

Assessing therapist and clinician competency in parent-infant psychotherapy: The REARING coding system (RCS) for the group attachment based intervention (GABI)

Kelsey Armusewicz,¹ Miriam Steele,² Howard Steele,² Anne Murphy¹

¹Rose F. Kennedy Children's Evaluation and Rehabilitation Center, Montefiore Medical Center; ²The New School for Social Research, New York, NY, USA

Correspondence: Kelsey Armusewicz, Rose F. Kennedy Children's Evaluation and Rehabilitation Center, Montefiore Medical Center, 116 East 124th Street, 2nd fl., 10035 New York, NY, USA.
E-mail: karmusewicz@gmail.com

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ABSTRACT

The development of fidelity and quality measures for the dissemination of evidence-based practices is an often-neglected, vital step in the implementation of psychological interventions, especially within parent-infant mental health. The current study aims to address this gap by developing a competency-based measure for clinicians delivering the Group Attachment Based Intervention (GABI). GABI is an intervention aimed at supporting family preservation in parents who have experienced disparities across multiple systems of care. After observing over 100 hours of clinical video, the research team, comprised of clinicians and academic researchers, developed a competency coding system to measure clinician efficacy titled the REARING coding system (RCS). This paper outlines the development and structure of the measure, including a detailed discussion of the model of therapeutic action (*i.e.*, REARING: *reflective functioning, emotional attunement, affect regulation, reticence, intergenerational transmission of attachment, nurturance, and group therapy context*), as well as provides a clinical case study to illustrate the utility, flexibility, and depth of the measure. The case study details a family session consisting of a mother, father, and two children (one infant, one toddler), and how RCS can be used in supervision to foster clinical competency and effectiveness in the GABI model. RCS seeks to address the dissemination gap in Evidence Based Practices (EBPs) by contributing to the limited number of existing fidelity and competency measures in infant mental health and psychodynamic dyadic psychotherapy. RCS is an important tool for monitoring clinical competency in the dissemination of GABI and gives supervisors the ability to provide fidelity-focused supervisions.

Key words: Attachment; parent-infant psychotherapy; clinical competency; case study.

Introduction

Need for competency-based measures

The development of clinical competency measures for psychotherapy practice is an important step in the dissemination of evidence-based practices in infant and children's mental health (Baker, 2001). A sobering finding emerged in the 1990's indicating that, despite numerous local and state service initiatives in children's mental health, such as the Stark County Evaluation Project and the Fort Bragg Demonstration Project, there remained a lack of evidence

that these initiatives actually impacted child outcomes (Bickman, 1996; Bickman, Summerfelt, Firth, & Douglas, 1997). This dissemination gap, *i.e.*, the documented differences in the effects of treatment in research settings *versus* community-based settings, is likely due to inadequate or insufficient training and the lack of monitoring for treatment fidelity (Schoenwald, Henggeler, Brondino, & Rowland, 2000; Weisz, Donenberg, Han, & Kauneckis, 1995; Weisz, Donenberg, Han, & Weiss, 1995). Due to the pressure to deliver evidence based interventions and the rapid dissemination, clinical quality measures and fidelity monitoring are essential in addressing the dissemination gap and establishing efficacious mental health services (Bruns *et al.*, 2004; Fixsen, Naoom, Blase, & Friedman, 2005; Garland, Bickman, & Chorpita, 2010; Schoenwald, Henggeler, Brondino, & Rowland, 2000).

Why develop efficacy and competency measures for infant mental health?

In the literature there are two components of treatment efficacy: adherence and competence. Adherence demonstrates the clinician's knowledge of how to apply treatment, while competence requires the knowledge of when and when not to apply specific interventions with distinct patient populations (Barber, Sharpless, Klostermann, & McCarthy, 2007). Adherence appears to be the quantitative aspect of treatment delivery (*i.e.*, did the clinician perform the intervention), while competence is a qualitative measure of treatment dissemination (*i.e.*, how well the intervention was delivered; Perepletchikova, & Kazdin, 2005). Studies have indicated that moderate levels of adherence lead to the greatest patient improvements, as low adherence indicates that core components of the intervention are not executed, while high adherence indicates potential rigidity and lack of flexibility (Barber *et al.*, 2006; Hogue, Henderson, Dauber, Barajas, Fried, & Liddle, 2008). Competence is highest at a mid-range model of adherence. This highlights the importance of both adhering to treatment guidelines where appropriate, but also maintaining adaptive flexibility when necessary to address the patient's unique needs and presentation. Perhaps most importantly, competence predicts better outcomes for patients than adherence alone (Barber, Crits-Christoph, & Luborsky, 1996; Barber *et al.*, 2006; Boyer, MacKay, McLeod, & van der Oord, 2018; Ginsburg, Becker, Drazdowski, & Tein, 2012; Owen, & Hilsenroth, 2014; Wampold & Imel, 2015). As such, both the American Psychological Association (APA) and the Association of Psychology Postdoctoral and Internship Centers (APPIC) have adopted competency-based models for evaluating clinical psychology trainees and practitioners (Kaslow *et al.*, 2004).

Current competence measures in dyadic therapy

Of interest to the current study is the utilization of clinical competence measures in the dissemination of dyadic,

infant and child psychotherapies. Two notable competency measures are those used in Child Parent Psychotherapy (CPP; Lieberman, 2004) and Attachment and Biobehavioural Catch-up (ABC; Dozier, Bernard, & Roben, 2017). CPP monitors clinician performance through intensive weekly case conferences consisting of either of a review of narrative process notes or video session (Lieberman, Ippen, & Van Horn, 2006). The ongoing learning collaborative between CPP experts and clinicians disseminating the intervention allow for the sustainability of the CPP model (Noroña & Acker, 2016). In ABC, treatment fidelity is conceptualized as both the frequency and quality of clinician's feedback to parents in session (Caron, Weston-Lee, Haggerty, & Dozier, 2016). Clinicians are evaluated on whether their comments are on target (*i.e.*, relevant) in response to parents' behaviour. Clinicians are evaluated on whether their comments were successful in providing either a description of parent's behaviour, an intervention that targets the behaviour, or a link between behaviour and outcome. When a relevant parent behaviour is detected, the coding system is used to determine if the clinician is on target. The frequency of parent coaching is quantified and used as the primary marker of fidelity. All sessions are videotaped, and intervention experts supervise new clinicians in fidelity focused supervisions (Caron, Weston-Lee, Haggerty, & Dozier, 2016). Importantly, the clinicians and supervisors review the fidelity coding together. Clinicians receive feedback on their coding accuracy as well as their performance in the session. This method of assessing competency is ideal for a number of reasons, including the use of video footage. The process of coding and supervision allows clinicians to evaluate themselves in a real therapy setting, while also beginning to internalize the principles of the intervention via the process of coding themselves.

