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**Competence Rating Scale for Cognitive Behaviour Therapy**

**Rating Scale**

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| **Competence not demonstrated or requires major development**  | **1** |
|   | Relevant technique or process is not present, but should be  |
| Relevant technique or process is barely present and/or it is applied in a manner that is ineffective\* for this client |
| **Competence only partially and/or poorly demonstrated and requires significant development** | **2** |
|  | Only some aspects of the relevant technique or process are apparent, and/or it is applied in a manner that is only marginally effective\* for this client |
| **Competence demonstrated but requires further development**  | **3** |
|  | Relevant technique or process is present but delivered in a manner that is partial and so not as effective\* as it could be for this client, with a number of aspects requiring development (for example because it needs to be targeted more accurately to the client’s presentation, or applied more consistently or coherently) |
| **Competence demonstrated well but requires some specific development**  | **4** |
|  | Relevant technique or process is applied well and delivered in a manner that is effective\* for this client; however there are some specific (but not critical) areas for development  |
| **Competence demonstrated very well and requires no substantive development** | **5** |
|  | Relevant technique or process is applied fluently and coherently, in a manner that is demonstrably effective\* for this client |

*\* in this context, “effective” means that the action being rated would be expected to produce the desired or intended result. As such it is a reference to within-session behaviours/reactions, rather than longer-term clinical change*.

**Rating an item as ‘not applicable’**

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| This rating is used if an area of activity is not present, AND (in the rater’s view) does not need to be present because it is not relevant to, or required in, the specific session being rated. If an area of activity is not present but (in the rater’s view) it should be, then it should be rated as ‘1’ (indicating that the competence was not demonstrated and should have been).  |

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| Shading indicates areas of competence that may or not be present in a session (e.g. because of the stage of the intervention, or the client’s background/ presentation |

**Section 1: Underpinning CBT techniques**

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| **1** | **Agenda setting and structuring sessions**  | 1 | 2 | 3 | 4 | 5 |
| Does the therapist share responsibility for session structure and content with the client, by negotiating an explicit agenda? |
| Does the therapist structure and pace the session in relation to an agenda, holding in mind the client’s needs and learning speed?  |
| Does the therapist strike the right balance between maintaining structure and being flexible in response to session material that emerges?  |

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| **2** | **Using summaries and feedback** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist offer ‘capsule’ summaries of salient issues and topics covered in the session and use these to move the session on? |
| Does the therapist invite summaries from the client (to check that the therapist understands the client’s problems and that the client understands what the therapist is saying)? |

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| **3** | **Guided discovery and Socratic questioning** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist employ a flexible and responsive questioning technique to help clients discover useful information that they can use to develop alternative meanings/ perspectives and a better level of understanding? |
| Does the therapist use an open and inquisitive style aimed at helping the client to evaluate beliefs, behaviours, moods and plans for change? |
| Does the therapist frame and phrase questions in a way which is consonant with client’s likely current level of understanding? |
| Does the therapist help the client develop a range of perspectives regarding his/her experience (e.g. by examining evidence, considering alternatives, and weighing the advantages and disadvantages of different perspectives)? |
| Does the therapist help the client generate potential solutions for themselves? |
| Does the therapist refrain from imposing a particular point of view on the client, for example by reliance on debate, persuasion, “lecturing”, or “cross-examining” the client? |

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| **4** | **Identifying maintenance cycles (i.e. factors that feed into one another so as to maintain difficulties)** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist work with the client to develop hypotheses about how their thoughts, physical symptoms, behaviours and emotions inter-relate and feedback on themselves in a way which maintains the client’s problems? |
| Does the therapist work actively with the client to develop hypotheses about maintenance cycles, checking that they understand the concept of the cycle and sees its potential relevance to their problems, and (if relevant) modifying the cycle in the light of client feedback? |
| Does the therapist use the maintenance cycle in order to discuss appropriate targets for intervention?  |

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| **5** | **Sharing a longitudinal CBT formulation**  | 1 | 2 | 3 | 4 | 5 |
| Does the therapist work with the client to develop a plausible and longitudinal conceptualisation that helps them gain an understanding of how their perceptions and interpretations, beliefs, attitudes and rules relate to their problem?  |
| Does the therapist ensure that developing the formulation is a collaborative process, for example by inviting feedback in order to check their understanding, or titrating the amount of detail to the intellectual and emotional capacity of the client? |
| Does the therapist refer to the shared formulation in order to provide clients with a rationale for the activities they are asked to carry out (e.g. in-session interventions, or practice assignments)  |

