

A proposed conceptualization of therapeutic competence: the three level model

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ABSTRACT

A model of therapeutic competence that equally satisfies the requirements of practice and research is still lacking. The existing models are not widely accepted, at least partially because the postulated competences can often not be operationalized in a satisfactory manner. Yet, in order to be measurable, therapeutic competences need to be operationalized. We present the *Three Level Model of Therapeutic Competence* as a working model for studying therapeutic competence. The model proposes that therapeutic competence develops based on rather stable individual *Dispositions*, which promote the acquisition of therapeutic competences. We further distinguish between *Basic Competences*, which are mostly independent of the theoretical orientation of the therapeutic approach, and *Specific Competences*, which are defined based on the theoretical underpinnings of a therapeutic orientation (e.g. Cognitive Behavioral Therapy). We describe this model and outline how it can be used to operationalize and assess therapeutic competence.

Key words: Therapeutic competence; Conceptualization; Operationalization; Dispositions; Research.

Introduction

What is a good therapist? Over the years, numerous efforts have been made to answer this question and to identify core therapeutic competences (Fouad *et al.*, 2009; Guy, 1987; Purton, 1991; Rogers, 1957; Schaffer, Rodolfa, Hatcher, & Fouad, 2013). Despite this long research tradition, interest has subsided in the meantime and investigation in treatment models, intervention and outcome became more popular (Baldwin & Imel, 2013; Barkham, Lutz,

Lambert, & Saxon, 2017). Therefore, the person of the therapist became for some time an almost neglected variable in psychotherapy research (Bergin, 1997).

Nevertheless, understanding therapist's role in the therapeutic process requires a consensus-based definition as well as a generally accepted model of therapeutic competence. The approach to find a general accepted definition can be drawn on the work by Kaslow (2004). Following Kaslow (2004), competence is defined as *an individual's capability and demonstrated ability to understand and do certain tasks in an appropriate and effective manner consistent with the expectations for a person qualified by education and training in a particular profession or specialty thereof* (p. 775). In addition, Barber, Sharpless, Klostermann, and McCarthy (2007) adapted a definition from the field of medicine (Epstein & Hundert, 2002) on professional clinical psychology: *competence can be thought of as the judicious application of communication, knowledge, technical skills, clinical reasoning, emotions, values, and contextual understanding for the benefit of the individual [...] being served* (p. 494). While *competence* is understood as overall professional ability, the term *competency* describes single components of the performance. Accordingly, competencies are elements of competence (Kaslow *et al.*, 2004) and are further defined as involving the whole person and *being teachable, observable, measurable, containable, practical, derived by experts, flexible and transferable across settings, and continually reevaluated and redefined* (Rubin *et al.*, 2007, p. 453).

Besides a uniform definition, the investigation of therapeutic competence requires also a theoretical model. There is an ongoing debate about the question which therapeutic competences are central, especially in the area of Cognitive Behavioral Therapy [Cognitive Behavioral

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Therapy (CBT)] a generally accepted model is still lacking. A model of competence with a minimum of acceptance among researchers and clinicians is needed in order to allow measurement, to provide a framework of training and to possibly guide clinical practice. The lack of a consensus model is considered as a risk for science and practice of professional psychotherapy (Rodolfa *et al.*, 2013), especially because quality management is difficult and in fact impossible. Yet, it is a challenge to define therapeutic skills such that they are theoretically satisfying, but also allow operationalization (Schaffer *et al.*, 2013). Furthermore, the existing differences in theoretical orientations as well as national characteristics in training and licensure of psychotherapists also hinder reaching a consensus.

Most existing models of therapeutic competence can be subdivided depending on their focus. First, there are models elaborating the interaction between client and therapist within the therapeutic process. Examples are the experiential learning model of therapy process (Milne, Claydon, Blackburn, James, & Sheikh, 2001) or the generic model of psychotherapy by Orlinsky and Howard (1987). Second, other models focus on the acquisition of therapeutic competences. Examples are the declarative, procedural and reflective systems model (DPR-Model) of therapeutic skill development by Bennett-Levy (2006) or the phases of therapists and counselors development over the life span by Rønnestad and Skovholt (2013). Such acquisition models usually do not directly entail a competence perspective. Instead, they focus on the inner experience of the therapist in different phases of one's development as a professional. Third, some models of therapeutic competences describe the training of professional psychologists in general (Cube Model by Rodolfa *et al.*, 2005; Rodolfa *et al.*, 2013) or of psychotherapists in particular (Three-Stages Model by Hill, 2009). Those training models in most cases refer primarily to the training period starting with the beginning of therapeutic work and ending when the academic training is completed (*e.g.* licensure) or shortly thereafter.

Finally, Roth and Pilling (2007) published a competence framework as part of the British Improving access to Psychological Therapy (IAPT) program. Their map of CBT competences contains of generic therapeutic competences that are independent of the theoretical orientation of the psychotherapists as well as domains of specific competences that are formulated for CBT, for Psychoanalytic/Psychodynamic Therapy (Lemma, Roth, & Pilling, 2008) as well as for other theoretical orientation of psychotherapy and counseling.

