
Beyond Microskills: Toward a Model of Counseling Competence

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Abstract

Heeding the call to the profession, the authors present both a definition and model of counseling competence. Undergirding the model are 15 foundational principles. The authors conceptualize counseling competence as more complex and nuanced than do traditional microskills models and include cognitive, affective, and behavioral components. The model consists of 4 superordinate competencies—determining therapeutic outcomes, facilitating therapeutic outcomes, evaluating therapeutic outcomes, and sustaining therapeutic outcomes—and 12 subordinate competencies: self-appraisal/self-evaluating, structuring the therapy, building a therapeutic alliance, applying a conceptual map of therapeutic change, using therapeutic techniques, self-correcting, surmounting obstacles, leveraging opportunities, managing special situations, working with other systems of care, consulting other sources, and terminating therapy. Integral to the model is the integrated deep structure, which consists of 5 metacognitions: purposefulness, motivation, selection, sequencing, and timing.

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As the dominant model of entry-level training, the microskills approach focuses primarily on the development of observable skills. These discrete behaviors can be repeated and measured, which is the basis for the evaluation of counselor-trainee performance. At the time of its introduction, the approach was an advancement in training (Ivey, 1971; Truax & Carkhuff, 1967). However, other features not included in microskills training now are understood as integral to counseling competence (Byars-Winston & Fouad, 2006; Fauth, Gates, Vinca, Boles, & Hayes, 2007; Goodyear, 1997; Skovholt & Ronnestad, 2003). Furthermore, the effect of graduate training on therapists' treatment competence (Bein et al., 2000; Binder, 2004; Fauth et al., 2007; Stein & Lambert, 1995) and clinical judgment (Spengler et al., 2009) has been seriously questioned.

Stein and Lambert (1995) pinpointed what they framed as "a substantial challenge" facing graduate training programs in psychology, psychiatry, and social work:

Programs have yet to systematically demonstrate (a) whether the skills they teach relate directly to year-by-year increases in the successful number or quality of therapy outcomes among the patients of trainees or (b) that specific didactic or practicum experiences affect dropout rates over time. (p. 193)

In light of the above problems, a call for reform in counselor training has gone forth (Ridley, Kelly, & Mollen, in press [this issue]). In this article, we heed the call by attempting to define counseling competence and proposing a model that elucidates our definition. The model moves beyond skills-based models by integrating cognition and affect, which are essential but often unaddressed elements of competence. As Vakoch and Strupp (2000) stated, the training of beginning psychotherapists actually can hinder their development of complex clinical judgment. At the same time, our model does not overlook microskills; instead, it infuses them within a more comprehensive, complex conceptualization of competence.

This article is organized into four major sections. First, we explain the role of cognitive complexity in counseling competence. Second, we situate our call for reform of counselor training within the context of the competence movement in professional psychology. Third, we make our modest proposal for defining counseling competence. Fourth, we present our model of counseling competence.

Cognitive Complexity in Counseling Competence

Cognitive complexity is an important feature of counseling competence (Byars-Winston & Fouad, 2006; Fauth et al., 2007; Goodyear, 1997; Skovholt & Ronnestad, 2003). In this section, we provide research support for its role in expertise in general, counseling competence specifically, and apply it to counselor training.

Cognitive Complexity as Integral to Expertise in General

Cognitive complexity is critical to the development of expertise and therefore holds particular promise for improving counselor training. Experts across fields seem to respond similarly to unstructured problems and distinguish themselves from novices through the types of information they consider in problem solving and how they use them (O'Byrne, Clark, & Malakuti, 1997; O'Byrne & Goodyear, 1997). For example, experts in domains as varied as chess, football, music, and physics remember more and perform better than novices partly because they can "chunk" their specialized knowledge into meaningful patterns (Jennings, Hanson, Skovholt, & Grier, 2005). Although experts easily differentiate relevant and irrelevant information, novices often base their problem-solving approaches on concrete, immaterial details (Davidson & Sternberg, 1998; Jennings, Hanson, et al., 2005; O'Byrne & Goodyear, 1997). Before approaching a problem, experts usually spend considerable time planning and formulating a mental representation of the issue that accounts for its important abstract features, whereas novices spend less time planning and more time implementing solutions than do experts (Davidson & Sternberg, 1998; Dominowski, 1998; Jennings, Hanson, et al., 2005; Sitko, 1998). Experts also are distinguished from novices by the organization and structure of their knowledge, depth of their problem representations, quality of their mental models, efficiency of their problem-solving procedures, perception of patterns in their realm of expertise, automaticity and speed of their task performance, their superior memory for domain-specific information, and their ability to engage in metacognition about task performance (Goodyear, 1997; Jennings, Hanson, et al., 2005).

Metacognition, a central component of cognitive complexity, seems particularly important in promoting expertise. It refers to thinking about one's thoughts, including what one knows (metacognitive knowledge), what one is doing (metacognitive skill), and one's cognitive and affective state (metacognitive experience; Hacker, 1998). Regardless of the subject matter, these thoughts are deliberate, goal directed, and critical in nature (Davidson &

Sternberg, 1998; Georghiades, 2004; Hacker, 1998). They involve reflections on the learning process, including important procedural points, connections, and mistakes, as well as self-appraisal and self-management. Self-appraisal refers to individuals' reflections about their understanding during the learning process. Self-management refers to the mental processes people use to help them coordinate the components of problem solving (Georghiades, 2004; Hacker, 1998).

Metacognition is positively correlated with measures of effective learning (Romainville, 1994; Taraban, Rynearson, & Kerr, 2000) as well as with enhanced problem-solving abilities in the classroom (Davidson & Sternberg, 1998; Swanson, 1990). Berardi-Coletta, Buyer, Dominowski, and Rellinger (1995) demonstrated it also has been associated with success on puzzles and card problems. To explain the difference between the performance of the control group, which was asked "what" questions (e.g., What are the rules of the problem?), and the metacognitive group, which was asked "how" questions (e.g., How do you know this is a good move?), the authors stated:

Metacognitive participants switched from simple to more complex strategies, monitored themselves and the problem solution more often, and developed more sophisticated representations of the problem structure. . . . Metacognitive processing, therefore, seems to encourage a proactive, self-reliant discovery process that does not appear to be part of the average problem solver's repertoire. . . . Based on the findings from these students, broad-based problem-solving skills such as "learning how to learn," that is, becoming aware of what one is doing and why, need to be emphasized when problem-solving skills in any domain are being trained. . . . Problem solving in general has to be viewed in terms of processing skills, not the content of one's knowledge base. (p. 219)

Cognitive Complexity as Specifically Integral to Counseling Competence

Metacognition and other aspects of cognitive complexity have garnered little attention from counseling psychologists. Nevertheless, the limited literature on the topic suggests their central role in promoting expertise. According to Sakai and Nasserbakht (1997), issues in applied psychology are verbally based and therefore less structured than problems in realms like chess and medicine. The authors concluded, "This leads to problems in appropriate diagnosis and classification; it also leads to the reasonable belief that more

cognitively complex individuals would function better as professional psychologists” (p. 356).

Several studies have supported the notion that metacognition and other hallmarks of cognitive complexity are vital to the development of expertise in counseling. Unlike experts, novice counselors develop inadequate conceptual maps of client issues, leading them to quick problem formulation and advice giving (Skovholt & Ronnestad, 2003). Conversely, the ability to develop high-quality clinical hypotheses, which requires attending to client messages, categorizing data, and accurately integrating information, is associated with high therapeutic performance ratings (Morran, 1986).

Continuous self-reflection and self-awareness also are critical to quality therapeutic relationships and professional development (Fauth & Williams, 2005; Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005; Skovholt & Jennings, 2005; Skovholt & Ronnestad, 2003). Surveys and interviews with master therapists demonstrate the importance of these factors (Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005; Sullivan, Skovholt, & Jennings, 2005), which involve counselors’ understanding their own emotional and physical needs, understanding unfinished business, knowing the boundaries of their competence, seeing themselves as change agents, grasping their power in therapeutic settings, and comprehending their own capacity for relationships. Although some studies suggest that experience can have some influence on counselors’ growth, they emphasize that experience alone is insufficient for developing expertise. As Skovholt and Jennings (2005) observed, “The experience has to be used to grow in an environment that encourages exploration. One ingredient for turning experience into expertise is self-reflection” (p. 15). A master therapist explained it this way:

I don’t think years of experience by itself does it because I might have the same year of experience 20 times, and so I need to put that together with good consultation and a good collegial system. So that you actually are learning from what you’re doing and [learning] more about how you’re impacting and affecting people. (Jennings, Sovereign, et al., 2005, p. 41)

Application of Cognitive Complexity to Counselor Training

Given the clear connection between cognitive complexity and the development of expertise, counseling psychology must seriously consider integrating cognitive components of therapy into its training programs. As Davidson

and Sternberg (1998) noted, "Teaching metacognitive skills in conjunction with the domain-specific skills they are to control seems to be more effective than teaching each type of skill separately" (p. 63). The implication is that by solely emphasizing microskills, training programs are not realizing their full their potential.

Admittedly, incorporating metacognition into counselor training poses several challenges. As already noted, cognitive complexity has received little attention in the counseling literature, so modifying training programs initially will require drawing from studies in other fields and opening a relatively new line of research in counseling psychology (Kleiner, 2005). In addition, because metacognition is an internal process that can elude awareness, it poses methodological challenges in research (Georghiades, 2004; Hacker, 1998). Finally, adding a metacognitive component to counselor training would introduce another tax on courses that already are strapped for time (Sitko, 1998).

Fortunately, some counseling psychologists are beginning to incorporate cognitive considerations into their research and training. Several recent textbooks make an effort to address these concepts. Jennings, Hanson, et al. (2005) explained that the development of expertise entails novice counselors departing from rigid, context-free adherence to theories and skills and moving toward internalized, personal theories based on reflection and observed patterns. To this end, the authors proposed several topics to be covered in training programs, including how to set long-term goals and express personal feelings in session.

Other ideas for covering the cognitive components of therapy come from Byars-Winston and Fouad (2006), who noted the necessity of metacognition in multiculturally competent career counseling. They offered suggestions for incorporating it into their six-step culturally appropriate career counseling model. The authors listed questions related to one of these processes at each step of their model. When establishing a relationship with a client, for example, practitioners can develop a plan by asking themselves questions such as What are my strengths and areas of challenge? and What are any gaps in my knowledge about the client's context? Counselors can self-monitor when identifying clients' career issues through questions such as, What is the client's cultural context? and What are my reactions to that? Finally, counselors can evaluate their plan once they intervene by asking themselves, How helpful are my interventions? and On what basis am I determining how helpful are my interventions?