Use of video in psychotherapy to assess competence and provide supervision

As utilized in attachment and biobehavioural catch-up (Dozier, Bernard, & Roben, 2017), one of the most useful ways to assess competence is through the use of video in the supervision. Video provides a unique experience in which the supervisor and clinician gain access to both verbal and non-verbal aspects of the therapy session. There is a long history of utilizing video in supervision in adult psychotherapy, highlighting the importance of this practice for both psychotherapy training and patient outcomes (Haggerty, & Hilsenroth, 2011). Video can increase competence above and beyond adherence. While treatment manuals can lead novice therapists to apply interventions in a cookbook fashion, more experienced clinicians can engage in reflection-in-action (Schon, 2017) and deliberate practice (Rousmaniere, 2016). Reflection-in-action allows the therapist to construct new theories and techniques based on moment-to-moment interactions. Experienced clini-

cians are able to do this when they are in an ongoing conversation with themselves in the moment, and aware of why and how interventions should be disseminated (Safran & Muran, 2003). Video allows the clinicians to engage with themselves, their patients, and the material of the session in a way that facilitates a more nuanced understanding of their own skillfulness and efficacy in moments, allowing for reflection-in-action and consolidating a reflective stance towards their own clinical work more generally. Deliberate practice in psychotherapy includes individualized training designed to improve competence through, ‘repetition and successful refinement’ (Ericsson & Lehmann, 1996; p. 278-279). Deliberate practice in psychotherapy includes measuring baseline performance or competence and providing ongoing feedback that is specific to the goals of the patient or intervention, as well as continuously practicing and establishing a plan for improvement (Goldberg *et al.*, 2016; Miller, Hubble, Chow, & Seidel, 2013; Rousmaniere, 2016). Video provides a unique and accurate method of assessing and providing continually feedback in supervision and fostering deliberate clinical practice.

The Group Attachment Based Intervention

With all of this in mind, it is crucial that new evidenced-based practices in parent-child work establish effective clinical competence and efficacy measures. As such, the Group Attachment Based Intervention (GABI), established as an evidence-based treatment in a randomized controlled trial (Steele, Murphy, Bonuck, Meissner, & Steele, 2019), created a quality measure to determine efficacy in treatment and measure success in dissemination and implementation of the intervention. The aim of the current study is to describe the development and utility of a competency-based coding system in order to enhance training and establish best practices for therapeutic action under the GABI model of treatment.

GABI was developed by Dr. Anne Murphy at the Children’s Evaluation and Rehabilitation Center, located at the Albert Einstein College of Medicine, Montefiore Medical Center, in the Bronx, New York, in conjunction with Drs. Howard and Miriam Steele at the Center for Attachment Research, located at the New School for Social Research, in New York City. GABI is an intervention supporting parent-child attachment relationships in vulnerable, isolated families with ongoing exposure to psychosocial and socioeconomic stressors (Steele, Murphy, Bonuck, Meissner, & Steele, 2019; Steele, Murphy, & Steele, 2010). The children enrolled in the intervention are aged 0-3. Their parents, often referred by the Administration for Children’s Services (ACS), have experienced multiple Adverse Childhood Experiences (ACEs), current societal disparities, and bring complex internal working models to bear in their current relationships with their children.

GABI utilizes a group format which helps to combat the social isolation families experience. The intervention

consists of a two-hour session, including a parent-child group, a parent-only group, and a child-only group. Groups are offered six times per week and families are welcome to join as many sessions during the week as they wish, with the expectation that families will join session at least once a week. The first hour of the session consists of the parent-child dyadic psychotherapy. Clinicians during the parent-child group facilitate interactions between the parent and child in order to fortify the attachment relationship. Keeping with an attachment perspective and a focus on separations and reunions (Ainsworth, Blehar, Waters, & Wall, 1978), after the parent-child session, the parents leave the room to attend a parent-only group while the children engage with clinicians in a child-only session. This constitutes the second hour of the intervention. During the separation, clinicians support the parent and child in coping and managing this often-difficult transition. During the parent-only psychotherapy process group, a lead clinician facilitates conversations amongst parents enrolled in the intervention to combat stress and increase social understanding, while allowing participants to reflect on their own storied past and how this may affect their current relationship with their child. Offered concurrently, the child-only group not only allows children to interact with peers, but also promotes socio-emotional development through clinical support.

Group attachment based intervention model of therapeutic action

After watching over 100 hours of clinical video, the team of Dr. Anne Murphy and Drs. Howard and Miriam Steele, in conjunction with graduate students at the Center for Attachment Research, developed the conceptual framework for GABI known as REARING (Murphy, Steele, & Steele, 2013). REARING refers to the key components of GABI that facilitate therapeutic action including Reflective Functioning, Emotional Attunement, Affect Regulation, Reticence, Nurturance, and Group Context. All of these components can be seen as techniques clinicians use in order to foster change within the parent-child dyad but are also vital for parents and children to begin to exhibit these psychological skills themselves. It is this model of therapeutic action that GABI bases its competency measure, pulling from concepts deeply rooted within attachment and psychoanalytic theory. REARING was designed to organize the main constructs of GABI. While this framework provides distinct constructs, these concepts are interconnected as features of positive parent-child attachment and interaction. In creating a measure of clinical competence it is important to identify and defend the concepts within which it is embedded. As such, the REARING concepts are detailed below.

Reflective functioning. Reflective functioning is essential to healthy psychological functioning (Fonagy, Steele, Moran, Steele, & Higgitt, 1991) and the desired outcome in all psychological treatments (Levy *et al.*; Fon-

agy *et al.*; Kivity *et al.*). It is the ability to understand another's behaviour, as well as one's own, within the context of internal mental states and intentions. In order to develop healthy social relationships, a central capacity is the ability to consider the thoughts, wishes, and beliefs of the 'other.' This allows us to further contextualize the origins of another's behaviour, as well as anticipate their future actions (Fonagy & Target, 1998). The ability to reflect on mental states originates in the caregiver-child relationship and facilitates an individual's ability to make sense of their own subjective experience.

