# Therapeutische Kompetenz

## Theoretische Grundlagen, Erhebungsmethoden und Wirksamkeit in der Praxis

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The essence of therapy
is embodied
in the therapist.

Bruce E. Wampold, 2001
in *The Great Psychotherapy Debate*

***Danke***

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## Theoretischer Hintergrund



## Teilstudien 1-3

# 1. Einleitung

Welche Faktoren beeinflussen das Ergebnis einer Psychotherapie? Diese Frage ist bisher nicht eindeutig beantwortbar und auch Teil des „Schulenstreits“ verschiedener therapeutischer Orientierungen. Als Annäherung an eine Antwort hat sich eine Schätzung der für den Therapieerfolg relevanten Faktoren, basierend auf den Arbeiten von Wampold (2001) und Lambert (2013), etabliert. Demnach verteilt sich der Anteil verschiedener Faktoren an der Ergebnisvarianz wie folgt: 4-15% Erwartungen des Patienten, 40-80% Erfahrungen außerhalb der Therapie, 0-15% therapeutische Techniken und 0-30% allgemeine Wirkfaktoren. Unter diese allgemeinen Wirkfaktoren werden u.a. die therapeutische Beziehung (0-5%), die Person des Therapeuten[1] (0-5%) und Allegiance (0-10%) subsummiert. Der Fokus der Psychotherapieforschung lag in den letzten Jahren primär auf der Analyse der Wirksamkeit verschiedener therapeutischer Techniken, die nach der obigen Schätzung etwa 15% der Ergebnisvarianz erklären. Fairburn und Cooper (2011) sprechen hier sogar von einer „era of enthusiasm for evidence-based psychological treatments“ (Fairburn & Cooper, 2011, S. 373). Innerhalb dieser Forschung wurde der Therapeut meist als Störvariable angesehen (Beutler et al., 2004). Während somit die Frage der Effektivität verschiedener Interventionen einerseits relativ gut erforscht ist, gibt es andererseits deutlich weniger empirisch fundierte Erkenntnisse zur Person des Therapeuten, seinen persönlichen Charakteristika und seiner therapeutischen Kompetenz. In der sechsten Auflage des Standardwerks *Bergin and Garfield’s Handbook of Psychotherapy and Behavior Change* aus dem Jahr 2013 (Lambert) wurde auf eine Aktualisierung des Kapitels „*Therapist Variables*“ zum Zusammenhang zwischen Therapeutenvariablen und Therapieergebnis vorheriger Ausgaben (Beutler et al., 2004; Beutler, Machado, & Neufeldt, 1994) verzichtet, da es nach Ansicht der Autoren keine neuen Publikationen mit einschlägigen neuen Erkenntnissen gegeben hatte (Baldwin & Imel, 2013). Dies ist eine Entwicklung, die Beutler et al. bereits 2004 anmahnten, nachdem sie ein nachlassendes Forschungsinteresse beobachtet hatten.

Grundlage für empirische Forschung zur Person des Therapeuten, seinen Kompetenzen und persönlichen Eigenschaften sind das Vorhandensein einer Definition sowie eines theoretischen Modells therapeutischer Kompetenzen, das auch persönliche Charakteristika des Therapeuten berücksichtigt. Darüber hinaus sind Messinstrumente zur Erfassung dieser Kompetenz aus verschiedenen Perspektiven nötig, die auf den gleichen theoretischen Annahmen beruhen, so dass eine Vergleichbarkeit möglich ist. Zum gegenwärtigen Stand feh-

[1] Hinweis zur Gender-Formulierung: Bei allen Bezeichnungen, die auf Personen bezogen sind, meint die gewählte Formulierung beide Geschlechter, auch wenn aus Gründen der leichteren Lesbarkeit die männliche Form steht.

len sowohl eine allgemein akzeptierte Definition als auch ein theoretisches Modell sowie geeignete Messinstrumente zur multi-perspektivischen Erfassung therapeutischer Kompetenz.

Die vorliegende Dissertation besteht aus drei Teilstudien, die in einem forschungslogischen Zusammenhang gestellt und erörtert werden. In einem ersten Schritt wurde ein *Drei-Ebenen-Modell therapeutischer Kompetenz* entwickelt. Es enthält neben therapeutischen Kompetenzen auch persönliche Dispositionen des Therapeuten, für die ein Zusammenhang mit therapeutischer Kompetenz diskutiert wird. Dieses Arbeitsmodell wurde als theoretische Grundlage für die empirische Erfassung therapeutischer Kompetenzen konzipiert. Zentral ist dabei die Möglichkeit, auf seiner Basis einzelne Kompetenzen operationalisieren zu können. Das Modell diente zur Entwicklung von Messinstrumenten für verschiedene Perspektiven, die im Rahmen dieser Dissertation als zweite Studie vorgestellt und in ihrer psychometrischen Güte diskutiert werden.

Eine reliable und valide Erfassung stellt die Grundvoraussetzung dafür dar, dass Entwicklung und Erwerb therapeutischer Kompetenz sowie ihre Trainierbarkeit untersucht werden können. Für die vorliegende Dissertation steht dabei die Frage im Fokus, welche therapeutischen Basiskompetenzen studentischen Novizen-Therapeuten bereits im Kontext der universitären Ausbildung vermittelt werden können. Als Annährung an die Frage der Trainierbarkeit dieser therapeutischen Basiskompetenzen wurde im Rahmen der dritten Studie die Effektivität eines universitären Ausbildungsprogramms für studentische Therapeuten zur Reduktion der Stressbelastung studentischer Klienten untersucht. Des Weiteren wurde der Zusammenhang zwischen dem Beratungsergebnis und persönlichen Charakteristika der studentischen Therapeuten analysiert. Diese Untersuchung stellt dabei einen ersten Schritt der empirischen Überprüfung der im *Drei-Ebenen-Modell therapeutischer Kompetenz* postulierten Dispositionen dar.

# 2. Theoretischer Hintergrund

## 2.1 Therapeutenvariablen

Wie bereits beschrieben, wird der Anteil des Therapeuten an der Ergebnisvarianz von Psychotherapien auf etwa 5% geschätzt (Baldwin & Imel, 2013). Bislang gibt es nur wenig empirische Forschung dazu, welche Aspekte der therapeutischen Kompetenz und welche günstigen sowie ungünstigen Therapeutenmerkmale diese 5% ausmachen. Betrachtet man die Entwicklung der Forschung zu Therapeutenmerkmalen, so findet sich eine Häufung an meist naturalistischen Studien und theoretischen Publikationen im Zeitraum der 1970er bis frühen 90er Jahre (z.B. Guy, 1987; Purton, 1991), wobei die wenigen empirischen, meist naturalistischen Studien häufig einen psychodynamischen Hintergrund haben (z.B. Henry, 1993).

Die Arbeitsgruppe um Larry E. Beutler entwickelte 1992 basierend auf den Erkenntnissen dieser Zeit eine Taxonomie von Therapeutenvariablen. Die Therapeutencharakteristika sind in vier Quadranten eingeordnet, die sich aus den beiden Dimensionen objektive/subjektive Charakteristika und situationsübergreifender/therapiespezifischer Qualitäten bilden (Beutler et al., 2004; 1994) (siehe Abbildung 1). Die beiden Pole der ersten Dimension wurden später in beobachtbare (*observable)* versus zu erschließende (*inferred)* Charakteristika umbenannt (Beutler et al., 2004). Die vorherige Bezeichnung *subjektiv* habe nach Angaben der Autoren den Eindruck vermittelt, dass diese ausschließlich basierend auf dem therapeutischen Selbstbericht erfasst werden könnten. Um aber zu verdeutlichen, dass durchaus eine Erfassung basierend auf externen Beurteilungen (z.B. von Persönlichkeitseigenschaften) möglich ist, wurde der Pol in *zu erschließend* (*inferred)* umbenannt.

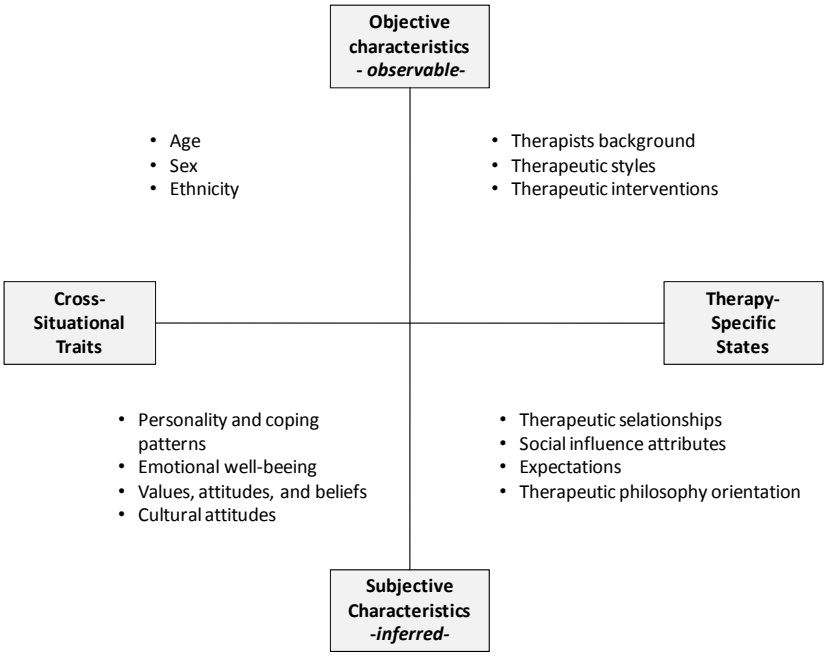


**Abbildung 1:** Taxonomie von Therapeutenvariablen (Beutler et al., 2004; 1994)

Die Taxonomie differenziert somit zwischen objektiven Eigenschaften und solchen, die erschlossen werden sowie zwischen situationsübergreifenden *Traits* und therapiespezifischen *States*. Die situationsübergreifenden *Traits* werden als stabil und nicht bewusst veränderbar beschrieben, die therapiespezifischen *States* hingegen als systematisch durch Training veränderbar. Beutler et al. (2004; 1994) ordnen dem ersten Quadranten der beobachtbaren *Traits* demographische Charakteristika des Therapeuten wie Alter, Geschlecht und Ethnizität zu. Dem Quadranten der beobachtbaren *States* werden sowohl die Ausbildung des Therapeuten, seine Erfahrung, Fertigkeiten und konkreten Interventionen sowie sein Interaktionsverhalten zugeordnet. Der dritte Quadrant der zu erschließenden *Traits* umfasst situationsübergreifende Persönlichkeitsmerkmale, Werte und Einstellungen des Therapeuten. Der vierte Quadrant der zu erschließenden *States* beinhaltet für den therapeutischen Kontakt relevante Aspekte wie die Einstellungen und Erwartungen des Therapeuten, seine Art der Beziehungsgestaltung und sein schulenspezifisches Behandlungsmodell.

Insgesamt sind die Arbeiten der Arbeitsgruppe um Larry E. Beutler und die Erstellung der Taxonomie von Therapeutenvariablen (Beutler et al., 2004; 1994) von großer Wichtigkeit für die Psychotherapieforschung. Die Formulierung der den Quadranten zugeordneten Therapeutenvariablen ist jedoch auf einem Komplexitätsniveau, das die Operationalisierung für die empirische Forschung erschwert. Diese praktische Operationalisierbarkeit ist jedoch zentral für die Erforschung und empirische Überprüfung der postulierten Therapeutenvariablen. Die Taxonomie von Therapeutenvariablen (Beutler et al., 2004; 1994) hat in der Entwicklung des *Drei-Ebenen-Modells therapeutischer Kompetenz* (siehe Kapitel 4) Berücksichtigung gefunden. Die in diesem Model aufgeführte Ebene *Dispositionen* soll beispielsweise eine prakti-

sche Operationalisierbarkeit des dritten Quadranten der zu schlussfolgernden *Traits* erlauben. Gleiches gilt für die Ebenen der *Basiskompetenzen* und der *Spezifischen Kompetenzen*, auf denen unter anderem therapierelevante *States* abgebildet sind.

Basierend auf den Publikationen bis 2004 kommen Beutler und Kollegen zu der Schlussfolgerung, dass die empirische Befundlage für alle Quadranten der Therapeutenvariablen sehr heterogen ist. Hinsichtlich des Zusammenhangs mit dem Therapieergebnis war die Forschungslage für die meisten Quadranten zu dünn, um kausale Schlüsse ziehen zu können. Einzig die Zusammenhänge zwischen therapeutischen Techniken und therapeutischer Beziehung und dem Therapieergebnis wurden als die am intensivsten beforschten Fragestellungen hervorgehoben. Darüber hinaus forderten die Autoren, dass der Forschungsfokus nicht ausschließlich auf der Untersuchung eines unidirektionalen Effektes von Therapeutenvariablen auf das Therapieergebnis liegen sollte, sondern ebenso Patienteneigenschaften und Ähnlichkeit zwischen Patienten und Therapeuten als mögliche Moderatoren berücksichtigt werden sollten.

Baldwin und Imel (2013) sehen den über die drei letzten Ausgaben des *Handbook of Psychotherapy and Behavior Change* (Baldwin & Imel, 2013; Beutler et al., 2004; Beutler et al., 1994) erkennbaren Rückgang der Forschung zu Therapeutenvariablen zum Teil darin begründet, dass frühere Studien keine vielversprechenden Ergebnisse lieferten. Das Forschungsfeld habe dadurch an Attraktivität verloren und sei gegenüber der Forschung zu Behandlungsmethoden in den Hintergrund getreten. Nach einer Periode, in der die Psychotherapieforschung auf Techniken und Manuale fokussierte und die Person des Therapeuten nahezu ausgeblendet wurde, rückte in den letzten Jahren die Person des Therapeuten wieder mehr in den Fokus der Forschung. Es ist zu beobachten, dass die Kompetenz des Therapeuten, die nach Beutlers Taxonomie (2004; 1994) dem Quadranten der beobachtbaren *States* zuzuordnen ist, wieder vermehrt zum Forschungsgegenstand gemacht wurde.

Des Weiteren ist der Zusammenhang von Therapeutenvariablen und therapeutischer Kompetenz zu diskutieren. Das später vorgestellte *Drei-Ebenen-Modell therapeutischer Kompetenz* postuliert, dass bestimmte Therapeutenvariablen unter anderem einen Einfluss auf die Erlernbarkeit therapeutischer Kompetenzen haben. Des Weiteren liefert die in Kapitel 5 vorgestellte Studie empirische Ergebnisse für den Zusammenhang von Therapeutenvariablen und Therapieerfolg.

Wie im Folgenden erläutert wird, ist die aktuelle Forschung zu therapeutischer Kompetenz nach wie vor durch das Fehlen einer einheitlichen Definition erschwert. Das folgende Kapitel wird zunächst diese Problemlage beschreiben und dann eine Definition therapeuti-

scher Kompetenz vorstellen, die die theoretische Grundlage für die Forschungsarbeiten im Rahmen dieser Dissertation bildet.

## 2.2 Der Kompetenzbegriff

Das Fehlen einer einheitlichen Definition therapeutischer Kompetenz führt dazu, dass unter dem Begriff therapeutischer Kompetenz Unterschiedliches verstanden wird. So gibt es sowohl störungsspezifische als auch störungsübergreifende Definitionen, des Weiteren therapieschulen-spezifische und -unabhängige Definitionen.

Als Versuche einer störungsübergreifenden und schulenunabhängigen Definition therapeutischer Kompetenz werden häufig zwei Definitionen herangezogen. Zum einen folgende Definition der Arbeitsgruppe um Waltz: *competence is "the level of skill shown by the therapist in delivering the treatment. By skill, we mean the extent to which the therapists conducting the interventions took the relevant aspects of the therapeutic context into account and responded to these contextual variables appropriately. Relevant aspects of the context include, but are by no means limited to, (a) clients variables such as degree of impairment; (b) the particular problems manifested by a given client; (c) the client's life situation and life stress; (d) and factors such as stage in therapy, degree of improvement already achieved, and appropriate sensitivity to the timing of interventions within a therapy session" (Waltz, Addis, Koerner, & Jacobson, 1993, S. 620).* Diese kontextuelle Definition zeichnet sich durch ihre hohe Behandlungsspezifität bezüglich einer konkreten Sitzung mit einem bestimmten Patienten und der Art der vorliegenden psychischen Störung aus. Die Autoren betonen, dass beispielsweise therapeutische Wärme für die eine Behandlungsart zentral sein kann, für andere Behandlungen jedoch nicht und distanzieren sich damit deutlich von einer situationsunabhängigen Kompetenzdefinition.

Die zweite häufig verwendete Definition entstammt ursprünglich aus der Medizin (Epstein & Hundert, 2002) und wurde von der Arbeitsgruppe um Jaques P. Barber auf (psycho-) therapeutische Kompetenzen übertragen: „*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 and community being served*" (Barber, Sharpless, Klostermann, & McCarthy, 2007, S. 494). Auch diese Definition betont die Kontextabhängigkeit therapeutischer Kompetenz, die in der Abgrenzung zur Adhärenz nicht das „*wie*", sondern das „*wann*" und „*wann nicht*" impliziert.

Während die zuerst genannten Definition von Waltz und Kollegen (1993) vor allem die Situationsabhängigkeit therapeutischer Kompetenz betont, gehen aus der zweiten Definition

von Barber und Kollegen (2007) wichtige Ergänzungen dazu hervor, was unter therapeutischer Kompetenz konkret verstanden wird. Doch diese Ergänzungen erscheinen für das Ziel, die Definition therapeutischer Kompetenz als Grundlage für ein operationalisierbares theoretisches Modell therapeutischer Kompetenz zu nutzen, nicht ausreichend zu sein. Daher wurde im Rahmen dieser Arbeit eine eigene Definition therapeutischer Kompetenz entwickelt.

Die dieser Arbeit zugrunde liegende eigene Definition therapeutischer Kompetenz berücksichtigt ebenfalls den kontextabhängigen Anteil der beiden aufgeführten Definitionen, berücksichtigt aber explizit auch bestimmte therapeutische Basiskompetenzen, die eher situationsunabhängig und auch schulenübergreifend zu verstehen sind: *Therapeutische Kompetenz ist das für eine Situation korrekte Verhalten eines Therapeuten, das sich aus einer Integration von Grundhaltung, Gesprächstechniken und Interventionen, die auf diagnostischen Erkenntnissen basieren, ergibt. Therapeutische Kompetenz setzt sich aus universalen Basiskompetenzen und schulenspezifischen Kompetenzen zusammen, die störungsabhängig sind und dem aktuellen Forschungsstand entsprechen. Therapeutische Kompetenz ist von persönlichen Charakteristika der Therapeuten beeinflusst. Therapeutische Kompetenz ist messbar, trainierbar und lebenslang verbesserbar, wobei sich die einzelnen Komponenten therapeutischer Kompetenz in ihrer Veränderbarkeit unterscheiden.* Diese Definition bildet die Grundlage für das in Kapitel 4 vorgestellte *Drei-Ebenen-Modell therapeutischer Kompetenz*. Das Modell liefert zudem eine Spezifizierung der in der Definition erwähnten *Basis-* und *spezifischen Kompetenzen*.

Auf Grundlage der bisher erfolgten theoretischen Betrachtung relevanter Therapeutenvariablen und der erfolgten Fokussierung auf therapeutische Kompetenz sollen zunächst Phasen der Entwicklung therapeutischer Kompetenz betrachtet werden, bevor im Anschluss die Frage der Trainierbarkeit therapeutischer Kompetenz einführend diskutiert wird.

## 2.3 Entwicklung therapeutischer Kompetenz

In der Literatur finden sich verschiedene Modelle sowie theoretische Überlegungen zu Entwicklungsstufen, die ein Therapeut als Teil seiner beruflichen Qualifizierung und in seinem Berufsleben durchläuft. Eine Gemeinsamkeit der meisten Entwicklungsmodelle ist, dass sie die gesamte Spanne des Berufslebens von den Anfängen als Novize bis zur jahrzehntelangen Berufstätigkeit umspannen. Die Arbeiten im Rahmen dieser Dissertation nehmen Bezug auf die Konzeptualisierung der Entwicklung von Therapeuten, wie sie im Phasenmodell der Therapeutenentwicklung von Rønnestad und Skovholt beschrieben werden (Rønnestad & Skovholt, 2003; 2013; Skovholt & Rønnestad, 1995). Das Modell hat seine empirische

Basis in der Minnesota-Studie, einer internationalen qualitativen Studie zur Entwicklung von Psychotherapeuten (Orlinsky et al., 1999; Skovholt & Rønnestad, 1992). Das Modell wurde über die Jahre mehrfach verändert und optimiert, so dass es von ursprünglich acht *Stufen* (Skovholt & Rønnestad, 1992) über sechs (Rønnestad & Skovholt, 2003; Skovholt, 2012) auf gegenwärtig fünf *Phasen* (Rønnestad & Skovholt, 2013) reduziert wurde. Das fünf-phasige unterscheidet sich von dem sechs-phasigen Modell im Kern jedoch nur dadurch, dass letzteres eine Phase *vor* der begonnenen professionellen Ausbildung berücksichtigt. Da die einzelnen Studien dieses Dissertationsprojektes im Kontext der praxisbezogenen Qualifikation von Studierenden durchgeführt wurden, soll diese Phase des Laienhelfers berücksichtigt bleiben. In Tabelle 1 sind die sechs Phasen der Entwicklung therapeutischer Kompetenzen dargestellt, die sich aus einer Synthese der Arbeiten von Rønnestad und Skovolt (2003, 2013) und Skovholt (2012) ergeben. Das im Rahmen dieses Dissertationsprojektes entwickelte Drei-Ebenen-Modell therapeutischer Kompetenz (siehe Kapitel 3) soll es erlauben, therapeutische Kompetenz ab der ersten Stufe dieses Entwicklungsmodells zu erfassen. Insgesamt fokussiert das Phasenmodell von Rønnestad und Skovolt (2013) auf den Entwicklungsprozess von Therapeuten. Die Ausarbeitung von konkreten Facetten therapeutischer Kompetenz und deren Zuordnung zu den einzelnen Phasen steht dabei nicht im Vordergrund.

Das Phasenmodell berücksichtigt sowohl den Zeitraum vor der Ausbildung zum Therapeuten (*pre-training*), als auch die Zeit der Ausbildung (*student stages*) und die Zeit danach (*post-graduate stages*) (Rønnestad & Skovholt, 2003). Für die im Rahmen dieses Dissertationsprojektes zentrale Frage, ob und welche therapeutischen Basiskompetenzen studentischen Novizen-Therapeuten vermittelbar sind, sind die beiden ersten Phasen des Laienhelfers (*layhelper*) und Anfängers (*Beginning* oder *Novice Student*) zentral. Dem Konzept der einzelnen Phasen liegt die Annahme zugrunde, dass dem Entwicklungsprozess im idealen Fall ein kontinuierlicher stufenförmiger Wachstumsprozess zugrunde liegt. Es besteht allerdings auch die Möglichkeit, dass der Therapeut innerhalb seiner Entwicklung in eine Stagnation gerät, ebenso sind zyklische Verläufe möglich (Rønnestad & Skovholt, 2013).

Neben den Phasen entlang des Qualifizierungsprozesses beschreiben die Autoren zentrale Themen der Entwicklung therapeutischer Kompetenz. Diese Themen resultierten aus der Beobachtung, dass sich nicht alle Entwicklungen phasenhaft darstellen lassen, sondern dass es auch einige linear verlaufende Veränderungen gibt. Die von den Autoren thesenartig formulierten Themen ergaben sich aus Interviews mit Therapeuten im Rahmen der qualitativen Studie. Auch diese Themen haben einen Prozess der Reanalyse und Reformulierung durchlaufen, so dass die Autoren gegenwärtig zehn Themen postulieren (Rønnestad

& Skovholt, 2013). Die folgenden drei Themen erscheinen dabei von besonderer Relevanz für die vorliegende Arbeit (Rønnestad & Skovholt, 2013, S. 146 ff):

- "***Theme 2**: The models of therapists/counselors functioning shifts markedly over time – from internal to external to internal*
- ***Theme 3**: Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience*
- ***Theme 7**: Many beginning practitioners experience much anxiety in their professional work: but over time, anxiety is mastered by most*"

Inwiefern diese Themen in dem in Kapitel 6 vorgestellten Training therapeutischer Basiskompetenzen Berücksichtigung finden, soll in der abschließenden Gesamtdiskussion betrachtet werden.

**Tabelle 1:** Sechs Phasen der Therapeutenentwicklung von Rønnestad und Skovholt (2003, 2013) und Skovholt (2012).

| | Phase | Zeitraum | Allgemeine Beschreibung | Befinden | Entwicklungsaufgabe | Professionelle Rolle |
|---|---|---|---|---|---|---|
| 1 | **Laienhelfer** | *Vor* der Ausbildung | - Helferrolle im Privatleben: natürlich und authentisch<br>- Hilfe durch Ratschläge, basierend auf eigenen Erfahrungen<br>- Interaktion ist von Sympathie für das Gegenüber geprägt<br>- Hohe (Über) Identifikation mit dem Hilfesuchenden<br>- Gelernt wird durch Ausprobieren | | | |
| 2 | **Anfänger**<br>*"At times I was so busy thinking about the instructions given in class […], I barely heard the client."*[1] | 1. - 2. Ausbildungs-jahr | - Erkenntnis, dass vorherige Konzepte des Laienhelfers nicht mehr angemessen sind<br>- Kluft zwischen Theorie und Praxis<br>- Überwältigende Konfrontation mit neuen Impulsen und Inhalten und einer Vielzahl neuer Techniken<br>- Hohe Verletzbarkeit<br>- Eignung für den Therapeutenberuf wird angezweifelt<br>- Gelernt wird durch Modelllernen (Dozenten, Kollegen, Supervisoren) und Versuch-Irrtum | - Aufregung<br>- Belastung+ Ängstlichkeit<br>- Anstrengung + Ermüdung | - Methoden aneignen<br>- Basiskompetenzen zeigen<br>- eigene emotionale Reaktion regulieren<br>- Offenheit für Neues erhalten | - Unklar<br>- Naives Rollen-bild |
| 3 | **Fortgeschrittener**<br>*"I've learned that the basic stuff […] suffices at many times […]. But it is also true that there is so much to know about specifics. I have to learn, but don't have time."*[1] | Ende der Ausbildung, zunehmend eigenständige Tätigkeit | - Hoher Anspruch an die eigene Performanz<br>- Rigides, vorsichtiges und gründliches Verhalten<br>- Wenig Spontanität<br>- Weiterhin von außen abhängig<br>- Druck durch die nahende Lizensierungsprüfung<br>- Kampf um Autonomie<br>- Gelernt wird weiterhin durch die Imitation von Experten, allerdings kritischer als zuvor | - Anspannung<br>- Verletzlichkeit + Unsicherheit | 1. Komplexeres Wissen aneignen<br>2. Geforderte Kompetenzen zeigen<br>3. Offenheit für Neues und Selektion von Theorien + Techniken<br>4. Unrealistisches und perfektionistisches Therapeutenbild modifizieren<br>5. Verwirrung bewältigen, dass Therapie unendlich an Komplexität zunimmt | - Komplexeres, elaboriertes Rollenbild |

[1] zitiert nach Rønnestad und Skovolt (2013), S. 55 und 71.

**Tabelle 1 (Fortsetzung)**

| | Phase | Zeitraum | Allgemeine Beschreibung | Befinden | Entwicklungsaufgabe | Professionelle Rolle |
|---|---|---|---|---|---|---|
| **4** | **Novizen-Experte**<br><br>*"I felt like it was only me going through the disillusionment with what I didn´t know. Once I started talking with colleagues, I found that there were others in the same place."* [1] | Die ersten 2-5 Jahre nach der Lizensierung | – Bestätigung der eigenen Kompetenzen nach Lizensierung → Desillusionierung bzgl. der begrenzten eigenen Kompetenz und der Ausbildung → Exploration der eigenen Person und des Berufsstandes<br>– Therapeutische Arbeit wird flexibler<br>– Zunehmende Individualisierung<br>– Herausbilden eines eigenen Stils<br>– Gelernt wird durch Reflexion | – Selbst-vertrauen<br>– Angst + Frustration<br>– Zufriedenheit + Hoffnung | 1. Eigene berufliche Identität entwickeln<br>2. Transformation der vorherigen Abhängigkeit in Unabhängigkeit<br>3. Bewältigung der Desillusionierung bzgl. Ausbildung, Selbst und Profession<br>4. Die eigene Rolle explorieren und festigen | - Differenzierung zwischen eigener Verantwortung und der Verantwortung des Klienten |
| **5** | **Erfahrener-Experte**<br><br>*"I learned all the rules and so I came to a point […] where I knew the rules very well. Gradually I modified the rules. […] Lately I haven't been talking so much in terms of rules."* [1] | Mehrere Jahre Berufs-tätigkeit | – Konzeptualisierungen, Methoden und Veränderungsprozesse integrieren und konsolidieren<br>– Entwicklung eines konsistenten und kohärenten Selbst (persönlich/professionell)<br>– Festigung eigener Authentizität<br>– Niveau optimaler professioneller Involviertheit/Identifikation wird erreicht<br>– Methoden werden personalisiert und flexibel angewandt<br>– Gelernt wird aus eigenen Erfahrungen | – Sicherheit<br>– Heraus-forderung<br>– Vertrauen in eigene Kompetenzen und eigenes Urteils-vermögen | 1. Fortschreitendes professionelles Wachsen beibehalten, auf eigene Resilienz achten<br>2. Das eigene Selbst in ein kohärentes professionelles Selbst integrieren<br>3. Eine Therapeutenrolle entwickeln, die mit dem eigenen professionellen Selbst kongruent ist | – Therapeutische Rolle wird über Techniken und Methoden konzeptualisiert<br>– Eigener Stil |
| **6** | **Senior-Experte**<br><br>*"It became remarkable to me that someone would have the willingness to share their private world with me and that my work with them would bring positive results for them."* [2] | ab 20-25 Jahre nach der Lizensierung | – Von anderen als Experte angesehen werden<br>– Auseinandersetzung mit dem Ende der Berufstätigkeit<br>– Konfrontation mit eigenen (physischen) Grenzen<br>– *Loss of innocence* → verbessertes Gespür für die Grenzen des Machbaren<br>– Gelernt wird aus eigenen Erfahrungen | – Selbst-akzeptanz + Zufriedenheit<br>– Bescheidenheit<br>– Intellektuelle Apathie + Langeweile | 1. Fortschreitendes professionelles Wachsen beibehalten, auf eigene Resilienz achten<br>2. Mit dem Selbst kongruente Therapeutenrolle beibehalten<br>3. Ein Konzept für den Ruhestand entwickeln | - Eigener Stil |

[1] zitiert nach Rønnestad und Skovolt (2013), S. 82 und 98. [2] zitiert nach Rønnestad und Skovolt (2003), S. 27.

