongly agree (4). Those who responded "strongly disagree and disagree" were given the option to fill in a blank space to explain their reasons.

The survey assessed: 1. how much they agreed with the specific objectives of each class that made up the modules; 2. how much they agreed with the contents of the respective classes per module; and 3. to gather their overall impressions and suggestions regarding each of the classes. This survey was administered online through the platform http://surveygismo.com/. Figure 8 illustrates how the survey questions were asked.

Figure 8. *Example of a survey question*



6.2.4 *DATA ANALYSIS*

A quantitative analysis of the survey was carried out by calculating the percentage of agreement/very much agreement of the participants for each specific objective and content proposed in each class. In addition, a qualitative content analysis (Cho & Lee, 2014) of the filled-in responses was carried out, in which experts argued their disagreements, provided comments and suggestions. Their qualitative feedback was included in a new edition of the modules; also, suggestions given in modules that reached consensus in the first round were considered.

6.2.5 RESULTS OF THE DELPHI VALIDATION PROCESS

6.2.5.1 RESULTS OF ROUND 1.

Table 5 shows the percentages of agreement/strong agreement with the objectives and contents set by each class (the objectives and contents of the 12 classes are detailed in Annex B). The results obtained for each class are described below. Unlike the other modules, module II (class 3 and 4) was the only one that did not reach the expected consensus in this first round.

Table 5. *Round 1: Percentage of agreement with specific objectives and contents of PECP-1*

Classes	Specific Objectives							Contents					
	1	2	3	4	5	6	7	1	2	3	4	5	6
1. Empirical-theoretical basis of PECP	100	85.7	100	85.7	100	100		100	100	85.7	100	85.7	
2. Introduction to Complex Depression	100	100	100	85.7	100	100	85.7	100	100	100	85.7	100	100
3. Tools for addressing functioning vulnerabilities and personality styles	100	100	100					71.4[1]	85.7	71.4[2]			
4. BA strategies for depression and strategies for dealing with childhood adversity experiences	85.7	85.7						71.4[3]	85.7				
5. Therapeutic relationship	100	100	100	100	100			100	100	100	100	100	
6. Strategies to address ruptures and protect therapeutic alliance	100	100	100	100	100			100	100	85.7			
7. Objectives, goals and focus in psychotherapy	100	100	100	100				100	100	85.7	85.7	85.7	100

Classes	Specific Objectives							Contents					
	1	2	3	4	5	6	7	1	2	3	4	5	6
8. Crisis intervention	100	100	100					100	85.7	85.7			
9. Conceptualisation of suicide risk	100	100	100					85.7	85.7	85.7	85.7	100	100
10. Suicide risk assessment and intervention	100	100	100	100	100			85.7	85.7	85.7	100	85.7	
11 Social dimension of depression	100	100	100	100	100	100		100	100	100	100	100	
12 Networking	100	100	100	100				100	100	100	100		

Note. Classes with expert agreement ≤ 80%, and which went to the second round: [1] How to carry out structural personality diagnosis; [2] Dialectical behavioural therapy skills for the management of structural vulnerabilities in patients with depression; [3] Behavioural activation therapy skills for patients with depression

MODULE I CLASS 1: THEORETICAL AND EMPIRICAL BASIS OF PECP-1.

This class aimed to know the theoretical, empirical, and clinical experience-derived foundations underlying the Psychotherapeutic Competence Training Protocol (PECP-1). Concerning the six objectives, four reached 100% agreement. The other two objectives reached 85.7% agreement. One expert disagreeing with knowing the factors that can complicate the depressive client, because in her opinion, "it was not clear that it was an objective that was derived from the general objective of the module" (Judge 2)-which was to know the theoretical-empirical foundations of the model that underlies the PECP-1-. The second objective, which received disagreement, was to understand the role of the relationship in the whole therapy process, especially in personality structure dysfunctions. The disagreement was along the lines of not considering that it was "especially relevant for personality structure dysfunctions" (Judge 4).

Regarding the five proposed contents, 3 of them obtained a 100% consensus (judges evaluated it as agreeing and strongly agreeing). Still, judge 2 disagreed with factors complicating depression because she did not find that "it would contribute much if it were dealt with in another class later on". The Psychotherapeutic competencies: patient, professional and expert perspectives content had one disagreement from judge 1, who noted that "rather than disagreeing with the content, the methodology for achieving these

competences was not clear". Each content reached a consensus of 85.7%. This class did not go to the second round because all its objectives and content were above the consensus percentage (≥ 80%).

Qualitatively, there was an upbeat assessment of the contents that support the PECP (n=6). However, several judges suggested improving the wording, clarifying contents in the line of how to achieve or develop the knowledge or competences suggested, as expressed by Judge 4: "I think the contents are very relevant, and most of them seem to me to be excellent foundations for the PECP. I would only try to change some of the organisation of the contents, as the structure of the presentation does not give me the impression that it favours didactics [...] it seems to me that there is something that is not so intuitive in the path that the text follows".

MODULE I CLASS 2: INTRODUCTION TO COMPLEX DEPRESSION.

This class aimed to identify the factors that add complexity to the depressive picture in primary care patients in order to consider them in the management and therapeutic plan as an introduction to the contents that will be deepened in module II.

Of the seven specific objectives set out, five reached 100% acceptance, and two obtained 85.7% agreement. These referred to identifying the history of early adversity as a factor to be considered in depression, where Judge 3 agreed to consider this history but not to investigate it if the patient does not spontaneously point it out. The other objective on which one judge disagreed was to know that the clinical and psychosocial complexity of the patients, as well as the place of work, impacts the therapist in his/her work because he/she felt that the way it was written was redundant and confusing (Judge 2).

Regarding the content, the one referring to complexity from early adversity and trauma achieved 85.7% acceptability, judge 3 disagreed because he did not consider it appropriate to inquire into this background "in a psychotherapy that will have so few sessions". The judges agreed and strongly agreed with the other five contents (100% consensus). This class did not pass to the second round because all its objectives and contents were above the percentage of consensus (≥ 80%).

MODULE II CLASS 3: TOOLS FOR ADDRESSING FUNCTIONING VULNERABILITIES AND PERSONALITY STYLES.

This class aimed to identify and address dysfunctions and characteristics of personality functioning that complexity the depressive picture. The judges indicated that they agreed

or strongly agreed with them regarding the proposed pedagogical objectives, achieving 100% acceptability.

This class had a total of three contents to be evaluated. One judge disagreed with all the contents because they considered that there were too many (Judge 1). The most critical contents, where two judges disagreed, were: how to perform structural personality diagnosis and skills based on dialectical behavioural therapy to treat patients with depression. Each reached 71.4% agreement, being below the expected consensus (≥ 80%), which is why this class passed to the second round.

Qualitatively, in this round, two experts pointed out that despite agreeing with the objectives, they felt that "there was a lot of content", and "they were concerned about how long it would take to make a structural diagnosis considering the context of PHC" (Judge 1), and that the way and depth in which the content for the diagnosis was presented was insufficient. As Expert 4 points out, "I think it would improve a lot with more detail, more examples and also more depth in the conceptual frameworks of the OPD". There were no specific references to dialectical behavioural therapy skills.

MODULE II CLASS 4: BEHAVIOURAL ACTIVATION MODEL STRATEGIES FOR DEPRESSION AND STRATEGIES FOR DEALING WITH CHILDHOOD ADVERSITY EXPERIENCES.

This class aimed to develop competencies in using behavioural activation to address childhood experiences of adversity in patients with complex depression.

This class had two specific objectives. The first was to learn the rationale, procedure and competencies for using the behavioural activation technique for depression, which judge 2 disagreed with. Regarding the second objective, to identify and develop skills for therapeutic enquiry of childhood experiences of adversity in patients with depression, judge 3 strongly disagreed. Even so, both reached 85.7% agreement respectively.

At the content level, strategies for dealing with childhood experiences of adversity in patients with depression reached 85.7%, with judge 3 disagreeing. The content of behavioural activation therapy skills for patients with depression presented one evaluation in disagreement (Judge 1) and another one in strong disagreement (Judge 2), reaching 71.4% approval, being below the expected consensus, which is why this class passed the second round.

Qualitatively, regarding the objective and content corresponding to developing skills to investigate early adversity experiences, Judge 3 presented his concerns that it did not seem a good idea to explore these topics in the depression programme, where in his opinion, "processes may be opened that cannot be elaborated in 8-12 sessions". Regarding behavioural activation skills, Judge 1 disagreed because the methodology for developing these skills was not clear. For her part, judge 2 pointed out that the objectives and contents were well stated, but that the behavioural activation technique seemed to her "could be very demanding for patients who are not methodical, or for therapists who do not have time to review the task in the context of PHC", expressing her concern about the number of sessions necessary for the technique to work.

MODULE III CLASS 5: THERAPEUTIC RELATIONSHIP: CLINICAL RELEVANCE, COMPONENTS AND ATTITUDES FAVOURING THERAPEUTIC ALLIANCE.

The general aim of this class was to understand the theoretical, empirical and clinical foundations of the role of the therapeutic relationship in psychotherapy and develop competencies to foster the therapeutic alliance in working with clients with complex depression.

All judges strongly agreed with the specific objectives. In contents, all judges agreed with them, reaching 100% consensus. This class did not go to the second round.

Qualitatively, in general, the panel (n=7) valued positively the inclusion of the therapeutic relationship in a training programme in the treatment of depression. There were also several suggestions to deepen some topics, such as: strengthening aspects of teamwork to strengthen the therapeutic alliance, promoting supervision (Judge 6), considering that the methodology and form of evaluation allow the objective of sufficiently developing competencies and attitude to generate a good therapeutic alliance with consultants (Judge 1) to be met. A more divergent opinion was received by Judge 5, who pointed out that the "approach was a bit goodistic", considering that patients with depression generated intense negative emotions in the therapist. However, the latter point was addressed in the next class.

MODULE III CLASS 6: STRATEGIES AND TECHNIQUES TO DEVELOP AND STRENGTHEN THERAPEUTIC ALLIANCE ADDRESSING RUPTURES AND TENSIONS IN RELATIONSHIPS.

The general objective of this class was to distinguish strategies, techniques, develop a therapeutic attitude for strengthening the therapeutic alliance, and know how to deal with relationship breakdowns. All the specific objectives proposed achieved 100% agreement from the experts. Concerning the contents of this class, two of them reached 100%, while the content on handling difficulties and tensions in the therapeutic relationship obtained 85.7% acceptance, with one judge disagreeing (Judge 4) because he did not consider the way of presenting the strategies and techniques for dealing with break-ups to be sufficient. Overall, the consensus was over 80%, so this class did not go to the second round.

Qualitatively, the panel emphasised the interestingness of dealing with break-ups and giving space to negative emotions and the "inevitability" (Judge 5) of break-ups in the therapeutic relationship with depressed patients. Although they generally agreed or strongly agreed (n=6), each judge made suggestions to strengthen this module, such as reinforcing the role of teamwork (Judge 2, 6), highlighting therapist-oriented strategies such as personal psychotherapy, self-care, supervision (Judge 5, 6), and going more deeply into techniques for dealing with break-ups (Judge 4).

MODULE IV CLASS 7: OBJECTIVES, GOALS AND FOCUS IN PSYCHOTHERAPY.

This class aimed to distinguish the theoretical concepts of psychotherapeutic indication, psychotherapeutic focus and joint planning of brief psychotherapy with the patient. All the judges agreed very strongly with the proposed objectives, reaching 100% consensus. Regarding the six proposed contents, half of them reached 100% agreement, and in the other three contents, one judge disagreed because he felt that they were too much content and lacked more depth and examples (judge 1). These contents were: OPD-2 as a tool for focusing, focusing on personality structure, and focusing on Complex Depression. They achieved 85.7% approval, respectively. This class did not go to the second round.

Qualitatively, there was also a positive evaluation of this class by the majority of the judges (n=6) due to the importance of "agreeing on goals" and knowing how to "focus" in a context of high care pressure. Some constructive suggestions were also made, in terms of better ordering the objectives, contents and didactics, by adding more diagrams or diagrams. One of the contributions that generated a change in the organisation came from judge 4, who said: "I think it is a central class, with very valuable contents for its

application in PHC. Without prejudice to this, and as I have pointed out above, I think that the material can be improved in terms of structuring and didactics [...] Finally, I think that this class could be improved by increasing its linkage with module II. Perhaps without interposing the module III class." A suggestion that was considered in the final reorganization of the protocol.