It has been shown that parental reflective functioning has consequences for not only infant attachment classification, (Ensink, Begin, Normandin, & Fonagy, 2016), but also reflective functioning capacity well into childhood and adolescence (Benbessat & Priel, 2012; Ensink *et al.*, 2015; Kriss, Steele, & Steele; 2012). High levels of reflective functioning are also associated with the development of mature psychological defenses and improvements in affect regulation (Tanzilli *et al.*, 2021). Low levels of reflective functioning and mentalization are often associated with serious psychological disorders and personality pathology (Fischer-Kern *et al.*, 2010; Fischer-Kern *et al.*, 2008; Fonagy, Gergely, Jurist, & Target, 2002; Gagliardini, Gullo, Caverzasi, Boldrini, Blasi, & Colli, 2018; Ward, Ramsay, Turnbull, Steele, Steele, & Treasure, 2001). Parents with poor reflective functioning who often show signs of affect dysregulation in themselves, are unable to mirror the child's emotions effectively, therefore inhibiting the child's ability to develop this capacity. Particularly, when a child is exposed to misattuned caregiving, they are unable to construct a coherent sense of themselves within the social world (Fonagy & Target, 2002). Even worse, children of abusive parents have little to no opportunity to understand themselves or others in the face of the parent's projections and malevolence. Thus, these children often integrate their parent's aggression into their own psyche, via an identification with the aggressor (Fraiberg, Adelson, & Shapiro, 1975) or, in cases of severe abuse, resist exploring the mind of the other entirely, which can be too terrifying to consider. This often then leads to a protective disinterest in the mental states of oneself and others in order to defend against the abuser's harmful state of mind (Slade, 2005). Additionally, it has been found that children with somatic symptom disorders and disruptive behaviour disorders exhibit significantly diminished reflective capacities and were significantly more likely to also have insecure and disorganized attachments (Bizzi, Ensink, K., Borelli, Mora, & Cavanna, 2019).

Emotional attunement. Emotional attunement is a crucial aspect of caregiving and infant development (Bowlby, 1969). Mary Ainsworth and her colleagues emphasized the importance of maternal attunement and sensitivity on the child's development of a sense of self and on the development of a healthy dependency on the caregiver to

meet their needs (Ainsworth, Blehar, Waters, & Wall, 1978). Beebe and Sloate (1982) note that, 'the provision of an appropriate amount and quality of stimulation, and the maternal capacity to modulate the intensity of stimulation within a comfortable range, is an important aspect of successful *attunement*' (p. 602).

Attunement is the ability to respond to the child's emotional state in a way that does not overstimulate or provide an inaccurate external representation of their internal experience. Oftentimes this includes 'mutual gaze' and 'cueing' (Robson, 1967; Stern, 1971). Cueing refers to an acknowledgement of the child as an external entity sharing in an emotional experience with the mother, while mutual gaze is most commonly shown in both play and feeding (Beebe & Sloate, 1982). The ability of the caregiver to notice and then match these expressions is important in the development of the child's emotional world. However, attunement can be inhibited by the mother's own psychopathology, leading the mother to be unable to match the infant's rate of information processing or rhythm (Tronick, Als, & Adamson, 1979), further hindering this vital aspect of emotional development.

Ruth Feldman (2007) also discusses the concept of synchrony, which includes the ability to attune to another's emotional state. Synchrony is the 'intricate dance' that occurs in interactions between parent-child dyads and builds upon the familiarity established with each partner's behaviours and rhythms of interaction (Feldman, 2007; Fogel, 1993; Tronick, 1989; Trevarthen, 1979). Feldman (2007) further describes this as rooted in time in the caregiver's responsiveness and interactive flow. She also notes the importance of the caregiver's ability to match affective states and mirror the infant's communicative cues.

Affect regulation. Fonagy and Target (2002) state the goal of child development is the enhancement of self-regulation. Parents who are able to turn volatile expressions into emotional states that can be more easily understood promote attachment security in themselves and in their children (Bowlby, 1988). Through the attachment relationship and through moments of affective synchrony, an attuned parent can regulate the child's emotional state. The caregiver is able to achieve this synchrony through psychobiologically attuning to the child's bodily-based internal states through mutual gaze, activity level, body tone, and vocalizations (Beebe & Lachman, 2020; Feldman, 2007; Gottlieb, 1976; Levine, 2002; Richter, 1995; Sanders, Bor, & Dadds, 1984). This interactive regulation serves as a primary regulator for the infant's own developing central and autonomic nervous systems (Schore & Schore, 2008). Dyadic synchrony (Feldman, 2007) is a major component of co-regulation in parent-child dyads. Synchrony facilitates self-regulation in the infant via the co-regulation established with the caregiver (Feldman, 2003; Feldman, 2007; Pickens, Field, Nawrocki, Martinez, Soutullo, & Gonzalez, 1994; Fogel, 1993; Tronick, 1989).

A caregiver's inability to soothe the child can be in-

fluenced by the attribution of negative intentionality (Beebe & Sloate, 1982), leading the caregiver to a failure in reflective functioning and an experience of helplessness in calming the child. The inability to regulate the infant's emotions can lead to a myriad of physiological reactions with adverse outcomes, including increased heart rate (Sroufe & Waters, 1977) and increased cortisol production (Gunnar, Mangelsdorf, Larson, & Hertsgaard, 1989; Spangler & Grossman, 1993). Establishing the mother as a secure base for which the child can turn when she is upset, can lessen these physiological reactions and their long-term consequences.

Reticence. Colwyn Trevarthen stated, 'Good parenting is defined by reticence on the part of the parent' (Trevarthen 1979, p. 343). While reticence can be conceptualized negatively, as wariness or caution, here it is celebrated as a way for the parent to step back in order to allow the child to grow, problem solve, and become efficacious on their own. This concept, as we have defined it, is informed by the practice of psychoanalytic infant observation, beginning at the Tavistock Clinic in London. The observation of the infant is the observation of the earliest formation of the psyche (Bick, 1964).

Assuming an observational, rather than intervening, stance limits clinician bias and over-identification with the baby or the parent (Rustin, 2006). This moment of stillness allows the clinician to meaningfully respond. This is the essence of Reticence, which harkens back to Freud's notion of 'evenly hovering attention' and Reik's notion of 'the third ear.' Freud first commented on this idea in 1912, stating that the clinician should not fix their attention to anything in particular, but rather maintain, 'evenly-suspended attention (p. 111).' Reik's (1983) third ear refers to listening to multiple layers of meaning at once and is a profoundly present way of being reticent. It is important for therapists to pause in order to turn their attention inward and not become too attached to any aspect of the interaction or observation, and to suspend judgment. By using the 'third ear,' therapists are able to further understand the nuances of their patients and the patient's interactions with others (Safran & Muran, 2003).

