The competences required to deliver effective Cognitive Analytic Therapy (CAT)

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The full listing of the CAT competences described in this report is available online at www.ucl.ac.uk/CORE

[1] We are grateful to members of ACAT Training Committee and to ACAT Equality and Diversity Committee for refinements to this document.

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Short summary (reader box)

This document identifies the activities associated with the delivery of high-quality CAT and the competences required to achieve these. It describes a model of the relevant competences, discusses its advantages for clinicians, trainers and commissioners, and makes recommendations for its application.

Acknowledgements

This work described in this report was commissioned and funded by Association for Cognitive Analytic Therapy (ACAT). The project team was headed by Dawn Bennett, Glenys Parry and Anthony Roth.

The work was overseen by an Expert Reference Group (ERG) whose invaluable advice and collegial approach contributed enormously to the development of the work. The ERG comprised Jason Hepple, Stephen Kellett, Ian Kerr and Liz Fawkes[2]

We were extremely fortunate to be able to invite peer-review of competence lists from members of ACAT Training Committee.

Who can apply the competence framework?

The framework describes what a CAT therapist might do; it does not identify who can implement it. The standards set by the framework can be met by CAT therapists with a range of professional backgrounds, on the basis that they have received at minimum an ACAT accredited practitioner training which equips them to carry out the therapy competently.[3]

The issue of competence and of relevant training is the critical factor, rather than the title of the person offering the therapy. Some therapists will use the professional title of 'psychotherapist' while others will be denoted as 'counsellors' or other core profession. The distinction in title reflects a mix of factors, such as the type and the length of training. It needs to be emphasised that counsellors, psychotherapists and other core professionals could offer the competences embodied in this framework, so long as they have had an appropriate level of CAT training.

[2] Appendix 1 lists affiliations of ERG

[3] CAT is also practised by CAT psychotherapists who have completed an additional CAT training and are eligible for membership of United Kingdom Council for Psychotherapy (UKCP) as CAT Psychotherapists

Competences for the practice of psychological therapies

The Improving Access to Psychological Therapies (IAPT) programme, which was launched in May 2007, provided the backdrop for the first wave of work on the development of competences for the practice of psychological therapies. Competence frameworks have been developed for a number of therapeutic modalities: CBT, psychoanalytic/psychodynamic, systemic and humanistic person-centred/experiential therapies and Interpersonal Psychotherapy (IPT), along with a description of the competences required for supervision of these therapies and specific presentations. These are available at www.ucl.ac.uk/CORE/competence-frameworks.

Although Cognitive Analytic Therapy (CAT) was included as part of the Personality Disorder Framework, in 2018 ACAT took the decision to specify a set of CAT competences applicable across presentations.

Executive summary

The competences required to deliver effective CAT

Executive summary

The report begins by briefly describing the background to the work on competences for psychological therapies.

It will then outline an evidence-based method for identifying competences, and presents a competence model for CAT. This organises the competences into five domains:

1. Generic competences - used in all psychological therapies
2. Knowledge of the theory of CAT and rationale for therapy
3. Reformulation and Engagement Phase of CAT – which concerns knowledge of reformulation and how a CAT therapist engages the client to reach a shared focus for therapy
4. Recognition and Revision phase: Knowledge of working at change in CAT - which concerns how a CAT therapist facilitates change and works with the time limited nature of CAT
5. Meta-competences and CAT-specific Metacompetences -overarching, higher-order competences which practitioners need to use to guide the implementation of CAT

The report then describes and comments on the type of competences found in each domain, before presenting a 'map' which shows how all the competences fit together and inter-relate.

Finally the report comments on issues which 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 CAT competences and (based on empirical evidence of efficacy) 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 should be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE/competence-frameworks). They are available as pdf files, accessed directly or by navigating the map of competences (as represented by Figure 2 in this report).

Background

The Improving Access to Psychological Therapies (IAPT) programme, which was launched in May 2007, provided the backdrop for the first wave of work on the development of competences for the practice of psychological therapies[4]. The IAPT programme initially focused on delivering CBT for adults with common mental health problems because CBT has the most substantial evidence base supporting its effectiveness in the treatment of depression and anxiety in particular (e.g. NICE, 2004a, 2004b, 2005a, 2005b). Consequently, the first wave of work was concerned to identify the

[4] There are currently competence frameworks for a number of therapeutic modalities: CBT, psychoanalytic/psychodynamic, systemic and humanistic therapies and Interpersonal Psychotherapy (IPT), along with a description of the competences required for supervision of these therapies. CAT was included in 2019

competences needed to deliver good quality CBT. The development of the CBT competence model was used as a "prototype" for developing the competences associated with other psychological therapies. The work reported here is based on this model.

How the competences were identified

Oversight and peer-review: The work described in this project was overseen by an Expert Reference Group (ERG). Members of the group were identified on the basis of their expertise in CAT – for example, their involvement in the development of CAT, the evaluation of CAT in formal trials, the development and delivery of supervision and training models in CAT and process research in CAT including evaluation of competence.