MODULE IV CLASS 8: CRISIS INTERVENTION.

This class was oriented towards identifying the state of crisis in a patient and carrying out an intervention in accordance with this. The panel, in general, was very much in agreement with the proposed objectives, achieving 100% consensus. Of the three proposed contents, one reached 100% agreement. Judge 1 disagreed with the other two contents that referred to crisis intervention: definition and phases, and clinical example, arguing that there was a lack of clarity and detail of the techniques used in the clinical case. These contents achieved 85.7% consensus, respectively. Because the consensus was ≥ 80%, this class did not go to the second round.

Qualitatively, although the majority of judges (n=6) considered it an adequate and interesting class, several suggestions for improvement were received: synthesising content (Judge 1), incorporating vital crises (Judge 5), modifying some of the backgrounds of the clinical case to make it more applicable to the context of PHC and crisis intervention, and complementing it with multidisciplinary or teamwork (Judges 3, 4, 6, 7).

MODULE V CLASS 9: CONCEPTUALISATION OF SUICIDE RISK.

This class aimed to understand suicidal risk, its background (contextual and personal), protective and risk factors, dynamics, and the therapeutic dyad's responsibilities. The entire panel of judges was in strong agreement on the specific objectives proposed, reaching 100% consensus. Regarding the six proposed contents, only judge 1 disagreed with four contents: contextualisation of suicide in the world and Chile, conceptualisation of suicidal risk, the trajectory of suicidal risk throughout life, protective factors and suicidal risk factors. These contents reached 85.7% consensus.

For example, the judge did not agree that the term "psychological fragility" should be used in the conceptualisation because it could be stigmatising. She also requested clarification that protective and risk factors varied according to gender and age group, among other considerations.

MODULE V CLASS 10: SUICIDAL RISK ASSESSMENT AND INTERVENTION.

This class aimed to distinguish assessment tools and intervention strategies for suicide risk, and the panel of judges agreed strongly with the objectives set out, achieving 100% acceptance. Regarding the five contents, one achieved 100% agreement, and 4 achieved 85.7%. In the latter, judge 1 disagreed with: progressive clinical assessment of suicidal risk, assessment with psychometric instruments, what to do when suicidal risk is detected, and crisis intervention strategies (individual and family). The judge made several suggestions on improving the module, including the need to better differentiate self-injurious behaviour from suicide attempts with low intent to die and incorporate suicide assessment instruments and referral and admission criteria provided by the Ministry of Health. However, due to a consensus of ≥ 80%, this class did not proceed to the second round.

Qualitatively, in general (n=7), the judges found the suicide module to be adequate, with recurrent positive statements such as "I think it is an excellent class" (Judge 5), "I really liked the way the subject was approached and the complement between the two classes" (Judge 2). Along with expressing their agreement with this module, some judges gave suggestions such as "strengthening aspects linked to countertransference or emotional resonance in the psychologist" (Judge 6). For his part, Judge 4 suggested changing the order of this class so that there would be a greater concordance with previously dealt with topics: "The contents seem to me to be useful for the objectives set out. I only observe that the particularity of the contents in the trajectory of the previous and subsequent contents [in reference to the contents of the modules] is misaligned for the level of abstraction. Perhaps [this module] would be better placed after module II" (Judge 4).

MODULE VI CLASS 11 AND CLASS 12: SOCIAL DIMENSION OF DEPRESSION AND NETWORKING IN THE MANAGEMENT OF DEPRESSION.

Both classes achieved 100% consensus on objectives and content.

Class 11, regarding the social dimension of depression, aimed to promote a flexible and sensitive attitude towards the social dimension in the management of depression and models for its approach in primary health care. All judges strongly agreed with its objectives, and for the five proposed contents, the judges agreed and strongly agreed.

Class 12, called networking, aimed to identify the relevance, characteristics, and models conducive to networking in the management of depression. The expert panel agreed and strongly agreed with the objectives and content.

Qualitatively, this module was generally valued by the panel. Some of the judges' statements were: "it is an excellent chapter" (Judge 3), "I think it is a well presented, synthetic and consistent set of contents" (Judge 4). However, some modifications were also suggested, such as highlighting more the role of the psychologist in the construction and orientation in the use of support networks (Judge 6), including a section on psychosocial challenges of PHC (Judge 2), considering "the community" not as an approach or strategy of intervention, but as an action or method of territorial work (Judge 4), including more literature on domestic violence and returning to the background of early childhood adversity (Judge 5).

6.2.5.2. RESULTS OF ROUND 2.

Table 6 shows the consensus percentages for this round.

MODULE II CLASS 3: TOOLS FOR ASSESSING PERSONALITY VULNERABILITIES AND EXPERIENCES OF ADVERSITY IN CHILDHOOD.

The general objective of this class was to recognise and assess personality dysfunctions and characteristics and childhood experiences of adversity in patients with complex depression. Of the three specific objectives proposed, two of them achieved 100% approval, and one referred to identifying and developing skills for the therapeutic enquiry of childhood experiences of adversity in patients with depression reached 85.7% (Judge 3 marked disagree). Regarding the three proposed contents, two achieved 100% consensus with strongly agree and agree responses, and the content strategies for therapeutically inquiring about childhood experiences of adversity reached 71.4% agreement (judges 1 and 3 disagreed). This class moved to the third round.

Overall, the panel assessed in general agree and strongly agree with this class (n=6) (including judge 1, who had marked a disagreement on the content). Qualitatively, regarding the content that did not reach the expected consensus (strategies to therapeutically investigate experiences of adversity in childhood), Judge 1 expressed that it was necessary to delve a little deeper into how to deal with traumatic experiences, and Judge 3 expressed that due to an issue of "the setting in PHC" he saw little feasibility in dealing with experiences of early adversity in the depression programme. It should be

noted that Judge 4, who agreed with this content, suggested incorporating a guide regarding lines of action when a traumatic experience constituting a crime is revealed in a therapeutic session.

MODULE II CLASS 4: THERAPEUTIC TOOLS TO ADDRESS RESISTANT DEPRESSIVE SYMPTOMATOLOGY AND PERSONALITY VULNERABILITIES.

This class aimed to learn techniques and skills to address resistant depressive symptoms and structural vulnerabilities of the personality. The three specific objectives proposed: 1. to know the rationale, procedure and competencies to use the behavioural activation technique for depression; 2. to develop general skills to address structural vulnerabilities in depressive patients; 3. to develop skills to address structural vulnerabilities in depressive patients based on the DBT model, reached 85. Only one judge (5) strongly disagreed with them because he found that there were contents that "overlapped between OPD and DBT" and requested a better integration between this class and 4, so that it would be clearer "in which cases or when to use OPD, behavioural activation or DBT tools" in patients with depression.

Regarding their contents, two of them referred to behavioural activation therapy skills for patients with depression, and general skills for the management of patients with structural vulnerabilities reached a consensus of 85.7% with strongly agree and agree responses. Judge 5 maintained his disagreement (for the reasons stated above). The content DBT-based skills for managing structural vulnerabilities in patients with depression reached 71.4% agree and strongly agree, judge 1 and judge 5 disagreed and strongly disagreed respectively. Judge 1 pointed out that the proposed DBT skills could also be considered "general skills to be developed from other models". Judge 5 maintained his earlier argumentation. Because the consensus was less than 80%, this class went to the third round.

In global terms, the majority agreed (n=6) with how this module was presented (including judge 1, who disagreed). Qualitatively, a positive assessment of the objectives and contents was expressed, receiving comments such as: "The class manages to deliver concrete tools to address cases of resistant depression and structural vulnerabilities, it is done in a detailed and practical way" (Judge 2); "Nothing to add. I agree with the quantity and quality of the contents as well as their coherence with the objectives of the module" (Judge 4).

Table 6. *Round 2: Percentage of agreement with the objectives and contents of classes 3 and 4*

Classes	*Objectives*			*Contents*		
	1	2	3	1	2	3
3. Tools for assessing personality vulnerabilities and experiences of adversity in childhood	85,7	85,7	85,7	85,7	85,7	71,4[1]
4. Therapeutic tools to address resistant depressive symptomatology and personality vulnerabilities	85,7	85,7	85,7	85,7	85,7	71,4[2]

Note. Contents with agreement ≤ 80% and which moved on to the next round: [1] Strategies for therapeutic inquiry into childhood experiences of adversity. [2] Skills based on dialectical behaviour therapy for managing structural vulnerabilities in patients with depression

6.2.5.3 RESULTS OF ROUND 3.

Table 7 presents the results of Round 3.

MODULE II CLASS 3: TOOLS FOR ASSESSING PERSONALITY VULNERABILITIES AND EXPERIENCES OF ADVERSITY IN CHILDHOOD.

In this round, the Delphi judges were asked how much they agreed with the corrections made to the objectives and contents that did not reach consensus in round 2. In this class, the panel as a whole expressed "strongly agree" with the corrections made, reaching 100% consensus, so their evaluation was concluded.

MODULE II CLASS 4: THERAPEUTIC TOOLS FOR ADDRESSING PERSONALITY VULNERABILITIES AND RESISTANT DEPRESSIVE SYMPTOMATOLOGY.

The judges were asked the same question (how much they agreed with the corrections made to the objectives and contents). Six judges expressed that they strongly agreed with the corrections, only judge 2 expressed disagreement, arguing that she found the way the contents were presented "a bit confusing and disorganised", requesting not to fall into so

much description of the skills or techniques and "give concrete tools" such as breathing techniques, and "others that are proposed in this class". She agreed with the substance of behavioural activation, but in her opinion, the technique could be explained in a more synthetic way. This class reached 85.7% consensus, and for this reason, it did not go to a fourth round.

Table 7. *Round 3: Percentage of agreement on whether the corrections made to the content facilitate understanding and fulfilment of objectives*

Classes	Do content corrections facilitate understanding and achievement of objectives?
3. Tools for assessing personality vulnerabilities and experiences of adversity in childhood	100% (N=7)
4. Therapeutic tools for addressing personality vulnerabilities and resistant depressive symptomatology	85,7% (N=6)

6.3 GENERATION OF FINAL WORKSHOP PROTOCOL "PECP-2."

The FONIS editorial team oversaw the corrections and final editing of the document, which was constructed as study material for the future professionals who participated in the training. An online b-learning platform was also designed based on this protocol, which contained on-demand classes, the chapters of the protocol according to each class, patient care simulation capsules, activities, and exercises (see the final protocol in the file attached to this thesis, and the information of platform in Appendix C, figure 10, 11 and 12).

6.3.1 CORRECTIONS MADE TO THE PRELIMINARY WORKSHOP PROTOCOL (PECP-1)

Module II was one of the modules that did not reach the expected consensus and was subjected to evaluation in three rounds. The suggestions of the Delphi panel of judges were mainly related to making the objectives and the contents to achieve them more precise and to making improvements in the logical organisation and integration of classes 3 and 4.

The corrections in class 3, “Tools for Assessing Personality Vulnerabilities and Adversity Experiences in Childhood”, were along the lines of clarifying how to make a diagnosis of the complexities of depression, how to assess the presence of traumatic antecedents, along with giving more concrete guidelines regarding what to do in the presence of these antecedents in depressed patients considering the primary care context.

Regarding class 4, “Therapeutic Tools for Addressing Personality Vulnerabilities and Resistant Depressive Symptomatology”, the corrections focused on explaining, in a simpler and more integrative way, skills that come from specific cognitive models such as skills from DBT for supportive work on personality structure vulnerabilities, and behavioural activation for the management of resistant depressive symptomatology.

