

# Can competency frameworks boost therapeutic effectiveness

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**Is there an argument  
for competence frameworks?**

## Harm and psychological therapy

- we intervene with the best intentions and assume our impacts are:
  - beneficial at best
  - neutral at worst
- but if treatments are effective (they can change people) they also have power to harm

## Incidence of harmful effects

- defining harm and deterioration is not straightforward
  - not easy to distinguish 'natural' from 'accelerated' deterioration pathways
  - causes of harm presumably multiple
- estimates vary, but best guess: 4-10% of therapy clients deteriorate

- across all orientations, client groups, modalities
- in practice-based studies of effectiveness
- in RCTs of 'empirically supported treatments'

# There are probably many ways of harming

## inappropriate treatment choices

- critical incident stress debriefing
- grief counselling for normal bereavement
- psychodynamic therapy for schizophrenia

## misapplied therapy

- couples therapy that benefits one partner at the cost of the other

## sub-optimal therapy

- failure to adequately treat using exposure techniques
- applying "technique" in the absence of a good alliance

## mistakes

- therapist error

## Minimising harm by maximising effectiveness

helpful to try to do the right thing in the right way

- research trials demonstrate efficacy of clearly-specified therapies in relation to a range of mental health conditions
- could be argued that this represents a demonstration of best practice, in terms of:
  - training
  - monitoring
  - supervision

# Claims for efficacy rest on competence

Roth, Pilling and Turner (in prep)

- 27 “exemplar” trials of CBT
- depression, GAD, social phobia, panic and PTSD
- (almost) universal focus on fidelity / competence of therapy delivery

- therapist selection
- therapist pre-trial experience
- training for trial
- supervision during trial
- fidelity monitoring

## Minimising harm by maximising effectiveness

- in routine settings therapists often adapt these therapies in uncertain ways
- if adherence and competence of delivery make a difference, it makes sense to enhance this
  - competence frameworks can help to bridge research and practice

## Defining terms: distinguishing adherence and competence

**Adherence** - is the intervention carried out as intended/prescribed (e.g. in a manual)?

**Competence** - is the intervention delivered skilfully?

- adherence and competence easily conflated
  - competence usually assumes adherence
  - adherence may or may not indicate competence
- it's not what you do, it's the way that you do it
  - following a recipe doesn't make you a good cook

**What sort of therapy do therapists deliver  
in routine settings?**

# What sort of therapy do therapists deliver in routine settings?

- we don't know.....
- but it probably isn't the same as :
  - the therapy specified in textbooks
  - therapy as delivered in research
    - which forms the basis for any claims for the efficacy of psychological therapy

# Therapy adherence/competence in routine practice

Brosnan et al. (2006)

- 24 CBT therapists
  - all had received 'some' training in CBT
- submitted mid-treatment tape session
  - rated on Cognitive Therapy Rating Scale (CTRS)

# Therapy adherence/competence in routine practice

Quality of therapy highly variable, and unrelated to

- years of experience
- frequency of supervision
- accreditation

was related to formal post-qualification training in CBT

- reasonable to assume that this variability in quality is usual

# Self-evaluation of competence

Brosan et al. (forthcoming)

- 22 CBT therapists, each submit tape of one session
- rated on CTS by:
  - therapist (self-rating)
  - independent expert rater
- on basis of expert rater, therapists coded as:
  - competent (N=12)
  - not competent (N=10)

## Self-evaluation compared to expert evaluation

- correlation of 0.57 between self-ratings and expert ratings - BUT

- self-ratings are higher than expert ratings
- compared to competent therapists
  - less competent therapists show a significant tendency to overestimate their competence

# Is therapy as delivered what it claims to be?

Stobie et al. 2007

- 57 clients referred for trial of CBT for OCD
  - all had prior (failed) psychological intervention
- 40% reported previous treatment with CBT/ BT
  - 50% did not recall receiving core elements which characterise CBT/ BT (e.g. exposure)
  - some indication that those who had CBT/ BT had better specific improvements in OCD

**Does competence make a difference?**

## Evidence for competence

- some general evidence for competence and outcome
- some evidence for links between specific areas of competence and outcome

