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ORIGINAL ARTICLE

WILEY

What do laypersons believe characterises a competent psychotherapist?

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Abstract

Aim: Although research and clinical definitions of psychotherapeutic competence have been proposed, less is known about the layperson perspective. The aim was to explore the views of individuals with different levels of psychotherapy experience regarding what—in their views—constitutes a competent therapist.

Method: In an online survey, 375 persons (64% female, mean age 33.24 years) with no experience, with professional experience, or with personal pre-experience with psychotherapy participated. To provide low-threshold questions, we first presented two qualitative items (i.e. "In your opinion, what makes a good/competent psychotherapist?"; "How do you recognize that a psychotherapist is not competent?") and analysed them using inductive content analysis techniques (Mayring, 2014). Then, we gave participants a 16-item questionnaire including items from previous surveys and from the literature and analysed them descriptively.

Results: Work-related *principles*, *professionalism*, *personality* characteristics, caring *communication*, *empathy and understanding* were important categories of competence. Concerning the quantitative questions, most participants agreed with items indicating that a therapist should be open, listen well, show empathy and behave responsibly.

Conclusion: Investigating layperson perspectives suggested that effective and professional interpersonal behaviour of therapists plays a central role in the public's perception of psychotherapy.

KEYWORDS

client preferences, expectancies, psychotherapeutic competencies, psychotherapy process, public involvement

1 | INTRODUCTION

Cognitive and emotional aspects such as stereotypes, negative attitudes or anxieties regarding mental health providers have an impact on the motivation to seek treatment (von Sydow, 2007). According to a survey by the World Health Organization regarding mild-to-moderate mental disorders, negative attitudes towards treatment (e.g. perceived ineffectiveness) were more often barriers to adequate care than structural reasons (e.g. costs), and approximately 30% of severely ill patients dropped out of treatment due to negative experiences

with their treatment providers (Andrade et al., 2014). Self-perceived health, duration and severity of symptoms, comorbidity and disability are among the most consistent factors associated with the use of mental health services (Magaard, Seeralan, Schulz, & Brütt, 2017; Roberts et al., 2018), whereas negative attitudes and beliefs seem to impede receiving adequate support (Magaard et al., 2017). Moreover, many (especially older) laypersons seem to have incomplete knowledge about psychotherapy and how it differs from psychiatry or counselling (Patel, Caddy, & Tracy, 2018; von Sydow, 2007). Not only the perspectives of those who are affected, but also of their relatives and of other healthcare providers are crucial to the recognition of mental disorders, to psychotherapy access and thus to reducing the risk for chronification (Jorm, 2012; von Sydow, 2007).

In this context, different theoretical concepts are relevant. First of all, psychotherapeutic *competence* includes a therapist's general and treatment-specific *knowledge* and *skills*, as well as his/her *values* or *attitudes* while implementing interventions (Barber, Sharpless, Klostermann, & McCarthy, 2007; Muse & McManus, 2016; Roth & Pilling, 2007; Waltz, Addis, Koerner, & Jacobson, 1993). From the perspective of cognitive behavioural therapists, competence is a "complex and fuzzy" concept (p. 246), which refers to the "therapists' ability to deliver techniques skilfully, flexibly and appropriately in line with the individual patient's formulation, CBT theory and research" (p. 250; Muse & McManus, 2016). To date, less is known about layperson perspectives on this concept. In accordance, "therapist *credibility* refers to a patient's belief about a given practitioner's ability to help, often conceptualized as expertness, trustworthiness, and attractiveness" (Constantino, Coyne, Boswell, Iles, & Vîslă, 2018, p. 487).

Third, *role preferences* include "the behaviors and activities that clients desire themselves and their therapists to engage in while in therapy", *therapist preferences* include "characteristics that clients hope their therapists will possess" and *treatment preferences* involve "specific desires for the type of intervention that will be used" (Swift, Callahan, & Vollmer, 2011, p. 156). Meta-analytic results revealed that involvement in treatment decisions and meeting patient preferences was associated with lower treatment dropout, higher completion rates, better clinical outcomes and higher patient satisfaction (Lindhiem, Bennett, Trentacosta, & McLear, 2014; Swift, Callahan, Cooper, & Parkin, 2018; Swift et al., 2011).

Fourth, expectations play a crucial role. Although related, expectations may differ considerably from what patients would basically prefer (Constantino, 2012). In this respect, *outcome expectations* (regarding the personal efficacy and usefulness of treatment) may be distinguished from *treatment expectations* (e.g. concerning interventions, format, duration or roles) and *interpersonal expectations* (e.g. on expected mutual responses; Constantino, 2012; Constantino et al., 2018). An evidence synthesis by Constantino, Arnkoff, Glass, Ametrano, and Smith (2011) revealed a small but significantly positive association between pre/early-therapy outcome expectations and post-treatment outcomes.