Morran, Kurpius, Brack, and Brack (1995) also put forth concrete techniques for integrating cognitive complexity into training curricula. Noting that instruction in cognitive skills improves trainees' ability to empathize,

communicate, and problem solve, they proposed a four-phrase model for teaching three essential cognitive skills: (a) attending to and seeking information about oneself, the client, and the counseling relationship; (b) organizing and integrating this information into clinical hypotheses and conceptual models; and (c) planning, guiding, and evaluating therapeutic interventions. The authors stated that their model, which uses techniques such as thought-listing exercises, self-instruction, and hypothesis formulation, can supplement and coordinate with traditional behavioral skills training. Although they have employed it successfully with novice, intermediate, and advanced trainees, they added that empirical testing is needed to validate their approach.

Counselor training programs also can look to other fields for guidance in incorporating metacognition. Suggestions from educational psychology are particularly promising. Dominowski (1998) and Kuhn and Dean (2004) recommended that instructors ask probing questions to determine what students are thinking, including *How do you know?* and *What makes you say that?* Davidson and Sternberg (1998) mentioned pair problem solving, which involves students thinking aloud through problems while peers listen to and monitor the students' encoding and thinking processes. These types of exercises and probing questions could serve as starting points for counselor training programs as they work to address areas beyond microskills.

The Competence Movement in Professional Psychology

Psychologists and other mental health professionals have a vested interest in professional competence (e.g., Fantuzzo, 1984; Fantuzzo, Sisemore, & Spradlin, 1983; Masterpasqua, 1989; McNamara, 1975; Peterson & Bry, 1980; Shaw & Dobson, 1988; Tyler & Weaver, 1981). During the 1990s, after modest attention in earlier years, the field moved to identify competency domains with the expectation that psychologists would demonstrate proficiency in these areas (Bent, 1992; Bent & Peterson, 1998; Bourg, Bent, McHolland, & Stricker, 1989; Committee on Accreditation, 1996; Stigall et al., 1990). Emanating from this work was a national survey that resulted in the identification of eight competency domains (Kaslow, 2004). Despite these important advancements, two prominent problems were noted: (a) the absence of a consensus framework interrelating the various competency domains and (b) difficulties in the development and assessment of competencies (Rodolfa et al., 2005; Sumerall, Lopez, & Oehlert, 2000).

Corresponding to the growth of general interest in competence was the specific call for multicultural counseling competencies (Arredondo et al.,

1996; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982). The competencies were organized into three domains—awareness/attitudes, knowledge, and skills—and they were expanded on through successive documents. The tripartite model of multicultural competencies was an attempt to address the concerns of clients in an increasingly diverse society and redress the marginalization of minority clients in the mental health delivery system (Ridley, 2005).

During the past decade, we have witnessed a dramatic increase in attention given to the topic of professional competence in applied psychology. Accreditation requirements and the Ethical Principles of Psychologists and Code of Conduct have catapulted competence into a central role in the national conversation on training, education, and practice (American Psychological Association [APA], 2002; Committee on Accreditation, 2002). For instance, the boundaries of competence and maintenance of competence are explicitly addressed in standards 2.01 and 2.03, respectively, of the APA Ethics Code (APA, 2002; Rubin et al., 2007). To address the many issues concerning competencies, a national conference—Competencies Conference, 2002: Future Directions in Education and Credentialing in Professional Psychology—was convened (Kaslow, Collins, & Illfelder-Kaye, 2004). The conference resulted in the proliferation of numerous articles and presentations on the topic and has captured the attention of counseling, clinical, and school psychologists. Clearly, competency-based education, training, and credentialing have emerged as standard practice (Kaslow, 2004; Kaslow, Collins, & Illfelder-Kaye, 2004; Rubin et al., 2007).

The publication of the competency benchmarks, representing the latest in this emergent standard of practice, builds on previous initiatives within psychology (Fouad et al., 2009). The document outlines 15 core competencies deemed by the authors as foundational and fundamental in professional psychology. These competencies are described across three levels of professional development: readiness for practicum, readiness for internship, and readiness for entry to practice. The descriptions include components of the core competencies and behavioral indicators. While exclaiming the benefits of the benchmarks document, the authors acknowledge the need to determine its practical utility and predictive validity as well as its linkage to best practices in the assessment of competence.

We recognize the benchmarks document as a landmark in the field. Its scope of competencies is broad, whereas its levels of professional development are deep. We agree with the authors that the document builds on and is informed by previous efforts to identify and assess trainee learning outcomes. In this regard, we are confident about its long reach in shaping education

and training in professional psychology. We also believe that the behavioral anchors give grounding to the various competencies. The anchors are reference points for identifying and assessing learning outcomes.

On the other hand, we raise three concerns that are not identified by the authors. Most notably, although differentiating competencies from and subsuming them under competence, the widely used definition of competence in the document is oversimplified and ambiguous. Second, like the microskills approach, the benchmark document limits its attention to the cognitive and affective components of competence—the intrapersonal processing needed by clinicians to facilitate therapeutic change. Third, although the competencies are behaviorally anchored, many of the anchors are framed descriptively rather than prescriptively, a constructive criticism previously noted about cultural competencies (Ridley, Baker, & Hill, 2001). The anchors describe what clinicians should do, but they do not provide guidance on how to perform the competencies. Therefore, although allowing clinicians considerable discretion in their performance, the lack of guidance gives them too little direction. Perhaps it gives clinicians so much room that they might miss altogether the aim of a competency. We consider the behavioral anchors in the document to be initial references for prescribing more specific counselor behaviors.

Overall, a host of issues have emanated from the national conversation, all pointing to the dire challenge of defining, developing, and maintaining competence among professional psychologists. Nothing is more critical to the conversation on competence than actually defining the term. However, there remains no universal agreement on what composes competence (Barnett, Doll, Younggren, & Rubin, 2007). On this subject, Rubin and colleagues (2007) made a disconcerting observation:

The issue of competence is not new to practicing psychologists who aim to work effectively within their scope of practice. However, when psychologists ask themselves specifically, “What is competence?” as applied to professional psychology, the answer is not readily forthcoming. (p. 453)

Similarly, Barnett (2007) was prompted to ask a series of provocative questions: “Yet just what is competence, how does one achieve it, how does one maintain it, and what are the threats to it that psychologists must guard against?” (p. 510). Finally, Barber, Sharpless, Klostermann, and McCarthy (2007) went a step further, implicating the definitional problem as an issue of accountability:

Defining therapists' competence is no easy task. In fact, we have serious doubts that the field, using the measures reviewed, is ready to meet the challenges raised by different bodies asking for evaluations of therapists' competency. Be this as it may, there are continued pressures to come up with such requirements. (p. 495)

Serious problems center on the training of competent psychologists. With increased pressures for accountability, professionals find it difficult to validate their competence. Then, they may be tempted to practice beyond the scope of their competence (Doll, 2007). As already mentioned, the effectiveness of graduate training stands in serious question. These problems demand solutions. In recognition of such an arduous task and in the spirit of modesty, we now attempt to conceptualize counseling competence.

A Modest Proposal for Defining Counseling Competence

Joining the current discourse on professional competence, we developed a model to address the gaps in training and inability of the field to establish a clear relationship between training and expertise. We took serious stock of Kaslow's (2004) admonition that "psychologists must not define competencies in a manner that reduces the profession to a collection of specific skills . . . and, as a result, train technicians rather than professionals" (p. 779). And we received the counsel from several scholars that additional development in professional competence is necessary (Kaslow, Borden, et al., 2004; Rubin et al., 2007; Schulte & Daly, 2009).

Several definitions of competence have been set forth (i.e., Epstein & Hundert, 2002; Rodolfa et al., 2005; Spruill et al., 2004; Willis & Dubin, 1990). Although these definitions helped to further the competence conversation, they are marked by oversimplification and ambiguity. Each definition omits critical components of competence. Multiple meanings can be assigned to each definition, depending on the context in which it is used or the lack of clarity in a particular context (Halpern, 1996; Moore & Parker, 1995). The indeterminable meaning makes it impossible for professionals to reach consensus on how to actually demonstrate and evaluate competence.

Consider the widely cited definition of competence put forth by Epstein and Hundert (2002): "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," which depends on "habits of mind, including attentiveness, critical

curiosity, self-awareness, and presence” (p. 227). The authors list a host of attributes that they consider defining features of competence. We cannot help but question several points in their definition, however. Does the wording “habitual and judicious” mean that each of these attributes is an independent or interdependent demonstration of competence? The definition provides no clue. Even if independence or interdependence is established, how are these attributes demonstrated? No one knows. Are not many of the attributes listed in the definition, such as clinical reasoning, critical curiosity, and presence, themselves ambiguous? They too can be assigned multiple meanings, indicating ambiguity embedded in ambiguity.

Key Definitions

We now attempt to offer a precise definition of competence. To this end, we also define four related constructs: counseling competence, competencies, microskills, and performance. We believe the distinctions between these constructs are essential for explicating our definition and model of competence.

Competence. We define competence as the determining, facilitating, evaluating, and sustaining of intended outcomes. These outcome operations hinge on a set of relevant competencies and microskills, which must be coordinated and integrated to determine, attain, evaluate, and sustain the intended outcomes. This definition is generic in that it is applicable to competence in any endeavor and across all professions. Profession or task-specific applications of this definition have their unique exigencies, but our definition has general utility and application.

Counseling competence. In the phrase *counseling competence*, the word *competence* is a noun, and the word *counseling* is an adjective, modifying competence. Therefore, drawing on our generic definition, we define counseling competence as the determination, facilitation, evaluation, and sustaining of positive therapeutic outcomes. Like competence in any vocation or task, counseling competence consists of a set of competencies, and each competency consists of subsets of microskills, both behavioral and cognitive. In demonstrating their competence, clinicians must coordinate and integrate these competencies and microskills as a means of determining, facilitating, evaluating, and sustaining therapeutic outcomes. Our use of the phrase counseling competence has similar referents such as clinical expertise (APA, 2005), clinical competence (Barnett et al., 2007), intervention competence (Barber, Sharpless, Klos-termann, & McCarthy, 2007), and psychotherapeutic effectiveness (Fauth et al., 2007). Again, however, our use of the phrase is intended to be a more comprehensive, complex conceptualization than other referents in the literature.