In addition, suggestions were taken into consideration regarding changing the order of the modules to provide greater coherence between the successive classes, so Module I Theoretical-empirical bases of the protocol, and Module II Complex depression were kept at the beginning of the programme as they provided the conceptual-technical domains for the therapeutic approach to complex depression. Then, the classes corresponding to Focus on Psychotherapy and Crisis Intervention were left in Module 3, with the aim of directing the trainees to develop a greater technical repertoire for the planning of therapy and intervention in a limited way (considering the limitations of the setting to propose extensive psychotherapeutic processes). In module IV, the classes on addressing suicidal risk were left out because it was more coherent to continue with this theme after having taught how to identify intervention foci; this module also had a broad conceptual and technical background. Considering also the judges' suggestions, it was decided to leave the therapeutic relationship class in Module V because this module dealt in depth with the skills to generate and care for the therapeutic bond, skills that acquire greater relevance by being more aware of the factors that complicate depression and make the work more demanding for the therapist - issues that were addressed in the previous modules - and which in turn can generate negative reactions in therapists and affect the management of the bond. Finally, Module VI, which dealt with the management of depression from a social and network perspective, was retained. Table 8 shows a synthesis of how the final workshop protocol was organised and structured with the suggestions and corrections that emerged from the Delphi panel.

Table 8. *Modules of final workshop protocol PECP-2*

Modules and Classes	Contents
Module I.	Theoretical-empirical basis of the model, introduction to complex depression
Class 1. The theoretical basis of PECP-2	• Evidence-based psychotherapy • Generic Model-Common Factors Model (CFM) • Adaptive Indication • Psychotherapeutic Competence: patient, practitioner and expert perspectives
Class 2. Introduction to Complex Depression	• How we understand complexity in the depressed patient • Physical and mental comorbidity • Complexity given by personality, vulnerabilities and styles • Complexity stemming from early adversity and trauma • Complexity associated with suicidal risk • Complexity and socio-demographic and cultural variables
Module II	Complex Depression
Class 3. Tools for assessing personality vulnerabilities and adversity experiences in childhood	• How to perform structural personality diagnosis • Dealing with variable self-criticism and dependency in depressed patients Strategies for therapeutic inquiry into childhood experiences of adversity
Class 4. Therapeutic tools for addressing personality vulnerabilities and resistant depressive symptomatology	• General therapeutic skills for the management of patients with structural vulnerabilities • Therapeutic skills for the management of specific structural vulnerabilities in patients with depression • Behavioural activation therapy skills for patients with depression
Module III	Treatment goals and objectives, focus and crisis.
Class 5. Objectives, goals and focus in psychotherapy	• Indication, prerequisites for treatment • Goals and therapy planning • Targeting • OPD-2, a tool for focusing • Focus on personality structure • Focusing on Complex Depression • Closure in brief therapy

Class 6. Crisis intervention	• Definition of crisis • Crisis Intervention: Definition and Phases • Clinical example
Modules and Classes	Contents
Module IV	Conceptualisation, assessment, and intervention on suicide risk
Class 7. Conceptualisation of suicide risk	• Contextualisation of suicide in the world and in Chile • Conceptualisation of suicide risk • Trajectory of suicidal risk throughout life • Protective and suicide risk factors • Expected emotional states in the therapist • Delimitation of responsibilities of consultant and therapist
Class 8. Suicide risk assessment and intervention	• Progressive clinical assessment of suicidal risk • Assessment with psychometric instruments • What to do when suicidal risk is detected • Designing a safety plan • Crisis intervention strategies (individual and family)
Module V	Therapeutic relationship between professional and user. Concepts and tools for its development and strengthening
Class 9. Therapeutic relationship: clinical relevance, components and attitudes favouring therapeutic alliance.	• Clinical relevance of the therapeutic relationship • Relational model of the mind and clinical implications • The components of the therapeutic relationship • The therapeutic alliance as a driver/factor of change Therapists' attitudes that contribute to the proper development and maintenance of the consultant-therapist relationship
Class 10. Strategies and techniques to develop and strengthen therapeutic alliance addressing ruptures and tensions in relationships	• Strategies and techniques to promote the therapeutic alliance • Identifying the characteristics of patients' ruptures and actions • Management of difficulties and tensions in the therapeutic relationship

Modules and Classes	Contents
Module VI	Social dimension and networks in the management of depression in primary health care
Class 11. The social dimension of depression	• The social dimension of depression • The complexities of depression: opening up to the social dimension. • Social determinants of health. • Depression and psychosocial factors. • Guiding principles for mental health workers in primary health care. • The insertion of psychologists in primary health care.
Class 12. Networking	• Principles for the network management of depression in primary health care • Depression management in the health network: mental health thematic network • Working models for the networked management of depression: the role of primary health care Social support as a community strategy for the management of depression

7. DISCUSSION

The second study had three stages: 1. the construction of a preliminary workshop protocol to train psychotherapeutic competences PECP-1 that was designed based on qualitative study 1, and the inputs from the research accumulated by the Millennium Institute for Research on Depression and Personality (MIDAP) on complex depression, suicide and the model of care in the Chilean institutional context; 2. The validation of this protocol by means of a panel Delphi; 3. The generation of the final protocol.

In global terms, the panel of Delphi judges had no objections to the topics and competencies addressed in each module. Their concern was more focused on the methodology for developing the competences of each module, in the terms in which they have been defined in the literature (set of knowledge, skills and attitudes and their integration, see Hatcher et al., 2013; Kaslow et al., 2004; McDaniel et al., 2014). In this regard, authors have pointed out that there is a lack of research aimed at assessing the impact of training programmes on competence development, and thus identifying the most appropriate methodologies to foster competences (Milne et al., 2003; Bennett-Levy & Beedie, 2006; Orlinsky & Rønnestad, 2005).

It should be noted that the training protocol (PECP-1) that was corrected based on the feedback from the Delphi panel (PECP-2) will be evaluated and corrected again in the near future, but based on an acceptability study that will be carried out with the professionals who participated in its pilot implementation - this implementation began in March 2021 and ended in June of this year - with the precise objective of verifying whether the protocol helped them to develop competencies. In addition, based on their evaluation of acceptability, the aim is to modify those contents and methodologies that were not useful for their professional development and practice. In this regard, there is evidence that educational interventions made available to trained professionals help improve their performance in diagnosing and treating depression (Shirazi et al., 2011).

In reference to the Delphi evaluation, most of the modules were accepted in the first round. Only module II, "Complex Depression," did not reach the expected consensus. This module aimed to develop knowledge, skills, and attitudes to identify factors that make depression complex and have technical tools to intervene. The first class aimed to know how to make a "therapeutically relevant diagnosis" of depression, assess the personality style and vulnerabilities of the depressed patient, and investigate antecedents of early childhood adversity. The second class sought to develop more technical skills for working with personality structure vulnerabilities (e.g., self-esteem dysregulation) through Dialectical Behavior Therapy (DBT) and treating inhibitory symptoms of depression through Behavioral Activation (BA). The most controversial contents in the Delphi judging panel were: strategies for therapeutically probing childhood experiences of adversity, skills from DBT and BA models. Mainly, the disagreements were along the lines that these interventions could not be done in a setting whose frequency and number of sessions is not ideal for "opening up" complex issues such as trauma or deploying techniques that require "discipline" on the part of the patients and "follow-up", such as behavioural activation.

These contents of module II were proposed because they followed the recommendations of the experts interviewed in study 1, who pointed out, on the one hand, that it was important to have a background on what depression is and to know its comorbidities (among them self-critical, dependent personality styles, personality pathologies, and traumatic background); and on the other hand, that it was necessary to have knowledge of interventions that had evidence to apply in public health, and that were brief (oriented to problem-solving). In addition, from the patients' perspective, the need to receive help in emotional regulation and self-esteem and develop resources to prevent crises emerged

(aspects that converged with the views of the experts interviewed). Based on this background, the editorial team decided to incorporate skills from cognitive models such as DBT, which has extensive evidence to offer support in terms of emotional and behavioural regulation, considering the comorbidity between depressive disorders and personality pathologies (see Beck et al. 2015; Linehan et al. 2006). Regarding behavioural activation, it has recently been recommended for its effectiveness and ease of implementation by different types of professionals (not only psychologists) working in primary health care (Cuijpers et al., 2019).

On the other hand, regarding the content “strategies for therapeutic inquiry into childhood experiences of adversity”, this was questioned from the beginning by one of the Delphi judges, who expressed a concern that is common among clinicians in the Chilean primary care context: "opening up content" in a setting that does not offer a continuous or extended therapeutic process over time. Taking this observation into consideration, the document was edited to clarify that the therapeutic enquiry strategies were designed with a limited setting of care in mind and that their proposal was based on the work of Vitriol and colleagues (2020; 2014), who have developed an emerging model for addressing the history of adversity in childhood, demonstrating that with brief interventions, positive results are obtained in the reduction of symptomatic distress in patients with complex depression (comorbid depression with traumatic antecedents) (Vitriol et al., 2017).

Suggestions regarding clarifying why to use BDT skills for personality structure vulnerabilities were also considered. Given the documented overlap between depression and personality pathologies presented in the theoretical framework - Complex depression: why do we adopt this term and not just "depression" - some authors (e.g. Behn et al., 2018) have recommended knowing how to make a comprehensive diagnosis of personality structure vulnerabilities with axis 4 (Structure) of the OPD System (OPD Task Force, 2008), and using interventions from therapeutic models such as DBT to manage some vulnerabilities such as emotional dysregulation and interpersonal hypersensitivity, among others. Similarly, the objection of one of the judges that many of the competencies from this approach could be developed from other therapeutic models was considered. In this regard, a modification was made to the protocol, and the DBT inputs were complemented with general skills for the psychiatric management of borderline personality disorders from Gunderson & Links (2014). Based on the integrated analysis of the perspectives of patients, therapists and experts conducted in study 1, a model was proposed in which the

various domains of competence - Knowledge, Technical Skills, Interpersonal Skills and Attitude, Professional Skills and Therapist Persona - interacted with some bridging categories that strengthen the bond (know-how and adapting technique, being active, being committed, being flexible). In the following, we will discuss the final construction of each of the protocol modules in light of the findings of study 1 and the literature.

Module I: Theoretical-empirical basis of the model, introduction to complex depression. This module was given a strong emphasis on evidence-based practise - which is in line with the science domain posited by the competency model in PHC (McDaniel et al., 2014) - and common factors in psychotherapy (CBM) as a global-trans-theoretical competency (following the works of Kohrt et al., 2015; Orlinsky, 2009; Wampold, 2015); adaptive cueing (Thomä & Kächele, 1989; or Responsiveness, Stiles & Horvath 2017); and to the evidence from qualitative study 1 for knowing how to offer a therapeutic relationship that meets the expectations of the consultants (they were presented with a synthesis of the most salient competencies from the perspective of patients, therapists and experts).

These highlighted contents were intended to situate the trainees in the importance of being flexible in their professional practice and having the tools to adapt the intervention to the needs of the depressed patient, which will contribute to generating a therapeutic bond, which in this protocol is not an achievement, but a "competence to be developed", "an active ingredient" of the model. In this regard, authors have proposed that therapeutic bonding is a prerequisite for working with patients with complex depression (Behen et al., 2018).

This capacity for flexibility and responsiveness has been highlighted in other work as a genomic competence (e.g. Roth & Pilling, 2007; Lemma, Roth & Pilling, 2008); it has also been considered a metacompetence (Hatcher, 2015), with a responsive therapist being particularly relevant for fostering the therapeutic relationship and positively impacting therapy outcomes (Hatcher, 2015; Stiles & Horvath 2017; Wampold 2015; Elkin et al., 2014). Below is a box from Module 1 of PECP-2 (p. 18) that illustrates some of these ideas:

> Competences: the psychologists pointed out the importance of adapting the technique to the patients' needs for improvement, being flexible and open to incorporate other clinical tools independent of the psychotherapeutic school to which they belong (adaptive indication, see above). It is this competence of flexibility, from a trans-theoretical point of view, supported by the CFM that we hope to promote in this module I.

Module II: Complex Depression. One of their core competencies was based on the convergence of patients, therapists and experts on "knowing how to make a therapeutically relevant diagnosis", which would help the patient to "better understand their problem", and which would help therapists to plan the treatment, "knowing where to focus". In this way, the diagnosis is aimed at helping the patient to meet their expectation (described in study 1) to understand themselves better/discover why they are depressed, which will undoubtedly have an effect on the bond. It should be noted that in other studies, clients with depression value that treatment helps them to understand and change their way of functioning (Kan et al., 2020).

