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Competency model of training in psychotherapy integration

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Abstract: Competency models can be a cornerstone of the development of effective education in psychotherapy. This study aimed to develop a competency model for the Training in Psychotherapy Integration program in the Czech Republic. Method: The model was developed using the principles of cooperative inquiry and action research. Six trainers and three researchers participated in the study. Data were drawn from focus groups and individual interviews held with trainers and from archival materials of the training program. The research process involved several cycles of data collection, qualitative analysis, implementation, and feedback. Results: The Training in Psychotherapy Integration competency model was organized into three domains focusing on the therapeutic relationship, the client, and the therapist. Each domain was further divided into three layers, namely: personal, procedural, and contextual. Conclusion: The Training in Psychotherapy Integration competency model proved useful and contributed to the training program in several respects, providing identity, structure, a path to consensus, and a trainee evaluation tool.

Keywords: psychotherapy integration; training, supervision, competency model

The focus on competencies potentially offers a new paradigm for psychotherapeutic training and practice (Sperry, 2010). Although it has been a subject of intensive discussion for at least two decades (Kaslow, 2004; Roberts et al., 2005), consensus on what constitutes therapeutic competencies and how to best assess and develop them remains to be achieved. The situation is complicated by the existence of multiple psychological and psychotherapeutic traditions (Rief, 2021; Sharpless & Barber, 2009) and institutional contexts (Alberts & Edelstein, 1990). If psychotherapy is to evolve as an evidence-based and ethically sound discipline, there needs to be further dialogue about the relevance and use of competencies (Levant, 2005).

Terminologically, we must distinguish between competence and competency. Epstein and Hundert (2002) defined professional *competence* as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (p. 226). Competence thus points to therapists' overall capacity to provide treatment to contemporary professional standards (Beutler et al., 1986; Rodolfa et al., 2005). On the other hand, *competencies* refer to knowledge, skills, and attitudes necessary for professional functioning that, in sum, constitute overall competence (Kaslow et al., 2004).

Competency-based training models differ from more traditional "time-based" models. Competency-based models place less emphasis on the time dedicated to training

components (although a certain minimal number of hours may be required by regulating bodies). Instead, the level of acquired competencies is the decisive criterion for determining trainee progress (Donovan & Ponce, 2009), which allows training programs to be more flexible and sensitive to trainees' individual needs based on their unique profiles of strengths and weaknesses (Hatcher et al., 2013). Competencies can be assessed regularly during the training process and can thus provide both trainees and trainers with valuable feedback (Fouad et al., 2009).

Competency Models in Psychology and Psychotherapy

The most general scheme for organizing competencies was provided by the cube model (Rodolfa et al., 2005), which defined three dimensions of competency, namely, foundational, functional, and developmental. While it offered an overarching framework for competency domains, it did not articulate specific competencies (Sburlati et al., 2012). This limitation was overcome by initiatives such as the *Professional Competencies of a European Psychotherapist* (European Association for Psychotherapy, 2013), which defined core competencies common to psychotherapists across theoretical orientations, supplemented by specific competencies related to specific modalities, such as Gestalt therapy (European Association for Gestalt Therapy, 2014). More recently, a similar initiative has been launched by the European Federation of Psychologists Associations (Plantade-Gipch et al., 2020). Independently, specific theory-driven competencies have been described for many psychotherapy approaches, such as cognitive-behavioral therapy (Hayes & Hofmann, 2018), solution-focused and strategic therapy (Quick, 2011), and relational psychoanalysis (Barsness, 2018). Competency-based frameworks also exist for key psychotherapeutic processes, such as empathy (Ho, 2023) and multicultural competencies (Sue et al., 1998).

A comprehensive overview of competencies in counseling and psychotherapy was provided by Sperry (2010), who summarized six core competencies (i.e., conceptual foundation, relationship building and maintenance, intervention planning, intervention implementation, intervention evaluation and termination, and culturally and ethically sensitive practice). In a similar vein, Timulak (2011) distinguished the following areas of competency: building the therapeutic alliance, case conceptualization, ethical aspects of psychotherapy and counseling, interventions facilitating exploration and understanding, promoting change and its application outside the therapy session, and specific therapeutic techniques.