Competencies. We differentiate competencies from competence in that the former are subsets of the latter. Our view aligns with the view of other authors (e.g., Kaslow, Borden et al., 2004; Marrelli, Tondora, & Hoge, 2005; Parry, 1996). As Leigh and colleagues (2007) state, “competencies are demonstrable components of competence” (p. 464). They reflect well-done performance, and they can be evaluated against well-accepted standards. We add further clarification to the definition. The most important characteristic is that each competency serves a unique purpose in the process of facilitating therapeutic change. Apart from its specificity of purpose, a competency has no therapeutic value. Moreover, we assert that competencies can be informational and metacognitive as well as behavioral.

Microskills. These counselor behaviors are subsets of competencies, and like competencies, they serve a unique purpose. They too are demonstrable units, reflect well-done performance, and can be evaluated against well-accepted standards. Each microskill has a purpose, apart from which it has no therapeutic value. Microskills also can be informational and metacognitive as well as behavioral.

Performance. Performance is the level of skill exhibited in executing a particular competency or microskill. In that sense, performance can vary along a continuum from poor to exceptional. We differentiate performance from competencies and microskills themselves. Performance on various competencies and microskills is behavioral activity. It can be framed and rated behaviorally, allowing evaluators to make judgments about an individual’s skill level. Because competence is a broader concept, its evaluation requires more than judgments about an individual’s skill level. It requires attunement to outcomes and the processes in which outcomes are attained.

Foundational Principles

Fifteen principles underlie our definition of counseling competence. Principles are accepted or professed rules of action or conduct (Flexner, 1987). We consider our principles as foundational; they provide the basis for elaborating on our definition in a model and translating theory into practice. Sexton, Ridley, and Kleiner (2004) pointed out an often overlooked characteristic of principles: “During therapy, the principles exist in the background as the basis of specific interventions and therapeutic actions exist in the foreground” (p. 144). Because principles often are implicit and not as obvious as other aspects of therapy (e.g., observable behaviors), clinicians may be unaware of the principles they accept as rules of practice. We overcome this obstacle by making our principles explicit.

1. *An outcome orientation is fundamental to counseling competence.* The demonstration of counseling competence is impossible without an outcome orientation (Sexton, Whiston, Bleuer, & Walz, 1997), and this principle is equally true of competence in any profession. Although each type of competence has its unique outcomes and specific operations to attain those outcomes, having such an outcome orientation is a defining feature of competence. An outcome orientation is consistent with one of Covey's (1990) most important habits of highly effective people: beginning with the end in mind. Highly effective people set goals for themselves, envision them as outcomes for the future, and work to attain them.

Similarly, competent clinicians master and perform the operations necessary for determining, facilitating, evaluating, and sustaining therapeutic outcomes. Conversely, clinicians cannot claim competence if they perform operations that do not determine, facilitate, evaluate, and sustain therapeutic outcomes. On the surface, an outcome orientation would seem obvious to even the most novice professional. However, we argue that many professionals are so preoccupied with their therapeutic orientations and the processes of counseling that they lose sight of the central importance of outcomes. Moreover, we critiqued the microskills approach specifically for its failure to account for linkage to therapeutic outcomes (Ridley et al., in press [this issue]).

2. *Competence consists of cognitive, emotional, attitudinal, and behavioral components.* This principle departs from skills-based approaches, which primarily emphasize the mastery of counseling behaviors or microskills. Our view of competence emphasizes (a) how clinicians think and feel about themselves in regard to their performance and (b) the attitudes they have about themselves in regard to their performance. Essentially, counseling competence reflects the full range of psychological attributes, not simply the behaviors of counselors.

3. *Intentionality underlies the performance of competent clinicians.* Focused on an outcome orientation, competent clinicians do not perform their tasks in a random, casual, careless, or haphazard manner. They engage only in operations related to determining, facilitating, evaluating, and sustaining therapeutic outcomes, and they avoid operations that are superfluous, counterproductive, and otherwise inconsistent with an outcome orientation. Most professionals will accept this principle in theory, but we wonder about its manifestation in actual practice. We raise this question for consideration: To what extent do the operations of mental health professionals actually contribute to the determining, facilitating, evaluating, and sustaining of therapeutic outcomes? This is an empirical question that begs reliable data. It is possible that an unacceptable portion of clinicians' operations are missing the mark of determining, facilitating, evaluating, and sustaining therapeutic outcomes.

4. *Competent clinicians differentiate themselves from less competent clinicians by more consistently facilitating, evaluating, and sustaining therapeutic outcomes.* Determining therapeutic outcomes begins the demonstration of competence. It is not the ending, however. It also is not what separates competent clinicians from novice clinicians. Competent clinicians are comprehensive in their outcome orientation. Competence certainly does not mean perfection—always facilitating, evaluating, and sustaining therapeutic outcomes—for everyone makes mistakes or sometimes fall short of his or her goals. After all, to err is human. When competent clinicians err, however, they learn from and correct their mistakes. They also understand that some extreme circumstances, beyond their control, hinder the facilitating and sustaining of therapeutic outcomes. Here they do not internalize their lack of success as their lack of competence.

5. *Counseling competence is a process of progressive movement toward therapeutic outcomes.* A process is a series of operations or actions, the unfolding of which is marked by gradual changes leading toward a particular result (Mish, 1984). Because therapeutic change can be daunting, the unfolding of the operations of competence typically takes time and patience. We refer to the operations involved in counseling competence as competencies, metacognitions, and microskills. In our model, excluding any of these operations undermines the demonstration of competence. We acknowledge that in the real world of counseling and psychotherapy, change typically is not straightforward. Therapist missteps or client lapses are not uncommon. Consequently, we frame counseling competence as progressive but not necessarily linear—an open acknowledgement of the very human nature of the process.

6. *The process involved in counseling competence is complex.* Complexity of any phenomenon is indicated by (a) the number and variety of its constituent elements and (b) the intricacy of the interactions among these elements (Rescher, 1998). As the number of elements increases, the interactions become more intricate and elaborate, and by implication, the explanation of the complexity becomes more challenging. This issue of complexity underlies the notation of Leigh et al. (2007) that the assessment of competence in professional psychology is perplexing. In our model, we attempt to simplify the complexity of counseling competence by identifying its constituent elements. We also attempt to avoid oversimplification by including relevant constituent elements, and to avoid unnecessary complication by excluding irrelevant constituent elements of the process. We believe most descriptions of counseling competence are oversimplifications, which stem from inadequate conceptual frameworks and can cause therapists to inadequately determine, facilitate, evaluate, and sustain therapeutic outcomes.

7. *The operations of counseling competence (competencies, microcognitions, and microskills) are interdependent and complementary.* Competence is not merely the sum of disjointed competencies and microskills. It is a holistic set of operations. As Aristotle's principle of holism states, the whole is more than the sum of its parts (Sachs, 1999). Therefore, as long as the operations involved in competence are handled independently and not treated as complementary, the process will be inexplicable. For an adequate, conceptually coherent explanation, each operation must be considered in relation to all other operations as well as to the entire process.

8. *Competence is more than high performance on competencies and microskills.* High performance is necessary for competence, but it is not sufficient. Consider the extensive training of graduate students in the performance of microskills. Certainly, they are expected to perform at high levels. However, the disjointedness in their performance begs the issue of interdependence and complementarity, which are essential for determining, facilitating, and sustaining therapeutic outcomes. Our experience has taught us that many graduate students are befuddled by their training in microskills. They believe the training has benefits, but they are hard-pressed to explain how it is beneficial. Of course, research is needed to determine the generalization of this assertion. In our opinion, a flawed assumption underlies the skills-based movement: High performance on relevant competencies equals competence. Missing in action are an explicit outcome orientation and metacognitive skills.

9. *Competent counselors use mental maps of therapeutic change to guide their operations.* Maps indicate the pathways for counselors to navigate the complex terrain of therapeutic change. To be of use, maps must be comprehensive and coherent. Prochaska's (1999) transtheoretical model is a good example of a well-integrated mental model of how people change. In our opinion, some clinicians have implicit mental maps that are based on their professional experience and pieced together through their own critical thinking. These maps no doubt vary in complexity and utility. We speculate that many clinicians do not operate from well-integrated maps, resulting in hit-and-miss operations with regard to an outcomes orientation. As this is an unexplored area of research, we acknowledge the speculative nature of this assertion.

10. *Flexibility is integral to counseling competence.* Counseling competence is not rote performance, for rote performance of competencies and microskills is impervious to the realities of clinical cases. Competent clinicians adjust themselves to nonroutine circumstances, at times modifying their strategies. They generate and act on many problem-solving options, whatever is ethically and practically required of the situation. Incompetent clinicians, by contrast, are

rigid and limit themselves to a narrow range of operations. Hill, Stahl, and Roffman (2007) stated:

Given the complexity of therapy and helping and the lack of evidence that specific skills are substantially more effective than others overall . . . , it is important for trainees to be taught to use skills flexibly and with clinical judgment rather than to use them in a prescribed or robotic way (e.g., cookbook approach). (p. 366)

According to several authors, competent clinicians are judicious (Barber et al., 2007; Binder, 2004; Borkovec & Sharpless, 2004). They weigh the merits of various interventions. Where routine is not effective, they implement alternative interventions. They also match their interventions to the specific needs of clients (Hill et al., 2007).

11. To achieve the flexibility needed for competence, clinicians need to manage the operations inherent in the process. The management of competence entails the coordination and integration of its various competencies and microskills. The coordination and integration is rooted in critical thinking, sound judgment, and evaluation of the problems and options in a given context. Whereas the performance of competencies and microskills is behavioral, coordination and integration is metacognitive, affective, and attitudinal.

Lichtenberg and colleagues (2007) accord with our perspective, punctuating the importance of integration.

Psychology does not currently have the methods to readily or reliably assess the integration of knowledge, skills, and attitudes in the performance of professional functions that comprise competence (e.g., professional judgment, scientific mindedness, relationship skill, teamwork, internalized ethical orientation, reflective practice/self-awareness, openness to learning, and commitment to professional growth). Yet it is this integration that reflects the construct of competence. (p. 476)

12. Science is the foundation upon which competent clinicians practice. The conventional aims of science are to explain, predict, and control natural phenomena. Therapeutic change is the phenomenon of interest to competent clinicians. Therefore, the aim of practice is to employ evidence-based interventions that facilitate therapeutic change. The facilitation of therapeutic change presupposes clinicians having an explanation of therapeutic change such that they predict and control this outcome through the employment of their interventions.