On the other hand, the patients' expectations of the therapists' working technique hinted at a desire for a process where the therapist is involved in helping the patient to cope by finding out why they have a problem, developing resources, and managing their mood. Thus, psychotherapeutic models that focus on the construction of a subjective theory of illness (Krause, 2005) or consider the elaboration of disruptive events in the development of their personal identity that make them more vulnerable to a depressive disorder (e.g. Luyten, et al., 2005) may be more likely to be depressed. g. Luyten & Blatt, 2012), and at the same time support mentalisation (e.g. Bateman & Fonagy, 2015), enhance emotional self-regulation, and provide support and guidance (e.g. Beck et al., 2015), may respond well to patients' expectations for help. These components were addressed in this module, and the Delphi judges' corrections allowed us to be more concrete and integrative in proposing the use of psychodynamic tools such as OPD with skills from DBT, BA and general psychiatric management.

Below is an extract from this module (PECP-2, p.46) that reflects this diagnostic competence and the accompanying intervention-level skills and that responds to the expectations for change expressed by the patients in the study1 and other research (e.g. Kan et al., 2020; Chevance et al., 2020).

Competences: To make a therapeutically oriented psychological diagnosis, to distinguish focuses of attention aimed at strengthening structural functions of the personality, to help the patient to understand aspects of himself/herself related to the depressive condition (e.g. emotional dysregulation, regulation of self-esteem).

In study 1, the experts contributed with competences to handle self-criticism and dependency of patients with depression and to have interpersonal skills to take care of the bond. In this respect, PECP-2 conveyed the ability to distinguish between these two profiles and be careful with handling criticism, "not focusing on the content of the criticism" but on the mechanism "when it appears". In the case of patients with a dependent profile, differentiation was promoted - as suggested by the experts - with "self-disclosure" by the therapist, e.g., "I know you need to talk a bit longer, but I have to finish because I don't want to keep the next patient waiting, but please don't forget this last point, I won't forget either, so we can see it next time" (PECP-2, p. 48). It should be noted that these contents were accepted by the Delphi panel, showing a concordance with the sample of experts in study 1.

In this module, the development of a committed attitude towards the patient was encouraged: "a committed, warm, and even compassionate attitude of therapists towards these patients are important levers for change by offering a restorative emotional experience" (PECP-2, p. 57). In this way, it is pointed out that interventions cannot be done "cold" but require the warmth that a bond can provide to address the most critical symptoms of depression, especially if they are accompanied by a traumatic history or personality pathology (Vitriol et al., 2013; Gunderson & Links, 2014; Linehan et al. 2006).

Finally, as mentioned above, one of the most controversial contents in the Delphi evaluation was "developing strategies for therapeutic enquiry into childhood adversity histories". One judge did not agree with proposing competencies for inquiring into these aspects but finally accepted the corrections that clarified the concern about dealing with these issues in a limited context of care and also complemented this section with guidance information for reporting if necessary.

It should be noted that there is a significant prevalence of these antecedents in the Chilean population (42% in men and 33% in women, Zlotnick et al., 2006), and studies indicate significant comorbidity with depressive disorders (Vitriol et al., 2017), so this workshop took on the challenge of breaking the myth that circulates in our clinical reality and often acquired in the university of "not opening topics that cannot be closed". Based on the clinical experience of a primary and secondary health care team in the Maule Region, it was proposed to train the competence of "therapeutic enquiry" as a way of giving people

the opportunity to unveil in a session those traumatic experiences - that due to shame or fear of rejection - people have not been able to share with others, thus highlighting the figure of the psychologist as a valid interlocutor who can offer the patient a unique opportunity to unburden him/herself, and to understand interpersonal patterns of re-victimisation or internalisation of guilt that are actualised in the present, but which are derived from these traumatic experiences (Vitriol et al., 2020).

The box shows some therapeutic probing questions from PECP-2 (p. 53):

> Do you remember if you were ever corrected as a child?
>
> Do you remember any difficult sexual moments? And, if yes: I thank you for your trust and understand that talking about this can be difficult and very painful, but we also know that it can be relieving to talk about it.
>
> Would you like to comment on this experience? You can tell me what you feel is right for you and of course we can stop whenever you feel like it too".
>
> Have you ever witnessed serious difficulties or fights between your parents? And, if yes: Were there any blows between them?
>
> Do you remember ever having to separate your parents while they were fighting, or doing anything to prevent them from getting upset? Do you remember having to look after either of them, or take care of the house or younger siblings?

Module III: Treatment goals and objectives, focus and crisis. It aimed to have the competencies to offer efficient, productive, focused help, which emerged as a need of the patients in study 1 when they expected that "therapy is not just going to talk and talk". This module was also intended to help professionals to have more tools to intervene in a crisis, and in this way, to be able to model resources in patients, which also responds to the expectations of our consultants.

The ability to collaboratively build objectives and goals that are realistic to achieve was a competence typically highlighted by the psychologists interviewed, which can be explained by the need to know how to delimit and plan psychological help due to the need to respond to the high demand for care in a resolute manner (MINSAL, 2018a). On the other hand, in the PHC competency model (McDaniel et al., 2014), the agreement of objectives and goals appears as part of the competencies for developing and sustaining the therapeutic relationship.

In this module, it was proposed that knowing how to carry out crisis interventions contributed to the expected "resoluteness" in the primary health sector (De la Parra et al., 2019; MINSAL, 2017b). In this way, therapists were strengthened in their ability to cope with the pressure of care and sustain their willingness to work in institutional contexts (a competence generally noted by therapists and experts in study 1).

This module was underpinned by two bridging categories, "knowing what to do and adapting the technique to the needs and goals of patients" and "being active", noting that one of the first things to be demystified for crisis intervention was "the belief that being an active therapist is inappropriate" (PECP-2, p. 77). It also demystified that patients required lengthy therapeutic processes to get better; instead, “a good enough improvement” could be achieved by considering the patient's needs and range of change (Trepka et al., 2004; Owen & Hilsenroth 2014). In this regard, it has been shown that more than 50% of patients improve with brief processes. In Chile, a clinically significant improvement has been observed in 9.2 sessions on average (De la Parra et al., 2018), and in the international literature, improvement has been observed in a range between 12-18 sessions (Hansen et al., 2002), this model being compatible with what the depression programme suggests in terms of treatment duration for severe -or "complex" according to our conceptualisation- depressions in the update of the clinical guide for depression (MINSAL, 2017a).

Below is a table extracted from the brief focal therapy class (PECP-2, p. 87), which includes the need to receive more structured help (as mentioned above), and the expectation expressed by patients "to leave with something meaningful from the session", which makes them feel that going to therapy or going to talk to their therapist is "worthwhile". Responding to these expectations of receiving help that enables patients' relief or well-being, in Rodolfa et al. (2005) model, is part of the consultation domain a functional competency.

Do not forget in the first session in brief focal psychotherapy:

- Establish contact and rapport

- Explain at the beginning of the session the purpose of this first meeting and the steps to follow for the next ones.

- Orient and psychoeducate the patient about psychotherapy and depression.

- Create an opportunity for the patient to express thoughts, feelings and behaviour.

- Testing an initial intervention, evaluating its effects, and adjusting the therapeutic strategy.

- Attend to issues such as future sessions

- In the first session it is important to "engage" with the patient and introduce something new: he/she should "walk away with something".

Module IV: Conceptualisation, assessment, and intervention on suicide risk. It should be noted that while most patients (N=12 out of 16) who were interviewed in study 1 had some level of suicidal risk, none of the clients expressed an expectation of receiving help with this problem or receiving help with self-harming behaviours as has emerged in other studies (Chevance et al., 2020).

This finding highlights the importance for professionals working in primary care to have the skills to recognise the risk factors (e.g. loneliness, isolation, minority group membership, personality styles) described in the PECP-2 in order to detect a patient at risk of suicide early and be able to intervene. It may be that due to cultural factors, our population does not ask for help in a first consultation or requires more confidence to reveal their intention. This is a topic that could be investigated in the future. However, this reinforces the importance of considering depression as a "complex disorder" (NICE, 2017; Botto et al., 2014; Delgadillo et al. 2017) so that professionals do not continue to underestimate the severity of the condition in primary care (Alvarado & Rojas, 2011; Acuña et al., 2016; Burroughs et al., 2006; Shah & Harris, 1997) and persist in a simple understanding of the disorder without considering the diverse characterological, clinical, demographic factors that contribute to the heterogeneity of depression, and bring with

them, the risk of dying (Behn et al., 2018; Fazaa & Steward, 2003; Klein et al., 2011; Clarkin et al., 2019).

The patients interviewed in study 1 revealed that institutional barriers to offering psychological treatment in primary care could make it more difficult to meet patients' care expectations. Chilean patients can wait up to two months between sessions, and there is no guarantee they will see the same professional from one session to another (MINSAL, 2018b; De la Parra et al., 2019). That is a precedent for "consulting one professional after another", a phenomenon that entails considerable risks for depressive patients if the disorder worsens. Furthermore, if patients' attempts to obtain help fail, they may become even more desperate, resulting in an imminent risk of suicide (Hawton et al., 2013). Considering this fact, it is all the more relevant that the protocol has devoted an entire module to suicide risk management.

The team of authors of this module significantly considered the competencies at the level of technical, interpersonal and attitudinal domains for bonding care with these patients that emerged in qualitative study 1, e.g., listening skills, empathising, conveying hope, being emotionally attuned, whose parent category was "being engaged" (a bridge to fostering the alliance). In addition, they considered the therapist's person-level skills (self-awareness and frustration tolerance). The following extract from this module illustrates some of these competencies (PECP-2, p. 115):

Relational competences of the contents reviewed:

- Ability to be emotionally attuned to the user and listening skills to understand the particularity of their experience.
- Ability to delimit responsibilities and scope of help.

Personal competences:

- Self-awareness and tolerance of frustration: maintaining awareness of the therapist's emotional states, promoting the ability to tolerate frustration when dealing with highly complex patients; tolerance of anguish, fear and helplessness with regard to life-threatening situations.
- Development of an empathic attitude, of transmitting hope and validating suffering (not the idea of dying).

Module V: Therapeutic relationship between professional and user. Concepts and tools for its development and strengthening. This module was well accepted by the Delphi panel and generated several comments and suggestions regarding putting more emphasis on some proposed competencies such as: strategies for repairing the alliance and some skills from the domain of professional and personal competencies that were presented in order to address the "person and the therapist's role in the relationship" such as reinforcing teamwork, self-care, personal psychotherapy, and supervision. This means that the Delphi panel confirmed the relevance of this skill set that emerged in study 1.

Offering and caring for the therapeutic bond was one of the central categories in the competence model proposed in study 1. Therapists and experts generally mentioned the ability to offer and care for a therapeutic bond. The competencies most associated with this category were taken into consideration in the writing of this module: managing transference-countertransference (typical for therapists and experts); being humble in front of the patient (when mistakes are made) (general for therapists and typical for experts); and knowing how to manage alliance ruptures, through metacommunication, which was a contribution that emerged only from the perspective of some experts, but which has high empirical support (Safran et al., 2001). The competence of knowing how to repair alliance breakdowns is even more relevant in the management of patients with interpersonal hypersensitivity that is present in depressive styles (self-critical and dependent) (Hermanto et al., 2016; Overholser & Dimaggio, 2020; Fazaa & Steward, 2003), and in personality pathologies (Behn et al., 2018; Gunderson & Links, 2014). An excerpt from the module (PECP-2, p. 164) reflects some of the competencies mentioned in study 1 and discussed here:

> Competences: a central role is played by the interpersonal skills of the therapist to communicate with humility his or her emotional states and to accept without judgement the mistakes that may have been made in the relationship: what was my role in the rupture, in the disagreement? How can I face this state with the client? Transmitting this honest willingness to repair the situation helps to offer a corrective and modelling link, which can be internalised as a more constructive strategy for resolving interpersonal conflicts.

This extract reflects what the interviewed experts emphasised about making the patient feel "that we are part of a dyad", and in this way, the conditions are created to be able to express negative emotions, complex experiences, without judgement, "without contradicting, or convincing the patient otherwise" as they also suggested.

