THE COMPETENCES REQUIRED TO DELIVER EFFECTIVE COUPLE THERAPY FOR PARTNERS WITH DEPRESSION

BACKGROUND DOCUMENT FOR CLINICIANS AND COMMISSIONERS

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The format, and some of the text in this report, is drawn from the report on the competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders (Roth & Pilling, 2007), and on the report of competences for delivering effective psychoanalytic/psychodynamic therapy (Lemma, Roth & Pilling, 2009). A detailed account of the methodology and procedures used in this project can be found in Roth & Pilling (2008). Although the authors focus on the development of the CBT framework, the methodology they used and issues they raised are relevant to the present framework.
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THE COMPETENCES REQUIRED TO DELIVER EFFECTIVE COUPLE THERAPY FOR PARTNERS WITH DEPRESSION

EXECUTIVE SUMMARY:

The report begins by summarising the background to the work on competences for psychological therapies. It then outlines the evidence based method used for identifying competences, and presents a competence framework for couple therapy for depression. This organises the competences into five domains:

1. Generic competences – used in all psychological therapies.
2. Basic competences for couple therapy for depression.
3. Specific techniques used in couple therapy for depression.
4. Adaptations of couple therapy for depression.
5. Meta-competences – overarching, higher-order competences, which guide practitioners in implementing any intervention.

The report concludes by commenting 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 a framework of couple therapy competences for treating depression based on empirical evidence of efficacy, 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. They can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (www.ucl.ac.uk/CORE). They are available as PDF files, accessed directly or by navigating the map of competences (see page 16 of this report).

BACKGROUND:

The Improving Access to Psychological Therapies (IAPT) programme (Department of Health, 2007) provided the backdrop for the first wave of work on the development of competences for the practice of psychological therapies. The IAPT programme has focused to date on delivering Cognitive Behavioural Therapy (CBT) for adults with common mental health problems because CBT has the largest evidence base supporting its effectiveness in the treatment of depression and anxiety in particular (NICE, 2004a, 2004b, 2005a, 2005b). Consequently, the first wave of work was concerned to identify the competences needed to provide good quality CBT. The CBT competence model was specifically developed to be a ‘prototype’ for developing competences associated with other psychological therapies. The work reported here is based on this model.

The final version of the report on Depression in Adults produced by the National Institute for Health and Clinical Excellence (NICE, 2009) identified the potential role of couple relationships in triggering, maintaining and resolving depression. Defining couple therapy as a “time-limited, psychological intervention derived from a model of interactional processes in relationships where:
• the intervention aims to help participants understand the effects of their interactions on each other as factors in the development and/or maintenance of symptoms/problems [and]
• the aim is to change the nature of the interactions so that they may develop more supportive and less conflictual relationships” (pp 207-208), a search uncovered six studies indicating the efficacy of couple therapy as a treatment for depression. On the basis of this evidence the report recommended couple therapy (based on a behavioural model) for patients in established relationships where the relationship played a role in developing, maintaining or resolving the depressive disorder.

The IAPT programme is premised on a stepped-care model of service provision, distinguishing between low and high intensity interventions. ‘High intensity’, in this context, denotes a formal psychological therapy delivered by a relatively specialist psychological therapist. The commission to which this report relates was for the high intensity intervention of couple therapy to treat depression.
**National Occupational Standards**: The work undertaken in this report also 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 NOSs that describe standards relevant to mental health workers, downloadable at the Skills for Health website ([www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)), and the work in this report will be used to inform the development of standards for couple therapy.

**HOW THE COMPETENCES WERE DEVELOPED:**

**Oversight and peer review:**
The work described in this project was overseen by an Expert Reference Group (ERG), which comprised national experts selected for their experience of developing, evaluating, providing training for and supervising different approaches to couple therapy. The competences framework that emerged sought to integrate different approaches rather than settle on any one established model. The competences framework was sent to the authors of the therapy manuals associated with the NICE evidence base, and to some others associated with ERG approved studies, for peer review. Given that some of the competences describe procedures outlined by these individuals, it is reasonable to expect that their scrutiny will be especially vigilant. This open process of peer review ensured that the competences, and especially the procedures associated with specific interventions, were subject to a very high level of scrutiny.

**Identifying competences by looking at the evidence of what works**: The project began by identifying those therapeutic approaches with the strongest claims for evidence of effectiveness, 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

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1 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 which 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 the modifications are always in ways that 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.
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 procedures 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. 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.