Additionally, practicing reticence also allows the clinician to, 'meet the family where they are at.' This can be particularly important in cases of cultural or identity difference. A moment of empathic observation can be used to further understand specific parenting practices or cultural expectations, forestalling immediate judgment or the need for change. Some infant observation studies describe the utility of restraint and curiosity when engaging with communities that are perhaps socially and culturally different from the clinician's (Ellis, 1997; Grier, 2002; Lin, 1997; Maiello, 2000). There are studies that also indicate that meaningful pauses or silences can be productive to the process of psychotherapy and facilitate patient collaboration as well (Cutler, Hill, King, & Kivlighan Jr, 2019).

Intergenerational transmission of attachment patterns.

The 'ghosts' of previous generations often repeat the past in the present (Fraiberg, Adelson, & Shapiro, 1975). It is evident that a parent's own attachment history greatly affects their relationships thereafter, especially with their children. Bowlby posited that attachment is transmitted between parents and children through, 'Internal working models,' which influence the ways in which these parents internalize and therefore apply their own representations of their first relationship with their caregivers to those that occur thereafter (Bowlby, 1969). It is theorized that the parent's state of mind with respect to their attachment is transmitted to the child via the provision, or lack thereof, of sensitivity and responsiveness in caregiving practices (van IJzendoorn, 1995; van IJzendoorn, & Bakermans-Kranenburg, 2019). In Main, Kaplan, & Cassidy's (1985) hallmark study, it was found that mother's Adult Attachment Interview classifications (AAI; George, Kaplan, & Main, 1985) and infant's Strange Situation (SSP; Ainsworth, Blehar, Waters, & Wall, 1978) classification were correlated. This pointed to the move to the 'level of representation' in attachment theory that involves consolidating thoughts and feelings regarding early caregiving experiences into mental representations that parents bring to bear in their relationships with their children. This concept also highlights the ability of individuals to disrupt negative attachment patterns, if provided with positive attachment experiences (Fonagy, Steele, Steele, Higgitt, & Target, 1994; Main *et al.*, 1985; van IJzendoorn, 1995).

Furthermore, a study conducted by Steele, Steele, & Fonagy (1996) examined both mother's and father's attachment classification as measured by the AAI and infant's attachment classification measured by the SSP. The study found that parents with maladaptive working models of attachment are more likely to misunderstand relational signals from the infant, and therefore provide inconsistent or misleading feedback to the child, activating an unhealthy cycle of interaction. Conversely, secure patterns are likely to give the infant helpful feedback about parent-child relationships and support the child in developing other relationships. It is vital that clinicians address the ways in which parent's own histories impact the ways in which they interact and understand their children.

Nurturance. Nurturance is primarily informed by Bowlby's notion of the parent as a 'haven of safety,' or a secure base which the child can access in moments of distress (Bowlby, 1969). It is also influenced by the notion of a, 'holding environment' (Winnicott, 1974), or 'containment' (Bion, 1962), in which the parent provides a space where she can be present with the child and responsive to the child's needs. The concept of *nurturance* is derived here from the overarching notion of maternal sensitivity, defined originally by Ainsworth as the mother's ability to understand and react appropriately to her child's signals and communications (Ainsworth *et al.*, 1978). Many parents with difficult attachment histories are unable, or perhaps defend against, against interpreting

their children's emotional state (Bernard, Meade, & Dozier, 2013). This dismissive state of mind may lead the parent to neglect the child in moments when the child needs care the most.

Nurturance is also a basic tenant of all psychological interventions. Through this basic provision of empathy, the patient can experience a 'corrective emotional experience' (Alexander, 1948). The therapist provides the patient with an alternative emotional and relational experience. Nurturance is not only an intervention specifically geared to GABI but is also proposed as a general factor of competent therapy in any therapeutic modality. Waltz, Addis, Koerner, and Jacobson (1993) suggest that warmth, empathy (Knight, 2020), and nurturance should be viewed as a therapeutic universal. This is imperative in dyadic psychotherapies and fostering nurturance is a common target of therapeutic action in parent-child interventions (Dozier, Roben, Caron, Hoye, & Bernard, 2018).

Group context. The Group Context of GABI refers to the important sources of social support and the facilitation of peer relationships amongst the children and parents alike, combating the inherent social isolation often faced by GABI group members (Murphy, Steele, & Steele, 2013). It is evident that in group psychotherapy, the group itself can serve as its own secure base from which the patient can explore new modes of being and new internal working models (Tasca, 2014; Tasca & Maxwell, 2021). The emotional bond held by an individual for the entire group is considered the group therapy alliance (Gaston & Marmar, 1993). The group alliance also strengthens when there are shared goals and tasks of the treatment. According to the aims of GABI, all parents share a common goal: to improve their relationship with their children and ensure family preservation.

Yalom conceptualized the group as a social microcosm and noted that patients change and heal through interpersonal learning and feedback (Yalom, 1995). Just as the nurturing relationship with the therapist can provide a corrective emotional experience (Alexander, 1948), the members of the group can also provide corrective empathy and shared experience. It has also been found that individual's attachment styles can become more salient and clearer when engaged in a group therapy format. Tasca, Balfour, Ritchie, and Bissada (2007), noted that individuals with anxious or avoidant strategies employ these when faced with affect exploration in groups and when focusing on the here-and-now in interpersonal relationships. Thus, the group provides a way in which these difficult attachment relationships are illuminated and worked through with members of the group. This is especially important given that, while anxious or avoidant strategies are often consistent throughout the individual's life (Thompson, 2000), these strategies are not always employed in all situations. Attachment strategies are most likely to be activated in interpersonally and emotionally challenging situations, such as the group therapy context (Mikulincer & Florian, 1998; Tasca, Balfour, Ritchie, &

Bissada, 2007). These reactions and interpersonal dynamics are often unique to group therapy and are not elucidated in individual therapy alone. As such, the group provides unique opportunities to work through a range of attachment conflicts.

REARING coding system

With these basic tenants in mind, the REARING coding system (RCS) was developed to integrate these factors of therapeutic action into a competency-based measure for monitoring clinician effectiveness. The team began with creating a coding system for parent-child dyadic sessions with the REARING concepts as the target of the clinician's interventions. While all aspects of GABI foster attachment security, it is within the parent-child group where parents can learn to interact, understand, and ultimately bond with their children. Therefore, it was imperative that this aspect of the GABI intervention was prioritized and monitored for efficacy in treatment delivery.