Probably, the psychologists interviewed were not so familiar with the concept of alliance breaking or metacommunication. Perhaps, for this reason, they did not mention it, but in the testimony of therapist 8, when he pointed out that sometimes patients left banging on the door (angry), and over time he had learned to manage these tensions by expressing his willingness to fix the situation at the moment when the breakdown occurs, it is clear that there is a notion of acting contingently when there is a tension in the alliance, especially in the context of primary care, where "there is no certainty if the patient will be seen again" due to institutional barriers such as scheduling with another professional, not having continuity of processes due to the high demand for care, among other aspects (De la Parra et al., 2018). The experience narrated by the psychologist reflects what Minoletti & Zaccaría (2005) remarked that insufficient community mental health and psychiatry training forces professionals to acquire competences in their everyday practice.

Ruptures are phenomena that also occur in primary care, and that repairing them leads to better therapeutic outcomes, even compared to therapies without patterns of ruptures (Larsson et al., 2018).

It should be noted that a positive relationship, therapeutic relationship, the active participation between client and therapist, and the qualities of being warm, empathic, acceptance are common factors in psychotherapy (Lambert & Bergin, 2013) that have even been shown to be more important in terms of their contribution to therapy outcomes compared to specific components (Wampold, 2015). The ability to build and sustain a therapeutic relationship is a component of the interpersonal or relational competency domains in the various competency models reviewed (PHC model, McDaniel et al., 2014; Contextual model, Anderson & Hill 2017; Expert Reference Group Roth, 2015; Cube model Rodolfa et al., 2005).

This module incorporated the bridging competencies proposed in the competency model of study 1 (see figure 5), being active ("remembering what was worked on in previous sessions"), and being committed to the patient ("being empathetic, showing interest in the patient"), together with presenting one of the most saturated interpersonal skills from the

patients' perspective, which is related to being welcoming, showing warmth, not judging what the patient says or does and which are illustrated in the quadrant extracted from this module (PECP-2, p. 150):

> Competences: the above contents point to technical competences for clarifying expectations, managing transference-countertransference and resolving ruptures. As well as relational competencies such as the ability to show interest in the user, remembering the user from previous sessions and cultivating attitudes such as warmth and empathy, being welcoming and recognising one's own mistakes.

As noted above, at the professional level, this module addressed the importance of the therapist's self-awareness of his or her capacities and limits, the use of supervision and self-care, and fostered teamwork to "support and collaborate with colleagues in the timely detection of tensions and difficult feelings in the therapeutic relationship" (PECP-2, p.161). The interviewed therapists mostly mentioned these categories of competencies and converged with the experts' views. It should be noted that the competencies of supervision, professionalism, self-care are also present in the models cited above (PHC model, McDaniel et al., 2014; Expert Reference Group Roth, 2015; Cube model Rodolfa et al., 2005).

In summary, the ability to offer and care for the therapeutic bond with depressed patients is particularly important to keep in mind when treating depressed patients in precarious care contexts - such as primary care - because these contexts lead to professionals feeling over-stretched and without tools to cope with the care needs of some patients who are more difficult to manage (Barley et al., 2011; Fischer et al., 2019; Haas et al., 2005, Koekkoek et al., 2006). In study 1, the interviewed therapists reported experiencing intense negative emotions in the care of depressed patients, and on the other hand, patients expressed the need to feel a unique, special bond with the therapist, appearing a concrete demand to see a therapist engaged (empathic, involved and attuned) with their person and suffering. This module aimed to develop a set of competencies to meet patients' expectations of "meeting a good therapist" on an interpersonal and personal level - which is in line with international literature (Van Grieken et al., 2014; Weitkamp et

al., 2017) - and on an interpersonal skills level to help them provide a corrective emotional (interpersonal) experience (Lambert, 2013; Gunderson & Links, 2014).

Module VI: Social dimension and networks in the management of depression in primary health care. This module was one of the modules that reached the highest consensus by the Delphi panel in the first round. The judges valued positively the incorporation of the social dimension of depression and the use of networks in its approach.

In qualitative study 1, in general, the experts pointed out that it was necessary to have knowledge of who the primary care users are, having experience of living with this population. In their opinion, this background allowed them to "know what interventions to do" (adapt the technique), "know what to say", "know how to establish links with these people". It should be noted that primary care users value that professionals not only understand them but also share or belong to their socio-cultural group (Ashcroft et al., 2020).

Both groups of therapists and experts interviewed in study 1 referred generally to being socio-culturally sensitive, "you can't be disconnected from the reality of your country," said one therapist. In this regard, various reports and studies have pointed out that an underlying component of depression is adverse social factors, with women being a vulnerable group to suffer from depression (ELSOC 2018; Barley et al., 2011; Levy & O'Hara, 2010; Patel et al., 2018).

Considering this background and cultural sensitivity, this module promoted having a comprehensive understanding of depression, taking into consideration social and gender determinants, in this regard it states: "when presenting depressive symptoms in women it is always advisable to inquire into psychosocial determinants (e.g. physical, sexual and psychological violence)" (PECP-2, p. 179). Responding to the lack of competences regarding how to include social antecedents in the management of depression was observed among practitioners (Barley et al., 2011).

In addition to addressing this socio-cultural competence, this module also aimed to foster the ability to work in multidisciplinary teams, management, and networking skills, which are professional competencies that are part of the frameworks for working in primary health care (PHC) institutional settings (McDaniel et al., 2014) and academics health care (AHC) (Kaslow et al., 2009).

In this module, networking was presented as a way of making the patient feel welcomed and supported by the care system, as seen in the extract from the module, which reflects this ethos (PECP-2, p. 189):

> This way of understanding the user not only as the subject of a network of links but also as being sustained by a networked system, implies that the user will not only have a significant link with the professional in charge of him/her, but also with the institution and its networks that receive him/her.

This way of understanding networking could "repair" the experience of some of the users of not having been "welcomed in their needs" due to institutional barriers - limitations in the number of sessions, not having specialised help, being referred without assistance - hindrances that appeared in the report of previous negative experiences of the patients interviewed and that appeared in the phenomenon of patients' expectations (see figure 2).

Both the therapists and the experts interviewed (in the study1) generally mentioned having the motivation to work in public institutional settings (or “non-ideal settings”), which speaks of having a sensitivity and involvement towards populations that have been more discriminated or precarious. In the literature, some authors have even highlighted that part of the role of clinical psychologists is to advocate for these communities (Cooke et al., 2019). In light of this study's findings, this engagement also sustains professionals in the face of limited institutional resources and is closely related to cultural competence, involving adapting techniques (e.g., language) to the cultural context of patients (Kaslow, 2004; Kohrt et al., 2015; Patel et al., 2011; McDaniel et al., 2014).

The “cultural competence” increases interventions' effectiveness in both developed countries and LMICs (Griner & Smith 2006; Levy & O'Hara 2010). Patel et (2018) have suggested that, in LMICs, this competence should be called "structural competences" to highlight the need for clinicians to be aware of the sociocultural context of their patients and actively mitigate the determinants of their mental health problems. In this sense, considering the reality of third world countries, it seems that this positive disposition to work in the public system ("love for public health" as one of the psychologists interviewed referred) leads professionals to become relevant actors to articulate the networks of the

health system, but also the social fabric, so that people with less access to specialised mental health treatment "to move forward."

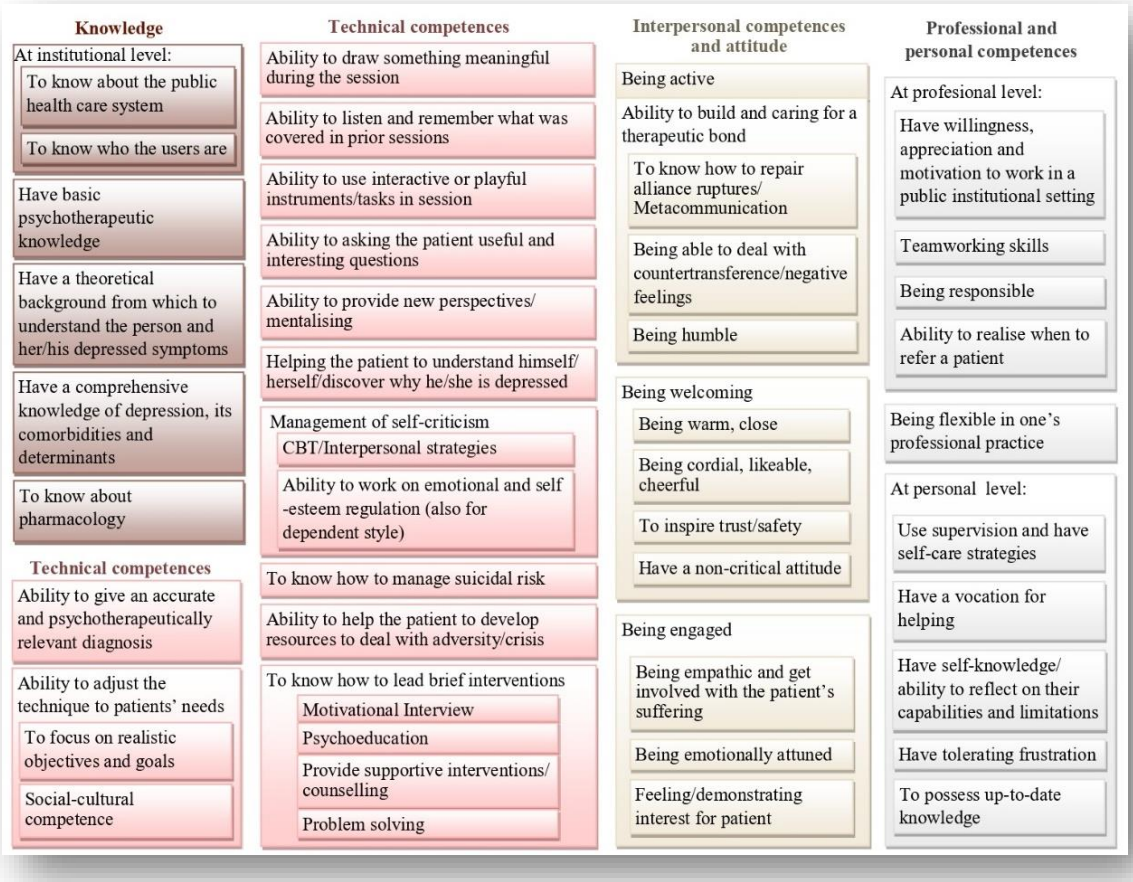
8. CONCLUSIONS

This doctoral research took on the challenge of responding to one of the critical knots and weaknesses of the national mental health plan, which refers to the lack of training and competencies to treat depression in professionals (psychologists) working in primary health care (Minsal, 2018 a; b; Minoletti & Zaccaría, 2005; Bedregal, 2017). Given the high heterogeneity in the training of psychologists (Scharager & Molina, 2007; Bedregal, 2017), it was proposed to explore and propose a transtheoretical-integrative competency framework based on the reality of care by incorporating the perspectives of patients and professional psychologists working in different institutional settings, and the opinion of various experts. A workshop mechanism was then constructed to develop these competencies.

While there are several specific treatments for the effective management of depression, these treatments and therefore the skills to implement them, have been developed primarily in high-income countries (HICs) (Cuijpers et al., 2018), with few studies on psychotherapeutic competencies in low- and medium-income countries (LMICs) (Kohrt et al., 2015; Patel et al., 2018). It is hoped that this protocol on competency training may be closer to the treatment manuals for depression for therapists working in countries similar to Chile.

Considering that evidence-based practice rests on three pillars (APA, 2006): 1. the best available evidence; 2. the expertise of the clinician and the characteristics, culture; and 3. preferences of the patient; as noted above, this doctoral research set out to propose a new framework of competences where the local voices of patients, psychologists, and national and international experts converge. In this way, it is hoped to have contributed evidence to improve the clinician's expertise. In order to facilitate the reading of the emerging competences, an outline of this framework is shown in figure 9 (see quotes in detail in appendix A).

Figure 9. *Framework of competences to treat depression in an institutional setting (PHC)*



Study 1 generated several inputs for the competency framework: 1. Phenomenon of expectations of psychological care (Figure 2); 2. Phenomenon of competencies from the psychologists' perspective (Figure 3); 4. Proposal of a psychotherapeutic competence model, where the dynamics between the four competence domains - 1.knowledge; 2. technical competences; 3. interpersonal competences-attitude; 4. professional and personal competences - from which bridge categories emerge that contribute to building and caring for a therapeutic bond in the treatment of depression (Figure 5). Thus, therapist competence should be nurtured not only by a particular competence but should also be enriched by these phenomena that ultimately revolve around how a therapist can be more responsive to the needs of patients with depression.