All in all, the existing models of therapeutic competence have certain limitations. First, models developed for the training context are limited to the stages of the formal training. One may question whether such formal training stages (*e.g.* practicum, internship) describe the acquisition of therapeutic competences adequately. Indeed, these stages are not compatible with the acquisition of compe-

tences outlined by respective models such as the phases of professional development formulated by Rønnestad and Skovholt (2013). Accordingly, target skills for training are defined, but qualitative aspects of the acquisition of a competence are not outlined. Furthermore, although it is generally agreed upon that the gain in competence does not end with licensure but continues over the professional life-span, most competence models are formulated within the context of academic psychology and training and therefore *end* with licensure (Rodolfa *et al.*, 2013).

Besides, authors used different strategies for identifying key competences. As an example, Roth and Pilling (2007) focused on outcome research and reviewed the outcome literature for identifying effective manuals of psychological approaches and extracted the associated competences. Similarly, many authors studied therapeutic competence within the context of outcome (see Heinonen, Knekt, Jääskeläinen, & Lindfors, 2014; Hill *et al.*, 2008). Yet, therapy outcome studies are not designed to explore the influence of therapists' individual characteristics on the acquisition and development of therapeutic competence. Furthermore, outcome is influenced by many circumstances beside the competence of the therapist (James, Blackburn, Milne, & Reichfelt, 2001). The simple interpretation of the total correlation between therapists' variables and outcome is an oversimplification because not considering the level of analysis. Moreover, variability in therapists' variables are due to the patient and/or to the therapist (Wampold, Baldwin, Grosse Holtforth, & Imel, 2017). Therefore, any inferences about therapeutic competences driven from analyses of these total correlations must be treated with caution. Nonetheless, results from outcome studies might provide first clues which competences are relevant.

Furthermore, practical usability of some models must be questioned. Sometimes, the behavioral examples entail rather broad and abstract descriptions of a therapist's behavior and seem to have been derived in many cases without reliance on empirical findings. Beyond that, a clear operationalization is mostly lacking. In consequence, the use for within-session assessment of therapeutic competence is complicated. Moreover, competences and associated behavioral examples appear already quite complex for the first phase of professional development called as novices student phase (Rønnestad & Skovholt, 2013). In consequence, they do not seem to be applicable for beginner therapists in the pre-training phase (Skovholt, 2012) prior to professional training. Furthermore, Sharpless and Barber (2009) asked for teaching those competences to students that have been demonstrated to be teachable. The existing models do not differentiate between therapeutic skills that may be easier to train and learn as opposed to other domains that may more strongly reflect a person's dispositions. Similarly, the existing models do not specifically take into consideration that the acquisition of therapeutic compe-

tence may also be influenced by the therapist's individual characteristics.

All in all, a theoretical model of therapeutic competence is needed, that allows multi-method and multi-informant operationalization for assessment (Hatcher *et al.*, 2013; Kaslow, 2004), with high practicability and applicability to initial stages of clinical training.

We propose a new conceptualization of therapeutic competence. This working model is conceptualized such that it is empirically testable and, for the purpose of assessment, allows an operationalization of the defined competences. Also, it aims to facilitate a multimodal assessment of therapeutic competence by therapists, clients and non-participant observers. Furthermore, it is applicable for within-session assessment of therapeutic competence in initial stages of clinical training. The model further aims at providing a framework for the analysis of the developmental process including the consideration of individual traits that may or may not foster the competence development. Finally, the model takes into account that therapeutic competence is not exclusively defined based on a specific therapeutic approach. In the following, the *Three Level Model* will be described as a working model for investigating therapeutic

competence in the field of CBT. For identifying the competences, we combined a theoretical and an empirical research-driven approach. Accordingly, we reviewed theoretical essays from the last decades as well as therapeutic outcome literature.

In the following the *Three Level Model of Therapeutic Competences* will be presented in detail.

The three level model of therapeutic competence

We propose a *Three Level Model of Therapeutic Competence* as a heuristic framework for investigating therapeutic competence and its dispositions (Figure 1).

The *Three Level Model* proposes that therapeutic competence develops and can be trained, but also takes into account individual *Dispositions* which are postulated to be the basis for the acquisition of therapeutic competences. We further distinguish between *Basic Competencies*, which are mostly independent of the theoretical orientation, and *Specific Competencies*, which differ depending on the theoretical orientation. Here we refer to competences relevant in CBT.