The ERG ensured that the right trials, guidelines and texts were identified and that the process of extracting competences was appropriate and systematic. Additional peer review was provided by the researchers, trainers and clinicians who had developed the therapies contained in the framework. All this was designed to assure the fidelity of the framework in relation to the therapy it claimed to represent. Overall, this process of open peer-review ensured that the competence lists were subject to a very high level of scrutiny.

Identifying competences by looking at the evidence of what works [5]

This project began by looking for evidence of efficacy of CAT, based on the outcome of clinical controlled trials. The strongest evidence for the effectiveness of CAT is for clients with a diagnosis of personality disorder (Chanen, Jackson, McCutcheon, Jovev, Dudgeon, Yuen, Germano, Nistico, McDougall, Weinstein, Clarkson, and McGorry 2008, 2009; Clarke, Thomas and James, 2013). CAT has also been used with a range of other presentations and the project drew on Calvert and Kellett's (2014) systematic review of the methodological quality of the CAT outcome studies. Most of the studies reviewed were completed in typically 'hard-to-treat' clinical populations. The work also drew on the evaluation of CAT in routine practice by Kellett, Bennett, Ryle and Thake (2013) which included competency ratings of the therapy and provided the most rigorous and relevant evidence to date. This suggests that CAT delivered under routine clinical conditions can be effective for Borderline Personality Disorder and that CAT in routine practice was being delivered in a competent manner.

The therapy offered in these research trials was based on a manual or clinical guidelines which describes the therapy model and associated therapeutic techniques. Treatment manuals are

[5] 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 judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways which does 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. On the other hand, we are aware that a weakness of competence frameworks derived from manuals is that, whilst excellent as a training and heuristic aid, they are not grounded in empirical evidence that these competences are observable in practice (see Bennett & Parry, 2004).

developed by research teams to improve the internal validity of research studies: they explicate the technical principles, strategies and techniques of particular models of therapy. 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. Because research trials monitor therapist performance (usually 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 on 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 out logically. The first step is to review the 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 using the manuals to extract competences 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.

In addition, members of the ERG are experienced trainers and supervisors familiar with the core texts specifying CAT theory and practice; are authors and co-authors of the core texts, both general Introductory texts to CAT and specialist applications; researchers of both quantitative (e.g. CAT effectiveness) studies and qualitative process studies; as well as developing the Competency in CAT (C-CAT) measure. The CAT competences identified in this project were influenced by all of the above.

Scope of the work

The focus of this framework is on the practice of individual therapy. CAT is not a problem focused approach and the CAT competences apply to any age and any presentation.

Although CAT is applied in a group context and working in a consultative capacity this work is not a focus of the framework as there are insufficient robust trials to support the inclusion of the competences for group CAT or consultation. Such trials will hopefully be forthcoming.

CAT is an integrative therapy and because therapists are expected to have prior and additional training, CAT can contain within it variations in models of practice and integrations of other techniques within the CAT framework. Though these variations can differ in matters of emphasis, all practitioners agree on a common 'core' of philosophy and practice.

Contents

The competence model for CAT

Organising the competence 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 which reflects the practice they describe, set out in a framework that is both understandable (in other words, is easily grasped) and 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:

Generic Competences

Generic competences are those employed in any psychological therapy, reflecting the fact that all psychological therapies, including CAT, 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.

The next set of domains reflect the overlapping phases of CAT:

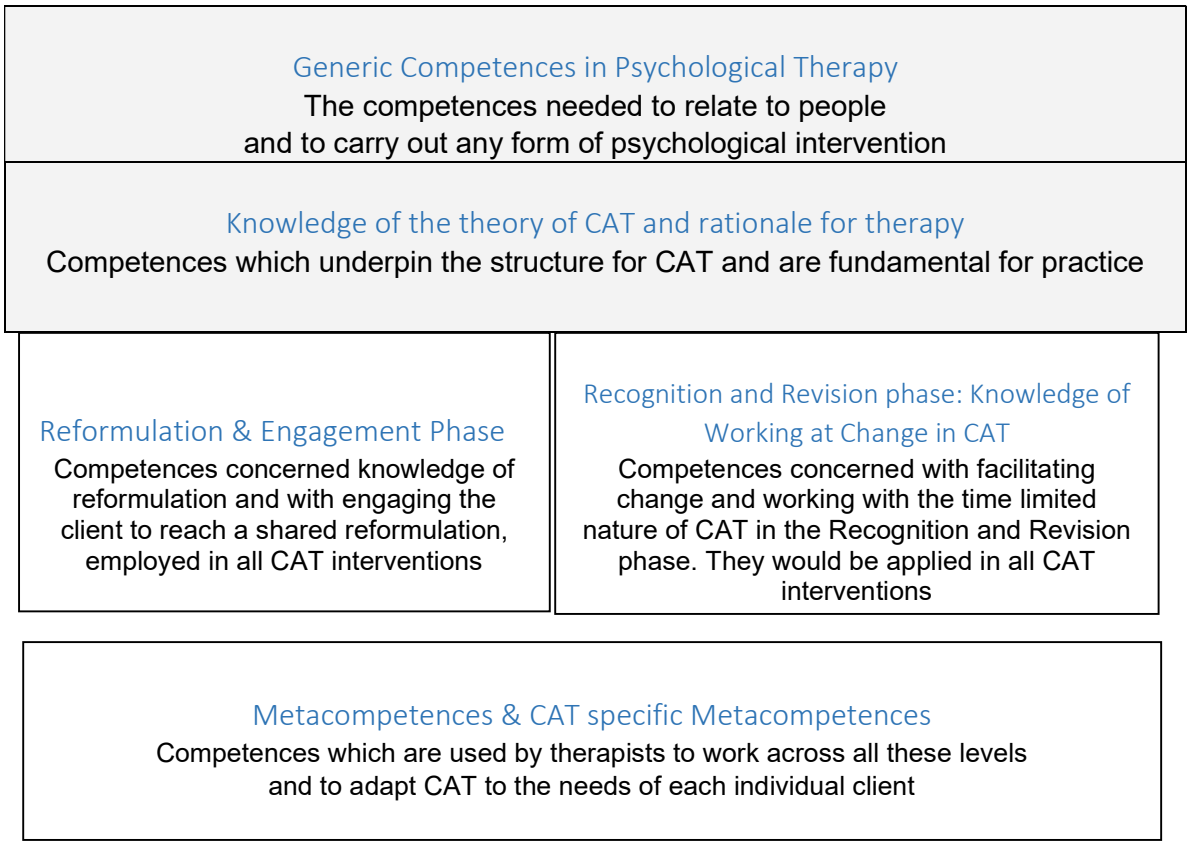
- Knowledge of the theory of CAT and rationale for therapy
- Reformulation and Engagement Phase of CAT – which concerns knowledge of reformulation and the ways a CAT therapist engages the client to reach a shared focus for therapy
- Recognition and Revision phase: Knowledge of working at change in CAT - which concerns the process of facilitating change in the context of the time limited nature of CAT

Knowledge of the theory of CAT and rationale for therapy

These competences establish the underpinning structure for CAT: that there is a focus for the therapy, that it is integrative and time-limited and that these considerations shape the context for engaging with the client in the three phases of CAT. The competences set out a stance and focus that all CAT trained therapists would acknowledge as fundamental to their practice. CAT prioritises a focus on the therapeutic relationship and competences in this domain attend to competences which contribute to establishing, maintaining and ending the therapeutic relationship.

Figure 1

Outline model for CAT competences



Reformulation and Engagement Phase of CAT - Knowledge of Reformulation in CAT and engaging the client to reach a shared reformulation

This domain sets out the therapist's knowledge and use of CAT concepts and tools in their work with the client as they work to agree a shared understanding. It covers CAT's collaborative approach to reformulation and the explicit engagement of the client in co-creation of the CAT reformulatory letters and 'maps'.

Recognition and Revision phase: Knowledge of working at change in CAT - Facilitating change and working with the time limited nature of CAT

Competences in this domain list the therapist's knowledge and use of CAT tools as they work to help the client work at change, and the use of methods and techniques to support the strategies and goals of revision, within the framework offered by the CAT reformulation. This domain also includes the therapist's use of the therapeutic relationship and the ability to work therapeutically with re-enactment of problematic patterns in the therapy relationship.

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: they are 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. In addition, there are **CAT-specific metacompetences** for example, the therapist needs to move between task and process flexibly.

Specifying the competences needed to deliver CAT

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 their skills, but also why they are implementing them.

Beyond knowledge and skills, the therapist's attitude and stance to therapy is 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 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.

