



The competences
required to deliver
effective cognitive and
behavioural therapy for
people with depression
and with anxiety
disorders

DH INFORMATION READER BOX

Policy	Estates
HR/Workforce	Commissioning
Management	IM & T
Planning	Finance
Clinical	Social care/partnership working
Document purpose	Best practice guidance
Gateway reference	8666
Title	The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders
Author	Improving Access to Psychological Therapies (IAPT) Programme
Publication date	September 2007
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of Nursing, Special HA CEs, Allied Health Professionals
Circulation list	N/A
Description	This document identifies the activities associated with the delivery of high-quality cognitive and behavioural therapy and the competences required to achieve these. It describes a model of the relevant competences and discusses how this should be applied by practitioners, its advantages for clinicians, trainers and commissioners and the uses to which it can be put.
Cross reference	IAPT Best Practice Guidance
Superseded documents	N/A
Action required	N/A
Timing	N/A
Contact details	Roslyn Hope Director, NIMHE National Workforce Programme CSIP Development Centre Genesis 5, Innovation Way Heslington York YO10 5DR roslyn.hope@csip.org.uk
For recipient's use	

*The competences required to deliver
effective cognitive and behavioural
therapy for people with depression
and with anxiety disorders*

September 2007

Anthony D. Roth and Stephen Pilling

*Sub-Department of Clinical Health Psychology,
University College London*

*The full listing of the cognitive and behavioural
therapy competences described in this report is
available online at www.ucl.ac.uk/CORE*

This publication is sponsored by: the British Association for Behavioural and Cognitive Psychotherapies; the British Psychological Society; the Care Services Improvement Partnership/National Institute for Mental Health in England; and Skills for Health.



This publication is also endorsed by the British Association for Counselling and Psychotherapy; the Royal College of Psychiatrists; and the United Kingdom Council for Psychotherapy.



Author affiliations

Dr Anthony Roth, PhD Clinical Psychology, Joint Course Director,
Sub-Department of Clinical Health Psychology, University College London

Mr Stephen Pilling, Director of the Centre for Outcomes, Research and Effectiveness,
Co-Director of the National Collaborating Centre for Mental Health, Sub-Department
of Clinical Health Psychology, University College London

Acknowledgements

The work described in this report was commissioned by the Improving Access to Psychological Therapies (IAPT) programme, with additional funding from Skills for Health and the Centre for Outcomes, Research and Effectiveness (CORE).

The project team was headed by Anthony Roth and Stephen Pilling, and included Rachel Newman (who contributed to the process of competence extraction) and Jenny Turner (Research Assistant, CORE).

The work was overseen by an Expert Reference Group (ERG)¹ whose invaluable advice and collegial approach contributed enormously to the development of the work. The ERG was ably chaired by Professor Philippa Garety, and comprised Professor Ian Baguley, Gillian Butler, Professor David Clark, Amanda Cole, Professor Anke Ehlers, Professor Mark Freeston, Professor Willem Kuyken, Professor Glyn Lewis, Christopher Mace, Dr David Mathews, Freda McManus, Professor Dave Richards, Professor Graham Turpin, Dr David Veale, Dave Westbrook and Dr Chris Williams.

We were extremely fortunate to be able to invite peer review of the problem-specific competence lists from the originators of the therapies the lists represent. We are very grateful to the following reviewers for their comments:

- **in the United States:** Professors Michael Addis, David Barlow, Aaron T. Beck, Tom Borkovec, Michelle Craske, Rob DeRubeis, Rick Heimberg, Steve Hollon, Christopher Martell, Gail Steketee, Patricia Resick, Barbara Rothbaum and Rick Zinbarg
- **in the United Kingdom:** Professors David Clark, Anke Ehlers, Mark Freeston and Dave Richards

Colleagues at UCL contributed to the review of competence lists at various stages of their development. We are very grateful to Dr Debbie Lee, Dr Louise Payne, Dr Sue Watson and Ms Kerry Young for their very helpful comments.

¹ Appendix A shows the professional affiliations of members of the ERG

Contents

Executive summary	1
How to use this report	2
Background	3
How the competences were identified	5
The competence model for CBT	7
Specifying the competences needed to deliver CBT	10
The map of CBT competences	11
Implementing the competence framework	19
Applying the competence framework	22
References	26
Appendix A: Members of the Expert Reference Group	28

Executive summary

The report begins by briefly describing the Improving Access to Psychological Therapy (IAPT) programme, which forms the background to this work. It outlines the organisation of services into 'low-intensity' and 'high-intensity' interventions, and discusses the requirement of the IAPT programme for a description of the competences of the practitioners who contribute to it.

It briefly describes an evidence-based method for identifying competences, and presents a competence model for cognitive and behavioural therapy (CBT). This organises the competences into five domains:

- Generic competences – used in all psychological therapies
- Basic cognitive and behavioural therapy competences – used in both low- and high-intensity interventions
- Specific cognitive and behavioural therapy techniques – the core technical interventions employed in most forms of CBT
- Problem-specific competences – the packages of CBT interventions for specific low- and high-intensity interventions
- Metacompetences – overarching, higher-order competences which practitioners need to use to guide the implementation of any intervention

The report then describes and comments on the types of competence found in each domain, and presents a 'map' which shows how all the competences fit together and interrelate.

Finally, the report comments on issues that are relevant to the implementation of the competence framework, and considers some of the organisational issues around its application.

How to use this report

This report describes the model of CBT competences, and indicates the various areas of activity that, taken together, represent good clinical practice. The report does not include the detailed descriptions of the competences associated with each of these activities.

These can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE). They are available as PDF files, accessed directly or by navigating the map of competences (as represented by Figure 2 on page 12 of this report).

Background

The Improving Access to Psychological Therapies (IAPT) programme: This work formed part of the IAPT programme, which was launched in May 2007² (Department of Health, 2007; Turpin *et al.*, in press). This programme focuses on delivering psychological therapy for adults with common mental health problems, with a particular emphasis on depression and anxiety disorders.³ While there is no intent to exclude other therapies, CBT would usually be the preferred mode of treatment, because CBT has the most substantial evidence base supporting its effectiveness in the treatment of depression and anxiety (e.g. NICE, 2004a; 2004b; 2005a; 2005b), and in the area of anxiety disorders there is good evidence for the benefits of CBT over other psychological therapies (Roth and Foa, 2005).