# Challenges - measuring competence (1)

## Measures

- current measures have poor reliability
- Cognitive Therapy Rating Scale (CTRS)
  - low inter-rater reliability even when raters well trained
  - lack of agreement raises questions about validity
- familiarity with clinical material influences ratings and observed associations
  - stronger results for ratings made by "supervisors" than for independent raters

# Challenges to linking specific technique to outcome (1)

- rather few studies
- usually too few therapist-patient combinations for analysis
- rather few consistent results
- relationship to outcome varies in relation to instrument (e.g BDI vs HRSD)

## Challenges to linking specific technique to outcome (2)

- focus on fidelity in clinical trials reduces variance attributable to therapists
  - therapist 'titration' of technique may reduce variance attributable to competence
  - may not be observing at the right time
    - rate/pattern of change highly variable across patients
- most studies measure single sessions and correlate with outcome
  - rare to have data which is able to link change to time course

# Competence and outcome in IPT

O'Malley et al (1988)

- 11 therapists treating 35 patients in NIMH trial
- ratings of competence considers
  - formulation
  - strategies for bringing about change
  - application IPT techniques

## Competence and outcome

- correlation of 0.56 between supervisor skill rating and patient-rated outcome
- median split of therapists to "high" and "low" in competence
  - greater patient change in more skilled group

- therapist performance contributes 23% outcome variance in patient-rated change beyond initial patient factors (e.g. level of functioning)

## Links between specific techniques and outcome

- few studies link *specific* techniques to outcome
- (DeRuibies et al) - studies of CBT for severe depression
- better outcomes when therapists:

deploy 'concrete' CBT competences early in treatment  
- i.e. those associated with pragmatic, structuring aspects of the therapy

focus on specific (concrete) beliefs and behaviours early in treatment

## **“Concrete” CBT competences (concerned with ‘pragmatic aspects of therapy)**

- set and followed agenda
- reviewed homework
- assigned homework
- asked patient to report cognitions verbatim
- asked for specific examples of beliefs
- labelled cognitive errors
- examined evidence concerning beliefs
- practised rational responses with patient
- assigned/ reviewed self-monitoring
- asked patient to record thoughts

## Cognitive therapy - “abstract” competences

some (but weaker) evidence of association between abstract competences and outcome