Evaluating the evidence for couple therapy: issues and considerations
The six studies constituting the evidence base for couple therapy as a treatment for depression identified in the NICE (2009) report were examined, along with the main treatment manuals used in the studies. They appear in Figure 1 below. Five of the six couple therapy approaches were rooted in Behavioural Couple Therapy, the sixth used Conjoint Marital Interpersonal Psychotherapy.

NICE’s criteria for the inclusion or exclusion of trials are based on a threshold for scientific rigour, and in their own terms are reasonable and hard to argue against. However, strict compliance with NICE recommendations would have the consequence of restricting the number of trials on which the ERG could draw, and also the range of therapeutic approaches which could be considered in drawing up the framework. While this can be justified on scientific grounds (it makes little sense to include approaches with no evidence for efficacy), the ERG undertook careful professional appraisal and interpretation of the evidence, and considered that it would be reasonable to broaden the scope of the framework, while ensuring that it was concordant with NICE’s recommendations. The rationale for this position follows.

a) Many of the NICE exemplar studies used manuals that were between 20 – 30 years old, and there have been important developments in the practice of couple therapy since then. This observation applies with some force to Behavioural Couples Therapy (BCT); as currently practised it has evolved beyond the approach tested in one of the primary studies included in the NICE database (Jacobson & Margolin, 1979). Indeed one of the primary authors promoted a revision of BCT that includes a wider range of therapeutic techniques (referred to as ‘integrative’ BCT, as contrasted to ‘traditional’ BCT). Although this newer approach shows comparable efficacy in reducing relationship distress (Christensen et al., 2004, 2010) its efficacy specifically in relation to depression has not been directly tested. The group noted a conundrum: a literal reading of NICE guidance results in foregrounding an approach rarely practised, but equally foregrounding integrative BCT goes beyond a strict reading of the evidence. The ERG debated this problem, and recognised that while neither position is entirely satisfactory, it makes more clinical sense to be consonant with current practice. For this reason both traditional and integrative BCT are delineated in the framework.
The NICE evidence base


The NICE studies’ treatment manuals


(Although not part of the NICE evidence base, to update traditional behavioural couple therapy we have added the integrative behavioural couple therapy manual: Jacobson, N. & Christensen A. (1998) *Acceptance & change in couple therapy. A therapist’ guide to transforming relationships*. New York: Norton.)


b) The ERG identified and reviewed additional trials which, while falling short of NICE standards did meet three important criteria (all were controlled trials focusing on alleviating depression, and using manualised treatments), and considered that some justified inclusion despite methodological problems. Thus, Leff et al. (2000) indicated the cost-effectiveness of systemic couple therapy as compared with anti-depressant medication. Although excluded by NICE because of the rate of fall-out in the control group on medication, it was nevertheless a carefully conducted study, with a manual that specified a range of competences relevant to the conduct of couple therapies. For similar reasons, a small pilot study indicating the efficacy of Emotion Focused Therapy (EFT) for couples in treating depression (Dessaules et al., 2003) was also included.

c) Limiting the evidence base to studies with a depressed population means that other relevant studies, which demonstrate the efficacy of couple therapy for a non-depressed population are excluded. While, on the face of it this is logical the underlying assumption in the NICE report is that the mechanism for reducing depression was improvement in a couple’s relationship. In fact only two of the NICE exemplar study manuals focus specifically on techniques for working with depressed partners (Rounsaville et al., 1986; Beach, 1990). The remainder are generic manuals. If generic, RCT tested, and manualised approaches improve couple relationships then it may be that they have the same potential to reduce and protect against depression as those used in the exemplar studies. Although this is an untested assumption, the ERG considered that it justified the inclusion of two additional studies, one using integrated BCT (Christensen et al., 2004, 2010), the other using Insight-Oriented Marital Therapy (Snyder et al., 1991).

Providing an overview of the past four decades of research and practice, Gurman (2008) concludes that only since 1993 has research into couple therapy attended to a variety of more sophisticated and clinically relevant questions than simply asking ‘does it work?’. As research methods become increasingly finessed we are likely to learn more about how couple relationships and therapeutic procedures interact to produce different outcomes. In the meantime, it is interesting to note the convergence of approaches, and often overlapping techniques, that have characterised developments in couple therapy over recent years.