**Section 2: Change techniques based on discussion and experiential methods**

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| **6** | **Using a thought record** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist explain the rationale for using a thought record (e.g. to help the client become an active participant in their own therapy and to provide information that can guide the intervention)? |
| Does the therapist prepare the client to use the thought record (e.g. by working with them in the session to identify an important automatic thought and/or the specific situations in which these are triggered)?  |
| Does the therapist discuss the content of the thought record and work with the client to check that they client understand how it is completed? |
| Does the therapist review and discuss with the client thought records completed as part of previous practice assignments, so that these are integrated into the intervention?  |
| Does the therapist identify and help the client manage any difficulties in completing the thought record (e.g. by identifying automatic thoughts associated with completing the record itself, or taking a problem-solving approach to overcoming obstacles)?  |

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| **7** | **Working with safety behaviours** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist help the client to identify and become aware of overt and covert safety behaviours that:  |
| impact on the development and maintenance of their problems? |
| are associated with the management of distressing emotions?  |
| Does the therapist help the client draw links between behaviours and emotions so that they can identify the role of safety behaviours in maintaining problems?  |

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| **8** | **Detecting, examining and helping clients reality test automatic thoughts and images** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist help clients notice automatic thoughts that:  |
| arise in specific situations (e.g. by a detailed discussion that focuses on these events)? |
| arise in the session (by commenting on verbal and nonverbal cues which might indicate shifts in their affect and helping them focus on the thoughts which were going through their mind)? |
| Does the therapist help the client:  |
| to specify the actual phrasing of their thoughts (to help them distinguish thoughts from interpretations and feelings)? |
| to identify the thoughts which are most closely associated with significant distress and/or problems in functioning? |
| explore the validity of thoughts/ images (e.g. by exploring evidence, considering alternative explanations)?  |
| explore the validity of thoughts/ images without implying that the client’s thinking is erroneous? |
| consider the utility of automatic thoughts which (valid or not) are strongly believed by the client? |
| evaluate automatic thoughts for themselves (e.g. using appropriate homework assignments)?  |

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| **9** | **Identifying and modifying assumptions** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist work collaboratively with the client in order to help them identify assumptions, attitudes and rules (e.g. by taking an unknowing stance, using a downward arrow technique)?  |
| Does the therapist help the client frame assumptions as understandable and valid reactions to a particular stage in life, or to particular circumstances? |
| Does the therapist help the client to challenge unhelpful assumptions (e.g. by using Socratic questioning, behavioural tests of assumptions, considering advantages or disadvantages of holding assumptions, behavioural experiments in which they act against their assumptions)? |

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| **10** | **Working with beliefs** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist help the client identify central core beliefs (e.g. by using downward arrow techniques, by looking for central themes in the client’s automatic thoughts and by direct elicitation)  |
| Does the therapist help the client perceive beliefs as ideas whose validity can be tested (e.g. by using Socratic questioning) |
| Does the therapist use a range of cognitive techniques to help the client modify core beliefs and strengthen new beliefs (e.g. Socratic questioning, behavioural experiments, role play, consideration of historical origins of core beliefs, restructuring of early memories using role playing/re-enactment)  |

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| **11** | **Working with imagery** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist help the client identify and discuss distressing spontaneous images, and to manage their distress (e.g. by responding empathically and/or offering normalisation)?  |
| Does the therapist help reduce the distress associated using cognitive techniques (e.g. ‘jumping ahead in time’ to a point where the situation is resolved, or reworking the image so as to imagine themselves coping with the situation, or changing its ending (with the aim of encouraging problem solving))?  |
| Does the therapist use Socratic questioning to help the client to re-evaluate the image? |
| Does the therapist help the client repeat images which are particularly distressing, with the aim of helping the client reappraise the image and reduce associated distress? |
| Does the therapist help the client to use imagery induction (e.g. practicing coping strategies in imagination or using imagery to help the client gain a new perspective which they can use to problem solve or for reappraisal)? |

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| **12** | **Planning and reviewing practice assignments** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist work with the client to agree practice assignments that are appropriate to the formulation and intervention plan, that have clear and specific goals,  |
| Does the therapist work with the client to identify and problem-solve any obstacles to implementing the agreed practice assignment? |
| If practice assignments were agreed in previous sessions, does the therapist review them with the client, considering their outcomes and integrating learning into the work? |