Besides theoretical considerations (see Figure 1), it is the responsibility of clinical psychologists and researchers to provide knowledge on mental disorders, on efficacious treatments and on the roles of different providers and thus to increase mental health literacy (Jorm, 2012; Patel et al., 2018). As health systems differ between countries, a comparison of viewpoints across European countries may prove valuable. In Germany, current psychotherapy training takes three to five years, consisting of a 1200-hour placement at a psychiatry facility, a 600-hour placement at a psychosomatic facility, treating outpatients for 600 hr, theory courses totalling 600 hr, self-reflection, and regular supervision (EAP, 2020). Due to a basic change in the law, psychotherapy training will be further extended, and parts of it will be institutionalised at universities

Implications for practice

- Since less is known about the layperson perspective of what constitutes a competent therapist, we explored the views of individuals with different levels of psychotherapy experience.
- Interpersonal behaviour, personality variables and professionalism were most important for our participants.
- Regardless of whether individuals have psychotherapy experience or not, their beliefs are important to include in therapy to enhance treatment outcomes.

Implications for policy

- Including layperson perspectives may contribute to the reduction of barriers to, and misconceptions about, psychotherapy and, thus, to explaining therapy in a way that increases patients' motivation to seek treatment.

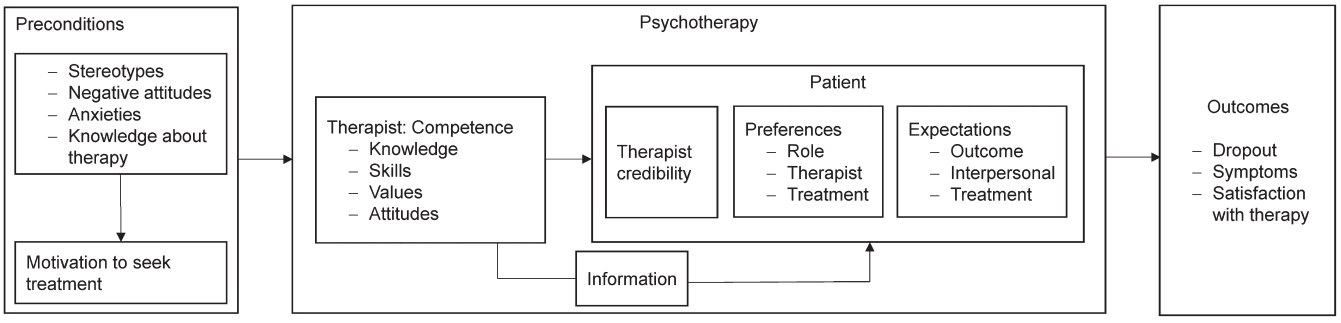

FIGURE 1 Theoretical concepts considered by the study

(PsychThApprO, 2020). In the United Kingdom, therapists with more diverse core professions (such as medicine, nursing, social work) than in Germany have access to postgraduate psychotherapy training at universities. Training continues for at least one year and includes theoretical courses and supervised placements of 200 hr each (BABCP, 2020).

Our explorative study therefore aimed to explore, on a low-threshold basis, the perspectives of laypersons on what constitutes a competent therapist. The study aimed to compare the views of laypersons from different countries (namely, English- and German-speaking countries) and of persons with various levels of psychotherapy experience (namely, no vs. professional vs. personal experience).

2 | METHOD

2.1 | Procedure

The cross-sectional study was conducted via two online platforms, a noncommercial platform (SoSci Survey; Leiner, 2019; February–April 2019) and a commercial platform (Clickworker, 2019; July 2019). We anticipated that it would be more difficult to include laypersons with little prior experience with psychology and psychotherapy and thus specifically approached this group by using the commercial platform that includes laypersons with different backgrounds. English- or German-speaking adults (≥18 years) were eligible to participate.

Regarding the noncommercial survey, the convenience sample was recruited via postings at the campuses of the University of Potsdam, the university's society campus, online marketplaces, faculty and department homepages, student representatives (other than psychology), other universities, Twitter and other social networks. Participation took an average of four minutes; no financial compensation was provided.

In contrast, the commercial participants received an expense allowance of 0.50€. They are registered within the platform, get information about different studies and then decide in which studies they wish to participate. All participants were informed about the study, the anonymous data collection and privacy, and they gave informed consent for participation. The study was approved by our university's data protection officer.

2.2 | Survey questions

To receive unbiased appraisals, we first asked the participants to answer two open-ended questions on their views of psychotherapeutic competence (i.e. "In your opinion, what makes a good/competent psychotherapist [e.g. indications, characteristics, traits]?"; "How do you recognize that a psychotherapist is not competent?") and gave them the opportunity to answer in an open format.

There are two related questionnaires that cover attitudes towards psychologists (Ashton, 2003) and perceptions of psychology in general (Rietz & Wahl, 1998). Since they are rather long (90 items: Ashton, 2003; 32 items: Rietz & Wahl, 1998) and also cover aspects unrelated to our research question, we derived items from these questionnaires, but also from publications on the scientist–practitioner model (e.g. Drabick & Goldfried, 2000; Shapiro, 2002) and from research on stereotypes regarding therapists (Prüß, Speerforck, Bahlmann, Freyberger, & Schomerus, 2014). The resulting 16 items are answered on a 4-point Likert scale (1 = strongly disagree, 4 = strongly agree; see Table 2).