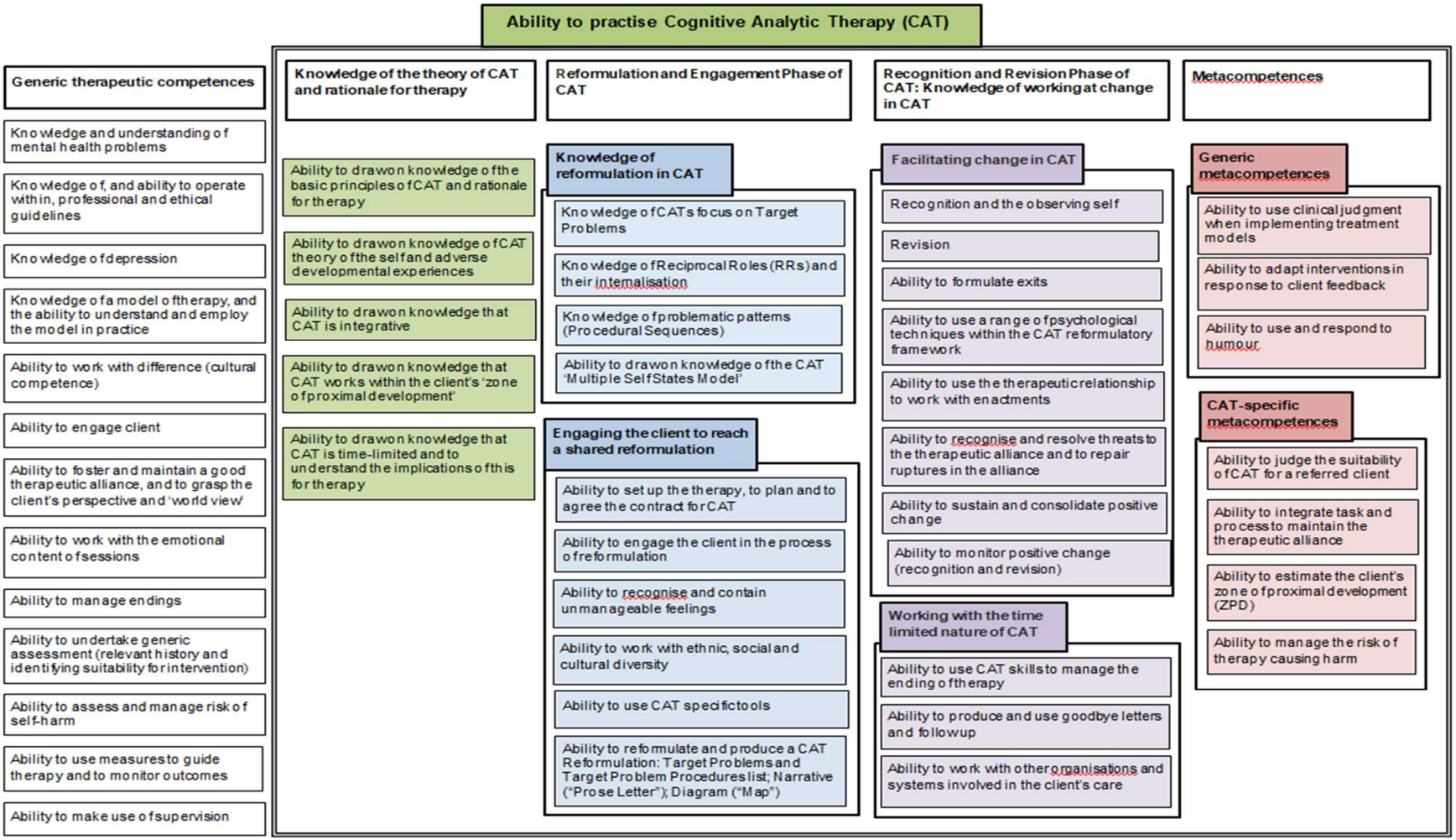
The map of CAT competences

Using the map

The map of CAT 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.

Figure 2: The map of competence domains for Cognitive Analytic Therapy (CAT)



Generic therapeutic competences

Knowledge: Knowledge of mental health problems, of professional and ethical guidelines and of the model of therapy being employed forms a basic underpinning to any intervention, not just to CAT. Being able to draw on and apply this knowledge is critical to the delivery of effective therapy. 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 competences 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 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.

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 focussed assessment described in the problem-specific competence lists or the assessment specific to the likely suitability of a CAT approach. 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 for 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 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 which supervision reveals.

Knowledge of the theory of CAT and rationale for therapy

In CAT, there is a very direct and close relationship between theory and practice and to be a competent CAT therapist requires understanding a range of quite complex concepts. But CAT is also a pragmatic therapy - the aim is to be able to put these concepts to use, as conceptual tools, putting theory into practice. This domain contains a range of activities that are fundamental areas of skill; they represent practices that underpin CAT.

Knowledge of the basic principles of CAT and rationale for therapy refers to the set of core assumptions underpinning CAT, most notably that CAT

a) is a fundamentally interpersonal (or relational) model, both in its view of human development and in its practice of psychotherapy

b) is rooted in the development of an empathic, respectful and collaborative, meaning-making relationship between the client and therapist within the therapeutic boundaries
c) is a time limited structured therapy
d) focuses on what problems a person brings to the therapy and the deeper patterns of relating that underlie them
e) is less concerned with traditional psychiatric symptoms, syndromes or labels
f) is a therapy which takes into account socio-cultural and political context and the real social and material world in which we all exist. It takes account of ways in which the 'outside' co-exists and influences what is 'inside'. It recognises and responds to how what becomes internalised from the social world can be reproduced and re-enacted externally and reciprocally between parties, including in the therapeutic relationship.

Consequently, the process of a CAT therapy is to look at patterns of relating, and the effect these patterns have on relationships, work and the way clients are with themselves. CAT prioritises understanding the client's presenting problems in this inter and intrapersonal context, including patterns that may arise in the therapy relationship. It is conceptualised as consisting of three overlapping phases (Reformulation, Recognition and Revision) of problematic patterns, each with its own distinctive strategies and objectives.