Legt man das Postulat des Phasenmodells der Entwicklung von Therapeuten, dass sich die Therapeutenentwicklung über seine gesamte Berufstätigkeit erstreckt, auch für die Erfassung therapeutischer Kompetenz zugrunde, so bedeutet dies, dass Messinstrumente in der Lage sein sollten, sowohl die therapeutische Kompetenz von Anfängern als auch von Senior-Experten zu erfassen. Die gegenwärtig existierenden Instrumente zur Erfassung therapeutischer Kompetenz setzten jedoch bereits an einer fortgeschrittenen Entwicklungsstufe an, so dass die differenzierte Erfassung therapeutischer Kompetenz zum Ende der ersten Phase (Laienhelfer), beziehungsweise zu Beginn der zweiten Phase (Anfänger) problematisch ist. Eine Diskussion dieser sowie anderer assoziierter Schwierigkeiten in der Erfassung therapeutischer Kompetenz soll nach einer allgemeinen Einführung im nächsten Kapitel erfolgen.

## 2.4 Erfassung therapeutischer Kompetenz

Muse und McManus (2015) haben in einer qualitativen Studie die Meinung von Experten zur Erfassung kognitiv-verhaltenstherapeutischer Kompetenz erfasst und drei übergeordnete Fragestellungen abgeleitet, die die gegenwärtigen Herausforderungen in der Erfassung therapeutischer Kompetenz widerspiegeln: „(i) what to assess; (ii) how to assess; (iii) who is best placed to assess“ (Muse & McManus, 2015, S. 1).

Die erste Herausforderung *what to assess* bezieht sich auf die bereits beschriebene Problematik des Fehlens einer allgemeingültigen Definition und eines einheitlichen Modells therapeutischer Kompetenz. Dies führt dazu, dass es kein einheitliches Konzept dazu gibt, was im Rahmen der Erfassung therapeutischer Kompetenz eigentlich zu erfassen ist.

Mit der zweiten Frage *how to assess* haben sich die Autoren bereits zuvor in einer Überblicksarbeit auseinandergesetzt (Muse & McManus, 2013) und aus der aktuellen Forschungslage die zehn wichtigsten Methoden abgeleitet. Basierend auf Millers Hierarchie klinischer Fertigkeiten (Miller, 1990), lassen sich diese den Stufen (1) Wissen (*knows*), (2) praktisches Verständnis (*knows how*), (3) praktische Anwendung des Wissens (*shows how*) und (4) Klinische Praxis (*does*) zuordnen (siehe Tabelle 2).

**Tabelle 2:** Die zehn wichtigsten Methoden zur Erfassung therapeutischer Kompetenz nach Muse und McManus (2013) basierend auf Millers Hierarchie klinischer Fertigkeiten (1990)

**Wissen** (*knows)*

1. Multiple Choice Fragen
2. Essays

**Praktisches Verständnis** (*knows how*)

3. Kurzantworten zu klinischen Fallvignetten
4. Fallberichte

**Praktische Anwendung des Wissens** (*shows how*)

5. Standardisierte Rollenspiele

**Klinische Praxis** (*does*)

6. Begutachtung von Therapiesitzungen (durch Beobachter mittels transdiagnostischer oder störungsspezifischer Ratingskalen)
7. Supervision (basierend auf der Beurteilung der Leistung eines Therapeuten in der Supervision durch den Supervisor)
8. Selbstbeurteilung des Therapeuten
9. Patientenfragebögen
10. Therapieergebnis

Muse und McManus (2013) stellen für die einzelnen Methoden existierende Instrumente vor, betonen aber über alle Verfahren hinweg die begrenzte Anzahl zur Verfügung stehender standardisierter Instrumente sowie deren meist fehlende psychometrische Güte. Des Weiteren werden Limitationen der einzelnen Methoden aufgeführt. Für die an zehnter Stelle genannte Methode, die therapeutische Kompetenz über das Therapieergebnis abzuleiten, werden beispielsweise als Limitationen genannt, dass die Methode nur eine indirekte Erfassung erlaubt und darüber hinaus mit verschiedenen anderen Faktoren konfundiert ist (z.B. durch Patientenvariablen wie Schweregrad und Komplexität der vorliegenden Störung sowie Lebensumstände). Ebenso wird die Validität der Selbstbeurteilung therapeutischer Kompetenz (Methode 8) angezweifelt. Die Autoren bezeichnen die Beurteilung durch einen Beobachter als Goldstandard, verweisen jedoch auch hier auf eingeschränkte empirische Evaluation. Hier sind zum einen eine niedrige Beurteilerübereinstimmung sowie fragliche Validität zu nennen (Fairburn & Cooper, 2011). Außerdem sind die Kriterien, welcher Punktwert einer zufriedenstellenden Kompetenz entspricht, in der Regel nicht empirisch begründet (McManus, Westbrook, Vazquez-Montes, Fennell, & Kennerley, 2010). Darüber hinaus ist bisher nicht empirisch erforscht, ob tatsächlich eine Generalisierung der Kompetenz, basierend auf einzelnen beurteilten Sitzungen oder Sitzungsausschnitten auf die klinische Praxis, tatsächlich möglich ist (Fairburn & Cooper, 2011). Insgesamt werden für alle Methoden Vor- und Nachteile genannt, eine differentielle Betrachtung, unter welchen Bedingungen welche Methode oder welche Kombination zu verwenden ist, existiert bisher nicht (Muse & McManus, 2015).

In dieser Arbeit bezieht sich die Erfassung therapeutischer Kompetenz primär auf die Beurteilung der tatsächlich in einer Sitzung gezeigten therapeutischen Kompetenz. Dazu wurden die Beurteilung der Sitzung durch einen Beobachter basierend auf einer standardisierten Ratingskala, die Selbstbeurteilung des Therapeuten und die Einschätzung durch den Patienten als Methoden verwendet. Darüber hinaus wurde auch die globale, sitzungsunabhängige Selbsteinschätzung des Therapeuten erfasst. Die dazu entwickelten Methoden, die die Erfassung therapeutischer Kompetenz von Anfängertherapeuten erlauben, werden in Kapitel 4 vorgestellt. Die in Kapitel 5 beschriebene Untersuchung der Effektivität einer Peer-to-Peer-Intervention berücksichtigt mit dem Einschluss des Therapieergebnisses eine weitere Methode zur Erfassung therapeutischer Kompetenz.

Die in Tabelle 2 zusammengestellten wichtigsten Methoden zur Erfassung therapeutischer Kompetenz beinhalten verschiedene Beurteilungsperspektiven. Die Frage, welche dieser Perspektiven nun zur Erfassung therapeutischer Kompetenz heranzuziehen ist, entspricht der dritten von Muse und McManus (2013) genannten Herausforderung (*who is best placed to assess*). Es herrscht Einigkeit darüber, dass therapeutische Kompetenz nicht über eine einzige Erhebungsmethode zufriedenstellend erfasst werden kann (Kamen, Veilleux, Bangen, VanderVeen, & Klonoff, 2010; Muse & McManus, 2013). Vielmehr setzt eine valide Erfassung therapeutischer Kompetenz verschiedene Methoden und Beurteilungen aus verschiedenen Perspektiven voraus (Hatcher et al., 2013; Kaslow, 2004; Leigh et al., 2007). Dieser Forderung liegt die Annahme zugrunde, dass es nicht die eine Möglichkeit der validen Erfassung therapeutischer Kompetenz gibt, sondern vielmehr jede Methode und jeder Perspektive einen wichtigen Aspekt therapeutischer Kompetenz erfasst (Orlinsky, Grawe, & Parks, 1994). Dass verschiedene Studien geringe bis gar keine Zusammenhänge zwischen verschiedenen Erhebungsmethoden gezeigt haben, unterstreicht die Notwendigkeit der verschiedenen Beurteilungsperspektiven (Dennhag, Gibbons, Barber, Gallop, & Crits-Christoph, 2012; Fitzpatrick, Iwakabe, & Stalikas, 2005; Mallinckrodt, 1993; Mathieson, Barnfield, & Beaumont, 2009; McManus, Rakovshik, Kennerley, Fennell, & Westbrook, 2012). Es ist anzumerken, dass eine multi-methodische und multi-perspektivische Erfassung therapeutischer Kompetenz eine Möglichkeit darstellt, die Limitationen der einzelnen Messverfahren auszugleichen.

Die beschriebene Heterogenität in der Erfassung therapeutischer Kompetenz, den einbezogenen Perspektiven und den zugrundeliegenden theoretischen Modellen therapeutischer Kompetenz erschwert die Vergleichbarkeit der Ergebnisse verschiedener Studien. Auch für die im Folgenden diskutierten Fragen zur Trainierbarkeit therapeutischer Kompetenz und deren Zusammenhang mit dem Therapieergebnis ist diese fehlende Einheitlichkeit als methodische Einschränkung zu berücksichtigen.

Der Ausbildung von Psychotherapeuten unterliegen zwei Grundannahmen: Zum einen, dass intensiveres und längeres Training einen Kompetenzzuwachs bedingt und zweitens, dass höhere Kompetenz zu einem verbesserten Therapieergebnis auf Seiten der Patienten führt (McManus et al., 2010). Diese beiden Annahmen sollen im Folgenden genauer betrachtet werden.

## 2.5 Training therapeutischer Kompetenz

Trainings zur Vermittlung therapeutischer Kompetenz unterscheiden sich darin, wem welche Kompetenzen vermittelt werden sollen. Da es international große strukturelle Unterschiede der Gesundheitssysteme gibt, sind auch die Trainingsinhalte sowie die Auszubildenden selbst sehr verschieden. Der Fokus dieser Dissertation liegt auf der Erfassung und Vermittlung praktischer therapeutischer Kompetenz innerhalb des deutschen Ausbildungssystems. Entsprechend steht dabei die Qualifikation von psychologischen Psychotherapeuten, beginnend mit dem Studium und fortgeführt in der Ausbildung zum Psychologischen Psychotherapeuten, im Mittelpunkt dieser Arbeit. Die internationale Vielfalt der Trainingsprogramme und ihrer Adressaten ist jedoch bei der Vorstellung internationaler Studien zu berücksichtigen.

Schmelzer beschrieb bereits 1997 die unter Psychotherapeuten verbreitete Annahme, dass langes und intensives Training für die therapeutische Arbeit mit Patienten unerlässlich sei. Er stellte weiter die gesamte Kultur der Ausbildung von Psychotherapeuten überhaupt in Frage und brachte zur Diskussion, ob nicht vielmehr die „effektive Selektion der begabtesten *Naturtalente*“ (Schmelzer, 1997, p. S. 155) im Fokus stehen sollte. Ähnlich fragten zuvor auch bereits Dobson und Shaw (1993), ob therapeutische Kompetenz angeboren oder trainierbar sei. Bis heute fehlen hinsichtlich der postulierten Trainierbarkeit therapeutischer Kompetenz eindeutige empirische Belege (McManus et al., 2010), so dass diese jahrzehntealte Debatte auch weiterhin aktuell bleibt. Auch die Frage, ob Trainingsmaßnahmen zur Vermittlung therapeutischer Kompetenzen effektiv sind, ist bisher nicht eindeutig geklärt. Dem entsprechend ist bisher auch unklar, welche Trainingsformen in diesem Bereich am besten geeignet sind. Es wird zwar gefordert, dass Trainingsmaßnahmen evidenzbasiert sein sollten, in der Praxis ist dies jedoch bisher nicht gegeben (Rakovshik & McManus, 2010).

Insgesamt ist die Forschungslage heterogen. So finden sich sowohl Studien, die begrenzte oder keine Zusammenhänge zwischen Training und therapeutischer Kompetenz berichten (Dobson & Shaw, 1993; Keen & Freeston, 2008) als auch Studien, die signifikante Trainingseffekte beschreiben (Hill et al., 2008; Hill & Lent, 2006; McManus et al., 2010). Bei

Fokussierung auf einzelne Kompetenzbereiche zeigt sich ebenfalls ein heterogenes Bild: Für den Bereich der Empathie postulierte Rogers (1957) beispielsweise, dass diese nicht trainierbar sei, nachfolgende empirische Untersuchungen zeigten jedoch durchaus eine Trainierbarkeit (Hill et al., 2008; Korn, 1980). Die heterogene Befundlage könnte darin begründet liegen, dass der Diskurs über Trainierbarkeit nicht pauschal geführt werden kann, da sich die einzelnen Aspekte therapeutischer Kompetenz möglicherweise in ihrer potentiellen Trainierbarkeit unterscheiden (Bennett-Levy, 2006). So gibt es beispielweise im Bereich der therapeutischen Beziehungen Befunde dazu, dass die Fähigkeit eine therapeutische Beziehung aufzubauen nicht trainierbar sei, die Fähigkeit eine Beziehung aufrechtzuerhalten hingegen schon (Crits-Christoph et al., 2006; Horvath, 2001). Auch Vogel und Alpers (2009) postulierten, dass sehr persönlichkeitsnahe Aspekte therapeutischer Kompetenz möglicherweise gar nicht durch Ausbildung veränderbar sind.

Mehrere Übersichtsartikel aus dem Jahr 2010 (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010; Rakovshik & McManus, 2010) haben die aktuelle Forschungslage zu Therapeutentrainings zusammengefasst. Die Übersichtsarbeit von Beidas und Kendall (2010) kommt zu dem Schluss, dass Training das Wissen von Therapeuten und ihre arbeitsbezogenen Einstellungen verbessert. Dennoch sollte diese Arbeit nicht als pauschaler Beleg für die Wirksamkeit von Trainings therapeutischer Kompetenzen herangezogen werden. So wird bei genauerer Betrachtung zum einen deutlich, dass sich die Arbeit auf Trainings zur Verbesserung evidenz-basierter psychologischer Interventionen bezieht und die inkludierten Studien entsprechend hinsichtlich der Profession äußerst heterogene Stichproben enthalten. Des Weiteren ist zu betonen, dass Wissen nur eine Facette therapeutischer Kompetenz darstellt. Weitere Aspekte therapeutischer Kompetenz, v.a. hinsichtlich praktischer Anwendung, bleiben unberücksichtigt. In Anlehnung an die Arbeit von McManus et al. (2010), die zeigen konnten, dass der berufliche Hintergrund ein Moderator für den Kompetenzerwerb ist, ist eine Interpretation dieser Arbeit im Zusammenhang mit der Trainierbarkeit therapeutischer Kompetenz von therapeutisch tätigen Psychologen also nur eingeschränkt möglich. Des Weiteren zieht die Übersichtsarbeit von Beidas und Kendall (2010) als Outcomemaße für den Trainingserfolg neben dem Wissen der Therapeuten auch ihre berufsbezogenen Einstellungen, ihre Wirksamkeitserwartungen und ihre Supervisionsbereitschaft heran. Therapeutische Kernkompetenzen bleiben allerdings unberücksichtigt.

Auch die Arbeit von Herschell et al. (2010) fokussiert auf psychosoziale Tätigkeitsfelder, so dass psychotherapeutische Kompetenzen auch hier nur einen Teilbereich darstellen. Die Arbeitsgruppe um Herschell (2010) hat die vorhandenen Trainingsstudien in sechs verschiedenen Kategorien gruppiert: Manual-basiert, interaktiv selbstgesteuert, Basis-Workshop, Aufbau-Workshop, Training von Experten als Multiplikatoren und Multi-Komponenten

Training. Die Autoren schlussfolgern, dass Multi-Komponenten Trainings am konsistentesten zu positiven Trainingsergebnissen führen. Weniger umfassende Weiterbildungs- und Trainingsmöglichkeiten hingegen bedingen nicht zwangsläufig einen Kompetenzzuwachs. Fairburn und Cooper (2011) kritisieren auch an dieser Übersichtsarbeit, dass Studien mit Stichproben verschiedener Professionen und Ausbildungsgraden (bspw. Krankenschwestern, Berater, Medizinstudenten) inkludiert wurden, so dass die bereits diskutierten Einschränkungen für die Interpretierbarkeit gelten.

Die Arbeit von Rakivshik und McManus (2010) hingegen kann eher für die Diskussion der Trainierbarkeit therapeutischer Kompetenzen wie sie im Rahmen dieser Dissertation verstanden werden, herangezogen werden. Im Fokus der Übersichtsarbeit stehen ausschließlich Trainingsmaßnahmen der kognitiven Verhaltenstherapie. Die Autoren untersuchten die Ergebnisse von 41 Studien hinsichtlich der Frage eines signifikanten Kompetenzzuwachses nach dem Training, des Erreichens eines zuvor definierten Kompetenzkriteriums und des Therapieergebnisses des Patienten. Demnach wurde in 19 Studien ein signifikanter Kompetenzzuwachs, verbunden mit dem Erreichen eines zuvor definierten Kompetenzkriteriums oder ein positives Therapieergebnis, berichtet. Des Weiteren zeigten 13 Studien einen signifikanten Kompetenzanstieg, der jedoch nicht das zuvor definierte Kriterium erreichte oder ein Therapieergebnis, das unter dem erwarteten lag oder aufgrund von spezifischen Messinstrumenten nicht mit anderen Studien verglichen werden konnte. Für 5 Studien wurde schließlich entweder kein signifikanter Kompetenzzuwachs oder kein zufriedenstellendes Therapieergebnis (im Vergleich zur Baseline, zur Kontrollgruppe oder zu unter *treatment-as-usual* erwarteten Effekten) berichtet. Darüber hinaus zeigen die Autoren einen Zusammenhang zwischen der Länge eines Trainings und dem erreichten Kompetenzzuwachs: längeres Training führt zu stärkerem Kompetenzzuwachs. Des Weiteren wurden die analysierten Studien hinsichtlich der Frage betrachtet, welche Bestandteile eines Trainings ein Training effektiv machen (*active training elements*). Die Autoren haben traditionelle didaktische Formen der Wissensvermittlung (Lesen von Manualen, Teilnahme an Fortbildungen) und interaktive und erfahrungsbezogene Methoden (Rollenspiele, Fallkonzeptualisierungen, Gruppendiskussionen, Supervisionen) in den analysierten Studien miteinander verglichen. Sie kommen schließlich zu dem relativ pauschal gehaltenen Ergebnis, dass traditionelle Formen der Wissensvermittlung nicht ausreichend sind um einen signifikanten Kompetenzzuwachs zu erreichen. Das Fazit von Rakovshik und Mc Manus (2010) lautet entsprechend, dass Trainingsmaßnahmen eine große Bedeutung bei der Vermittlung therapeutischer Kompetenzen zukommt. Doch auch bei dieser Übersichtsarbeit ist kritisch anzumerken, dass sich die analysierten Studien deutlich im Hinblick auf den professionellen Hintergrund, bzw. die Grundausbildung der Studienteilnehmer unterscheiden. Darüberhinaus ist kritisch anzumerken, dass die Autoren auch aus positiven Therapieergebnissen auf Patientenseite auf einen

Kompetenzzuwachs auf Seiten der Therapeuten schlossen. Da das Therapieergebnis jedoch wie bereits erläutert von vielen weiteren Faktoren abhängig ist, kann dieser Rückschluss nicht ohne weiteres gezogen werden.

Fairburn und Cooper (2011) stellen die Generalisierbarkeit von Studien zu Trainingseffekten aufgrund der Heterogenität der Stichproben grundsätzlich in Frage. Sie kritisieren, dass die meisten Studien die Effektivität von Trainings basierend auf einfachen Interventionen (z.B. Verhaltenstrainings bei sozialen Phobien) untersuchen, die der Komplexität realer Behandlungen nicht gerecht werden würden. Des Weiteren merken die Autoren an, dass in vielen Studien keine einheitlichen oder sogar aus methodischer Sicht schlechten Messinstrumente verwendet wurden. Auch haben Studien häufig eine geringe statistische Power und es fehlen Follow-up Erhebungen.

In Anbetracht der Tatsache, dass der Diskurs über die Trainierbarkeit therapeutischer Kompetenzen seit Jahrzehnten andauert, ist es umso überraschender, dass Training und Erwerb therapeutischer Kompetenzen nicht intensiver und methodisch fundierter erforscht sind. Auffallend ist außerdem, dass sich Ausbildungsmethoden in den letzten Jahrzehnten kaum verändert haben (Fairburn & Cooper, 2011). Nach aktuellem Stand ist der Zusammenhang von intensiverem Training und verbesserten therapeutischen Kompetenzen keinesfalls eindeutig belegt. Darüber hinaus bleibt auch die Frage, wie therapeutische Kompetenzen am besten zu vermitteln sind, bisher nicht eindeutig geklärt. Wobei es hier, wie auch Sharpless und Barber (2009a) anmerkten, möglicherweise nicht den einen optimalen Trainingsweg gibt. Es erscheint durchaus denkbar, dass sich die einzelnen therapeutischen Kompetenzen darin unterscheiden, durch welche Trainingsmethoden sie optimal vermittelt werden können. Des Weiteren könnten auch persönliche Eigenschaften des Therapeuten, wie sie als Dispositionen im *Drei-Ebenen-Modell therapeutischer Kompetenzen* (siehe Kapitel 4) beschrieben sind, einen Einfluss darauf haben, wie eine Kompetenz für einen Therapeuten am besten zu erlernen ist.

Im Anschluss soll nun die zweite der von McManus et al. (2010) postulierten Grundannahmen, die besagt, dass höhere Kompetenz zu einem verbesserten Therapieergebnis auf Seiten der Patienten führt, betrachtet werden.

## 2.6 Zusammenhang von therapeutischer Kompetenz und Therapieerfolg

McManus et al. (2010) betrachten den Zusammenhang zwischen dem Ausmaß an Kompetenz und besserem Therapieergebnis als gut erforscht und empirisch belegt. Dabei verweisen die Autoren beispielsweise auf die Forschungsarbeiten der Arbeitsgruppe um Kuyken, die für eine naturalistische psychotherapeutische Depressionsbehandlung zeigen konnten, dass höhere therapeutische Kompetenz mit einem besseren Therapieergebnis assoziiert ist, und zwar unabhängig vom Ausmaß der Belastung durch komorbide Störungen des Patienten (Kuyken & Tsivrikos, 2009). Im Gegensatz dazu zeigte eine ebenfalls 2010 publizierte Metaanalyse (Webb, DeRubeis, & Barber, 2010), dass therapeutische Kompetenz nicht eindeutig mit einer Veränderung der Symptomatik verbunden war. So zeigte diese Metaanalyse für den Zusammenhang zwischen therapeutischer Kompetenz und Behandlungserfolg lediglich eine minimale Effektstärke von $r$ = .07. Das Ergebnis beruht auf der Analyse von 17 Studien, die die Assoziation von Kompetenz und Behandlungsergebnis bei verschiedenen psychischen Störungen untersuchten. Möglicherweise sind also therapeutische Kompetenz und klinische Veränderung nur gering assoziiert. Die oben erwähnte Problematik einer fehlenden allgemeingültigen Definition therapeutischer Kompetenz in Kombination mit einer noch größeren Variabilität der Erhebungsmethoden therapeutischer Kompetenz bedeutet, dass in den in Metaanalysen inkludierten Studien die Operationalisierung therapeutischer Kompetenz bisweilen fragwürdig ist. Über Studien hinweg sind Ergebnisse nur begrenzt vergleichbar, entsprechend sind auch die Ergebnisse der Metaanalyse kritisch zu betrachten. Metaanalysen, die speziell den Zusammenhang zwischen therapeutischer Allianz und dem Therapieergebnis untersuchten, zeigen hingehen konsistent einen zumindest moderater Zusammenhang (Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000). Der Anteil, den der Therapeut zur therapeutischen Allianz beiträgt, determiniert maßgeblich den Zusammenhang von Allianz und Therapieergebnis (Del Re, Fluckiger, Horvath, Symonds, & Wampold, 2012). Vor dem Hintergrund der vorhandenen empirischen Befundlage zeichnet sich ab, dass es vermutlich keinen engen Zusammenhang zwischen therapeutischer Kompetenz und Therapieerfolg gibt.

Aufgrund der Komplexität des Konstrukts therapeutischer Kompetenz sollten zukünftige Studien differenziert den Zusammenhang einzelner Facetten therapeutischer Kompetenz mit dem Therapieerfolg untersuchen. Ebenso sollten Studien zum Einfluss von Therapeutenvariablen den Zusammenhang einzelner Therapeutenvariablen mit therapeutischer Kompetenz und Behandlungserfolg untersuchen.

# 3. Ziele des Gesamtvorhabens und seiner Teilstudien

Ziel dieses Dissertationsprojekts war es, ein theoretisches Modell therapeutischer Kompetenzen zu entwickeln, das als Grundlage für die Entwicklung von Messinstrumenten zur multi-perspektivischen und multi-modalen Erfassung therapeutischer Kompetenz herangezogen werden kann, um die Vermittlung und den Erwerb therapeutischer Kompetenzen bei Novizen-Therapeuten zu untersuchen.

Daher wurde in einem ersten Schritt (Studie 1; Kapitel 4) das *Drei-Ebenen-Modell therapeutischer Kompetenzen* entwickelt.

Als zweites Teilprojekt dieser Dissertation (Studie 2; Kapitel 5) wurden basierend auf dem *Drei-Ebenen-Modell therapeutischer Kompetenzen* verschiedene Messverfahren konzipiert, um therapeutische Kompetenz aus der Perspektive der Therapeuten (Selbst-Beurteilung), der Patienten (Fremd-Beurteilung) und unabhängiger Beobachter zu erfassen. Die entwickelten Messinstrumente sowie die Ergebnisse der psychometrischen Überprüfung sind in Kapitel 5 dargestellt.

Das dritte Teilprojekt (Studie 3; Kapitel 6) schließlich bestand darin, die Vermittlung und den Erwerb therapeutischer Kompetenzen im Rahmen einer Peer-to-Peer-Intervention zur studentischen Stressbewältigung zu untersuchen. Um die Effektivität dieser Intervention zu überprüfen, wurden zunächst Veränderungen der Zielvariablen (z.B. Stressbelastung und Depressivität) studentischer Klienten evaluiert. Ergänzend wurden mögliche Zusammenhänge zwischen dem Interventionserfolg und persönlichen Charakteristika der studentischen Therapeuten, wie sie im *Drei-Ebenen-Modell therapeutischer Kompetenzen* als *Dispositionen* beschrieben sind, untersucht.

# 4. Study 1: A working model of therapeutic competence[2]

## 4.1 Abstract

A common definition of therapeutic competence and a model of therapeutic competence which equally satisfies the requirements of practice and research are still lacking. The existing models of therapeutic competence 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 a *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.

## 4.2 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; Schaffer, Rodolfa, Hatcher, & Fouad, 2013). Beginning with Carl Rogers' work in the 1950, research on therapeutic competence was popular till a decline in the 80ies of the last century. Although these long tradition in defining core characteristics of psychotherapists, recently, research has focused then much more on therapy process and outcome (Baldwin & Imel, 2013; Strauss & Kohl, 2009). While in the meantime the therapist as a person has been considered in psychotherapy research more as a source of error, since the beginning of the 21st century the therapist is regarded again to be a key element of therapy (Beutler et al., 2004). Interest in therapeutic competence has been renewed, Kaslow even speaks of a "competencies-based movement" (2004, p. 774).

Answering the initial question requires a definition of therapeutic competence, as well as the availability of instruments for assessing therapeutic competence. Kaslow, Dunn, and Smith (2008) proposed *knowledge*, *skills* and *attitudes* as constituents of competence. The dimension *knowledge* seems to be easier to assess, some instruments already exist (e.g. national licensure exams such as the Examination for Professional Practice in Psychology in

[2] Das entsprechende Manuskript zu Studie 1 wird zur Publikation vorbereitet.

the USA (EPPP; Rehm & Lipkins, 2006)). Yet, there is quite a controversy with regard to the validity of these instruments (Sharpless & Barber, 2009b). *Skills* and *attitudes* are more difficult to define and assess because, to name just some aspects, they are complex and depend on the theoretical orientation. Furthermore, it is a challenge to define therapeutic skills such that they are theoretically satisfying, but also allow operationalization (Schaffer et al., 2013), whereas criteria for the assessment of knowledge are easier to specify (despite limitations). A major challenge with regard to assessing skills and attitudes also arises from the question whom to ask: therapist, client, independent observer or all three?

There are several aspects that make it difficult to find a uniform definition, derive a model and develop good measuring instruments. Indeed, it has been argued that competence is contextually defined (Yager & Bienenfeld, 2003) and hence influenced by numerous determinants (e.g. type of client, severity of psychopathology, setting, theoretical orientation of the therapist; Langer & Frank, 1999). The existing differences in theoretical orientations as well as national characteristics in training and licensure of psychotherapists also hinder reaching a consensus. Furthermore, any model of therapeutic competence needs to take into account the development and/or training of therapeutic competence. 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). Finally, therapeutic competence should be measurable and such an assessment would ideally be multimethod and multi-informant (Hatcher et al., 2013; Kaslow, 2004). Specifically, a multimodal assessment of therapeutic competence entails the perspectives of the therapist, the client and of the observer (i.e. independent rater or supervisor) and standardized knowledge tests (Kaslow et al., 2009; Sharpless & Barber, 2009a). Despite this consensus, available instruments do not fully meet these requirements (Sharpless & Barber, 2009a). Indeed, the available assessment tools lack validity and reliability (Lichtenberg et al., 2007).

However, 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. To sum, a clear definition is needed, as a base on which a model of therapeutic competence can be derived. At this point, there are several generic definitions of therapeutic competence that do not entail a model amenable to operationalization (e.g. Dobson & Shaw, 1993). In fact, a working model of therapeutic competence is needed that it can be used as a framework for the development of instruments for multidimensional assessment of therapeutic competence.

Existing models of therapeutic competence can be subdivided into three categories 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 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. Therefore, most acquisition models cover the entire professional life span. Third, some models of therapeutic competences describe the training of psychotherapists (Three-Stages Model by Hill, 2009; Cube Model by Rodolfa et al., 2005; 2013). The latter models focus directly on competences and refer to the formal training process. Accordingly, training models are limited to a certain period of time and usually end with certification or licensure. If training models include a time perspective, it mostly relates to the formal training steps and not to the development as a professional psychotherapist. Whereas Hill's (2009) three-stages model outlines the process of training, Rodolfa et al.'s (2005) cube model postulates target competences, which a trainee should have after completion stages of the training. Thus, it is also promising as a measurement model. In contrast to the acquisition models, the 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. Hence the acquisition of competence across life and work as a professional is largely neglected. In the last category of training models, the United States (US) competency model of the Association of State and Provincial Psychology Boards (ASPPB) or the so-called "cube model" as formulated by Rodolfa et al. (2005; 2013) stands out due to its elaboration. The model will be described here in more detail as an example for outlining the relationship between competence and training in a model. Later, limitations of the model will be addressed and further considerations that led us to outline a new working model of therapeutic competence with a special focus on its being amenable to measurement.