Competency-Based Training Models in Psychotherapy

One of the most prominent competency-based training models in psychotherapy is the helping skills model (Hill, 2009), which is based on a three-phase model of the psychotherapy process, namely: exploration, insight, and action. Individual skills are then related to the objective of the respective phase. Another model is that created by Beitman and Yue (1999), in which competencies are organized around six modules, namely: verbal response modes and intentions, working alliance inducing patterns, change, resistance, and transference and countertransference. Later, Plakun et al. (2009) formulated the Y model in which the stem of the letter Y represents core therapeutic competencies. The authors identify the working alliance as be the overarching factor allowing for the understanding of features common to various therapeutic approaches (cognitive-behavioral and psychodynamic, in their case). The branches of the letter Y then represent the diversification of therapeutic approaches and allow trainees to appreciate their differences.

The McMaster Psychotherapy Program (Weerasekera, 1997; Weerasekera et al., 2003) emphasized the empirical base and integrated research findings into the training program through seven modules covering client-centered therapy, cognitive-behavioral therapy for depression and anxiety, psychodynamic therapy, family therapy, interpersonal therapy, and couple and group therapy. Research-based findings were also emphasized in Snyder and Elliot's (2005) matrix model, where competencies were taught at four levels, namely, the individual, interpersonal, institutional, and societal-community levels.

Training in Psychotherapy Integration Program

Training in Psychotherapy Integration is a Czech Republic psychotherapy training program focused on the development of trainees' individual integrative psychotherapy perspectives and personal therapeutic approaches (Řiháček & Roubal, 2017). In Training in Psychotherapy Integration, psychotherapy integration is conceived as a continuous learning and creativity process rather than as a ready-made product to be used by the therapist (Kostínková & Roubal, 2018). Theoretically, the Training in Psychotherapy Integration concept is grounded in the common factors approach to psychotherapy integration, emphasizing the principles of therapeutic change (Goldfried, 1980). On a practical level, the program is inspired by the helping skills approach (Hill, 2009), the use of which is guided by case formulation skills (Eells, 2007).

As is typical for training programs in the Czech Republic, Training in Psychotherapy Integration is provided by a private training institute. The training structure consists of four components: (a) personal therapy (300 hours of group self-experience and 50 hours of individual therapy experience), (b) theoretical lectures and skills training (500 hours), (c) supervision (150 hours), and (d) supervised practice (400 hours). The program takes five years to complete and concludes with a final exam based on a case presentation. Applicants must have at least a bachelor's degree in psychology, medicine, social work, or another helping profession to be enrolled in the program.

Study Aim

This study aimed to develop the Training in Psychotherapy Integration program's competency model. The development was based on the principles of cooperative inquiry and action research, for which the trainers' team collaborated with a group of researchers. Rather than on methodological purity, this study focused on the practical utility of both the development of the competency model and the resulting competency model. The study thus identifies opportunities of fertile practice-oriented collaboration between psychotherapy trainers and researchers in creating a competency model.

The trainers of the Training in Psychotherapy Integration recognized a need for a competency model for several different reasons: They needed to create a tool for the final evaluation of training graduates. Such a tool could be used on an ongoing basis during training both for self-evaluation of trainees and for providing ongoing feedback to trainers. Such a competency model provides a unifying basis for the work of trainers, who each come from a different approach. At the same time, it allows Training in Psychotherapy Integration to present itself in the psychotherapy community as an internally consistent system of psychotherapeutic training, which is particularly important in the relatively loosely theoretically anchored integration in psychotherapy.

Method

Participants

Trainers

The entire Training in Psychotherapy Integration training team participated in the study, including three female and three male therapists whose ages ranged from 42 to 50 and whose length of practice varied between 14 and 24 years. The participants represented a variety of theoretical orientations, including psychoanalysis, psychodynamic psychotherapy, logotherapy and existential analysis, Gestalt therapy, person-centered therapy, mindfulness-based therapy, Pesso-Boyden therapy, systemic/family therapy, art therapy, and transpersonal therapy. The trainers' primary professions focused on psychology, psychiatry, and social work.

Researchers

Three researchers participated in the study throughout the whole research process. At the time of the study, J. K. was a 36-year-old female psychologist with 12 years of part-time psychotherapeutic practice trained in group therapy. T. R. was a 42-year-old male psychologist with 15 years of part-time psychotherapeutic practice trained in Gestalt therapy. A. H. was a 31-year-old male psychology student with no psychotherapy practice at the time of the study. The third author, J. R., was the director of the training institute and one of the participants. He did not take part in the analysis but participated in the writing phase.