Activities in all domains of CAT competence need to be carried out in the context of an overarching competence: The **Ability to draw on knowledge of CAT theory of the self and adverse developmental experiences**. This refers to CATs view of the self as developing through social experience (both interpersonal and cultural), and by internalising these reciprocal interactions and their 'voices' ('reciprocal roles') which then govern self-concept and self-management, and are enacted with others. It is a fundamental tenet of CAT that we can only develop a sense of self in relation to another. CAT views the developing self to be damaged by adverse experiences and aims to understand the impact of key relational experiences on the developing sense of self, in the past but also throughout the lifespan. Consequently, CAT therapists will maintain a focus on relational patterns to help the client to understand the impact of their development and additionally any current, ongoing relational influences, both proximal and distal.

Ability to draw on knowledge that CAT is integrative refers to the concept of the procedure, which allows CAT therapists to incorporate cognitive, behavioural and analytic understandings and techniques and those of other theories in an integrated coherent framework.

Ability to draw on knowledge that CAT works within the client's 'zone of proximal development' refers to how CAT therapists use this concept to understand the need to be 'in advance' of the client, stretching them but not moving too far ahead. CAT therapists aim to create a reflective space but it is fine tuned in that the therapist is making a judgment about what reflection the client is able to enter into. It is an inter subjective act where for example, the therapist picks up something from the client (wish, belief etc.), adds the therapist's meaning to it (reframing or challenging it, placing it in a wider context) and returns it to client. In CAT the therapist uses their own language to describe how the client relates to themselves in the hope that the client will gain a new understanding, and that it will stretch their current awareness. This process is inevitably two-way, and CAT acknowledges that the therapist too will have their own ZPD in relation to understanding the client. This is influenced by their own life experience and aspects of the cultural, socio-economic, and political 'lens' through which they are able to engage and respond to the client's experience. Therapists are likely to carry unconscious or implicit bias and will be open to acknowledging and

seeking ways to remain aware of these and how they may influence therapy. **(See Ability to work with ethnic, social, and cultural diversity).**

This is also influenced by neurodiversity which includes not only the client's neurological differences which may include intellectual and emotional constraints in adaptability and learning, but also how the therapist who is embedded in wider society, as well as current social norms impacts on the client. These social responses impact on access to education, (for example, denied or poor quality), access to employment or daytime activities (mostly unemployed with little alternative options) and on access to health care throughout the lifespan (severely reduced).

Ability to draw on knowledge that CAT is time-limited, and to understand the implications of this for therapy refers to how the time limit in CAT therapy makes it vital that CAT therapists hold the ending of the work in mind throughout but brings this to the fore in at least the last 3 or 4 sessions. CAT therapists explicitly focus on the client's experience of contracting, of the agreed time frame, the meaning of ending the therapy as well as on helping the client to review the gains and changes they have made, with a view to planning for the future. The process of ending is aided by ensuring that the session schedule is signalled from the outset, and that there is discussion about the feelings and meanings associated with ending for the client.

Reformulation and Engagement Phase of CAT

Knowledge of reformulation in CAT

These competences list the therapist's knowledge and use of the CAT concepts and tools in their work with the client and represent the distinguishing features of CAT's collaborative approach to reformulation. They cover the explicit engagement of the client in co-creation and use of the CAT reformulatory letters and 'maps' to assist the focus on the 3 R's of CAT: Reformulation, Recognition and Revision.

Knowledge of CAT's focus on Target Problems Target problems are developed from the client's presenting complaints. During the reformulation period in CAT, there is an important process of converting a complaint into a target problem, which involves turning it into something do-able, manageable and preferably couched in interpersonal language.

Knowledge of Reciprocal Roles (RRs) and their internalisation The term 'reciprocal role' is used in CAT to make sense of internalised relationship experience. For example, when a baby is responding to a comforting, soothing parent, they are learning what it is to be comforted, but are also learning the role of being a comforter. This can then be enacted in relation to themselves (self-soothing in infants who may suck a thumb) or to others (e.g. cradling a doll). Equally, when they experience a harsh, critical parent, they learn what it is to be crushed and demoralised, feeling not good enough. They also learn to be self-critical and to be critical of others. Each reciprocal role procedure (RRP) can be enacted in three different ways:

- others do it to me
- I do it to myself
- I do it to others

This is a central focus of the reformulatory work in CAT. Reciprocal roles can be understood as inferred, abstract structures which, unbeknownst to us, continually influence how we appraise the world: this links to both cognitive and object relations theories.

CAT therapists work with the client to identify their repertoire of reciprocal roles, how flexible and 'fit for purpose' this is, or whether the same few fixed and problematic roles are re-enacted in new situations, preventing them from being elaborated or modified. Reciprocal roles would be clustered together around key themes (e.g. absence of care, attacking care or idealised roles). The role is not just about an individual (e.g. father was neglecting and attacking) but roles that may have been occupied at different times by different figures. A CAT therapist would build up a picture of the reciprocal roles from the person's history, from their own transference and counter-transference responses, from examples of enactments in the consulting room and in the person's narrative of everyday life.