## 4.3 The Cube Competency Model and its modified version

Interest in the definition and training of therapeutic competence has a long tradition in the US. In recent years, researchers have emphasized that instead of assuming sufficient competence upon completing academic training and obtaining licensure, the demonstration of specified competences is required (Fouad et al., 2009; Kaslow & Keilin, 2006; Lichtenberg et al., 2007). At a Competencies Conference held in 2002, the research group of the ASPPB (Rodolfa et al., 2005) proposed a three-dimensional *Cube Model*, which was later revised (Rodolfa et al., 2013). Specifically, the first cube edge of the cube model encompasses six *foundational competency domains* which are "the building blocks of what psychologists do" (Rodolfa et al., 2005, p. 350), e.g. "relationships and ethical & legal standards/policy issues". The second cube edge entails the six *functional competency domains* including more specific competences like intervention and research/evaluation. The third dimension represents the five *stages of professional development,* beginning with *"*doctoral education" and ending with "continuing competency" as a professional. The original *Cube Model* has been criticized as being very complex and therefore difficult to use for guiding training, practice as well as research (Rodolfa et al., 2013). Therefore, the original model was condensed and revised for enhancing its practical use. This *Competency Model for the Practice of Psychology* (Rodolfa et al., 2013) contains six clusters with 37 specific competencies and 277 behavioral examples, supplemented by four stages of competence training (practicum, internship, licensure, four years licensed/registered). For illustrative purposes, Table 1 shows the six clusters, and in addition for the third cluster the content areas, and for one content area also the behavioral examples (Greenberg, Caro, & Smith, 2010).

When compared to other models, the *Competency Model for the Practice of Psychology* is unique both with regard to the extent of competences which are considered, the perspective of different stages of competence acquisition and the behavioral examples as a means to operationalize competences. Yet, the *Competency Model for the Practice of Psychology* has certain limitations. First, the reduced number of six cluster and the dropping of the three-dimensional structure of the anterior cube is a example of the danger of oversimplification outlined by Lichtenberg et al. (2007). Second, the *Competency Model for the Practice of Psychology* was developed for the training context, hence it is limited to the stages of the formal training in the US. 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 competences outlined by respective models such as the phases of professional development formulated by Rønnestad and Skovholt (2013). Furthermore, the *Competency Model for the Practice of Psychology* defines target skills for training, but qualitative aspects of the acquisition of a competence are not

outlined. Third, rather surprisingly, interpersonal competence is not sufficiently considered in model. The competence to build and maintain an alliance is not defined, although current understanding emphasizes the crucial importance of relationship building (e.g. Horvath et al., 2011). Fourth, the purported increased practical usability of the revised model must be questioned. 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. In addition, the model is of limited usefulness for the within-session assessment of therapeutic competence because the competences are not operationalized such that they can be assessed. Also, at least some competences may not be regarded as genuinely therapeutic competences (e.g. *commitment to the profession through continuing education* in cluster 4), which might be due to the generic approach of the model. Finally, the *Competency Model for the Practice of Psychology* (Rodolfa et al., 2013) does not differentiate between therapeutic skills which may be easier to train and learn as opposed to other competences which may more strongly reflect a person's dispositions. Similarly, it does not specifically take into consideration that the acquisition of therapeutic competence may also be influenced by the therapist's individual characteristics.

**Table 1:** Cluster of the Competency Model for the Practice of Psychology and examples for Content Areas and Behavioral Examples (Rodolfa et al., 2013)

**Competency Model for the Practice of Psychology**

***Cluster***

**1.** Scientific Knowledge

**2.** Evidence-Based Decision-Making/Critical Reasoning

**3.** Cultural and Interpersonal Competence

***Content Areas of Cluster 3***

1. Integrate and apply theory, research, professional guidelines, and personal understanding about social contexts to work effectively with diverse individuals, families, groups, communities, organizations, and research participants
2. Communicate effectively with individuals, families, groups, communities, and/or organizations

***Behavioral examples of the second Content Area of Cluster 3***

- Listen and communicate respectfully while showing empathy for others
- Demonstrate knowledge of importance of verbal and non-verbal cross-cultural, social, and communication
- Collaborate effectively in routine professional interactions with individuals, families, groups, communities, and/or organizations
- Recognize when verbal and non-verbal cross-cultural social and communication cues are occurring
- Collaborate effectively in complex situations with individuals, families, groups, communities, and/or organizations
- Use appropriate verbal and non-verbal cross cultural social and communication
- Develop insight regarding emerging situations that involve cross-cultural, social and interpersonal differences
- Collaborate effectively in conflictual situations with individuals, families, groups, communities, and/or organizations
- Provide consultation/training/supervision on appropriate verbal and non-verbal cross cultural social and communication

3. Integrate a collaborative perspective with all aspect of professional life
4. Identify and manage interpersonal conflict between self and others

**4.** Professionalism/Ethics

**5.** Assessment

**6.** Intervention/ Supervision / Consultation

***Note***: For sake of brevity, only the content areas of cluster 3 are provided.

Due to the limitations of the *Competency Model for the Practice of Psychology* (Rodolfa et al., 2013) we propose a working model 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, especially in session. 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 spe-

cific therapeutic approach. In the following, *the Three Level Model* will be described as a working model for investigating therapeutic competence.

## 4.4 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 (see Figure 1). The working model relies on the following definition of therapeutic competence: "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" (Barber et al., 2007, p. 494). Although originally proposed for clinical medicine (Epstein & Hundert, 2002), this definition includes all relevant aspects of competence. Nonetheless, it needs to be extended with "competencies involve the whole person and are teachable, observable, measurable, containable, practical, derived by experts, flexible and transferable across settings, and continually reevaluated and redefined" (Rubin et al., 2007, p. 453)**.**

The *Three Level Model* proposes 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 Competences*, which are mostly independent of the theoretical orientation, and *Specific Competences*, which differ depending on the theoretical orientation (e.g. Cognitive Behavioral Therapy (CBT)).

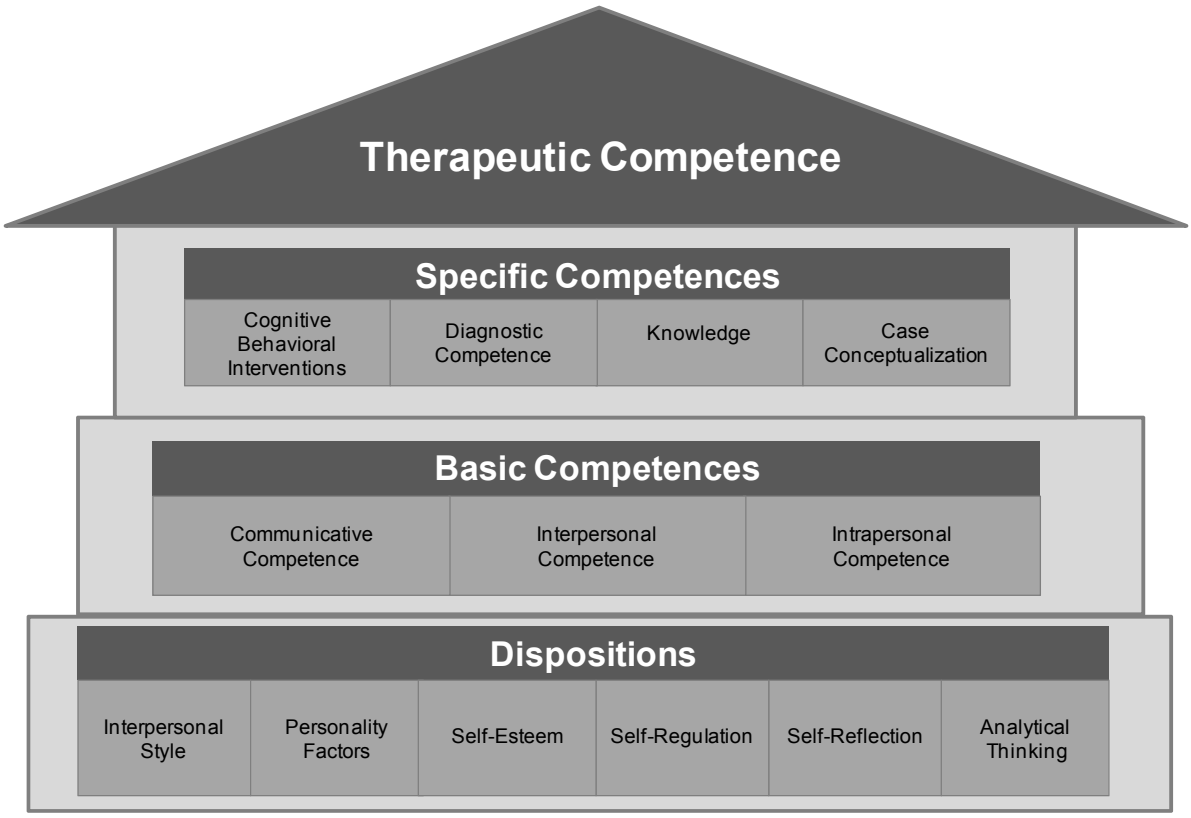


**Figure 1: The *Three Level Model of Therapeutic Competence* within a cognitive-behavioral framework**

### 4.4.1 Individual *Dispositions* as the basis of therapeutic competence

Dating back to the 1980s, the predictive value of certain individual characteristics of the therapist as a person was investigated (Costanzo & Philpott, 1986; Guy, 1987). Findings were often inconsistent and lacked robustness, and research on the therapist as a person declined (Beutler et al., 1994; Caspar & Eversmann, 2009). As a consequence, theoretical accounts about potentially more or less favorable individual characteristics of therapists' are still rather vague. Schmelzer (1997) concluded that the catalogue of therapists' personal characteristics represents mostly a collection of socially desirable personality traits. 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). 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.

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 psychometrical validation of the used assessment methods or only indirect assessment of therapeutic competence via essays or role-plays, only allow rather limited conclusions. 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. The role of therapists' characteristics has mostly been studied 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). Therefore, any inferences about beneficial characteristics must be treated with caution. Nonetheless, results from outcome studies might provide first clues which characteristics are relevant for therapeutic competence. 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.

We assume that such *Dispositions* characterize an individual even prior to the professional training and/or work as a therapist. Accordingly, *Dispositions* are presumed to be less malleable or even trainable. Importantly, however, depending on an individual's *Dispositions* the acquisition of therapeutic competences might differ in difficulty during training and in the competence level that may be achieved. In the *Three Level Model* the level *Dispositions* consists of six components: *interpersonal style, personality factors, self-esteem,*

*self-regulation, self-reflection and analytical thinking.* In the following, each of these components will be addressed in more detail.

***Interpersonal Style***

Some models of therapeutic competence like the SCIP model (Mallinckrodt, 2000) consider the aspect of the therapist's interpersonal behavior. 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 individual 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, Schüler, & 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 e*motion 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*, s*elf-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 favorable 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, 1969b). 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 homogenous 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.

### 4.4.2 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. C*ommunicative 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, basic attitude and several basic communication skills and as such it is also included in the US competency model (Rodolfa et al., 2013). 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). Whereas Rogers (1957) concluded that empathy was not teachable, others view empathy as an attitude that can be trained (Carkhuff, 1969b). 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. Some authors emphasize the importance of the cognitive aspects of empathy for the therapeutic profession (Hassenstab, Dziobek, Rogers, Wolf, & Convit, 2007), this is referred to as "therapeutic empathy" (Burns & Auerbach, 1996, p. 135). Being a rather broad category, communicative competence also encompass other aspects of therapists' basic attitudes such as genuineness and unconditional positive regard which Rogers had postulated as key variables for successful work as a therapist (Rogers, 1957). Similarly, the personality of the therapist has been supposed to be characterized by warmth, caring, kindness and trustworthiness (Ackerman & Hilsenroth, 2003; Guy, 1987), thus making these attributes candidates for selecting trainees (Dobson & Shaw, 1993). 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.

The importance of a therapeutic alliance is highlighted in numerous models and theoretical considerations (Grawe, Donati, & Bernauer, 1994; Horvath et al., 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 et al., 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.

### 4.4.3 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). Clearly, models and theoretical accounts of therapeutic competence differ in whether they refer to competences or skills or both. Yet, the difference between competence and skill are not specified (e.g. Guy, 1987). However, the effectiveness of psychotherapy is widely investigated and its effect is confirmed (Pfammatter & Tschacher, 2012). 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 understand 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 (c.f. 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 (e.g. 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 (e.g. in 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 (e.g. Kuyken, Fothergill, Musa, & Chadwick, 2005; Sudak et al., 2003). Clearly, *case conceptualization* 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 (cf. Cognitive Conzeptualization 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.

## 4.5 The *Three Level Model of Therapeutic Competence* and its practical use

As outlined earlier, the *Three Level Model of Therapeutic Competence* draws heavily on the *Competency Model for the Practice of Psychology* (Rodolfa et al., 2013). In the latter model (Rodolfa et al., 2013) those competences which we referred to as *Basic Competences* and *Specific Competences* are defined extensively. For example, the component *knowledge* of the *Three Level Model of Therapeutic Competence* corresponds to the first cluster *scientific knowledge base* in the model of Rodolfa et al. (2013). While some areas of knowledge are extensively specified (e.g. biological bases of behavior) others like building and maintaining an alliance are less specified in the model by Rodolfa et al. (2013) as compared to the model outlined here. Consistent with the idea of formulating a model that can be used more readily for research purposes, the levels *Basic Competences* and *Specific Competences* of our working model condense and summarize many of the numerous facets of therapeutic competence as proposed by the *Competency Model for the Practice of Psychology*. According to the three-dimensional structure of the first version of the *Cube Model* (Rodolfa et al., 2005) we organized the *Three Level Model of Therapeutic Competence* hierarchically and added the level *Dispositions*. Such individual dispositions were included in order to facilitate the investigation of the development and acquisition of therapeutic competence that takes into account the potential interaction between individual characteristics and psychotherapy training. Moreover, we believe 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. The main reason for developing this working 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 s*elf-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. *Basic Competences* and *Specific Competences* could be assessed by therapists' self-rating as well as by clients' or observers' ratings. 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.

# 5. Study 2: Multi-informant assessment of therapeutic competence[3]

## 5.1 Abstract

Therapeutic competence is discussed as a central element for the process and outcome of psychotherapy. Valid and reliable measurements are the basis for investigating therapeutic competence. Accordingly, assessment of therapeutic competence is required to be multi-informant and should therefore include the perspectives of therapists, clients and observers. There are several instruments assessing therapeutic competence from one of the requested perspectives. But yet there is no valid and reliable set of measurements that allows the assessment of therapeutic competence from the different perspectives based on the same theoretical background, what is central for making comparisons possible. We developed a set of measurements assessing therapeutic competences from different perspectives: therapists' global (GloRa-T) and session self-rating (SeRa-T), clients' session rating (SeRa-C) and observer rating (CoRa-O). All measurements assess the same components of therapeutic competence as illustrated in the Three Level Model of Therapeutic Competence, a working model of therapeutic competence. Because of the same theoretical base comparisons among the perspectives are possible. The set of measurements is presented and results of psychometric analysis are discussed.

## 5.2 Introduction

The investigation of therapeutic competence requires a clear definition and adequate assessment instruments. While a consensus-based definition of therapeutic competence is still lacking, the following definition derived from the field of medicine is frequently used (Epstein & Hundert, 2002): "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" (Barber et al., 2007, p. 494). Additionally, we recommend the supplement "competencies involve the whole person and are teachable, observable, measurable, containable, practical, derived by experts, flexible and transferable across settings, and continually reevaluated and redefined" (Rubin et al., 2007, p. 453).

Focusing on the assessment of therapeutic competence, a multi-method and multi-informant approach is required because of the special circumstances of the therapeutic setting (Hatcher et al., 2013; Kaslow, 2004). There is a broad consensus that "no single method is able to provide a comprehensive assessment of all aspects of [...] competence" (Muse

[3] Das entsprechende Manuskript zu Studie 2 wird zur Publikation vorbereitet.

& McManus, 2013, p. 495). Accordingly, with special regard to the assessment of therapeutic competences in single sessions, these should be assessed from three different perspectives: (a) therapists' self-report, (b) clients' rating and (c) observers' rating. Indeed, all three perspectives allow equally valid assessment of therapeutic competence, since each perspective taps different aspects of therapeutic competence (Orlinsky et al., 1994). Concerning the therapeutic session, the perception of both the therapist and the client might be biased subjectively, so the rating of an independent observer may provide a more objective additional perspective. Investigating the associations among the different perspectives ratings, various studies have shown low (e.g. McManus et al., 2012) or even no correlation among the different perspectives (Dennhag et al., 2012; Fitzpatrick et al., 2005; Mallinckrodt, 1993; Mathieson et al., 2009). These findings underline the importance of multi-perspective assessment.

***Therapists' self-report***. Therapists' self-assessment of therapeutic competence is frequently used because of low costs and simple application. However, therapists' self-ratings are also considered invalid due to the risk of therapists' personal bias and according lack of reliability (Kaslow et al., 2009; Mathieson et al., 2009). To give an example of a self-rating measurement, Bennett-Levy and Beedie (2007) developed the Cognitive Therapy Self-Rating Scale (CTSS). Items of the CTSS resulted of a modification of items of a frequently used observer rating scale (CTS; Young & Beck, 1980). Despite Cronbachs Alphas, which were reported for a sample size of 24 therapists from one training study, were adequate (Bennett-Levy & Beedie, 2007), the CTSS lacks further analysis of reliability and validity. Another self-rating questionnaire focusing on therapists perception of relevant working mechanism of the therapeutic process (Grawe, 2000) is the therapist version of the Berner Post Session Report (TSTB, Flückiger, Regli, Zwahlen, Hostettler, & Caspar, 2010). Its subscales were well confirmed by confirmatory factor analysis, reported reliability and validity were satisfying (Flückiger et al., 2010). While some subscales (e.g. resource activation) may well be used for the assessment of therapeutic competence, others are more specific variables of the therapeutic process (e.g. openness) and, therefore, not applicable to the assessment of therapeutic competence.

***Clients' rating***. Whether or not the clients' perspective is of relevance when assessing therapeutic competence continues to be a matter of controversy. On the one side, it is called that assessing the client perspective increases the quality of the assessment of therapeutic competence (Lichtenberg et al., 2007) and that clients' perspective reflects directly their experience of a skill (Hill & Kellems, 2002). On the other side, it has been argued that clients' view on the therapist's competence is likely not to match what therapists themselves as well as observers would consider to be competent (Fitzpatrick et al., 2005). Hence, it has been

questioned that clients' ratings are meaningful judgments of a therapist's competence at all (Muse & McManus, 2013), what might explain why clients' perspective are usually not assessed in research studies (Dennhag et al., 2012). It must be considered that clients are only able to rate some specific aspects of therapeutic competence like establishing and maintaining a therapeutic relationship or certain specific behaviors. Accordingly, many of the existing instruments assessing clients' rating of therapeutic competence deal with clients' perception of the therapeutic relationship (e.g. Working Alliance Inventory (WAI, Horvath & Greenberg, 1989)). The authors report for the WAI adequate reliability and validity. But the high intercorrelations of the three subscales (bond, goals and tasks), however, questions their distinctness. Of course those clients' ratings rather assess the consequence of therapist's competence to establish and maintain a therapeutic relationship and thereby only allow an indirect inference of therapeutic competence. A more general assessment of relevant aspects of the therapeutic process allows the patient version of the Berner Post Session Report (PSTB, Flückiger et al., 2010) with focus on Grawe's working mechanisms (2000). The reported psychometric quality is as satisfying as the therapists' version. Like for the TSTB, some scales of the PSTB assess specific process variables which can be interpreted as aspects of therapeutic competence (e.g. experience of clarification) whereas others are not specific for the therapeutic process (e.g. coping experiences).

***Observers' rating***. Objective ratings of therapeutic competence by external observers such as supervisors or independent judges are usually based on single sessions (live or videotaped). Independent observers are frequently used in clinical studies, whereas supervisor ratings are widespread in training of psychotherapists. Yet, studies have shown that supervisors and independent judges differ in their ratings of therapeutic competence, with supervisor ratings mostly being more positive (Dennhag et al., 2012; Martino, Ball, Nich, Frankforter, & Carroll, 2009). However, it has not been finally clarified yet whether supervisors have a bias because of their personal relationship to the therapist or whether their rating is more valid because of their knowledge of relevant contextual factors of the therapeutic process (Dennhag et al., 2012). A frequently used observer rating tool is the Cognitive Therapy Scale (CTS; Young & Beck, 1980) and its revised version CTS-R (Blackburn et al., 2001). Muse and McManus (2013) summarized the research findings of several studies investigating the CTS and reported high internal consistencies but high intercorrelations of the subscales, an instable inter-rater reliability and as main criticism poor content validity because of overly focusing on the treatment of depression, overlaping in the content of items and lacking of key competences. Reporting in addition the psychometric quality of the CTS-R the authors came to the conclusion that even the revised version "may not have fully overcome the limitations of the CTS" (Muse & McManus, 2013, p. 491). In addition, Roth (2016) questioned the generic nature of the CTS by pointing out the need to adapt the scale in dependence of the conditions

of the therapeutic setting and furthermore criticized that several interventions concerning clients' change are represented by only one item. Recently, Roth (2016) published ideas for the development of a new scale (University College London – Scale (UCL-Scale)) based on the competence framework (Roth & Pilling, 2007). Yet, the evaluation study is still running, so the psychometric quality of the scale is still unknown.

All in all, the requirement to consider subjective and objective perspectives for the assessment of therapeutic competence (Hill et al., 2008) is actually not met satisfactory. Although there are several instruments to assess therapeutic competence from a certain perspective, the assessments are mostly limited to one perspective. Additionally, some measurements only allow an indirect estimation of a competence because of assessing a consequence of rather than the therapeutic competence itself (e.g. assessments of the therapeutic alliance). Problematically, the assessment tools are based on different theoretical foundations, so finally the results are not comparable and measurements assessing different perspectives cannot be integrated (Muse & McManus, 2013). Furthermore, most assessments are rather not based on a theoretical model of therapeutic competence but rather reflect the understanding of the researchers which therapeutic competences are important. Finally, the existing instruments cannot be used for the assessment of therapeutic competence of graduate students starting their clinical training or in context of psychotherapy training because the content of some items was inappropriate for this field (e.g. item *application of cognitive therapy techniques* from the CTS (Young & Beck, 1980)). Some items require a level of competence above the one that can be expected at an initial stage.
In sum, there is a lack of multi-informant measurements of therapeutic competence sharing the same theoretical basis, being applicable at initial stages of clinical training, empirically validated and efficient to use.

## 5.3 Development of a set of multi-informant measures

Our set of multi-informant measurements of therapeutic competence was developed based on theoretical considerations about central components of therapeutic competence illustrated in the *Three Level Model of Therapeutic Competence*. This model summarizes currently discussed aspects of therapeutic competence and integrates these aspects on three levels: First, on a rather stable individual level of *Dispositions (interpersonal style*, *personality factors*, s*elf-esteem*, *self-regulation, self-reflection* and a*nalytical thinking)* which are postulated to be the groundwork for the achievement of therapeutic competence. We further distinguish between the second level *Basic Competences (communicative competence*, *interpersonal competence* and *intrapersonal competence)*, which are universal components that are postulated to be essential for any therapist regardless of his/her theoretical

background and on the third level *Specific Competences (cognitive behavioral interventions*, *diagnostic competence*, *knowledge* and *case conceptualization*) which differ depending on the theoretical orientation (e.g. CBT).

On the basis of the *Three Level Model of Therapeutic Competence* our aim was to multi-method measurement tools for assessing therapeutic competences from the perspectives of therapists, clients and observers. As the measurements should allow for direct comparisons between the perspectives, the same components of therapeutic competence should be assessed by all of them.

## 5.4 Materials and Methods

### 5.4.1 Setting

The measures were developed and evaluated as part of a therapeutic training program at the Department of Clinical Psychology at Justus Liebig University Giessen, Germany. Advanced Master level students in clinical psychology were trained in basic therapeutic and certain CBT-skills after which they provided individual sessions in stress management to student clients not enrolled in a psychology program. The clients were seeking help for problems related to student life (e.g. time management, relaxation techniques, emotion regulation). Each student therapist provides 10 individually tailored sessions to two clients.

### 5.4.2 Samples

***Student therapists***. A total of *N* = 48 graduate student therapists (age: *M* = 24.6 yr, *SD* = 2.0; gender: 96% female) rated their perceived therapeutic competence.

***Clients***. A total of *N* = 96 student clients (age: *M* = 25.3 yr, *SD* = 5.1; gender: 80% female; area of study: 19% teacher training class, 17% nutrition science, 8% veterinary medicine, 8% law studies, 48% other) rated their student therapist.

### 5.4.3 Measures of therapeutic competence

Based on a-priori theoretical considerations and results of preliminary analysis we decided to limit therapists self-rating, clients rating and observer rating to the components *communicative competence*, *interpersonal competence* (both *Basis Competences*) and *cognitive behavioral interventions* (*Specific Competences*) of the *Three Level Model*. For the remaining components of the Three Level Model (e.g. *intrapersonal competence* or *case conceptualization*) additional instruments were used which were not part of the present study.

#### 5.4.3.1 Therapists self-ratings

***Therapist's global rating*.** To measure the global self-assessment of therapeutic competence we developed based on the Three Level Model the 22-item questionnaire *Global Rating - Therapist* (GloRa-T, original German title: Selbsteinschätzung therapeutischer Kompetenz, SetK). GloRa-T consists of two subscales *Basic Competences* (*communication skills* (# 1-5) and *interpersonal competences* (# 6, 7)) and *Specific Competences* (*cognitive behavioral interventions* # 8-22). The component *cognitive behavioral interventions* includes general CBT competences (# 8-17) and in addition techniques of Kanfer's (2006) self-management therapy (# 18-22). Therapists rate how much they agree on a 5-point Likert scale ranging from 0 (not at all) to 4 (fully agree). Subscales are formed by summing up the item raw scores and dividing by the number of items per scale.

***Therapist's session rating***: For assessing self-perceived in-session therapeutic competence, we developed a session rating questionnaire (Session Rating Therapist, SeRa-T; original German title: Stundenbeurteilungsbogen Therapeut; StB-T). SeRa-T was developed based on a selection of items from the Bern Post Session Report (Flückiger et al., 2010). Some items were adapted (e.g. *patient* was replaced by *client*). In addition, some newly formulated items were added (see Table 7) for those components of the *Three Level Model* which are not represented by items of the Bern Post Session Report. SeRa-T consists of 27 items, which assess *Basic Competences* (*communicative competence* # 4-6, *interpersonal competence* # 1-3, 7) and *Specific Competences* (*cognitive behavioral interventions* # 8-27). The component *cognitive behavioral interventions* includes general CBT skills (# 8-22) and in addition items assessing the competence in techniques of Kanfer's (2006) self-management therapy (# 23-27). According to the Bern Post Session Report therapists rate their agreements to items 1 - 7 on a bipolar 7-point Likert scale ((-3) not at all *to* (+3) yes, exactly). These item answers are for analysis recorded to 0 - 6. For items 8 - 27 therapists rate on a 5-point Likert scale (0 = not at all to 4 = fully agrees) how much they agree. Subscales are formed by summing up the item raw scores and dividing by the number of items per scale.

#### 5.4.3.2 Clients session rating

Similar to the therapists' version, the session rating questionnaire for clients (Session Rating Client, SeRa-C; original German title: Stundenbeurteilungsbogen Klient; StB-K) was developed based on some items taken from the Bern Post Session Report (Flückiger et al., 2010). Some of the items were adapted (e.g. *therapist* was replaced by *counselor*). New items were added (see Table 11) for those components of the Three Level Model which were not covered by the Bern Post Session Report and the Therapy Rating Sheet. SeRa-C contains of 20 items assessing the subscales *Basic Competences* (*communicative competence*

# 7, 14; *interpersonal competence* # 1, 5, 6) and *Specific Competences* (*cognitive behavioral interventions* # 2-4, 8-13, 15, 16; *techniques in self-management therapy* # 17-20). According to the Bern Session Report, clients rate their agreement on a 7-point Likert scale ((-3) not at all to (+3) yes, exactly). For analysis item answers are recorded to 0 – 6. Subscales are formed by summing up the item raw scores and dividing by the number of items per scale.

#### 5.4.3.3 Observer rating

The Competence Rating for Observer (CoRa-O, original German title: Kompetenz-Rating, KoRa) was used to assess observer ratings of therapeutic competence based on videotapes of sessions. CoRa-O consists of 12 items including two subscales (*Basic Competences* and *Specific Competences),* a global rating of therapeutic competence (# 1) and a rating of the difficulty of working with this specific client (# 14). The subscale *Basic Competences* consists of the components *communicative competence* (# 2-4) and *interpersonal competences* (# 5, 6). The subscale *Specific Competences* (# 7- 13) entails items assessing *cognitive behavioral interventions* (# 7-12) and *techniques in self-management* (# 13) therapy. Observers rate on a 5-point Likert scale (1 = barely competent; 3 = moderately competent; 5 = very competent) how competent they perceived the therapist. For the end and midpoints of the scale (scale levels 1, 3 and 5) verbal anchors were formulated (see Table 2 for an example). Subscales are formed by summing up the item raw scores and dividing the sum by the number of items per scale.

For the present study, video-based observer ratings were obtained for N = 71 sessions. Raters were two female psychology students. The two raters participated in 15 hours of training. First, items were explained and videos with exemplary ratings were presented. Finally, three ratings were done by the raters and after that discussed in group. During training a total agreement between the two raters (both rating the same score) or a maximal deviation of one scale point between both raters was sought. During the rating process raters discussed their ratings of every tenth video to avoid drifting apart, subsequent revisions were not allowed. Observers rated student therapists' competence for a window of 20 minutes (minute 20 to 40 of the one-hour sessions).