Several authors have commented on the importance of the scientific foundation of competence. Bieschke, Fouad, Collins, and Halonen (2004) presented a potpourri of subcomponents associated with scientific practice. Hill et al. (2007) stated that clinicians using scientific information can choose the best interventions for particular clients. But Spruill et al. (2004) pointed out what they deem as the profession's major challenge: developing ways to translate scientific knowledge into actual practice.

13. Counseling competence is multicultural counseling competence. The mental health profession extols the virtues of multiculturalism. Leaders in the competence movement recognize that "competence must be sensitive to and highlight the importance of individual and cultural differences" (Kaslow et al., 2007, p. 446). Therefore, we assert that competent counselors consistently incorporate cultural data into counseling, and they must be careful never to relegate cultural diversity to the status of a sidebar. The incorporation contributes to the determining, facilitating, evaluating, and sustaining of therapeutic outcomes. Counseling always occurs in a cultural context, and culture encompasses the full range of human experiences. Because of its ubiquity and complexity, culture always is relevant. Draguns (1989) made the point that culture is always at least a silent participant in counseling. The challenge before the profession is how to put "multicultural" in counseling competence.

14. Competence can be developed but not with uniformity across trainees. Individual differences in capacity, potential, and experience exist among clinicians. They vary at the rate in which and degree to which they develop competence. In fact, clinicians differ considerably in their ability to work with specific types of clients and range of problem presentations (Andrusyna, Luborsky, Pham, & Tang, 2006; Luborsky et al., 1999; Luborsky, McLellan, Diguier, Woody, & Seligman, 1997).

Barber and his colleagues (2007) made the case for levels of competence, suggesting that competence exists on a continuum. In the absence of an unambiguous definition of competence, not surprisingly, professional functions are difficult to specify. The benchmarks document is a step forward in describing the developmental trajectory of psychologists (Fouad et al., 2009). But we argue that the three levels of professional development in the document are not necessarily synonymous with the counseling competence. Although much of the descriptions of the benchmark's core competencies are relevant to counseling, only two of the competencies—assessment and intervention—directly relate to counseling. Therefore, it might be erroneous to assume that professionals who enter into practice are any more competent in counseling and therapy than trainees who enter into internships. For instance, using our model, clinicians may demonstrate that they can determine therapeutic outcomes but

fail to facilitate those outcomes. They may be at the practicum or internship level. We should expect clinicians at high levels of development to be at higher levels of competence. Without a conceptually coherent, unambiguous definition of competence, however, the profession is unequipped to ensure that clinicians at high levels of professional development function at high levels of competence.

15. The development of counseling competence requires a new training paradigm. Old training paradigms that primarily emphasize the acquisition of behavioral skills must give way to paradigms that also emphasize what Vakoch and Strupp (2000) called complex clinical judgment. The training must be rigorous, carefully designed, and developmentally sensitive to the needs of trainees. As Rubin and colleagues (2007) put it: "Competence is developmental, incremental, and context dependent" (p. 453). On that note, we encourage professionals to consider our model, challenge its underlying principles, test its usefulness in making clinical decisions, and most important, investigate its effectiveness in advancing an outcome orientation. We welcome the dialogue.

A Model of Counseling Competence

Our model of counseling competence is designed to account for the foundational principles that we set forth. The model consists of three interrelated operations: competencies, an integrated deep structure, and microskills. See Figure 1. The placement of therapeutic outcomes in the center of the figure underscores the central importance of an outcome orientation to counseling competence.

Competencies

We postulate two types of competencies of counseling competence: superordinate and subordinate. Both types are integral to the demonstration of competence.

Superordinate competencies. Superordinate competencies distinguish competence in one vocation, task, or endeavor from another. They also provide the foundation for competence. All other operations hinge on the superordinate competencies. Four constitute counseling competence: determining therapeutic outcomes, facilitating therapeutic outcomes, evaluating therapeutic outcomes, and sustaining therapeutic outcomes.

Determining therapeutic outcomes lends purpose and direction to counseling. Counselors who fail to determine goals easily can fall into an unproductive trap of pointless, aimless activity. This competency should be executed

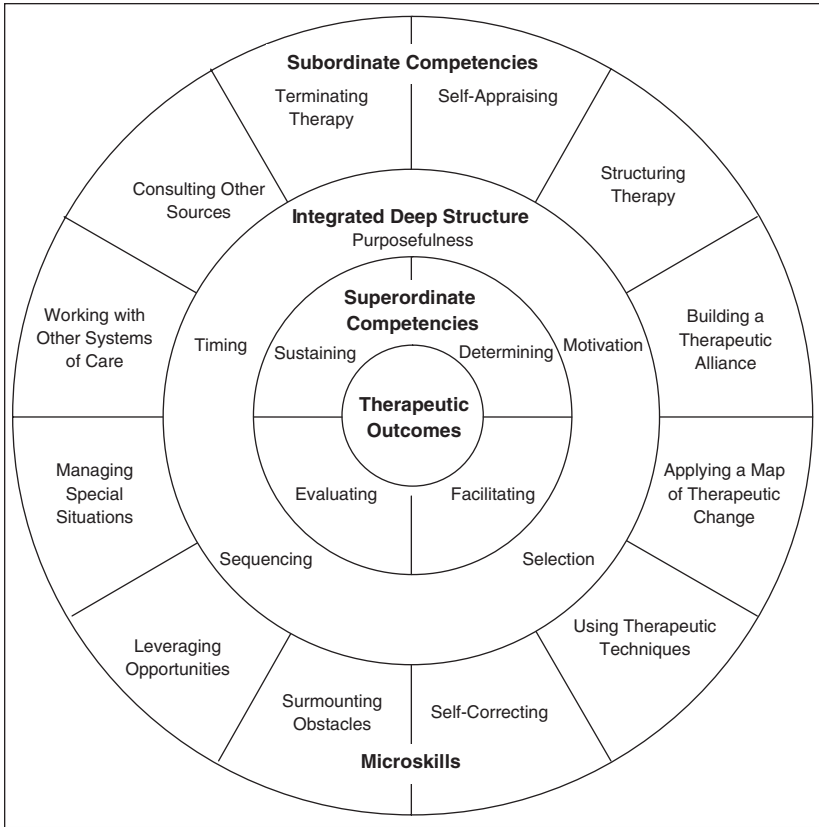


Figure 1. Model of counseling competence

almost from the outset of therapy. Two factors here are critical: Outcomes always must be individualized for each client, and clinicians should assist in revising outcome goals as new information about clients is gathered.

Facilitating therapeutic outcomes makes the process beneficial to clients, apart from which counseling would be a futile exercise. Counselors who fail to help clients attain their goals may lack the necessary knowledge, attitudes, or skill sets. In executing this competency, clinicians should have at their command a broad range of evidence-based interventions, and they must demonstrate flexibility in using the interventions.

Evaluating therapeutic outcomes gives validity to counseling by enabling counselors to ascertain whether or not they have helped clients achieve change.

Evaluation should occur throughout the counseling process and not merely at the conclusion of therapy. Continued evaluation is important because it allows counselors to acknowledge and correct their errors. Counselors who fail to evaluate cannot be certain if the outcome goals of counseling are met and how well they are met. Although the field has much to learn to enhance its evaluation formats in counseling, therapeutic outcomes should be measurable, and clinicians must do the measuring (Lambert, Okiishi, Finch, & Johnson, 1998). To evaluate therapeutic outcomes, they can employ quantitative and qualitative and formal and informal strategies.

Sustaining therapeutic outcomes is the ultimate test of counseling competence. Here clinicians have the dual tasks of helping clients transfer gains from treatment and prevent relapse at posttreatment (Ridley & Shaw-Ridley, 2010). To achieve these ends, they assist clients in drawing on themselves as resources and structuring their social support systems.

The interdependence and complementariness of these superordinate competencies is paramount. Determining therapeutic outcomes without facilitating those outcomes is not a demonstration of competence, and facilitating therapeutic outcomes without first determining them is impossible. Obviously, the determination of specific outcomes and the facilitation of those outcomes vary from client to client, as clients have enormous individual differences. Furthermore, outcomes may change during the course of therapy, as counselors gather new information and gain deeper insight into clients. However, the determination and facilitation of therapeutic outcomes amount to nothing more than an exercise in futility if those outcomes are not sustained. Finally, success in facilitating and sustaining therapeutic outcomes is indicated through an evaluation of the process.

Subordinate competencies. Therapeutic competence consists of 12 subordinate competencies: (a) self-appraisal/self-evaluating, (b) structuring the therapy, (c) building a therapeutic alliance, (d) applying a conceptual map of therapeutic change, (e) using therapeutic techniques, (f) self-correcting, (g) surmounting obstacles, (h) leveraging opportunities, (i) managing special situations, (j) working with other systems of care, (k) consulting other sources, and (l) terminating therapy. Therapists coordinate and integrate these competencies in the interest of determining, facilitating, and sustaining therapeutic outcomes. Though each competency is relevant to overall competence, the competencies may not be of equal importance in specific cases. By critically thinking through each case, clinicians may show considerable latitude in how they employ the competencies. In addition, some of the competencies are generic to professional competence. For instance,

self-correcting is relevant to any professional endeavor. How it is played out in therapy depends on the unique demands of determining and facilitating positive outcomes. On the other hand, some of the competencies are specific to psychotherapy. Using therapeutic techniques and building a therapeutic alliance are deemed therapy-specific competencies.

Self-appraisal/self-evaluating allows counselors to examine their performance, recognize their strengths and weaknesses, understand their boundaries of competence, and continually assess their work. Self-awareness is integral to this competency. Fauth and Williams (2005) found that therapist-trainees' level of in-session self-awareness was linked to therapeutic processes. The more they were self-aware, the more helpful they experienced themselves; the more helpful they experienced themselves, the more they became interpersonally engaged and present in session. Similarly, clients of self-aware trainees felt supported, close to, and helped by their counselors. An example of self-appraisal/self-evaluating occurs when a therapist becomes aware of a countertransference reaction to a client who is dealing with the death of a parent. The therapist, cognizant of her or his own unfinished business with a parent, recognizes that she or he is not being effective with the client. By addressing her or his own concerns in a suitable format separate from therapy, such as through personal therapy or supervision, the therapist is subsequently better able to work effectively with the client.