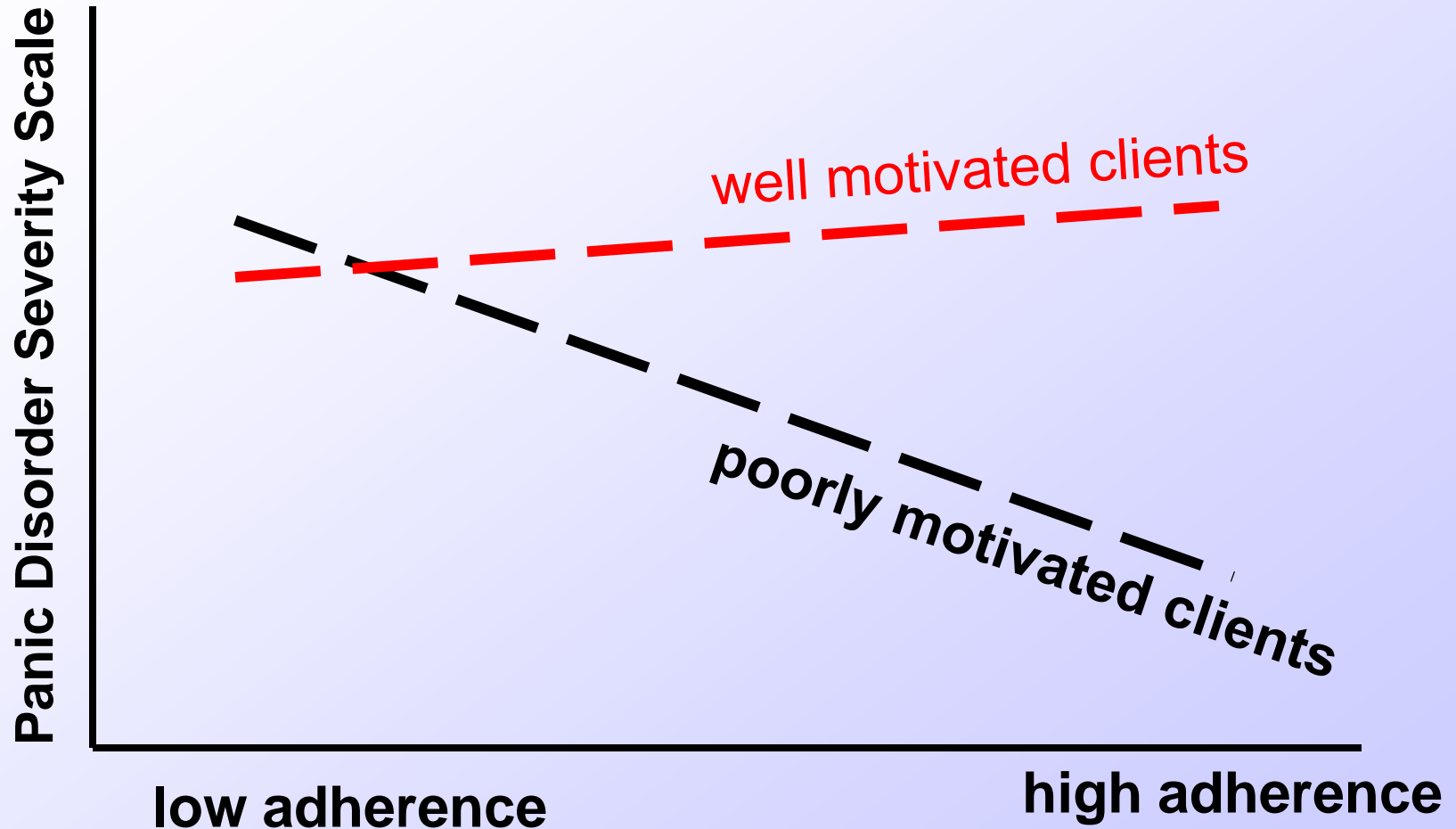
- encouraged independence
- explained rationale for cognitive therapy
- explored personal meaning of thoughts
- explored underlying assumptions
- encouraged distancing of beliefs
- recognised adaptive/functional value of beliefs
- negotiated content of session with client

## Adherence and treatment outcome

- how many poor outcomes relate to poor adherence?
  - not knowing enough about the therapy to apply it properly
- how many poor outcomes " relate to an **excess** of adherence?
  - problems in making the method tractable, relevant and acceptable...

# Adherence and client motivation in PCT

Huppert et al. 2006



# Therapists often like to travel “off-piste”

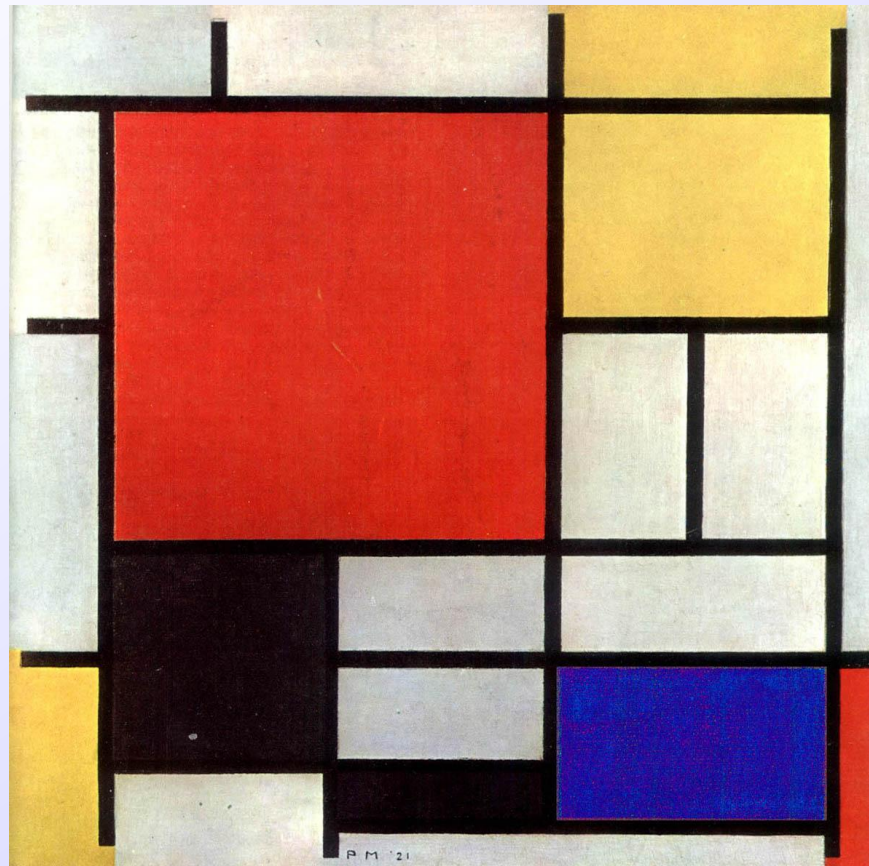
Schulte and Eifert (2002)