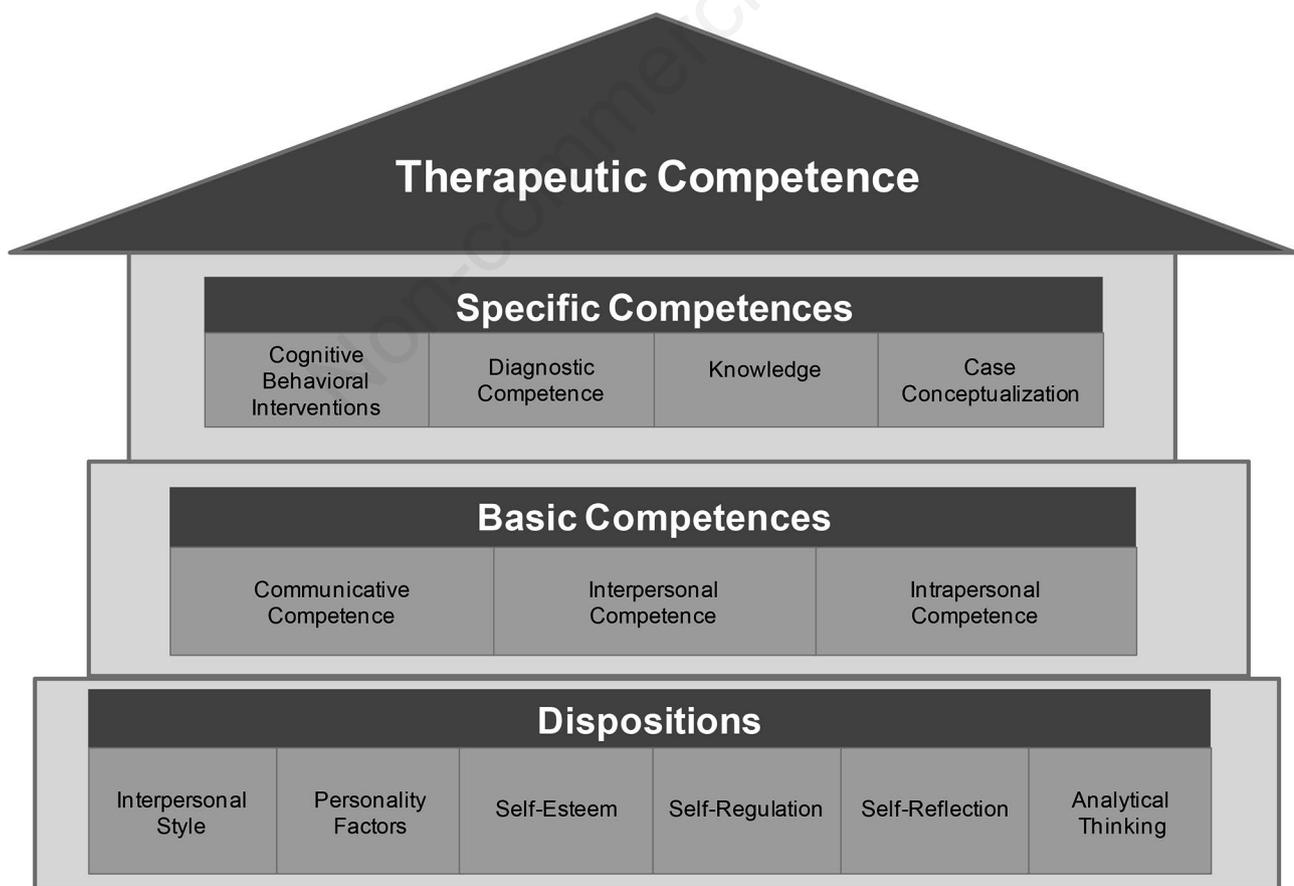


Figure 1. The *Three Level Model of Therapeutic Competence* within a cognitive-behavioral framework.

Individual dispositions as the basis of therapeutic competence

During the last decades, dating back to the 1980s, therapists' individual dispositions were investigated in terms of their predictive value (Costanzo & Philpott, 1986; Guy, 1987). Findings were often inconsistent and lacked robustness, and finally research on the therapist as a person declined (Beutler, Machado, & Neufeldt, 1994; Caspar & Eversmann, 2009). As a consequence, theoretical accounts about potentially more or less favorable individual characteristics of therapists' are still rather vague. Concerning the finding that some therapists are consistently more successful than others (Wampold *et al.*, 2017), the discussion about what characterizes this exceptional therapists goes on and brings new power to the topic of therapists' characteristics.

Although the lack of consideration of *beneficial and malign characteristics* (Aveline, 2005, p. 155) has been widely criticized (Ackerman & Hilsenroth, 2001; Aveline, 2005; Bergin, 1997), dispositions find little consideration in current models of therapeutic competence. An exception is the aspect *interpersonal behavior of the therapist* that is considered in the Social Competencies in Interpersonal Process (SCIP) Model by Mallinckrodt (2000). The SCIP model focuses on the contribution of therapists' *social competencies and dispositions* to the therapeutic process (Mallinckrodt, 2000, p. 241). In a similar vein, Hatcher and Lassiter (2007) emphasized the importance of personality characteristics and intellectual and personal skills that students bring with them to professional training. Accordingly, they specify several interpersonal, cognitive and reflective skills such as *the ability to listen and be empathic and respectful of others...critical thinking...[and] the ability to examine and consider one's own motives, attitudes and behaviors* (Hatcher & Lassiter, 2007, p. 60). All in all, Schmelzer (1997) concluded that the catalogue of therapists' personal characteristics represents mostly a collection of socially desirable personality traits. Overall, current models regarding therapeutic competencies outline the role of dispositional factors only tentatively or not at all. To what extent such individual traits may influence the training and acquisition of therapeutic competency is often not specified and, therefore, research is lacking. In order to enable empirical research, *Dispositions* should be included in theoretical models of central therapeutic competences. That therapists' interpersonal skills are discussed as central in the research about exceptional therapists (Barkham *et al.*, 2017) is further evidence of this approach.