Structuring therapy is the second subordinate competency. Counseling always has a beginning, and how it is structured sets the tone for the process to unfold. Brammer, Abrego, and Shostrom (1993) defined structuring as the way in which counselors define the nature, limits, roles, and goals within the counseling relationship. Structuring has a number of benefits, such as reducing anxiety and providing safety for clients (Cormier & Hackney, 2005), fulfilling counselors' ethical obligation for informing clients about the nature of counseling (American Counseling Association, 2005), honoring the respective cultures of the client and therapist (Helms & Cook, 1999), and informing and clarifying matters of confidentiality (Cormier & Hackney, 2005).

Kottler (1991) gave a helpful summary of the components of structuring: providing an overview and preview of counseling, assessing clients' expectations and promoting positive ones, describing counselors' expectations, orienting clients to new language and new behaviors, helping clients to increase their tolerance for frustration and discomfort, and obtaining clients' commitment. We consider these counselor behaviors to be microskills that are subsets of structuring.

The third competency is building a therapeutic alliance. The importance of a strong therapist–client relationship has been long recognized (Bachelor & Horvath, 1999; Rogers, 1957). In fact, the therapeutic relationship is more predictive of positive outcomes than the clinician’s therapeutic orientation (Nuttall, 2002), and it accounts for about twice as much success in counseling as therapeutic techniques (Lambert, 1986). The therapeutic alliance emphasizes the collaboration of the therapist and client to achieve the aims of therapy (Bordin, 1979, 1994; Greenson, 1965). The alliance influences therapeutic outcomes across a variety of therapeutic orientations (Gaston, Marmar, Thompson, & Gallagher, 1988; Horvath, 1994). Competent therapists actively co-create an enduring, collaborative, supportive relationship with their clients by demonstrating empathy, authenticity, and approachability in session.

The fourth competency, applying a coherent conceptual map, provides that competent professionals develop a vocational framework outlining a path for achieving therapeutic outcomes. Counselors possessing coherent conceptual maps understand the complex therapeutic change process, and they use this understanding to guide treatment. This competency encompasses microskills such as recognizing and identifying the complexities of therapy and becoming familiar with well-integrated maps outlined in scholarly literature (e.g., Prochaska, 1999).

The fifth competency is using therapeutic techniques. Counselors must master and skillfully employ interventions that are evidence based. Then they must match the interventions to clients’ problem presentations. Competent counselors should have mastery of a variety of interventions, which allows them to select the ones that are most efficacious in individual cases.

We believe that our training culture promotes flawed ideas about the use of therapeutic techniques. In our opinion, two messages are particularly undermining of counseling competence. The first of these ideas is all that matters for successful counseling is the counselor’s skillful use of therapeutic techniques. Here techniques are considered the exclusive source of therapeutic change. Manualized treatments, among other things, help to send this message. Though this message may be unintentional, it nevertheless is unproductive. Using therapeutic techniques clearly is an important competency. However, in our model, it is only one of 12 subordinate competencies, and it is not one of the superordinate competencies. This recognition alone should underscore the importance of taking a comprehensive perspective on counseling competence, while cautioning counselors not to overlook or minimize other competencies needed to demonstrate competence.

The second flawed idea is that allegiance to a single therapeutic orientation is acceptable. We assert that counselors should have a plethora of interventions because no one intervention has the sole propriety on therapeutic change. Counselors can judiciously select techniques as required by the needs of the client, the obstacles they encounter, and the opportunities that present themselves. Furthermore, given that counseling is complex and clients present with a host of problems, it is in the interest of therapists to be pragmatic. Employing therapeutic techniques such as systematic desensitization or cognitive restructuring requires that counselors understand how the intervention works, what research support exists for it, and how it is optimally executed.

The sixth competency found in the model is self-correction. As we stated previously, even competent professionals sometimes make mistakes. They handle these mistakes appropriately according to professional standards, however, and they use their errors as learning opportunities. Self-correction requires continually evaluating the process and outcome of therapy to gauge the promotion of positive change. This evaluation entails the microskills of using multiple avenues for evaluating counselor performance and client improvement, seeking and incorporating supervisory feedback, and developing the metacognitive abilities necessary to assess one's own strengths and weaknesses (Kruger & Dunning, 1999). Another aspect of counselor self-correction is revising goals and interventions as necessary. Such revision would be warranted if therapeutic change is not materializing, for example, or if new information surfaces about a client. To revise treatment appropriately, counselors use microskills such as adding new goals and revising old ones as additional problems arise, recognizing issues as they surface during the evolution of therapy, and including clients in the discovery and revision process. An example of self-correction is the therapist who, sensing she or he has ineffectively administered an intervention, acknowledges the mistake, corrects it, and ensures that the therapeutic alliance is intact before proceeding.

The seventh competency is surmounting obstacles. Professionals sometimes encounter difficult situations where obstacles seem insurmountable, standard operating procedures cannot achieve desirable outcomes, and creative problem solving is warranted. Competent professionals do not shrink in the face of barriers. Instead, they strive to solve problems and overcome hurdles that might otherwise keep them from achieving their predetermined outcomes. They take measured risks that can help them attain their goals, and they approach problem solving carefully. Although competent professionals cannot solve every problem that interferes with therapeutic change, they have patterns of problem solving that set them apart from counselors who are not as successful in facilitating therapeutic change. A therapeutic rupture is a

surmountable obstacle. When a therapist becomes aware that a rupture has occurred—for example, if a client conveys having felt misunderstood by the therapist in a profound way—she or he can take steps to surmount the obstacle by acknowledging and addressing it, asking the client for clarification, and checking in with the client to ensure a more accurate sense of understanding has been achieved.

Leveraging opportunities is the eighth subordinate competency. Professionals sometimes encounter unanticipated circumstances that they can use advantageously. They recognize these opportunities and employ them in enriching therapy. For example, clients often come to therapy with a particular presenting problem that may become the focus of several sessions of therapy. Competent therapists pay careful attention to other recurrent themes, realizing that a well-spring of possibilities for therapy may become apparent and addressing these during the course of treatment.

Managing special situations is the ninth competency. In addition to managing everyday clinical problems, clinicians must manage behavioral emergencies or crises (Kleespies, 1998; Spruill et al., 2004). Emergencies, often carrying legal and ethical overtones, require clinicians to follow protocols that extend beyond normal therapeutic interventions. Suicidal or homicidal threats, reporting of neglect or abuse, and medical crises are examples of emergencies that pose an immediate threat of danger.

The tenth competency is working with other systems of care (Spruill et al., 2004). Most therapists currently work within complex systems of care that may necessitate coordinating care with psychiatrists, social workers, and physicians. From a multicultural perspective, some clients both want and expect therapists to be able to consult with family members, healers, clergy, and community elders. It is imperative, then, that therapists be able to skillfully function interdisciplinarily, while maintaining appropriate boundaries and respecting confidentiality.

An eleventh competency is consulting other sources. Our model recognizes that all therapists have limitations in knowledge, experience, and skills. Competent therapists acknowledge and understand the importance of consulting with others during the course of treatment. An example might occur in the case of a client in a polyamorous relationship who is in treatment with a marriage and family therapist whose training did not include nonmonogamous partnerships. Therapists can and should consult recent literature, colleagues, and supervisors who have more experience with nonmonogamy.

The twelfth competency is terminating therapy. Though many nontherapeutic relationships end abruptly, competent therapists recognize that terminating therapy effectively provides a rare opportunity for a relationship to end

purposefully and constructively. Moreover, therapists can help clients capitalize on therapeutic gains, prepare for posttherapy concerns, and say goodbye in ways that are meaningful to the client and the therapist.

Integrated Deep Structure

As our definition states, competence requires the coordination and integration of relevant competencies. Rodolfa and his colleagues (2005) stated, “Simply having knowledge or skill is insufficient for someone to be considered competent. . . . Appropriate and effective action requires judgment, critical thinking, and decision making” (pp. 348–349). Fauth and his colleagues (2007) made the compelling argument that psychotherapy training should develop trainees’ metacognitive skills. In demonstration of the superordinate competencies, counselors need the judgment to determine which subordinate competencies to use, when to use them, and how to use them. Halpern’s (1998) definition of critical thinking is consistent with the outcome orientation in our conceptualization of counseling competence: She defined it as the “deliberate use of skills and strategies that increase the probability of a desirable outcome” (p. 449).

Currently, the field’s training models do not provide a comprehensive compendium of metacognitions—the thought structures of therapists necessary for effective counseling and psychotherapy. Therefore, trainees typically do not know what they should be thinking, or for that matter, how they should be thinking. Consider this statement, attributed to pioneering psychologist William James: “A great many people think they are thinking when they merely are rearranging their prejudices” (Platt, 1989, p. 240). In light of James’s observation and the Spengler and colleagues’ (2009) disconcerting finding that training and experience do not meaningfully improve psychologists’ clinical judgment, it is easy to conclude that their styles of thinking are not significantly different from those of the general population. We assert that necessary metacognitions should mediate therapist skills while facilitating therapeutic change.

In our model, the coordination and integration of competencies are guided by the integrated deep structure. This domain is the control center of competence. It is the dynamic, interactive system of cognitive and affective resources that creates and informs successful outcome attainment. This structure encompasses the “unobservables,” including the thoughts and emotions that skills-based models often overlook. We borrow this concept from Wood and Power (1987), but we extensively elaborate on it. This structure encompasses the

“unobservables,” including the cognitive and affective processes of competence that skill-based models often overlook. In our conceptualization, this domain consists of five metacognitions: (a) purposefulness, (b) motivation, (c) selection, (d) sequencing, and (e) timing.

Purposefulness. Purposefulness requires professionals to direct all job-related activities toward attaining predetermined outcomes. For counselors, purposefulness entails intentionally structuring sessions and employing interventions to promote therapeutic change. Regardless of their theoretical orientation, counselors who explicitly develop and understand the rationale behind their actions throughout the therapeutic process increase the likelihood of competent practice. Acting purposefully means that therapists reflect deeply between sessions and utilize supervision and consultation meaningfully to help them best guide therapy intentionally. Therapists choose their words carefully so that each intervention is maximally beneficial.