Knowledge of problematic patterns (Procedural Sequences) Target problems are underpinned by target problem procedures (TPPs). The therapist would identify the sequences of appraisal, emotion, aim, action, consequence and re-appraisal that maintain the problem. Typically in a 16 session CAT, the therapist would agree with the client one or two identified Target problems with up to 4 or 5 Target Problem Procedures.

Ability to draw on knowledge of the CAT 'Multiple Self States Model' CAT therapists working with people with a diagnosis of borderline personality disorder[6] realised that their very extreme and volatile mood and behaviour could be conceptualised in terms of discrete, alternating "self states." These difficulties arise from the procedures that clients have developed to cope with their experiences. Here, the different reciprocal roles which have formed (along with accompanying mental states) have never been integrated and remain partially dissociated. So, when in a particular state, the person has limited access to memories or recognition of how they are when in a different state. Hence the term 'self-state', as the self is fragmented into these different experiences, which of course is extremely confusing and undermining for the person, as well as others involved.

CAT theory suggests that there is a continuum between well integrated and poorly integrated functioning, not a dichotomy. We can all move along this continuum and we all have some experience of "multiple selves" (e.g. in the way that we act and feel in different ways depending on the social context) but the flexibility of our reciprocal role repertoire, the degree of integration and the capacity to reflect determine how well we function. A central feature in CAT is the ability to draw on knowledge that where a client presents with partially dissociated self-states, the focus of therapy is the impaired capacity for self-reflection and "meta-perspective" and that engaging with the client usually starts by acknowledging and validating their story and identifying characteristic, repeatedly experienced mental states that mapping the self-states and helping to client gain recognition of them, supports the development of a meta-perspective and self-reflective capacity.

[6] CAT considers that the psychiatric diagnoses of 'personality disorder' are understood to be descriptions of specific difficulties (e.g. unstable mood, intense negative affect, suicidality) rather than 'disease entities', and that these difficulties arise from the procedures that clients have developed to cope with their experiences, including their difficulty in integrating multiple self-states

Reformulation and Engagement Phase
Engaging the client to reach a shared reformulation

Ability to set up the therapy, to plan and agree the contract for CAT refers to attending to and ensuring that the client's motivation is based on informed consent, agreement on a contract about the structure of the therapy and considering the impact of the limits placed on the therapeutic relationship in terms of role procedures, for example as an experience of insufficient care or of lack of control in relation to a powerful other.

Ability to engage the client in the process of reformulation CAT therapists find that sketching out the key words of target problem procedure or the movement within and between a reciprocal role or a number of provisionally identified states can help build the alliance, show the client how a CAT understanding works and prepare the ground for active participation in the therapy. Such open, side by side sketching can increase trust that the therapist is not making hidden evaluations and help the client share their more difficult thoughts and feelings.

Ability to recognise and contain unmanageable feelings CAT therapists monitor the client's emotional state for signs of over-arousal or dissociation, and respond to these by helping the client manage their level of arousal. They would also communicate a preparedness to talk about and contain a discussion of traumatic events, whilst respecting a client's feelings about discussing and recognise areas where the client may experience trauma-related dissociation and states of unmanageable feelings. This would include where unmanageable feelings arise from trauma linked to repetition of adverse experiences in the therapeutic relationship (for example, relating to empathic failures linked to a form of implicit bias or discrimination such as inadvertent racism and a failure to make adequate adaptations owing to disability).

In the early sessions of CAT, people can be helped to develop a stable, continuous and positively-toned sense of self, through collaborative work to describe the self states. This begins the process of recognising them, realising they are predictable and repetitive, and developing a more integrated 'observing eye'. Such work in itself can aid the development of a new reciprocal role of 'compassionately understanding' to 'compassionately understood'. In other words the person can be helped to develop the capacity for self-reflection, and to foster a compassionate and curious stance in relation to the self. This is enormously helpful but unfamiliar for most people with severe dissociation and is a first step before they are able to track the rest of the damaging procedures.

Ability to work with ethnic, social and cultural diversity CAT therapists draw on knowledge of the influence of wider ethnic, social, cultural and political factors on the self and their impact in therapy. This is fundamental to CAT theory and practice. Roles and procedures are created in the interaction with the other, within a social context; cultural norms and values within a society play a central role in the development of the self. A reciprocal role or self state in CAT reflects words, emotions, language, culture, values and identity which operate in dialogue and the therapist should maintain an attitude of self-awareness of the unconscious nature of many attitudes.