On the other hand, the findings of study 1 served as input to propose a training protocol (study 2) and not a treatment manual for depression in PHC. This protocol aimed to increase the conceptual, technical, interpersonal, and professional repertoire for treating

depression to foster the ability of treaters to "do what is most appropriate to the emerging needs of the therapeutic context". In this way, the protocol, which was validated by a Delphi panel, functions as "a toolbox of modules" to which practitioners can turn to increase their competence. Interestingly, but rather moves towards a competency model that complements some of the skills already possessed by psychologists working in institutions (e.g. professionalism, network management) and encourages the development of other skills, which have been reported to be diminished (e.g. specific interventions, sociocultural approach, treatment plan, and clinical diagnosis) (Bedregal, 2017).

As future lines of research, it would be interesting to evaluate in the near future the generalization of the workshop-device in the results of care and patient satisfaction of psychologists trained. Another line of research is to carry out a review of university curricula for psychology degrees and to analyse whether there are coincidences with respect to the framework of competences that emerged in this thesis and with respect to the contents of the proposed protocol, in order to contribute early on to the training of future professionals and to build a bridge between research into competences and university training. A third line of research is related to building intercultural collaborations with low-income countries (LMICs), which can pilot the implementation of the protocol and compare the acceptability and/or generalization and relevance of its cultural adaptation with the Chilean proposal and findings.

Finally, in terms of the limitations of this thesis, it is considered that the lead author and the research team that was assembled to carry out the two studies have an attachment to the contextual model and common factors, which may have led to both the interpretative process of the first qualitative study and the training protocol proposal being biased by a transtheoretical and integrative perspective on competencies. Taking this subjective bias into account, consensus through intersubjective agreement processes were carried out (Altimir et al., 2017; Hill and Knox, 2021), and particular care was taken to ensure that the Delphi study was also carried out with external researchers.

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10. APPENDIX A

Table 8. *Domains and categories of competences with their frequencies based on the three perspectives*

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
Knowledge				
At institutional level:				
To know about the public health care system		Typical (11)	Typical (6)	"[Psychologist] has to have a detailed knowledge of all the procedures, which public health defines, and [he/she] must know the networks of the system, too" (T7) "Therapists should be trained in how to fit into the health care system and understand what primary care is" (E7).
To know who the users are			General (7)	"Psychologists should have a knowledge of the kind of patients who consult in primary care" (E4)
At the psychotherapeutic level:				
Have basic psychotherapeutic knowledge			Typical (6)	"So, in terms of content, knowing basic elements of psychopathology, basic elements of psychotherapy, I wouldn't take anything for granted" (E6)
Have a theoretical background from which to understand the person and her/his depressed symptoms		Typical (14)		"I have a more phenomenological perspective. For me, one of the main objectives is to understand the phenomenon in which some symptoms emerge, and from there the next objective is to understand how the construction of identity leads to low mood, to meaninglessness" (T13)

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
Have a comprehensive knowledge of depression, its comorbidities and determinants			General (8)	"[…] you have to have an idea what depression is or what it is not, you have to know about comorbidities, you have to know about epidemiology, you have to know about additive problematic things like nutrition, like sports. Of course, it's clear you have to know about the influence of family of having roots of being integrated into your social field orbit, not being integrated. And this comes together in the aspect of personality structure" (E1)
To know about pharmacology		Typical (9)		"Psychologists working with complex depression need to know more or less about the pharmacological treatments, which are used for this type of depression" (T4)
Technical competences				
Adapt the technique/intervention to the needs/requirements/ objectives of the patient		General (15)	General (8)	"A challenge in practice has been having to really adjust to the therapeutic need of patients, so one skill is... like... how to find that point of adjustment" (T12) "Not wanting to cure the whole patient if you have a very limited setting, but to think about well what does this patient really need in his or her external but also internal world and they would make an impact make a difference right now for that I can offer" (E3)
• Being able to focus on objectives (collaboratively with the patient) and realistic goals to achieve		Typical (9)	Rare (2)	"Try to focus, to be more aware of and negotiate objectives with the patient to be more efficient, to have more defined objectives and a clearer focus on institutional work" (T4) "The ability to focus, to realise what is central to work on is very important, to establish focused treatments, in contexts where there is little time for attention" (E4)

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
• Socio-cultural competence: having socio-cultural sensitivity in order to be able to intervene		General (15)	General (7)	"You have to be connected to the reality of your country, to know the different realities, how a worker lives, which is what it means since childhood to have had, for example, situations of significant poverty, which is what it means to be told that 'we went through such and such troubles, and I had to put on my broken shoes'... something must resonate with you [...]" (T5) "There are many therapists who, not understanding the reality that patients experience, find it difficult to empathise, to build a good therapeutic relationship because they do not understand much of the content that patients are talking about; they do not understand some situations that are either cultural or associated with social determinants" (E6)
Ability to draw something meaningful during the session	Typical (11)			"If the psychologist can make me… um… discover something new… and go home with an idea… with something in my head… with clear insight, even if it's a new question… if the psychologist manages that in a session, I think… that's going to result in something important!" (P6)
Ability to give an accurate and psychotherapeutically relevant depression diagnosis	Variant (4)	Typical (13)	General (7)	"I expect that psychologist analyses well everything that I said, to reach a diagnosis because I´ve received thousands of diagnoses... of mental illness, and at the end one gets confused!" (P2) "Make a good clinical diagnosis, descriptive, of the symptomatic clinical manifestations...I would, uh...do a lot of training in clinical diagnosis" (T2) "Briefly with regard to doctors, I think it is very important that they have the clinical skills to be able to detect depression

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
				[...] and not just stop at the headline "he has depression" but that they can also see and diagnose the degree of severity of that depression and what is triggering that depression, because only with this more integrated diagnosis will they be able to refer the case, work correctly with the team and provide the indications, whether psychotherapeutic or pharmacological" (E5)
Ability to listen and remember what was covered in prior sessions	Typical (14)	Variant (10)	Variant (4)	"I want the psychologist to listen to me...to listen actively; I feel it's too important because I feel like I notice it in the details that...later on, like in the other sessions, he remembers and is clear about the things I said" (P9) "We worked with a patient on the situation of her drug addict son, who was stealing from her, she told me "I don't want to do anything about this, because I'm not going to leave him alone" (...) I asked her how do you want me to support you, she answered "to listen to me once a month" so I'm seeing her once a month, she should come, she should cry, and that is not psychotherapy in any way, it is giving the person space, it is like trying to respond from this popular idea that the psychologist is there to listen " (T15) "Always what you have to do is great listening, right? the one you are listening to, you are listening to their strengths, you are listening to their issues, they expect you to maintain your professional role and to listen to them" (E7)
Ability to use interactive or playful instruments/tasks in	Typical (9)			"That the psychologist tries to interact with entertaining tasks, so that people raise their self-esteem, help us... as in

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
the session that foster self-knowledge or insight				personality like drawing a picture, doing interesting, didactic things" (P15)
Ability to asking the patient useful and interesting questions	Variant (6)			"I want a psychologist who can help me with the questions, who knows how to ask exactly what I really need" (P10)
Ability to help the patient to understand himself/herself-understand/discover why he/she is depressed	Typical (9)	Variant (5)	Typical (6)	"Help me to, to understand myself because sometimes I still fight over something silly or get angry; I get frustrated by myself" (P12) "When you have a patient, who is recurrent for him/her to have depression, first they need to start a process of knowing and accepting themselves in the sense of saying 'yes, I have this condition in which my mood tends to go down.' When the patients manage to recognize and accept themselves [...], the next step is how they take care of themselves in that." (T.4) "I was working at that time on the impact of work outside the home on women's mental health, and I found that the women who suffered most from depression were not those who worked but were housewives because they are more isolated from a social support network [...] we went back to their homes and explained these aspects of depression to them, how those who were at home were more depressed, right? the women were happy to see themselves in a mirror and commented, "of course, I had thought about it, yes, that's important", and that's when we realised how important it is to help women to understand this" (E7)
Ability to provide new perspectives and help to see	Variant (7)	Variant (8)	General (8)	"I hope that psychologist opens his/her mind... because suddenly one is here in a circle, and the person who is outside

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
things differently (Mentalising)				is always going to see it in a different way. So that's what I like, for the psychologist to let me know things from another point of view" (P15) "For some patients, I give them options based on what they tell me. In other cases, I ask them, 'What else do you do that can lead to another result? And from that, we put together answers, and then, seeing what keeps repeating itself, you see how the patterns can be changed" (T8) "It is important to apply the concept of mentalisation, which is basically a therapist who promotes certain skills in these patients who are in deficit, such as, to be aware of oneself, of the mental states of others, to adequately associate the behaviour, the conduct of the person with the affective state that lies behind it, and this is extremely useful to apply" (E8)
Abilities to deal with self-criticism/negative view of self/others			General (7)	"You can offer patient great techniques to combat self-criticism in a way that he or she feels she's doing it wrongly. But then again, the way you do that if the patient thinks I know I have to get rid of my self-criticism in one week. And if I don't do it, I'm the worst person in the world. Then you have an enactment in the patient relationship […] For some patients, and I mean self-criticism, different ways of things happened because it's a piece of patients need working more with the aggression part of that, and others need to work more with your soothing and caring part. I think if you're confused about interventions between these two groups, that won't benefit you. (E3)
• CBT interventions		Variant (6)	Rare (2)	"The idea is to work with cognitive behavioural; we start with negative thoughts, when it is very difficult to work with

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
				negative thoughts, we try to be conscious in our thoughts, then to be conscious of our emotions, which is the most predominant emotion, why is it that anger appears more, why is it that sorrow appears more, why does this mainly happen to me?" (T14) "You explain to them [patients] strategies like changing thoughts, what kind of thoughts you think are negative, and you tell them what the alternatives are, then you know as a psychologist your strategies, you know how to do cognitive behavioural therapy" (E7)
• Interpersonal strategies (from Interpersonal Theory)			Variant (4)	How should the young therapist deal with the self-critical patients who make them feel so powerless with patient because you can't argue with a person who says, "I'm shit". Because if you try to argue: "No, look, this is wonderfully life and death". They always find a reason to show you and the way to show you that these that you are wrong. So, let's just doesn't make sense to certain kinds of use this power struggle. So, this is one of the basic technical knowledge therapists have to learn because they see these interpersonal strategies. It's a tool to evaluate yourself as an interpersonal strategy, is not a neutral psychic strategy, also an intrapsychic strategy, but basically, something that is happening with other people (E1)
• Ability to work on emotional and self-esteem regulation	Typical (10)		General (7)	"To love me...to love myself a lot! That's what I want, I want my self-esteem to rise...that I am worth a lot to others" (P3) "Someone who is more hypersensitive than we know tends to quickly deregulate in terms of his/her self-esteem when he/she feels some rejection or feels more invisible in interpersonal

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
				relationships [...]. It is important to be attentive to how this relational pattern is replicated in the relationship here and now in therapy so that it can be alluded to and to be able to elaborate and put a magnifying glass on that sensitivity" (E8)
To know how to manage suicidal risk		Variant (5)	Variant (4)	"You have to consider that in the course of treatment there are moments where for example, patients are there with a suicidal, active condition, and somehow you have to put some plan in place that goes in the protection of the patient and also of oneself" (T12) "I think you have to know about the risk of suicidality all this kind of stuff" (E3)
Ability to help the patient to develop resources to deal with adversity/crisis	Variant (7)	Typical (10)	Rare (2)	"What I'm looking for personally is how to acquire tools and realise what things I can do and what things are not really in my control" (P9) "I believe that psychotherapy should focus on the possibility of developing strategies that the patient does not necessarily have, which will allow them to cope with their life in a healthier way" (T13) "You have to see what the patients' resources are, notice that many of these people [low-income women], their greatest resource is their resilience (...) so you have to start by reflecting their strengths to them a lot" (E7)
Knowing how to make brief, limited, and collaborative interventions. Example of interventions:		Typical (12)	Typical (6)	"A model that is more adapted to the institutional setting then appears, which is to carry out brief therapies, crisis intervention, and then things work much better" (T3)