Motivation. Motivation encompasses professionals’ degree, type, and source of effort devoted to attaining predetermined outcomes. Degree refers to the duration and intensity of professionals’ energy in working toward predetermined outcomes, and type indicates the target area of professionals’ motivation (e.g., academics, competence, etc.; Bandura, 1996; McClelland, 1985; McClelland, Atkinson, Clark, & Lowell, 1976; Sternberg, 1998). Source indicates whether effort is intrinsic or extrinsic (Amabile, 1996; Sternberg & Lubart, 1996). Often counselors’ degree of motivation changes when issues like burnout, countertransference, and anxiety surface. Counselors also may be differentially motivated in attending to the therapeutic process; a counselor might focus solely on confrontation at the expense of the counselor–client relationship, for example. When counselors are motivated to attain predetermined outcomes, they not only better manage the therapeutic process but also strive to overcome obstacles that might otherwise prevent positive change. Competent counselors have a nuanced understanding of themselves and their motivations. When issues of burnout, countertransference, and anxiety arise, therapists ought to have well-developed, healthy mechanisms for coping and receiving support to ensure that they can replenish themselves and continue to serve their clients effectively.

Selection. Selection involves professionals’ deciding which competencies to use and not to use given the circumstances facing them. Merely possessing the ability to execute competencies is not enough: Professionals must identify and employ only those competencies that are relevant, usually with the aid of predetermined outcomes and a coherent map. Counselors in particular

must select competencies appropriate to individual needs to help foster therapeutic change. This selection often entails an awareness of clients' culture, avoidance of generalizations, and knowledge of between- and within-group differences. An example is employing the use of therapeutic confrontation. Selecting this intervention entails much more than knowing the words to pose a challenge to a client. Competent therapists select confrontation only when they have considered the range of effects as well as contextual variables that may increase or decrease the effectiveness of the intervention. Competent therapists consider an array of interventions and select the ones that have the highest likelihood of positively affecting therapeutic outcomes.

Sequencing. Sequencing refers to professionals' ability to execute the selected competencies in an order that fosters the attainment of predetermined outcomes. Counselors who select relevant competencies but apply them out of order are at risk for failing to facilitate positive change in their clients. Consider a counselor who decides first to confront a client, then worries about developing rapport. Although the counselor might have selected confrontation and relationship development properly, sequencing them in this manner could hinder the counselor's and client's productive work together or even drive the client to early termination. To properly sequence competencies, competent counselors monitor the progress of therapy, attend to clients' needs, and regularly analyze the therapeutic relationship.

Timing. Timing requires pacing the execution of selected competencies. This pace should maximize the chance of attaining predetermined outcomes. In counseling, competent practitioners must attend to the timing of their interventions, which depends on factors such as the state of the therapeutic relationship and clients' needs. For example, competent practitioners may space confrontations to give clients time to process issues and foster the rebuilding of rapport. Without this time allowance, clients may feel attacked or overwhelmed and prematurely terminate counseling. A compelling example of the importance of timing comes from the experience of the second author of this article during her graduate training. As she recalls, a student brought in an audio tape from a session in which he demonstrated a skillful example of an empty chair technique with a client who presented with substance abuse issues. The faculty member and class were mesmerized by the adroitness with which the student implemented the technique. When the tape concluded, the student was asked what had happened in therapy since the recording of the session, to which the student replied that the client had dropped out of therapy immediately following the session. One explanation is that the counselor mistimed the client's readiness for the intervention.

Microskills

In our model, microskills are the building blocks of counseling competencies, which in turn, form the larger subsets of counseling competence. Just as each competency in the model serves a distinct purpose, each microskill serves a distinct purpose—one that ultimately contributes to therapeutic change. A microskill without a distinct purpose is useless and, therefore, irrelevant to therapeutic change. As the overarching umbrella, counseling competence necessitates that each microskill not only has a distinct purpose but aligns itself with the purpose of the competency or competencies of which it is subordinate. The alignment mirrors how each counseling competency aligns itself with the superordinate purpose of counseling competence.

Although an exhaustive detailing of microskills here is not possible given the scope and focus of our contribution and page limitations, we recognize microskills as the basic tools that, when executed intentionally and in the context of the other facets of our model, contribute to the facilitation of therapeutic change. For example, when considering the third competency in our model—building the therapeutic alliance—we conceptualize a wide array of microskills that formulate this competency. Examples include—but certainly are not limited to—demonstrating empathy, orienting clients to therapy, and engaging in active listening. None of these microskills independently facilitate therapeutic change, nor, for that matter, does the single competency. Yet we acknowledge the importance of microskills even as we seek to deepen understanding and facilitate a discourse that moves beyond a microskills-only approach in the field. .

Guidelines for Expanding and Clustering Microskills. Our model of counseling competence is a blueprint in need of further elaboration. Expanding the number of microskills and clustering them within the counseling competencies makes the model a more valuable resource. Here are ten guidelines to achieve these ends.

1. *Determine how the current compendium of microskills supports the various counseling competencies.* The microskills for which the field already is familiar range in their application. Some may support a limited number of competencies, whereas others support a larger number. Determining where and how the current microskills fit into the model is the first step in continuing our understanding of counseling competence.

2. *Develop new microskills.* Once we fit existing microskills into the model of counseling competence, we can begin to expand the number of microskills. As a reminder, current microskills do not cover the full range of skills indicative of counseling competence (Ridley et al., in press [this issue]). Because

counseling competence is complex and multilevel, the full potential of our model has yet to be realized. We believe that many more microskills can be identified and developed.

3. Specify a distinct purpose for each new microskill. A microskill's purpose is the objective for which it exists. If we cannot specify a microskill's purpose, we should neither expect a sound definition to come forth nor ascertain how it is integral to counseling competence. In specifying the distinct purposes of microskills, on the other hand, professionals are less likely to define them ambiguously and more likely to clarify the differences between them.

4. Clearly define new microskills. If we give unclear, ambiguous definitions of microskills, professionals will be unable to get maximal utility out of them. A good rule is to use simple, concise, and straightforward language. Then, avoid poor word selection and complicated sentence structure (Henson, 1991). In essence, write with precision so that readers are not confused by what we mean.

5. Cluster microskills appropriately under more than one counseling competency. The distinct purpose of some microskills makes them relevant to multiple competencies. The most important factor in clustering is the alignment of purpose: Cluster microskills under counseling competencies in which the microskills' distinctive purpose aligns with the distinctive purpose of the counseling competencies in which it is subordinate.

6. Develop microskills that incorporate culture into counseling competence. As previously noted, the role of culture is ancillary in many microskills (Ridley et al., in press [this issue]). New microskills specifically designed to use culture in promoting therapeutic change are necessary. Examples of such skills are assessing acculturation (Fontes, 2008), cultural confrontation (Ridley, Ethington, & Heppner, 2008), and cultural empathy (Ridley & Udipi, 2002).

7. Develop new sets of microskills for counseling competencies for which current microskills are not applicable. We hope that our model of counseling competence sheds new light on competencies, and we believe these competencies deserve further elucidation. Because the number of current microskills is limited, those that we now know and use may not be helpful in elucidating some of the model's competencies. The solution to this problem is the development of new sets of applicable microskills.

8. Develop microskills that are cognitive and affective in nature in addition to those that are behavioral. Clearly, this guideline represents a departure from the microskills tradition, which almost exclusively has emphasized the prescription of concrete counselor behavior. Defining prescriptions of clinicians' meta-cognitive and affective processes in all likelihood presents a challenge. In our opinion, this is an exciting frontier in counselor training.

9. *Collaborate with other professionals.* Collaboration increases the chances of harnessing the best ideas. Scholars who work in the academy join forces with clinicians who work on the front lines of professional practice. Psychologists should initiate collaborations with professionals from other disciplines and specialties. The important principle here is to advance the understanding of counseling competence based on collective insights of professionals.

10. *Provide case vignettes.* Brief scenarios of counseling can be illuminating, and they are a hallmark of the microskills training. Vignettes bring to life the real world of clinical practice. They are excellent resources for skill acquisition in that trainees can model concrete examples of counselor behavior.

Examples of Clustering Microskills. We draw on the recent work of the progenitor of microskills to illustrate clustering in our model (Ivey & Ivey, 2007). The authors identify 14 microskills—six of which are framed as basic listening skills, seven of which are framed as influence skills, and one of which is famed as a combined skilled. We select several of the skills to demonstrate clustering.

Reflecting feelings. The purpose of this microskill is to make the “implicit, sometimes hidden emotions explicit and clear to the client” (Ivey & Ivey, 2007, p. 89). By making feelings explicit, counselors are presumed to facilitate greater clients’ self-awareness. In our model, reflecting feelings is relevant to a number of counseling competencies and possibly most of them. Building a therapeutic alliance, for instance, requires reflection of feelings. As clients disclose their true feelings, they increase their trust in the therapist who provides clarification and affirmation of their feelings.

Terminating therapy is another competency in which reflection of feelings is relevant. Clients often harbor deep feelings about therapy moving toward closure. Sometimes they develop deep attachments to their therapists, and termination may conjure up feelings of loss and separation. Surmounting obstacles is yet another competency requiring therapists to skillfully reflect feelings. As clients work through difficult issues or face impasses, the sheer intensity of the working through is an opportunity for therapists to prevent clients from avoiding or repressing painful emotions.

Directives. The purpose of this microskill is to lead clients into following strategies and actions suggested by the therapist. Ivey and Ivey (2007) indicate that this skill is central to cognitive-behavioral therapy and assertiveness training. We agree with the authors. However, we suggest that giving directives applies to any intervention and, therefore, it is generally applicable to the competency of using therapeutic techniques. The purpose of an intervention is to get clients to change some aspect of their behavior and lifestyle choices.

According to Ivey and Ivey, directives provide clients with clear and useful instructions in applying new ways of thinking to their daily lives.

Conclusion

Building on our previous work (Ridley et al., in press [this issue]), we heeded the call to the profession: Improve both training and counseling outcomes by proposing a definition and complex model of counseling competence. We explicated the principles that undergird our model and the superordinate and subordinate competencies essential to counseling competence. We affirmed the importance of microskills and explained how they integrate into our model as building blocks of counseling competencies. Integral to our model also is the integrated deep structure, of which our elaboration is unique to discussions of counseling competence. This structure compels counselors to practice with intention and conscientiousness, and it taps into their cognition and affect. These themes must become a part of training models and curricula.

We realize that much work remains. Our model of counseling competence is a blueprint, not a final product. It should be critically examined, empirically tested, revised as warranted, and further developed. New microskills must be developed and clustered under the various counseling competencies. The microskills and competencies must be defined with prescriptions of how counselors should behave, think, and process their feelings. The continual linkage of counselors' thoughts, feelings, and actions to therapeutic change is paramount in these endeavors. Our intention is to contribute to an ongoing conversation about the interface of counseling competence, training in counseling, and therapeutic outcomes. We invite our colleagues and students to participate in this worthwhile conversation.