This concordance is reflected in the nature of the competences and techniques identified by this project. It also informed the decision to incorporate up-to-date successors of original manuals to capture developments in the field. Hewison (2010) summarises the evidence base approved by the ERG for the purpose of identifying treatment manuals. The evidence base and manuals used for the project are depicted in Figure 2, which also charts the process of identifying practitioner competences. Reflecting its integrative nature, we have called the competences framework Couple Therapy for Depression (CTD).
THE COMPETENCE FRAMEWORK FOR COUPLE THERAPY FOR DEPRESSION

Organising the competences lists:
Competence lists need to be of practical use. The danger is that they either provide too much structure and hence risk being too rigid, or they are too vague to be of use. The aim has been to develop competence lists structured in a way that reflects the practice they describe, set out in a framework that is both understandable (easily grasped) and valid (recognisable to practitioners as something that accurately represents the approach, both as a theoretical model and in terms of its clinical application).

Figure 3 shows the way in which competences have been organised into five domains, and how they feed into each other. The components are as follows:

Generic competences:
Generic competences are those employed in any psychological therapy, reflecting the fact that all psychological therapies, including couple therapy, 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 such a 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 competences for couple therapy for depression:
Basic competences establish the structure for couple therapy for treating depression, and form the context and structure for the implementation of a range of specific techniques. For example, all couple therapy focuses on the interactive processes operating between partners. It is in this context that the therapist needs to deploy techniques that maintain a balanced relationship with each partner if s/he is to work effectively with them to change their relationship as a couple.

Specific techniques for couple therapy for depression:
These are the core technical interventions likely to be employed in couple therapy for depression, and reflect the set of commonly applied techniques found to a greater or lesser extent in most forms of couple therapy. An example would be helping enmeshed couples to bound their communications with each other by encouraging partners to speak only about their own experience and not for each other.

Distinguishing ‘basic competences’ from ‘specific 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 necessary to any couple therapy intervention, and provide the backdrop to the commonly applied techniques that may be more or less used according to the model of couple therapy deployed.
Figure 3

Outline model for couple therapy for depression competences:

**Generic competences in Psychological Therapy**
The competences needed to relate to people

**Basic couple therapy competences**
Relevant to most couple therapy interventions and focused on couples presenting with depression

**Specific couple therapy techniques**
Specific techniques from which interventions are drawn for working with couples presenting with depression

**Specific adaptations of couple therapy**
Therapeutic models used in the NICE exemplar studies

Metacompetences
Competences used to work across all levels to adapt couple therapy to the needs of each couple
Specific adaptations of couple therapy for depression: 
Because all the competences and techniques identified in this report are relevant to using couple therapy to treat the specific problem of depression, the format used by other competence frameworks (which identify problem specific adaptations of the general model) does not apply. Instead, and primarily for illustrative purposes, this section summarises the approaches used in the NICE exemplar studies (with the addition of integrative behavioural couple therapy to update the traditional behavioural couple therapy model).

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 that needs to be recognised in any competences model. Reducing psychological theory to a series of rote operations makes 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 adapt therapy to the needs of particular couples. 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 and judgement of the therapist. They can be difficult to observe directly but can be inferred from therapist actions, and may form an important part of discussions in supervision.

SPECIFYING THE COMPETENCES NEEDED TO DELIVER CTD: 

Integrating knowledge, skills and attitudes: 
A competent clinician brings together knowledge, skills and attitudes. It is this combination which 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 these skills but also why they are implementing them.

Beyond knowledge and skills, the couple therapist’s attitude and stance to therapy is also critical – not just their attitude to the relationship with the couple 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 couple’s needs and cultural contexts.
In assembling the competences and techniques for CTD account has been taken of the frequency with which different models described similar processes and actions, although the language used might be specific to the model. The framework for CTD adopts an integrative approach in iterating competences and techniques, using as far as possible non-technical language that privileges no one model, and which attempts to allow couple therapists trained in different models to draw on in ways that can be accommodated coherently within their pre-existing therapeutic approach.

THE MAP OF CTD COMPETENCES:

Using the map:
The map of CTD competences is shown in Figure 4. 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 the ways in which the activities fit together and need to be ‘assembled’ in order for the practice to be proficient. A commentary on these competences follows.
Ability to work with interactional processes in couples to alleviate depression

### Generic therapeutic competences
- Knowledge and understanding of mental health problems
- Knowledge of depression
- 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 work with difference (cultural competence)
- Ability to engage client
- Ability to foster and maintain a good therapeutic alliance, and to grasp the
- Ability to work with the emotional
- Ability to manage endings
- Ability to undertake generic assessment (relevant history and identifying suitability for intervention)
- Ability to assess and manage risk of self-harm
- Ability to use measures to guide therapy and to monitor outcomes
- Ability to make use of supervision