Low- and high-intensity interventions: The IAPT programme is premised on a stepped-care model of service delivery, in line with National Institute for Health and Clinical Excellence (NICE) guidance (e.g. NICE, 2004b). Stepped care can be implemented in slightly different ways – either offering clients the least intrusive, most effective intervention first, or offering the lowest intensity, highest capacity effective interventions first (the difference lying in the degree to which all or only some clients pass through the low-intensity phase). However configured, because the most effective intervention will not be the same for all clients, in practice this means that some will receive ‘low-intensity’ and others ‘high-intensity’ interventions. In this context, ‘high-intensity’ denotes a formal psychological therapy delivered by a relatively specialist psychological therapist. Low-intensity interventions are very varied, including, for example, guided self-help delivered through books and leaflets, structured exercise, computerised forms of CBT, or brief interventions which retain a sense of self-help, albeit in the context of meetings with a relevantly trained individual (for example, behavioural activation in depression).

There is a risk that low-intensity interventions are thought of only as a partial version of the ‘proper’ treatment, with the implication that clients are deprived of their entitlement to a

2 Further work is being undertaken to extend the work described in this report to other psychological therapies, specifically psychodynamic, systemic and integrative/humanistic therapies

3 The competence model described in this report is broadly applicable to interventions with adults of all ages. However, further work is required to consider how it needs to be adapted to apply to work with children and adolescents. More information about the development of the IAPT programme can be found at the Choices in Mental Health/Care Services Improvement Partnership (CSIP) website (www.mhchoice.csip.org.uk/psychological-therapies/-iapt-commissionerled-pathfinder-sites/resources.html)

full intervention package. In fact, it is clear that some clients respond to relatively circumscribed interventions, and for these responders, treatment duration and intensity is clearly matched to need. On this basis, it makes no sense to describe their therapy as partial and from this perspective, it is helpful to see low-intensity interventions as treatments in their own right, and not as substitutes for 'the real thing'.

Why the IAPT programme needs to identify competences: Because the IAPT programme involves delivering low- and high-intensity CBT to a good and coherent standard, it requires competent practitioners who are able to offer effective interventions. Identifying individuals with the right skills is important, but this is not straightforward. Within the NHS, a wide range of professionals deliver psychological therapies, but there is no single profession of 'psychological therapist'. Most practitioners have a primary professional qualification, but the extent of training in psychological therapy in general, and CBT in particular, varies between professions, as does the extent to which individuals have acquired additional post-qualification training. This makes it important to take a different starting point, identifying what competences are needed to deliver good-quality CBT, rather than simply relying on job titles to indicate proficiency.

National Occupational Standards (NOS): The work undertaken in this report needs to be seen in the context of the development of National Occupational Standards (NOS), which apply to all staff working in health and social care. There are a number of NOS that describe standards relevant to mental health workers, downloadable at the Skills for Health website (www.skillsforhealth.org.uk), and the work described in this report will be used to inform the development of standards for psychological therapies.

How the competences were identified

Identifying competences by looking at the evidence of what works:⁴ This project began by identifying those therapeutic approaches with the strongest claims for evidence of efficacy, based on the outcome of therapies in clinical controlled trials.

Almost invariably, the therapy delivered in these trials is based on a manual which describes the treatment model and associated treatment techniques. In this sense, the manual represents best practice for the fully competent therapist – the things that a therapist *should* be doing in order to demonstrate adherence to the model and to achieve the best outcomes for the client. Because research trials monitor therapist performance (by inspecting audio or video recordings), we know that therapists adhered to the manual. This makes it possible to be reasonably confident that if the procedures set out in the manual are followed there should be better outcomes for clients.

Once the decision is taken to focus on the evidence base of clinical trials and their associated manuals, the procedure for identifying competences falls into place logically. The first step is to review the psychological therapy outcome literature, which identifies effective therapeutic approaches. Secondly, the manuals associated with these successful approaches are identified. Finally, the manuals are examined in order to extract and to collate therapist competences.⁵ A major advantage of this approach is that, by using the evidence base to narrow the focus, it sets clear limits on debates about what competences should or should not be included.

4 An alternative strategy for identifying competences could be to examine what therapists actually do when they carry out a particular therapy, complementing observation with some form of commentary from the therapists in order to identify their intentions as well as their actions. The strength of this method – it is based on what people do when putting their competences into action – is also its weakness. Most psychological therapies set out a theoretical framework that purports to explain human distress, and this framework usually links to a specific set of therapist actions aimed at alleviating the client's problems. In practice, these 'pure' forms of therapy are often modified as therapists exercise their judgement in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways which do not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it does make it risky to base conclusions about competence on the work done by practitioners, since this could pick up good, bad and idiosyncratic practice

5 A detailed account of the methodology and procedures used in this project can be found in the companion technical report (Roth and Pilling, in preparation, a)

CBT has a strong research tradition, and evidence for its efficacy rests on a substantial number of trials demonstrating the efficacy of specific packages of treatment. This means that we can be reasonably confident about which of a variety of approaches represent the best exemplars of effective therapy.

Oversight and peer review: The work described in this project was overseen by an Expert Reference Group (ERG) which comprised national experts in CBT, selected for their expertise in the development of novel CBT treatments, the evaluation of CBT in formal trials, and the development and delivery of supervision and training models in CBT. In addition, each of the competence lists for specific interventions (both low- and high-intensity) were sent to the developers of the therapy described in the manual. Given that these competence lists are intended to capture the procedures outlined by these individuals, it is reasonable to expect that their scrutiny will be especially vigilant. This process of open peer review ensured that the competence lists were subject to a very high level of scrutiny.