RCS was developed to address gaps in other competency measures by providing concrete anchors and examples of each rating for clarity and inter-rater reliability. Examples were identified to characterize what each score would look like within the intervention context and were gleaned from actual GABI sessions. The team identified anchors and examples for different levels of quality in each REARING concept within the parent-child session. The scores are rated on a scale from 1 to 5, with higher scores indicating greater competence. A score of 3 was the metric for meeting expectations, anything less than a 3 was considered to be below expectations, and above 3 as exceeding expectations. Generally, scores were given based on the following metric:

- 1 = Clinician missed an opportunity for intervention;
- 2 = Clinician's intervention had an unclear clinical focus;
- 3 = Clinician recognized an opportunity and performed a basic intervention;
- 4 = Clinician seized an opportunity for intervention with clear therapeutic intent and intervention was meaningful;
- 5 = Clinician created an opportunity for intervention and/or included the parent enacting the concept with the child.

Additionally, there are certain therapeutic moments within the parent-child sessions in which a concept may not be relevant for the dyad or situation. As such, scores of N/A can also be given as to not penalize the clinician. These scores are to be given sparingly.

In the RCS coding system, Reflective Functioning is coded when the therapist explores why a person behaved the way they did, and/or comments on the parent's or child's emotional states. The concept is coded when the therapist explores the reasons (*i.e.*, thoughts, feelings, and intentions) that underlie behaviour for one or both members of the dyad. This often involves labelling emotions that are not yet articulated or expressed.

In GABI, Emotional Attunement is a critical skill through which therapists try to engage parents in a way that facilitates recognition and understanding of their children's emotional states, conveying to the child a sense of being understood. Additionally, therapists also support the parents' understanding of their child's emotions, scaffolding their own ability to attune to their children, therefore fostering the attachment relationship (Murphy, Steele, & Steele, 2013). Emotional Attunement in RCS is conceptualized as the therapist's attempts at, 'taking the temperature of the room.' It involves empathizing with, and reflecting back, an expressed feeling. It often involves reflecting the emotion in a modulated or modified form, which can also have a regulating effect.

Affect regulation is coded, not only in instances of negative affect, but also in moments of flat affect, reflecting the clinician's ability to up-regulate affective states. Affect Regulation is coded with higher scores at times when the parent-child dyad is visibly distressed, and the interventions are intended to reduce this distress. Affect Regulation is achieved by therapists who are sensitive to the expression of volatile feeling states. This often involves slowing down, encouraging the parent to observe and listen to the child, and engaging the dyad in calming activities, such as singing, squeezing Play-Doh, the back and forth of bubble blowing, or other developmentally appropriate calming activities.

Reticence is coded when the clinician mindfully steps back in the service of not interrupting the interaction while tolerating discomfort and maintaining a strong supportive presence. This often includes facilitating play and interaction between the dyad, while exhibiting the flexibility to move in and out of reticence as needed. Reticence involves waiting to intervene, giving parents and children the space to discover their own feeling states and enhance self-efficacy. Both therapists and parents practice reticence in order to have access to important information that would otherwise be lost.

Intergenerational Context is coded when the primary purpose of the clinician's intervention is to acknowledge the parent's past experiences and how their experience of being parented affects them in their relationship with their child. This is coded when the clinician helps the parent make connections between their past experiences, their current psychological state, and their reactions to their children. This is also coded when there is an acknowledgement of the intergenerational transmission of attachment patterns from one generation to the next.

Nurturance involves providing both instrumental care (*i.e.*, offering food or drink), as well as providing warmth and empathy with a non-judgmental stance. It involves nurturing both the parents (as motherhood generates a strong wish for the mother to be cared for; Bowlby, 1988) and children, and promotes the nurturance of the children by their parents. While nearly every intervention can be seen as nurturing in some way, this is coded highly in in-

stances when the primary purpose of the intervention is aimed at making the parent and/or child feel comfortable and cared for. Nurturance is coded highly in instances where the clinician maintains warmth towards the parent and child throughout the coded segment.

Group Context is coded when the intervention provides a source of social support or facilitates further understanding of emotional states through the use of connections and interactions within the group. It is coded when the group is the primary vehicle of the therapeutic intervention and the clinician makes efforts to engage the multiple group members in a way that fosters other therapeutic aims, such as Reflective Functioning or Emotional Attunement. This code focuses on the clinician's bids to connect group members.

Utilizing REARING coding system as a measure of competence and as a supervision tool

The impetus for creating the RCS measure was to focus on these critical aspects in training clinicians and to explore the sources of therapeutic action. In order to ensure fidelity in the model and quality of dissemination, RCS was used to code new clinicians for their competence in the REARING model of therapeutic action within GABI.

Clinical training in group attachment based intervention

New GABI clinicians are trained in the model via a workshop with Drs. Miriam Steele, Howard Steele, and Anne Murphy. Additionally, clinicians are provided with an online training platform (GABIONLINE) that includes supplementary lectures on attachment, specifics on the implementation of GABI, and videos of clinical work. The web-training also includes an introduction to RCS and example videos from which clinicians can practice identifying and coding REARING concepts. Upon completion of this training, clinicians deliver the GABI intervention under an apprenticeship model with experienced clinicians and are videotaped at three-month intervals to assess competence in the intervention.

Coding procedure

It was determined most useful for clinicians and expert raters to identify smaller, discrete moments within parent-infant interactions. As such, clinicians submitted ten-minute videos, coded in one-minute intervals. Doing so would allow both clinicians and supervisors to better assess interventions within the temporal landscape of the dyad. While one-minute segments are certainly not as fine-grained as Beebe's microanalysis (normally coding 27 frames per 1 second of video), employing a more detailed approach aids in determining discrete moments of sensitivity and contingency, which are the building blocks of secure attachment (Beebe & Steele, 2013).

Videos are coded independently by the clinicians ad-

ministering GABI (*i.e.*, the clinician in the video) and expert raters. A coding group consisting of Drs. Howard and Miriam Steele and Dr. Anne Murphy, as well as clinical psychology PhD graduate students trained in the GABI model, met weekly to code videotaped sessions for clinician's quality on the delivery of the REARING concepts using RCS. The PhD graduate students were trained in the coding procedure from the GABI intervention experts, attended an in-person training, and were given access to the online training.

The videos coded by expert raters are used to assess fidelity and competence within the intervention and are also utilized as a supervision tool. Clinicians are trained to 'code' themselves in order to develop a nuanced understanding of the goals of the intervention and to support 'reflection-in-action.' The clinicians meet with expert raters every three months to discuss their sessions and fidelity to the REARING model. Dr. Miriam Steele, who played a key role developing the intervention (Steele, Murphy & Steele, 2010), provides targeted supervision using the RCS coding system and 10-minute videos provided by clinicians of the parent-child portion of GABI.