### Basic couple therapy competences
- Knowledge/understanding of the basic principles of couple therapy
- Knowledge of sexual functioning in couples
- Knowledge of depression and its manifestation in couples
- Knowledge and experience of working within a model of couple therapy
- Ability to assess if couple therapy is suitable where depression is present in one or both partners
- Knowledge of and ability to liaise with other services
- Ability to establish and convey the rationale for couple therapy
- Ability to initiate couple therapy
- Ability to maintain and develop a therapeutic process with couples
- Ability to end couple therapy

### Specific couple therapy techniques
- Ability to use techniques that engage the couple
- Ability to use techniques that focus on relational aspects of depression
- Ability to use techniques that reduce stress upon and increase support within the couple
- Improving communication
- Coping with stress
- Managing feelings
- Changing behaviour
- Solving problems
- Promoting acceptance
- Revising perceptions

### Specific adaptations of couple therapy for depression
- Behavioural Couple Therapy
- Marital Therapy for Depression
- Conjoint Marital Interpersonal Psychotherapy
- Coping Oriented Couple Therapy

### Metacompétences
- Generic metacompétences
- Capacity to respect and tolerate the complexity of the human condition
- Capacity to use clinical judgement when implementing therapy
- Capacity to reflect critically on the experience of therapy
- Capacity to convey and respond to interest, affect and humour

### Specific metacompétences
- Capacity to work reflexively with complex relational systems
- Capacity to manage the tension between competing duties of care
- Capacity to work with difference and uncertainty
- Capacity to apply different levels of therapeutic response appropriately and coherently
Generic therapeutic competences (see column 1 of Figure 4):

Knowledge: Knowledge of mental health problems and of depression, of professional and ethical guidelines and of the model of therapy being employed forms a basic underpinning to any intervention, not just to CTD. Being able to draw on and apply this knowledge is critical to the delivery of 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 that 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 competences is concerned with the capacity to build and 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 difficult 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. The ability to work with difference when engaging with clients and delivering therapy is also a critical area of competence.

Assessment: The ability to make a generic assessment is crucial if the therapist is to begin understanding the difficulties which concern the client. This is a different activity to the focused assessment described in the couple therapy competences list. 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 for workers to know the limits of their competence and when to make use of support and supervision, will be crucial.

Use of measures: Measures make an important contribution to the initial assessment, and are necessary when monitoring the impact and outcome of the intervention. The ability to use and interpret measures is an important skill.

Supervision: Making use of supervision is a generic skill which 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 that supervision reveals.

IMPLEMENTING CTD USING A BALANCED APPROACH (see columns 2-5 of Figure 4):

Activities in all domains of CTD need to be carried out in the context of an overarching competence: the ability to implement couple therapy in a balanced manner that keeps the focus on the couple relationship, without discounting the two individuals who comprise it. This is sometimes referred to as seeing the ‘couple as patient’, and requires a perspective that takes full account of how each partner acts on, and is acted on, by the other. By focusing on the interaction between partners, and by seeing their relationship as constituting a third element that has the potential to supplement or diminish the resources of each partner, therapists need to have the ability to understand couple relationships as self-regulating systems, while also not losing sight of the individual impact on the system of each partner’s constitutional and characteristic profile (physical, psychological and relational). Therapists also need to have the ability to understand couple conflict as resulting from intrapsychic as well as interpersonal meanings, through linking individual perceptions and relationship ‘events’. In addressing the complex strands of perspectives, actions and meanings that constitute a couple’s experience, the therapist must be able to act in a manner that assures both partners that their position is recognised and respected, especially when that position may be disagreed with. This lies at the heart of what is meant by ‘balance’ in the therapist’s approach to the couple.

BASIC CTD COMPETENCES (see column 2 of Figure 4):

Knowledge:
Four areas of basic knowledge are relevant to the application of couple therapy for depression: the basic principles of couple therapy, sexual functioning, depression and the ways it manifests in couple relationships, and a model of couple therapy.

Assessment:
Assessing the nature of a couple’s relationship, and whether and how it might have a role in precipitating, maintaining or exacerbating depressive symptoms is a complex process, and one that requires couple therapists to have the ability to assess whether the realities of (usually) one partner’s depression can usefully be worked with in the context of the couple’s relationship. Included in the process is the ability to identify and manage risk in embarking on couple therapy, and the ability to liaise with other services that might have a role to play in supporting one or both partners.