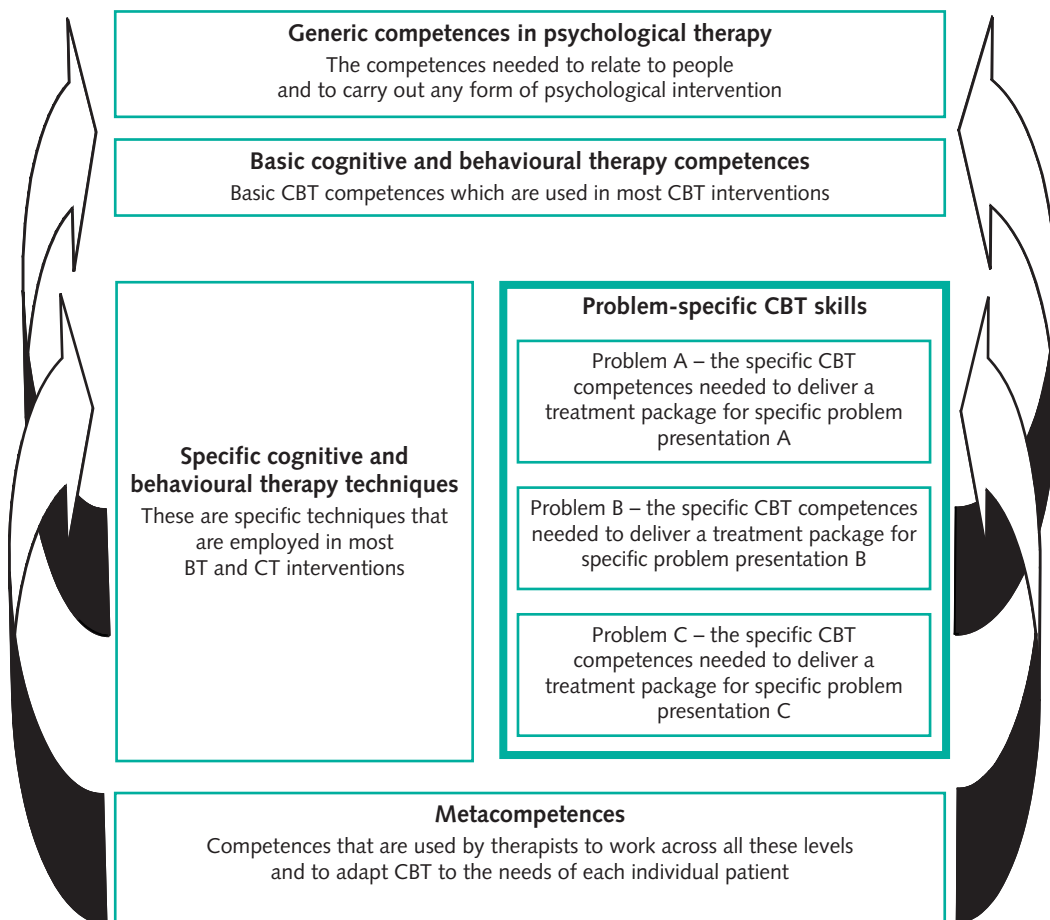
The competence model for CBT

Organising the competence lists

Competence lists need to be of practical use. To achieve this they need to be structured in a way which reflects the practice they describe, be set out in a structure that is both understandable (in other words, is easily grasped) and be valid (recognisable to practitioners as something which accurately represents the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the way in which competences have been organised into five domains. The components are as follows:

Figure 1: Outline model for CBT competences



Generic competences in psychological therapy

Generic competences are those employed in any psychological therapy, reflecting the fact that all psychological therapies, including CBT, share some common features. For example, therapists using any accepted theoretical model would be expected to demonstrate an ability to build a trusting relationship with their clients, relating to them in a manner which is warm, encouraging and accepting. Without building a good therapist–client relationship, technical interventions are unlikely to succeed. Often referred to as ‘common factors’ in therapy, it is important that the competences in this domain are not overlooked or treated as an afterthought.

Basic cognitive and behavioural therapy competences

Basic competences establish the structure for both low- and high-intensity CBT interventions, and form the context and structure for the implementation of a range of specific cognitive and behavioural therapy techniques. For example, CBT sessions follow an agenda explicitly negotiated and agreed between therapist and client, something that will not happen unless the therapist introduces this idea and follows it through. Another example would be the use of ‘homework’ or ‘practice assignments’ tasks, in which (broadly speaking) therapist and client agree on activities which allow the client to test out ideas discussed during sessions. Again, this depends on therapist facilitation, which involves working with the client to identify appropriate homework tasks and negotiating with them to ensure that these seem relevant and manageable.

Distinguishing ‘basic cognitive and behavioural therapy competences’ from ‘specific cognitive and behavioural therapy techniques’: There is a fine line between these domains. The distinction between the two is as much pragmatic as conceptual, and is intended to improve the legibility and utility of the model. Essentially, ‘basic competences’ are employed in both low- and high-intensity interventions, while (at least in the form described here) most of those which come under the domain of specific techniques are more usually associated with high-intensity interventions.

Specific cognitive and behavioural therapy techniques

These are the core technical interventions employed in most CBT applications – the set of commonly applied techniques found to a lesser or greater extent in most forms of CBT. Examples would be using exposure techniques, eliciting and working with problematic behaviours, or using Socratic questioning to help clients identify and appraise their cognitions.

Problem-specific competences

Competence lists in this domain represent the ‘package’ of CBT interventions for specific disorders, as described in treatment manuals. They are the sets of specific procedures for which there is evidence of benefit for particular problem presentations.

Metacompetences

A common observation is that carrying out a skilled task requires the person to be aware of why and when to do something (and, just as important, when not to do it!). This is a critical skill which needs to be recognised in any competence model. Reducing psychological therapy to a series of rote operations would make little sense, because competent practitioners need to be able to implement higher-order links between theory and practice in order to plan and, where necessary, to adapt therapy to the needs of individual clients. These are referred to as ‘metacompetences’ in this framework: the procedures used by therapists to guide practice and operate across all levels of the model. These competences are more abstract than those in other domains because they usually reflect the intentions of the therapist. These can be difficult to observe directly but can be inferred from their actions, and may form an important part of discussions in supervision.

Although there is a sense in which these are higher-order competences, it is important that they are not seen as the exclusive preserve of high-intensity interventions. For example, metacompetences which focus on the ability to implement models in a manner that is flexible and tailored to the needs of the individual client would be employed in both high- and low-intensity interventions.

Specifying the competences needed to deliver CBT

Integrating knowledge, skills and attitudes

A competent clinician brings together knowledge, skills and attitudes. It is this combination that defines competence; without the ability to integrate these areas, practice is likely to be poor.

Clinicians need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps the practitioner understand the rationale for applying their skills; to think not just about *how* to implement their skills, but also *why* they are implementing them. It is worth remembering that the various techniques used in CBT are not ends in themselves, but are a means to an end. For example, helping clients to self-monitor their behaviours and cognitions helps them to act as their own therapist by giving them an opportunity to test out and appraise their ideas. For many clients this experience enhances their sense of autonomy, and so helps improve their morale and helps increase their active engagement in the therapy. This means that self-monitoring actually has a variety of functions, and if therapists understand this they are more likely to see its intrinsic value, and hence make consistent use of it. If they perceive it simply as one of a number of ‘tasks’, it may well fall off their agenda, and they will be less likely to ask clients to undertake it, or fail to ask clients to review any of the self-monitoring they have been doing.

Beyond knowledge and skills, the therapist’s attitude and stance to therapy are also critical – not just their attitude to the relationship with the client, but also to the organisation in which therapy is offered, and the many cultural contexts within which the organisation is located (which includes a professional and ethical context, as well as a societal one). All of these need to be held in mind by the therapist, since all have a bearing on the capacity to deliver a therapy that is ethical, conforms to professional standards, and which is appropriately adapted to the client’s needs and cultural contexts.