Procedures

Data Creation

Multiple sources of data were used in the study:

1. Trainers' written documentation of the training program's development (including meeting minutes and e-mail correspondence) was made available to the researchers as a starting point of analysis.

2. A series of three focus groups was conducted by J. K. over a three-year period to explore what the trainers taught their trainees, what competencies they expected their trainees to master, and how they would define an acceptable level of these competencies for trainees to pass.

3. J. K. conducted a series of 12 in-depth interviews with two trainers specializing in teaching theory and skills (as opposed to the other four trainers who served as group facilitators in the self-experiential part of the training).

4. Feedback from the trainers was repeatedly elicited via e-mail during the study. The focus groups and individual interviews were recorded and transcribed.

Data Analysis

The study was based on the principles of cooperative inquiry (Heron, 1996) and action research (Reason & Bradbury, 2001). In cooperative inquiry, all participants engaged in the process become researchers, take part in formulating research questions, and codetermine the course of the study. At the same time, all participants become informants, sharing their own experiences and ideas. In accordance with action research, the study was motivated by trainers' practical need for a competency model. Alongside, provisional versions of the competency model were immediately incorporated and tested during training practice (e.g., discussed with trainees and supervisors and used by the trainers to formulate requirements for the final exam).

The study proceeded in a cyclical manner following the action research spiral of (a) planning, (b) action taking, (c) observing the consequences of actions, (d) reflecting on these consequences, (e) replanning, and so forth (Kemmis & McTaggart, 2005). In our case, the following steps were alternated to develop a competency model: (1) the trainers provided their ideas about required therapeutic competencies, which served as data; (2) the data were analyzed by the research team; (3) the results of this analysis were presented to the trainers' team; and (4) the trainers provided their feedback, which again served as data for the next cycle of the analysis. This cycle was repeated four times.

The data were analyzed using open and axial coding procedures (Strauss & Corbin, 1998). The researchers coded parts of the data related to competencies and gradually developed a list of competencies and their definitions (open coding). Later, the researchers explored relationships among the competencies and developed an organizing scheme (axial coding).

The researchers each had a specific role in the analysis process. These roles were complementary but also partially overlapping in the joint discussion. J.K. in particular brought an experience-based approach, A.H. in particular contributed theoretical knowledge of the literature, and T.R. in particular elaborated on the research methodology. Initially, the researchers were more passive, merely reflecting the trainers' input and not adding their own ideas. Later, however, they became more active in proposing new competencies, citing their knowledge of the literature, and suggesting a framework for organizing competencies.

In other words, the process was not purely data-driven. Rather, it combined the data, knowledge of the literature, and all of the study participants' professional experience. Creative techniques were used to facilitate the process of defining competencies and organizing them within a framework (e.g., a defragmentation of the model was used, during which the whole model was divided into individual competencies and built anew).

Trustworthiness

We used Charmaz's (2006) four quality criteria, namely, credibility, originality, resonance, and usefulness, to guide our study. First, the *credibility* of the resulting model stems from the cyclical nature of data collection, analysis, implementation (i.e., test by practice), and feedback. Second, the model can be considered *original* since it was generated with a bottom-up approach based on data provided by the trainers and reflects the reality of the training program under study. The existing literature was used to provide terminology and organize various competencies into a coherent system, but the result was not an adoption of any existing competency model. Third, we repeatedly checked whether the emerging model *resonated* with the trainers' experience and was compatible with their work reflections. Fourth, *usefulness* was determined based on the perceived meaningfulness and applicability of the model and its ability to inspire further the development of the Training in Psychotherapy Integration program.

Ethical Considerations

In action research, ethics include the key moments that support the collaboration between respondents and researchers, or the whole outcome of the research. In our study, stakeholder motivation and open communication were key for both sides of the research. The motivation on the part of the trainers was to improve the training program through research feedback, which encouraged their openness to the research team. The researchers were motivated by the action nature of the research, where the research process was shaped by the interaction with the respondents.

The authors of this study (i.e., "researchers") cooperated with the trainers of the Training in Psychotherapy Integration (i.e., "participants") strictly on an equal basis. The trust between the two teams was based on informed consent, which explained to the respondents how to handle the data collected during the research. The trainees were also aware that the training was part of the research project. The openness between the two parties was further promoted by making the respondents aware of the researchers' preconceptions about integrative psychotherapy and all relevant issues on the topic (teaching, timing of integration, effectiveness of integrative psychotherapy, etc.). It also contributed to mutual trust that one member of the research team was also a member of the lecturing team. His insight into the research often helped the lecturers to understand the research procedures.