Clinical case example

The following section presents a case example to illustrate the use of RCS with clinical video. The video described includes one clinician in a GABI parent-child session with a mother, Sarah, father, Andrew, toddler, Jessica (approximately 2 years old), and infant child, Arianna (approximately 1-2 months old) [All names have been changed to protect confidentiality]. The 10-minute video was filmed for a competency focused and fidelity-based supervision with Dr. Miriam Steele. The clinician in the video had over 10 years' experience in the GABI model and held an LCSW degree. A detailed description of the session and therapeutic interventions are provided below, along with the associated RCS codes and rationale.

0-1: The session begins with the clinician sitting on the floor next to the mother, Sarah, with the infant, Arianna, laying down on a pillow. Sarah is directly facing Arianna on her knees. The father, Andrew, is sitting on a couch above the mother and clinician, looking on, while the older child, Jessica, is out of the frame. Jessica approaches the clinician. Clinician exclaims, 'Oh, look whose coming over!' Jessica crawls into her mother's lap and mother says, 'You're still mommy's baby.' The clinician responds to Sarah, directing her comment at Jessica, stating, 'It's hard to share mommy. You want to be right on that lap too.' Jessica then reaches for her father, who picks her up readily. Clinician turns back to the mother and baby, vocalizing softly with the baby and adjusting her positioning to simultaneously attend to the father and the older child. Clinician softly provides Arianna with her pinky finger and Arianna grasps

on. Clinician delights with mother, stating, 'Wow, look at those eyes.'

Coding: In this segment, the clinician receives codes of 5 for Reflective Functioning, Emotional Attunement, and Nurturance, with codes of 4 for Affect Regulation and Reticence. A code of N/A is given for the Group Context throughout the ten-minute segment because during this interaction, group interventions were not therapeutically indicated, and it is unclear from the video if other parents were present in group that day. A code of N/A is also given throughout the video for Intergenerational Transmission of Attachment Patterns due to the nature of the discussion. Oftentimes this intervention is most appropriate for the GABI parent group. The clinician here receives a code of 5 for Reflective Functioning for articulating Jessica's difficulties in adjusting to the new baby and having to, 'share mommy,' allowing mother to also reflect on this experience for her child. Her Emotional Attunement and Nurturance are high due to the clinician's ability to enlist the mother in attending to Arianna as well, through her interest and pointing out the child's features to facilitate face-to-face interaction.

1-2: Clinician continues to delight in Arianna with mother. Another clinician sitting close by comments about how Arianna is getting bigger every day. Clinician says, 'Yeah, you can see it, huh?' to which mother replies, 'I can see it and I can feel it.' Clinician asks, 'And in her face you see...?' as she circles her face with a pointed finger, signalling to mother to attend to the child's face. Mother instead picks back up on the thread she began moments before, commenting on the physical weight of Arianna and how she manages to support and carry her throughout the day. Sarah says, 'I mostly carry her in the carrier, and it puts the weight on my shoulders...the weight gets heavier as she gets bigger,' and mother uses her hands to gesture to the weight of the carrier straps on her shoulder. At this point, the clinician comes eye to eye with mother where she had previously bent over to face the baby on the pillow, listening to mother empathically and nodding. She pauses for a moment and says, 'Her face looks so different to me' (it had been a few weeks since the family had attended a session). Sarah replies, 'Her facial features are kicking in.' Jessica, who has been sitting with father listening to this conversation, then slides off father's lap and clings to mother shoulder.

Coding: The clinician here receives codes of 3 for Reflective Functioning. A code of 3 indicates that the clinician is meeting expectations. The clinician could have received a higher code had she commented on the mother's assertion that Jessica is 'heavy,' alluding to the weight or burden she feels

in her role as a mother, an all too common experience. The clinician is not penalized by a lower score because she appears to target other interventions in this segment, mainly Emotional Attunement which she scored at a 5. The clinician's consistent efforts to orient mother to the infant's face and emotionality, while also commenting on Jessica's emotional state through vocalizations and facial expressions, is masterful. Clinician receives codes of 3 for Affect Regulation, as she is again meeting expectation for this code, but has not yet needed to enlist a more nuanced skill or intervention in this segment. Instead, she relies on Emotional Attunement. She receives a score of 4 for Reticence due to her ability to allow interactions to unfold while also maintaining a strong support presence indicating her ability to tolerate discomfort.

- 2-3: Jessica begins to fuss and vocalizes distress. Mother picks her up and hugs her saying, 'It's okay, I'm here, Jessie. I got you baby. I'm right here.' Jessica continues to fuss, and clinician asks, 'What is she telling us?' with a pained expression and says, 'Yeah she's telling us she's having a hard time.' Mother then asks Jessica, 'Yeah...what happened?' Child continues to cry and fuss. Clinician matches child's vocalizations and facial expressions. Mother says, 'I know you're mad, but it's okay.'

Coding: Clinician receives scores of 5 for Reflective Functioning, Emotional Attunement, Affect Regulation, Reticence, and Nurturance in this minute. The clinician's efforts to elicit reflection and care from mother towards the child, by asking reflective questions ('What is she telling us?') and by providing a supportive presence, attuning to the child while also privileging mother by practicing reticence so that mother can try to tolerate and cope with child's negative affect, all receive high scores for clinical acuity and skill. This minute highlights that it is not always necessary to 'do something' as a clinician, but rather support the dyad in navigating complex emotional and mental states.

- 3-4: While Jessica soothes, Arianna begins to fuss. Clinician gets up on her knees slowly while vocalizing, softly matching the distress of the infant. She touches father's shoulder gently, and asks, 'Can I give Arianna to you, Dad?' Father agrees. Clinician picks up Arianna while also making repetitive soothing sounds which appear to have a regulating affect for Arianna. Clinician hands Arianna to father. Once Arianna is in her father's arms, Jessica looks intently at her sister. Clinician smiles at Jessica and says, 'Yeah, you watch Arianna closely. You were watching her closely.' Jessica then becomes upset. Clinician matches child affect, scrunching her face and frowning. Mother asks

child, 'What happened?' while clinician looks to the toys on the other side of the room and gets up to retrieve a baby doll.

Coding: This segment is largely transitional and sets up for the next interventions. Clinician here receives a code of 3 for Reflective Functioning based on her comments directly towards Jessica, acknowledging her pause and awareness of Arianna. She receives a code of 5 for Emotional Attunement and Affect Regulation, especially regarding her support in calming Arianna. She receives a code of 5 for Reticence as well because she exhibits flexibility and is able to move in and out of a reflective and active stance as needed.