Much of what we know about the predictive value of certain therapists' characteristics for therapeutic competence comes from older studies (Costanzo & Philpott, 1986; Guy, 1987; Loo, 1979; Purton, 1991), which, due to methodological problems like absence of psychomet-

rical validation of the used assessment methods or only indirect assessment of therapeutic competence via essays or role-plays, only allow rather limited conclusions. Furthermore, these earlier studies have focused mostly on aspects such as the academic performance and interpersonal interaction style as potential predictors. By contrast, other possible predictors like self-esteem have not been systematically investigated. Other studies investigated relevant dispositions based on results of outcome studies. For example, in a study on the outcome of patients suffering from various mental disorders, therapists' professional self-doubt was positively associated with outcome (Nissen-Lie, Monsen, Ulleberg, & Rønnestad, 2013). However, it must be noticed that the study included primarily psychoanalytic/psychodynamic therapist, only one-third of the participants reported a mainly cognitive orientation. The theoretical orientation of the investigated sample might have had an influence on the reported results. Nevertheless, such self-doubting is possibly influenced by dispositional self-reflection. Similarly, hostility has been shown to be negatively related to outcome (Henry, Schacht, & Strupp, 1986, 1990) and as a trait may constitute a disposition that negatively impacts therapeutic competence. The limitations of findings driven from outcome studies are already discussed above. Wampold *et al.* (2017) call for a differentiation between therapists' action and the personal characteristics he already brings to the therapy for understanding the beneficial therapists' variables. In our understanding, the inclusion of individual *Dispositions* in a model of therapeutic competence as a separate level is a further necessary step in promoting research in this area.

We define *Dispositions* as therapists' individual characteristics that already present prior to the professional training and/or work as a therapist. We postulate *interpersonal style, personality factors, self-esteem, self-regulation, self-reflection* and *analytical thinking* as central characteristics. *Dispositions* are presumed to be less malleable or even trainable. Importantly, however, we postulate that they effect the acquisition of therapeutic competences. Depending on therapists' individual characteristics, the difficulty of training might differ and as well the competence level that may be achieved.

The level *Dispositions* of the *Three Level Model* consists of six components that will be addressed in the following in more detail.

Interpersonal style

Some models of therapeutic competence like the SCIP model (Mallinckrodt, 2000) consider the aspect of the therapist's interpersonal behaviour. While Mallinckrodt (2000) clearly regards this as a disposition, other models like the US Benchmark Model (Fouad *et al.*, 2009) do not differentiate strictly between interpersonal behavior as a dispositional trait versus a therapeutic competence. Accordingly, descriptions of beneficial interpersonal behavior are often

global and unspecific like *maintains satisfactory interpersonal relationships with clients* (Fouad *et al.*, 2009, p. 12). Operational definitions of appropriate interpersonal competence are often lacking, thus making the assessment quite challenging. The role of therapists' *interpersonal style* has mostly been studied within the context of therapeutic outcome. For example, Benjamin's (1974) structural analysis of social behavior (SASB) model has been used to elucidate this relationship. Hostile, belittling and blaming behaviors of the therapist were found to be associated with less successful therapies (Henry *et al.*, 1986, 1990). In sum, however, our knowledge of beneficial (or maleficent) interaction behavior of therapists is quite limited. Moreover, there is little consensus which interaction behaviors are helpful or not helpful. A good example is the behavior style *dominance*. Some researchers advocate less dominance as positive (Beutler *et al.*, 1994), others question a purported detrimental influence of therapist's dominance. Specifically, therapeutic outcome may be enhanced by a more dominant behavioral style of the therapist because the patient may feel safer (Engvik, 1999).

We suggest that *interpersonal style* refers to an adequate interpersonal behavior, this means a person can adjust their interpersonal behavior depending on the counterparts' feelings and is able to engage in positive interpersonal interactions. The interaction style is cooperative and open (Purton, 1991) and not characterized by craving for power or recognition and by a desire to control (Dobson & Shaw, 1993; Guy, 1987) or by hostility (Dobson & Shaw, 1993; Henry *et al.*, 1986). While dominance may be sensitive to change by training, we assume that other facets of interpersonal style are less malleable by training (*e.g.* caring attitude or dependability).