**Table 2:** CoRa-O, Item 8 with the formulated verbal anchors

| **Item 8: Encourages active engagement of the client** | |
|---|---|
| **1** | Tends towards condescending instructions, appears bossy. Hardly motivates the client to actively engage. Hardly leaves client freedom to act.<br>*Ziele werden kaum erfragt. Arbeitet kaum zielorientiert. Lenkt Aufmerksamkeitsfokus fast nie zielgerichtet. Hilft wenig beim Erwerb von Strategien zur Bewältigung von Problemen, fokussiert kaum auf Verbesserung der Handlungskompetenzen. Deutlich problemorientiert.* |
| **2** | |
| **3** | Partly motivates the client to actively engage and leaves them freedom of action. However, also tends to give advice and highlights connections, leaves the client little space for independent thought.<br>*Ziele werden erfragt, jedoch eher global. Arbeitet nicht immer zielorientiert. Lenkt die Aufmerksamkeit nicht immer zielgerichtet. Hilft meistens beim Erwerb von Bewältigungsstrategien,jedoch auch manchmal problemorientiert.* |
| **4** | |
| **5** | Intensively motivates the client to engage actively, leaves optimal freedom of action. Encourages the client's independent thought processes very appropriately/adequately.<br>*Erfragt Ziele sehr detailliert, arbeitet stets sehr zielorientiert, lenkt Aufmerksamkeit immer zielgerichtet. Unterstützt durchgängige Strategien zur Bewältigung von Problemen, verbessert stets Handlungskompetenzen.Deutlich lösungsorientiert.* |

Interclass coefficients (ICC) as measurements of interrater reliability were calculated for the total scale and for individual items. The interclass coefficient for the total scale was *ICC* = .63**, which is below the recommended lower limit of .75 (Portney & Watkins, 2014). For the individual items ICCs were spread over a large range (.41*** ≤ *ICC* < .68**, see Table 15) and are all just moderate.

### 5.4.4 Instruments for validity measures

#### Interpersonal behavior

We used the German translation of the short version of the Inventory of Interpersonal Problems (IIP-C; Horowitz, Strauß, & Kordy, 2000). Each item has to be answered on a 5-point Likert scale (0 = not at all *to* 4 = extremely). The IIP-C entails eight subscales which are formed by summing up item raw scores. The German version was shown to be reliable and valid (Horowitz et al., 2000). Because of a priori theoretical consideration we used the subscales *self-sacrificing* and *socially inhibited* for validity analysis.

#### Personality

To assess personality traits we used the German translation of the NEO-FFI (Borkenau & Ostendorf, 1993). The NEO-FFI contains 60 Items rated on a 5-point Likert scale (0 = strongly disagree *to* 4 = strongly agree). Validity and reliability of the German NEO-FFI have been

demonstrated (Borkenau & Ostendorf, 1993). The NEO-FFI entails five subscales which are formed by summing up the item raw scores and dividing the sum by the number of items per scale. We used the subscales *neuroticism*, *extraversion*, *agreeableness* and *consciousness* for validity analysis.

**Empathy**

The German version of the Interpersonal Reactivity Index (IRI, Davis, 1980; SPF, Saarbrückener Persönlichkeitsfragebogen, V3.1, Paulus, 2009) was used to assess empathy. The SPF contains 16 items to be answered on a 5-point Likert scale (1 = does not describe me well *to* 5= describes me very well). The German version SPF shows good reliability, validity and discrimination coefficients (Paulus, 2009). The SPF consists of 5 subscales and the score of each is calculated by summing up its item raw scores. We used the subscales *perspective taking* and *empathic concern* for validation analysis.

**Self-Esteem**

The Rosenberg Self-esteem Scale (RSES, Ferring & Filipp, 1996) was used to assess self-esteem. The RSES consists of 10 items rated on a 4-point Likert scale (0 = strongly disagree *to* 3 = strongly agree). The German version shows satisfactory validity and reliability (Ferring & Filipp, 1996). Subscales are formed by summing up the item raw scores and dividing them by the number of items per scale.

### 5.4.5 Procedure

All student therapists' self-ratings (GloRa-T, IIP-C, SPI, RSES) were conducted via an online platform prior to the beginning of the training and after completing sessions with both clients. The NEO-FFI was only performed once at the beginning. For all validity analyses we used the data from the post-measurement, except pre-data of the NEO-FFI. For psychometric analysis of GloRa-T we only used the data from the end of the project. *N* = 2 student therapists missed completing these questionnaires, so a final data set of *N* = 46 student therapists was analyzed.

Session ratings (SeRa-T, SeRa-C) were completed after sessions 2 and 9 in a paper-pencil version. For evaluating SeRa-T we used the session ratings of the ninth session with the second clients. *N* = 3 student therapists missed completing these session ratings and *N* = 3 clients dropped out of the therapy so finally *N* = 43 surveys were evaluated. For SeRa-C

the ratings of all clients of the ninth session were used. *N* = 5 clients dropped out of the project, *N* = 6 clients had not participated in the study and *N* = 3 clients missed completing session ratings. Finally, session ratings of *N* = 82 clients were evaluated (*N* = 40 first clients and *N* = 42 second clients). For evaluation the validity of SeRa-C we only used the ratings of the second client in the ninth session (*N* = 42). Sessions 2 and 9 were videotaped. Psychometric analysis of CoRa-O referred to the records of the ninth session. 11 clients did not agree with the video recording, 5 clients dropped out of the project, 5 tapes must be excluded due to technical problems and 4 videos were used for training and therefore excluded from the rating. Finally N = 71 videotapes of session 9 were rated (N = 36 with the first client, N = 35 with second client). For the analysis of validity only ratings of the ninth session with the second client (N = 35) were used.

### 5.4.6 Data analysis

***Descriptive statistics and item analysis***: First, descriptive statistics (Mean (*M*), standard deviation (*SD*) and results of item analysis (minimum and maximum ratings, range, skewness and kurtosis) were described. Item total correlations values above $r_{it}$ = .30 were interpreted as good (Fisseni, 2004). According to Miles and Shevlin (2001) skewness and kurtosis were interpreted as follows: First, concerning the absolute values of skewness and kurtosis, values smaller than 1 were assessed as acceptable, values between 1 and 2 as critical but tolerable and values higher than 2 as inacceptable. Second, the ratio of the values of skewness and kurtosis in relation to the values of the standard error (*SE*) were conducted. Values of skewness and kurtosis greater than twice the standard error were interpreted as significantly differing from the normal distribution. Subsequently, at the level of the subscales, means, standard deviations and item total correlations ($r_{it}$) were conducted and in addition we used Cronbach's alpha ($\alpha$) as measurement for internal consistency.

***Validity analysis***: Correlations between the multi-informant ratings (GloRa-T, SeRa-T, SeRa-C and CoRa-O) and scores of the other standardized questionnaires rated by the therapists were evaluated by Pearson product-moment-correlations ($r_{xy}$). A significance level of $p < .05$ was used for these analyses. For therapist's self-ratings (GloRa-T, SeRa-T) and observer ratings (CoRa-O) we expected correlations between *Basic Competences* and interpersonal behavior (subscale *self-sacrificing* (IIP)), personality *(*subscales *extraversion* and *agreeableness* (NEO)), empathy (subscales *perspective taking* and *empathic concern* (SPF)) and self-esteem (RSES) which were interpreted as convergent validity. Additionally, correlations between *Basic Competences* and interpersonal behavior (subscales *cold* and *socially inhibited* (IIP)), and personality (subscale *neuroticism* (NEO)) were expected, which were interpreted

as divergent validity. Furthermore, correlation between *Specific Competences* and personality (subscale *consciousness* (NEO)) were expected, which was also interpreted as convergent validity. For clients' ratings (SeRa-C) we do not expect correlations between their ratings of *Basic* and *Specific Competences* and therapists' self-ratings of personality (NEO), interpersonal behavior (IIP) and any intrapersonal characteristics (SPF, RSES), which was interpreted as divergent validity.

***Interrater reliability***: Interrater reliability of CoRa-O was determined by calculating intraclass-correlations (Shrout & Fleiss, 1979; unadjusted two-way random model, all ratings from both raters (ICC(2,2))). All statistical analyses were calculated using SPSS 22.

## 5.5 Results

### 5.5.1 Therapists self-ratings

#### 5.5.1.1 Global-Rating-Therapist (GloRa-T)

**Descriptive statistics and results of item analysis**

Means of all GloRa-T items gathered around the midpoint of the Likert scale ($M$ = 2.93, $SD$ = .77 (# 18) to $M$ = 3.63, $SD$ = .53 (# 6)) (see Table 3). The range of the item scores was generally rather small, with no ratings on the end points of the Likert scale. Furthermore, the items were skewed to the left, analysis of kurtosis showed that most items were leptokurtic. All in all, the distribution of the items was tolerable with exception of item 16 (*Kurtosis* = -2.09, $SE$ = .69), that was not distributed normally (see Table 4). The subscales showed good or acceptable internal consistencies (*.72* ≤ *α* < *.86*), except for subscale *interpersonal competences* (*α* = .29). Therefore, the two items of the subscale, *working alliance* (# 6) and *role behavior* (# 7) were considered separately in former analysis and no item discrimination coefficients were calculated. Accordingly, for this scales internal consistencies and item discrimination coefficients were not calculated. The remaining item discrimination coefficients of the subscales were all above the recommended lower limit of $r_{it}$ = .3. GloRa-T's subscales *communicative competence*, *working alliance*, *CBT interventions* and *techniques in SMT* were highly intercorrelated (.44** ≤ $r_{xy}$ < .86***, see Table 5). In contrast, there were no correlations between *role behavior* and the other subscales.

**Table 3:** Items of the GloRa-T (Global Self Rating - Therapists) and scale properties: Means (M), standard deviations (SD), minimal and maximal ratings, range, skewness and kurtosis

| | | *M (SD)* | *min-max* | *Range* | *Skewness* | *Kurtosis* |
|---|---|---|---|---|---|---|
| 1* | I can meet clients with appreciation<br>*Ich kann Klienten wertschätzend begegnen* | 3.59 (.50) | 3-4 | 1 | -0.37 | -1.95 |
| 2* | I can feel with the clients and understand their problems<br>*Ich kann mich in Klienten hineinversetzen und ihre Probleme nachvollziehen* | 3.24 (.48) | 2-4 | 2 | 0.62 | -0.11 |
| 3* | I really fulfill the role of being a counselor, I don't just pretend to do so<br>*Ich kann mich in die Rolle des Beraters einfühlen und spiele sie nicht nur* | 3.48 (.55) | 2-4 | 2 | -0.34 | -1.05 |
| 4* | I can listen attentively<br>*Ich kann aktiv zuhören* | 3.50 (.62) | 2-4 | 2 | -0.86 | -0.21 |
| 5* | I can establish a warm and welcoming atmosphere<br>*Ich kann eine warme und freundliche Atmosphäre schaffen* | 3.48 (.59) | 2-4 | 2 | -0.60 | -0.55 |
| 6* | I can built up a relationship with clients<br>*Ich kann eine Beziehung zu Klienten aufbauen* | 3.63 (.53) | 2-4 | 2 | -1.02 | -0.03 |
| 7* | I can take up a friendly, yet professional position towards clients<br>*Ich kann eine freundliche, aber nicht zu private Position gegenüber Klienten einnehmen* | 3.04 (.67) | 1-4 | 3 | -0.52 | 1.06 |
| 8 | I can work goal-oriented<br>*Ich kann auf ein Ziel hinarbeiten* | 3.26 (.61) | 2-4 | 2 | -0.20 | -0.50 |
| 9 | I can establish a positive efficacy expectation<br>*Ich kann eine positive Wirksamkeitserwartung aufbauen* | 2.96 (.70) | 1-4 | 3 | -0.35 | 0.31 |
| 10 | I can refer to the client's current life circumstances<br>*Ich kann einen Bezug zur aktuellen Lebenssituation des Klienten herstellen* | 3.26 (.65) | 2-4 | 2 | -0.31 | -0.64 |
| 11 | I can notice the clients' resource and strengths<br>*Ich kann die Stärken der Klienten beachten* | 3.26 (.71) | 2-4 | 2 | -0.43 | -0.90 |
| 12 | I can develop strategies for problem-solving<br>*Ich kann Problemlösestrategien erarbeiten* | 3.13 (.65) | 2-4 | 2 | -0.14 | -0.58 |
| 13 | I can emphasize on new approaches to various problem areas and their relationship<br>*Ich kann Klienten neue Sichtweisen auf Zusammenhänge verschiedener Problembereiche aufzeigen* | 3.17 (.64) | 1-4 | 3 | -0.69 | 1.85 |
| 14 | I can motivate clients to participate actively<br>*Ich kann Klienten zur aktiven Mitarbeit anregen* | 3.15 (.73) | 1-4 | 3 | -0.60 | 0.36 |
| 15 | If it is necessary and reasonable, I can let go of my pre-structured session agenda and attend to the clients' recent situations<br>*Ich kann mich – falls notwendig & sinnvoll – von meinem Sitzungsplan lösen und auf die aktuelle Situation der Klienten eingehen* | 3.43 (.69) | 2-4 | 2 | -0.83 | -0.46 |
| 16 | I can structure the sessions<br>*Ich kann Sitzungen strukturieren* | 3.50 (.51) | 3-4 | 1 | 0.00 | -2.09 |
| 17 | I can choose reasonable interventions<br>*Ich kann sinnvolle Interventionen auswählen* | 3.24 (.64) | 2-4 | 2 | -0.25 | -0.58 |
| 18 | I can turn the clients' focus towards controllable behavioral variables and away from personality traits<br>*Ich kann die Blicke der Klienten auf beeinflussbare Verhaltensweisen (und weg von Persönlichkeitseigenschaften) lenken* | 2.93 (.77) | 1-4 | 3 | -0.19 | -0.54 |
| 19 | I can point out a reasonably positive view to the clients<br>*Ich kann Klienten eine angemessen positive Sichtweise aufzeigen* | 3.20 (.58) | 2-4 | 2 | -0.03 | -0.19 |
| 20 | In cooperation with the client I can divide the relevant problem into sub-steps<br>*Ich kann gemeinsam mit Klienten das zu lösende Problem in Teilschritte zerlegen* | 3.22 (.73) | 2-4 | 2 | -0.36 | -1.00 |
| 21 | I can encourage clients to let go of fixed opinions and provide flexible viewpoints instead<br>*Ich kann Klienten von absoluten Sichtweisen lösen und ihnen eine flexiblere Sicht der Dinge vermitteln* | 3.11(.67) | 2-4 | 2 | -0.13 | -0.72 |
| 22 | I can help the clients to focus on the future<br>*Ich kann den Blick der Klienten auf die Zukunft lenken* | 3.20 (.72) | 2-4 | 2 | -0.31 | -0.97 |

**Table 4:** Subscales of GloRa-T: Means (*M*), standard deviations (*SD*), minimal and maximal item discrimination coefficients ($r_{it}$) and internal consistency (Cronbachs *α)*

| | | *M (SD)* | $r_{it}$ *(min/max)* | *α* |
|---|---|---|---|---|
| **GloRa-T** | *Basic competences* | | | |
| | Communicative competence | 3.46 (.38) | .30/.62 | .72 |
| | Working alliance | 3.63 (.53) | - | - |
| | Role behavior | 3.04 (.67) | - | - |
| | *Specific competences* | | | |
| | Cognitive behavioral interventions | 3.24 (.44) | .46/.66 | .86 |
| | Techniques in SMT | 3.13 (.50) | .39/.61 | .76 |

**Table 5**: Intercorrelations ($r_{xy}$) of GloRa-T

| | | | Interpersonal competence | | | |
|---|---|---|---|---|---|---|
| | | Communicative competence | *Working alliance* | *Role behavior* | CBT interventions | Techniques in SMT |
| **GloRa-T** | Communicative c. | - | .60*** | .11 | .72*** | .56*** |
| | Working alliance | | - | .17 | .59*** | .44** |
| | Role behavior | | | - | .06 | -.03 |
| | CB interventions | | | | - | .86*** |
| | Techniques in SMT | | | | | - |

Note: **= $p \leq .01$; *** = $p \leq .001$.

## Validity analysis

Results of validity analysis concerning subscales assessing *Basic Competences* are shown in Table 6. Divergent validity of GloRa-T is supported by the significant negative correlations between *Basic Competences* and the interpersonal styles (IPP-C) *cold* (*communicative competence:* $r_{xy}$ = -.42**; *working alliance:* $r_{xy}$ = -.53***) and *socially inhibited* (*working alliance:* $r_{xy}$ = -.30*; *role behavior:* $r_{xy}$ = -.53***) as well as between *Basic Competences role behavior* and the personality style *neuroticism* (NEO-FFI) ($r_{xy}$ = -.34*). Convergent validity is supported by the positive correlations between the *Basic Competence working alliance* with the interpersonal style *self-sacrificing* (IIP-C; $r_{xy}$ = .30*) and the personality factor *agreeableness* (NEO-FFI; $r_{xy}$ = .50***), positive correlations between *Basic Competence communicative competence* and the personality factor *extraversion* (NEO-FFI) ($r_{xy}$ = .40**), the rating of *self-esteem* (RSES) ($r_{xy}$ = .31*) as well as positive correlations between *Basic Competence working alliance* and self esteem (RSES) ($r_{xy}$= .34*). Furthermore, convergent validity is supported by the correlation between *communicative competence* and the subscale *empathic concern* of the SPF ($r_{xy}$ = *.30**). Correlations between all subscales with the subscale *perspective taking* of the SPF were not as postulated. Since the separate interpretation of the subscale *role behavior* was not planned in advance, the negative correlation with *empathic concern* (SPF) was not expected ($r_{xy}$ = *-.31**).

Although the expected positive correlations between *Specific Competences* and *consciousness* (NEO-FFI) only reached a borderline statistical significance (Co*gnitive behavioral techniques*: $r_{xy}$ = .28; *SMT* $r_{xy}$ = .27$^{+}$), they might be carefully interpreted as convergent validity.

**Table 6:** Correlation between self and observer rated *Basic Competence* of GloRa-T and therapists' self-rating for validity analysis

| | | GloRa-T | | |
|---|---|---|---|---|
| | | Communicative competence | Working alliance | Role behavior |
| Interpersonal Style (IIP-C) | *Cold* | **-.42**** | **-.53***** | -.22 |
| | *Socially inhibited* | -.29$^{+}$ | **-.30*** | **-.32*** |
| | *Self-sacrificing* | .24 | **.30*** | -.27$^{+}$ |
| Personality (NEO-FFI) | *Neuroticism* | -.11 | -.03 | -.**34*** |
| | *Extraversion* | **.40**** | .24 | .04 |
| | *Agreeableness* | *.29*$^{+}$ | **.50***** | .16 |
| Empathy (SPF) | *Perspective taking* | .07 | .10 | .09 |
| | *Empathic concern* | **.30*** | .28$^{+}$ | **-.31*** |
| Self-esteem (RSES) | | .**31*** | .**34*** | .07 |

*Note*: $^{+}$ = $p \leq .1$; *= $p \leq .05$; ** = $p \leq .01$; *** = $p \leq .001$.

#### 5.5.1.2 Session-Rating-Therapist (SeRa-T)

**Descriptive statistics and results of item analysis**

For the first part for the SeRa-T (# 1-7), averaged means were almost in the upper half of the scale (*M* = 4.95, *SD* = .90 (# 3) to *M* = 5.44, *SD* = .63 (# 4)). In the second part (# 8-27) means were also above the middle point *M* = 2.23 (*SD* = 1.00; # 11) and *M* = 3.47 (*SD* = .63; # 18) (see Table 7). Range was rather small. Items were skewed left, kurtosis showed lepto-kurtic distribution. *Skewness* = -3.53 (*SE* = .36) and *kurtosis* = 17.98 (*SE* = .71) of item 6 and additionally kurtosis of items 19, 20, 22 and 23 were critical (2.02 ≤ *kurtosis* < 2.90, *SE* = .71) and differed significantly from a normal distribution.

**Table 7:** Items of the SeRa-T (Session Rating - Therapists) and scale properties: Means (M), standard deviations (SD), minimal and maximal ratings, range, skewness and kurtosis

| | | *M* (*SD*) | *min-max* | *Range* | *Skewness* | *Kurtosis* |
|---|---|---|---|---|---|---|
| 1* | Today I felt comfort in my relationship with the client[B]<br>*Heute habe ich mich in der Beziehung zum Klienten wohl gefühlt* | 5.14 (.80) | 3-6 | 3 | -0.84 | 0.62 |
| 2* | The client and me understood each other[B]<br>*Der Klient und ich haben uns verstanden* | 5.21 (.64) | 4-6 | 2 | -0.21 | -0.55 |
| 3* | The client and me work on mutual goals[B]<br>*Der Klient und ich arbeiten an gemeinsamen Zielen* | 4.95 (.90) | 3-6 | 3 | -0.53 | -0.41 |
| 4* | I met my client with appreciation[n]<br>*Ich bin dem Klienten wertschätzend begegnet* | 5.44 (.63) | 4-6 | 2 | -0.68 | -0.45 |
| 5* | I empathized with the client and understood his problems[n]<br>*Ich habe mich in den Klienten hineinversetzt und seine Probleme verstanden* | 5.21 (.71) | 3-6 | 3 | -0.75 | 0.93 |
| 6* | I really fulfilled my role as a counselor and did not only „played“ it [n]<br>*Ich habe mich in meine Rolle als Berater eingefühlt und habe sie nicht nur „gespielt“* | 5.23 (1.00) | 0-6 | 6 | -3.53 | 17.98 |
| 7* | I took up a friendly but not too private attitude towards the client[n]<br>*Ich habe eine freundliche. aber nicht zu private Haltung gegenüber dem Klienten eingenommen* | 5.02 (.80) | 3-6 | 3 | -0.62 | 0.24 |
| 8 | Today I tried to use the client's strengthen in a targeted manner[B]<br>*Ich habe heute versucht. Ressourcen des Klienten gezielt zu nutzen* | 2.95 (.87) | 1-4 | 3 | -0.81 | 0.37 |
| 9 | Today I worked towards a better client's handling of situations that are difficult for him[B]<br>*Heute habe ich darauf hingearbeitet. dass der Klient für ihn schwierige Situationen besser bewältigen kann* | 3.40 (.62) | 2-4 | 2 | -0.51 | -0.57 |
| 10 | Today I tried to improve the client's action competence in a targeted manner[B]<br>*Heute habe ich gezielt versucht. die Handlungskompetenzen des Klienten zu verbessern* | 3.12 (.76) | 1-4 | 3 | -0.54 | -0.02 |
| 11 | Today I have touched on sore spots of the client[B]<br>*Heute habe ich an wunde Punkte des Klienten gerührt* | 2.23 (1.00) | 0-4 | 4 | 0.11 | -0.49 |
| 12 | Today I used the opportunity that the client experiences his positive sides[B]<br>*Ich habe heute gezielt Gelegenheiten genutzt. dass der Klient auch seine positiven Seiten erleben kann* | 3.02 (.94) | 0-4 | 4 | -1.14 | 1.61 |
| 13 | Today I tried that the client feels more self confident for the solution of problems[B]<br>*Ich habe heute gezielt darauf hingearbeitet. dass der Klient sich einem bestimmten Problem besser gewachsen fühlen kann als bisher* | 3.16 (.72) | 1-4 | 3 | -0.66 | 0.62 |
| 14 | Today I tried intensively to improve clients' worth[B]<br>*Ich habe aktiv versucht. den Klienten in seinem positiven Selbst aufzuwerten* | 3.14 (.94) | 0-4 | 4 | -1.19 | 1.68 |
| 15 | Today I tried that the client sees his problems in new contexts[B]<br>*Ich habe heute aktiv darauf hingearbeitet. dass der Klient seine Probleme in neuen Zusammenhängen sehen kann* | 2.52 (1.04) | 0-4 | 4 | -0.27 | -0.53 |
| 16 | Today I tried to refer to clients current life circumstances[B]<br>*Heute habe ich mich ausdrücklich darum bemüht. einen Bezug zur realen Lebenssituation des Klienten herzustellen* | 3.21 (.83) | 1-4 | 3 | -0.94 | 0.51 |
| 17 | I tried that the client accepts responsibility[n]<br>*Ich habe mich darum bemüht. dass der Klient Verantwortung übernimmt* | 2.86 (.89) | 0-4 | 4 | -1.00 | 1.64 |
| 18 | Today I worked goal-oriented[n]<br>*Ich habe heute auf ein Ziel hingearbeitet* | 3.47 (.63) | 2-4 | 2 | -0.76 | -0.36 |
| 19 | I conveyed to the client that the counseling might have positive influence on his problems[n]<br>*Ich habe dem Klienten die Sichtweise vermittelt. dass er durch die Beratung einen günstigen Einfluss auf seine Probleme nehmen kann* | 3.19 (.91) | 0-4 | 4 | -1.39 | 2.62 |
| 20 | I tried that the client works on his own initiative [n]<br>*Ich habe darauf hingearbeitet. dass der Klient hat Eigenaktivität/Initiative zeigt* | 3.21 (.74) | 1-4 | 3 | -1.10 | 2.02 |
| 21 | I adapted my agenda to the current needs of the client[n]<br>*Ich habe meinen Plan für die Sitzung den aktuellen Bedürfnissen des Klienten angepasst* | 3.33 (.64) | 2-4 | 2 | -0.42 | -0.63 |
| 22 | Today I have actively tried to direct clients attention on influenceable behavior[n]<br>*Heute habe ich aktiv versucht. den Blick des Klienten auf beeinflussbare Verhaltensweisen zu lenken* | 3.09 (.84) | 0-4 | 4 | -1.19 | 2.90 |
| 23 | I encouraged the client to a solution-oriented approach[n]<br>*Ich habe den Klienten zu einer lösungsorientierten Sichtweise ermutigt* | 3.23 (.72) | 1-4 | 3 | -1.19 | 2.68 |
| 24 | I have tried to offer a positive perspective to the client[n]<br>*Ich habe mich darum bemüht. dass der Klient eine positive Perspektive einnimmt* | 3.33 (.75) | 1-4 | 3 | -0.98 | 0.82 |
| 25 | I tried to show the client to divide problems into sub-steps[n]<br>*Ich habe gezielt darauf hingearbeitet. dass der Klient bei der Bewältigung von Problemen in Teilschritten denkt* | 2.65 (1.04) | 0-4 | 4 | -0.42 | -0.40 |
| 26 | I have tried to convex to the client flexible attitudes toward different solutions[n]<br>*Ich habe mich darum bemüht. den Klienten von zu absoluten Sichtweisen zu lösen und ihm eine flexiblere Sicht der Dinge zu vermitteln* | 2.49 (1.22) | 0-4 | 4 | -0.22 | -1.01 |
| 27 | I directed the view of the client on the future[n]<br>*Ich habe den Blick des Klienten auf die Zukunft gelenkt* | 2.95 (.75) | 1-4 | 3 | -0.27 | 0.27 |

*Note*: Items a priori postulated as assessing *Basic Competences* are marked with *. Ratings of these items were done on a Likert scale from (-3) to (+3), recorded as 0 to 6. The remaining items were rated on a Likert-Scale from 0 to 4.[B] = item from the BPSR-T; [n] = new formulated item.

For reasons of consistency the subscale *interpersonal competence* was also split into two further subscales *working alliance* (# 1, 2, 3) and role behavior (# 7). Internal consistencies of all subscales ranged from critical to good (.57 ≤ *α* < .88). Item discrimination coefficients were good and above the recommended level, except for item 11 (subscale *CBT interventions;* $r_{it}$ = .23) (see Table 8).

**Table 8:** Subscales of SeRa-T: Means (*M*), standard deviations (*SD*), minimal and maximal item discrimination coefficients ($r_{it}$) and internal consistency (Cronbachs *α)*

| | | *M (SD)* | $r_{it}$ *(min/max)* | *α* |
|---|---|---|---|---|
| **SeRa-T** | *Basic competences* | | | |
| | Communicative competence | 5.29 (.58) | .30/.53 | .57 |
| | Working alliance | 5.10 (.62) | .43/.59 | .69 |
| | Role behavior | 5.02 (.80) | - | - |
| | *Specific competences* | | | |
| | Cognitive behavioral interventions | 3.06 (.52) | .23/.76 | .88 |
| | Techniques in SMT | 2.96 (.66) | .57/.65 | .82 |

Almost all subscales were significantly intercorrelated (.32* ≤ $r_{xy}$ < .83***) except correlations between *communicative competence* and *techniques in SMT* that reached only a borderline significance ($r$ = .29$^{+}$, $p$ =.06) and between *working alliance* and *role behavior* ($r_{xy}$ = .11) (see Table 9).

**Table 9**: Intercorrelations ($r_{xy}$) of SeRa-T

| | | | Interpersonal competence | | | |
|---|---|---|---|---|---|---|
| | | Communicative competence | *Working alliance* | *Role behavior* | CBT interventions | Techniques in SMT |
| **SeRa-T** | Communication c. | - | .54*** | .38* | .34* | .29$^{+}$ |
| | Working alliance | | - | .11 | .56*** | .42** |
| | Role behavior | | | - | .39** | .32* |
| | CB interventions | | | | - | .83*** |
| | Techniques in SMT | | | | | - |

Note: $^{+}$ = p ≤ .1; * = p ≤ .05; **= $p$ ≤ .01; *** = $p$ ≤ .001.

## Validity Analysis

Results of the validity analysis for the subscales assessing *Basic Competence* are shown in Table 10, The only significant correlation was found between the *Basic Competence role behavior* and the interpersonal style *cold* ($r_{xy}$ = -.34) and is interpreted as divergent validity. Correlation of the *Specific Competences Cognitive behavioral techniques* ($r_{xy}$ = .00) and *SMT* ($r_{xy}$ = -.06) *with consciousness* (NEO-FFI) were not statistically significant.

**Table 10:** Correlation between self and observer rated *Basic Competence* of SeRa-T and therapists' self-rating for validity analysis

| | | SeRa-T | | |
|---|---|---|---|---|
| | | Communicative competence | Working allian-ce | Role behavior |
| Interpersonal Style (IIP-C) | *Cold* | -.06 | -.06 | **-.34*** |
| | *Socially inhibited* | .08 | .12 | -.14 |
| | *Self-sacrificing* | .14 | .00 | -.07 |
| Personality (NEO-FFI) | *Neuroticism* | .14 | -.08 | .01 |
| | *Extraversion* | -.03 | -.03 | -.18 |
| | *Agreeableness* | .04 | .08 | .18 |
| Empathy (SPF) | *Perspective taking* | -.06 | .11 | -.25 |
| | *Empathic concern* | .13 | -.03 | .17 |
| Self-esteem (RSES) | | -.00 | .16 | .18 |

*Note*: *= $p \leq .05$

### 5.5.2 Clients session rating (SeRa-C)

#### Descriptive statistics and results of item analysis

Averaged means of SeRa-C were mostly in the upper half of the Likert skale ($M$ = 3.55, $SD$ = 1.25 (# 15) to $M$ = 5.41, $SD$ = .63 (# 17)) (see Table 11). Distributions of items 6 (s*kew-ness* = -2.01, $SE$ = .27; *kurtosis* = 8.48, $SE$ = .53) and items 1, 7 and 14 were problematic (2.74 ≤ *kurtosis* < 5.60, $SE$ = .53).