The map of CBT competences

Using the map

The map of CBT competences is shown in Figure 2. It organises the competences into the **five** domains outlined above and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences. The details of these competences are not included in this report; they can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE).

The map shows the ways in which the activities fit together and need to be ‘assembled’ in order for practice to be proficient. A commentary on these competences follows.

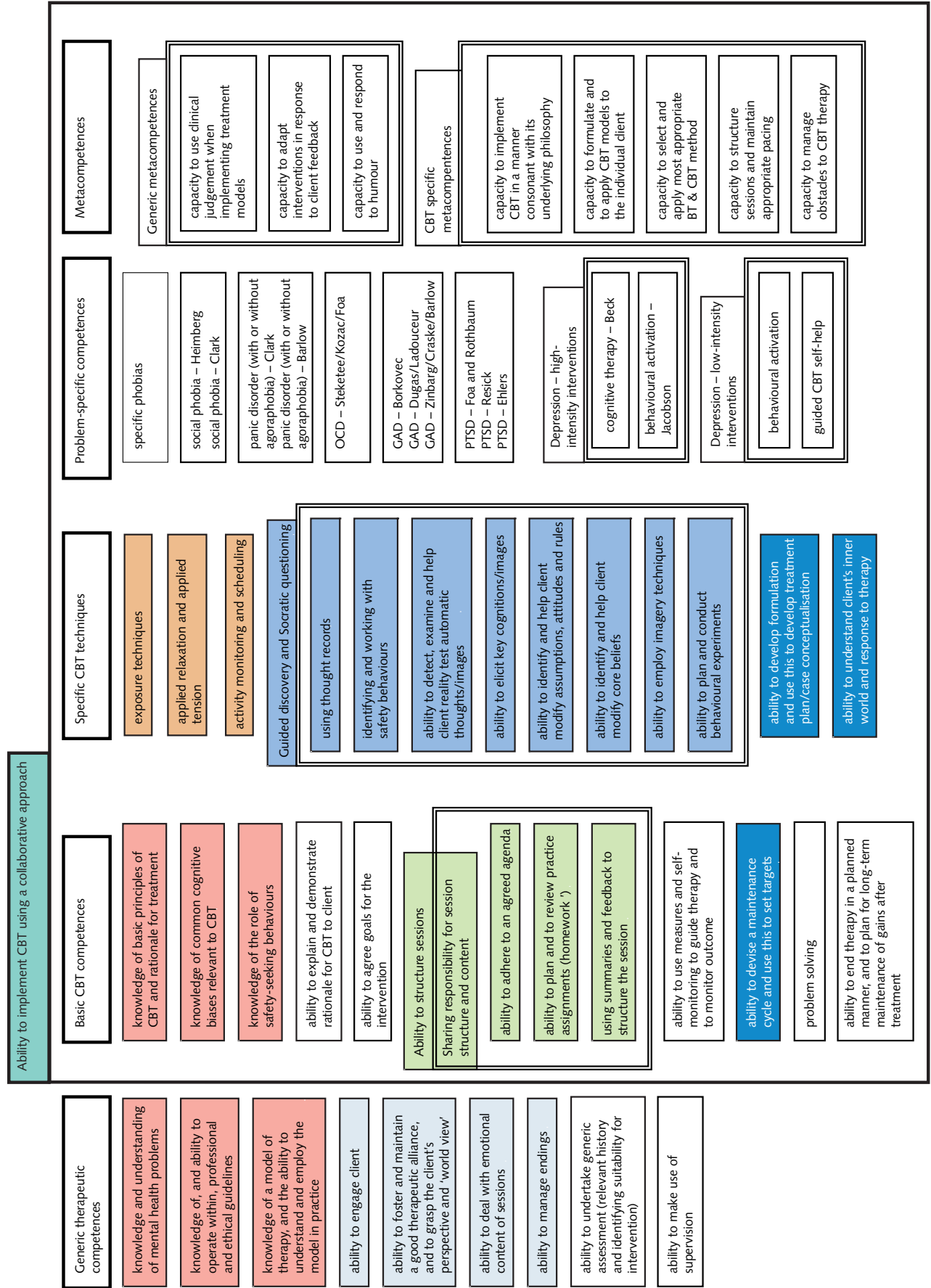
Generic therapeutic competences (see column 1 of Figure 2)

Knowledge: Knowledge of mental health problems (the first three competences shown in terracotta), professional and ethical guidelines and the model of therapy being employed forms a basic underpinning to any intervention, not just to CBT. Being able to draw on and apply this knowledge is critical to effective therapy.

The ability to operate within professional and ethical guidelines encompasses a large set of competences, many of which have already been identified and published elsewhere (for example, profession-specific standards, or national standards such as the Ten Essential Shared Capabilities (Hope, 2004), and the suites of National Occupational Standards relevant to mental health (available on the Skills for Health website at www.skillsforhealth.org.uk). Embedded in these frameworks is the notion of ‘cultural competence’, or the ability to work with individuals from a diverse range of backgrounds, a skill which is important to highlight because it can directly influence the perceived relevance (and hence the likely efficacy) of an intervention.

Building a therapeutic alliance: The next set of four competences shown in light blue is concerned with the capacity to build and to maintain a therapeutic relationship. Successfully engaging the client and building a positive therapeutic alliance is associated with better outcomes across all therapies. Just as important is the capacity to manage the end of treatment, which can be a difficult time for clients and for therapists. Because disengaging from therapy is often as significant as engaging with it, this process is an integral part of the ‘management’ of the therapeutic relationship.

Figure 2: The map of CBT competences for depression and anxiety disorders



Assessment: The ability to make a generic assessment (single competence shown in white) is crucial if the therapist is to begin to understand the difficulties that concern the client. This is a different activity to the focused assessment described in the problem-specific competence lists. In contrast a generic assessment is intended to gain an overview of the client's history, their perspectives, their needs and their resources, their motivation for a psychological intervention and (based on the foregoing) a discussion of treatment options.

Assessment also includes an appraisal of any risk to the client or to others. This can be a challenging task, especially if the person undertaking the assessment is a junior or relatively inexperienced member of staff. Bearing this in mind, the ability of workers to know the limits of their competence and when to make use of support and supervision will be crucial.

Supervision: Making use of supervision (single competence shown in white) is a generic skill that is pertinent to all practitioners at all levels of seniority because clinical work is demanding and usually requires complex decision making. Supervision allows practitioners to keep their work on track and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals.

