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What Competencies Should Therapists Acquire and How Should They Acquire Them?

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Arguably, the primary goal of training in psychotherapy is to help trainees develop and/or improve competencies. *Competencies* can be viewed as knowledge, skills, and attitudes that are components of acceptable clinical performance (Fouad et al., 2009) or, in the absence of clear empirical definition, of what is assumed to be acceptable performance. The goal of this chapter is to present a landscape of current training practices with regard to competencies that are being taught and methods that are used to do so. This landscape should be viewed as neither comprehensive nor prescriptive. Furthermore, it unveils no new territory. Our intention is to offer a brief overview, or primer, of a wide range of training practices that have been implemented, more or less systematically, and that programs might want to consider when making decisions about what competencies to foster in students and how to foster them. In doing so, we also aim to provide a conceptual context for the training and supervision practices that are presented in this book. In this respect, the current chapter is complementary to the empirical context provided by Chapters 3 and 4: While we address some of what has been done, Chapters 3 and 4 describe what we know empirically about what has been done.

https://doi.org/10.1037/0000364-002
Becoming Better Psychotherapists: Advancing Training and Supervision, L. G. Castonguay and C. E. Hill (Editors)
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In order to offer a broad view, the first two authors recruited scholars (all one of them involved in the Penn State Conferences on training) who, as a group, represent different orientations (behavioral change and insight-oriented approaches), regions of the world (Europe, North America, Latin America), professional backgrounds (clinical and counseling psychology), and graduate programs (PhD and PsyD). In addition, while all authors have been involved in the training of graduate students or medical residents, a number of them have also trained and supervised experienced therapists in private practice or clinical trials.

To guide our effort, we reviewed three well-known competency-based training frameworks, spanning perspectives from the European and North American continents (EACLIPT [European Association of Clinical Psychology and Psychological Treatment] Task Force on "Competence of Clinical Psychologists," 2019; Fouad et al., 2009; Roth & Pilling, 2008). All of them include competency domains that substantially converge, but only one of them focuses specifically on psychotherapy training (Roth & Pilling, 2008). This framework was thus adopted to collect our diverse perspectives on training. Specifically, the first two authors asked their colleagues (and themselves) to identify competencies related to three broad domains: generic therapeutic competencies, basic theory-specific competencies, and metacompetencies. In addition, authors were asked to identify training methods to facilitate the development of competencies identified within each of the three categories. The first two authors then integrated the answers provided—adopting, whenever possible, a transtheoretical perspective. They did so while recognizing the somewhat arbitrary nature of their decisions with regard to the categorization of competencies within particular domains. They also combined the answers regarding the methods of training within one section because of the substantial level of overlap among the methods identified across domains.

GENERIC THERAPEUTIC COMPETENCIES

Generic therapeutic competencies pertain to basic (though not necessarily simple or straightforward) capacities that are broadly relevant to most of the activities in which psychotherapists find themselves involved. Important generic competencies cut across demonstration of knowledge attainment and application in areas, such as assessment, case formulation and treatment planning, intervention delivery, and ethics.

Assessment

Generic assessment-related psychotherapy competencies involve knowledge of assessment methods and diagnostic models. This can include formal systems of disorder categories such as the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), the *International Statistical Classification of Diseases and Related Health Problems* (World Health Organization, 2019), and the *Psychodynamic Diagnostic Manual* (Lingiardi & McWilliams, 2011). However, assessment-related competencies should not be limited to these diagnostic classification systems and should extend to pandiagnostic factors that are relevant to problem formulation and prognosis. One such factor is patient motivation for change (Arkowitz et al., 2015). Knowledge of risk indicators (e.g., harm to self or others) and risk assessment approaches can also guide decisions related to treatment modality (e.g., crisis interventions) and referrals (Reeves, 2015; Swift et al., 2021).