**Table 11**: Items of the SeRa-C (Session Rating - Clients) and scale properties: Means (M), standard deviations (SD), minimal and maximal ratings, range, skewness and kurtosis

| | | *M* (*SD*) | min-max | Range | Skewness | Kurtosis |
|---|---|---|---|---|---|---|
| 1* | Today I was comfortable with my counselor[B]<br>*Heute habe ich mich in der Beziehung zum Berater wohlgefühlt* | 5.40 (.89) | 2-6 | 4 | -1.87 | 4.09 |
| 2 | I feel that I can better understand me and my problems [B]<br>*Ich habe das Gefühl, dass ich mich selbst und meine Probleme besser verstehen kann* | 5.21 (.83) | 3-6 | 3 | -0.81 | 0.02 |
| 3 | Today we got closer to the core of my problems[B]<br>*Heute sind wir dem Kern meiner Probleme näher gekommen* | 4.85 (.89) | 3-6 | 3 | -0.14 | -0.97 |
| 4 | The counselor shows me my strengths [B]<br>*Der Berater lässt mich spüren, wo meine Stärken liegen* | 5.20 (.92) | 3-6 | 3 | -0.89 | -0.19 |
| 5* | My counselor and I understand each other[B]<br>*Mein Berater und ich verstehen einander* | 5.40 (.73) | 3-6 | 3 | -1.18 | 1.27 |
| 6* | I think my counselor really cares about my wellbeing[B]<br>*Ich glaube, der Berater ist wirklich an meinem Wohlergehen interessiert* | 5.28 (.81) | 1-6 | 5 | -2.01 | 8.47 |
| 7* | Today I felt understood from my counselor [S]<br>*Ich habe mich in dieser Sitzung vom Berater verstanden gefühlt* | 5.24 (.81) | 2-6 | 4 | -1.34 | 2.74 |
| 8 | I experienced the session as planned and purposeful[S]<br>*Den Ablauf der Sitzung habe ich als planvoll und zielgerichtet erlebt* | 5.34 (.72) | 3-6 | 3 | -1.03 | 1.11 |
| 9 | At the moment my counselor supports me in how I would like to be[B]<br>*Im Moment fühle ich mich durch den Berater darin unterstütz, wie ich gerne sein möchte* | 5.23 (.86) | 3-6 | 3 | -0.94 | 0.16 |
| 10 | I fell more confident that I can solve my problems on my own[B]<br>*Ich traue mir jetzt mehr zu, meine Probleme aus eigener Kraft zu lösen* | 4.93 (1.07) | 1-6 | 5 | -0.95 | 1.11 |
| 11 | Now I know better what I want[B]<br>*Ich weiß jetzt besser, was ich will* | 4.56 (1.15) | 1-6 | 5 | -0.81 | 0.80 |
| 12 | Today I was emotionally heavily involved[B]<br>*Heute war ich gefühlsmäßig stark beteiligt* | 3.89 (1.33) | 1-6 | 5 | -0.05 | -0.75 |
| 13 | Today the counselor directed my attention to behaviors that I can actively influence [n]<br>*Der Berater hat heute meinen Blick auf Verhaltensweisen gelenkt, die ich selber aktiv beeinflussen kann* | 5.05 (.84) | 1-6 | 3 | -0.75 | 0.26 |
| 14* | I feel that my counselor appreciates me[B]<br>*Ich spüre, dass der Berater mich wertschätzt* | 5.04 (.85) | 1-6 | 5 | -1.66 | 5.60 |
| 15 | I was strongly affected by what we have done today[B]<br>*Was wir heute gemacht haben, ging mir sehr nahe* | 3.55 (1.25) | 0-6 | 6 | 0.06 | 0.18 |
| 16 | I get along with situations better than before[B]<br>*Ich fühle mich jetzt Situationen besser gewachsen, denen ich mich bisher nicht gewachsen gefühlt habe* | 4.74 (1.00) | 3-6 | 3 | -0.06 | -1.21 |
| 17 | Today the counselor was bothered that I get a positive perspective[n]<br>*Der Berater hat sich heute bemüht, dass eine positive Sichtweise einnehme* | 5.41 (.63) | 3-6 | 3 | -0.90 | 1.32 |
| 18 | Today I experienced that my problem consists of several small parts[n]<br>*Ich habe heute die Erfahrung gemacht, dass sich mein Problem in mehrere kleine Probleme zerteilen lässt* | 4.60 (1.21) | 0-6 | 6 | -0.99 | 1.32 |
| 19 | Today the counselor conveyed to me that there are usually several ways to solve a problem[n]<br>*Der Berater hat mir heute vermittelt, dass es zur Lösung eines Problems meist mehrere Wege gibt* | 4.59 (1.03) | 2-6 | 4 | -0.48 | -0.41 |
| 20 | Today the counselor directed my attention to the future [n]<br>*Der Berater hat meinen Blick heute auf die Zukunft gelenkt* | 5.02 (.93) | 3-6 | 3 | -0.81 | -0.07 |

*Note*: [B] = Item extracted from the BPSR-P; [S] = Item extracted from the SB-K; [n] = new formulated item; Items a priori postulated as assessing *Basic Competences* are marked with *.

Subscales *communicative competence* and *CBT interventions* had acceptable to good internal consistencies (α = .72 and .87). In contrast the subscales *interpersonal competences* and *techniques in SMT* had poor internal consistencies (α = .64 and .68) (see Table 12). Item discrimination coefficients of the subscales were all above the recommended level (.32 ≤ $r_{it}$ < .57). All subscales had very high intercorrelations (.46*** ≤ $r_{xy}$ < .74***) (see Table 13).

**Table 12:** Subscales of SeRa-C: Means (*M*), standard deviations (*SD*), minimal and maximal item discrimination coefficients ($r_{it}$) and internal consistency (Cronbachs *α)*

| | | *M (SD)* | $r_{it}$ *(min/max)* | *α* |
|---|---|---|---|---|
| **SeRa-C** | *Basic competences* | | | |
| | Communicative competence | 5.14 (.73) | .56 | .72 |
| | Interpersonal competence | 5.36 (.62) | .39/.51 | .64 |
| | *Specific competences* | | | |
| | Cognitive behavioral interventions | 4.77 (.67) | .32/.57 | .87 |
| | Techniques in SMT | 4.90 (.69) | .32/.57 | .68 |

**Table 13**: Intercorrelations ($r_{xy}$) of SeRa-C

| | | | Interpersonal competence | | | |
|---|---|---|---|---|---|---|
| | | Communicative competence | *Working alliance* | *Role behavior* | CBT interventions | Techniques in SMT |
| **SeRa-C** | Communication c. | - | .74*** | | .67*** | .46*** |
| | Interpersonal competence | | - | | .68*** | .48*** |
| | CB interventions | | | | - | .57*** |
| | Techniques in SMT | | | | | - |

Note: **= $p \leq .01$; *** = $p \leq .001$.

## Validity analysis

For analyzing the validity of the SeRa-C correlations with student therapists' self-ratings of interpersonal and intrapersonal behavior (NEO-FFI, IIP-C, SPF and RSES) were considered. With regard to divergent validity, there were no significant correlations between the subscales of SeRa-C and other therapists' self-ratings (see Table 14).

Correlation of the *Specific Competences Cognitive behavioral techniques* ($r_{xy}$ = .14) and *SMT* ($r_{xy}$ = .10) *with consciousness* (NEO-FFI) were not statistically significant.

**Table 14:** Correlation between self and observer rated *Basic Competence* of SeRa-C and therapists' self-rating for validity analysis

| | | SeRa-C | |
|---|---|---|---|
| | | Communicative competence | Interpersonal competence |
| Interpersonal Style (IIP-C) | *Cold* | -.05 | -.07 |
| | *Socially inhibited* | -.01 | .08 |
| | *Self-sacrificing* | .15 | .22 |
| Personality (NEO-FFI) | *Neuroticism* | -.14 | -.08 |
| | *Extraversion* | -.07 | -.08 |
| | *Agreeableness* | .01 | .20 |
| Empathy (SPF) | *Perspective taking* | -.07 | -.01 |
| | *Empathic concern* | .07 | .15 |
| Self-esteem (RSES) | | .11 | .08 |

### 5.5.3 Observer rating (CoRa-O)

#### Descriptive statistics and results of item analysis

Means of observer ratings were slightly below or almost around the Likert's scales midpoint (*M* = 1.85, *SD* = .62 (# 2) to *M* = 3.37, *SD* = .83 (# 12)) (see Table 15). Global competence rating (# 1) was also around the Likert scale's midpoint (*M* = 2.88, *SD* = .65). The difficulty of the client (# 14) was rated as moderately (*M* = 2.40, *SD* = .86). Skeness and kurtosis were acceptable for all items.

**Table 15**: Items of the CoRa-O (Competence Rating - Observer) and scale properties: Means (M), standard deviations (SD), minimal and maximal ratings, range, skewness, kurtosis and interclass coefficients ($ICC_{(2,2)}$)

| | | M (SD) | min-max | Range | Skewness | Kurtosis | ICC |
|---|---|---|---|---|---|---|---|
| 1 | Global competence<br>*Globale Kompetenz* | 2.88 (.65) | 1-4 | 3.00 | -0.56 | 0.84 | .54*** |
| 2* | Empathy<br>*Empathie* | 1.85 (.62) | 1-3.5 | 2.50 | 0.31 | -0.36 | .53*** |
| 3* | Basic attitude<br>*Grundhaltung* | 3.20 (.83) | 1-4.5 | 3.50 | -0.74 | 0.22 | .66*** |
| 4* | Communication skills<br>*Gesprächstechniken* | 3.26 (.71) | 1-4.5 | 3.50 | -0.81 | 1.22 | .60*** |
| 5* | Working alliance<br>*Arbeitsbündnis* | 2.67 (.73) | 1-4 | 3.00 | -0.53 | -0.19 | .49*** |
| 6* | Role behaviour<br>*Rollenverhalten* | 3.18 (.85) | 1-5 | 4.00 | -0.47 | 0.46 | .64*** |
| 7 | Solution orientation<br>*Lösungsorientiertes Arbeiten* | 2.84 (.70) | 1-4 | 3.00 | -0.61 | 0.37 | .51*** |
| 8 | Resource orientation<br>*Ressourcenorientierung* | 2.23 (.80) | 1-4 | 3.00 | 0.35 | -0.43 | .57*** |
| 9 | Encourages active engagement of the client<br>*Fördert die aktive Mitarbeit des Klienten* | 3.07 (.67) | 1-4 | 3.00 | -0.66 | 0.61 | .46*** |
| 10 | Positive efficacy expectation<br>*Wirksamkeitserwartung* | 3.13 (.72) | 1.5-4.5 | 3.00 | -0.40 | -0.51 | .43*** |
| 11 | Flexibility<br>*Flexibilität* | 3.11 (.71) | 1-4 | 3.00 | -0.66 | 0.21 | .48*** |
| 12 | Structuring<br>*Strukturierung* | 3.37 (.83) | 1-5 | 4.00 | -0.77 | 0.74 | .68*** |
| 13 | Encouragement of clients self-management<br>*Förderung des Selbstmanagements des Klienten* | 2.68 (.62) | 1-4 | 3.00 | -0.24 | -0.01 | .41*** |
| 14 | Difficulty of the client<br>*Schwierigkeit des Klienten* | 2.40 (.86) | 1-5 | 4.00 | 0.54 | 0.25 | .52*** |

*Note*: Items a priori postulated as assessing *Basic Competences* are marked with *. ***= $p \leq .001$.

Internal consistency of all subscales was good ($.84 \leq \alpha < .87$), all item discrimination coefficients were good ($.56 \leq r_{it} < .83$) (see Table 16). Further analyses showed that all subscales were very highly intercorrelated ($.66*** \leq r_{xy} < .90***$) (see Table 17).

**Table 16:** Subscales of CoRa-O: Means (*M*), standard deviations (*SD*), minimal and maximal item discrimination coefficients ($r_{it}$) and internal consistency (Cronbachs *α)*

| | | *M (SD)* | $r_{it}$ *(min/max)* | *α* |
|---|---|---|---|---|
| **CORA-O** | *Basic competences* | | | |
| | Communicative competence | 2.77 (.63) | .61/.83 | .85 |
| | Interpersonal competence | 2.92 (.84) | .73 | .84 |
| | *Specific competences* | | | |
| | Cognitive behavioral interventions | 3.00 (.58) | .56/.73 | .87 |
| | Techniques in SMT | 2.68 (.62) | - | - |

**Table 17**: Intercorrelations ($r_{xy}$) of CoRa-O

| | | | Interpersonal competence | | | |
|---|---|---|---|---|---|---|
| | | Communicative competence | *Working alliance* | *Role behavior* | CBT interventions | Techniques in SMT |
| **CoRa-O** | Communicative c. | - | .86*** | | .88*** | .66*** |
| | Interpersonal competence | | - | | .90*** | .79*** |
| | CB interventions | | | | - | .76*** |
| | Techniques in SMT | | | | | - |

Note: *** = $p \leq .001$.

## Validity analysis

Correlations between CoRa-O and questionnaires filled in by the student therapists (NEO-FFI, IIP-C, SPF and RSES) are displayed in Table 18.With regard to convergent validity, only the correlations between the *interpersonal competence* and the personality styles *agreeableness* (NEO-FFI; $r_{xy}$ = .38*) and between *communicative competence* and *self-esteem* (RSES; $r_{xy}$ = 39*) were statistically significant, correlations between the *Basic Competences* and *empathic concern* (SPF) reached a borderline statistical significance ($r_{xy}$ = $.30^{+}$ - $.33^{+}$). The observer-rated *Specific Competences* and therapists' personality style *consciousness* (NEO-FFI) were not associated.

Correlation of the *Specific Competences Cognitive behavioral techniques* ($r_{xy}$ = -.07) and *SMT* ($r_{xy}$ = -.05) *with consciousness* (NEO-FFI) were not statistically significant.

**Table 18:** Correlation between self and observer rated *Basic Competence* of CoRa-O and therapists' self-rating for validity analysis

| | | **CoRa-O** | |
|---|---|---|---|
| | | Communicative competence | Interpersonal competence |
| Interpersonal Style (IIP-C) | *Cold* | -.10 | -.27 |
| | *Socially inhibited* | -.11 | -.27 |
| | *Self-sacrificing* | .17 | .16 |
| Personality (NEO-FFI) | *Neuroticism* | -.01 | -.18 |
| | *Extraversion* | .28 | .24 |
| | *Agreeableness* | $.31^{+}$ | **.38*** |
| Empathy (SPF) | *Perspective taking* | -.15 | -.10 |
| | *Empathic concern* | $.30^{+}$ | $.33^{+}$ |
| Self-esteem (RSES) | | **.39*** | $.30^{+}$ |

*Note*: $^{+}$ = $p \leq .1$; *= $p \leq .05$.

### 5.5.4 Intercorrelations of the multi-informant ratings

Comparing therapists' global and in-session self-ratings (GloRa-T and SeRa-T), correlations reached from weak for *interpersonal competences* ($r_{xy}$ = .23 - .26) to rather strong for *CBT-interventions* ($r_{xy}$ = .50**) (see Table 19).

**Table 19**: Correlation of all used measurement tools for assessing therapeutic competence

| | | **SeRa-T** (2nd client, 9th session) | | | | **SeRa-C** (2nd client, 9th session) | | | | **CoRa-O** (2nd client, 9th session) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Commun. | Interpersonal C. *Working Alliance* | Interpersonal C. *Role behavior* | CBT | SMT | Commu. | Interp. | CBT | SMT | Commun. | Interp. | CBT | SMT |
| **GloRa-T** | Commu | **.35*** | .17 | **.46**** | **.31*** | .17 | | | | | | | | |
| | *Alliance* | .26+ | .26+ | **.52***** | **.36**** | .26+ | | | | | | | | |
| | *Role* | -.10 | .13 | .23 | -.01 | -.03 | | | | | | | | |
| | CBT | **.31*** | .26 | **.49**** | **.50**** | **.47**** | | | | | | | | |
| | SMT | .23 | .06 | **.33*** | **.32*** | .30+ | | | | | | | | |
| **SeRa-T** | Commu | | | | | | .07 | -.00 | -.11 | -.17 | -.06 | .05 | .05 | -.01 |
| | *Alliance* | | | | | | **.45**** | **.37*** | .30+ | .03 | .19 | .24 | .28 | .26 |
| | *Role* | | | | | | .04 | -.12 | -.18 | -.11 | .30+ | .32+ | .32+ | .31+ |
| | CBT | | | | | | **.33*** | .17 | .14 | .13 | **.40*** | .31+ | **.48**** | .26 |
| | SMT | | | | | | .19 | .09 | -.05 | .03 | .25 | .19 | **.37*** | .25 |
| **SeRa-C** | Commu | | | | | | | | | | .31+ | .26 | .31+ | .15 |
| | Inter | | | | | | | | | | .23 | .19 | .17 | .17 |
| | CBT | | | | | | | | | | .28 | .26 | .25 | .03 |
| | SMT | | | | | | | | | | .09 | .05 | .14 | -.02 |

Note: + = p ≤ .1; * = p ≤ .05; **= *p* ≤ .01; *** = *p* ≤ .001.

## 5.6 Discussion

The present study introduced and evaluated a set of measurements of therapeutic competence that are based on the *Three-Level Model of Therapeutic Competence* and allow multi-informant assessments of therapists', clients' and observers' ratings. This set allows direct comparison of the different rating perspectives because all measurements entail the same components of therapeutic competence.

Therapists' global self-ratings of their therapeutic competence (GloRa-T) were comparably high for all items as reflected in high means, small ranges and skewed left distributions. Analyses showed that distributions were all in all tolerable except kurtosis of item 16 (*kurtosis* = - 2.09). Internal consistencies of the subscales *communicative competence*, *CBT interventions* and *techniques in SMT* were good or acceptable. Furthermore item discrimination coefficients of these subscales were adequate. Due to problematic internal consistency and item discrimination coefficients of the subscale *interpersonal competences,* the two items of this scale were examined separately. This procedure is confirmed when looking at the content of the two items: while item 6 assesses the competence to build and maintain a working alliance (*I can build up a relationship with clients*), item 7 reflects the competence to an adequate role behavior (*I can take a friendly, yet professional position toward clients)*. Concerning the validity analyses, evidence for convergent and divergent validity of GloRa-T was obtained. Divergent validity of the subscales assessing *Basic Competences* was supported by the negative correlations between *communicative competence* and *working alliance* and the interpersonal style *cold,* by the correlation between *working alliance* and *role-behavior* and the interpersonal behavior *socially inhibited* (IIP-C) and finally by the negative correlation between *role-behavior* and the personality style *neuroticism* (NEO-FFI). Beyond that, the negative correlation between *role-behavior* and *empathic concern* (SPF) supported the divergent validity of this subscale and supports the assumption that *role behavior* is an aspect of *interpersonal competence* independent of empathy. Convergent validity was confirmed by the positive correlations between *communicative competence* and *extraversion* (NEO) and *self-esteem* (RSES), further by the correlations between *working alliance* and the interpersonal behavior *self-sacrificing* (IIP-C), the personality style *agreeableness* (NEO-FFI) and *self-esteem* (RSES). Regarding the subscales assessing *Specific Competences*, the borderline statistical correlations between *CBT interventions* and *techniques in SMT* and the personality style *consciousness* (NEO-FFI) are carefully interpreted as convergent validity. All in all, there were first indications that GloRa-T is a valid measurement of self-rated therapeutic competence and that a meaningful building of subscales is possible.

The second evaluated self-rating instrument for therapists' self-ratings was the session rating SeRa-T. Therapists' in-session ratings of their therapeutic competence were in all

items rather high. SeRa-T showed satisfying distribution except item 6 with problematic skewness and kurtosis and in addition items 19, 20, 22 and 23 with inacceptable kurtosis. All these problematic items were newly formulated by the authors of the study. For reasons of consistency with GloRa-T, the subscale *interpersonal competence* was also in SeRa-T interpreted separately as *working alliance* and *role behavior*. Internal consistencies of the subscales ranged from bad for *communicative competence* (α = .57) to good for *CBT interventions* (α = .88). All item discrimination coefficients were above the recommended level of .3 except for item 11 ($r_{it}$ = .23).

With regard to validity, results showed that, contrary to our expectations, almost no correlations between SeRa-T and the questionnaires became significant. The only significant finding between *role behavior* and the interpersonal style *cold* was interpreted as divergent validity. In contrast to the global self-rating of therapeutic competence (GloRa-T), the in-session rating SeRa-T seems to be more influenced by situational aspects of the session than by personality or interpersonal behavior style and, therefore, could be less associated with those aspects. Another explanation for the non-correlations might be that the ratings of student therapists' were influenced by inner tensions concerning the session. Since session ratings referred to session that were videotaped and coded by observers, this might have caused additional nervousness in student therapists leading to a situational imprinting. Possible correlations with personal characteristics might be covered by effects of nervousness on self-rating.

Considering the session ratings of clients, analyses of SeRa-C consistently showed relatively high ratings with item means high above the middle point of the Likert Scale. The distribution of the items was good except of four items with inacceptable scores for skewness and kurtosis. Three of these items (# 1, 6, 14) were taken from the Bern Post Session Report (Flückiger et al., 2010), one item (# 7) had been newly formulated. With regard to psychometric properties of the subscales, internal consistencies and item discrimination coefficients of *communicative competence* and *CBT interventions* were satisfying. The subscales *techniques in SMT* and *interpersonal competences*, however, had lower internal consistencies, yet item discrimination coefficients were tolerable. All subscales were highly intercorrelated. Results revealed that there were no associations between clients' ratings and therapists' self ratings of their personal characteristics (e.g. NEO). We interpreted these findings as divergent validity of SeRa-C. Clients rated in SeRa-C obviously something quite different than the personality of the therapist. This raises the question whether clients are able to a more differentiated rating of therapeutic competence than generally assumed (Muse & McManus, 2013).

With regard to CoRa-O, descriptive inspection showed ratings around the midpoint of the Likert-Scale. Distributions of all items were acceptable as were internal consistencies and item discrimination coefficients of the subscales. All subscales were highly intercorrelated. Analyses of validity showed positive correlations between *Basic Competences* and *agreeableness* (NEO-FFI), *self-esteem* (RSES) and *empathic concern* (SPF) which can be interpreted as convergent validity.

The low inter-rater reliability, however, was problematic (ICC = .63). Possibly, the low agreement was a consequence of our raters being novices. Weck, Hilling, Schermelleh-Engel, Rudari, and Stangier (2011) compared competence ratings of novice and expert raters and found that ratings of novice raters were less reliable than those of expert raters. Due to these findings further analysis of CoRa-O with more experienced raters are necessary.

With regard to all four investigated measurements, the items reported as critical (e.g. those that significantly differ from the normal distribution or with unsatisfactory values of internal consistencies) need further consideration. However, they should not yet be eliminated from the scales due to the exploratory character of these analyses and the relatively small sample size. Furthermore, during the initial developmental stage of measurement tools even low levels of internal consistency (i.e. $\alpha < .5$) are tolerable (Field, 2013). Nevertheless, further psychometric analyses based on greater sample sizes allowing for factor analysis need to carefully address the items in question. Their results will help to decide whether the items need to be removed.

Considering all questionnaires the subscales *communicative competence*, *working alliance*, *CBT interventions* and *techniques in SMT* were highly correlated. In contrast, the subscales role-behavior was, especially in GloRa-T, not correlated with any other subscales. These findings are consistent with those of other measurements of therapeutic competence. For example, Weck, Hautzinger, Heidenreich, and Stangier (2010) reported a correlation of .59** ($p \leq .001$) for the two subscales of the German Version of the CTS. These high intercorrelations led to the consideration that there is maybe only one global factor of therapeutic competence. Accordingly, the subdivision into several individual components is not necessary or neither possible. In this case, the formation and further interpretation of total scores would be quite acceptable.

When investigating therapeutic competence from the different perspectives by analyzing the intercorrelations of the measurements, only some subscales of therapists' global (GloRa-T) and in-session (SeRa-T) self-ratings were correlated. Accordingly, global and session-based self-ratings of therapists at the beginners' level are accordingly quite stable and independent of situational influences of a single session. Looking at in-session ratings of

therapists (SeRa-T) and clients (SeRa-C), only therapists' rating of *working alliance* and clients' ratings of *interpersonal competence* were correlated ($r_{xy}$ = .37*). That therapists and clients agree in their rating of working alliance is in line with Mallinckrodt (1993), who reported a positive but small agreement between counselors' and clients' ratings of alliance but in contrast with Fitzpatrick et al. (2005), who reported a divergence between the two alliance ratings. Results regarding therapists' in-session ratings (SeRa-T) and observers' ratings (CoRa-O) also revealed very few significant associations as only the ratings of *CBT interventions* were statistically significant ($r_{xy}$ = .48**). This behavioral based competence was possibly easier to observe, conceptualize and in consequence easier to rate than other components of therapeutic competence. These findings are consistent with previous findings from Mathieson et al. (2009) who reported no correlations between therapists' self-assessment of therapeutic competence and the assessment by independent observer or supervisors. Correlations between observer ratings' (CoRa-O) and clients' ratings (SeRa-C) of the same session were weak but positive. The highest correlation was found for *communicative competence* ($r_{xy}$ = .31$^{+}$, $p$ = .08). Clients seem to have an intuitive concept of *communication competence* that matches with the professional concept underlying the observers' ratings. This is another indication that clients' ratings of therapeutic competence are more profound than assumed.

It is interesting that from all perspectives therapeutic competence of the student therapists was rated as quite high. These findings may have been a result of overestimation by the novice therapists which has already been found by Brosan, Reynolds, and Moore (2008). Another possible explanation might be that the sample of our student therapists was highly self-selected. Since the project was associated with a higher workload than common classes, only particularly motivated students might have registered. In addition, providing 10 self-directed sessions to two fellow students may have been deterrent for students less self-confident with regard to their competences. Mallinckrodt & Nelson (1991) supposed that clients' ratings could be biased by knowledge of their own level of expertise as therapists. Accordingly, student clients might have rated their student therapists' competence more positively since they had been informed about all student therapists were beginners. High competence ratings from observers (Cora-O) may be due to observers in the present study being novices. Weck et al. (2011) showed that therapeutic competence could not be evaluated satisfying by novice raters. In addition, student raters might be biased when having to rate fellow-students of the same age.

Some limitations of the present study need to be addressed. First, it should be noted, that the study sample was quite small for psychometric evaluations so that certain statistical analyses such as factor analyses could not be calculated. It is important to replicate and expand

the findings of the present study. Furthermore, the generalization of the results is limited since our sample consisted of student therapist. Although valid measurements of therapeutic competence should also be applicable to the special group of therapist at the beginners' level, further analysis need to include also experienced therapists. Not yet addressed has been the question whether the measurements are sensitive to changes in competence. Assessing validity has been proves difficult due to the lack of validated assessment tools for therapeutic competence.

Despite some limitations, the initial evaluation suggested satisfactory psychometric properties of the presented measurements. Hence, they are promising instruments for multi-informant assessment of therapeutic competence. Our research has several clinical implications. Having a set of multi-informant measurements of therapeutic competence available for use may help to close the gap of previously not available multi-informant measurements of therapeutic competence. Since all measurements were based on the model, ratings of the individual perspectives are comparable. Based on our practical experience, the questionnaires are easy to administer, well accepted by therapists and clients and therefore suitable for routine use. Also CoRa-O was named as user-friendly by the observers.

# 6. Study 3: Efficacy of a peer-to-peer intervention and relation to therapists characteristics[4]

## 6.1 Abstract

In this naturalistic study we investigated the effectiveness of a peer-to-peer intervention for reducing students' stress level associated with time pressure or learning difficulties. Graduate students with advanced Psychology Master Levelwere trained as student therapists and provided ten sessions to two fellow-students.

We investigated student clients' stress before and after the peer-to-peer intervention. Students stress was operationalized using primary outcome measurements (assessing stress level, depressive mood, psychological distress, study relevant working behavior and procrastination) and secondary outcome measurements (assessing emotion regulation, self-efficacy and self-management). In addition, we explored personal characteristics of student therapists' that were postulated to have an impact on the outcome (interpersonal style, personality factors, self-esteem, self-regulation, empathy, self-care).

Clients showed a statistical significant improvement in their levels of stress, distress and all other outcome measurements. Calculating percentages of clinical significant pre-post changes (RCI), 40.2% of clients reported a clinical significant reduction in perceived stress (PSQ-20), 37% in depressive mood (BDI-II) and 30.5% in psychological distress BSI). There were only few correlations between therapists' personal characteristics and clients' outcome.

The reported results allow the conclusion, that the peer-to-peer intervention is an effective intervention for reducing students' stress and improving general psychological complaints. The impact of therapists' personal characteristics on outcome is only weak.

## 6.2 Introduction

### 6.2.1 Psychological complaints of students

Mental health of students has received growing attention in the last years, several studies report a high stress level among students. An investigation of the American College Health Association showed 44% of college students rated their self-perceived stress level as above-average (ACHA, 2014). Some studies even reported higher stress levels than in age-matched peers (Seliger & Brähler, 2007; Turiaux & Krinner, 2014) and spoke of "an at-risk

[4] Das entsprechende Manuskript zu Studie 3 wird zur Publikation vorbereitet.

population" (Stallman, 2010, p. 249). Regehr, Glancy, and Pitts (2013) summarized the results of various studies and concluded that "approximately half of the university students report moderate levels of stress-related mental health concerns" (Regehr et al., 2013, p. 7). Furthermore, high general psychological distress as well as depressive mood and anxiousness are described (Dyrbye, Thomas, & Shanafelt, 2006; Stallman, 2010). Stallman (2010) showed for a sample of Australian students that a percentage of 83.9% reported elevated distress levels, a percentage higher than in the general population. Reviewing studies investigating psychological distress among US American and Canadian medical students, Dyrbye et al. (2006) also concluded that students' levels of overall psychological distress were higher than in general population and age-matched peers.

Some studies also report higher rates of mental disorders like depression and anxiety in student samples than in age-matched peers (Dyrbye et al., 2006; Ibrahim, Kelly, Adams, & Glazebrook, 2013; Jurkat et al., 2011; Seliger & Brähler, 2007). The American College Health Organization (ACHA, 2014) assumed a12-month prevalence of 32% for depressive disorders. In contrast, other studies did not support this higher rates of mental disorders in student samples (Bailer, Schwarz, Witthöft, Stübinger, & Rist, 2008). Hunt and Eisenberg (2010) proved this finding in a reviewing article reporting no difference between students and age-matched peers in the prevalence of mental disorders.