Further, participants were asked for sociodemographic information (age, gender and country), asked whether they had any prior knowledge about psychology (e.g. education in the fields of psychology, medicine, nursing) and asked whether they had any previous experience with psychotherapy (e.g. as a patient, as a professional, in their family).

2.3 | Analysis of the qualitative data

Drawing on content analysis (Mayring, 2014), we inductively derived meaningful and mutually exclusive categories for the two open-ended questions separately. If the content of an answer could be assigned to multiple categories, it was split into parts. First, two independent student researchers (LPW and TP) grouped all statements of the German-speaking convenience sample to derive categories. Subsequently, ambiguous aspects were discussed with another researcher (FK) to reach consensus. The category system was then used by a third rater (PEH) who independently categorised a random sample of 20% of the answers. The random sample was used to determine agreement, and Cohen's kappa of $\kappa = 0.86$ indicated strong agreement (McHugh, 2012). During categorisation, we differentiated between participants based on whether they had any previous experience with psychotherapy.

2.4 | Analysis of the quantitative data

We first calculated descriptive statistics (means, SDs, frequencies) and then used *t* tests to identify differences on the basis of language (English- vs. German-speaking) and sample (convenience vs. commercial). Univariate ANOVAs were used to determine differences according to psychology/psychotherapy experience (no, professional, personal). Despite the exploratory nature of the analyses, we used Bonferroni correction to adjust the *p*-values to .003. All analyses were performed using Microsoft Excel and IBM SPSS Statistics 25 (IBM Corp., 2017) software.

3 | RESULTS

3.1 | Participants

Overall, 392 individuals participated in our study. We then excluded 15 participants who did not respond to any relevant item and two cases in which the participants did not comply with the instructions. Therefore, 375 (female: 64.27%, $n = 241$) individuals with a mean age of 33.24 years ($SD = 11.10$, range: 17–78) were included in our analyses (see Table 1). Participants were from Germany ($n = 208$), Austria ($n = 59$), the United Kingdom ($n = 55$), the United States ($n = 44$) and Switzerland ($n = 7$).

3.2 | Descriptive differences between the subsamples

We included three subsamples in our analyses, namely, a convenience sample and the German- and English-speaking commercial samples (Table 1). The results revealed significant differences between the samples. First, while both clickworker samples included as many men as women, the convenience sample was mostly composed of female participants ($X^2(4) = 26.03$, $p < .001$). Second, the subsamples showed significant differences in age ($F(2, 372) = 10.66$, $p < .001$). Post hoc analyses showed that the participants in the convenience sample ($M = 30.52$, $SD = 11.02$) were younger than both the German- ($M = 34.71$, $SD = 10.63$) and English-speaking clickworkers ($M = 36.40$, $SD = 10.66$), while the clickworkers did not differ significantly in age from each other. Third, the commercial and convenience samples differed significantly regarding their prior knowledge of psychology ($X^2(2) = 35.98$, $p < .001$). While most clickworkers had no prior knowledge (German: 88.24%, English: 79.20%), approximately half of the convenience sample had no prior knowledge (56.40%). A similar pattern was found for prior experience with psychotherapy ($X^2(4) = 23.44$, $p < .001$): While most clickworkers had no