Rationale for couple therapy:
Assessment is a two-way process, and it might not be immediately obvious to the non-depressed partner why couple therapy is the treatment of choice for depression. Couple therapists must be able to take account of each partner’s
perspective in working towards a collaborative formulation of the problem with which they would like help, one that links their relationship with the depressive symptoms and carries conviction about the potential benefits of focusing on their relationship.

**Initiating therapy:**
In the knowledge that there is a higher than usual risk of withdrawal from couple therapy when one partner is depressed, the importance of instilling confidence in the process and achieving small but recognisable improvements from the outset is especially important. Couple therapists must be able to find ways of offering sufficient realistic hope about the therapy to counter negative thoughts and predictions about its likely success.

**Maintaining and developing therapy:**
In the middle phase of work couple therapists have opportunities to deepen understanding as well as increase skills that might help couples with their difficulties. Their ability to maximise these opportunities will be important for the nature and durability of the therapeutic outcomes they and the couples they see can achieve together.

**Ending therapy:**
The ability to end therapy constructively implies an ability to structure and evaluate (sometimes with the help of formal instruments) the therapeutic process from the outset. It also implies an ability to engage with the couple’s feelings about ending, and to exercise judgement and discretion where necessary about agreed upon timings.

**SPECIFIC CTD TECHNIQUES (see column 3 of Figure 4):**

**Engaging the couple:**
Given the central importance of engaging both partners in contributing to and collaborating with the therapeutic process, and of maintaining balance in the therapeutic alliance with each partner and their relationship as a couple, these techniques have a central role in all couple therapies. Some are adapted to take account of the specific needs of couple relationships where one or both partners are depressed. Techniques that validate the experience of each partner, and which encourage curiosity and a preparedness to explore and experiment with new situations and perceptions, are especially valuable in creating a change-favourable climate.

**Focusing on the relational aspects of depression:**
These techniques aim to change each partner’s perceptions and experience of depression through working with and modifying interactive patterns in the couple. They are closely connected with the techniques described in the following section, which aim to reduce stress upon and increase support from within the couple relationship.
Reducing stress and increasing support:
These processes lie at the heart of the rationale for using couple therapy to treat depression. They are drawn from different models of couple therapy, and there is no expectation that all therapists will be able to use all the techniques. Nevertheless, it is likely that most therapists will recognise and may use techniques drawn from across the spectrum described here, although there may well be differences in the frequency with which the techniques are used and the manner in which they are applied. Specifically, the techniques are geared towards improving communication, reducing stress, managing feelings, changing behaviour, solving problems, promoting acceptance and revising perceptions.

SPECIFIC ADAPTATIONS OF CTD (see column 4 of Figure 4).

Other frameworks have used this section to articulate problem-specific competences linked to exemplar models of intervention for specific conditions. There was much debate within the ERG about what the couple therapy framework should include here, given that the competences and techniques listed in earlier sections were all concerned with using couple therapy to treat the specific condition of depression. One approach was to use this section to provide a brief description of the therapeutic models used in the NICE exemplar studies, despite the limitations which have been described earlier. An alternative view was to update the mainly (but not exclusively) behavioural model of couple therapy used in the NICE studies by including a description of integrative behavioural couple therapy (Jacobson & Christensen, 1998). The problem with this was that it might privilege this approach above other approaches which also have an evidence base and were similarly excluded by the NICE criteria for exemplar studies. It also risked truncating the integration of other approaches into the framework, and was likely to result in difficulties rolling out the service given that most couple therapists in the UK are not trained in the traditional or integrative behavioural models of couple therapy. Notwithstanding these concerns, and in order to provide a snapshot of contemporary behavioural couple therapy, the latter approach has been adopted. This is not to propose any of the models in this section as the one to adopt for CTD, but to provide a snapshot of the different approaches (the competences and techniques associated with these models are already assimilated into those for CTD).

METACOMPETENCES (see column 5 of Figure 4):

Therapy cannot be delivered in a ‘cook-book’ manner. By analogy, following a recipe is helpful but it does not necessarily make for a good cook. This domain describes some of the procedural rules (eg Bennett-Levy, 2005) that enable therapists to implement therapy in a coherent and informed manner.

Technical flexibility – the ability to respond to the individual needs of a couple at a given moment in time – is an important hallmark of competent therapists. The
interaction of a particular therapist and a particular couple also produces dynamics unique to that encounter, resulting in context-dependent challenges for the therapist. In other words, in psychotherapy the problems to be addressed can present differently at different times, the contextual meanings of the therapist and the couple’s actions change, and the therapist is engaged in a highly charged system of relationships that need to be managed. What is required, therefore, are a range of techniques and complex interpersonal skills that are applied under the guidance of very sophisticated mental activities.