Implementing CBT using a collaborative approach (see columns 2-5 of Figure 2)

Activities in all domains of CBT competence need to be carried out in the context of an overarching competence: the ability to implement the CBT approach in a collaborative manner which stresses the shared responsibility of therapist and client and which takes a collegial approach to therapy. Collaboration implies that therapist and client should be working together as a team, in an environment structured so as to help clients to learn more about themselves, for themselves. Many of the activities that take place in CBT interventions mirror this sense of collaboration and shared responsibility, for example establishing a mutually agreed agenda at the start of each session, or the active engagement of clients in therapy tasks such as self-monitoring thoughts and behaviours, or developing ways of testing out clients' ideas and observations through practice assignments.

The extent to which collaboration is genuinely integrated into the therapy is partly determined by the therapist's attitudes. They need to maintain a consistent sense of the value of this mode of operating, as well as an explicit sense of curiosity, trying not to make assumptions that they understand the client's construction of their problems without this first being elaborated upon by the client themselves.

The structured nature of CBT is often misunderstood, with therapy seen as a series of techniques delivered in a didactic manner by a directive therapist who (in effect) tells the client that their way of thinking is 'wrong' and shows them how to think in a more

constructive manner. This caricature is common, but unhelpful on at least two counts. If CBT were to be implemented in this way it would be unlikely that enduring change would result. And as should be clear from this report, it would not really be CBT.

Basic cognitive and behavioural therapy competences (see column 2 of Figure 2)

This domain contains a range of activities that are basic in the sense of being fundamental areas of skill; they represent practices that underpin any CBT intervention.

Knowledge: Three areas of basic knowledge (first three competences shown in terracotta) are relevant to the application of all forms of cognitive and behavioural therapies: the basic principles of CBT, the common cognitive biases relevant to CBT, and the role of safety behaviours.

Explaining the rationale for CBT: Clients need to understand the rationale for CBT (the next two competences shown in white) in order to begin actively engaging with the intervention. As a basic competence, explaining the rationale to clients is often a matter of orienting them to important features of the model, since all the problem-specific intervention packages include procedures for helping the client to understand the rationale for the particular approach being taken.

Structuring sessions: The ability to structure sessions (four competences shown in pale green) is fundamental to the practice of CBT. In the map, this is represented through a set of overlapping, but distinct, activities. A fundamental characteristic of this structuring is that therapists need to ensure that they work in a way that ensures that there is a sharing of responsibility for the session and the work. This reflects the underlying philosophy of CBT, which assumes that clients need to become active participants in their therapy if they are to benefit from it. Because it cannot be assumed that this will happen naturally, it is helpful for therapists to make this aspect of the intervention explicit from the outset. All the other activities associated with structuring the session – setting the agenda, planning and reviewing homework, and using summaries and feedback – are assumed to be enacted in the context of sharing responsibility.⁶

The first two competences refer to agenda setting, firstly in relation to the therapy as a whole and secondly for each session. Next is the ability both to plan and to review 'homework' or 'practice assignments'. As discussed in the later sections of this report, these are actually two activities; there is evidence that reviewing homework makes it more likely that clients will carry it out, and also that many therapists set homework but fail to review it (Roth and Pilling, in preparation, b). Since carrying out homework is associated with better

6 There is, of course, a close link between the notions of 'shared responsibility' and 'collaboration'

outcomes, there is obvious value in distinguishing setting homework from the process of its review. The last competence shown in pale green focuses on the use of summaries and two-way feedback to structure the session, using careful listening and observation to give feedback to the client about how the therapist understands them, and eliciting feedback from the client to help the therapist appraise their understanding of the issues under discussion. Along with periodic explicit ‘capsule’ summaries, this process makes an important contribution to the structure of the session.

Using measures and self-report records (single competence shown in white): Although there is considerable value in clients’ ‘informal’ reports regarding their problems and any changes they have noticed, it is usual for CBT therapists to make use of systematic ways of recording these factors by using measures or questionnaires, or self-report records. These are somewhat distinct sources of information, because measures usually capture phenomena that are common in individuals with a particular problem, whereas self-report records are a way of helping the client to elaborate on their own idiosyncratic concerns. Nonetheless, both help to anchor therapy by making use of information that is current and (broadly speaking) objective.

Developing hypotheses about a maintenance cycle (single competence shown in dark blue): It is helpful to conceptualise how the client’s thoughts, physical symptoms, behaviours and emotions interact to maintain their problems, and to share this with the client. This is not a matter of telling the client about the maintenance cycle, but of sharing initial hypotheses with them and using their feedback to arrive at a jointly constructed understanding of their problems. This can be used to guide treatment planning and hence to provide a framework that helps the client to begin resolving their difficulties.

Problem solving (single competence shown in white): This is a procedure for helping clients to develop, appraise and implement solutions to a specific difficulty but, just as importantly, it helps them to learn a procedure which can be applied to many difficulties that confront them. The utility of problem solving is clear and, though it has been applied as a stand-alone therapeutic procedure (Mynors-Wallis et al., 2000), it is commonly used as one of a number of strategies in many interventions.

Ending therapy (single competence shown in white): Finishing therapy in a planned manner is important not only because clients (and often therapists) may have strong feelings about ending, but also because this allows for discussion of how the client will manage on their own. This process is aided by ensuring both that the likely schedule for sessions is signalled from the outset and that there is explicit discussion towards the end of therapy that is oriented to thinking about the maintenance of gains. This usually includes a review of progress and any concerns that the client has about how they will manage after therapy

ends, connecting this to a discussion of what the client has learned and thinking about how this can be applied in the face of future challenges such as risk of relapse.

Specific cognitive and behavioural therapy techniques (see column 3 of Figure 2)

This domain includes the main therapeutic cognitive and behavioural techniques and strategies usually employed by CBT therapists. Not all of these would be employed for any one individual, and different sets of techniques would be deployed for different problems.

The main behavioural techniques in this domain are exposure, applied relaxation and tension, and activity monitoring and scheduling (these are shown in terracotta). The remaining procedures represent central activities in cognitive therapy.

Guided discovery and Socratic questioning (eight competences shown in medium blue): A fundamental technique is the use of guided discovery. Technically this involves the use of Socratic questioning, through which the therapist facilitates the client's exploration of their thoughts, images, beliefs and feelings. Guided discovery should mean just that – although the therapist acts as a guide, the intent is for the client to take a leading role and for discoveries to be jointly constructed. This means that – however tempting – therapists need to be wary of attempting to lead clients towards a preconceived idea, because this may or may not fit with the client's actual perception of events.

Specific cognitive techniques: Using guided discovery, clients are helped to identify relevant cognitions, automatic thoughts, assumptions and beliefs, a process which broadly follows this temporal sequence across a number of sessions, largely because this sequence also describes a deepening of content and understanding. Cognitive therapists increasingly work with imagery as well as cognitions; although this activity is usually integrated into the areas described above it makes sense to identify them separately.