- studies of the application of manualised CBT for anxiety disorders
- therapists make surprisingly large numbers of changes to their initial plans
  - usually response to sense of pessimism or a lack of control over therapeutic direction
- significant negative correlation (-0.49) between outcome and the frequency of changes of method

## Adherence and competence

- some evidence for the benefit of adherence and competence
  - adherence alone is not enough
- competence involves the judicious manipulation of adherence
  - flexible (but not over-flexible) in technique
  - capacity for alliance management
- metacompetence also important
  - ability to employ procedural knowledge

# Competence frameworks



# Background to the CBT competence framework for depression and anxiety disorders

commissioned as part of the IAPT programme

- IAPT employs "High" and "Low" Intensity workers
  - what competences do people need to deliver the programme?
- CBT framework was the prototype for others (completion through 2008-9):

# Progress with frameworks

## completed

- CBT
- supervision competences
- psychoanalytic/ psychodynamic

## in progress (completion late 2008/ early 2009)

- systemic
- humanistic person-centred experiential

## Developing the CBT framework

- evidence-based approach
  - differs from the "task-analysis" approach usually adopted for National Occupational Standards
- assume that the competences associated with effective delivery of CBT are those used by therapists in research trials which demonstrate efficacy
  - manuals describe these competences and hence yield information about "best practice"

# Methodology

## find the right trials

- identified 'exemplar' trials of CBT for people with depression and with anxiety
  - derived on the basis of review of the literature and oversight by Expert Reference Group

## find the manuals associated with these trials

- locate the (published and unpublished) manuals used in these trials
  - from these identified sets of competences

## Organising competence lists

- “undifferentiated” competence lists are rarely helpful
- an ‘architecture’ is needed to help users navigate through the lists
- model needs to encompass LI and HI competences within one framework

## **Generic Competences in psychological therapy**

competences needed to relate to people and to carry out any form of psychological intervention

## **Basic behavioural and cognitive competences**

CBT competences used in most CBT interventions

## **Specific behavioural and cognitive techniques**

specific techniques employed in most CBT interventions

## **Problem specific CBT skills**

Problem A – specific competences needed to deliver a treatment package for specific problem presentation A

Problem B – specific competences needed to deliver a treatment package for specific problem presentation B

## **Metacompetences**

Competencies used by therapists to work across all these levels and to adapt CBT to the needs of each individual patient

**Ability to implement CBT using a collaborative approach**

**Generic therapeutic competences**

- knowledge and understanding of mental health problems
- knowledge of, and ability to operate within, professional and ethical guidelines
- knowledge of a model of therapy, and the ability to understand and employ the model in practice
- ability to engage client
- ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world view'
- ability to deal with emotional content of sessions
- ability to manage endings
- ability to undertake generic assessment (relevant history and identifying suitability for intervention)
- ability to make use of supervision

**Basic CBT competences**

- knowledge of basic principles of CBT and rationale for treatment
- knowledge of common cognitive biases relevant to CBT
- knowledge of the role of safety-seeking behaviours
- ability to explain and demonstrate rationale for CBT to client
- ability to agree goals for the intervention
- Ability to structure sessions**
- Sharing responsibility for session structure & content**
  - ability to adhere to an agreed agenda
  - ability to plan and to review practice assignments ('homework')
  - using summaries and feedback to structure the session
- ability to use measures and self monitoring to guide therapy and to monitor outcome
- ability to devise a maintenance cycle and use this to set targets
- problem solving
- ability to end therapy in a planned manner, and to plan for long-term maintenance of gains after treatment