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| **13** | **Planning and conducting behavioural experiments (designed to test a prediction)** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist help the client to devise behavioural experiments (usually a ‘stand-alone’ assignment designed to test the validity of their beliefs or assumptions about themselves or the world, which help construct and/or test new, more adaptive beliefs, and which can be carried out in the session or as homework)? |
| Does the therapist ensure that the form, timing and content of behavioural experiments are congruent with their intended aim, and are likely to have positive outcomes? |
| Does the therapist plan the experiment collaboratively (e.g. checking that any reservations held by the client are fully accounted for)? |
| Does the therapist plan the experiment with the client, checking that the client is aware of the specific cognitions being targeted by the experiment  |
| Does the therapist anticipate (and discuss with the client) any possible problems, along with ways of overcoming these? |
| Does the therapist review the experiment with the client:  |
| by recording the outcome and the learning which has occurred? |
| by identifying its impact on their thinking or behaviour, and the meaning the outcome of the experiment has for them? |
| by building on this learning by identifying further behavioural experiments? |

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| **14** | **Activity monitoring and scheduling** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist explain the rationale for activity scheduling and the way that this will be implemented?  |
| Does the therapist help the client complete an activity chart that includes rating of pleasure and mastery associated with activities? |
| Does the therapist review charts with the client (e.g. identifying areas over- or under-represented, associated with low or high levels of pleasure and mastery)?  |
| Does the therapist work with the client to identify and plan specific changes to activities, identifying any thoughts (assumptions or beliefs) which might make it difficult for them to implement these changes? |
| Does the therapist use the activity chart to help clients schedule activities for the forthcoming week (e.g. pleasurable activities, previously avoided activities, therapy homework)? |
| Does the therapist review activities with the client (e.g. contrast predicted and actual levels of pleasure and mastery associated with scheduled activities, or discuss how these activities test out any automatic thoughts or beliefs which emerge prior to, or while carrying out, activities)? |

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| **15** | **Problem solving (as an explicit strategy)** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist explain the rationale for problem-solving?  |
| Does the therapist help the client select problems that are relevant to the client and for which achievable goals can be set? |
| Does the therapist help the client follow problem-solving procedures (e.g. specify the problem(s), breaking down larger problems into smaller (more manageable) parts, identifying achievable goals, brainstorming solutions, identifying preferred solutions and planning and implementing solutions)?  |
| Does the therapist help the client evaluate the outcome of any attempts at problem-solving agreed in earlier sessions? |

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| **16** | **Conducting exposure (planned, repeated, prolonged exposures to the same situation(s)** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist explain the rationale for exposure and the way that this is conducted? |
| Does the therapist help the client to construct a hierarchy of feared situations for both situational and interoceptive items, and their combination? |
| Does the therapist work with the client to plan interoceptive, in vitro or in vivo exposure in a manner which maximises the probability of benefit, in terms of its structure (e.g. number of situations faced, duration and pacing), as well as helping the client identify and circumvent any covert avoidance or the use of safety behaviours? |
| Does the therapist work with the client to review exposure experiences that were agreed as practice assignments in earlier sessions? |

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| **17** | **Working with endings** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist help the client identify and elaborate any concerns about ending therapy (e.g. worries about needing support to manage on their own and/ or that they will relapse)? |
| Does the therapist work with the client to review their overall progress, identifying areas of improvement as well as any areas that remain unresolved, and discussing actions/ strategies the client can follow to manage the latter?  |
| Does the therapist help the client review problematic events which led to difficulties in the past, and the CBT coping strategies used to manage these more effectively? |
| Does the therapist work with the client to develop a plan for implementing relevant CBT coping strategies should problematic events recur in the future? |

**Section 3: Change techniques deployed for specific conditions**

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| **18** | **Specific change techniques for working with panic** | 1 | 2 | 3 | 4 | 5 |
| Did the therapist use change techniques (including both discussion and behavioural experiments) that address: |
| the client’s misinterpretation of bodily sensations in a catastrophic manner |
| hypervigilance (especially to introceptive cues)  |
| safety-seeking behaviours and patterns of avoidance which maintain negative interpretations of bodily sensations |