Thought records are a specific form of self-monitoring, and are both a starting point and subsequently an underpinning to much of the work of cognitive therapy. They help clients to identify and subsequently to appraise behaviours and thoughts (and often images) that are relevant to their difficulties. This process of self-monitoring, and the integration of self-monitoring into the therapy process, is important. Not only does it provide some of the 'raw data' for the intervention, it also helps the client to learn skills that enhance their capacity to understand themselves better and to cope by themselves.

All these techniques involve discussion within the therapy session, but it is usually important that they are brought alive through the use of 'behavioural experiments'. These are assignments that help the client to test out the validity of their cognitions and beliefs. Carrying out the assignment also helps them to become more aware of the way in which they

perceive and react to events and to those around them, further contributing to the process of self-understanding. Although behavioural experiments can be carried out in the session, they are particularly helpful when carried out in the client's everyday life; on this basis they are a core activity in CBT and make a fundamental contribution to the process of change.

Understanding the way the client sees the world, reaching a formulation and developing a treatment plan (last two competences shown in dark blue): Therapists need to experience something close to an immediate appreciation of the client's own thoughts, feelings and beliefs, and in this way be able to grasp the client's perspective as a gestalt, rather than as a series of separate elements. This sense of immediacy enables the therapist to be responsive and fully engaged with the client.

Closely linked to this facility is the capacity to derive a formulation which accounts for the development and maintenance of the client's problems and which helps to create a framework for the application of specific therapy techniques. A formulation helps to bridge theory and practice, and helps to ensure that therapy is mapped to the needs of the individual client. Because it is usually shared with the client it gives them a chance to conceptualise their own difficulties and to appraise the degree of fit between the formulation and their own experiences. If the formulation does not feel right to the client it can be discussed and, if appropriate, revised. This process is important because there is usually a close link between the treatment plan and the formulation; if it makes sense to the client they are more likely to be engaged with therapy.

Problem-specific competences (see column 4 of Figure 2)

This domain contains competence lists (all shown in white) for the exemplar interventions for the anxiety disorders (specific phobia, social phobia, panic disorder, obsessive-compulsive disorder, generalised anxiety disorder and post-traumatic stress disorder) and for low- and high-intensity CBT interventions for depression.

The lists in this domain are intended to read as a coherent description of the critical elements of (and pathways through) each intervention. Working through the list should identify the elements which, taken together, constitute the treatment 'package' and hence best practice. By intent the problem-specific lists include some repetition of basic or specific CBT competences, partly because this makes them easier to digest and partly because some interventions modify standard CBT techniques in order to apply them to a particular disorder. Nonetheless, it should be clear that the effective delivery of problem-specific interventions will always rest on a range of generic, basic, specific and metacompetences.

In a number of instances there are competence lists for more than one approach to a disorder. This reflects the fact that within CBT there can be differences in the way a disorder is conceptualised, and hence in the emphasis placed on different aspects of

intervention. As there is strong evidence for the effectiveness of all the approaches listed in this domain, it is for the therapist (perhaps in conjunction with the client) to decide which intervention to select.

Low- and high-intensity interventions: Two low-intensity interventions for depression are described – behavioural activation and guided CBT self-help. There are no descriptions of low-intensity interventions for anxiety disorders because the programmes that employ guided (as opposed to ‘pure’) self-help for anxiety are less well developed and, as a consequence, there is less evidence for their benefit.

Metacompetences (see column 5 of Figure 2)

Therapy cannot be delivered in a ‘cook book’ manner; by analogy, following a recipe is helpful, but it doesn’t necessarily make for a good cook. This domain describes some of the procedural rules (all shown in white) (e.g. Bennett-Levy, 2005) that enable therapists to implement therapy in a coherent and informed manner and to apply an intervention in a way that is responsive to the needs of each individual client.

On the whole these are more abstract competences than are described elsewhere and, as a result, there is less direct evidence for their importance. Nonetheless, there is clear expert consensus that metacompetences are relevant to effective practice. Most of the list has been extracted from manuals, with some based more on expert consensus⁷ and some on research-based evidence (for example, an ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise or an ability to implement models flexibly, balancing adherence to a model against the need to attend to any relational issues that present themselves).

The lists are divided into two areas. Generic metacompetences are employed in all therapies and broadly reflect the ability to implement an intervention in a manner that is flexible and responsive. CBT-specific metacompetences apply to the implementation of CBT in a manner that is consonant with its philosophy, as well as the way in which specific techniques are applied. As is the case in other parts of the model, this division is pragmatically useful, but it is the case that many of the competences described as CBT-specific could easily be adapted and apply to other interventions or techniques.

7 Through discussion and review of metacompetences by the Expert Reference Group (ERG)

Implementing the competence framework

A number of issues are relevant to the practical application of the competence framework.

Do clinicians need to do everything specified in a competence list? Most of the competence lists are based on manuals, which are packages of techniques. Some of these techniques may be critical to outcome, but others may be less relevant or, on occasions, irrelevant. Based on research evidence we know that the package works, but we are less certain about which components actually make for change, and by exactly what process.

It needs to be accepted that the competences that emerge from a manual could represent both ‘wheat’ and ‘chaff’: as a set of practices they stand a good chance of achieving their purpose, but at this stage there is little empirical evidence that can be used to sift effective from potentially ineffective strategies. This means that competence lists derived from manuals may include therapeutic culs-de-sac as well as critical elements.

Does this mean that clinicians can use their judgement to decide which elements of an intervention to include and which to ignore? This would be a risky strategy, especially if this meant that major elements or aspects of an intervention were not offered – in effect clinicians would be making a conscious decision to deviate from the evidence that the package works. Equally, manuals cannot be treated as a set of rigid prescriptions, all of which have to be treated as necessary and all of which must be applied. Indeed most of our competence lists for problem-specific interventions include an important metacompetence – the ability to introduce and implement the components of a programme in a manner which is flexible and which is responsive to the issues the client raises, but which also ensures that all relevant components are included. Clearly this involves using informed clinical judgement, rather than opinion.

CBT has evolved over time, especially as research helps to identify the elements that make a difference. By way of example, until recently most anxiety management approaches placed great emphasis on training clients to use progressive relaxation. However, current manuals for the treatment of panic disorder do not include relaxation training because its value has been questioned by both theory and research. This means that clinicians can implement a more focused therapy that no longer employs procedures which are now viewed as redundant. It is likely that this process of systematic adaptation will apply across the interventions described in the competence lists (although the observation that intervention packages are not tablets of stone is not a reason for adopting a pick-and-mix approach to the therapies).