**Specific behavioural and cognitive therapy**

- exposure techniques
- applied relaxation & applied tension
- activity monitoring & scheduling
- Guided discovery & Socratic questioning**
  - using thought records
  - identifying and working with safety behaviours
  - ability to detect, examine and help client reality test automatic thoughts/images
  - ability to elicit key cognitions/images
  - ability to identify and help client modify assumptions, attitudes and rules
  - ability to identify and help client modify core beliefs
  - ability to employ imagery techniques
  - ability to plan and conduct behavioural experiments
- ability to develop formulation and use this to develop treatment plan /case conceptualisation
- ability to understand client's inner world and response to therapy

**Problem specific competences**

- Specific phobias
  - Social Phobia – Heimberg
  - Social Phobia - Clark
  - Panic Disorder (with or without agoraphobia) - Clark
  - Panic Disorder (with or without agoraphobia) - Barlow
- OCD – Steketee
- OCD – Kozac
- GAD – Borkovec
- GAD – Dugas/ Ladouceur
- GAD – Zinbarg/Craske/Barlow
- PTSD - Foa & Rothbaum
- PTSD - Resick
- PTSD – Ehlers
- Depression – High intensity interventions
  - Cognitive Therapy – Beck
  - Behavioural Activation - Jacobson
- Depression – Low intensity interventions
  - Behavioural Activation
  - Guided CBT self help

**Metacompetences**

- Generic metacompetencies
  - capacity to use clinical judgment when implementing treatment models
  - capacity to adapt interventions in response to client feedback
  - capacity to use and respond to humour
- CBT specific metacompetencies
  - capacity to implement CBT in a manner consonant with its underlying philosophy
  - capacity to formulate and to apply CBT models to the individual client
  - capacity to select and apply most appropriate BT & CBT method
  - capacity to structure sessions and maintain appropriate pacing
  - capacity to manage obstacles to CBT therapy

# Generic competences - underpin all therapies

- knowledge and understanding of mental health problems
- knowledge of, and ability to operate within, professional and ethical guidelines
- knowledge of a model of therapy, and the ability to understand and employ the model in practice

- ability to engage client
- ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world view'
- ability to deal with emotional content of sessions

# CBT - the instantiation of a philosophy, not a series of techniques

ability to implement CBT using a  
collaborative approach

generic

basic

specific

problem specific

metacompetnces

# Basic CBT competences

ability to structure sessions

ability to share  
responsibility for session  
structure and content

ability to adhere to an agreed agenda

ability to plan and review practice  
assignments

using summaries and feedback to  
structure the session

## Specific BT and CBT techniques

guided discovery and Socratic questioning

using thought records

identifying & working with safety behaviours

ability to detect, examine and help client reality test negative thoughts /images