Case Formulation and Treatment Planning

Case formulation refers to the generic skill of integrating information that is relevant to the patient's complaints, difficulties, and strengths, as well as the factors involved in the development and maintenance of current problems (Eells, 2015). The case formulation sets up initial plans for treatment: the targets of therapy, the interventions that could be implemented, and ways to implement them to foster patient improvement (King & Boswell, 2019). The establishment of case formulations and treatment plans involves more than the cognitive ability to process and synthesize the complex realm of clinical information. It also requires an ability to work collaboratively with patients to establish agreement on the nature of the concerns, the framework for the treatment, and the expectations regarding the tasks and goals of the treatment (also referred to as a treatment "contract"; King & Boswell, 2019). Part of this process involves providing sensitive and clear feedback to patients regarding one's understanding of the concerns and what is likely to be helpful within the treatment (Finn, 2020). Aspects of this early treatment contracting process may not be obvious to novice trainees; for example, setting rules and boundaries regarding patient responsibilities related to attendance, payment of fees, and expectations about the availability of the therapist outside of sessions. Many of these elements fall under the umbrella of role-induction, which includes the explicit communication about the nature and goals of therapy, task and outcome expectations, and preparation for common therapeutic impasses (Walitzer et al., 1999).

Intervention

Varied generic intervention-related competencies relate to the knowledge, skills, and attitudes associated with developing and maintaining positive therapeutic relationships. Far from being exhaustive, these include communication skills (e.g., verbal fluency; Anderson et al., 2016; see also Chapter 8, this volume), working alliance development and maintenance capacity, empathy, acceptance, and genuineness/congruence (see Norcross & Lambert, 2019). Motivation enhancement skills (e.g., rolling with resistance and supporting self-efficacy) have also proved to be transtheoretically relevant and worthy of focus in training (Arkowitz et al., 2015). In addition, knowledge related to and application of a

multicultural orientation (cultural humility, cultural comfort, and cultural opportunities; Davis et al., 2018; Owen et al., 2017) can also be considered a generic competency (Owen et al., 2017), as is the development of an "other-oriented" stance and ability to sensitively explore effects of oppression (e.g., due to racism, sexism, classism) on the patient's personal experiences and concerns (Tao et al., 2015).

Interpersonal and communication skills extend beyond immediate work with the patient to effective collaboration with other professionals (Falender & Shafranske, 2020). For psychotherapists, this involves consultation with medication prescribing professionals, which also underscores the importance of a basic knowledge of commonly prescribed pharmacotherapies. Communication and consultation skills are also relevant when navigating the decision to refer a patient to another therapist when treatment is stalled or there is an indication for an alternative approach.

Nevertheless, generic competencies are not restricted to relationship-oriented interventions. An additional skill that may assist in learning and implementing these factors is the skill of measurement-based care (Boswell et al., 2015). This includes routine monitoring of agreed-upon valued outcomes as well as patient perceptions of process related to factors, such as cultural comfort and humility, alliance quality, and empathy. Tracking process and outcome can also facilitate collaborative discussions of the termination process by increasing the probability that patients and therapists will be on the same page regarding progress in treatment (Duncan, 2014).

Ethics

Being trained in psychotherapy, as in any profession, typically requires the acquisition of knowledge about ethical practice. At a conceptual level, this can include learning ethical standards within specific jurisdiction(s) (e.g., local and federal government, accrediting bodies), in addition to the more universal principle of "first, do no harm" (Strauss et al., 2021). At an interpersonal level, this might involve teaching trainees to hold high standards of morality and decency, such as being honest, straightforward, and trustworthy (see Chapter 16). This can also encompass a high level of professionalism, such as being reliable about sessions (neither cancelling sessions abruptly nor arriving late) and maintaining boundaries lest the therapy become "the sale of a form of friendship" or exploitative in some way.

BASIC THEORY-SPECIFIC COMPETENCIES

In addition to generic therapeutic competencies that cut across different patient populations and models, many programs train students in one or more particular approaches to psychotherapy. Similar to generic therapeutic competencies, basic theory-specific competencies include elements of both conceptual knowledge and practical application.