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References

Amabile, T. M. (1996). *Creativity in context*. Boulder, CO: Westview.

- American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.
- American Psychological Association. (2002). Ethical principles and code of conduct. *American Psychologist, 57*, 1060–1073.
- American Psychological Association. (2005). *Report of the 2005 Presidential Task Force on Evidence-Based Practice*. Washington, DC: Author.
- Andrusyna, T. P., Luborsky, L., Pham, T., & Tang, T. Z. (2006). The mechanisms of sudden gains in supportive–expressive psychotherapy for depression. *Psychotherapy Research, 16*, 526–536.
- Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*, 42–78.
- Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133–178). Washington, DC: American Psychological Association.
- Bandura, A. (1996). *Self-efficacy: The exercise of control*. New York, NY: Freeman.
- Barber, J. P., Sharpless, B. A., Klostermann, S., & McCarthy, K. S. (2007). Assessing intervention competence and its relation to therapy outcome: A selected review derived from the outcome literature. *Professional Psychology: Research and Practice, 38*, 493–500.
- Barnett, J. E. (2007). In search of competence: Are we there yet? *Professional Psychology: Research and Practice, 38*, 510–514.
- Barnett, J. E., Doll, B., Younggren, J. N., & Rubin, N. J. (2007). Clinical competence for practicing psychologists: Clearly a work in progress. *Professional Psychology: Research and Practice, 38*, 510–517.
- Bein, E., Anderson, T., Strupp, H., Henry, W., Schact, T., Binder, J., & Butler, S. (2000). The effects of training in time-limited dynamic psychotherapy: Changes in therapeutic outcome. *Psychotherapy Research, 10*, 119–132.
- Bent, R. J. (1992). The professional core competency areas. In R. L. Peterson, J. D. McHolland, R. J. Bent, E. Davis-Russell, G. E. Edwall, E. Magidson, K. Polite, D.L. Singer, & G. Stricker (Eds.), *The core curriculum in professional psychology* (pp. 77–81). Washington, DC: American Psychological Association and National Council of Schools of Professional Psychology.
- Bent, R. J., & Peterson, R. L. (1998). The core competency curriculum for the professional psychology model: Implications and implementation. In R. L. Peterson, D. R. Peterson, J. C. Abrams, et al. (Eds.), *Standards for education in professional psychology: Reflections and integration* (pp. 118–139). Washington, DC: American Psychological Association and National Council of Schools of Professional Psychology.

- Berardi-Coletta, B., Buyer, L. S., Dominowski, R. L., & Rellinger, E. R. (1995). Metacognition and problem solving: A process-orientated approach. *Journal of Experimental Psychology: Learning, Memory, and Cognition*, *21*, 205–223.
- Bieschke, K. J., Fouad, N. A., Collins, F. L., & Halonen, J. S. (2004). The scientifically-minded psychologist: Science as a core competency. *Journal of Clinical Psychology*, *60*, 713–723.
- Binder, J. L. (2004). *Key competencies in brief dynamic psychotherapy: Clinical practice beyond the manual*. New York, NY: Guilford.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, Practice, Training*, *16*, 252–260.
- Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13–37). New York, NY: Wiley.
- Borkovec, T. D., & Sharpless, B. (2004). Generalized anxiety disorder: Bringing cognitive behavior therapy into the valued present. In S. Hayes, V. Follette, & M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavior tradition* (pp. 209–242). New York, NY: Guilford.
- Bourg, E. F., Bent, R. J., McHolland, J. D., & Stricker, G. (1989). Standards and evaluation in education and training of professional psychologists: The National Council of Professional Psychology Mission Bay Conference. *American Psychologist*, *44*, 66–72.
- Brammer, L. M., Abrego, P. J., & Shostrom, E. L. (1993). *Therapeutic counseling and psychotherapy: Fundamentals of counseling and psychotherapy* (6th ed.). Englewood Cliffs, NJ: Prentice Hall.
- Byars-Winston, A. M., & Fouad, N. (2006). Metacognitions and multicultural competence: Expanding the culturally appropriate career counseling model. *The Career Development Quarterly*, *54*, 187–201.
- Committee on Accreditation. (1996). *Guidelines and principles for the accreditation of programs in professional psychology*. Washington, DC: American Psychological Association.
- Committee on Accreditation. (2002). *Guidelines and principles for the accreditation of programs in professional psychology*. Washington, DC: American Psychological Association.
- Cormier, S., & Hackney, H. (2005). *Counseling strategies and interventions* (6th ed.). Boston, MA: Pearson.
- Covey, S. (1990). *The seven habits of highly effective people: Powerful lessons in personal change*. New York, NY: Fireside.
- Davidson, J. E., & Sternberg, R. J. (1998). Smart problem solving: How metacognition helps. In D. J. Hacker, J. Dunlosky, & A. C. Graesser (Eds.), *Metacognition in educational theory and practice* (pp. 47–68). Mahwah, NJ: Lawrence Erlbaum.

- Doll, B. (2007). How do we know when we have found competence? *Professional Psychology: Research and Practice*, 38, 514–516.
- Dominowski, R. L. (1998). Verbalization and problem solving. In D. J. Hacker, J. Dunlosky, & A. C. Graesser (Eds.), *Metacognition in educational theory and practice* (pp. 25–45). Mahwah, NJ: Lawrence Erlbaum.
- Draguns, J. G. (1989). Dilemmas and choices in cross-cultural counseling: The universal versus the culturally distinctive. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (3rd ed., pp. 3–21). Honolulu: University of Hawaii Press.
- Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *Journal of the American Medical Association*, 287, 226–235.
- Fantuzzo, J. W. (1984, Winter). Mastery: A competency-based training model for clinical psychologists. *The Clinical Psychologist*, 37(1), 29–30.
- Fantuzzo, J. W., Sisemore, T. A., & Spradlin, W. H. (1983). A competency-based model for teaching skills in the administration of intelligence tests. *Professional Psychology: Research and Practice*, 14, 224–231.
- Fauth, J., Gates, S., Vinca, M. A., Boles, S., & Hayes, J. A. (2007). Big ideas for psychotherapy training. *Psychotherapy: Theory, Research, Practice, Training*, 44, 384–391.
- Fauth, J., & Williams, E. N. (2005). The in-session self-awareness of therapist-trainees: Hindering or helpful? *Journal of Counseling Psychology*, 52, 443–447.
- Flexner, S. B. (Ed.). (1987). *Random House dictionary of the English language* (2nd ed.). New York, NY: Random House Reference.
- Fontes, L.A. (2008). *Interviewing clients across cultures: A practitioner's guide*. New York, NY: Guilford.
- Fouad, N. A., Hatcher, R. L., Hutchings, P. S., Collins, F. L., Grus, C. L., Kaslow, N. J., . . . Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology*, 3, S5–S26.
- Gaston, L., Marmar, C. R., Thompson, L. W., & Gallagher, D. (1988). Relation of patient pretreatment characteristics to the therapeutic alliance in diverse psychotherapies. *Journal of Consulting and Clinical Psychology*, 56, 483–489.
- Georghiades, P. (2004). From the general to the situated: Three decades of metacognition. *International Journal of Science Education*, 26, 365–383.
- Goodyear, R. K. (1997). Psychological expertise and the role of individual differences: An exploration of issues. *Educational Psychology Review*, 9, 251–265.
- Greenson, R. R. (1965). The working alliance and transference neurosis. *Psychoanalytic Quarterly*, 34, 155–181.
- Hacker, D. J. (1998). Definitions and empirical foundations. In D. J. Hacker, J. Dunlosky, & A. C. Graesser (Eds.), *Metacognition in educational theory and practice* (pp. 1–23). Mahwah, NJ: Lawrence Erlbaum.

- Halpern, D. F. (1996). *Thought and knowledge: An introduction to critical thinking* (3rd ed.). Mahwah, NJ: Lawrence Erlbaum.
- Halpern, D. F. (1998). Teaching critical thinking for transfer across domains: Dispositions, skills, structure training, and metacognitive monitoring. *American Psychologist*, *53*, 449–455.
- Helms, J., & Cook, D. (1999). *Using race and culture in counseling and psychotherapy*. Boston, MA: Allyn & Bacon.
- Henson, K. T. (1991). *Writing for publication*. Bloomington, IN; National Education Service.
- Hill, C. E., Stahl, J., & Roffman, M. (2007). Training novice psychotherapists: Helping skills and beyond. *Psychotherapy: Theory, Research, Practice, Training*, *44*, 364–370.
- Horvath, A. O. (1994). Research on the alliance. In A. O. Horvath & L. S. Greenberg (Eds.). *The working alliance: Theory, research, and practice* (pp. 259–287). New York, NY: Wiley.
- Ivey, A. E. (1971). *Microcounseling: Innovations in interviewing training*. Springfield, IL: Charles C Thomas.
- Ivey, A. E., & Ivey, M. B. (2007). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (6th ed.). Pacific Grove, CA: Brooks/Cole.
- Jennings, L., Hanson, M., Skovholt, T. M., & Grier, T. (2005). Searching for mastery. *Journal of Mental Health Counseling*, *27*, 19–31.
- Jennings, L., Sovereign, A., Bottorff, N., Mussell, M. P., & Vye, C. (2005). Nine ethical values of master therapists. *Journal of Mental Health Counseling*, *27*, 32–47.
- Kaslow, N. J. (2004). Competencies in professional psychology. *American Psychologist*, *59*, 774–781.
- Kaslow, N. J., Borden, K. A., Collins, F. L., Forrest, L., Illfelder-Kaye, J., Nelson, P. D., Rallo, J. S., Vasquez, M. J. T., & Willmuth, M. E. (2004). Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology. *Journal of Clinical Psychology*, *60*, 699–712.
- Kaslow, N. J., Collins, F. L., & Illfelder-Kaye, J. (Eds.). (2004). Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology [Special issue]. *Journal of Clinical Psychology*, *60*(7).
- Kaslow, N. J., Rubin, N. J., Bebeau, M. J., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., Portney, S. M., & Smith, I. L. (2007). Guiding principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice*, *38*, 441–451.
- Kleespies, P. M. (1998). *Emergencies in mental health practice: Evaluation and management*. New York, NY: Guilford.