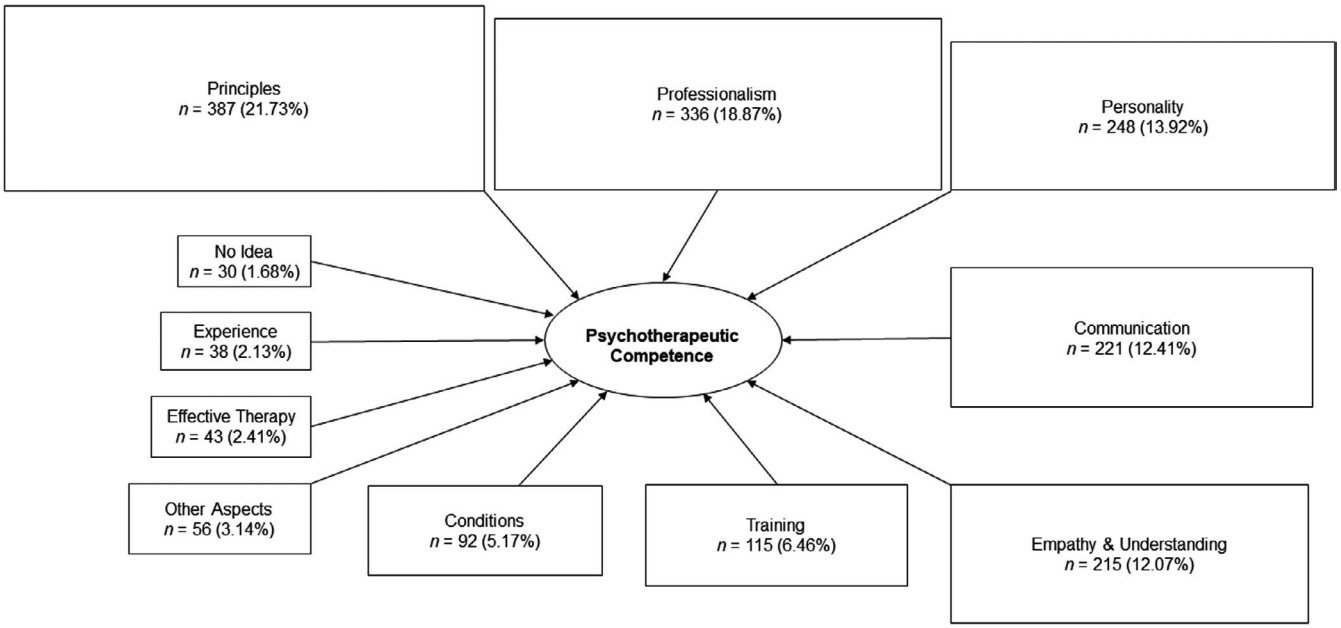

FIGURE 2 Categories derived from the qualitative data (the size of the categories is related to the number of units mentioned within each category: the largest category *Principles* is predefined as 100%, and, for example, the area of *Experience* is 10%)

TABLE 1 Sample characteristics

	Age *M* (*SD*)	Female	Psychology knowledge[a]	Psychotherapy experience[b]
Overall ($N = 375$)	33.27 (11.10)	241 (64.3%)	108 (28.80%)	159 (42.40%)
Convenience sample ($n = 172$)	30.52 (11.02)	133 (77.3%)	75 (43.60%)	96 (55.81%)
Germany ($n = 119$)	32.39 (12.14)	93 (78.2%)	51 (42.85%)	81 (68.07%)
Austria/ Switzerland ($n = 51$)	26.49 (6.32)	38 (74.5%)	24 (47.06%)	15 (29.41%)
German-speaking clickworkers ($n = 102$)	34.71 (10.63)	50 (49%)	12 (11.76%)	31 (30.39%)
English-speaking clickworkers ($n = 101$)	36.40 (10.66)	58 (57.4%)	21 (20.79%)	32 (31.68%)

Note: *n* (%).

[a]Prior knowledge about psychology (e.g. education in the fields of psychology, medicine and nursing).

[b]Pre-experience with psychotherapy (e.g. as a patient, professionally and in the family).

TABLE 2 Descriptives and ranking of the quantitative items and differences according to group

Competent psychotherapists…	*M* (*SD*)	Strongly/agree % (*n*)	Language				Psychology/psychotherapy experience				
			M_{German}	M_{Engl}	*T*	*d*	M_{none}	$M_{professional}$	$M_{personal}$	*F*	ω^2
… interact openly/without prejudices with patients.	3.78 (0.57)	96.5 (357)	3.79	3.74	0.77	−0.09	3.65	3.83	3.93	8.00*	0.04
… are listening well.	3.76 (0.56)	95.7 (354)	3.75	3.79	0.58	0.07	3.68	3.74	3.87	3.45	0.01
… are reliable.	3.71 (0.58)	95.7 (354)	3.73	3.67	0.88	−0.10	3.61	3.77	3.81	4.07	0.02
… are empathic.	3.70 (0.61)	95.2 (351)	3.72	3.66	0.92	−0.01	3.62	3.68	3.81	2.94	0.01
… behave responsibly.	3.69 (0.64)	94.9 (351)	3.69	3.69	0.02	0.00	3.56	3.77	3.85	6.86*	0.03
… attend advanced trainings.	3.43 (0.68)	91.6 (341)	3.46	3.34	1.49	−0.18	3.32	3.60	3.48	4.20	0.02
… know a lot about psychology.	3.40 (0.70)	91.0 (337)	3.32	3.60	3.78*	0.40	3.40	3.42	3.40	0.02	−0.00
… adhere to legal requirements during training.	3.16 (0.85)	79.7 (295)	2.98	3.64	8.22*	0.83	3.26	2.98	3.12	2.58	0.01
… adhere to scientific guidelines during treatment.	2.90 (0.78)	75.0 (276)	2.76	3.28	5.98*	0.70	2.94	2.94	2.87	0.32	−0.00
… have a great deal of life experience.	2.87 (0.76)	69.5 (257)	2.80	3.05	2.86	0.33	2.94	2.66	2.86	2.76	0.01
… offer different forms of psychotherapy.	2.82 (0.89)	64.1 (237)	2.68	3.19	5.64*	0.59	2.94	2.66	2.83	2.14	0.01
… have treated many patients.	2.71 (0.74)	63.0 (233)	2.61	3.00	4.76*	0.54	2.87	2.58	2.62	5.66	0.03
… conduct their own research.	2.61 (0.92)	53.0 (196)	2.46	3.02	5.76*	0.63	2.75	2.36	2.56	4.52	0.02
… appear intellectual and well-educated.	2.61 (0.87)	56.9 (210)	2.51	2.87	3.56*	0.42	2.65	2.55	2.58	0.39	−0.00
… have a doctorate degree.	2.22 (1.00)	39.3 (145)	1.91	3.08	12.58*	1.37	2.57	1.79	2.01	18.78*	0.10

Note: Cohen's $d = 0.2$ (small), 0.5 (medium), 0.8 (large effect; Cohen, 1992).