Although the roles of the two teams' participants differed to some degree, they retained a spirit of lively and friendly

collaboration throughout the whole process, and the final model is thus to be considered a collective piece of work. We did not notice any power issues that might contaminate the development process. On the contrary, people with different perspectives and levels of experience participated in the process, and everyone's voice was welcome as a unique contribution to the "polyphony".

Action research relies on constant reflection by the researchers. The research process itself encouraged the researchers to do this. Interim results were reported to the lecturing team, either in the form of interim written reports or face-to-face meetings during interviews. Several rounds of data elicitation and feedback provided multiple opportunities for all members of the team to share their ideas and add what they felt was missing.

Maintaining an ethical level was also supported by feedback from the professional community as researchers presented interim research results at local and global conferences. In the case of training research, it is clear that some data cannot be anonymised. For one thing, it is clear which training is involved and who is training in it. The training team explicitly articulated their willingness to be recognized. Individual trainer statements were anonymized in the interview transcripts. Here, we want to explicitly acknowledge the trainers of the Training in Psychotherapy Integration S. Dudová, R. Karpíšek, M. Rokytová, J. Roubal, M. Skálová, and M. Stiburek for their crucial role in the competency model development.

Results

Domain	**Layer of competency**		
	Personal	**Procedural**	**Contextual**
Therapeutic relationship	Can act sensitively and autonomously in a relationship	Has mastered partial skills related to creating a safe space, contracting, continuously and collaboratively evaluating the therapy, and dealing with client-therapist conflicts	Can work with the therapeutic alliance and with alliance ruptures; can adapt the therapeutic relationship to the client's needs
Client Mapping	Can perceive the phenomenological reality of another person and distinguish it from their own perspective	Has mastered partial skills pertaining to listening, observing, and inquiring	Can recognize important information and purposefully acquire it from the client
Client Conceptualization	Can reflect on their evaluative judgments about the other and postpone them	Can recognize and describe essential aspects of the client's functioning and can formulate a therapeutic hypothesis about the client's actual situation from various theoretical perspectives. Can determine the severity of the problem. Can recognize transference and countertransference	Can develop a case formulation using multiple theoretical perspectives and countertransferential information
Client Intervention	Can both accommodate to the situation and assume leadership in a situation. Can both support and confront the other. Can motivate the other to discover their potential	Can routinely use a range of techniques and interventions based in various therapeutic approaches	Can formulate a therapeutic intention. Can develop an intervention plan tailored to a particular client and evaluate the effectiveness of the intervention
Therapist Self-reflection	Can reflect on their internal processes, resources, and weaknesses ("traps")	Can reflect on their professional limits and countertransferential reactions	Can reflect on the strengths and limits of their personal therapeutic approach. Can reflect on their values, beliefs and assumptions that enter the therapy
Therapist Self-support	Can support themselves in emotionally demanding situations	Trusts their abilities and can tolerate uncertainty	Pursues continuous self-directed professional development

Table 1. Competency Model of Training in Psychotherapy Integration

The iterative analysis process resulted in the creation of a competency model describing the competencies Training in Psychotherapy Integration trainees were expected to acquire. Since the Training in Psychotherapy Integration emphasized the development of each trainee's personal therapeutic approach rather than mastering a specific set of techniques, the model's competency categories represented general areas within which a Training in Psychotherapy Integration trainee should become skilled. In terms of content, the competency model covered three domains related to the therapeutic relationship between the client (further divided into mapping, conceptualization, and intervention) and the therapist (further divided into self-reflection and self-support). Across all domains, we distinguished three competency layers, namely, personal, procedural, and contextual. See Table 1 for the model overview.

Competency Domains

The domains represent clusters of conceptually similar competencies. The *therapeutic relationship* domain contains skills related to the creation, development, maintenance, reparation, and termination of the psychotherapeutic relationship. The domain includes, for instance, self-regulation in the context of the therapeutic relationship, balancing therapists' empathy and support with autonomy and directivity, respecting the client's individuality, setting boundaries, and dealing with conflicts.

The *client/mapping* domain represents skills necessary to acquire information about the client that is then used in the therapeutic process. The domain includes, for instance, distinguishing clearly between the therapist's and client's perspectives; inquiring a client purposefully, yet empathically; attending to both psychopathology and strengths/resources; and considering a broader context.