- Kleiner, A. J. (2005). *Effects of counselor process change model and microskills training on counseling self-efficacy and treatment conceptualization ability* (Unpublished doctoral dissertation). Indiana University, Bloomington.
- Kottler, J. (1991). *The compleat therapist*. San Francisco, CA: Jossey-Bass.
- Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: How difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology*, 77, 1121–1134.
- Kuhn, D., & Dean, D., Jr. (2004). Metacognition: A bridge between cognitive psychology and educational practice. *Theory Into Practice*, 43, 268–273.
- Lambert, M. J. (1986). Implications of psychotherapy outcome research for eclectic psychotherapy. In J. C. Norcross (Ed.), *Handbook of eclectic psychotherapy* (pp. 436–462). New York, NY: Brunner Mazel.
- Lambert, M. J., Okiishi, J. C., Finch, A. E., & Johnson, L. D. (1998). Outcome assessment: From conceptualization to implementation. *Professional Psychology: Research and Practice*, 29, 63–70.
- Leigh, I. W., Smith, I. L., Bebeau, M. J., Lichtenberg, J. W., Nelson, P. D., Portnoy, S., Rubin, N. J., & Kaslow, N. J. (2007). Competency Assessment models. *Professional Psychology: Research and Practice*, 38, 463–473.
- Lichtenberg, J. W., Portnoy, S., Bebeau, M. J., Leigh, I. W., Nelson, P. D., Rubin, N. J., . . . Kaslow, N. J. (2007). Challenges to the assessment of competence and competencies. *Professional Psychology: Research and Practice*, 38, 474–478.
- Luborsky, L., Digeur, L., Seligman, D. A., Rosenthal, R., Krause, E. D., Johnson, S., . . . Schweizer, E. (1999). The researcher's own psychotherapy allegiances: A "wild card" in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice*, 6, 95–106.
- Luborsky, L., McLellan, A. T., Diguier, L., Woody, G., & Seligman, D. A. (1997). The psychotherapist matters: Comparison of outcomes across twenty-two therapists and seven patient samples. *Clinical Psychology: Science and Practice*, 4, 53–65.
- Marrelli, A. F., Tondora, J., & Hoge, M. (2005). Strategies for developing competency models. *Administration and Policy in Mental Health*, 32, 533–561.
- Masterpasqua, F. (1989). A competence paradigm for psychological practice. *American Psychologist*, 44, 1366–1371.
- McClelland, D. C. (1985). *Human motivation*. New York, NY: Scott Foresman.
- McClelland, D. C., Atkinson, J. W., Clark, R. A., & Lowell, E. L. (1976). *The achievement motive*. New York, NY: Irvington.
- McNamara, J. R. (1975). An assessment proposal for determining the competence of professional psychologists. *Professional Psychology: Research and Practice*, 6, 135–139.

- Mish, F. C. (Ed.). (1984). *Webster's ninth new collegiate dictionary*. Springfield, MA: Merriam-Webster.
- Moore, B. N., & Parker, R. (1995). *Critical thinking* (4th ed.). Mountain View, CA: Mayfield.
- Morran, D. K. (1986). Relationship of counselor self-talk and hypothesis formulation to performance level. *Journal of Counseling Psychology, 33*, 395–400.
- Morran, D. K., Kurpius, D. J., Brack, C. J., & Brack, G. (1995). A cognitive-skills model for counselor training and supervision. *Journal of Counseling and Development, 73*, 384–389.
- Nuttall, J. (2002). Modes of therapeutic relationship in brief dynamic psychotherapy: A case study. *Psychodynamic Practice, 8*, 505–523.
- O'Byrne, K., Clark, R. E., & Malakuti, R. (1997). Expert and novice performance: Implications for clinical training. *Educational Psychology Review, 9*, 321–332.
- O'Byrne, K. R., & Goodyear, R. K. (1997). Client assessment by novice and expert psychologists: A comparison of strategies. *Educational Psychology Review, 9*, 267–278.
- Parry, S. R. (1996). The quest for competencies. *Training, 33*, 48–56.
- Peterson, D. R., & Bry, B. H. (1980). Dimensions of perceived competence in professional psychology. *Professional Psychology: Research and Practice, 11*, 965–971.
- Platt, S. (Ed.). (1989). *Respectfully quoted: A dictionary of quotations requested from the Congressional Research Service*. Washington, DC: Library of Congress.
- Prochaska, J. O. (1999). How do people change, and how can we change to help more people? In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 227–255). Washington, DC: American Psychological Association.
- Rescher, N. (1998). *Complexity: A philosophical overview*. New Brunswick, NJ: Transaction.
- Ridley, C. R. (2005). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention* (2nd ed.). Thousand Oaks, CA: Sage.
- Ridley, C. R., Baker, D. M., & Hill, C. L. (2001). Critical issues concerning cultural competence. *The Counseling Psychologist, 29*, 822–832.
- Ridley, C. R., Ethington, L. L., & Heppner, P. P. (2008). Cultural confrontation: A skill of advanced cultural empathy. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (6th ed., pp. 377–393). Thousand Oaks, CA: Sage.
- Ridley, C. R., Kelly, S., & Mollen, D. (in press [this issue]). Microskills training: Evolution, reexamination, and call for reform. *The Counseling Psychologist*.

- Ridley, C. R., & Shaw-Ridley, M. (2010). Termination within the context of culture: A three-phase model. In M. M. Leach & J. D. Aten (Eds.), *Culture and the therapeutic process: A guide for mental health professionals* (pp. 201–227). New York, NY: Routledge.
- Ridley, C. R., & Udipi, S. (2002). Putting cultural empathy into practice. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (5th ed., pp. 317–333). Thousand Oaks, CA: Sage.
- Rodolfa, E., Bent, R., Eisman, E., Nelson, P., Rehm, L., & Richie, P. (2005). A cube model for competency development: Implications for psychology educators and regulators. *Professional Psychology: Research and Practice, 36*, 347–354.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95–103.
- Romainville, M. (1994). Awareness of cognitive strategies: The relationship between university students' metacognition and their performance. *Studies in Higher Education, 19*, 359–366.
- Rubin, N. J., Bebeau, M., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., Portnoy, S., . . . Kaslow, N. J. (2007). The competency movement within psychology: An historical perspective. *Professional Psychology: Research and Practice, 38*, 452–462.
- Sachs, J. (Trans.). (1999). *Aristotle's metaphysics*. Santa Fe, NM: Green Lion.
- Sakai, P. S., & Nasserbakht, A. (1997). Counselor development and cognitive science models of expertise: Possible convergences and divergences. *Educational Psychology Review, 9*, 353–359.
- Schulte, A. C., & Daly, E. J. (2009). Operationalizing and evaluating professional competencies in psychology: Out with the old, in with the new? *Training and Education in Professional Psychology, 3*, S54–S58.
- Sexton, T. L., Ridley, C. R., & Kleiner, A. J. (2004). Beyond common factors: Multi-level-process models of therapeutic change in marriage and family therapy. *Journal of Marital & Family Therapy, 30*, 131–149.
- Sexton, T. L., Whiston, S. C., Bleuer, J. C., & Walz, G. R., (1997). *Integrating outcome research into counseling practice and training*. Alexandria, VA: American Counseling Association.
- Shaw, B. F., & Dobson, K. S. (1988). Competency judgments in the training and evaluation of psychotherapists. *Journal of Consulting and Clinical Psychology, 56*, 666–672.
- Sitko, B. M. (1998). Knowing how to write: Metacognition and writing instruction. In D. J. Hacker, J. Dunlosky, & A. C. Graesser (Eds.), *Metacognition in educational theory and practice* (pp. 93–115). Mahwah, NJ: Lawrence Erlbaum.
- Skovholt, T. M., & Jennings, L. (2005). Mastery and expertise in counseling. *Journal of Mental Health Counseling, 27*, 13–18.

- Skovholt, T. M., & Ronnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development, 30*, 44–58.
- Spengler, P. M., White, M. J., Ægisdottir, S., Maugherman, A. S., Anderson, L. A., Cook, R. S., . . . Rush, J. D. (2009). The meta-analysis of clinical judgment project: Effects of experience on judgment accuracy. *The Counseling Psychologist, 37*, 350–399.
- Spruill, J., Rozensky, R. H., Stigall, T. T., Vasquez, M., Bingham, R. P., & Olvey, C. D. (2004). Becoming a competent clinician: Basic competencies in intervention. *Journal of Clinical Psychology, 60*, 741–754.
- Stein, D. M., & Lambert, M. J. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced? *Journal of Consulting and Clinical Psychology, 63*, 182–196.
- Sternberg, R. J. (1998). Abilities are forms of developing expertise. *Educational Researcher, 27*, 11–20.
- Sternberg, R. J., & Lubart, T. I. (1996). Investing in creativity. *American Psychologist, 50*, 912–927.
- Stigall, T. T., Bourg, E. F., Bricklin, P. M., Kovacs, A. L., Larsen, K. G., Lorion, R. P., . . . Wiens, A. N. (Eds.). (1990). *Report of the Joint Council on Professional Education in Psychology*. Baton Rouge, LA: Land & Land.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, 477–486.
- Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*(2), 45–52.
- Sullivan, M. F., Skovholt, T. M., & Jennings, L. (2005). Master therapists' construction of the therapy relationship. *Journal of Mental Health Counseling, 27*, 48–70.
- Sumerall, S. W., Lopez, S. J., & Oehlert, M. E. (2000). *Competency-based education and training in psychology: A primer*. Springfield, IL: Charles C Thomas.
- Swanson, H. L. (1990). Influence of metacognitive knowledge and aptitude on problem solving. *Journal of Educational Psychology, 82*, 306–314.
- Taraban, R., Rynearson, K., & Kerr, M. S. (2000). Metacognition and freshman academic performance. *Journal of Developmental Education, 24*, 12–17.
- Truax, C. B., & Carkhuff, R. R. (1967). *Toward effective counseling and psychotherapy: Training and practice*. Chicago, IL: Aldine.
- Tyler, J. D., & Weaver, S. H. (1981). Evaluating the clinical supervisee: A survey of practices in graduate training programs. *Professional Psychology: Research and Practice, 12*, 434–437.

- Vakoch, D. A., & Strupp, H. H. (2000). The evolution of psychotherapy training: Reflections on manual-based learning and future alternatives. *Journal of Clinical Psychology, 56*, 309–318.
- Willis, S. L., & Dubin, S. S. (Eds.). (1990). *Maintaining professional competence*. San Francisco, CA: Jossey-Bass.
- Wood, R., & Power, C. (1987). Aspects of the competence-performance distinction: Educational, psychological and measurement issues. *Journal of Curriculum Studies, 19*, 409–424.

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