- 4-5: Jessica becomes interested in the clinician's behaviour, crawling off mother's lap and standing, looking on, but still protesting. Clinician gently picks up a baby doll but remains where she is located on the opposite side of the room and says, 'Oh, I thought I would grab another baby.' She presents the baby doll to the child slowly, 'We found another baby.' She slowly crouches down to Jessica's eye level. Jessica smiles, appearing interested and has since ceased crying. Clinician remains where she is, holding the baby, for a few moments while Jessica appears to consider all of this. Clinician repeats softly, 'We've got another baby here.' Jessica appears a bit apprehensive and mother notices, caressing Jessica's back. This leads Jessica to turn around and reach back out to her mother for comfort, beginning to cry again. Clinician says, 'Yeah, you don't want to leave mommy right now,' and comes closer to the child slowly with doll in hand. Once Jessica is in mother's lap, clinician comes close to child and mother, sitting on the floor, and places the baby doll gently in front of Jessica, saying, 'Hi baby.' Jessica settles in her mother's lap, again absorbed in the clinician's behaviour. Clinician picks up the baby doll, cradles it in her arms, and says, 'Aw, this baby has been crying too.' Clinician rocks the baby doll and rubs its head. Jessica is riveted, watching the clinicians every move. Mother says, 'See, it's okay.' Clinician looks down at the baby doll and says, 'See, it's okay baby.' Jessica then outstretches her arms, reaching for the baby doll, which clinician offers gently, much like one would with a real infant with the baby doll's head cradled in the crook of her elbow. Jessica smiles as she holds the baby herself. Clinician sits back and says, 'Hi baby,' softly and vocalizes calmly. Child looks intently at the baby doll as mother instructs, 'Nice. Nice.'

Coding: This is one of the most interesting and impactful segments of the entire video. The clinician here receives codes of 5 across all REARING concepts. The clinician here allows for the child to

symbolize her own experience within the baby doll but also provides an opportunity for Reflective Functioning, *i.e.*, babies have feelings too, allowing Jessica to become more comfortable with the idea of sharing her mother with Arianna. Therapist allows for child to see how to care for an infant through the doll, removing the distress and discomfort currently associated with Arianna.

5-6: Jessica remains interested in the baby doll's face. Clinician softly points to the baby doll's features, saying, 'Eyes,' and caressing the doll's face gently. Mother continues to instruct, 'Nice, nice.' Clinician says, 'Mouth, the baby's mouth,' and gently touches Jessica's arm as well. As clinician points out and touches the doll's mouth, mother protests, 'Don't do that.' Clinician states, 'You're worried that if she does it to the doll, she will do it to her sister,' pointing out mother's worry that Jessica will poke Arianna in the mouth.

Mother responds, 'All I know is she might stick a finger in there and ah!'

Clinician asks, 'Why do you think she does that?' While mother is thinking, Jessica hugs the baby doll and pats it on its back.

Clinician comments, 'Oh patting the baby,' and affectionately touches the child as well.

Mother responds, 'I don't know why she did, but she did it before.'

Clinician: 'I wonder if it's like a curious thing. It's almost like, suddenly she's seeing a little alive, little person.'

Coding: The clinician here continues the important therapeutic work from before helping Jessica attend to the baby doll, while also addressing some of mother's more practical worries about ensuring the safety of Arianna. The clinician here continues to receive scores of 5 in all REARING concepts, especially in her efforts to elicit Reflective Functioning from mother in wondering about Jessica's experience of adjusting to this new, 'little alive person.'

6-7: Clinician looks over to Arianna in father's arms, who is now beginning to fuss. Jessica continues to play with the baby doll as clinician softly asks, 'What do you see, Jessica?' as she looks over the doll. Clinician becomes aware that the separation from parent-child group to parent-only and child-only group is about to occur. She asks, 'For you guys for separation, do you want to try that? I know that from what we've been talking about with Jessica, it might be...' she pauses waiting for mother to fill in the blanks and to reflect on Jessica's experience. Mother doesn't respond so clinician continues gently, '...difficult for her?' She pauses, looking back and forth from mother to father, '...difficult for you?' Mother says, 'Not dif-

ficult for me, but maybe difficult for him. I don't know,' and gestures towards father. Clinician says to father, '...Because you don't get to see them as often and she's got them all the time,' as father does not currently live in the home with mother and the children. Father says, 'Yeah, and I worry she screams too much,' alluding to Jessica's difficulties with separation. Clinician understands how difficult this separation will be for all family members given the context of father's limited engagement with the children and Jessica's heightened sensitivity coping with the birth of a sibling. *Coding:* The clinician here is mindful about the impact of the separation on all family members at this vulnerable time, given father's limited interaction with the children and Jessica's vulnerability. The clinician here receives a score of 4 for Nurturance, and Reflective Functioning receives a score of 5 in her suggesting the difficulty with separation is not only felt by the children, but also by the parents. As such Emotional Attunement is rated a 5 as well, where Affect Regulation is rated a 4 because it is not the primary intervention, but clinician is working to ensure the regulation of potential future affects. Reticence is rated a 3 as it is also not the primary intervention at this time as clinician inhabits a more active stance.

7-8: Arianna begins to fuss. Clinician adjusts herself aligning more with Arianna and coming to face to face with her as father holds her in his lap. Clinician matches infant's affect and facial expression. Father works to soothe child and clinician places a hand on father's back which has a regulating effect on father as well. Jessica returns from playing on the other side of the room. Clinician looks at her playfully and mother says to Jessica, 'I'm here. I didn't go nowhere.'

Coding: During this segment, the clinician continues to support the family through the upcoming transition to parent-only/child-only group. As before, Reticence is rated a 3 as it is also not the primary intervention at this time and Nurturance is score as a 4. Emotional Attunement and Affect Regulation are paramount in this minute, as clinician assists father in regulating Arianna's affect while also remaining interested in Jessica's play. As such the clinician receives scores of 5 for these. Reflective Functioning receives a score of 3 as clinician promotes RF but it is not the primary therapeutic goal.