Frame

Based on conceptual and epistemological assumptions about human functioning and change, each particular orientation defines, more or less explicitly, a general treatment frame or structure that guides the choice and implementation of specific interventions. Learning cognitive behavior therapy (CBT), for example, requires adopting a primarily directive as well as behavioral-change– and problem-solving–oriented approach toward therapy (King & Boswell, 2019). In contrast, patient-centered theory emphasizes the importance of establishing a nondirective and exploratory (or insight-oriented) frame of intervention (Rogers, 1951). In psychodynamic psychotherapy, the structure of the treatment can vary on its primary focus (exploratory or supportive) and its length (time-limited or long-term; Summers & Barber, 2010).

Techniques

Each model of therapy is also characterized by a diversity of techniques that can become part of the trainee's repertoire of interventions. Depending on the type of patient (and/or supervisor expertise and preference), CBT trainees could learn exposure methods, cognitive restructuring, and activity scheduling (Tolin, 2016). As part of a humanistic-oriented training, trainees could implement several specific interventions aimed at helping patients become aware of, symbolize, and accept their emotional experience, including reflection of feelings, empty-chair and two-chair dialogues, as well as bodily focused experiencing work (Elliott et al., 2004; Rogers, 1951). Within a psychodynamic-oriented training, tracking and interpreting core conflict, working with a patient's attachment orientation, exploring the meaning of dreams, fantasies, and memories, interpreting transference/countertransference, and interpreting broader relational patterns are all technical procedures that trainees could be trained in (Gabbard, 2009; Summers & Barber, 2010).

Additional examples exist outside of individual psychotherapy. Couples or family therapies require trainees to learn interventions aimed at strengthening the within-system alliance; teaching patients communication and compromise skills; tracking within-session interactions to reveal system structure; creating enactments (e.g., blamer softening techniques); modifying enmeshed and disengaged boundaries; exploring, explaining, and disrupting circular causality of problematic behaviors; de-triangulating children from marital problems; modifying power imbalances that maintain mental health/behavioral problems; promoting attachments in families and emotional intimacy in couples; and exploring transgenerationally transmitted values, norms, and behaviors (Gurman, 2008; Pitta & Datchi, 2019; Sexton & Lebow, 2016). Training in group therapy also involves a distinct set of skills, such as creating and sustaining group cohesion, fostering patient interaction, and working effectively with group dynamics (e.g., scapegoating; Conyne, 2011; DeLucia-Waack et al., 2004).

Importantly, less tangible or less observable competencies are also emphasized in different orientations, competencies that are viewed as key for the successful

implementation of particular techniques. For example, to become competent CBT therapists, trainees need to learn complex skills, such as the establishment of a highly interactive and task-oriented relationship (collaborative empiricism), aimed at the joint discovery and evaluation of patient thoughts, as well as the ability to identify and address subtle manifestations of anxiety and avoidance of such anxiety during sessions. In addition, learning to properly implement insight-oriented interventions in psychodynamic therapy requires the capacity of listening "below the surface" with patients (which can involve adopting an attitude of "evenly hovering attention" or "unfocused listening" in sessions and, in general, being curious about what crosses patients' minds), the ability to be in the moment with the patient as well as help them relate to their past. It also requires immersing oneself in the patient's subjectivity without bringing to bear normative, evaluative frameworks, and being open to the unexpected, to a journey that is different than that envisaged in one's initial case formulation. In another context, Heschel (1963) called this "radical amazement." Students trained in humanistic orientations need to understand, intellectually and experientially, that the use of exploratory interventions needs to embody more fundamental attitudes of therapist's empathy, positive regard, and genuineness/congruence (Rogers, 1951).