$\omega^2 = 0.01$ (small), 0.06 (medium), 0.14 (large effect; Kirk, 1996).

*$p < .003$ (Bonferroni-corrected: $p = .05/15$).

experience (German: 69.61%, English: 68.32%), a minority of the convenience sample did not have prior psychotherapeutic experience (44.19%).

3.3 | Categories derived from the open-ended questions

Overall, 365 participants answered the open-ended questions, resulting in a total of 1.781 meaningful units (for the categories, see Figure 2 and Appendix 1). Preferences for competent psychotherapists were often reflected in the answers regarding noncompetent psychotherapists; for example, participants named empathy as an important characteristic of competent psychotherapists, while they described noncompetent psychotherapists as being not empathic. To deduce an overall category system, both entries were then included in one main category (e.g. Empathy and Understanding). In the following, each category is explained in detail, examples are given for better comprehension, and the number of participants is added in brackets afterwards. German answers were translated into English.

3.3.1 | Principles

The majority of participants referred to aspects of how a psychotherapist should work with patients. This main category comprises six subcategories. *Problem Focus* includes therapeutic techniques and skills, for example, *"Being able to provide advice and tools that will help the patient feel better"*). In the subcategory *Individual Approach*, participants expressed their wish for adaptation; that is, psychotherapists should adjust therapeutic techniques to patient specifics (*"He does not stereotype and treats his patients as individuals"*). Regarding *Directiveness*, participants' answers differed: While some wanted a psychotherapist to provide concrete ideas (*"Name precise proposals for solutions"*), most participants wanted the therapist to take the lead so that the patient can develop (*"A good therapist does not tell me what I should do but rather lets me realize what to do through questions and/or tasks and does not force ideas on me"*). Further, psychotherapists are supposed to show *Transparency* by explaining therapeutic methods and approaches, providing information (*"Knowledge that is shared with the patient"*) and being consistent and comprehensible throughout all sessions. *Sincerity* refers to participants' wishes to be taken seriously (*"Gives you the feeling of being taken seriously"*). Furthermore, participants wished that *Medication* would be used only rarely (*"Someone who doesn't just prescribe drugs"*).

3.3.2 | Professionalism

Here, we categorised specific therapist behaviours that might differ from the behaviour linked with other professions. First, participants wished for *Trustworthiness* to feel protected and safe in order to talk openly about problems (*"Someone you can trust, feel at ease with quite quickly"*). *Calmness* (e.g. *"Calm presence"*) seemed to be an important characteristic since there are almost no noncompetent aspects in this subcategory. Third, participants wanted to build a stable *Therapeutic Relationship*, and there should be clear boundaries in order to prevent the relationship from becoming unprofessional (*"Does not respect the patient's boundaries, becomes intimate"*). Additionally, psychotherapists should neither take the clients' problems to heart nor be completely detached from them. Further, psychotherapists should be *Attentive* during sessions and interested in their patients (*"Takes interest in the patient"*), whereas *Self-referentiality* is unanimously seen as a characteristic associated with a lack of competence (e.g. *"Tells a lot about himself, you get the feeling that the therapist needs someone to listen to him"*). Individual participants mentioned that therapists should not put pressure on a client and should not disclose any personal information.

3.3.3 | Personality

This category describes traits and characteristics that are attributed to competent psychotherapists. Most notably, participants asked for a *neutral*, nonjudgemental psychotherapist who is not biased (*"I would recognize that a psychotherapist is not competent if they were unable to keep an open mind or came in with preconceptions"*). In the participants' view, psychotherapists need to be *friendly*, *honest*, *patient* and *appreciative*. Moreover, some participants wanted a psychotherapist to be motivating or humorous.

3.3.4 | Communication

This category includes verbal and nonverbal aspects. Statements focused on participants' wish that competent psychotherapists be good listeners, maintain eye contact, use goal-oriented questions and enable their clients to talk for most of the session (*"Asks the patient instead of making assumptions; talks less than the patient during a therapy session"*).

3.3.5 | Empathy and understanding

Participants wanted their psychotherapist to be empathic, understanding, compassionate and caring (*"Patients seek therapy because they want help and want to get better, and if their therapist isn't caring and devoted to helping that patient, the patient will never get better"*). A few participants added that noncompetent psychotherapists might only *appear* to be understanding (*"When he sees and understands the situation but cannot show personal interest"*) or could be too empathic (*"Constant validation and understanding everything"*).

3.3.6 | Training

Participants wanted psychotherapists to have graduated and completed their training in order to have (sufficient) skills, knowledge and qualifications to provide therapy (*"They should have the ability to treat my mental problems with the scientifically most current method […] a suitable degree is a good sign"*). Therapists were expected to update their knowledge and methods by taking part in advanced trainings.

3.3.7 | Conditions

In this category, participants addressed issues concerning appointments, such as rarely being able to contact a psychotherapist, as well as the attractiveness of therapy rooms, the availability of information on the Internet and the costs of therapy (*"Not calling back, poor homepage, provides little information"; "Unreasonably expensive"*). *Frequency and pace* were also mentioned, since participants felt that competent psychotherapists should adapt the number of sessions, as well as the pace within each session, to the patients' needs to help them. In contrast, psychotherapists are seen as noncompetent "if they rush them [the patients] through the conversation as if they aren't interested".