On the whole these competences are more abstract than those described elsewhere, and as a result there is less direct evidence for their importance. Nevertheless there is clear expert consensus that metacompetences are relevant to effective practice. The list is divided into two areas. Generic metacompetences are common to all therapies, and broadly reflect the ability to implement an intervention in a manner that is flexible and responsive. Specific metacompetences apply to the practice of couple psychotherapy.

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 there is less certainty about which components actually make for change, and exactly by what process.

It needs to be accepted that the competences which emerge from a manual could contain 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 cul de sacs 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 it meant that major elements or aspects of an intervention were not offered – in effect clinicians would then be making a conscious decision to deviate from the evidence that a 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, the inclusion of metacompetences precludes such an approach by underlining the importance of applying the components of therapy in ways that are flexible, contextually sensitive and responsive to the issues a couple brings. Clearly this involves using informed clinical judgement, rather than opinion.
Are some competences more critical than others?
For many years researchers have tried to identify links between specific therapist actions and outcomes. Broadly speaking, better outcomes follow when therapists adhere to a model and deliver it competently, but this observation really applies to the model as a whole rather than its component parts.

The impact of treatment formats on clinical effectiveness:
The competence lists in this report set out what a therapist should do, but do not set out the way in which therapy is organised and delivered (for example, the duration of each session, how sessions are spaced and the overall length of therapy). Treatment manuals drawn on for the competences usually specified a three-stage process (initiation, middle, ending) for up to twenty hours of therapy. There were variations in the number and spacing of sessions, and over whether assessment should include seeing partners separately as well as together.

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. It is reasonable to suppose that training and supervision make their contribution to headline figures for efficacy, and that it may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces practice from the support systems which 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 components are neglected.

APPLYING THE COMPETENCE FRAMEWORK:
This section sets out the various uses to which the CTD competency framework 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 might be developed.

Development of manuals:
The CTD framework brings together the competences and techniques identified from a range of manuals that are likely to be effective in treating depression. Because the framework integrates a number of models and specifies necessary competences and permissive techniques, it lends itself to the ready conversion into a practice manual that might, in turn, be tested by research.

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

**Service organisation:**
The framework represents a set of evidence-based competences, and aims to describe best practice: the activities that individuals and teams should follow in providing evidence-based treatments. Although further work is required on the utility and associated method of measurement, they will enable the identification of:
- key competences required by a practitioner to deliver couple therapy interventions;
- the range of competences that a service or team would need to meet the needs of an identified population;
- the likely training and supervision competences of those managing the service.

This level of specification carries the promise that 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 can help ensure that evidence-based interventions are 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. Monitoring the quality and outcomes of psychological therapies is a key clinical governance activity. The framework will allow providers to ensure that:
- couple therapy 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 HCC and similar bodies.

**Supervision:**
The couple therapy competence framework provides a potentially useful tool to improve the quality of supervision by helping supervisors to focus on a set of competences that are known to be associated with the delivery of effective treatments. Used in conjunction with a supervision competences framework it can:
- provide a structure which helps to identify the key components of effective practice in couple therapy;
- help in the process of identifying and remedying sub-optimal performance.

Supervision commonly has two (linked) aims: improving the performance of practitioners and improving outcomes for clients. The couple therapy framework could achieve these aims 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 which can guide and refine the structure and curriculum of training programmes (including pre and post-qualifying professional training as well as training offered by independent organisations);
- a system for the evaluation of the outcome 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 testing the efficacy of related manuals, developing and refining appropriate psychometric measures of therapist competence, exploring further the relationship between therapy process and outcome, and evaluating training and supervision systems.

**CONCLUDING COMMENTS:**

This report describes a framework that identifies the activities characterising effective couple therapy for depression, and locates them in a ‘map’ of competences.

The work has been guided by two over-arching principles: First, it stays close to the evidence base, meaning that an intervention carried out in line with the competences described in the framework should be close to best practice and therefore likely to result in better outcomes for couples. Second, it aims to have utility for those who use it, clustering competences in a manner that reflects the way interventions are actually delivered and hence facilitating their use in routine practice.

Putting the framework into practice – whether as an aid to curriculum development, training, supervision, quality monitoring or commissioning – will test its worth, and 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 framework 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.

LIST OF MANUALS:


**LIST OF ADDITIONAL REFERENCES:**