Personality factors

Beutler *et al.* (1994) is one of very few researchers who explicitly referred to personality as a relevant trait contributing to therapeutic competence. Unfortunately, the role of therapists' personality in regard to therapeutic competence has rarely been explored (Baldwin & Imel, 2013). Conclusions are difficult to draw given that there are few findings and that the obtained effects seem small and even heterogeneous (Antonuccio, Lewinsohn, & Steinmetz, 1982; Beutler *et al.*, 1994). Based on the *Big Five* (McCrae & John, 1992), agreeableness, conscientiousness, low levels of neuroticism, and a moderate degree of extraversion have been for example proposed as beneficial characteristics of a therapist (Engvik, 1999). In Engvik's study (1999), students were asked whom of their fellow students they would choose as therapist. These individuals' preferences were related to the personality of the chosen *therapist*, as rated by peers. Clearly, one may argue that these individual preferences primarily reflect a person's popularity and the social desirability of certain personality traits rather than actual interpersonal style. Other authors also emphasize the relevance of openness

to experiences for therapeutic work (Doering-Seipel, Schüller, & Seipel, 2000).

In line with these findings, we suggest that high agreeableness, high conscientiousness, high openness to experiences, low to moderate neuroticism and moderate extraversion are beneficial personality traits that, in and by themselves, are relevant for the acquisition of therapeutic competence by hindering or facilitating it (Doering-Seipel *et al.*, 2000; Engvik, 1999).

Self-esteem

Therapist's self-esteem is less considered in models of therapeutic competence and is accordingly little explored. There are some research findings that clients of therapists with higher self-confidence benefit more from the therapy (Williams & Chambless, 1990). Though, Williams and Chambless (1990) refer to clients' prospective ratings of therapists' characteristics. Although findings regarding therapists' self-esteem are inconsistent, they suggest that low self-confidence is an unfavorable characteristic of psychotherapists (Beutler *et al.*, 2004).

In our model, we refer to *self-esteem* primarily as the emotional component of a person's self-concept. Putatively, an adequately (but not excessively) high positive self-esteem and a concomitant absence of severe self-doubts are beneficial dispositions for acquiring therapeutic competence.

Self-regulation

As *self-regulation*, we summarize *self-efficacy*, *emotion regulation* and *self-care*. *Self-efficacy* describes an individual's expectation that a situation is manageable by one's own resources and competences (Bandura, 1977), in addition, a distinction is made between general and more behavior-related (*e.g.* occupational) self-efficacy. We know no model of therapeutic competence that explicitly includes therapists' self-efficacy as disposition for therapeutic competence, accordingly there is less research on its impact on therapeutic competence. However, occupational self-efficacy has been investigated in counseling. In these studies, occupational self-efficacy correlated positively with performance and counselors' satisfaction and negatively with anxiety during counseling (Larson & Daniels, 1998; Lent, Hill, & Hoffman, 2003). Considering theories of general self-efficacy, self-efficacy is amongst other factors associated with higher staying power, higher thoroughness and less anxiety for difficult tasks and more physical and mental health (Aronson, Wilson, & Akert, 2002). At least some of these aspects might be of relevance for the development of therapeutic competence. Possibly, these aspects are also relevant and beneficial for the acquisition of therapeutic competence and for psychotherapists in general. Hence, higher perceived *self-efficacy* regarding to the optimistic estimation of general life coping strategies may be an important beneficial disposition for therapeutic competence.

Emotion regulation refers to the therapists' strategies to influence their own experience of emotions. The ability to influence one's own emotional state has been considered as a beneficial therapeutic characteristic because it promotes therapists' emotional stability (Beutler *et al.*, 2004; Strauss & Kohl, 2009). Adequate emotion regulation has even been discussed as a criterion for selecting candidates for psychotherapy training (Purton, 1991). Other models postulate that emotion regulation constitutes a therapeutic competence primarily relevant for handling emotional topics during session (Roth & Pilling, 2007).

We understand *emotion regulation* as the ability to modulate the emotional experience by emotional regulation strategies (*e.g.* acceptance or refocusing) and thereby controlling and positively influencing its intensity, length and expression. In our model, emotion regulation is a dispositional trait contributing to therapeutic competence: therapists' own emotional stability and, concomitantly, not being overwhelmed by own feelings are the basis for responding professionally (*i.e.* empathically and sensitively) to the needs of the patient.

Self-care describes therapists' individual strategies (such as optimism, vitality and positive mood) to restore and conserve one's own personal resources and to maintain emotional stability for preventing distress by integrating self-care strategies into everyday life (Wise, Hersh, & Gibson, 2012). In contrast to the previous disposition *emotion regulation*, *self-care* relates to specific behaviors and includes activities like exercising, reading or traveling, but also includes spiritual activities such as religious exercises (*e.g.* praying) or meditation (Mahoney, 1997; Wise *et al.*, 2012). Emotional well-being is closely related to ongoing self-care and, as such, has already been suggested by Beutler *et al.* (1994) as a pertinent therapist characteristics. The importance of psychotherapists' self-care (Elman, Illfelder-Kaye, & Robiner, 2005; Norcross, 2000; Wise *et al.*, 2012), and especially potential difficulties in engaging in self-care has been addressed by many experts in the field (Figley, 2002). Wise *et al.* (2012) emphasize *the interplay between care of the self and care of the other* (p. 488). Although there are some approaches for ensuring therapists' well-being by methods of self-care (Norcross & Guy, 2007), there is surprisingly little empirical evidence that demonstrates the relevance of self-care as a therapeutic competence.