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
				"Many therapies have managed to reduce the extent of the therapy, without deteriorating its quality, so these brief psychotherapies have emerged, therapies of a few sessions for some specific situations that are obviously quite attractive from the point of view of implementation in the public system" (E6)
• Psychoeducation		Typical (9)	Variant (3)	"Well, I always include a family member with the most severe depressive patients to explain the diagnosis, to do psychoeducation, to explain the treatment, what to do or what they have to stop doing, as well as being super-targeted" (T1) "So being able to psychoeducation from the point of view that these symptoms occur to you for these reasons, these symptoms comprise this, and that, what depression is, what psychotherapy is, and so many other basic elements, can help quite a lot, let's say, the work and the effect" (E6)
• Problem solving	Typical (13)	Variant (6)	Rare (2)	"I would like them to give me strategies to solve these problems. To be told how to get out of this, that's what I would really like to be told" (P6) "The ability to be able to solve and understand a problem [...] I think that this is an ability that has to be worked on day by day, to think that the patient has been waiting for a month, and to have the ability to be able to solve a problem in 40 minutes" (T11) "I really like to apply problem-solving techniques, because generally, the patients I see have a depression that is secondary to some problem" (E5)

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
• Motivational Interview			Rare (2)	"I also think it is important for therapists to be trained in motivational interviewing so that they can encourage adherence to treatment" (E5)
• Provide supportive interventions/counselling	Typical (13)	Variant (7)	Typical (5)	"Who can advise and guide you to get better" (P5) "So, the patient is asking you for help, and then you have to say 'look, this is his way, but I can teach him another way that will help him'; and here you take on a more directive role, perhaps more of a guiding role, more of a counselling role" (T8) "Accompanying is better than supportive, accompanying in the approach. You stay as get rid of who's a button, so to speak, with father of this approach says: "stay next to your patient, not opposite to him". Stay opposite to a typical neurotic patient and offer yourself as some plague column, so to speak, but you stay next to your patients." (E1)
Interpersonal competences and attitude				
Being active	(Emergent quality)	Typical (13)	General (7)	"That psychologists can say something that really calms you down or helps you, that doesn't just come and vomit up everything that happens to us... No! that they give little tips, that maybe at the moment they will help you a lot" (P8) "You need to be active, ask questions, understand, and intervene" (T3) "It has been seen and proven worldwide that in patients with personality pathology [complex depressions] a fluid, energetic, active attitude works […]" (E8)
Ability to build and caring for a therapeutic bond		General (16)	General (8)	"With depressed people, it has been very useful for me to try to make an alliance. I worry a lot about that even if it takes me

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
				many sessions, I don't know if it takes me a lot, but I try to really work on that bond because I feel that it is fundamental" (T9) "So, it's almost like you need to build a relationship, so that you can then capitalize later on having that close relationship." (E2)
• To know how to repair alliance ruptures/ Metacommunication			Variant (4)	"[...] So, you know, "I have a sense that I've upset you. I'm also not sure how to fix it. And I really would like to, but I'm not sure how. What are your thoughts?" So that is just sort of sharing with the patient that you are in a dyad. It's a relationship, and you're both sharing it. To me, metacommunication is a meta competency that all therapists should possess whether they're doing therapy A therapy B, therapy C, or integration of therapy A, B and C. Metacommunication, I think, is a skill or an intervention that is available at any time" (E3)

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
• Being able to deal with negative feelings-countertransference		Typical (12)	Typical (5)	"...eh...it is a type of patient that is very difficult for me...it is difficult for me because that depressive discourse is so circular [...]'I can't do anything because I am depressed and I see everything black'… it's hard for me to get out of that discourse, it's like it's contagious, it demoralises me, and I start to despair, it gives me impotence" (T3). "To make therapists sensitive eh about what happens to a therapist in public care contexts, with patients with such characteristics, eh would make the therapist more attentive to his/her own sensations regarding the patient, to what happens to him, to what he feels, and that awareness translates into better treatment" (E8).
• Being humble		General (16)	Typical (5)	"I think you have to be super humble, and super ethical too, to understand that if you are not linked, it is not that you are bad, nor that the other is bad; it is that we are human beings and we are different, and there are things that link us and things that do not link us, but I think you have to constantly have that reflection, that there are times when one will generate a super enriching link and will allow us to favour a work of relief regarding the pain that you have, and there are times when it will not happen, and one has to take a step to the side and say 'you know what, it is not happening, let's look for someone who can respond and with whom you can feel comfortable" (T16) "So, I think one way that you build a relationship is that you're willing to be humble, so you're willing to admit when you've said something that's a mistake, or you've said

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
				something that may hurt somebody, or you've said something insulting" (E2)
Being welcoming	General (16)	General (15)		"I want her to be cordial, that you feel welcome with her...or with him, that she or he is pleased to receive me, to listen to me (P3)." "Try to welcome her, to listen to her in the first instance and not to intervene quickly, before validating her feelings" (T9) "So, going back to the initial statement, what should I say to this man who is so depressed? I can only welcome him, lift him up... help him to re-order himself" (T7)
• Be warm, close	Typical (9)	Variant (3)	Variant (3)	"I think [psychologist] has to be a person who is close and warm" (P6) "The ability to be close but professional at the same time" (T3) "An important therapeutic attitude is to be close, but at the same time professional" (E8)
• Being cordial, likeable, cheerful	Variant (7)			"Be cordial, likeable, cheerful." (P3) "Personality that is cheerful, I don't know, that She is likeable" (P15)
• To inspire trust/safety	Typical (13)			"[…] the most important thing is that it is a person who inspires a lot of trusts." (P4)
• Have a non-critical attitude	Variant (8)		Variant (3)	" […]and the therapist doesn't judge one! because many times, one can be talking about something and it happened to me, a lot with the (previous) psychologist, that made me angry, like she was talking to me, and I felt like she was

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
				attacking me ...or telling me, 'no, that's bad, what are you doing, you're so bad'.…' (P7) "To have a therapeutic stance of being non-judgemental" (E8)
Being an engaged therapist: demonstrate empathy, involvement, attunement, interest for the patient	Typical (12)	General (15)	Typical (6)	"Get involved, engage with the problem and with the person who is suffering the problem" (P14) "I think a good psychologist is someone who, to begin with, has a strong engagement to what he/she is doing, to the profession, to others, because that leads you to study, reflect, do personal work… it leads you to everything that's important" (T5) "What makes the difference in a good professional is the engagement" (E4)
• Being empathic/putting yourself in his/her shoes/understanding his/her suffering	Typical (9)	Variant (8)	Typical (6)	"That the psychologist empathises, that the psychologist gets involved in my suffering, in what I am feeling" (P1) "One of the skills is to be able to be empathic; the truth is that I put myself in their shoes quite a lot." (T14) "But the older you get, the more experience you have, but the problem is you think experience helps depressed patients. No. Empathy helps" (E1)
• Being emotionally attuned	Variant (5)	Variant (5)	Rare (2)	"As if he knew how to put himself in the context of each patient. If a serious patient comes to him...yes, he should also be serious... If a patient comes to him as a talkative patient, as a chatterbox...or, who laughs...that he also does the same, so that he can be involved to the relationship, like this…he attuned to the patient" (P7)

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
				"An ability to be in tune with the patient, to know when to say things, when to keep quiet (T3) "The success of the team intervention that was done with this patient who dissociated was because they tuned in to her. It is important that the patient feels that the team tuned in to her" (E.4)
• Feeling or demonstrating interest for the patient	Typical (13)	Typical (9)		"[What attitude is important for you to see in the psychologist?] Interest. The interest in wanting to know how I feel, how I am doing." (P13) "I don't know if it is a therapeutic skill...but I think it is. I think you have to have a genuine interest in the patient" (T4)
Professional and personal competences				
At professional level:				
Have willingness, appreciation, and motivation to work in a public institutional setting		General (16)	General (7)	"We must have a social awareness that public health is important, that the better professionals there are in primary care, the better the Chilean people will be [...]. That, I think, is the disposition, the love for public health. To be able to be there, you also have to have a kind of stamina and be clear that you are going to encounter administrative and technical difficulties" (T.15) "I think that, if therapists have that consideration (limitations of PHC) and evidently a good resilience and motivation to work in non-ideal settings, this is a profile, let's say, that can be perfectly suitable for primary care" (E6)

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
Teamworking skills		General (15)	Typical (6)	"Team working is essential with all these cases [...] having a team with whom you can share your concerns about patients" (T2) "With these types of patients, teamwork should be encouraged, so that the therapist is not left working alone" (E.4)
Being responsible	Variant (5)			"I think it's very important that the psychologist is responsible...that he doesn't leave me hanging around during the sessions...that he isn't looking after other things...that, if he is going to see the time, it doesn't show (laughs)" (P.6)
Ability to realise when to refer a patient		Typical (9)		"I think it's really important for you to know your limitations and know when you can help and when you can't, and when you can harm your patient even though you're trying to help […] I think you need to know your limitations, know when you can't help, acknowledge when you are emotionally overburdened when treating a patient and refer him to a colleague" (T.11)
Being flexible in one's professional practice		General (16)	General (8)	"Having flexibility in your strategies is like using everything you have at hand... not staying, like... rigid in a technique, in a theory, and in the same case seeing what works and what doesn't work.…" (T3) "A good psychologist will be flexible in terms of theoretical tools, of being able to listen to other theories, eh the non-omnipotence" (E.4)
At personal competences level:				

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
Use supervision and have self-care strategies		Typical (13)	General (7)	“What makes a therapist a good one is an openness, in the sense of being able to show a bit of your work, to be given feedback, like if you don't know or don't understand, or if you feel you are stuck, to be able to ask for help, I think that can still make an important difference when working in these settings because you are always exposed to getting burnt, and if you get burnt you can't do the job well [...] supervision makes even more sense when you are working here” (T12) “There also have to be elements of self-care, because we all know that when a professional is emotionally exhausted, he or she is less empathetic” (E6) “I would emphasise the importance of supervision, [that it should be carried out] however, in whatever context it takes place” (E.8)
Have a vocation for helping	Typical (9)			“If the psychologist doesn't have a vocation or doesn't know how to reach the person...it's not much use either, he's not going to help the person, and he [the psychologist] is going to be there trying to get something out of them, and he's never going to get to the bottom of the matter.” (P5)
To possess up-to-date knowledge	Variant (5)	Typical (9)		"That the person be as he or she is, but that in the psychological area he or she has sufficient knowledge to care to the patient following the advances in research and the times. That also makes him or her a good psychologist" (P.8) “¿How can I be a better instrument to help the patient? Well, by studying, by perfecting my skills” (T16).