8-9: One of the psychology trainees, Ana, leaves the room to prepare for the separation to parent group. Jessica looks up at the trainee leaving and clinician says, 'Bye, Bye, Ana!' and waves, modelling healthy separation. Mother is talking about how Andrew, the father, is connecting with the new

baby, Arianna, but expresses concern that Jessica may not be getting enough time with her father. Arianna lets out a soft cry and mother says loudly, 'What happened?' Clinician responds softly, 'Hmm,' and then looking at Jessica, who has now redirected her gaze from the toy to her sister says, 'Oh, that baby.' Clinician turns to mother and says, 'Because she sees you caring for Arianna a lot, right?' Jessica approaches Arianna and brings a bubble wand close to Arianna's face. Clinician gets closer to father and Arianna to help facilitate this interaction. Clinician says, 'You want to share?' and gently touches Jessica's hand with the bubble wand to prevent any adverse contact on Arianna's face. Jessica hands the bubble wand to father and clinician sits back to allow this interaction to unfold. Clinician says, 'Daddy blow?' and hands the father the bubbles so he can insert the bubble wand. Father blows a bubble and clinician says, 'Wow!' and laughs with father when one of the bubbles lands on Arianna's head, stating, 'Oh! It's her first bubble.' Jessica offers father the bubble wand again, but this time reaches out both arms wanting to be picked up. Father responds, pulling Jessica into his lap and clinician responds, 'Ah, you want to get up too.' Mother exclaims, 'See!' feeling validated for her comment before about Jessica's need for father's attention and affection.

Coding: Clinician receives scores of 5 for Affect Regulation and Emotional Attunement for her efforts to attune to both children and to regulate mother with vocalizations when mother's response is loud and incongruent from the infant's. Clinician receives a score of 4 for Reticence, as she appears comfortable to tolerate uncertainty but is overall more active in this segment. She receives a score of 4 for Reflective Functioning due to her comments eliciting mother's understanding of Jessica's emotional states, but again, this is not the primary intervention as clinician makes efforts to connect father, Jessica, and Arianna.

- 9-10: Clinician says to father, 'You've got two sides,' as both girls are on either side of his lap. Father continues to play with Jessica as clinician practices reticence, looking on. Arianna begins to fuss and therapist leans in, placing a hand on the infant's back and making soothing repetitive noises. She strokes Arianna's hair, looking at Jessica on the other side of father's lap, and says, 'Yeah, just like the other baby,' and hands Jessica the baby doll again, 'Two little babies.' Clinician strokes the baby doll's head in a similar manner and Jessica is again absorbed in the clinician's play with the baby doll. Father smiles while looking at Jessica holding the baby. The session clip ends.

Coding: The clinician receives scores of 5 in Emo-

tional Attunement, Affect Regulation, Reticence, and Nurturance. Reflective functioning is scored as a 4 here, which while very high and above expectations, is not a 5 due to the verbal nature of RF comments which are not necessary here but often influence higher scores. This segment reconnects and solidifies many of the themes evident throughout the session. Clinician here is able to reconnect the interaction with the baby doll to the infant Arianna, bringing the symbolic into the tangible and into the here-and-now.

It is evident that even ten minutes of video can provide a rich and detailed narrative of the family's composition and the clinician's clinical acuity and skill. The clinician here builds upon the parents' innate strengths, as both mother and father show moments of reflection and understanding of both children's emotional and physical needs. It is clear that even the seemingly mundane moments in session can be understood more fully utilizing the observational power of one minute. The video example detailed above receives impressive scores for GABI competence throughout and is used as a training video for new clinicians due to the clinician's ability to attend to the entire family system, while also fostering symbolic play and providing a containing space for infant, toddler, and parents.

Discussion

The RCS is an important contribution to the ever-growing and intensely needed field of efficacy measures. It is one of a limited number of existing competency measures in children's mental health, and furthermore, one of a very few competency measures developed specifically for dyadic psychotherapy with parents and their infants and toddlers. The team began the development of RCS by referring to the literature and consulting directly with the developers of the intervention, Dr. Anne Murphy and Drs. Howard and Miriam Steele. This collaboration allowed for an accurate depiction of the core features of therapeutic action and provided the REARING model. These concepts, rooted in attachment research, psychoanalytic theory, and infant development, provided a useful framework from which clinicians could situate their interventions.

It is vital that clinicians utilize the REARING framework in order to disseminate GABI as its creators intended. As noted, novice GABI clinicians are trained in this framework via in-person training, taught by the developers of the model, and also receive an online training platform with theoretical lectures and clinical videos. While these types of training are vital, and establish the theories and practice of an intervention, they often lack the experiential component of disseminating the intervention in real time with real patients exhibiting a wide range of psychopathology.

RCS adds to this existing training structure by allow-

ing clinicians to practice coding videos of lead clinicians on these concepts, in order to hone their attention to these discrete features of therapeutic action unique to the GABI model. The vignette discussed above is one such video that new clinicians are expected to code in order to develop an understanding of the REARING model. In the example above, there are clear moments of impressive clinical skill, but also moments of missed opportunities, allowing clinicians to think further about how they might address such issues should they encounter similar interactions or content during their own sessions. In the interaction with mother and child, there were times the clinician could have attuned and reflected on mother's experience, such as the moment during which mother comments on the heaviness or burden she feels in her role as a mother. Clinicians in training can see such moments and extrapolate what they might do or say in similar situations, fostering reflection-in-action.

Furthermore, by allowing clinicians to code themselves, clinicians can evaluate the competency of their therapeutic interventions through this particular lens, ensuring treatment fidelity and an adherence to the specific principles of GABI, while fostering clinical skill and acumen. By assigning scores of 1 to 5, while considering what intervention may have warranted a higher score, is a valuable skill in promoting clinical agility and aptitude. As such, the RCS provides clinicians, supervisors, and researchers with a vital tool to measure the competency of interventions within an important parent-child attachment psychotherapy model.

Future directions

This paper outlines the development and structure of the REARING Coding System (RCS) and provides a case study to exemplify its use in supervision and training. A future study will detail in depth the piloting and iterative process of RCS, establishing the groundwork for reliability and content validity of the measure. It is the eventual goal of this measure to establish predictive validity; *i.e.*, that increased clinician competence as measured by RCS leads to better patient outcomes. RCS is currently being used in the dissemination sites for supervision purposes only.

Conclusions

RCS is one of the first clinician competency ratings of its kind, specifically developed for a dyadic attachment-informed psychotherapy for families with significant psychosocial stressors. RCS employs distinct anchors and provides examples from actual clinical video, allowing it to be easily understood and coded even by inexperienced clinicians and research assistants. It provides a way to conceptualize clinician effectiveness above and beyond simple adherence measures. Where adherence measures focus on the quantitative aspects of the inter-

vention, *i.e.*, whether the clinician employed the intervention or not, competence measures such as these, allow for observers and supervisors to evaluate if the intervention was effective within the larger context of the clinical interaction.

It is pivotal for all evidence-based treatments to measure competency in order to ensure the intervention is disseminated in a way that is both adherent to the manual, but also indicative of advanced clinical skill and an ability to flexibly employ interventions to meet the patient where they are in regard to demographics, psychopathology, and stage of therapy. It is our hope that the RCS provides one such way of measuring these nuanced clinical skills within the Group Attachment Based Intervention (GABI).

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