We define *self-care* as those individual strategies which a therapist relies on for promoting their own emotional well-being. This component includes one's ability to get one's mind off the job, to relax without thinking about work as well as knowing and performing activities to switch off and recover.

Self-reflection

Self-reflection can be defined as *the observation, interpretation and evaluation of one's own thoughts, emotions and actions, and their outcomes* (Bennett-Levy, 2006, p. 60). Therapist ability to self-reflect is often listed as a fa-

vorable therapist characteristic (Dryden & Feltham, 1994; Guy, 1987) and *reflection* is postulated as key competence for the development of expertise in the models by Bennett-Levy (2006) and Skovholt and Rønnestad (1992). Furthermore, the US competency models entail reflective practice as a relevant competence (Hatcher *et al.*, 2013; Rodolfa *et al.*, 2005). Although self-reflection has also been proposed as a selection criterion for candidates (Purton, 1991), there is no empirical research on this subject known to us. One of the main reasons for this is most likely the difficulty to operationalize this competence and accordingly the lack of appropriate assessment instruments.

We define *self-reflection* as mental self-observation of one's own thoughts, emotions and actions during and after a certain situation or directed on the future (Dauber, 2006). The therapist is able to observe their own behavior, to think without prejudices from different perspectives, and to accept and reflect criticism (Dryden & Feltham, 1994). Furthermore, *self-reflection* is the basis that enables therapists to make selective decisions about the appropriate use of certain interventions (Bennett-Levy, 2006).

Analytical thinking

Models of therapeutic competence and theoretical elaborations on key competences differ in how they construe the role of the therapist's intellectual ability. Some authors suggest that therapeutic competence is unrelated to intellectual abilities as inferred from academic performance (Carkhuff, 1969). Consistent with this line of thinking, current grade-point average did not predict the success of college students participating in a counseling training for improving helping-skills (Hill *et al.*, 2008). This finding might be limited by the fact that competence was only rated by counselors, clients and in addition derived from counselors' verbal behavior, but there was no rating by an external observer. In contrast, intellectual ability has been proposed as a prerequisite, and accordingly as a selection criterion (Dobson & Shaw, 1993; Dryden & Feltham, 1994; Purton, 1991). Indeed, intellectual ability has been conceptualized as a part of *thinking like a psychologist* (Elman *et al.*, 2005, p. 369) with a particular emphasis on critical and logical thinking. In addition, Hatcher and Lassiter (2007) emphasize cognitive skills as one of the intellectual abilities a trainee must bring to graduate training. It should be noted that, at least implicitly, analytical thinking is implemented as a selection criterion for psychotherapy students in many countries (*e.g.*, USA, Germany, Netherlands) due to the fact that admission to training programs in clinical psychology is highly competitive with academic performance often being the most crucial requirement. As a consequence, psychotherapy students are quite likely to be rather homogeneous which could obscure the actual influence of analytical thinking. Possibly, there is a benefit of intellectual ability in accounting for therapeutic competence initially, which may dissipate over the course of training (Costanzo & Philpott, 1986).

We conceptualize *analytical thinking* as the ability to take the meta-perspective by abstracting, reasoning and recognizing rules and principles toward developing an appropriate case formulation and treatment plan as well as adjusting the latter in an ongoing manner.

Level basic competences

The second level *Basic Competences* represents competencies, which are postulated to be basic skills for working as a therapist. They are conceptualized as universal regardless of the theoretical therapeutic approach. *Communicative competence*, *interpersonal competence* and *intrapersonal competence* are postulated to be teachable components of therapeutic competence.

Communicative competence

The first component *communicative competence* comprises key elements of therapeutic communication like empathy, beneficial basic attitude and several basic communication competences. Empathy is indisputably a key element of therapeutic competence (Dobson & Shaw, 1993; Guy, 1987) and its relation to therapy outcome has been discussed intensively (Greenberg, Watson, Elliott, & Bohart, 2001). In fact, there seems to be a moderate correlation between empathy and therapy success (Elliott, Bohart, Watson, & Greenberg, 2011). Whether empathy is teachable or not, is a matter of controversy (Hill & Lent, 2006). By conceptualizing empathy as a *Basic Competence*, we share the view that empathy is teachable – at least to some extent. Within the context of client centered therapy (Rogers, 1957), empathy has been defined as the understanding of the emotional connotation in addition to mere content. The therapist is able to develop and show both an emotional and cognitive understanding of clients' assumed emotional state (Thwaites & Bennett-Levy, 2007) and to take on the clients' perspective and their individual system of thoughts and personal values. Being a rather broad category, communicative competence also encompasses other aspects of therapists' basic attitudes such as genuineness and positive regard for which recent studies had shown moderate associations with therapeutic outcome (Farber & Doolin, 2011; Kolden, Klein, Wang, & Austin, 2011). Similarly, the personality of the therapist has been supposed to be characterized by warmth, caring, kindness and trustworthiness (Ackerman & Hilsenroth, 2003; Guy, 1987). Finally, communicative competence also entails basic communication skills like active listening, the art of questioning and guided discovery (Guy, 1987; Newman, 2010; Rogers, 1957; Roth & Pilling, 2007).