All in all, students describe high self-reported stress and general psychological distress but do not seem to have higher rates of mental disorders than same-aged non-students. Furthermore, in the last years there was an intensive research on the use of cognitive enhancing substances for improving academic performance of students. Dietz et al. (2013) investigated the use of cognitive-enhancing drugs like amphetamines as brain doping for improving cognitive performance in a sample of German university students and estimated the 12-month prevalence of brain doping substance use at 20%.Focusing on the reported reasons for illicit use, improvement of concentration and increased alertness were claimed as most common motives (Mache, Eickenhorst, Vitzthum, Klapp, & Groneberg, 2012; Teter, McCabe, LaGrange, Cranford, & Boyd, 2006). Furthermore, managing the pressure to succeed and stress reduction were additional reported reasons (Mache et al., 2012). Especially these latter motives can be interpreted as associated to students' stress level. The use of brain drugs might be a dysfunctional strategy for coping with stress and mental problems because of the risk of addiction.

All in all, the high levels of stress and psychological distress discussed above must be seen as problematic because of the associated danger of the development of severe mental illness (Stallman, 2010). Furthermore, there is a well documented negative impact of higher

stress levels on students' academic performance as well as personal wellbeing (Choi, Buskey, & Johnson, 2010; Hysenbegasi, Hass, & Rowland, 2015; Myers et al., 2012).

What are the factors leading to the distinct psychological complaints of students? Students' stress level is influenced by stressors related to studying and examinations (e.g. amount of homework, number of exams) and as well by private issues (e.g. financial problems, relationship problems) (ACHA, 2014; Robotham, 2008). Furthermore, personal beliefs and assumptions like perfectionism, self-efficacy (Chemers, Hu, & Garcia, 2001; Misra & Castillo, 2004) and procrastination (Sirois, 2013; Sirois, Melia-Gordon, & Pychyl, 2003; Stead, Shanahan, & Neufeld, 2010) affect the self-perceived stress level.

### 6.2.2 Interventions for reducing student distress

The amount of students suffering with distress marks clear that student stress is a critical issue for universities (Bayram & Bilgel, 2008; Regehr et al., 2013). Counseling centers at universities have a long tradition and are a mandatory part in many universities worldwide. Nevertheless, counseling centers are not always available (Prince, 2015; Rückert, 2015). Surely, they take of a large part of interventions reducing student distress and in the prevention of possible resulting mental disorders. Choi et al. (2010) investigated in a naturalistic study the efficacy of counseling sessions in a US counseling center (mean six sessions) and reported statistical significant (48%) and clinical significant (32%) changes in students' psychological distress. Hofmann, Sperth, and Holm-Hadulla (2015) analyzed the efficacy of counseling sessions at a German counseling center (mean six sessions) in a naturalistic single-group pre-post study and demonstrated its effectiveness in reducing general psychological distress. Minami et al. (2009) concluded that the effectiveness of treatments delivered at US university counseling centers is comparable to treatment efficacy in clinical trials. Of course, interventions are not always allocated at counseling centers. Häfner, Stock, and Oberst (2015) reported less student stress two and four weeks after a short 4-hour time management training. Beyond that, web-based interventions are currently used more often. Hintz, Frazier, and Meredith (2015) designed a web-based randomized-control study investigating the efficacy of an intervention focusing on time management competences of US American college students. After completing the web-modules and in a 3 week follow-up the experimental group reported a greater decrease in perceived stress than the control group. All in all, Regehr et al. (2013) concluded in their meta-analysis "that cognitive, behavioral, and mindfulness interventions are effective in reducing stress in university students" (Regehr et al., 2013, p. 1).

In addition to interventions provided by counseling centers and research based interventions, peer-to-peer interventions could offer further opportunities. To our knowledge, there is no research investigating the efficacy of peer-to-peer interventions. This fact is surprising, considering that there is a long research tradition in helping skills training for undergraduates (e.g. Carkhuff, 1969a; Hill et al., 2008). This research focused on, however, the acquisition of helping skills and not on the potential effect on the client side. Moreover in most of these trainings psychology students rotated through roles of helper and "client", recruited "real" clients were not included. Using undergraduate or graduate student therapists as peer-therapists providing sessions to student clients suffering from stress, might be a win-win situation. Clients might be offered a low-threshold intervention and student therapists might have the possibility to make first practical experiences.

In the field of outcome research of psychotherapy, the impact of personal characteristics of the therapist on outcome is still not well known (Baldwin & Imel, 2013). Accordingly, the same is for outcome of counseling. To our knowledge there is no study investigating the effect of counselors' personal characteristics on counseling outcome. In the following we want to summarize the existing literature about correlations between personal characteristics of therapists and outcome.

### 6.2.3 Outcome and personal characteristics of therapists

The existing empirical findings about the relationship between "beneficial and malign characteristics" (Aveline, 2005, p. 155) of therapists and outcome are still rather vague and partially heterogeneous. In addition, comparability of research findings is complicated by theoretical orientation of the conducted therapy (e.g. psychoanalytic versus cognitive-behavioral psychotherapy). Most of the few studies investigated the impact of objective characteristics like demographic factors (e.g. age, sex) or professional and academic properties (e.g. grade point average, pre-training professional experience). There are several heterogeneous findings about whether similarities or dissimilarities between therapist and client were positive or negative related to therapeutic outcome (Berry & Sipps, 1991; Herman, 1998; Sánchez-Bahíllo, Aragón-Alonso, Sánchez-Bahíllo, & Birtle, 2014).

In contrast, there is only little research on personal subjective characteristics of therapists. Regarding therapists' interpersonal style, hostility, belittling and blaming behaviors has been shown to be negatively related to outcome (Henry et al., 1986, 1990). In addition, some researchers advocate less dominant style as positive (Beutler et al., 1994), while others postulate that outcome might be enhanced by a more dominant style of therapists because that might make the patient feel safer (Engvik, 1999). The relation between therapists' empathy

and outcome has been discussed intensively (Greenberg et al., 2001). In fact, there seems to be a moderate correlation between empathy and therapy success (Elliott et al., 2011). 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) refered to clients' prospective ratings of therapists' characteristics. In addition, in a study on the outcome of patients suffering from various mental disorders, therapists' professional self-doubt was positively associated with outcome (Nissen-Lie et al., 2013).

To our knowledge, there is no study investigating the relationship between therapists' personality (e.g. operationalized via the "Big Five" (McCrae & John, 1992)) or emotional regulation strategies and outcome. At least, adequate emotion regulation has been discussed as a criterion for selecting candidates for psychotherapy training (Purton, 1991).

In addition, personal characteristics influencing the working alliance and therefore having a postulated indirect influence on the outcome are investigated. Ackerman and Hilsenroth (2001; 2003) reviewed therapists' characteristics impacting working alliance and listed characteristics like rigidity, uncertainty, criticism, distance, tension and distraction as negative associated with outcome. In addition they identified the characteristics trustworthiness, empathy, warmth, flexibility, honest, interest, confidence and openness as positive associated with the outcome. Accordingly, an interpersonal style described as being distanced and indifferent was found to be negatively correlated with working alliance (Hersoug, Høglend, Havik, Lippe, & Monsen, 2009).

Although Baldwin and Imel (2013) summarized that the effect of therapists' variables on outcome is with 5% of outcome variance rather small, we also know that some therapists consistently are more successful than others (Nissen-Lie, Monsen, & Rønnestad, 2010). For understanding why "some therapists outperform others" (Baldwin & Imel, 2013, p. 276), the investigation of correlations between outcome and personal characteristics of therapists might be a step in the right direction.

## 6.3 Research questions

The aim of the present study was to investigate changes in clients' stress level and the relationship to personal characteristics of student therapists'. Therefore we followed the following research questions.

First, we analyzed the levels of stress and general psychological distress as well as depressive mood in comparison to other student samples. We expect that the level of psychological complaints of our sample is comparable to that of clients of university counseling

services, but higher than in a field sample. Second, we investigated student clients' stress before and after the peer-to-peer intervention. Student stress was operationalized using primary outcome measurements (assessing stress level, depressive mood, psychological distress, study relevant work behavior and procrastination) and secondary outcome measurements (assessing emotion regulation, self-efficacy and self-management). We expected that clients' report after the intervention a reduced stress level, less depressive mood, less psychological distress, better work behavior and less procrastination (primary outcome measures) as well as better emotion regulation strategies, higher self-efficacy and improved self-management competences (secondary outcome measures). Finally, the third research question investigated the relationship between the outcome and personal characteristics of the student therapists. Because of the small number of previous research findings we did not formulate a hypothesis for this last research question and investigated the correlations form an explanatory point of view.

## 6.4 Method

### 6.4.1 Setting

The peer-to-peer stress management intervention has taken place at the department for clinical psychology at Justus Liebig University Giessen, Germany. Advanced graduate students in clinical psychology were trained in basic therapeutic and certain CBT-skills and provided individual sessions in stress management to students not enrolled in a psychology program. The clients were seeking help for problems related to student life (e.g. time management or relaxation techniques). For the clients participation in the project was free.

### 6.4.2 Selection of clients and student therapists

The peer-to-peer intervention was announced for student clients via multi-address message. Interested students e-mailed the project coordinator. In an interview with the project coordinator a mental disorder (according to ICD-10; Dilling & Freyberger, 2014) was excluded. Only student clients with a subclinical set of problems concerning academic studies like difficulties in time management, deficient studying techniques or nervousness before exams were included in the project. For student therapists the project was an elective course in their M.Sc. Psychology curriculum. The final inclusion in the project as student therapist was made after a meeting with the project coordinator.

### 6.4.3 The training course for student therapists

We trained M.Sc. Psychology students in basic therapeutic and certain CBT-skills. After an initial compact course concerning basic knowledge and skills (e.g. introduction to physiological and behavioral aspects of stress, introduction to Kanfer's self-management approach (Kanfer, 1999), guidelines for the initial session) there have been weekly training sessions (e.g. relaxation techniques, study techniques, time management). The training consists of theoretical contents as well as practice of skills in role play. Based on scripted reports about the session the further proceeding of the intervention was discussed in weekly group supervision led by the project coordinator.

### 6.4.4 The sessions

After a first meeting, analysis of problems and the formulation of goals for the peer-to-peer intervention followed individually tailored sessions. The content of the other sessions varied depending on clients' problems. Typically, sessions dealt with study skills, reduction of procrastination, improvement of time management, relaxation techniques and cognitive restructuring. Student therapists' provided 10 weekly sessions (1 hour) to two clients. Sessions with the second client started two to six weeks after the beginning with the first client.

### 6.4.5 Sample

***Clients***. A total of *N* = 92 clients (age: *M* = 25.0 yr, *SD* = 4.4; gender: 73% female; final school exam grade: 2.39, *SD* = .69 [ranging from 1.0 (best) to 4.0 (worst)]; area of study: 18% teacher training class, 13% nutrition science, 8% veterinary medicine, 7% law studies, 5% medical science, 49% other) participated in the intervention.

***Student therapists***. A total of *N* = 57 graduate M.Sc. Psychology student therapists (age: *M* = 24.8yr, *SD* = 2.2; gender: 91% female) conducted the sessions. All student therapists had a B.Sc. Psychology degree (final grade *M* = 1.4 (*SD* = .26)) and were at time of the participation in the peer-to-peer project in the first year of the M.Sc. Psychology program.

### 6.4.6 Outcome measurements

We used the following standardized self-rating questionnaires to assess level of stress, distress as well as coping and resilience factors of student clients.

#### 6.4.6.1 Primary outcome measurements

**Stress level**

A short version of the Perceived Stress Questionnaire (PSQ-20) was used in a German translation (Fliege, Rose, Arck, Levenstein, & Klapp, 2001). The PSQ-20 consists of 20 items that must be rated on a 4-point Likert-Scale (1=*fast nie*/almost never *to* 4=*meistens*/usually). In addition to four subscales a total score can be calculated by the summation of raw scores and division by the number of items, followed by subtraction of 1 and division by 3. The total score is a transformed score ranging from 0 - 1, higher values indicating higher stress level. Fliege et al. (2001) reported satisfying psychometric qualities (internal consistency of α = .83 for the total score in a student norm sample).

**Depressive mood**

We used a German version of the BDI-II (Beck-Depressions-Inventar; Hautzinger, Bailer, Worall, & Keller, 1990). The BDI is a self-rating questionnaire assessing the intensity of major symptoms and cognitive factors of depressiveness. The BDI-II consists of 21 items describing different symptoms in four different intensities (4-Point Likert-Scale (0-3)). The BDI-II is interpreted by calculating a total score. Hautzinger et al. (1990) documented the validity of the German BDI-II and reported good psychometric qualities (internal consistency of α = .90 in the student norm sample).

**General psychological distress**

We used a German translation of the BSI (Brief Symptom Inventory; Franke, 2000) a short version of the SCL-90 (Derogatis, 1977). The BSI is a 32-item self-rating questionnaire assessing general psychological distressin the last month. Items must be rated on a 5-point Likert-Scale (0 = *überhaupt nicht*/not at all *to* 4=*sehr stark*/extremely). We used the Global Severity Index (GSI) as description of the severity of general psychopathological symptoms. The psychometric quality concerning validity and reliability of the German versionare reported as satisfactory (Franke, 2000) (internal consistency of α = .95 for the GSI score in the student norm sample).

**Study relevant work behavior**

For assessing problems in study behavior we used a questionnaire developed by Holz-Ebeling (1997) and later revised by Grätz-Tümmers (2003). The FB-AP (original German title *Fragebogen Arbeitsprobleme*) consists of 47 items assessing two subscales. The first subscales assesses problems with study time (that means spending less time with studying than intended) and thereby reflecting the quantitative percentage of studying (original German title of the subscale: *Arbeitszeitprobleme*, 22 items). The second subscale assesses the efficacy of studying (making less use of the time spend with studying than intended) which reflects the qualitative percentage of studying (original German title of the subscale: *Arbeitseffektivitätsprobleme*, 25 items). Because of a significant intercorrelation ($r$ = .37, $p \leq .001$) between these subscales and a factory analysis with limited results because ofseveral double-barreled items (Grätz-Tümmers, 2003), we summed both subscales and interpreted a total score. Grätz-Tümmers (2003) reported satisfying item-total correlations ($.38 \leq r_{it} < .82$) and internal consistencies (α = .95 - .96) for both subscales.

**Procrastination**

We used a German translation of the Aitken Procrastination Scale (APS; Helmke & Schrader, 2000) for assessing trait procrastination. The APS consists of 19 items describing different behaviors and thoughts associated with procrastination. Items must be answered on a 5-Point Likert-Scale (0 = *trifft gar nicht zu*/false *to* 5 = *trifft genau zu*/true). Helmke and Schrader (2000) as well as Patzelt and Opitz (2005) analyzed the APS via factor analysis and reported three subscales. Because of intercorrelations between the subscales (.35 -.67; Patzelt & Opitz, 2005) and several double-barreled items we followed the original work and built a total score (Aitken, 1982; in Ferrari, Johnson, & McCown, 1995). Helmke and Schrader (2000) reported for this total score a internal consistency of α = .91.

#### 6.4.6.2 Secondary outcome measurements

**Emotion regulation**

We used a German translation of the Cognitive Emotion Regulation Questionnaire (CERQ; Loch, Hiller, & Witthöft, 2011) consisting of 36 items assessing multiple emotion regulation strategies. Items are rated using 5-point Likert scale (1 = (fast) nie/almost ever *to* 5 = (fast) immer/almost always). Because of the intercorrelations between the nine subscales, Loch et al. (2011) considered the building of two factors *functional strategies* and *dysfunctional strategies*. Despite a lack of clear support by the results of the conducted factor analysis, we followed there consideration and interpreted *functional* and *dysfunctional strategies*.

Accordingly, validation of the German version showed satisfying results for validity and reliability (Loch et al., 2011).

**Self-efficacy**

The German questionnaire SWE (Skala zur Allgemeinen Selbstwirksamkeitserwartung; Schwarzer & Jerusalem, 1999) was used for assessing clients' self-efficacy. The SWE is a 10-item questionnaire assessing self-efficacy expectancy. Items were rated on a 4-point Likert scale (1 = disagree *to* 4 = strongly agree). Validity and reliability were well documented. We used the total score of SWE.

**Self-management**

We used a German translation of the Lifestyle Approaches Inventory (LSA; Williams, Moore, Pettibone, & Thomas, 1992; unpublished translation by M. Stein). The LSA consists of 22 items representing several cognitive and behavioral strategies related to the achievement of personal goals. Agreement must be rated on a 5-Point Lickert-Scale (0 = *stimme nicht zu*/disagree to 4 = *stimme zu*/agree). Williams et al. (1992) postulated six factors that were only partly confirmed by factor analyses. Nevertheless, they reported moderate to strong correlation between the factors and total score (. 42 ≤ $r$ < .76). Because of these correlations we calculated the additive total score. The reported psychometric qualities concerning validity and reliability of LSA were satisfying (Williams et al., 1992).

### 6.4.7 Measurements assessing personal characteristics of the student therapists

We used the following standardized self-rating questionnaires to assess the personal characteristics of student therapist.

**Interpersonal Style**

We used the German translation of the short version of the Inventory of Interpersonal Problems (IIP-C; Horowitz et al., 2000). Each of the 64 items has to be answered on a 5-point Likert scale (0 = not at all *to* 4 = extremely). The IIP-C entails eight subscales which are formed by summing up item raw scores. The German version was shown to be reliable and valid (Horowitz et al., 2000).

**Personality factors**

Personality factors were assed using the German translation of the NEO-FFI (Borkenau & Ostendorf, 1993). The NEO-FFI contains 60 Items rated on a 5-point Likert scale (0 = strongly disagree *to* 4 = strongly agree). Validity and reliability of the German NEO-FFI have

been demonstrated (Borkenau & Ostendorf, 1993). The NEO-FFI entails five subscales which are formed by summing up the item raw scores and dividing by the number of items per scale. NEO-FFI consists of the subscales *neuroticism*, *extraversion*, *agreeableness, consciousness* and *openness to experiences*.

**Empathy**

The adapted German version of the Interpersonal Reactivity Index (IRI, Davis, 1980; SPF, Saarbrückener Persönlichkeitsfragebogen, V3.1, Paulus, 2009) was used to assess empathy. The SPF contains of 16 items to be answered on a 5-point Likert scale (1 = does not describe me well *to* 5= describes me very well). The German version SPF shows good reliability, validity and discrimination coefficients (Paulus, 2009). The SPF contains of 4 subscales which are formed by summing up the item raw scores (*fantasy*, *perspective taking, empathic concern* and *distress*). In addition, the subscales *fantasy*, *perspective taking* and *empathic concern a*re summed up for the score *empathy*.

**Self-Esteem**

The Rosenberg Self-esteem Scale was used in a German translation (RSES, Ferring & Filipp, 1996) with 10 items rated on a 4-point Likert scale (0 = strongly disagree *to* 3 = strongly agree). The German version shows satisfactory validity and reliability. We used the total score of RSES.

**Self-Efficacy**

The SWE (Schwarzer & Jerusalem, 1999) was already described above.

**Emotion Regulation**

The CERQ (Loch et al., 2011) was already described above.

**Self Care**

Based on Norcross' (2000) theoretical considerations Turner et al. (2005) developed the Intern Self Care Scale (ISCS). We translated the ISCS in a forward-back-translation process into German and adapted the questionnaire to German circumstances. Because of differences in German culture item 21 of the original ISCS was removed and in addition several items were rephrased. Our final version of the ISCS consists of 34 items describing different self-care strategies. Following Turner et al. (2005) items were rated twice: first the *frequency of use* was judged and second the perceived *effectiveness* was rated. Both ratings were made on a 5-Likert scale (1 = never *to* 5 = always). Item responses were summed for building the total scores of the subscales *frequency* and *effectiveness*.

### 6.4.8 Procedure

Data were collected routinely as part of the peer-to-peer intervention described above. From the 152 students who were examined in a personal consultation, 26 students must be excluded from the intervention because of a mental disorder (see Figure 2). In addition, 12 students canceled the participation for other reasons (e.g. date of session). From the remaining 114 students, 22 declined participation in the pre and post assessments. Finally, *N* = 92 clients took place in the intervention and agreed with the pre and post assessments. Clients conducted the BDI-II and BSI during the clinical interview with the project coordinator prior to the beginning of the sessions in a paper-pencil version. The post-assessment of BDI-II and BSI as well as pre and post assessments of all other questionnaires (PSQ-20, FB-AP, APS, CERQ, SWE, LSA) were conducted via an online platform. *N* = 3 clients discontinued the intervention, further *N* = 10 clients completed all sessions but did not participate in the post treatment assessment. Using intent-to-treat analysis, this *N* = 13 were analyzed by *pre values carried forward*. Late introduction of the APS to the set of measurements limited the number of available data for this questionnaire to *N* = 79. Student therapists' self-ratings (IIP-C, NEO-FFI, RSES, SWE, CERQ, ISCS, SPI) were conducted via an online platform prior to the training. Late introduction of the ISCS to the set of measurements limited the number of available data for this questionnaire to *N* = 40.

Because student therapists provided sessions to two clients, analyzes of the relationship between personal characteristics of student therapists and clients' outcome were conducted separate for the first and the second client. Because of the clients who declined to participate in the pre and post assessments, not all student therapists provided sessions to two clients included in this evaluation study (for *N* = 22 students therapists only the assessments of one client were included in this study (for *N* = 9 it lacks the assessments of the first client, for *N* = 13 it lacks the assessments of the second client)). Due to this, correlations with first clients' outcome were calculated for a sample of *N* = 48 student therapists and clients (for APS *N* = 42; for ISCS *N* = 31), the correlations with second clients' outcome for a sample of *N* = 44 (for APS *N* = 37; for ISCS *N* = 27). The flow diagram in Figure 2 shows the reported flow of participants.

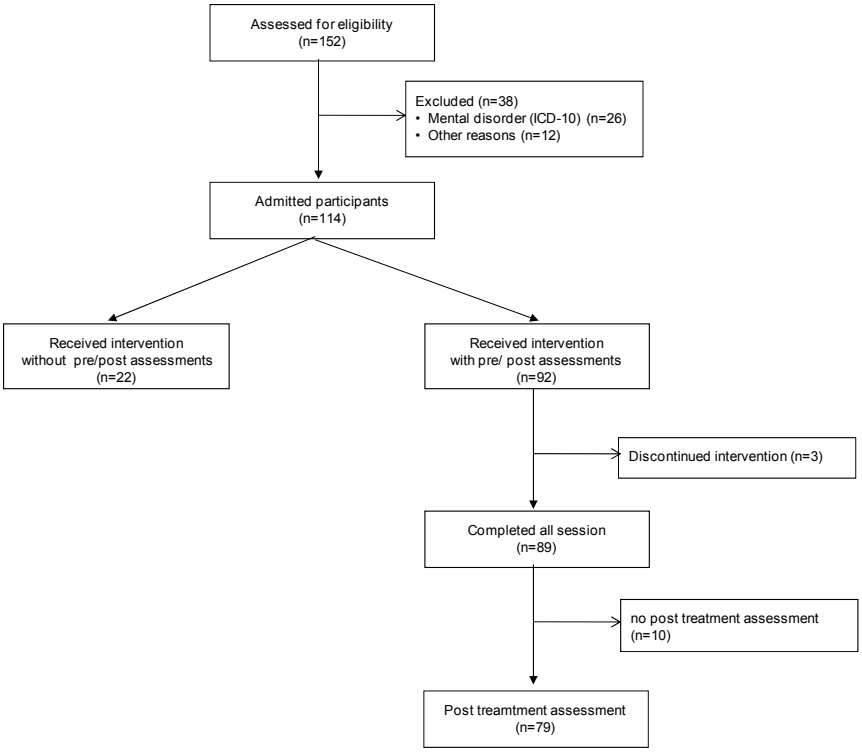


**Figure 2:** Flow diagram

### 6.4.9 Data analysis

The degree of general psychological distress in comparison to other samples was analyzed using independent *t*-tests and chi-square test. For investigating changes in clients' stress, first statistical significant changes were analyzed: Primary outcome measurements were analyzed using repeated measurement MANOVA with *time of measurement* (pre and post) as a within-subject factor (two levels) and the primary outcome measurements as dependent variables. According to Field (2013) we used the test statistic Pillai-Spur. In addition, univariat tests for the dependent variables were conducted, test statistic Greenhouse-Geisser was used. Finally, Cohen's effect size *d* was calculated. Second, we investigated clinical significant changes in the primary outcome measurements that reflected psychopathological symptoms (BDI-II, BSI, PSQ-20) by calculating a Reliable Change Index (RCI; Jacobson, 1984). For estimating the standard error of the measurement we used the standard deviation of the normative sample ($SD_1$) and according to Lambert and Ogles (2009) the scores of internal consistency as reliability measures (rel). A change was considered clinical significant if the RCI exceeded the difference between clients' pre ($x_1$) and post scores ($x_2$): $x_1 - x_2 >$ RCI with RCI = $1.96 * SD_1 * \sqrt{(2*(1-rel))}$. For the BDI-II we calculated a RCI = 6.39, for the GSI-Score of BSI a RCI = .48 and for PSQ-20 a RCI = .18. Secondary outcome measurements were analyzed using matched-pairs *t*-tests with Bonferroni correction. Cohen's effect size *d* was calculated. Correlations between outcome measurements and characteris-

tics of student therapists were evaluated by Pearson product-moment-correlations ($r_{xy}$). All statistical analyses were done by using SPSS 22.

## 6.5 Results

### 6.5.1 Clients' level of stress, psychological distress and depressive mood

We compared the levels of stress (PSQ-20) and of general psychological distress (GSI score of BSI) of our sample (PSQ-20 total score *M* = .59, *SD* = .18; GSI: *M* = .81, *SD* = .50) with other student samples (see Table 20). Regarding the level of stress (total score of PSQ-20), our sample reported a significant higher level of stress than a reference sample of students by Fliege et al.(2001) ($t$ (223) = 12.35, $p \leq .001$). Focusing on the degree of general psychological distress, Holm-Hadulla, Hofmann, Sperth, and Funke (2009) and Sperth, Hofmann, and Holm-Hadulla (2013) investigated the level of distress in a sample of German students contacting a university counseling center using the GSI score of the SCL-90. There was no difference between their samples and the distress of our clients operationalized by the GSI score of the BSI, a short version of the SCL-90. In addition, Fliege et al. (2001) reported the level of distress of a student' field sample of German university students. The distress of our sample was significant higher than in the field sample ($t$ (215) = 3.66, $p \leq .001$). As formulated in the manual (Hautzinger et al., 1990) total scores in BDI-II can be interpreted as follows: 0 – 10 normal; 11 – 17 moderate mood disturbance; ≥ 18 clinical symptoms of depression. According to this classification *N* = 36 (39.1%) of the clients reported no depressive symptoms (total score BDI-II 0-10), *N* = 26 (28.3%) reported moderate mood disturbance (total score BDI-II 11 – 17) and *N* = 30 (32.6%) reported clinical symptoms of depression (total score BDI-II ≥ 18). Jurkat et al.(2011) reported for a sample of *N* = 651 German medicine students a percentage of *N* = 38 (5.8%) with a total score ≥ 18. In comparison to this sample, the distribution of total BDI-II scores differed significantly ($\chi^2$ = 69.34; $p < .001$). In our sample, the percentage reporting clinical symptoms of depressions was higher than in the study by Jurkat et al. (2011).

**Table 20**: Level of stress and general psychological distress in comparison to other samples

| | N | Sample | *M* (*SD*) | *t* | *p* |
|---|---|---|---|---|---|
| | | | PSQ-20/ total score | | |
| Fliege et al., 2001 | 246 | Students | .34 (.16) | 12.35 | =.001 |
| | | | GSI | | |
| Holm-Hadulla et al., 2009 | 213 | University counseling center | 1.15 (.65) | -4.48 | 2.00 |
| | 125 | Students | .57 (.46) | 3.66 | =.001 |
| Sperth et a., 2013 | 121 | University counseling center | 1.01 (.58) | -2.64 | 2.00 |

### 6.5.2 Analysis of outcome measurements

#### 6.5.2.1 Primary outcome measurements

Repeated measure MANOVA showed for the primary outcome measurements a significant overall time effect ($F$ (5,74) = 14.08; $p \leq .001$), the subsequent univariat testing of the dependent variables showed in addition significant time effects in all primary outcome measurements (see Table 21). The general stress level assessment by the PSQ-20 also decreased from the beginning to the end of the intervention (pre $M$ = .59, $SD$ = .19; post $M$ = .43, $SD$ = .18; $F$ (1, 78) = 54.92; $p \leq .001$) (see Figure 3). The effect size of the change in PSQ-20 was large ($d$ = .87). Clients' total scores in BDI-II decreased from $M$ = 14.68 ($SD$ = 8.55) to $M$ = 10.07 ($SD$ = 7.77) ($F$ (1, 78) = 27.77; $p \leq .001$). Effect size Cohens $d$ = .56 what is a moderate effect. Clients reported general psychological distress (BSI-GSI) decreased from the beginning ($M$ = .81 ($SD$ = .50)) to the end of the intervention ($M$ = .52, SD = .42; $F$ (1, 78) = 27.66; $p \leq .001$), $d$ = .63). Clients reported a significant improvement in their working behavior (FB-AP; pre $M$ = 4.50, $SD$ = 1.20; post $M$ = 3.56, $SD$ = 1.29; $F$ (1, 78) = 56.27; $p \leq .001$). The effect size of change in AP-FB was moderate ($d$ = .76). Finally, improvement in clients' procrastination resulted in a decreased total score in APS from $M$ = 2.61 ($SD$ = .49) to $M$ = 2.40 ($SD$ = .58) ($F$ (1, 78) = 17277; $p \leq .001$). The effect size was small ($d$ = .39).