The *client/conceptualization* domain covers skills pertaining to the development of a therapeutic hypothesis, case formulation, and treatment planning. The domain includes, for instance, balancing a nonjudgmental attitude with theory-informed conclusions, utilizing multiple sources of information, referring to one's emotional experiences (countertransference), assessing problem severity, considering both diagnostic and nondiagnostic client factors, applying multiple theoretical perspectives, and testing one's therapeutic hypotheses.

The *client/intervention* domain represents technical skills needed to produce therapeutic change. These skills include, for instance, formulating a therapeutic plan; mastering techniques of multiple therapeutic approaches that pertain to a client's cognition, emotions, behaviors, relationships/systemic processes, and body; considering the phase of therapy/stage of change; utilizing the therapeutic relationship and client-therapist conflicts as a vehicle for therapeutic change; evaluating the effectiveness of an intervention; and referring clients to other professionals.

The *therapist/self-reflection* domain pertains to various aspects of the self-reflective stance. The domain includes, for instance, reflecting on one's internal processes, strengths and limitations, beliefs and assumptions about health, psychopathology, and therapeutic change; one's own therapeutic style; and the broader institutional, societal, and cultural context of psychotherapy.

The *therapist/self-support* domain pertains to the therapist's ability to trust and rely on his or her strength and resources, tolerate uncertainty, foster a sound sense of professional confidence, and pursue continuous and self-directed professional development.

Competency Layers

Each domain is divided into three layers. The *personal layer* covers general human competencies that serve as prerequisites to the development of professional competencies. Although often not sufficient on their own, these competencies reflect the fact that psychotherapy is based on a sense of natural human togetherness and interaction (Wampold, 2012). Such competencies serve as a foundation for the therapeutic relationship and are specific to interventions. The *procedural layer* covers partial technical and relational skills that compose the therapist's repertoire. The therapist can develop these skills one by one and focus on those not fully mastered. The *contextual layer* then represents the ability to use these procedural skills depending on the context of the particular therapeutic case. In this layer, all partial skills are integrated and applied differentially based on the unique features of the therapeutic situation.

Although the model was not conceived as sequential, the layers can be roughly connected to training phases. In the Training in Psychotherapy Integration model, the personal layer is targeted predominantly in the first phase (group self-experience), the procedural layer is mostly pursued in the second phase (theoretical lectures and skills training), and the contextual layer is most developed during the third phase (supervised practice). However, the model does not necessarily assume a sequence of phases, and the layers can, to a certain degree, develop in parallel or independently. This approach is in line with the Training in Psychotherapy Integration model's focus on the development of each trainee's personal therapeutic approach, which can follow various trajectories since each trainee may enter the training program with different talents and skills to build on. For

example, a trainee may be skilled in many therapeutic techniques (the procedural layer) yet be poor in adopting a nonjudgmental attitude (the personal layer). Another trainee may be proficient in formulating a case from multiple theoretical perspectives (contextual layer) yet have difficulties maintaining boundaries in therapeutic relationships (procedural layer).

Example: The Mapping Domain

Table 1 shows an overview of the model, summarizing the content of each cell. While presenting the model in full detail is beyond this article's scope, we illustrate the mapping domain to demonstrate how each domain is further elaborated. Table 2 shows the individual competencies identified within each layer.

Layer of competency		
Personal	**Procedural**	**Contextual**
Perceiving the phenomenological reality of the other Can distinguish their thoughts/emotions from the thoughts/emotions of the other **Distinguishing subjective from objective information** Can distinguish between "hard data" and their subjective interpretation	**Working with one's preunderstanding** Can identify and "bracket" their prior understanding of the client's situation **Skillful inquiring** Can ask appropriate questions in a sensitive manner **Mapping clients' wishes** Can identify what a client – on the conscious/verbalized level – does or does not want; Can give the client necessary space to determine the information **Attending to resources** Can map not only clients' pathology but also clients' strengths and resources **Collaborating with other professionals** Can provide and request a report to/from a colleague	**Acquiring information purposefully** Can distinguish information relevant for the therapeutic intention; Can find a suitable way to acquire such information **Considering the broader context** Can recognize clients' difficulties in interpersonal social and cultural contexts **Considering clients' views of health** Can explore and respect clients' ideas about health/illness and challenge them when justified **Registering change** Can continuously monitor positive and negative changes in clients' states, both on the micro- and macro levels

Table 2. The Mapping Domain

The personal layer covers basic human skills pertaining to perceptions of others that can be applied in various contexts, regardless of psychotherapy (e.g., distinguishing between one's own and others' subjective experience), and that serve as a foundation for the development of therapy-specific competencies. The procedural layer then covers partial skills needed to obtain information from a client (e.g., asking questions sensitively), which can be developed one by one and used as building blocks of contextual competencies (e.g., using questions to acquire relevant information connected to the treatment plan). The other domains were elaborated in a similar manner.