Problem-Specific Techniques

Most of the core techniques in humanistic and psychodynamic-oriented psychotherapies are typically applied across a wide range of presenting problems, rather than being differentially prescribed to address a particular presenting concern. Although recent years have witnessed the development of transdiagnostic CBT approaches (e.g., Barlow et al., 2017), more examples of problem-specific CBT strategies exist and represent important areas of competence in CBT. Examples include but are not limited to exposure and response prevention for obsessive-compulsive disorder, prolonged exposure and written exposure for posttraumatic stress disorder, behavioral activation for depression, and problem solving for behavioral and health disorders (D'Zurilla & Nezu, 2010). Interestingly, specific approaches in both CBT (e.g., dialectical behavior therapy) and psychodynamic (e.g., transference-focused therapy) orientations have been developed for borderline personality disorder. These approaches involve many techniques (e.g., mindfulness training, transference interpretations), some of them reflecting similar treatment strategies or goals (e.g., emotion regulation, cognitive flexibility, distress tolerance; Cristea et al., 2017).

METACOMPETENCIES

We view metacompetencies as general strategies that guide the therapist's ways of implementing the competencies previously reviewed, as well as of being and interacting in the session. We recognize that because of the arbitrariness of the three competency domains we have adopted, there is overlap between these

metacompetencies and others. In our view, however, the former focus primarily and more specifically on navigating the complexities of when, how, and for whom generic and theory-specific competencies are used, in ways that are most attuned to patients and/or more apt to attend to difficulties and impasses during treatment. In addition, although the acquisition of knowledge and skills is necessary, the adoption of attitudes (more broadly related to interpersonal and social interactions as well as the practice of psychotherapy in particular) is particularly key to mastering these competencies. Fully recognizing that there are many metacompetencies that can be developed during training, we highlight only a few of them, including responsiveness, which represents a particularly salient point of convergence across our diverse perspectives and experience.

Pivotal to a therapist's development is responsiveness (Stiles et al., 1998; Watson & Wiseman, 2021), a concept that manifests itself in many forms and in many types of clinical judgment (Tracey et al., 2014). One basic facet of responsiveness is at the core of the generic competencies of case formulation and treatment planning. Responsiveness by definition involves making appropriate decisions regarding whether or not a patient should be offered psychotherapy (as opposed, for instance, to crisis interventions to deal with a high level of suicidality) or should be referred to specialized services (e.g., intensive and possibly inpatient treatment for severe problems, such as obsessive-compulsive disorder, eating disorders, substance use disorders, or psychosis). Responsiveness also involves the ability to determine what types of psychotherapy might be beneficial to a patient and at what time, for example, which protocols are empirically supported for the patient's primary concern (e.g., depression) and which approaches and/or modes of interventions might be most adaptive to a patient's nondiagnostic features—such as the use of more or less directive interventions for patients with various levels of reactance (Beutler et al., 1991).

At a more complex level, responsiveness is involved in the fine-grained implementation of psychotherapy. Within a given protocol, responsiveness can mean flexibility within fidelity (Kendall & Frank, 2018), that is, the therapist's capacity to decide which of the prescribed techniques are likely to be the most effective for a given patient—such as the use of behavioral activation or cognitive restructuring in CBT, and the use of empty-chair or two-chair techniques in emotion-focused therapy. An even more specific example of such reflective practice is the ability to be supportive of the patient at the right moments and confrontative when that becomes necessary to move the therapy forward. This is often difficult for novice therapists, as they may fear offending or losing the patient. The therapist's attunement to this polarity of supportive and challenging needs has been emphasized in several models (e.g., Elliott & Macdonald, 2021; Linehan, 1993; Messer & Warren, 1995), helping trainees (and experienced therapists) to become competent in being "nondirective" (including in behavior change–oriented treatment) and in giving advice or being more challenging when it is called for (including in insight-oriented treatment).