Domain/categories	Patients (P) (n=16)	Therapists (T) (n=16)	Experts (E) (n=8)	Core Ideas
Have self-knowledge/ability to reflect on their capabilities and limitations		Typical (11)		"Psychology is a profession in which the person you are, the person of the therapist, what you have invested in working on yourself to improve your work with the patient, is very important. To have therapy, to see your judgements, to be aware of your prejudices, of your issues, of your own vision of things" (T.9)
Have tolerating frustration		Typical (11)	Variant (5)	"To see as many patients as possible, I mean, I think that's the main challenge, and that has to do with the therapists' frustration tolerance" (T.1) "[What personal skills of therapists are needed for primary health care setting?] Patience and tolerating frustration" (E.4)

11. APPENDIX B

Table 9. *Delphi Round 1. Percentage of agreement with objectives of classes*

Module and classes	Objectives	Agreement percentage (N=7)	Disagreement percentage (N=7)
Module I Class 1. The theoretical basis of PECP-1	To know the common factor model (CFM) and to understand it as a scientific basis for psychological work from different orientations	100	
	To know the factors that can complicate the depressive client	85.7	14.3
	To understand the concept of adaptive indication	100	
	To understand the role of the relationship in the therapy process, especially in personality dysfunctions.	85,7	14.3
	To develop a flexible attitude towards user needs, expectations and culture.	100	
	Valuing one's work (building confidence)	100	
Module I Class 2. Introduction to Complex Depression	To analyse the concept of complex depression and its components	100	
	To consider physical and mental comorbidities	100	
	To understand personality styles and vulnerabilities that are associated with the complexity of the depressive patient	100	
	To identify a childhood background of adversity as a factor to be considered in depression	85.7	14.3
	To identify suicidal risk as a factor that adds complexity to the patient's depressive episode	100	
	To identify that sociodemographic and cultural factor add to the complexity of each case	100	
	To be aware that the clinical and psychosocial complexity of patients, as well as the workplace, impacts the therapist's work	85.7	14.3
Module II. Class 3. Tools for addressing	To recognise structural personality functions and identifying vulnerabilities	100	

Module and classes	Objectives	Agreement percentage (N=7)	Disagreement percentage (N=7)
vulnerabilities in personality functioning and styles	To identify and address aspects of self-critical and dependent personality functioning	100	
	To develop skills for emotional regulation in depressive patients with vulnerable personalities, based on the DBT model	100	
Module II. Class 4. BA strategies for depression and strategies for dealing with childhood adversity experiences	To know the rationale and procedure of the behavioural activation technique for depression.	85.7	14.3
	To identify and develop skills for therapeutic enquiry into childhood experiences of adversity in patients with depression.	85.7	14.3
Module III Class 5. Therapeutic relationship: clinical relevance, components and attitudes favouring therapeutic alliance.	To understand the role and importance of the therapeutic relationship as a common factor and underpinning of the therapy process	100	
	To recognise the contribution of the subjectivities of consultant and therapist to the therapeutic relationship	100	
	To identify the components of the therapeutic relationship	100	
	To distinguish the components of the Therapeutic Alliance (TA)	100	
	To identify and encourage therapeutic attitudes that contribute to the proper development and maintenance of the consultant-therapist relationship	100	
Module III Class 6. Strategies and techniques to develop and strengthen therapeutic alliance addressing ruptures and tensions in relationships.	To identify strategies to promote a good therapeutic alliance	100	
	To distinguish the ruptures and the different actions of patients	100	
	To understand the importance of relationship tensions and the importance of addressing them promptly in the treatment of the patient	100	

Module and classes	Objectives	Agreement percentage (N=7)	Disagreement percentage (N=7)
	To develop a flexible and open attitude to the inclusion of relational aspects in therapeutic work	100	
	To distinguish strategies and techniques for resolving ruptures and repairing the alliance	100	
Module IV Class 7. Objectives, goals and focus in psychotherapy	To develop skills in defining the patient's current problem and treatment expectations to agree on therapeutic goals together	100	
	To develop skills to identify the difficulties underlying the current problem to build a therapeutic focus.	100	
	To develop skills to understand the main features of targeting complex patients	100	
	To develop skills for conducting agreed closures with the patient in the context of brief psychotherapy	100	
Module IV Class 8. Crisis intervention	To understand the concept of crisis and its therapeutic implications	100	
	To recognise a patient in crisis	100	
	To know the essential elements of crisis intervention	100	
Module V Class 9. Conceptualisation of suicide risk	To differentiate manifestations of suicidal risk	100	
	To distinguish protective and risk factors, from the social to the individual level	100	
	To develop the notion of maintaining awareness of the therapist's emotional states and the need to delineate therapist-user responsibilities	100	
Module V Class 10. Suicide risk assessment and intervention	To analyse suicide risk assessment tools according to clinical criteria and scales	100	
	To manage techniques to plan and implement safety measures for suicide risk	100	
	To develop skills to convey reassurance/hope	100	
	To develop an attitude of remaining calm, despite fear, anxiety and helplessness in the face of the complexity of the clinical situation	100	

Module and classes	Objectives	Agreement percentage (N=7)	Disagreement percentage (N=7)
	To develop therapeutic work skills aware of the therapist's emotional states and the need to delimit therapist-consultant responsibilities.	100	
Module VI Class 11. The social dimension of depression	To recognise the impact of the social dimension in the complexity of depression in primary health care	100	
	To understand the political-technical framework of the social determinants of health for a comprehensive approach to depression in primary health care.	100	
	To identify psychosocial factors influencing the presentation of depression in primary health care	100	
	To recognise the limits of therapeutic work with psychosocial risk factors for depression in primary health care	100	
	To characterise models of mental health care in primary health care that facilitate openness to the social dimension in the management of depression	100	
	To identify the work and competences of psychologists in addressing the social dimension in the management of depression in primary health care	100	
Module VI Class 12. Networking	To recognise the relevance of networking for the management of depression in primary health care	100	
	To characterise the work of the sectoral network in managing the complexities of depression in primary health care	100	
	To recognise working models to facilitate the functioning of sectoral networks in managing the complexities of depression in primary health care	100	
	To recognise the value of social support for working with the community in the management of depression in primary health care	100	

Table 10. *Delphi Round 1. Percentage of agreement with contents of classes*

Module and classes	Contents	Agreement percentage (N=7)	Disagreement percentage (N=7)
Module I Class 1. The theoretical basis of PECP-1	Evidence-based psychotherapy	100	
	Generic Model-Common Factors Model (CFM)	100	
	Introduction to Complex Depression	85.7	14.3
	Adaptive Indication	100	
	Psychotherapeutic Competences: patient, practitioner and expert perspectives	85.7	14.3
Module I Class 2. Introduction to Complex Depression	How we understand complexity in the depressed patient	100	
	Physical and mental comorbidity	100	
	Complexity given by personality, vulnerabilities and styles	100	
	Complexity from early adversity and trauma	85.7	14.3
	Complexity associated with suicide risk	100	
	Complexity and socio-demographic and cultural variables	100	
Module II. Class 3. Tools for addressing vulnerabilities in personality functioning and styles	How to carry out structural personality diagnosis	71.4	28.6
	How to deal with variable self-criticism and dependency in depressed patients	85.7	14.3
	Dialectical behavioural therapy-based skills for the management of structural vulnerabilities in patients with depression	71.4	28.6
Module II. Class 4. BA strategies for depression and strategies for dealing with childhood adversity experiences	Behavioural activation therapy skills for patients with depression	71.4	28.6
	Strategies for dealing with childhood experiences of adversity in patients with Depression	85.7	14.3
Module III Class 5. Therapeutic relationship: clinical relevance, components	Clinical relevance of the therapeutic relationship	100	
	Relational model of the mind and clinical implications	100	

Module and classes	Contents	Agreement percentage (N=7)	Disagreement percentage (N=7)
and attitudes favouring therapeutic alliance.	The components of the therapeutic relationship	100	
	The therapeutic alliance as a driver/changing factor	100	
	Attitudes of therapists that contribute to the proper development and maintenance of the consultant-therapist relationship	100	
Module III Class 6. Strategies and techniques to develop and strengthen therapeutic alliance addressing ruptures and tensions in relationships	Strategies and techniques to promote the therapeutic alliance	100	
	Identification of the characteristics of patient ruptures and actions	100	
	Dealing with difficulties and tensions in the therapeutic relationship	85.7	14.3
Module IV Class 7. Objectives, goals and focus in psychotherapy	Indication, prerequisites for treatment. Goals and therapy planning	100	
	Focalisation	100	
	OPD-2, a tool for focusing	85.7	14.3
	Focus on personality structure	85.7	14.3
	Focus on Complex Depression	85.7	14.3
	Closure in brief therapy	100	
Module IV Class 8. Crisis intervention	Definition of crisis	100	
	Crisis intervention: definition and phases	85.7	14.3
	Clinical example	85.7	14.3
Module V Class 9. Conceptualisation of suicide risk	Contextualisation of suicide in the world and in Chile	85.7	14.3
	Conceptualisation of suicide risk	85.7	14.3
	Lifetime trajectory of suicidal risk	85.7	14.3
	Protective and risk factors for suicide	85.7	14.3
	Expected emotional states of the therapist	100	
	Delimitation of responsibilities of consultant and therapist	100	
Module V Class 10. Suicide risk assessment and intervention	Progressive clinical assessment of suicidal risk	85.7	14.3
	Assessment with psychometric instruments	85.7	14.3
	What to do when suicidal risk is detected	85.7	14.3

Module and classes	Contents	Agreement percentage (N=7)	Disagreement percentage (N=7)
	Designing a security plan	100	
	Crisis intervention strategies (individual and family)	85.7	14.3
Module VI Class 11. The social dimension of depression	The Complexities of Depression: Opening up to the Social Dimension	100	
	Social determinants of health	100	
	Depression and psychosocial factors	100	
	Guiding principles for mental health work in primary health care	100	
	The insertion of psychologists in primary health care	100	
Module VI Class 12. Networking	Principles for the networked management of depression in primary health care	100	
	Depression management in the health network: mental health thematic network	100	
	Working models for the networked management of depression: the role of primary healthcare	100	
	Social support as a community strategy for the management of depression	100	

Table 11. *Delphi Round 2. Percentage of agreement with the objectives and contents of the classes*

Module and classes	Objectives and Contents	Agreement percentage (N=7)	Disagreement percentage (N=7)
Module II Class 3. Tools for assessing personality vulnerabilities and childhood experiences of adversity.	Objectives	100	
	• To recognise the level of structural personality functioning and identify vulnerabilities in patients with depression		
	• To identify and address aspects of self-critical and dependent personality functioning in patients with depression	100	

Module and classes	Objectives and Contents	Agreement percentage (N=7)	Disagreement percentage (N=7)
	• To identify and develop skills for therapeutic enquiry into childhood experiences of adversity in patients with depression	85.7	14.3
	Contents:		
	• How to carry out structural personality diagnosis	100	
	• Dealing with variables self-criticism and dependency in depressed patients	100	
	• Strategies for therapeutically inquiring experiences of adversity in childhood	85.7	14.3
Module II Therapeutic tools to address resistant depressive symptomatology and personality vulnerabilities.	Objectives		
	• To understand the rationale, procedure and competencies for using the behavioural activation technique for depression	85.7	14.3
	• To develop general skills to address structural vulnerabilities in depressive patients	85.7	14.3
	• To develop skills to address structural vulnerabilities in depressive patients based on the DBT model	85.7	14.3
	Contents		
	• Behavioural activation therapy skills for patients with depression	85.7	14.3
	• General skills for the management of patients with structural vulnerabilities	85.7	14.3
	• Dialectical behavioural therapy-based skills for the management of structural vulnerabilities in patients with depression	71.4	28.6

12. APPENDIX C

Figure 10.

Picture of the platform used for the workshop

Note. At the top of the page is the banner: Course of competence training for psychotherapy of depressive disorders in Primary Health Care (PHC). Below are tabs: Welcome to the course (Module 1); Module 2, Module 3, Module 4, Module 5, Module 6, Classroom Session, Final Exam. On the left side of the screen, there is a menu with drop-down options. On the right side of the screen, there are the latest notifications.

Figure 11.

Synchronous Activity Schedule

9:00-9:30	Presentaciones	Guillermo de la Parra y Carla Crempien
9:30-10:10	Presentación de casos	Susana Morales
10:10-10:50	Discusión de casos	Susana Morales
10:50-11:10	Recreo	
11:10-12:00	Presentación video entrevista	Carla Crempien y Guillermo de la Parra
12:00-13:00	Discusión video	Carla Crempien y Guillermo de la Parra
13:00-14:00	Almuerzo	
14:00-15:30	Simposio	
	De los factores comunes- modelo contextual a una psicoterapia efectiva (20')	Guillermo de la Parra
	Aproximación al trauma relacional en Salud Pública y APS (20')	Carla Crempien
	Mis pacientes no hacen la tarea: desafíos y enseñanzas (20')	Karina Zuñiga
	Dudas y Preguntas	
15:30-15:45	Café-Encuesta	
15:45-16:30	Debate final	
	¿Cómo es para mi trabajar en APS?	
	¿Cómo me cuido?	Guillermo de la Parra y Carla Crempien
	Palabras finales	

Note. Synchronous activity schedule with which the workshop was concluded. In the morning, presentations and discussion of clinical cases took place, and in the afternoon, a symposium was held on topics that were of interest to the participants through the course of the workshop: Common factors, trauma approach and an indication of therapeutic tasks.

Figure 12.

Picture Synchronous Activity

Note. The following link shows a video recording of the synchronous day:

https://www.youtube.com/playlist?list=PLpNQonyzsHqDHlHi0Xe9hm0b6y5XAZrdm