In CAT the therapist aims to learn, understand and sense the client and position their distress within the client's ethnic, social and cultural context and visualise and sense this distress within the client's world. In order to do so, the CAT therapist also needs to develop sufficient awareness of various aspects of their own cultural, ethnic, economic and socio-political positioning, in order to be able to identify how these interact relationally and reciprocally with clients in therapy. There may be areas

in which a therapist is relatively 'blind', and may hold unconscious or implicit bias, and make assumptions about others who are more or less similar to themselves. As a result of shared cultural or other experience, they may assume knowledge in a way which closes down exploration. Lacking knowledge or experience, or as a result of relative power or privilege, they may not be able to offer empathic responses, may mirror societal norms and processes in denying or invalidating others' perspectives, or may perpetuate discrimination or marginalisation in other ways. Knowledge, awareness and skills in relation to these issues is essential for working therapeutically and may be more evident when there is a higher degree of 'difference' on the basis of important identity markers. Rupture recognition related to these issues, and appropriate means to acknowledging, exploring, and repairing ruptures when they occur, are important competences in this respect. Awareness of, and ability to acknowledge, power differentials in the therapy relationship are crucial, as is therapeutic humility in equalising these as much as is possible.

Core areas which are likely to require ongoing reflection and awareness include:

- sex/gender,
- sexuality/sexual orientation,
- race, ethnicity, and culture
- ability/disability; physical and mental health/social marginalisation
- socioeconomic status (SES)/classism inherent in society
- age
- religion/belief system/spirituality
- pregnancy and maternity
- language and power; asylum seekers and refugees)

Ability use CAT-specific tools There are a variety of CAT tools - for example, the psychotherapy file, the personality structure questionnaire, the states description procedure, and rating sheets. In addition to the use of genograms during the reformulation period, the psycho-social checklist is a further tool which can help to open conversations about aspects of identity and the cultural self relevant to presenting difficulties. There are also adapted CAT tools to assist people with intellectual disabilities. The way those tools are used also requires a sensitive adaptation to the client's circumstances including awareness of how much control the client will have over their dissemination. Used well, these can help to engage the client in a process of self-reflection, convey to the client that their problems are not unique to them but reflect patterns and experiences which are recognisable and amenable to therapy.

The rationale for using these tools is the assumption that clients may not be able to articulate their own 'problematic procedures' or 'states' of mind but are more likely to recognise them when seeing them written down. However, it is possible to be driven by the need to use the correct tools in the right order in the right session, and to lose sight of the fact that they are there to facilitate therapy and are not the end purpose of therapy. CAT aims to hold an awareness that the use of each conceptual tool is only as good as the collaborative alliance and shared understanding that it builds.

Therapists should be alert to whether the tools help the alliance and if they are right for the therapist and the client in that moment. For example, some clients do not 'get' the psychotherapy file and do not find it useful. CAT therapists should have a basic competence in using the tools to give them more choice and the flexibility to respond to the needs of individual clients.

Specifically, there should be flexibility in adaptation of tools according to the client's ZPD, for example in relation to language needs where the client has limited language or literacy, has neurodiversity's which make such tools less accessible, or has a mother-tongue other than English. Liaising and consulting with relevant organisations, the international CAT community, and special interest groups within CAT is a further competency which will be helpful in this respect. (See '**Ability to work with other organisations and systems involved in the client's care**')

Ability to Reformulate and produce a CAT Reformulation:

Reformulation A defining feature of CAT is that it uses an explicit "reformulation" (a new understanding), created and shared with the client within the first five sessions of the therapy. CAT therapists work with the client to generate this new understanding, which aims to validate the client's story; describe how reciprocal roles and role procedures were established in the person's life and identify their impacts and consider the possibilities for change. The key feature of the reformulation is that it is the therapist's understanding of the client, set-out in a form that is attuned to the client. It has three elements:

Target Problems & Target Problem Procedures list CAT therapists identify target problems early in therapy as part of the collaboration and will have a clear aim in view. This gives therapist and client a way of monitoring progress and, as therapy progresses, they can decide if it has been successful or not (as it moves into recognition and revision of target problem procedures). It is important in a brief structured therapy to achieve a clear identification of target problem procedures which will later be listed in the prose reformulation letter. Early sketches of problems and procedures help engage the client and will be evident in a tidied diagram that the therapist develops. These would be shared and form the scaffolding for the main phase of therapy work together.

Narrative ("Prose Letter") The centrality of the relationship between the therapist and the client is captured by Ryle's statement that "In CAT the detailed acknowledgement of the client's real experience is regarded as both humanly necessary and, in its re-creation of a life narrative, as an essential part of the process of integration" (Ryle, 1997). The clarity with which many published reformulations are expressed hides the complexity of the process, which combines a capacity to formulate the client's problems and an awareness of how best to communicate this to the client. The reformulation is based on a number of sources: the presenting problem (which may or may not become the target problem); an exploration of the client's history); their description of key current relationships; the Psychotherapy File; any other questionnaires that may be used by the therapist; diaries or self monitoring that the client engages in the early sessions; the therapist's awareness of the client's reactions to them and the counter-transference feelings and thoughts they have about the client.