Across theoretical orientations, the latter form of responsive practice involves attending to potentially important markers (patient characteristics or in-session

behavior), identifying the marker when it presents itself, and responding adaptively (e.g., staying the course or temporarily departing from the current plan or model). The context-responsive integration framework (Constantino et al., 2013; see also Chapter 5, this volume) has delineated both the empirical support and specific training guidelines for several marker–response ("if/then") scenarios, enabling trainees to learn what evidence-based interventions can be used when encountering difficulties, such as a patient's low outcome expectations, resistance, and risk of deterioration, as well as alliance ruptures and cultural misattunement (Watkins et al., 2019). Another empirically supported and trainable approach to responsiveness is based on the Plan Analysis concept of case formulation (Caspar, 2022). This involves the identification of unproblematic motives that steer patient problematic behavior and then relational behaviors from the therapist that satisfy such motives without reinforcing the problematic behavior. As in the previous framework of responsiveness, this requires the therapist's awareness of why and when to do something (and when not to do something) based on contextual factors, for the sake of tailoring or personalizing treatment.

As its name implies, another type of metacompetence is metacommunication, which involves the ability to discern, be reflective about, and address for therapeutic value what is transpiring between the patient and therapist. It requires the therapist to communicate what is being communicated, verbally and nonverbally, during the session. Examining and working within the therapeutic relationship is a difficult competency to acquire as it touches the therapist in a more personal and emotional way compared with the other competencies. Such interpersonal processes, however, can provide opportunities for patients to become more reflective (more aware of their interpersonal patterns and impact on others) and to engage in more adaptive ways of relating to others in the safety of the therapeutic relationship (Hill et al., 2018; Safran & Muran, 2000).

Another metacompetency is the capacity of emotion regulation/affect management skills (e.g., attentional, cognitive, and response modulation strategies; see Gross et al., 2019). A trainee must learn how to manage and regulate one's own emotions and the ambiguities of clinical practice. This means learning about one's vulnerabilities and areas of sensitivity that might arise when working with patients (e.g., training of emotional competencies; Berking, 2010), which requires an openness to inner experience and a willingness to communicate this inner experience to patients when it can serve a therapeutic function (Greenberg, 2014). The competencies of emotion regulation and metacommunication are closely related, as they both require mentalization about ourselves and our contribution to the therapeutic relationship. They can also play an important role in addressing challenges and impasses during treatment, such as alliance ruptures (Eubanks et al., 2019; Muran & Eubanks, 2020; Safran & Muran, 2000; see also Chapter 6, this volume), countertransference (Hayes et al., 2019; see also Chapter 7, this volume), as well as transference and resistance (Castonguay et al., 2019). It may be apparent that a common link

between self- and contextual-awareness, emotion regulation, and metacommunication is represented by the metacompetency of reflectivity, or reflective practice (Ferreira et al., 2017). Reflectivity is the capacity to make meaning of personal values and experiences, and this extends to a therapist's understanding the patient as a person, as well as in the moment-to-moment context of the therapy interaction (Stedmon & Dallos, 2009).

An additional metacompetency is the ability to think and practice at the level of principles of change (Goldfried, 1980), rather than adhering to particular treatment protocols or manuals. This first requires a knowledge of more than one model of psychotherapy. It then necessitates an awareness that many of the techniques that are prescribed in several models reflect the same broad strategies of intervention, such as the acquisition of new perspectives of self and others (or insight; Castonguay & Hill, 2006) and the facilitation of corrective experiences (Castonguay & Hill, 2012). Complementary to the more specific competencies highlighted in the context-responsive model of Constantino et al. (2013), thinking at a level of principles of change may lead trainees to expand their repertoire of interventions when attempting to foster processes of change that can be beneficial for their patients. CBT trainees, for example, can be trained in humanistic-oriented interventions (e.g., two-chair techniques) in order to help patients symbolize and then examine previously implicit and emotionally painful views of self. This metacompetence also requires the advance skills of knowing when and how to use techniques that have been associated with different theoretical orientations in ways that maintain the cohesiveness of the treatment (Castonguay, 2000; Messer, 2001).