3.3.8 | Effective therapy

This category focuses on improvements in mental health and emotional well-being. Most answers related to broad outcomes (*"Helps their patients improve mental health"*); no participant addressed specific symptoms or disorders.

3.3.9 | Experience

Therapists should not only have experience in providing treatment but also have reached a certain age, according to some participants (*"Best estimated by his time in practice: the longer (older), the better"*).

3.3.10 | No idea

Some participants admitted that they had problems determining criteria for psychotherapeutic competence (*"I have no idea, since I never met one"; "All the more if you have no experience, it [competence] is not noticeable at all"*). A further participant thought about other variables that might influence outcomes (*"That is hard to say. If after some sessions I get the impression that there is no use, it is not necessarily due to competence issues"*).

3.3.11 | Other aspects

Some entries did not fit into any other category. For example, participants wanted the psychotherapist not to give up even in difficult situations, while others mentioned that one could infer competence on the basis of recommendations from physicians or other patients. Psychotherapists should not be motivated externally by financial incentives but rather motivated internally by wanting to help people. A few participants expressed a general rejection of psychology or psychotherapy (*"All are not competent. You can get this same advice from a person off of the street"*).

3.4 | Results from the quantitative survey

Most participants (>90%) agreed or strongly agreed that competent psychotherapists should be open, listen well, be reliable, show empathy and behave responsibly (Table 2). Furthermore, training, knowledge, adherence to legal and scientific guidelines, and life and therapeutic experience were important to the participants. Being a researcher, appearing educated or having a PhD degree appeared less important.

For the English-speaking participants, compared with the German-speaking participants, it was significantly more important that a psychotherapist adhered to legal requirements and scientific guidelines, had psychological and therapeutic experience, and conducted scientific research (for the individual items, see Table 2). Although the other significant differences were associated with small-to-medium effects, there were large effects regarding the adherence to legal requirements during training and concerning having a doctorate degree (Cohen, 1992).

No experience with psychology/psychotherapy was indicated by 174 (53.4%) of the participants, 99 (30.4%) mentioned personal experience (e.g. as a patient, in the family), and 53 (16.3%) indicated professional experience (e.g. in nursing, education, medicine, psychology). Altogether, there were small group differences regarding three items (see Table 2; Kirk, 1996). Post hoc analyses revealed that for participants without experience, it was less important that "The therapist interact[s] openly and without prejudices with […] patients" ($M = 3.65$) than for participants with personal psychotherapy experience ($M = 3.93$). Likewise, participants without experience agreed less with the item "The therapist behaves responsibly" ($M = 3.56$) than individuals with personal experience ($M = 3.85$). In contrast, it was more important for participants without experience ($M = 2.57$) than for participants with personal ($M = 2.01$) and with professional psychotherapy experience ($M = 1.79$) that the psychotherapist should have a doctorate degree.

4 | DISCUSSION

Despite different theoretical and empirical contributions, relatively little is known about the beliefs of laypersons of what characterises a competent therapist. As their concepts are crucial for their motivation to seek treatment, the main aim of our study was to explore laypersons' concepts of psychotherapists. As indicated by both methodological approaches, interpersonal behaviour,

personality variables and professionality were the most important characteristics of a competent psychotherapist. Self-referentiality was mentioned as a clear sign of incompetence—interestingly, more often by those with psychotherapy experience. Our survey focused on the therapist as a person, as reflected in the participants' answers. In accordance, other research has shown that variables such as empathy, alliance, collaboration or verbal and nonverbal communication have been correlated with client outcomes (e.g. Heinonen & Nissen-Lie, 2019; Hill, Spiegel, Hoffman, Kivlighan, & Gelso, 2017).

Although therapists' training and experience were generally less important to the participants, it was mentioned more often by those without psychotherapy experience. Most likely, they relied more on external information that is also available on the Internet or in therapist databases. Nevertheless, relying exclusively on credentials is inadequate since in most countries, a range of professionals can provide psychotherapy and the extent of pre- and post-qualification training varies considerably (Roth & Pilling, 2007; Strauß & Kohl, 2009). Furthermore, expertise is not the same as experience per se (Hill et al., 2017), and patients of experienced therapists do not necessarily benefit more from therapy (Goldberg et al., 2016). Therefore, a competence-based approach to training and supervision is the state of the art from a research perspective (Falender & Shafranske, 2009; Roth & Pilling, 2007). In addition, the effectiveness of former patient treatment was mentioned only occasionally as an indication of therapeutic competence by the laypersons. It is difficult to obtain reliable, trustworthy and publicly available information, and the criteria for effectiveness may differ dependent on the perspective (Brütt et al., 2017). Nonetheless, the criteria proposed by Hill et al. (2017), such as symptom change, quality of life, treatment dropout, sick leave or interpersonal functioning, may be rated as relevant by patients and professionals alike. Apart from that, therapy outcomes are not directly related to therapeutic competence, as a variety of variables, such as patient impairment, living conditions, therapy stage or the timing of interventions, all play a vital role (Waltz et al., 1993).