Interpersonal competence

This competence denotes both the establishment and maintenance of a working alliance, but also the adequate

role behavior of the therapist including a confident professional appearance. These aspects were summarized as *interpersonal competence* because they focus on the interaction between therapist and client. Barkham *et al.* (2017) summarized current research and concluded that differences in therapists interpersonal skills might explain most of the variability in therapists outcomes.

The importance of a therapeutic alliance is highlighted in numerous models and theoretical considerations (Grawe, Donati, & Bernauer, 1994; Horvath, Del Re, Flückiger, & Symonds, 2011; Sudak, Beck, & Wright, 2003). Most importantly, much research has been devoted to elucidating its influence on therapeutic outcome. Despite being somewhat heterogeneous, findings suggest that a good working alliance has a moderate sized favorable effect on patients' outcome (Horvath *et al.*, 2011; Martin, Garske, & Davis, 2000).

Aside from working alliance, *interpersonal competence* also refers to the therapist's ability to comply with the role of a professional therapist. Specifically, this concerns the optimal regulation of closeness and distance within the therapeutic setting (Langer & Frank, 1999; Willutzki & Laireiter, 2005). This aspect has received surprisingly little attention of researchers and, to the best of our knowledge, there are no international publications that address this aspect of competence. Also, an appropriate professional appearance is rarely mentioned in the literature. As an example, Leith, McNiece, and Fusilier (1989) see therapists' posture and clothes as an important part for conveying a professional and confident attitude to the clients (see also Hatcher & Lassiter, 2007).

We postulate that therapists' competences to develop and maintain a therapeutic alliance as well as an adequate role behavior and professional appearance are essential facets of *interpersonal competence*.

Intrapersonal competence

Intrapersonal competence focuses on therapists' emotional security during sessions. Few models of therapeutic competence explicitly address therapists' emotional stability during a session. Yet, Roth and Pilling (2007) emphasize the relevance of the competence to handle the emotionality of sessions, the same did Langer and Frank (1999). In our working model this component covers the aspects sovereignty, which is expressed in a calm and clear voice and also relaxed posture. All in all, the therapist is not overtaxed with the contents of the session.

Level specific competences

Finally, we propose that *Specific Competences* contribute to therapeutic competence. Unlike *Dispositions* and *Basic Competences*, we further assume that these *Specific Competences* need to be defined depending on the

theoretical assumptions of each therapeutic approach. Here, we outline *Specific Competences* within the context of CBT, and therefore specify the components *cognitive behavioral interventions, diagnostic competence, knowledge* and *case conceptualization*.

Cognitive behavioral interventions

This therapeutic competence refers to specific CBT competences which have already been proposed by previous models of therapeutic competences, though not necessarily all within one model (Hatcher *et al.*, 2013; Rodolfa *et al.*, 2013; Roth & Pilling, 2007). Yet, how much of the variance in outcome is due to specific techniques is not entirely clear, but it seems to be a small percentage (Beutler *et al.*, 2004; Wampold, 2001).

CBT represents a goal-oriented approach with a focus on problem solving and solution orientation (Grawe, 2007; Roth & Pilling, 2007; Sudak *et al.*, 2003). As such, CBT is explicitly resource-oriented (Duckworth, Steen, & Seligman, 2005; Grawe, 2007). Thus, therapists need to have competences in resource activation such as recognizing and reinforcing clients' strengths, and supporting clients in engaging in resource-oriented behaviors. In addition, CBT relies on the active participation of the client. Accordingly, the therapist is supposed to encourage the client to take on an active role and to come up with own solutions, and at the same time to abstain from specific advice. In addition, in order to gain a better understanding of the patients' behavior and its determinants, the therapist encourages the client in reflecting own behavior. Hence, the therapist is required to nurture clients' self-management competences (Kanfer, 2006; Kanfer & Schefft, 1988). To this end, the therapist should have expertise in conveying positive treatment expectations, what can be understood in terms of allegiance which was postulated by Wampold (2001) as a central factor for the efficacy of psychotherapy. Consistent with the underlying problem-solving approach, a CBT therapist should be competent at structuring the session. Formal structuring includes that the therapist plans a session as a sequence of different phases (warm-up, working, cool-down). Beyond the formal structure, the therapist needs to establish and pursue the focus of the session. Most models of therapeutic competence include the ability to structure a session (*e.g.* Roth & Pilling, 2007; Sudak *et al.*, 2003). Furthermore, the therapist needs to be able to recognize the emotional state of a client and flexibly adjust the session and own behavior. Our model does not explicitly list specific CBT techniques like cognitive restructuring, socratic questioning, behavioral activation, behavioral tests or exposure as these can be subsumed as problem-specific competences (Roth & Pilling, 2007). We believe that a model of therapeutic competence needs to be parsimonious and, therefore, should primarily define broader categories of competences rather than building upon more or less exhaustive lists of specific techniques.