HOW TO FOSTER COMPETENCE DEVELOPMENT

It is arguably easier to identify what therapeutic competencies are important to learn than to identify optimal training activities to foster them. Fortunately, there are resources and frameworks for supporting both knowledge and applied aims in the domain of generic therapeutic competencies. Examples include helping skills (Hill, 2020), microskills (Daniels & Ivey, 2007), motivational interviewing (Miller & Rollnick, 2002), and Prochaska and colleagues' (e.g., Prochaska & DiClemente, 1982) transtheoretical model. These generic frameworks describe different phases of psychotherapy and the goals of each phase, as well as basic interventions that can be used to foster goal attainment.

Within or outside specific frameworks, different training tools can be used. Of course, all formal training programs are expected to use didactic methods. Based on specialized readings (and hopefully substantiated with demonstrations by expert therapists), seminars and practicum-style courses can focus on the acquisition of generic skills (e.g., Anderson et al., 2016) as well as the development of specialized skills associated with a specific treatment model (e.g., Persons, 2012). Didactic tools can also be involved in the learning of metacompetencies. For example, training-oriented books and videos have been

developed to describe and demonstrate the use of metacommunication strategies to repair alliance ruptures (Eubanks et al., 2019; Muran & Eubanks, 2020; Safran & Muran, 2000). In addition, coursework on interpersonal theory and theories of personality can help trainees consider optimal modes of responding responsively to patients showing maladaptive interpersonal patterns (e.g., submissive vs. dominant patients; Kiesler, 1996). This can be supported by incorporating circumplex-related measures in courses and with training cases (Horowitz et al., 2000).

Learning is also doing (see Chapter 3). In the context of psychotherapy training, this involves supervised actions—whether in the context of role-plays and/or training cases. Like didactic methods, supervision is expected to be a cornerstone of any formal training program. While it can serve a multitude of functions (e.g., providing a safe and rewarding relationship to help trainees face the challenging task of helping others, fostering a sense of professional identity and self-efficacy, facilitating awareness of and/or working on unfinished personal issues interfering with the process of change), the principal function of supervision is arguably the provision of expert knowledge, guidance, and, most important, feedback to therapists in the appropriate and effective implementation of any competencies at play in the conduct of psychotherapy.

Feedback is also at the core of technologies that can be used in training to complement and/or guide supervision. These include the well-established routine outcome monitoring and clinical feedback systems (Wampold, 2015), as well as automated assessment and feedback tools for generic therapeutic competencies, such as empathy (Imel et al., 2019), and machine learning advancements to train psychotherapists in case formulation (Caspar et al., 2004). Also complementing the primary role of supervision are developments in role-playing and clinical feedback in recent years. This is the case, for example, in the use of actors and simulated patients (e.g., Anderson et al., 2016). One potential benefit of simulated training cases is standardization, allowing for benchmarking of skill achievement and repeated opportunities to refine one's skills in the context of particular clinical situations (Boswell & Constantino, 2022). The process for repeated practice and the provision of timely feedback has also been systematized in recent work on deliberate practice (e.g., Rousmaniere, 2019), a method that can be used to foster generic therapeutic competencies (see Chapter 9), theory-specific skills (Boswell & Constantino, 2022; Goldman et al., 2021), and metacompetencies (see Chapter 6).

Additional, much older methods that could serve the similar purpose of feedback are interpersonal process recall (Kagan, 1976) and brief structured recall (Elliott & Shapiro, 1988). These would involve recording one's sessions with training cases and then reviewing portions of sessions with supervisors and thinking out loud about significant in-session events and one's thinking and decision-making process in the session (Ivers et al., 2017). This is one of several methods that can be used to foster reflectivity which, particularly around challenging process (cf. Rønnestad & Skovholt, 2013), could help build trainees' mentalization capacity. As noted by Falender and Shafranske (2007), "self-assessment is at the heart of developing and maintaining competence . . . as an individual must identify areas of strength and weakness to establish priorities and to commit to learning strategies to ensure competent practice" (p. 236). These efforts may also involve discussions of the therapist's internal experience during challenging events. Such discussions are likely to be most beneficial if they take place in the context of a supervision where the trainee feels a sense of control or autonomy about what is disclosed or not disclosed (Fernández-Alvarez, 2016).