Are some competences more critical than others? For many years researchers have tried to identify links between specific therapist actions and outcome. Broadly speaking, better outcomes follow when therapists adhere to a model and deliver it competently (Roth and Pilling, in preparation), but this observation really applies to the model as a whole rather than its specific elements.

One set of activities that do seem to be related to outcome are the aspects of CBT that set out the basic structure of the approach. Thus better outcomes seem to follow when therapists set and follow an agenda, assign and review self-monitoring tasks and homework, ask clients to record their thoughts, ask for specific examples of beliefs, ask patients to report cognitions verbatim, and examine evidence concerning beliefs (DeRubeis and Feeley, 1990; Feeley, DeRubeis and Gelfand, 1999; Brotman, Strunk and DeRubeis, in preparation).

Reflecting these findings is the observation that clients are more likely to carry out homework if therapists review it at each session (e.g. Bryant, Simons and Thase, 1999). Given that there is also an association between better outcome and higher levels of homework compliance, the value of this therapist behaviour is clear. Although this may not seem an especially surprising finding, it is a potent one, since the same evidence suggests that therapists often neglect to follow up homework that they have assigned (something that is unlikely to encourage clients to carry it out).

Despite observations such as these, there are two reasons for not highlighting some competences as being more evidence-based than others. Firstly there is only limited evidence on which to base judgements about the value of specific activities, and comment on the relative value of competences may well be premature. Secondly it may be that competences cannot be safely disaggregated in a meaningful way. For example, although reviewing homework does seem to be important, there is also some (although not strong) evidence that homework compliance is enhanced if therapists carefully check that clients understand the task being planned and identify any problems that may arise when it is being carried out. It may be that these, along with homework review, form a set of coherent activities, all of which contribute to homework compliance and none of which can be safely neglected.

The impact of treatment formats on clinical effectiveness: The competence lists in this report set out what a therapist should do, but do not comment on the way in which therapy is organised and delivered – for example the duration of each session, how sessions are spaced (e.g. daily, weekly or fortnightly) or the usual number of sessions. However, these formats are often identified in manuals and research protocols, with the schedule constructed to match to clinical need and the rationale for the intervention.

For example, Foa and Rothbaum's (1998) manual for the treatment of post-traumatic stress disorder specifies a delivery pattern of bi-weekly 90-minute sessions. This intensity of treatment reflects the challenging nature of the debriefing process. Turning to depression, many research interventions schedule short bi-weekly sessions for the first two to three weeks of treatment. This is because severely depressed clients are likely to have poor concentration, and hence this is a more effective way of working with patients in the early stages of their treatment. In terms of duration, people with depression are usually offered around 20 sessions, while individuals with anxiety disorders usually receive slightly fewer (perhaps 12–15).

Treatment formats in routine services do not always pay regard to the schedules used in research trials. It would be reasonable to assume that making significant changes to the format may impact on effectiveness, although there is little direct evidence on this point. NICE clinical guidelines offer detailed advice on the mode of delivery of CBT for specific disorders, and readers wishing to consider this further can consult the NICE website (www.nice.org.uk).

The contribution of training and supervision to clinical outcomes: Elkin (1999) highlighted the fact that when evidence-based therapies are 'transported' into routine settings there is often considerable variation in the extent to which training and supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (in preparation) reviewed the training and ongoing supervision associated with the delivery of therapy in the exemplar trials that contributed to this report. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seems reasonable to suppose that these elements make their contribution to headline figures for efficacy – a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems that help to ensure the delivery of competent and effective practice. This means that claims to be implementing an evidence-based therapy could be undermined if the training and supervision associated with trials are neglected.

Applying the competence framework

This section sets out the various uses to which the CBT competence framework for depression and anxiety disorders can be put, and describes the methods by which these may be achieved. Where appropriate it makes suggestions for how relevant work in the area may be developed.

It is important to bear in mind that the model set out here could equally well apply to other psychological therapies, and although what follows links CBT, the evidence base and service organisation, this does not imply that services should be limited to offering CBT alone.

Commissioning: The CBT framework can contribute to the effective use of healthcare resources by enabling commissioners to specify the appropriate levels and range of CBT for identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences which is shared by both commissioners and providers, and to which services could be expected to adhere.

More effective commissioning can be achieved through linking commissioning to the service design issues discussed below, but will also be further supported by the use of the framework to support commissioning guidance issued by NICE.

Service organisation – the management and development of psychological therapy services: The framework represents a set of evidence-based competences and aims to describe best practice – the activities that individuals and teams should follow to deliver evidence-based treatments.

Although further work is required on the utility and associated method of measurement, the framework will enable:

- the identification of the key competences required by a practitioner to deliver interventions for depression or anxiety disorders
- the identification of the range of competences that a service or team would require to meet the needs of an identified population
- the likely training and supervision competences of those managing the service.

Because the framework converts general descriptions such as ‘cognitive behaviour therapy’ into a set of concrete specifications, it can link advice regarding the implementation of therapies (as set out in NICE guidance, National Service Frameworks, Policy Implementation Guidance and the IAPT programme, along with other national and local policy documents) with the treatments actually delivered. Further, this level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to that of the research trials on which claims for efficacy rest. In this way it could help to ensure that evidence-based interventions are likely to be provided in a competent and effective manner.

Clinical governance: Effective monitoring of the quality of services provided is essential if clients are to be assured optimum benefit. The monitoring of the quality and outcomes of psychological therapies is a key clinical governance activity; the framework will allow providers to ensure that:

- CBT is provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of therapist performance
- clinical governance systems in trusts meet their requirement for service monitoring from the Healthcare Commission and other similar bodies.

The introduction of the CBT competence framework into clinical governance can be achieved through local implementation plans for NICE guidance and their monitoring through the local audit procedures as well as through the monitoring systems of organisations such as the Healthcare Commission.

Supervision: The CBT competence framework potentially provides a useful tool to improve the quality of supervision for psychological therapies by focusing the task of supervision on a set of competences that are known to be associated with the delivery of effective treatments. Supervision commonly has two aims – to improve outcomes for clients and to improve the performance of practitioners. The framework will support both of these through:

- providing a structure by which to identify the key components of effective practice in CBT for specified disorders
- allowing for the identification and remediation of sub-optimal performance.

The framework could achieve this through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

Training: Effective training is vital to ensuring increased access to well-delivered psychological therapies. The framework will support this by:

- providing a clear set of competences that can guide and refine the structure and curriculum of training programmes (including pre- and post-qualification professional training as well as the training offered by independent organisations)
- providing a system for the evaluation of the outcomes of training programmes.

Registration: The registration of psychotherapists and counsellors is a key objective for the Department of Health. Although a clear set of competences associated with the key activities of these professional groups may well contribute to the process of establishing a register, one caution is that it represents only one aspect of a broad set of requirements for a formal registration system.