Diagnostic competence

Operationalized and criterion-oriented diagnostic is a central aspect of psychotherapy (Rief & Stenzel, 2011) and, moreover, qualified diagnostic is the basic requirement for a disorder-specific treatment. Various models of therapeutic competences include diagnostic competence (Hatcher *et al.*, 2013; Leith *et al.*, 1989; Rodolfa *et al.*, 2013). Interestingly, however, little is known about the actual relevance of diagnostic competence. In line with previous models (Kaslow, 2004) in our model, diagnostic competence refers to mastering diagnostic decisions based on classification systems (*e.g.* DSM-5, American Psychiatric Association, 2013) and to the evidence-based selection and use of assessment instruments and the psychometrically informed interpretation of psychological tests.

Knowledge

Many models of therapeutic competence include *knowledge* as a therapeutic competence (Fouad *et al.*, 2009; Kaslow, 2004; Rodolfa *et al.*, 2013; Roth & Pilling, 2007). Consistent with the scientist-practitioner model, a therapist is characterized as being *scientifically-minded* (Kaslow, 2004, p. 776). Generally, *knowledge* is conceptualized as an understanding about biological, psychological and sociological models of mental disorders, their development, distribution and treatment, and in addition an understanding about statistics and research methods (Rodolfa *et al.*, 2013; Strauss & Kohl, 2009). Although *knowledge* is included in many models of therapeutic competence, there is surprisingly little systematic research on the importance of knowledge. As stated earlier, there are several instruments for assessing knowledge which have a number of limitations (*e.g.* EPPP, Rehm & Lipkins, 2006). Yet, to the best of our knowledge, these instruments have not been investigated within the context of therapeutic competence.

In our model the component *knowledge* encompasses the knowledge of models of disorders and the psycho-bio-social processes involved in the development, maintenance and treatment of disorders. In addition, the therapist needs to have a thorough methodological expertise in order to be competent at making informed judgments of research findings.

Case conceptualization

As pre-requisite for treating clients, it is pivotal that the psychotherapist is able to organize and integrate assessment data in a meaningful way by taking into account available theoretical considerations and research findings in order to gain an understanding of the client's current symptomatology and behaviors (Porzelius, 2002). This so-called *case conceptualization* has been considered a core therapeutic competence which reflects theory, research and clinical practice (Kuyken, Fothergill, Musa, & Chadwick, 2005; Sudak *et al.*, 2003). Clearly, *case con-*

ceptualization strongly depends on the therapeutic approach. At least within the context of CBT, the therapist is supposed to think *like an empiricist* (Newman, 2010, p. 14). Moreover, we believe that CBT-therapists should be competent at formulating a cognitive conceptualization, *i.e.* that clients' underlying assumptions about themselves and the world are identified (Cognitive Conceptualization Diagram, Beck, 1995). For developing a conceptualization about an individual client, the therapist has to collect descriptive information about the client and then integrate them into hypotheses about causes, precipitant and maintenance (Eells, 1998). A *case conceptualization* is especially important for therapy outcome when clients' symptomatology is complex or when comorbidity is high (Kendjelic & Eells, 2007). Interestingly, there is ongoing controversy as to whether case conceptualization is trainable (Sudak *et al.*, 2003) or not (Dobson & Shaw, 1993).

Our model includes *case conceptualization* as an essential therapeutic competence.

The three level model of therapeutic competence and its practical use

The main reason for developing *Three Level Model of Therapeutic Competence* was to create a measurement model that holds promise for developing instruments for assessing therapeutic competence from different perspectives (*e.g.*, therapist, client), using self-report as well as observational measures, and relying on different measurement points (*e.g.*, during session, before/after therapy). *Dispositions* can be assessed using standardized self-report questionnaires. For example, *personality factors* can be measured using personality questionnaires such as the NEO-FFI (Costa & McCrae, 1985) and *self-esteem* can be measured by the Rosenberg Self-Esteem Scale (Rosenberg, 1989). Possibly, *analytical thinking* may be inferred from the performance in intelligence testing that specifically focuses on this intellectual ability. Accordingly, we postulate that most components at the levels of *Basic Competences* and *Specific Competences* are amenable to multi-informant (*i.e.* the different perspectives of therapist, client and observer) and multi-modal assessment (*e.g.* ratings, case vignettes, behavioral observations) and can potentially also be assessed during sessions.

Conclusions

In our view, the competency model as outlined here holds promise in that it provides a heuristic framework for developing and testing such assessment instruments, takes into account the issue of training and development of therapeutic competence, and its possible relationship to treatment outcome.

Crucial questions are whether the assumptions of the

Three Level Model of Therapeutic Competence concerning the influence of *Dispositions* and the differentiation between *Basic* and *Specific Competences* are empirically tenable. Furthermore, it needs to be tested if the model can indeed serve as theoretical basis for the development of multi-informant and multi-modal instruments to assess therapeutic competence.

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