Discussion

In this study, we described the development of the Training in Psychotherapy Integration competency model spanning several years and adopted an action research, cooperative approach. Importantly, we had no ambition to develop a pan therapeutic model that would define the whole profession and include all possible competencies. Instead, the model captures our experience with a single training program embedded in the Czech Republic professional context. The study demonstrates how practice-oriented research activity may support the development of a training program.

Model Structure

The structure of the model domains was inspired by Hill's (2009) exploration-insight-action model. However, Training in Psychotherapy Integration competency model is formulated on a more general level. The competencies are formulated as general principles a trainee should comply with but do not prescribe any particular style for how this should be achieved. In other words, trainees are granted freedom – within the boundaries of ethical practice – in how they implement these principles. Furthermore, our model emphasizes two domains that are only implicit in Hill's model, namely, the therapeutic relationship, which is considered a cornerstone of the therapeutic endeavor (Nocross, 2011), and self-reflection, which has also been emphasized as a core arena of therapists' competencies (Boswell et al., 2010; Farber, 2010; Sarnat, 2010; Celano et al., 2010). Unlike other models, ours also emphasizes the theme of self-support and professional confidence, which corresponds to the poorly structured and anxiety-provoking nature of psychotherapy integration and addresses the related need to endure uncertainty and tolerate the ambiguity of human existence (Greben, 2004).

Some competencies typically recognized in other models are not listed in our model, including ethical awareness and multicultural competencies (Beitman & Yue, 2004; Rodolfa et al., 2005; Hill, 2009; Plakun et al., 2009; Sburlati et al., 2012; Snyder & Elliot, 2005; Weerasekera, 1997). However, various ethical issues are covered by the included competencies (e.g., reflection on one's limits, power relations, and continuous development). The ethical dimension is thus implicitly present in the whole model. The lack of the multicultural dimension (e.g., Inman & Kreider, 2013) can be attributed to the fact that the population of the Czech Republic is very homogeneous compared, for instance, to that of the USA. Therefore, contact with cultural difference is much less a part of daily therapeutic practice in the Czech Republic. Nevertheless, this aspect is also implicitly present in our model (e.g., see the therapist/self-reflection domain).

Developmental Perspective

While some models assume a developmental sequence of phases (Beitman & Yue, 2004; Rodolfa et al., 2005; Weerasekera, 1997), our model is not primarily developmental. The model does not prescribe an order in which competencies should be acquired. In contrast, the model reflects the possibility that each trainee may have his or her own developmental trajectory. The personal, procedural, and contextual layers represent aspects that can be developed in parallel or, at least in part, independent of each other. This feature contrasts with Norcross and Halgin's (2005) integrative training model, according to which trainees should not be exposed to advanced content until they master basic relational and communicational skills. Instead, in line with Sharpless and Barber (2009), our model stems from the assumption that competency development is a life-long project, and individual developmental trajectories may differ considerably from each other. Furthermore, not all competencies are acquired during training to the same level. Mainly, the contextual layer contains competencies, the mastering of which requires considerable experience with a diverse clientele.

Integrative Nature of the Model

We may distinguish between "explicit" (i.e., combining two or more pure school approaches to develop a new system of psychotherapy) and "implicit" or "personal" integration (i.e., a personal journey of a therapist influenced by many approaches) (e.g., Norcross, 2006). Our Training in Psychotherapy Integration competency model relates more to the latter and defines a training program in which trainees are provided input from multiple theoretical orientations but, unlike in the model proposed by Weerasekera (1997), are not expected to master them as such. Instead, trainees are supposed to integrate these learnings with their personality inclinations, strengths, and weaknesses and develop a coherent personal approach to psychotherapy (Řiháček & Roubal, 2017). The Training in Psychotherapy Integration model's approach to the development of a personal therapeutic approach is in line with Allen et al.'s (2000) recommendation to render the exploration of trainees' personal beliefs and assumptions a way to make psychotherapy integration more personal and real.