While it remains to be seen whether these methods (new and old) will prove to be generalizable and retainable, it should also be noted that deliberate practice and other practice-oriented training methods can be used independently from direct or in-person observation from a supervisor. In the spirit of our earlier emphasis on self-reflection capacity, the ability to identify one's own areas of competence versus incompetence is a related metacompetence (Falender & Shafranske, 2007). For example, trainees can review their own sessions with training cases (Bennett-Levy, 2019) and possibly apply fidelity measures commonly used in research contexts (Pascual-Leone & Adreescu, 2013). Another deliberative strategy that might be particularly relevant to foster theory-specific competencies is writing case conceptualizations from different theoretical perspectives, as well as transcribing portions of one's sessions to compare the process with how strategies are described in the literature or relative to alternative theories. Interestingly, exposure to different models of psychotherapy may help trainees better understand the unique (or not so unique) features of a particular psychotherapy model (Norcross & Goldfried, 2019).

Personal psychotherapy, which is compulsory for certification as a psychotherapist in several European countries, can also be viewed as a method to foster generic therapeutic skills, and beyond. It may allow trainees to have a firsthand sense of what therapy is like for patients and to become more self-reflective (Bennett-Levy, 2019)—recognizing, for example, the impact that personal issues of therapists may have on their perceptions of patients. Relatedly, personal therapy might be helpful in developing emotion regulation, including affects that might be triggered by patients. These cognitive and emotional processes relate to what McCullough (2006) referred to as disciplined personal involvement, an ability rooted in an in-depth understanding of one's own functioning. This links back to the importance of mentalization, which is also crucial for using one's own reactions as information in a less biased way (e.g., when engaging in self-disclosure or immediacy). Outside one's own personal therapy, some attention to the importance of long-term self-care strategies seems prudent (e.g., how to establish a balance between professional and private life).

Perhaps stating the obvious, we believe that a multidimensional approach to training is optimal. While viewing examples of psychotherapy, engaging in role-plays, and receiving various forms of timely feedback are likely to be beneficial, so is the reading of theory (including classical texts by Freud, Rogers, and Beck), clinical textbooks (including but not restricted to treatment manuals), and research—in addition to lecture-based didactic instruction. We are also reminded

that the learning curve in psychotherapy is very steep. As such, it behooves instructors, supervisors, and peers to provide positive reinforcement and constructive, culturally informed feedback to trainees (Bernard & Goodyear, 2013).

CONCLUDING NOTE

We would like to conclude by restating that our goal in this chapter was to offer a landscape of competencies (and methods to foster them) based on our own knowledge and experience in a wide variety of training programs. We hope that this brief overview will provide helpful suggestions for trainers to expand their current practices—as well as for trainees and experienced therapists to further develop their knowledge, skills, and attitudes. These suggestions should be considered in light of the empirical evidence that is reviewed in Chapters 3 and 4, as well as new data (quantitative and qualitative) that are presented in most of the other chapters of this book. Although we recognize that the selection of competencies emphasized during training reflects the values (conceptual and philosophical) of particular programs, we also believe that competencies categorized in each of the three domains retained have potential value. More than being foundational skills, some of the generic competencies (e.g., ability to establish and maintain a good alliance and facilitative interpersonal skills) have been identified as factors explaining why some therapists are more effective than others (Wampold et al., 2017). Importantly, theory-specific competencies can provide trainees with a repertoire of empirically supported interventions for a range of clinical problems. Also based on empirical evidence, some metacompetencies can be helpful skills to acquire in order to improve (in terms of breadth, depth, and precision) trainees' ability to address the individual needs of their patients as well as difficult events in therapy. Hopefully, the information presented in this book about these (and other) competencies will serve as conduit to train and to learn beyond specific sets of values and practices.

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