Research: The competence framework can contribute to the field of psychological therapy research in a number of areas; these include the development and refinement of appropriate psychometric measures of therapist competence, the further exploration of the relationship between therapy process and outcome, and the evaluation of training programmes and supervision systems.

Concluding comments

This report describes a model which identifies the activities that characterise effective CBT interventions for people with anxiety and depression, and locates them in a 'map' of competences.

The work has been guided by three overarching principles. Firstly it stays close to the evidence base, meaning that an intervention carried out in line with the competences described in the model should be close to best practice and therefore be likely to result in better outcomes for clients. Secondly it aims to have utility for those who use it, clustering competences in a manner that reflects the way in which interventions are actually delivered and hence facilitates their use in routine practice. Finally, the development of the CBT model was intended to be a 'prototype' for developing the competences associated with other psychological therapies such as psychodynamic, systemic and integrative/humanistic approaches. Work on competence lists for these approaches is now under way and should be completed by the end of 2008.

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring or commissioning – will test its worth and will indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a cook book. Delivering effective therapy involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Therapists of all persuasions need to operate using clinical judgement in combination with their technical skills, interweaving technique with a consistent regard for the relationship between themselves and their clients.

Setting out competences in a way that clarifies the activities associated with a skilled and effective practitioner should prove useful for workers in all parts of the care system. The more stringent test is whether it results in more effective interventions and better outcomes for clients.

References

Bennett-Levy, J. (2005) Therapist skills: A cognitive model of their acquisition and refinement, *Behavioural and Cognitive Psychotherapy* 34, 57–78.

Department of Health (2007) *Commissioning a brighter future: Improving access to psychological therapies*, London: Department of Health.

Brotman, M. A., Strunk, D. R. and DeRubeis, R. J. (in preparation) Therapeutic alliance and adherence in cognitive therapy for depression.

Bryant, M. J. Simons, A. D. and Thase, M. E. (1999) Therapist skill and patient variables in homework compliance: Controlling an uncontrolled variable in cognitive therapy outcome research, *Cognitive Therapy and Research* 23, 361–399.

DeRubeis, R. J. and Feeley, M. (1990) Determinants of change in cognitive therapy for depression, *Cognitive Therapy and Research* 14, 469–482.

Elkin, I. (1999) A major dilemma in psychotherapy outcome research: Disentangling therapists from therapies, *Clinical Psychology: Science and Practice* 6, 10–32.

Feeley, M., DeRubeis, R. J. and Gelfand, L. A. (1999) The temporal relation of adherence and alliance to symptom change in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology* 67, 578–582.

Foa, E. B. and Rothbaum, B. O. (1998) *Treating the trauma of rape: Cognitive behaviour therapy for PTSD*. New York: Guilford Press.

Hope, R. (2004) *The ten essential shared capabilities – A framework for the whole of the mental health workforce*, London: Department of Health.

Mynors-Wallis, L. M., Gath, D. H., Day, A. and Baker, F. (2000) Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care, *British Medical Journal* 320, 26–30.

NICE (2004a) *Anxiety: Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care* (<http://guidance.nice.org.uk/CG22/guidance/pdf/English>).

NICE (2004b) *Depression: Management of depression in primary and secondary care*
(<http://guidance.nice.org.uk/CG23/guidance/pdf/English>).

NICE (2005a) *Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder*
(<http://guidance.nice.org.uk/CG31/guidance/pdf/English>).

NICE (2005b) *Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care* (<http://guidance.nice.org.uk/CG26/guidance/pdf/English>).

Roth A. D. and Pilling, S. (in preparation, a) Identifying the competences needed to deliver cognitive and behavioural psychotherapies: A methodology and a model.

Roth A. D. and Pilling, S. (in preparation, b) The impact of adherence and competence on outcome in CBT and in psychological therapies.

Roth, A. D., Pilling S. and Turner, J. (in preparation) Therapist training and supervision in CBT in major trials for depression and anxiety.

Roth, A. D. and Fonagy, P. (2005) *What works for whom: A critical review of psychotherapy research*, New York: Guilford Press.

Turpin, G., Hope, R., Duffy, R., Fossey, M. and Seward, J. (in press) Improving access to psychological therapies: Implications for the mental health workforce, *Journal of Mental Health Workforce Development* 1(2), 7–15.

Appendix A

Members of the Expert Reference Group

Professor Philippa Garety (Chair)	Professor of Clinical Psychology, King's College London and South London and Maudsley NHS Foundation Trust
Professor Ian Baguley	Director, Centre for Clinical and Academic Workforce Innovation, University of Lincoln and Associate Director, Education and Training, National Institute for Mental Health in England (NIMHE)
Gillian Butler	Oxford Cognitive Therapy Centre
Professor David Clark	Professor of Psychology and Director, Centre for Anxiety Disorders and Trauma, Institute of Psychiatry, King's College London
Amanda Cole	Chair, Accreditation and Registration Sub-Committee, British Association for Behavioural and Cognitive Psychotherapies (BABCP)
Professor Anke Ehlers	Professor of Experimental Psychopathology and Research Director, Centre for Anxiety Disorders and Trauma, Maudsley Hospital
Professor Mark Freeston	Professor of Clinical Psychology, University of Newcastle
Professor Willem Kuyken	Co-Director, Mood Disorders Centre, University of Exeter
Professor Glyn Lewis	Professor of Psychiatric Epidemiology, University of Bristol
Dr Christopher Mace	Chair, Psychotherapy Faculty, Royal College of Psychiatrists
David Mathews	Skills for Health
Freda McManus	Oxford Cognitive Therapy Centre
Professor Dave Richards	Professor of Mental Health, University of York
Dr David Veale	Honorary Senior Lecturer and Consultant Psychiatrist, Institute of Psychiatry, King's College London and South London and Maudsley NHS Foundation Trust
Dave Westbrook	Director, Oxford Cognitive Therapy Centre
Dr Chris Williams	Senior Lecturer in Psychiatry and Honorary Consultant Psychiatrist, University of Glasgow



© Crown copyright 2007
283713 1p 7k Sep 07 (CWP)
Produced by COI for the Department of Health

If you require further copies of this title quote
*283713/The competences required to deliver effective cognitive and behavioural
therapy for people with depression and with anxiety disorders*

John Allcock
Associate Director
National Workforce Programme (NWP) National Institute for Mental Health in England
Care Services Improvement Partnership
Wellington House
Second Floor, South Wing
133–155 Waterloo Road
London SE1 8UG

Fax: 020 7972 4681
E-mail: john.allcock@dh.gsi.gov.uk

www.dh.gov.uk/publications