One further objective of the present study was to compare the views of English- and German-speaking laypersons. Participants from English-speaking countries appreciated the adherence to legal and scientific guidelines, as well as a therapist's knowledge, experience and own research, more than the German-speaking laypersons. Although structured doctorate programmes in clinical psychology combining therapeutic and scientific training are established in English-speaking countries, they are not common in German-speaking countries.

Overall, from the participating laypersons' perspective, research experience as a sign of competence was not considered highly important. In a community study, mistrust in medical research was found to be more prevalent among persons from minority or disadvantaged groups or, sadly, among those with research experience (Smirnoff et al., 2018). The results indicate that the advantages of research for clinical practice are not always obvious to laypersons, and the scientist–practitioner gap (Teachman et al., 2012) suggests that the problem is relatively large. Beyond, weighted against the empirical evidence of treatments, future patients specifically emphasised the role of the therapeutic relationship and of therapist empathy and experience (Swift & Callahan, 2010). In comparison, future studies could investigate the perceptions of patients that completed appropriately delivered evidence-based psychotherapy.

4.1 | Limitations

As a limitation of the current study, the language and sample were confounding factors since the English-speaking participants were recruited via the commercial platform only. We considered this, as we did not discuss overlapping results. In the convenience sample, females and younger persons were overrepresented. Since participation is guided by interest, psychotherapy experience in the broadest sense was more common in the convenience sample. We could not include a representative sample, and we used a small number of items to increase feasibility. The quantitative measure included items on the therapist from related questionnaires, but also new items derived from important publications in the field. Thus, it was not an established and validated instrument, which limits the interpretability of the results.

As an adjunct to former studies, the current survey asked for feedback from laypersons independent from the actual beginning or completion of psychotherapy. As another limitation, we compared three rather broad categories of pre-experiences and did not refer to the quality of the experience that participants had with the therapists. Certainly, this has elicited stereotypes, but the results also give important insights into the views of laypersons, an important addition to former studies.

4.2 | Implications for practitioners

Explicitly incorporating patients' therapist preferences may contribute to the correction of misconceptions and to the development of a strong collaboration (Cooper & Norcross, 2016). In order to reduce barriers and misconceptions, and to increase the general motivation to seek treatment, it is crucial to be responsive to layperson concepts (von Sydow, 2007). As attitudes, beliefs and perceptions of one's own health are important factors contributing to the use of health services (Magaard et al., 2017; Roberts et al., 2018), information on mental disorders and on the effectiveness and the limitations of psychotherapy is central for seeking treatment. Our study suggests that effective and professional therapist behaviour that aims at establishing a sound working alliance also plays a key role in the motivation for psychotherapy. Therapist credibility may be fostered by formulating something like “I know that the treatment itself seems to suit you, but I wonder if you have any feeling about me being the one to deliver it? Sometimes people find that a therapist could be more or less suitable […] and I genuinely invite you to discuss any reactions to me

that you might have [...]" (Constantino et al., 2018, p. 493). The same holds for expectancy management, for example by fostering positive outcome expectations (e.g. "It makes sense that you sought treatment for your problems..."), referring to the empirical evidence (e.g. "Much research has shown to be beneficial for...") or normalising individual courses during therapy (e.g. "Often, change occurs gradual and nonlinear..."; cf. Constantino et al., 2011). Such procedures are central to patient empowerment and to the individual adaptation of psychotherapy.

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CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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APPENDIX 1