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| **19** | **Specific change techniques for working with GAD** | 1 | 2 | 3 | 4 | 5 |
| Did the therapist use change techniques (including both discussion and behavioural experiments) that address: |
| difficulties in tolerating uncertainty |
| beliefs about worry (both positive and negative) |
| client’s beliefs about their capacity to problem-solve, and where appropriate strategies to enhance these |
| cognitive or affective avoidance  |

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| **20** | **Specific change techniques for working with OCD** | 1 | 2 | 3 | 4 | 5 |
| Did the therapist use change techniques (including both discussion and behavioural experiments) such as:  |
| imaginal and in-vivo exposure with response prevention, targeted at overt and covert rituals, and behavioural and cognitive avoidance  |
| strategies that address cognitions pertinent to OCD (such as thought-action fusion (an over-developed sense of responsibility for thoughts), or appraisals of obsessional thoughts as significant and meaningful, and hence distressing)  |

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| **21** | **Specific change techniques for working with social anxiety** | 1 | 2 | 3 | 4 | 5 |
| Did the therapist focus on maintaining factors for social anxiety (e.g. the client’s negative predictions and beliefs about how they appear to others in social situations, self-focused attention, safety behaviours)? |
| Did the therapist help the client identify past traumatic social experiences that contribute to their beliefs, and to use appropriate change techniques to modify these?  |
| Did the therapist help the client distinguish between self-evaluations in social contexts and evaluations by others? |
| Did the therapist ensure that change strategies based on discussion are consistently accompanied by experiential strategies (e.g. behavioural experiments used to test specific predictions and beliefs)? |

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| **22** | **Specific change techniques for working with trauma** | 1 | 2 | 3 | 4 | 5 |
| Did the therapist address three areas of difficulty - helping the client to elaborate and integrate the trauma memory, modify problematic appraisals and desist from dysfunctional behavioural and cognitive strategies? |
| Did the therapist help the client reconstruct traumatic events, access problematic personal meanings, and ‘update’ the personal meanings associated with the trauma memory?  |
| Did the therapist help the client identify and discriminate triggers for intrusive memories?  |
| Did the therapist help the client ‘reclaim’ areas of their life previously avoided or inaccessible because of their response to trauma?  |

**Section 4: Reviewing the session as a whole**

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| **23** | **Implementing CBT using a collaborative approach** | 1 | 2 | 3 | 4 | 5 |
| Did the therapist consistently foster collaborative working - encouraging the client to take an active role in the therapy, such that the client and therapist work as a “team” |
| Did the therapist consistently use activities that encourage the client to share responsibility for the therapy (e.g. inviting shared agenda setting, shared discussion, shared problem solving, shared decision-making, Socratic questioning etc.) |
| Did the therapist identify and discuss any difficulties clients have in working collaboratively and discuss these with the client in a manner congruent with the CBT model  |

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| **24** | **Using measures** | 1 | 2 | 3 | 4 | 5 |
| Does the therapist make use of measures that are appropriate both to the client’s presentation and the approach being taken? |
| Does the therapist use measures collaboratively (e.g. inviting discussion about the rationale for their use, discussing scores and their implications for the intervention)?  |
| Does the therapist administer and interpret the measure/s correctly? |
| Does the therapist help the client to use and review any systematic self-monitoring techniques, and (e.g. keeping a diary or structured record) |

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| **25** | **Using change techniques appropriate to the client’s presentation and problems\*** | 1 | 2 | 3 | 4 | 5 |
| Did the therapist select change techniques appropriate to the formulation of the client’s presenting issues? |
| Did the therapist make use of specific CBT techniques that research evidence indicates are likely to maximise effectiveness?  |
| Did the therapist discuss the rationale for using specific change techniques with the client (e.g. linking their use to the formulation, and checking their understanding of this link) |

*\* in this question “appropriate” = those specific change techniques that research guidance indicates should be deployed in relation to the presentation*

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| **26** | **Metacompetences** | 1 | 2 | 3 | 4 | 5 |
| Did the therapist balance the tasks and techniques of therapy against the need to maintain an emotionally responsive and positive therapeutic relationship? |
| Did the therapist implement CBT in a manner which is flexible and responsive to the issues the client raises, but which also ensures that all relevant components of the model are included? |
| Did the therapist implement CBT in a manner which guards against it becoming didactic, directive, intellectual or controlling? |
| Did the therapist balance the need to structure sessions as against the need to allow the client to make choices and take responsibility? |
| Did the therapist maintain a problem-solving attitude in the face of difficulties and frustrations? |