etc

# Some examples of Metacompetences

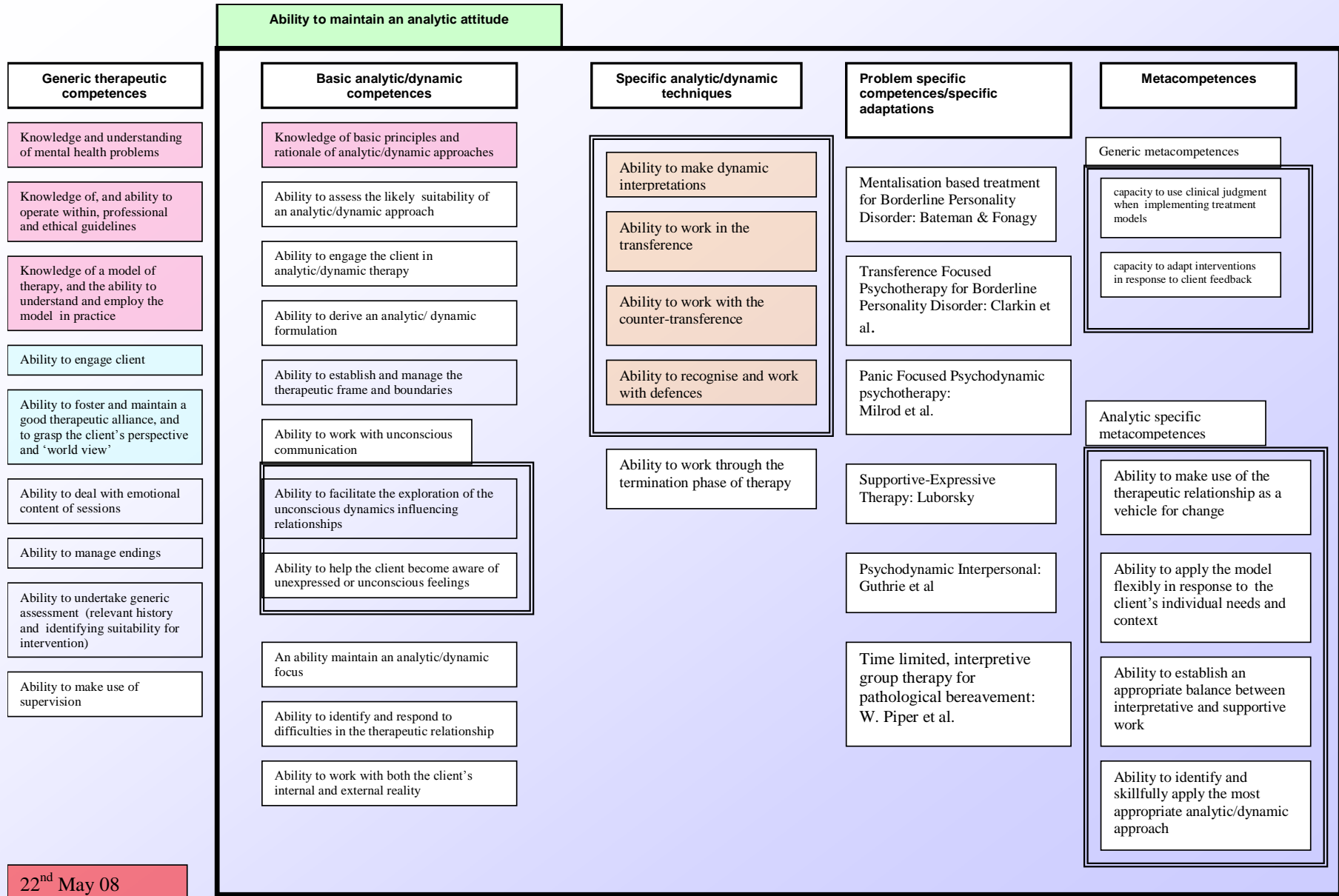
## Generic metacompetences

- capacity to use clinical judgment when implementing treatment
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- capacity to implement CBT in a manner consonant with its underlying philosophy
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- capacity to select and apply most appropriate BT & CBT method
- capacity to manage obstacles to CBT therapy

# Psychoanalytic/ psychodynamic competences



# Overarching competence in psychodynamic therapy

Ability to maintain an analytic attitude

generic

basic

specific

problem specific

metacompetences

## Basic psychodynamic competences

ability to work with unconscious communication

Ability to facilitate the exploration of the unconscious dynamics influencing relationships

Ability to help the client become aware of unexpressed or unconscious feelings

## Specific psychodynamic techniques

Ability to make dynamic interpretations

Ability to work in the transference

Ability to work with the counter-  
transference

Ability to recognise and work with  
defences

# Humanistic Person-Centred/ Experiential Framework

## Challenges:

- inclusion/ exclusion of approaches - maintaining "evidence-based" criteria
  - review of trials database (with Robert Elliot)
- differing perspectives about underpinning theory and philosophy
  - e.g. extent of non-directive practice
- focusing on primacy of relationship factors while also identifying technical procedures

## Using the framework

### map of competences represents:

- a way of linking the evidence-base to practice
- a curriculum for training e.g.
  - IAPT
  - psychodynamic training at the Tavistock
- an agenda for supervision
- a procedure for identifying competent practice
- a basis for research

## Publications to date

- background documents - published by DH
  - version for clinicians and commissioners
  - version for service users
- Behavioural and Cognitive Psychotherapy (March '08)
- full competence lists and pdf's of documents available on the web (CORE website at UCL)

[www.ucl.ac.uk/CORE/](http://www.ucl.ac.uk/CORE/)