The model is founded on a belief that there are skills and principles that are common to many or all psychotherapy approaches (Goldfried, 1980) and on the view that these have to do more with the fundamental humanistic nature of psychotherapy (Wampold, 2012) than with the specifics of diverse therapeutic schools. However, the model is explicitly integrational in that trainees are expected to be *able* to ponder a case from multiple perspectives and to reflect on the limitations of their favorite perspective. This approach is in line with Bailey and Ogles' (2019) recommendations on common-factor-based psychotherapy training.

Limitations

The combination of the principles of cooperative inquiry and action research in our study led to the creation of a competency model empirically founded on and connected to actual practice (Roth & Pilling, 2008; Sburlati et al., 2012). The fact that the model was co-developed by those who will be using it ensured its practical utility and high resonance with the training program's philosophy.

One limitation pertains to the inherent incompleteness of the model. The model, as presented in this study, represents a snapshot of just one stage of its development. If it is to remain faithful to the reality of the training program, it will have to be regularly revised and updated. Furthermore, the model remains rather conceptual and lacks behavioral anchors (Fouad et al., 2009) that would allow for a more formal assessment of trainees' development levels.

Another limitation relates to the spontaneous and creative nature of the research process, which was inevitably influenced by group dynamics and decision making. The model is based on the practical experience of a group of trainers, and although it is built on the literature, it is not evidence based in the strict sense of the word. The predictive validity of the model pertaining to trainees' treatment outcomes remains to be tested.

Conclusions and Professional Training Implications

Competency models can play a central - even vital - role in psychotherapy trainings. As we can attest through our first-hand experience, a competency model may serve several interrelated functions:

1. *Identity building:* By defining core competencies, a competency model helps build a training program's identity and define it relative to other programs. This may be especially important for integrative training programs where boundaries tend to be blurred and overly all-encompassing (Gold, 2005; Řiháček & Koutná Kostínková, 2012). In our case, the competency model helped us to explicitly focus our Training in Psychotherapy Integration on the individual development of each student´s personal therapeutic approach.

2. *Providing a map:* A competency model helps trainees understand training essentials and reduce anxiety so often reported in connection with trainings (Gold, 2005). An example from our Training is how the competency model used for self-evaluation at the beginning of training provides trainees with a self-supportive acknowledgment of the competencies they already possess and the ability to build on them.

3. *Structuring the curriculum:* Clarification of the training program foci helps further develop and structure the training curriculum (Sburlati et al., 2012). Specifically, a competency model allows trainers in our institute to move from a "what we want to teach" approach to "what our trainees should be able to do" approach.

4. *Continuous individualized feedback:* A CM provides clues for the evaluation of trainee progress in terms of both formative and summative assessment (Yager & Bienenfeld, 2003) as well as self-evaluation and goal setting for further development. Feedback can be individually tailored to identify specific competencies that require further development and thus support individual trajectories of trainees' personal therapeutic approach development. In our Training in Psychotherapy Integration, we use the competency model for students´ self-evaluation at the end of each school year. For each student then, there is an individual mentor (one of the trainers) who helps the student to establish a plan for the next school year to work on less-developed competencies.

5. *Objectivity and transparency in evaluation:* Trainers can ensure the evaluation criteria for assessing trainees are objective, open and transparent. When used for assessing performance in the final exam, competency models allow trainers to ground the evaluation of training graduates in concrete requirements that are set in advance. In the case of our Training in Psychotherapy Integration, the breadth of the integrative approach taught means that theoretical structures of specific approaches cannot be used to formulate evaluation criteria. Our competency model offers more objectivity and transparency.

6. *Consensus building:* Greater reliability across trainers and their teaching/evaluations can be ensured. In our case, having a shared formulation of core competencies helps the trainers coordinate across the training faculty, including group facilitators, theory lecturers, skills trainers, supervisors, and evaluators.

A challenge connected with using competency models in training programs is that their existence may give rise to anxiety and self-doubt in trainees (Klein & Babineau, 1974; Lowndes & Hanley, 2010). Therefore, competency models should be used with caution, and creative approaches should be explored to alleviate anxiety connected to the evaluation process. For instance, defining a minimally acceptable level of competency – instead of creating an ideal therapist prototype – might help trainees relate to a competency model with less anxiety and use it as a springboard for further professional development. With this caveat in mind, a competency model can be an invaluable help to all participants of the training process.

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