FREQUENCIES AND PERCENTAGES OF MEANINGFUL UNITS PER CATEGORY

Note

	Number of meaningful units				Percentage of meaningful units			
	No prior experience with psychotherapy		Prior experience with psychotherapy		No prior experience with psychotherapy		Prior experience with psychotherapy	
Category	Competent	Not competent	Competent	Not competent	Competent	Not competent	Competent	Not competent
Principles	34/37/32	25/35/22	65/24/20	59/21/13	16.4/22.8/17.7	19.4/31.0/17.2	20.8/28.6/18.5	27.0/32.8/17.3
Problem focus	14/16/23	10/14/11	39/12/14	22/4/8	6.8/9.9/12.7	7.8/12.4/8.6	12.5/14.3/13.0	10.9/6.3/10.7
Individuality	13/15/5	7/14/5	13/6/2	10/6/2	6.3/9.3/2.8	5.4/12.4/3.9	4.2/7.1/1.9	4.6/9.4/2.7
Directiveness	4/2/2	2/0/3	5/2/1	10/4/2	1.9/1.2/1.1	1.6/0.0/0.8	1.6/2.4/0.9	4.6/6.3/2.7
Transparency	2/3/1	2/2/1	3/1/1	6/1/0	1.0/1.9/0.6	1.6/1.8/0.8	1.0/1.2/0.9	2.8/1.6/0.0
Sincerity	1/1/0	4/3/1	5/2/1	10/3/0	0.5/0.6/0.0	3.1/2.7/0.8	1.6/2.4/0.9	4.6/4.7/0.0
Prescription of medication	0/0/1	0/2/1	0/1/1	1/3/1	0.0/0.0/0.6	0.0/1.8/0.8	0.0/1.2/0.9	0.5/4.7/1.3
Professionalism	32/19/22	25/20/26	70/15/22	53/11/21	15.5/11.7/12.2	19.4/17.7/20.3	22.4/17.9/20.4	24.3/17.2/28.0
Trustworthiness	7/4/7	0/7/4	21/4/7	3/1/3	3.4/2.5/3.4	0.0/6.2/3.1	6.7/4.8/6.5	1.4/1.6/4.0
Calmness	7/3/2	0/0/2	12/4/5	0/0/1	3.4/1.9/1.1	0.0/0.0/1.6	3.9/4.8/4.6	0.0/0.0/1.3
Therapeutic relationship	4/4/6	5/3/3	16/2/3	10/4/4	1.9/2.5/3.3	3.9/2.7/2.3	5.1/2.4/2.8	4.6/6.3/5.3
Attentiveness	10/5/4	11/5/11	12/2/3	12/6/5	4.8/3.1/2.2	8.5/4.4/8.6	3.9/2.4/2.8	5.5/9.4/6.7
Self-referentiality	0/0/0	2/2/1	0/0/0	17/0/7	0.0/0.0/0.0	1.6/1.8/0.8	0.0/0.0/0.0	7.8/0.0/9.3
Other	4/3/3	7/3/5	9/3/4	11/0/1	1.9/1.9/1.7	5.4/2.7/3.9	2.9/3.6/3.7	5.1/0.0/1.3
Personality	29/21/34	10/10/12	48/8/23	30/10/13	14.0/13.0/18.8	7.8/8.9/9.4	15.4/9.5/21.3	13.8/15.6/17.3
Neutrality	10/3/16	6/1/5	17/1/11	12/2/6	4.8/1.9/8.8	4.7/0.9/3.9	5.5/1.2/10.2	5.5/3.1/8.0
Friendliness	5/10/6	1/2/1	10/1/6	4/4/0	2.4/6.2/3.3	0.8/1.8/0.8	3.2/1.2/5.6	1.8/6.3/0.0
Honesty	3/2/1	0/0/2	10/0/1	0/0/0	1.5/1.2/0.6	0.0/0.0/1.6	3.2/2.4/0.9	0.0/0.0/0.0
Patience	3/1/7	0/2/1	5/2/2	4/2/0	1.5/0.6/3.9	0.0/1.8/0.8	1.6/2.4/1.9	1.8/3.1/0.0
Appreciation	3/1/0	0/0/0	4/0/0	0/0/0	1.5/0.6/0.0	0.0/0.0/0.0	1.3/0.0/0.0	0.0/0.0/0.0
Other	5/4/4	3/5/3	2/4/3	10/2/7	2.4/2.5/2.2	2.3/4.4/2.3	0.6/4.8/2.8	4.6/3.1/9.3

APPENDIX 1 continued

	Number of meaningful units				Percentage of meaningful units			
	No prior experience with psychotherapy		Prior experience with psychotherapy		No prior experience with psychotherapy		Prior experience with psychotherapy	
Category	Competent	Not competent	Competent	Not competent	Competent	Not competent	Competent	Not competent
Communication	30/17/33	23/4/18	30/9/19	25/4/9	14.5/10.5/18.2	17.8/3.5/14.1	9.6/10.7/17.6	11.5/6.3/12.0
Empathy and understanding	40/26/24	8/4/12	51/12/14	16/5/3	19.3/16.1/13.3	6.2/3.5/9.4	16.4/14.3/13.0	7.3/7.8/4.0
Training	23/16/13	8/19/4	14/5/4	6/1/2	11.1/9.9/7.2	6.2/16.8/3.1	4.5/6.0/3.7	2.8/1.6/2.7
Conditions	2/7/2	15/9/10	11/8/2	12/6/8	1.0/4.3/1.1	11.6/8.0/7.8	3.5/9.5/1.9	5.5/9.4/10.7
Frequency and pace	2/5/2	10/7/5	3/6/0	6/3/4	1.0/3.1/1.1	7.8/6.2/3.9	1.0/7.1/0.0	2.8/4.7/5.3
Other aspects	5/8/3	7/2/5	9/1/4	7/4/1	2.4/4.9/1.7	5.4/1.8/3.9	2.9/1.2/3.7	3.2/6.3/1.3
Effective therapy	7/2/3	4/2/8	6/0/0	5/1/5	3.4/1.2/1.7	3.1/1.8/6.3	1.9/0.0/0.0	2.3/1.6/6.7
Experience	3/7/7	2/6/3	7/2/0	1/0/0	1.5/4.3/3.9	1.6/5.3/2.3	2.2/2.4/0.0	0.5/0.0/0.0
No idea	2/2/8	2/2/8	1/0/0	4/1/0	1.0/1.2/4.4	1.6/1.8/6.3	0.3/0.0/0.0	1.8/1.6/0.0
	207/162/181	129/113/128	312/84/108	218/64/75				

Results are presented in the following order: Convenience sample/German clickworkers/English clickworkers. Percentages calculated using the overall number of meaningful units for each subgroup.