**Table 21**: Pre, post and pre-post difference scores of primary outcome measurements with results of univariat testing and effect size Cohens *d*.

| | | pre | | post | | pre-post difference | | *F* | *d* |
|---|---|---|---|---|---|---|---|---|---|
| | N | *M* | *SD* | *M* | *SD* | *M* | *SD* | | |
| PSQ-20 | 92 | .59 | .19 | .43 | .18 | .16 | .19 | 54.92*** | .87 |
| BDI | 92 | 14.68 | 8.55 | 10.07 | 7.87 | 4.62 | 8.37 | 27.77*** | .56 |
| BSI (GSI) | 92 | .81 | .50 | .52 | .42 | .30 | .49 | 27.66*** | .63 |
| FB-AP | 92 | 4.50 | 1.20 | 3.56 | 1.29 | .94 | 1.16 | 56.27*** | .76 |
| APS | 79 | 2.61 | .49 | 2.40 | .58 | .22 | .47 | 17.27*** | .39 |

*** = $p \leq .001$; *d* = Cohens *d*.

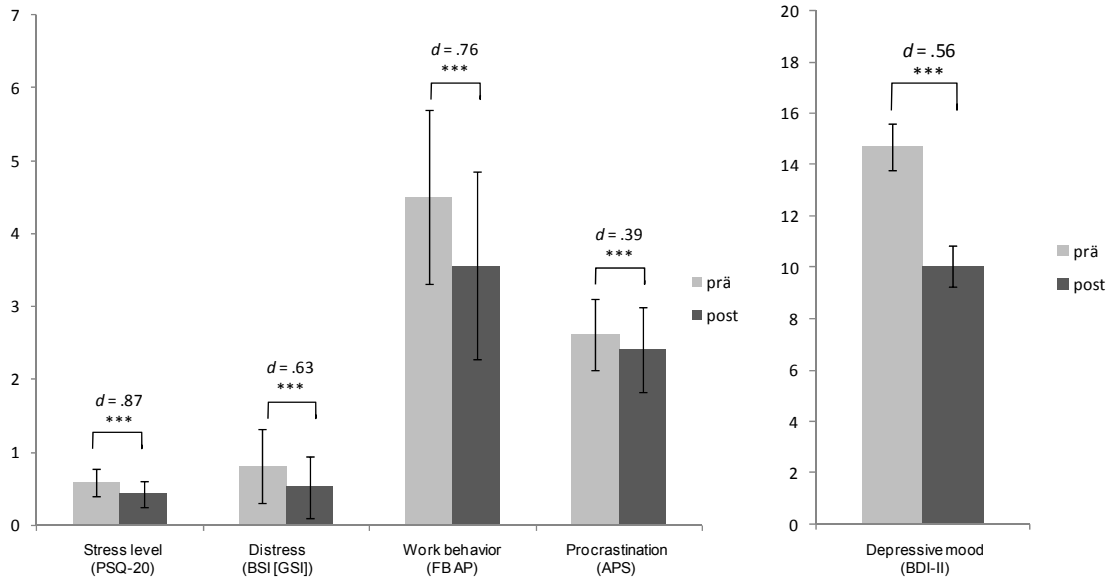


**Figure 3:** Pre and post means and standard errors of the primary outcome measurements (*** = $p \leq .001$, *d* = Cohens *d*)

Additionally, for analyzing the amount of clinical significant changes, the pre-post difference scores were compared to the previously reported scores of RCI ($x_1 - x_2 >$ RCI). *N* = 37 (40.2%) showed a clinical significant change in PSQ-20, *N* = 34 (37.0%) in BDI-II and *N* = 28 (30.5%) in the GSI score of the BSI (see Figure 4).

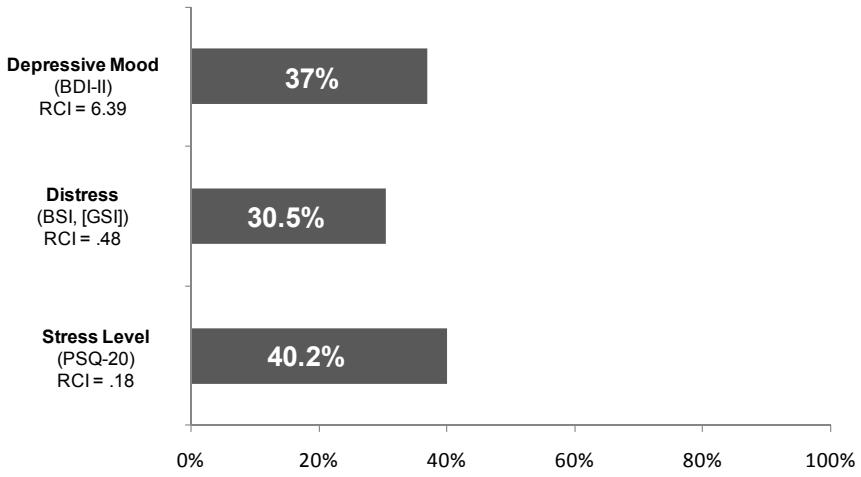


**Figure 4**: Percentage of clients with reliable improvement ((x1-x2) > RCI)

### 6.5.2.2 Secondary outcome measurements

Functional emotional regulation strategies (CERQ functional) increased from M = 46.65 (*SD* = 9.18) before the intervention to *M* = 51.51 (*SD* = 9.77) after completing the sessions (*t* (91) = -5.06; *p* ≤ .001). This change had a moderate effect size (*d* = .55). Accordingly, the use of dysfunctional emotion regulations strategies (CERQ dysfunctional) decreased from *M* = 31.10 (*SD* 7.67) before the intervention to *M* = 27.64 (*SD* = 6.39) after completing the sessions (*t* (91) = 4.20; *p* ≤ .001; *d* = .49). Clients reported self-efficacy (SWE) increased from the beginning (*M* = 25.61, *SD* = 5.33) to the end of the intervention (*M* = 29.09, *SD* = 5.11; *t* (91) = -7.06; *p* ≤ .001) with an effect size of *d* = .91, what is a large effect. Finally, clients perceived self-management strategies (LSA) raised from *M* = 38.88 (*SD* = 9.79) to *M* = 48.68 (*SD* = 11.69; *t* (91) = -8.66; *p* ≤ .001). The effect size for the change in self-management strategies was moderate (*d* = .67) (see Table 22). Figure 5 shows the reported changes.

**Table 22**: Pre, post and pre-post difference scores of secondary outcome measurements with results of *t*-test.

| | | | pre | | post | | pre-post difference | | *t* | *d* |
|---|---|---|---|---|---|---|---|---|---|---|
| | | *N* | *M* | *SD* | *M* | *SD* | *M* | *SD* | | |
| CERQ | functional | 92 | 46.18 | 9.52 | 51.51 | 9.77 | -5.33 | 10.10 | -5.06*** | .55 |
| | dysfunctional | 92 | 31.10 | 7.67 | 27.64 | 6.39 | 3.46 | 7.90 | 4.20*** | .49 |
| SWE | | 92 | 25.61 | 5.33 | 29.09 | 5.11 | -3.48 | 4.73 | -7.06*** | .91 |
| LSA | | 92 | 38.89 | 9.79 | 48.68 | 11.69 | -9.80 | 10.86 | -8.66*** | .67 |

*** = *p* ≤ .001 with Bonferroni correction; *d* = Cohens *d*.

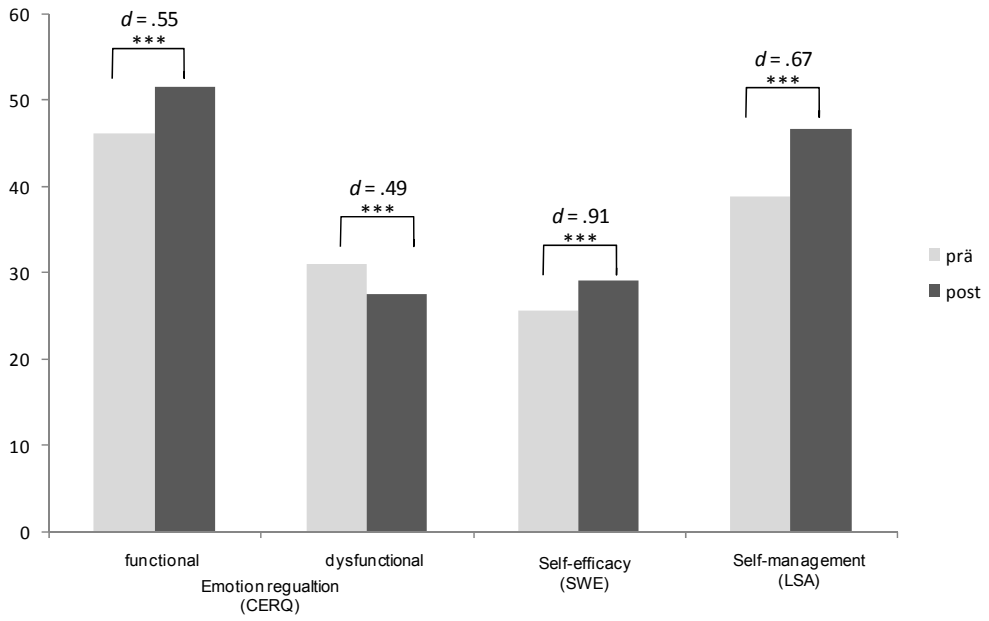


**Figure 5:** Pre and post means and standard errors of the secondary outcome measurements (*** = $p \leq .001$, $d$ = Cohens d)

### 6.5.3 Relationship between outcome and personal characteristics of therapists

Mean and standard deviations of the measurements assessing personal characteristics of student therapists are shown in Table 23.

**Table 23**: Means (*M*) and standard deviations (*SD*) of the measurements assessing personal characteristics of student therapists.

| | | *M* | *SD* |
|---|---|---|---|
| NEO-FFI | Neuroticism | 1.59 | .54 |
| | Extraversion | 2.59 | .49 |
| | Openess to experiences | 2.88 | .44 |
| | Agreeableness | 2.98 | .46 |
| | Consciousness | 2.93 | .53 |
| IIP-C | PA *domineering* | 5.49 | 3.65 |
| | BC *vindictive* | 6.00 | 3.73 |
| | DE *cold* | 4.75 | 3.85 |
| | FG *socially inhibited* | 6.96 | 4.03 |
| | HI *Non assertive* | 10.84 | 5.76 |
| | JK *Overly accommodating* | 11.26 | 5.25 |
| | LM *self-sacrificing* | 11.39 | 5.59 |
| | NO *intrusive* | 9.93 | 5.25 |
| SPF | Fantasy | 15.77 | 2.58 |
| | Perspective | 15.65 | 2.32 |
| | Empathic concern | 15.12 | 2.13 |
| | Distress | 9.19 | 2.50 |
| | Empathy | 46.54 | 4.80 |
| CERQ | Functional strategies | 50.30 | 9.17 |
| | Dysfunctional strategies | 27.12 | 5.38 |
| RSES | | 24.72 | 4.34 |
| SWE | | 29.98 | 3.13 |
| ISCS | Frequency | 29.87 | 3.61 |
| | Effectiveness | 32.15 | 4.47 |

In general, there were only few correlations between personal characteristics of student therapists and the outcome (pre-post differences) of clients (see Table 24 and Table 25). Nevertheless, correlations differ between the first and the second clients. While there are correlations between student therapists' neuroticism (NEO-FFI), emotional regulation strategies (CERQ) and self-efficacy (SWE) and several outcome measurements of first clients', we did not find these correlations for second clients' outcome.

Furthermore, there were no correlations with student therapists' self-esteem (RSES) and almost no correlations with self-care (ISCS). There were several correlations between student therapists' interpersonal style (IIP-C), empathy (SPF) and the outcome measurements.

**Table 24**: Correlations between personal characteristics of student therapists and outcome (pre post differences) of the first clients'.

| | | | Outcome (pre-post difference ) of the first clients' | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | BDI-II (N=48) | BSI (N=48) | PSQ-20 (N=48) | AP (N=48) | APS (N=42) | CERQ (N=48) functional | CERQ (N=48) dysfunct. | SWE (N=48) | LSA (N=48) |
| Personal characteristics of student therapists' | NEO-FFI (N=48) | Neuroticism | **-.26**$^{+}$ | **-.24**$^{+}$ | **-.28**$^{+}$ | **-.28*** | -.23 | .12 | -.22 | .00 | .14 |
| | | Extraversion | -.04 | -.08 | -.11 | -.06 | -.15 | .00 | -.14 | -.11 | -.15 |
| | | Openess to experiences | .06 | -.17 | .05 | .12 | .07 | .19 | .03 | .15 | -.08 |
| | | Agreeableness | .11 | .05 | .13 | .03 | -.14 | -.03 | -.05 | -.06 | -.11 |
| | | Consciousness | .08 | .05 | -.20 | -.17 | -.22 | .11 | .08 | -.01 | -.02 |
| | IIP-C (N=48) | PA *domineering* | **-.31*** | -.20 | -.21 | .02 | .17 | .06 | -.15 | .07 | -.07 |
| | | BC *vindictive* | -.17 | .00 | **-.27**$^{+}$ | -.14 | .08 | .01 | -.16 | -.16 | .03 |
| | | DE *cold* | -.21 | -.18 | -.17 | -.04 | -.01 | .01 | -.06 | .02 | .13 |
| | | FG *socially inhibited* | -.07 | .02 | -.09 | -.08 | .04 | -.03 | .01 | -.22 | .20 |
| | | HI *Nonassertive* | -.01 | .04 | -.07 | -.19 | -.24 | -.03 | -.17 | -.22 | .01 |
| | | JK *Overly accommodating* | .02 | .07 | -.13 | -.12 | -.04 | -.10 | **-.32*** | -.18 | .04 |
| | | LM *self-sacrificing* | -.09 | -.06 | -.16 | -.03 | -.08 | -.07 | **-.33*** | **-.27**$^{+}$ | -.01 |
| | | NO *intrusive* | -.17 | -.15 | -.20 | -.10 | -.16 | .12 | -.21 | -.10 | -.02 |
| | SPF (N=48) | Fantasy | .07 | -.01 | -.01 | -.01 | .03 | .15 | .07 | .21 | .14 |
| | | Perspective | -.15 | -.16 | .12 | **-.24**$^{+}$ | -.25 | .13 | **-.27**$^{+}$ | .13 | .13 |
| | | Empathyic Concern | -.15 | -.14 | -.04 | .13 | -.24 | .01 | -.05 | -.13 | **-.31*** |
| | | Distress | **-.29*** | -.18 | -.15 | **-.29*** | **-.41**** | .17 | -.21 | .02 | -.16 |
| | | Empathy | -.09 | -.15 | .03 | -.07 | -.23 | .15 | -.11 | .13 | .01 |
| | CERQ (N=48) | Functional Strategies | -.06 | .00 | -.17 | -.21 | -.22 | .16 | **-.25**$^{+}$ | .08 | -.09 |
| | | Dysfunctional Strategies | -.19 | -.24 | **-.27**$^{+}$ | **-.26**$^{+}$ | **-.35*** | **.36*** | -.14 | ***.37**** | .07 |
| | RSES (N=48) | | .13 | .13 | .21 | .22 | .10 | -.17 | .08 | -.14 | -.18 |
| | SWE (N=48) | | **.31*** | .27 | .16 | .17 | **.32*** | .14 | .00 | .07 | -.11 |
| | ISCS (N=31) | Frequency | -.22 | -.13 | -.20 | -.24 | -.08 | -.21 | -.18 | .08 | -.07 |
| | | Effectiveness | -.16 | .03 | **-.34+** | -.25 | -.14 | -.25 | -.15 | -.13 | -.26 |

*Note*: + = $p \leq .1$; * = $p \leq .05$; ** = $p \leq .01$.

**Table 25:** Correlations between personal characteristics of student therapists and outcome (pre post differences) of the second clients.

| | | | Outcome (pre-post difference ) of second clients' | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | BDI-II (N=44) | BSI (N=44) | PSQ-20 (N=44) | AP (N=44) | APS (N=37) | CERQ (N=44) functional | CERQ (N=44) dysfunct. | SWE (N=44) | LSA (N=44) |
| Personal characteristics of student therapists' | NEO-FFI (N=48) | Neuroticism | -.08 | -.08 | -.08 | -.17 | -.02 | -.03 | **-.29**$^{+}$ | .07 | -.14 |
| | | Extraversion | -.15 | .07 | -.17 | -.10 | -.06 | -.04 | -.08 | -.10 | .00 |
| | | Openess to experiences | .14 | **.27**$^{+}$ | -.02 | -.12 | .27 | .11 | .06 | **.36*** | -.06 |
| | | Agreeableness | .08 | .12 | -.14 | .00 | .10 | .00 | .00 | .08 | .13 |
| | | Consciousness | .19 | .02 | .03 | .10 | .16 | .07 | .14 | -.23 | .10 |
| | IIP-C (N=48) | PA *domineering* | **-.29**$^{+}$ | -.13 | .06 | -.16 | -.13 | .00 | -.11 | -.23 | -.10 |
| | | BC *vindictive* | -.04 | -.07 | **.30*** | -.04 | -.18 | -.15 | -.04 | -.22 | -.18 |
| | | DE *cold* | .04 | -.02 | .10 | -.10 | -.15 | -.03 | -.10 | -.23 | -.09 |
| | | FG *socially inhibited* | .07 | -.15 | **.27**$^{+}$ | .16 | -.05 | **-.35*** | .06 | -.15 | .02 |
| | | HI *Nonassertive* | -.06 | -.14 | .09 | -.05 | .09 | **-.34*** | -.20 | -.04 | .05 |
| | | JK *Overly accommodating* | -.21 | -.25 | -.16 | -.11 | -.12 | **-.27+** | -.11 | .07 | .10 |
| | | LM *self-sacrificing* | -.11 | -.01 | -.08 | -.14 | .06 | -.12 | -.14 | .09 | .10 |
| | | NO *intrusive* | -.20 | -.06 | .01 | -.10 | -.21 | -.19 | -.17 | -.05 | -.05 |
| | SPF (N=48) | Fantasy | -.02 | .03 | -.05 | .14 | **.40*** | -.18 | -.14 | **.30*** | .08 |
| | | Perspective | -.04 | .18 | -.15 | .04 | **.33*** | -.08 | .10 | -.01 | .09 |
| | | Empathyic Concern | -.12 | .03 | -.09 | **-.36*** | -.09 | .15 | **-.33*** | **.28**$^{+}$ | .10 |
| | | Distress | .03 | -.13 | **.26*** | .00 | -.13 | -.18 | -.10 | -.18 | -.12 |
| | | Empathy | -.08 | .11 | -.13 | -.07 | **.33*** | -.07 | -.17 | **.27**$^{+}$ | .13 |
| | CERQ (N=48) | Functional Strategies | -.18 | -.02 | -.10 | -.07 | .00 | .06 | -.08 | -.17 | .12 |
| | | Dysfunctional Strategies | .07 | -.07 | -.01 | -.11 | -.07 | .13 | .00 | -.11 | -.19 |
| | RSES (N=48) | | .00 | -.05 | .04 | .12 | -.09 | -.07 | .09 | -.05 | .22 |
| | SWE (N=48) | | -.23 | -.12 | -.03 | -.02 | -.10 | -.05 | .21 | .12 | .01 |
| | ISCS (N=28) | Frequency | .04 | .13 | -.11 | .15 | -.01 | .09 | **.32**$^{+}$ | -.26 | -.06 |
| | | Effectiveness | -.06 | .11 | .04 | .03 | .05 | -.12 | .15 | -.24 | .03 |

*Note*: + = $p \leq .1$; * = $p \leq .05$; ** = $p \leq .01$.

## 6.6 Discussion

We investigated the efficacy of a peer to peer intervention for reducing students' stress. All in all, the results of our naturalistic study showed that participation in the peer to peer intervention reduced stress level of clients and improved their general mental complaints. Furthermore, we found no clear association with personal characteristics of student therapists.

Regarding the general level of psychological complaints, we compared the levels of stress and of general psychological distress as well as depressive mood of our sample with the findings of other studies. The reported stress level (PSQ-20) of our clients was significantly higher than in a field sample of German students investigated by Fliege et al. (2001). The same was for general psychological distress (GSI): the clients in this study reported significantly higher levels of distress than in a field sample of German students (Holm-Hadulla et al., 2009). In contrast, there was no difference between clients of this sample and German students seeking help in a university counseling center (Holm-Hadulla et al., 2009; Sperth et al., 2013). Concerning the depressive mood, a percentage of 32.6% (N = 30) reported clinical symptoms of depression (total score ≥ 18 in BDI-II). Thus, the proportion of students reporting a severe mood disturbance was higher than in a field sample of German medicine

students investigated by Jurkat et al. (2011). All in all, clients of this sample showed higher stress, distress and more clinical symptoms of depressive mood than field samples of German students and reported a stress level comparable to that of clients in German university counseling centers.

Furthermore, we investigated student clients' stress before and after the peer-to-peer intervention (primary outcome measurements: stress level, depressive mood, psychological distress, study relevant work behavior and procrastination; secondary outcome measurements: emotion regulation, self-efficacy and competences in self-management). For investigating chances in the primary outcome measurements, the conducted repeated measurement MANOVA showed a significant overall time effect as well as significant time effects for all dependent measurements. After completing the intervention, clients reported a reduced stress level, less depressive mood, less psychological distress, better study related work behavior and less procrastination. Effect sizes for these pre-post changes ranged from small to large. Furthermore, for analyzing clinical significance of the reported pre-post changes, we calculated Reliable Change Indices (RCI) for BDI-II, BSI and PSQ-20 as the primary outcome measurements assessing psychopathological symptoms. Results indicated that 40.2% of the clients showed a clinical significant reduction in their stress level (PSQ-20), 37.0% reported a clinical significant reduction in depressive mood (BDI-II) and 30.5% reported a clinical significant improvement in psychological distress (BSI [GSI]). Regarding the secondary outcome measurements, we analyzed the difference between the pre and post ratings and found significant chances in all measurements. After completing the intervention, clients reported better emotion regulation strategies, higher self-efficacy and improved self-management competences. Effect sizes for these pre-post changes ranged from small to large.

All in all, it can be summarized that clients showed a considerable improvement in their levels of stress, distress and all other associated outcome measurements. The reported effect sizes and most notably the reported percentages of clinical significant pre-post changes allow the conclusion that the peer-to-peer stress intervention is an effective intervention for reducing students' stress and improving general psychological complaints. Comparing our results with previous research findings showed that the reported improvements in terms of clinical significant pre-post changes are quite comparable to other findings. Sperth et al. (2013) reported after an average of six sessions in a university counseling center a percentage of 40.5% of clinical significant improvement in GSI scores (SCL-90). Taking into account the circumstances that the sessions in our study were proceeded by therapists at the beginner level and not by graduated psychologists as employees in a counseling center as in the study by Sperth et al. (2013), the amount of 30.5% clinical significant change in BSI-GSI in our sample is interpreted as quite comparable. Furthermore, Sperth et al. (2013)

reported for pre-post changes an effect size of .73, which is also interpreted as comparable to the effect size of .63 in our sample. Using a different outcome measurement (Outcome-Questionnaire-45 OQ-45 by Lambert, Lunnen, Umphress, Hansen, and Burlingame (1994)) Choi et al. (2010) reported that 32% of clients improved clinical significant (RCI) after an average of six sessions in a US university counseling center. All in all, in comparison to previous findings, our intervention is effective and the effectiveness is comparable to other interventions. There is no limitation in effectiveness because of the beginner level of the student therapists. Therefore, we cannot support the conclusion of Hill et al. (2008) that it is because of ethical purposes not possible that students conduct session to recruited clients. Hill et al. (2008), however, refer in their remarks of negative experiences with not very skillful students on US upper-level undergraduate psychology major students. In contrast, student therapists in our sample already graduated in psychology (BA degree). This advance in education might explain first that we cannot report negative experiences and that in addition the training course our student therapists ensures a first necessary qualification.

Analyzes of the correlations between clients' outcome (pre-post difference) and personal characteristics of student therapists were conducted separately for the first and the second client. All in all, we did not find a clear correlation between therapists' personal characteristics and outcome. Keeping in mind that the general effect of therapists on outcome is estimated at 5% (Baldwin & Imel, 2013), then possible no larger correlations between therapists' personal characteristics and outcome can be expected.

Nevertheless, interesting findings are the negative correlations between therapists' neuroticism (NEO-FFI) and primary outcome measurements for first clients which are not found for the second clients. Possibly, while outcome of the first client is influenced by personal characteristics of therapists, the growth in experience and competence (even if it might be a small one) toward sessions with the second client a few weeks later reduced the influence of personal characteristics. Findings concerning therapists' empathy support the conclusion of changes in impact of characteristics on outcome from first to second client. At first, while almost all significant correlations between therapists' characteristics and outcome of first clients were negative, correlations with outcome of second clients were in the same extent also in the positive direction. Second, while there were no correlations with first clients change in self-efficacy, several subscales of therapists' empathy correlated positive with changes in self-efficacy of second clients. At least, there were negative correlations with therapists' perceived *personal distress* (SPI) and changes in BDI-II, FB-AP and APS of the first clients. In contrast, there is only one positive correlation between therapists' *perceived distress* (SPI) and outcome in PSQ-20 for the second client. It might stand to reason that there is a change in the impact of therapists' feelings of discomfort in reaction to observed distress

of others. Furthermore, correlations between therapists' dysfunctional emotion regulation strategies and first clients' outcome do not appear similarly in the second clients. First, we conclude that impact of therapists' personal characteristics on outcome is only moderate. Second, at the very beginning of conducting sessions personal characteristic of therapists have a different impact on outcome than later. Possibly, while outcome at the beginning of independent sessions is more influenced by therapists' characteristics, later professionalism is less influenced by therapists' characteristics but more by their therapeutic competence. This interpretation that first self-conducted sessions are more influenced by therapists' characteristics than later sessions with the second client and that later the impact of therapeutic competences is intensified must be verified in further studies.
As already discussed, the impact of therapists' personal characteristics on outcome has not been extensively investigated. Thus, a study by Hersoug et al. (2009) investigating the relationship between therapists' interpersonal behavior and working alliance should be discussed. They reported negative correlations between all subscales of IIP-C and ratings of working alliance by therapists and patients. We cannot fully support these findings. However, most of the significant correlations in our study were also negative, but second clients' change in PSQ-20 was positively correlated with the subscales *vindictive* and *socially inhibited* (IIP-C).

Concerning the possible win-win situation of a peer-to-peer intervention already mentioned above, the results of our study clearly support this. Considering first the side of clients, the presented peer-to-peer interventions represents an efficient low-threshold offer for student clients suffering from study related problems. Some studies conclude that only a few students with mental health problems receive adequate support and treatment (Downs & Eisenberg, 2012; Garlow et al., 2008).The fact that sessions are conducted by fellow students might reduce clients' reluctance. Further, considering student therapists' side, providing sessions means practical experiences. Moreover, the clear improvements in clients' stress allow the consideration that student therapists learned basic CBT-techniques and improved their therapeutic competences. Clearly, this assumption needs further investigation.

There are several limitations concerning our study. At first, Baldwin and Imel (2013) criticized the small sample sizes of studies investigating therapists' effect and gave as an example the study by Kim, Wampold, and Bolt (2006) that included 15 therapists. Referring to the sample size, our sample is quite satisfactory. The problem in our study is more to the fact that each therapist only provided sessions to two clients, so it was not possible to analyze the impact of personal characteristics on outcome using multilevel analysis.

Furthermore, the sample of our student therapists was highly self-selected. Since the project was associated with a higher workload than common classes, only particularly

motivated students might have registered. In addition, providing 10 self-directed sessions to two fellow students may have been deterrent for less self-confident students. For these reasons, our sample of student therapists was probably a very special one. We implemented a meeting with the project coordinator before inclusion in the project for ensuring that we only include those students as therapists in our program, we also dare to provide self-contained sessions to clients. The fact, that we have not excluded any student is further support for the self-selection of our sample. Probably our self-selected sample had higher "natural helping ability" (Hill, Stahl, & Roffman, 2007; Rønnestad & Skovholt, 2013), a fact that might surely be reflected in their personal characteristics and thereby influencing our analyses of correlations between personal characteristics of student therapists and outcome.
In addition, there might have been a confounding effect of clients' pre-session symptom level we did not control for. Future studies should consider this. In addition, our study was naturalistic with a single-trail design without control group. Furthermore, our study did not include a post-training follow up assessment. Following studies should include these points.
At least, for analyzing the correlation between outcome and personal characteristics of therapists it might be problematic that our sample was not a clinical sample, interested clients with a suspected mental disorder were excluded from the peer-to-peer project. Although other authors discussed this selection problem as a limitation of the study (e.g. Fitzpatrick et al., 2005), we do not agree. Of course, the nature of our non-clinical client sample may have influenced the obtained findings; Maybe the healthy student sample had made it easier for the student therapists. Finally, the positive outcome does not allow the direct conclusion that the training of the student therapists was efficient. This question must be as well investigated in further studies.

This explorative uncontrolled single sample study showed preliminary but strong evidence that trained graduate M. Sc. psychology students can provide a peer-to-peer intervention to clients for reducing their stress level as well as general mental distress.

# 7. Gesamtdiskussion

## 7.1 Zusammenführung der Befunde

Im Rahmen dieser Dissertation wurde ein theoretisches Modell therapeutischer Kompetenzen entwickelt, das als Grundlage für die Entwicklung von Messinstrumenten zur multiperspektivischen und multi-modalen Erfassung therapeutischer Kompetenz herangezogen wurde. Dieses Modell wurde herangezogen um die Vermittlung und den Erwerb therapeutischer Kompetenz bei Novizen-Therapeuten sowie den Einfluss persönlicher Eigenschaften von Therapeuten auf das Therapieergebnis zu untersuchen.

Ausgangspunkt war die Erkenntnis, dass bisher kein theoretisches Modell existierte, das als theoretisches Gerüst für die Entwicklung multi-perspektivischer und multi-modaler Verfahren zur Erfassung therapeutischer Kompetenz, speziell für den Bereich von Anfängertherapeuten, herangezogen werden konnte. In den bestehenden Modellen fanden sich außerdem verschiedene konzeptuelle und theoretische Probleme. So waren beispielsweise die einem Modell zu Grunde liegende Definition therapeutischer Kompetenz oder der theoretische Hintergrund nicht immer klar erkennbar. Außerdem fanden persönliche Charakteristika der Therapeuten bisher nicht ausreichend Betrachtung. Des Weiteren waren existierende Modelle oftmals derartig komplex, dass die Ableitung einer Operationalisierung nicht möglich erschien.

Zudem zeigte sich, dass für den deutschsprachigen Raum kein Set an Erhebungsinstrumenten zur Erfassung therapeutischer Kompetenz aus verschiedenen Perspektiven existierte, die auf den gleichen theoretischen Annahmen basierten und damit vergleichbar waren. Auch hier stellte das besondere Anwendungsfeld der Novizen-Therapeuten eine weitere Einschränkung dar. Bestehende Instrumente sind nur bedingt für die Erfassung therapeutischer Kompetenzen bei Anfängern geeignet. So enthält beispielsweise die validierte deutsche Übersetzung der CTS (Weck et al., 2010) Items, die sehr spezifische und komplexe Aspekte therapeutischer Kompetenz erfassen (z.B. Item 9 „Geleitetes Entdecken“ und Item 10 „Fokus auf zentrale Kognitionen und Verhalten“). Eine Beurteilung der therapeutischen Kompetenz von Novizen-Therapeuten, die am Anfang ihrer Ausbildung stehen und ihre zweite Einzelsitzung durchführen, erschien aufgrund zu erwartender Bodeneffekte nicht sinnvoll. Schließlich gab es bisher keine empirische Forschung zu der Frage, ob es möglich ist, therapeutische Basiskompetenzen bereits im Rahmen der universitären Ausbildung zu vermitteln. Damit einher geht auch die Frage, welche Kompetenzen das sein können. Auch hierzu fanden sich in der Literatur nur wenige empirische Befunde (z.B. aus der Arbeitsgruppe um Clara E. Hill).

Basierend auf dem aktuellen Stand der Forschung wurde daher in einem ersten Schritt ein Hybridmodell therapeutischer Kompetenz (siehe Kapitel 4) entwickelt. Das *Drei-Ebenen-Modell* bildet auf unterster Ebene *Dispositionen* ab, die als relevant für den Erwerb therapeutischer Kompetenzen postuliert werden. Ferner besteht das Modell aus der Ebene *Basiskompetenzen*, die als relativ schulenunabhängig angesehen werden, und darauf aufbauenden *Spezifischen Kompetenzen*, die sich in Abhängigkeit von der theoretischen Orientierung unterscheiden. Das Modell sieht vor, die einzelnen Komponenten der Ebenen *Basis*- und *Spezifische Kompetenzen* durch standardisierte Erhebungsinstrumente zu erfassen.

Basierend auf dem Modell wurden in einem zweiten Schritt Messverfahren zur multiperspektivischen Erfassung therapeutischer Kompetenz entwickelt (siehe Kapitel 5): (1) Globales Kompetenzrating GloRa-T (Global Rating Therapist) zur sitzungsunabhängigen allgemeinen Selbstbeurteilung, (2) die sitzungsbezogene Selbstbeurteilung des Therapeuten (SeRa-T, Session-Rating-Therapist), (3) die sitzungsbezogene Fremdbeurteilung durch den Klienten (SeRa-C; Session-Rating-Client) und (4) das Beobachterverfahren CoRa-O (Competence Rating Observer) zur Fremdbeurteilung des Therapeutenverhaltens in der Sitzung durch geschulte Beobachter. Diese Messinstrumente dienen der Erfassung von *Basis*- und *Spezifischen Kompetenzen*, wie sie das *Drei-Ebenen-Modell* postuliert. Die bisher durchgeführten Analysen liefern erste Belege für die psychometrische Güte der entwickelten Verfahren. Dass aufgrund des vergleichsweise geringen Stichprobenumfangs bisher keine faktorenanalytische Überprüfung der postulierten Skalenstruktur vorliegt, ist als methodische Einschränkung zu sehen, die zukünftig behoben werden sollte. Die Analysen zeigten des Weiteren, dass die verschiedenen Beurteilungsperspektiven kaum miteinander korrelierten. Dies entspricht früheren Forschungsbefunden (Mallinckrodt, 1993; Mathieson et al., 2009). Die Notwendigkeit, therapeutische Kompetenz aus verschiedenen Perspektiven zu erfassen und diese Urteile zu integrieren, wird auch von Kamen et al. (2010) gefordert: “neither students’ self-assessments nor “objective” (i.e., faculty members’, clinical supervisors’) judgments of competency development are sufficient. Rather, *both* are necessary to ascertain the progress of a given student” (Kamen et al, 2010, S. 232). Mit den vorgestellten Instrumenten steht somit für den deutschsprachigen Raum ein Set an multi-dimensionalen Messverfahren zur Verfügung, die eine multi-perspektivische und multi-modale Erfassung therapeutischer Kompetenzen erlauben. Da die Messverfahren auf der gleichen theoretischen Basis aufbauen, sind die einzelnen Kompetenzbeurteilungen miteinander vergleichbar.

Innerhalb der einzelnen Verfahren fanden sich zwischen den meisten Subskalen hohe Interkorrelationen. Möglicherweise stellt eine differenzierte Erfassung therapeutischer Kompetenz, wie sie nicht nur durch die im Rahmen dieser Arbeit vorgestellten Instrumente sondern auch in anderen Messinstrumenten vorgesehen ist (z.B. in der CTS, Young & Beck,

1980), ein Vorgehen dar, das dem Konstrukt therapeutischer Kompetenz nicht gerecht wird. Gegebenenfalls erweisen sich die einzelnen Komponenten therapeutischer Kompetenz in der Praxis als nicht trennbar. Eine derartige Abhängigkeit einzelner Kompetenzbereiche voneinander müsste auch in Modellen therapeutischer Kompetenz Berücksichtigung finden. Dieser Überlegung entsprechend, könnte eine globale Erfassung, wie sie zum Beispiel im vorgestellten Fremdbeurteilungsinstrument CoRa-O im ersten Item zum Globalkompetenzrating zu finden ist, ausreichend sein. Eine andere Möglichkeit könnte darin bestehen, Modelle auf die Aspekte therapeutischer Kompetenz zu reduzieren, die sich in Studien als relevant für den Therapieerfolg gezeigt haben. Diese theoretische Überlegung müsste durch Analysen zum Zusammenhang zwischen diesen Aspekten therapeutischer Kompetenz, die sich als zentral und damit relevant erwiesen haben, und dem Therapieerfolg überprüft werden.

Das *Drei-Ebenen-Modell* ist dabei nicht primär als ein Modell zur Beschreibung der Entwicklung therapeutischer Kompetenz zu verstehen. Es wird jedoch postuliert, dass es die theoretische Möglichkeit bietet, mit Entwicklungsmodellen wie z.B. dem Phasenmodell von Rønnestad und Skovholt (2013) verknüpft zu werden. So wäre es möglich, für die einzelnen Komponenten zu beschreiben, welche Kompetenz oder welcher Kompetenzgrad in welcher Entwicklungsphase erwartet wird. Untersuchungen therapeutischer Kompetenz finden meist im Zusammenhang mit Trainingsstudien für Novizen-Therapeuten statt. Erfahrene Therapeuten finden sich nur vereinzelt in solchen Studien, die fortgeschrittene, spezifische Kompetenztrainings evaluieren. Da jedoch immer wieder unterstrichen wird, dass Kompetenzerwerb ein „lebenslanger“ Prozess ist, wie er ja auch in den Entwicklungsmodellen abgebildet ist, sollten Trainingsstudien auch diese gesamte Entwicklungsspanne beleuchten. Sehr erfahrene Therapeuten mit jahrelanger Berufserfahrung, die entsprechend des Modells von Rønnestad und Skovholt (2013) als *Senior-Experten* beschrieben werden könnten, sind in der Regel nicht in den Stichproben von Studien zu finden. Das *Drei-Ebenen-Modell* würde hier die Möglichkeit bieten, auch diese lebenslangen Entwicklungsprozesse abzubilden, so dass es als theoretische Grundlage für die Untersuchung des gesamten therapeutischen Entwicklungsprozesses herangezogen werden könnte.

Insgesamt zeigten sich vor allem in den beiden Selbstbeurteilungsinstrumenten GloRa-T und SeRa-T sowie im Klientenurteil SeRa-C relativ hohe Kompetenzratings. Zukünftige Studien sollten diese Kompetenzbeurteilungen mit Fremdbeurteilungen durch externe Beobachter, zum Beispiel basierend auf CoRa-O, vergleichen. Da diese Analysen einer inhaltlichen Fragestellung nachgehen würden, waren sie bisher nicht Bestandteil der in Kapitel 5 berichteten psychometrischen Analysen. Diese Analysen sollen jedoch zukünftig durchgeführt werden, um aus den Ergebnissen Erkenntnisse über eine mögliche Tendenz zur Überschätzung der eigenen Kompetenzen durch Therapeuten oder Klienten abzuleiten. Bei Fokussierung

auf die therapeutische Selbstbeurteilung kann die Frage, ob Therapeuten ihre Kompetenz über- oder unterschätzen, nach gegenwärtigem Stand der Forschung nicht abschließend beantwortet werden. So finden sich sowohl Studien, die zu dem Fazit kommen, dass Therapeuten sich überschätzen (Brosan et al., 2008) als auch Studien, die eher eine Unterschätzung erkennen (McManus et al., 2012). Bei derartigen Überlegungen sollte jedoch die zuvor bereits erläuterte Maxime, dass es nicht die eine valide Kompetenzeinschätzung gibt, sondern dass multiple Kompetenzeinschätzungen von Nöten sind, nicht vergessen werden. Selbst wenn Befunde zeigen sollten, dass Therapeuten ihre Kompetenz im Vergleich zu anderen Beurteilungen höher oder niedriger einschätzen, sollte entsprechend der Annahme, dass keine einzelne Kompetenzbeurteilungsperspektive die gewissermaßen wahre Kompetenz abbilden kann, auf weitere Wertungen im Sinne einer Beurteilung als Über- oder Unterschätzung verzichtet werden.

Als dritter Schritt wurde in der vorliegenden Dissertation die Wirksamkeit einer universitären Peer-to-Peer-Intervention untersucht. Im Rahmen eines universitären Projektes führten studentische Therapeuten mit Klienten eine individuelle Intervention zu studiumsbezogenen Schwierigkeiten durch (10 Einzelsitzungen). Die in Kapitel 6 dargelegten positiven Effekte der Peer-to-Peer-Intervention belegen, dass es möglich ist, studentischen Therapeuten in ihrer grundständigen universitären Ausbildung erste therapeutische Basiskompetenzen zu vermitteln, die sie in Sitzungen mit studentischen Klienten effektiv anwenden können. Trotz nachvollziehbarer methodischer Limitation des beschriebenen Vorgehens ist es in der Praxis nicht unüblich, das Therapieergebnis als Merkmal für Kompetenzzuwachs auf Seite der Therapeuten heranzuziehen. Beispielsweise wählten Beidas and Kendall (2010) das Therapieergebnis neben Veränderungen im Verhalten des Therapeuten als weiteres Outcome-Maß für ihre Übersichtsarbeit zur Therapeutentrainings. Gleichwohl betonen Muse und McManus (2015) die Limitationen der Ableitung therapeutischer Kompetenz ausgehend vom Therapieergebnis und verweisen darauf, dass diese Methode nur eine indirekte Erhebung darstellt, die darüber hinaus unter anderem durch die Person des Patienten und das Störungsbild konfundiert ist. Von der berichteten Effektivität einer Intervention einen Rückschluss auf einen Zuwachs an therapeutischer Kompetenz auf Seiten der Therapeuten zu ziehen, wird auch von Fairburn und Cooper (2011) kritisch betrachtet. Die Autoren argumentieren, dass der Rückschluss vom Therapieergebnis auf therapeutische Kompetenz zunächst einmal naheliegend erscheint, da die Besserung des Patienten das zentrale Ziel einer Behandlung ist, verweisen aber auch auf die Grenzen und Einschränkungen dieser Methode. Als zentrale Einschränkung nennen Fairburn und Cooper (2011) ähnlich wie Muse und McManus (2015), dass das Therapieergebnis nur ein indirektes Maß ist. Um diese methodische Einschränkung wissend, ist der Rückschluss von der Effektivität der Peer-to-Peer-Beratung auf die Kompetenz der studentischen Therapeuten entsprechend nur eingeschränkt möglich. Erst eine

Analyse der prä-post Veränderungen, basierend auf den in Kapitel 5 vorgestellten Instrumenten, wird eine eindeutigere Beantwortung der Frage des Kompetenzzuwachses erlauben.

Neben Analysen der Effektivität der Peer-to-Peer-Intervention wurde in der dritten Studie (Kapitel 6) auch der Zusammenhang zwischen Therapieerfolg und persönlichen Eigenschaften der studentischen Therapeuten untersucht. Die durchgeführten Analysen liefern bezüglich des Zusammenhangs zwischen dem Therapieergebnis und persönlichen Eigenschaften der studentischen Therapeuten erste wertvolle Erkenntnisse für die empirische Validität des *Drei-Ebenen-Modells*. Die Ergebnisse können auch hinsichtlich der Therapeutenvariablen in Beutlers Taxonomie (1994; 2004) diskutiert werden. Es zeigte sich insgesamt nur ein sehr geringer Zusammenhang zwischen dem Therapieergebnis und persönlichen Dispositionen der studentischen Therapeuten. Die bisher durchgeführten Analysen legen nahe, dass sich der Zusammenhang zu Beginn des therapeutischen Arbeitens bereits in einem sehr kurzen Zeitfenster verändert. Hier scheint sich der moderate Zusammenhang mit persönlichen Charakteristika der Therapeuten, der sich für die ersten Klienten zeigte, für die zweiten Klienten so nicht zu wiederholen. Die Sitzungen mit dem zweiten Klienten starteten durchschnittlich vier Wochen später als die Sitzungen mit dem ersten Klienten und waren auch entsprechend etwas vier Wochen später beendet. Während die Sitzungen mit dem ersten Klienten und damit auch das Ergebnis dieser Beratung somit noch eher von den Charaktereigenschaften der Therapeuten geprägt waren, wird dieser Zusammenhang bereits durch ein kurzes Zeitfenster weiteren Trainings und praktischer Erfahrungen verändert. Die Hypothese, dass sich ein anfänglicher Einfluss persönlicher Therapeutencharakteristika nach vergleichsweise geringer klinischer Praxis reduziert, sollte Bestandteil zukünftiger Forschung sein.

## 7.2 Klinische Implikation

Zu Beginn dieser Arbeit wurde das dritte von Rønnestad und Skovholt (2013) beschriebene Thema in der Entwicklung von Therapeuten angeführt: "*Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience"* (Rønnestad und Skovholt, 2013, S. 149). Dieses Thema findet sich im *Drei-Ebenen-Modell* in der *Disposition Selbstreflexion (self-reflection)* wieder. Entsprechend der Annahme von Rønnestad und Skovholt (2013), dass Reflexion eine Voraussetzung für das Lernen in allen Entwicklungsphasen ist, wird die *Disposition Selbstreflexion* im *Drei-Ebenen-Modell* ebenfalls als persönliche Eigenschaft des Therapeuten verstanden, die einen Einfluss auf den Erwerb und auch die Frage der Trainierbarkeit therapeutischer Kompetenz hat. Neben dieser theoretischen Berücksichtigung findet die geforderte Selbstreflexion auch praktisch in der beschriebenen Peer-to-Peer-Intervention Berücksichtigung. So verfassen die studentischen

Therapeuten über jede durchgeführte Sitzung ein Stundenprotokoll, das an die Projektleitung gesendet wird. Es ist anzunehmen, dass bereits das Verfassen des Protokolls und die damit einhergehende Rückschau auf den Sitzungsverlauf die Selbstreflexion der studentischen Therapeuten schult. Des Weiteren wird auch die von Rønnestad und Skovholt (2013) geforderte formale Supervision, die im Rahmen der Peer-to-Peer-Beratung wöchentlich stattfindet, als für die Förderung der Fähigkeit zur Selbstreflexion zentraler Faktor angesehen.

Nach dem Phasenmodell der Entwicklung von Therapeuten von Rønnestad und Skovholt (2013) sind die studentischen Therapeuten der Peer-to-Peer-Intervention zu Beginn der Projektteilnahme der ersten Phase der *Laienhelfer* zuzuordnen und vollziehen dann den Übergang in die zweite Stufe der *Anfänger* (siehe Tabelle 1). In Kapitel 2 wurde bereits auf das zweite der von Rønnestad und Skovholt (2013) genannten Themen der Therapeutenentwicklung Bezug genommen: "*The models of therapists/counselors functioning shifts markedly over time – from internal to external to internal"* (Rønnestad und Skovholt, 2013, S. 146). Dieses Thema fokussiert ebenfalls auf Spezifika der *Laienhelfer* und *Anfänger*-Phasen und arbeitet Unterschiede zwischen diesen beiden Phasen heraus. Dabei betonen die Autoren einen distinkten Wechsel (*distinctive shift*) beim Übergang in die zweite Phase: Der *Laienhelfer* agiert basierend auf einem Wechselspiel persönlicher Erfahrungen und kultureller Einflüsse nach seinem „gesunden Menschenverstand" aus einem inneren Grundgefühl heraus. Zu Trainingsbeginn wird die Aufmerksamkeit des Therapeuten dann auf theoretische Konzepte und professionelle Methoden und Techniken gelenkt, wodurch sich der Fokus des Therapeuten nach außen verlagert. Dieser distinkte Wechsel ist mit Verunsicherungen verbunden. Das liegt an der Fülle sich aufzeigender klinischer Techniken und Interventionen und der Unsicherheit der *Anfänger*-Therapeuten, welche Intervention nun für den individuellen Klienten optimal ist und wie diese kompetent durchzuführen und anzuwenden ist. Diese Irritation kann im Rahmen des peer-to-peer Training Projektes aufgrund der Konzeption des Projektes eingegrenzt werden. So sind die vorgestellten Interventionen wegen des thematischen Schwerpunktes der Intervention auf Stressbelastungen im Studium begrenzt und entsprechend für die studentischen Therapeuten überschaubar. Die subklinische Belastung der Studierenden stellt hinsichtlich der reduzierten Komplexität der klinischen Symptomatik eine weitere Erleichterung für die Therapeuten dar. Die beschriebenen Rahmenbedingungen sind ebenfalls hinsichtlich des von Rønnestad und Skovholt (2013) beschriebenen siebten Themas relevant: *Many beginning practitioners experience much anxiety in their professional work: but over time, anxiety is mastered by most*" (Rønnestad & Skovholt, 2013, S. 151). In ihrem Phasenmodell gehen die Autoren ausführlich auf die in den ersten beiden Entwicklungsphasen präsente Angst der Therapeuten ein. Auch die Arbeitsgruppe um Orlinsky et al. (1999) schlussfolgert aus den Ergebnissen des SPR Collaborative Research Network, dass besonders die Gruppe der Anfängertherapeuten wegen eines aufreibenden und

erschöpfenden Berufslebens vergleichsweise anfällig und verletzlich ist. Der weitere Befund dieser Arbeitsgruppe, dass Therapeuten umso weniger von Erschöpfung berichten, je weiter sie in ihrer Entwicklung fortgeschritten sind, unterstreicht die besondere Belastung der Novizen-Therapeuten. Die empirische Forschung zur Vermittlung von *Helping Skills Competence* der Arbeitsgruppe um Clara E. Hill bestätigt dies. Die Autoren berichten, dass viele Studierende zu Beginn des Trainings vergleichsweise selbstbewusst auftreten, was durch ihre bisherige Erfahrungen als Laienhelfer erklärt wird. In der ersten Trainingsphase, wenn die ersten Techniken gelernt werden und die Studierenden erfahren, wie schwierig deren Umsetzung ist, zeigt sich jedoch ein deutlich herabgesetzter Selbstwert. Erst mit zunehmender Beherrschung der Techniken ist wieder ein Anstieg im Selbstwert zu beobachten. Das Projekt der Peer-to-Peer-Beratung zeichnet sich dadurch aus, dass subklinisch belastete Klienten behandelt werden und dass die Sitzungen in einem überschaubaren Zeitfensters von zehn Sitzungen mit einer engmaschigen Betreuung und Supervision durch die Projektleitung stattfinden. Insgesamt ist es gelungen, ein maximal praxisnahes Projekt zu konzipieren, in dem Novizen-Therapeuten in einem möglichst angstfreien Rahmen erste praktische Erfahrungen sammeln können. Des Weiteren nennen Rønnestad und Skovholt (2013) das Aneignen von Methoden und das daraus resultierende konkrete Zeigen von Basiskompetenzen als zentrale Entwicklungsaufgaben der Phase des *Anfängers*. Diese Aufgaben werden im Rahmen des peer-to-peer-Projektes gezielt angestrebt und umgesetzt. Entsprechend der von Rønnestad und Skovholt (2013) geforderten Lernmethoden kommt der Projektleitung als Therapeutenmodell und Supervisorin zentrale Bedeutung zu. Schließlich bietet die wöchentlich stattfindende Supervision auch die Möglichkeit eines Austausches zwischen den Beratern, was dem von Rønnestad und Skovholt (2013) beschriebenen Lernen durch kollegialen Austausch entspricht. Aufgrund der Kleingruppe von je achtstudentischen Beratern pro Semester ist eine intensive Betreuung und Begleitung jedes einzelnen studentischen Therapeuten möglich. Darüber hinaus beschreiben die Autoren für diese Entwicklungsphase eine drohende überwältigende Konfrontation mit neuen Inhalten und der sich möglicherweise auch stellenden Auseinandersetzung mit der Frage der Eignung für den Therapeutenberuf. Auch diese Schwierigkeiten können aufgrund der kleinen Gruppe im Rahmen des Projektes ausreichend Berücksichtigung finden. Dass die Studierenden in den Beratungssitzungen ausschließlich mit Klienten mit einer subklinischen Problematik konfrontiert waren, hat sich als gute Maßnahme erwiesen, der für diese Phase postulierten Verletzbarkeit und Unsicherheit entgegenzuwirken. Der geschützte Rahmen der Peer-to-Peer-Intervention ermöglicht den Studierenden einen „sanften Übergang“ von der Phase des *Laienhelfers* zum *Anfänger*. Gleichzeitig ist es möglich, die postulierte Kluft zwischen Theorie und Praxis zu minimieren oder wenn möglich gänzlich zu schließen.

## 7.3 Fazit und Ausblick

Berufsverbände unternehmen bereits seit den 1980er Jahren intensive Bemühungen, die Kompetenzen zu beschreiben, die notwendig sind, um Therapeut zu werden (Schaffer et al., 2013). Trotz dieses lange andauernden, wenn auch von Schwankungen begleiteten Forschungsinteresses, ist bisher kein Konsens über eine Definition therapeutischer Kompetenzen gefunden worden, ebenso wenig wie über ein Modell therapeutischer Kompetenzen. Des Weiteren existieren keine Erhebungsinstrumente, die eine multi-modale und multi-perspektivische Erfassung therapeutischer Kompetenz erlauben. Bennett-Levy (2006) betont, dass das Finden der Charakteristika guter Therapeuten eigentlich eine logische Parallele zur Entwicklung effizienter Behandlungsmethoden sein sollte. Umso erstaunlicher ist, dass der Erkenntnisstand zu Therapeuteneffekten im Allgemeinen und therapeutischen Kompetenzen im Konkreten sehr gering ist.

Die Arbeiten von Wampold (2001) und Lambert (2013) zeigen, dass die Therapeutenpersönlichkeit nur einen moderaten Anteil an der Ergebnisvarianz von Therapieergebnissen hat. Auch die Ergebnisse der vorliegenden Arbeit weisen darauf hin. Zukünftige Forschungsbestreben sollten sich deshalb darauf konzentrieren, diejenigen Therapeutenvariablen und Komponenten therapeutischer Kompetenz zu identifizieren, für die sich ein tatsächlicher Zusammenhang mit dem Therapieergebnis zeigt. Entsprechend sollten Modelle therapeutischer Kompetenz auf diese Komponenten beschränkt und auch Trainingskonzepte darauf ausgerichtet werden. Sollten sich auch in diesen weiterführenden Studien hohe Korrelationen zwischen den einzelnen Aspekten therapeutischer Kompetenz finden, sollte auch das Vorliegen eines allgemeinen Faktors therapeutischer Kompetenz in Erwägung gezogen werden.

Auch die Frage, wie der individuelle Erwerb therapeutischer Kompetenzen von persönlichen Eigenschaften der Novizen-Therapeuten geprägt wird, sollte Berücksichtigung finden. Herschell et al. (2010) betonen ebenfalls die Individualisierung von Kompetenztrainings als einen wichtigen Schritt, um den Trainingserfolg zu maximieren. Zukünftige weiterführende Untersuchungen zum Zusammenhang zwischen Therapeutenvariablen und Therapieerfolg können hier wertvolle Erkenntnisse liefern. Um den umfassenden Forschungsarbeiten von Rønnestad und Skovholt (2013) Rechnung zu tragen, sollte auch das Erleben der Ausbildungstherapeuten und die nach dem Phasenmodell zu erwartenden Ängste in dieser frühen Phase der Professionalisierung berücksichtigt werden. Kamen et al. (2010) betonen, dass das Erleben der Ausbildungstherapeuten in bisherigen Kompetenztrainings und in der entsprechenden Forschung bisher wenig Berücksichtigung erfahren hat.

Darüber hinaus sollte die Frage, welche Trainingselemente die aktiv wirksamen sind, weiter forciert werden. Das von Rahovshik und McManus (2010) gezogene Fazit, dass

interaktive erlebensbezogene Trainingsmethoden reiner frontaler Wissensvermittlung überlegen sind, erscheint doch sehr pauschal. Vielmehr sollte eine differenzierte Betrachtung angestrebt werden. Die Ausbildung der studentischen Therapeuten innerhalb des im Rahmen dieser Dissertation vorgestellten peer-to-peer Stressbewältigungsprojektes ist nach der Klassifikation von Herschell et al. ( 2010) als Multi-Komponenten-Training anzusehen, dem die Autoren die größte Effektivität zusprechen. Das Projekt enthält sowohl frontale Wissensvermittlung als auch Rollenspiele zur praktischen Umsetzung des zuvor theoretisch Gelernten sowie praktische Erfahrungen durch selbst durchgeführte Sitzungen und Supervision. Beidas und Kendall (2010) beschrieben in ihrer Übersichtsarbeit die Überlegenheit des aktiven Lernens gegenüber dem passiven und heben speziell Rollenspiele als wichtige Lernmethoden hervor. In Anlehnung an diese Befunde lässt sich vermuten, dass möglicherweise die Kombination aus aktiven und passiven Elementen in dem peer-to-peer Projekt einen zentralen Wirkmechanismus darstellt. Auch die unmittelbare Anwendung des Gelernten zuerst in geschützten Rollenspielen mit Kommilitonen und dann in realen Sitzungen mit studentischen Klienten könnte ein weiteres aktives Element sein. Weitere Studien sollten dies Überlegungen empirisch prüfen. In diesem Zusammenhang ist auch zu betonen, dass zukünftige Studien zur genaueren Analyse der Trainingskomponenten zwingend auch die Implementierung einer Kontrollgruppe notwendig machen. Insgesamt nennen McManus et al. (2010) als methodische Kritikpunkte bisheriger Trainingsstudien, dass die Analysen häufig auf einer zu kleinen Stichprobe beruhen, dass fragliche Messinstrumente und teilweise auch nur eine unidimensionale Erfassung therapeutischer Kompetenzen verwendet wurden, die auf unklaren Kompetenzdefinitionen beruhten. Abschließend nennen die Autoren auch das Fehlen einer Kontrollgruppe. So ist es auch mit dem in Kapitel 6 vorgestellten naturalistischen Studiendesign nicht möglich, die beobachteten Effekte eindeutig auf die therapeutischen Kompetenzen der studentischen Berater zurückzuführen und hier zwischen Einflüssen der praktischen Erfahrung durch die selbst durchgeführten Sitzungen, Einflüssen durch sonstige Studieninhalte und Einflüssen durch Training und Supervision zu differenzieren. Jedoch sind der Durchführung einer randomisierten kontrollierten Studie durch ethische Aspekte Grenzen gesetzt. So ist es sicher nicht vertretbar, dass studentische Therapeuten ohne entsprechendes Training oder ohne Supervision eigenständig Sitzungen mit echten Klienten durchführen. Hier könnte möglicherweise der von Hill et al. (2008) favorisierte Weg, dass Kommilitonen die Rolle der Klienten übernehmen, eine Alternative darstellen.

Bei aller geforderten Multi-Dimensionalität der Erfassung therapeutischer Kompetenz und dem Bewusstsein, dass die Selbstbeurteilung kein geeignetes „*Stand-alone*“-Messverfahren sein sollte (Mathieson et al., 2009), ist v.a. in der alltäglichen Praxis, außerhalb von Forschungsstudien, die Selbstbeurteilung von Therapeuten zentral (Kaslow et al., 2008). Insgesamt wird die Fähigkeit zur Selbsteinschätzung als eine zentrale Komponente für das

professionelle Selbstmanagement angesehen. Jedoch beklagten bereits Vogel und Alpers (2009), dass die Kompetenz zur Selbsteinschätzung zumindest in Ausbildungsprogrammen im deutschsprachigen Raum bisher kaum Beachtung findet. Eine individuelle Rückmeldung des Kompetenzprofils basierend auf der Selbstbeurteilung (vgl. Langer und Frank (1999)) und eine Gegenüberstellung mit einem möglicherweise divergierenden Profil basierend auf einer Fremdeinschätzung wären eine denkbare Möglichkeit, die Selbstbeurteilungskompetenz angehender Therapeuten zu schulen.

Die positiven Ergebnisse der beschriebenen Peer-to-Peer-Intervention sind auch in Anbetracht der aktuellen berufspolitischen Diskussion bezüglich zukünftiger Veränderungen im Studium der Psychologie und der Weiterbildung zum Psychologischen Psychotherapeuten von großer Relevanz. Das peer-to-peer Projekt stellt eine innovative Möglichkeit dar, wie zukünftige Lehre zu praktischem klinisch-psychologischem Handeln im Rahmen des Direktstudiums aussehen kann. Gleichzeit liefern die Ergebnisse und die eindrückliche Effektivität der studentischen Beratung einen klaren Gegenbeweis zur Haltung von Clara E. Hill, dass es aus ethischen Gründen nicht vertretbar ist, studentische Therapeuten auch ohne Training mit echten Klienten arbeiten zu lassen (Hill et al., 2008). Die in dieser Arbeit vorgestellten Ergebnisse zeigen eindeutig, dass ein anfänglicher eintägiger Blockkurs, verbunden mit weiteren theoretischen Sitzungen und einer Gruppensupervision, einen ausreichenden Rahmen für die Darstellung von eigenständigen Sitzungen der studentischen Therapeuten mit studentischen Klienten darstellen.

Insgesamt trägt das vorliegende Dissertationsprojekt mit der Entwicklung des *Drei-Ebenen-Modells therapeutischer Kompetenzen* und den multi-perspektivischen Erhebungsinstrumenten einen ersten Teil dazu bei, therapeutische Kompetenz bei Novizen-Therapeuten erfassbar zu machen und damit den Beginn des therapeutischen Arbeitens transparenter zu machen. Des Weiteren belegen die beschriebenen Arbeiten, dass therapeutische Basiskompetenzen bereits von Studierenden im Rahmen der universitären Ausbildung erworben und in Sitzungen mit studentischen Klienten erfolgreich angewandt werden können.

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# Erklärung

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