The prose reformulation is an early exercise in fostering collaboration and self-reflection. It is also vital in accurately defining what is going on, giving a new perspective through an empathic narrative, making sense of the person's chronically endured pain and showing how the seemingly intransigent problems are in fact endlessly re-created and maintained by the procedures. As a process, it is a collaborative exploration rather than a 'question and answer' assessment. This process of collaboration is enabled for many clients by working side by side to develop a shared understanding. The reformulation letter itself is a complex document with many components, and is always offered in a tentative, enquiring and provisional way, ensuring that the process of arriving at the reformulation is a joint activity

within the client's ZPD. The aim is to arrive at a prose description which has a spontaneous, mutual and open nature, uses ordinary language and stays close to the client's world. Equally important as the content of the letter is to reflect on the way the letter itself is offered and received within the relationship. It is a powerful vehicle for reciprocal role enactment, both between therapist and client ('expert therapist' to 'novice, inadequate and dependent client') and between therapist and supervisor ('expert supervisor' to 'novice, inadequate and dependent trainee'). When done well, the process of arriving at the reformulation letter and the reformulation itself can create hope and expectancy of change, develop trust, improve the working alliance and deepen the level of emotional experiencing within a safe framework. Writing a good prose reformulation is a key competence in CAT.

Diagram ("Map") The purpose of the 'map' is to provide an effective visual summary of the core reciprocal role repertoire, showing how these roles are enacted through the target problem procedures to maintain the target problems. It is useful in facilitating recognition (hence the colloquial term 'map') and when problem procedures are revised, the 'exits' can be added to the diagram to demonstrate this. A good diagram is grounded in collaborative exploration of procedures and self-states. Starting very early with simple mapping of RRs in the room or in the narrative, it moves quickly to a more 'joined up' overview of the person's sequences. It should accurately show how someone's procedures are problematic, showing self-to-self and self-to-other loops that reinforce harmful reciprocal roles and maintain the target problems. For people with greater dissociation, it shows how self-states switch.

The process of mapping is as important as the product. It is an opportunity for joint activity and allows the therapist and client to work transparently and openly together. The capacity of the client to begin to imagine being their own therapist begins with such joint mapping. It equalises the power relationship and demands a capacity of the therapist to show his or her working and be willing to be not yet expert about the client.

There are different ways for showing the role repertoire, the procedures and the target problems but trying to ground the diagram in the person's experience and being responsive to them is crucial.

Recognition and Revision phase
Knowledge of working at change in CAT

This domain refers to an ability to draw on **knowledge of working at change in CAT** in that CAT aims to help people to develop awareness of their procedures and develop new roles or procedures, have more agency within them and become an active agent or author of their own experience.

The Recognition and Revision phase
Facilitating Change in CAT

Recognition and the observing self The development of the observing self is central to CAT therapy where the client is helped to 'recognise' the procedures and reciprocal roles contributing to their difficulties. This overlaps with notions of 'mindfulness' in mindfulness-based cognitive therapy and ''mentalization" in mentalization based therapy. By helping the client develop awareness of their

patterns, they become able to predict and consider making changes to them. Therapist and client need to agree on a working version of the diagram / 'map' and use it in facilitating recognition.

Revision Being aware of these processes may be sufficient to enable procedures to be revised, but often in focusing on **Revision,** specific 'exits' are developed as well, where specific changes to the procedures are named and the client practises these (**Ability to formulate Exits)**. For example, a client may need to become conscious that they are not sufficiently assertive and then need to think through specific ways in which they can become assertive and plan to put these into practice.

Ability to use a range of psychological techniques within the CAT reformulatory framework refers to the techniques used by CAT therapists in order to support the strategies and goals of revision within the framework offered by the CAT reformulation (for example, the selective use of directive techniques, role play, unsent letters). None of these techniques are specific to CAT, but the way they are deployed to support the work on a specified pattern as identified in the reformulation is distinctive to CAT.

Ability to use the therapeutic relationship to work with enactments CAT therapists aim to provide an attentive, honest, and non-collusive relationship as they work to help the client to learn to recognise and revise problematic procedures. Both these tasks are supported by the CAT reformulation tools, especially the sequential diagram. Therapists, should be alert to the specific procedures that reformulation identifies as likely to be manifested in the therapy relationship. A key task of therapy is to address and resolve these, assisted by the reformulation tools. They would aim to identify enactments of problematic procedures through direct recognition or through their own elicited feelings. CAT views naming and accepting these feelings to have a major therapeutic effect; once they are recognised they can be challenged, to open up the discussion of alternatives. When an unhelpful reciprocal role has been enacted in the therapy relationship, the therapist would acknowledge this and accept their part of the enactment, framing it as a useful opportunity for learning. Importantly, the therapy relationship aims to offer a new experience, a new 'situational' reciprocal role, of being listened to non-judgementally, contained, and empowered. CAT views this experience as gradually internalised and healing in itself.

Ability to recognise and resolve threats to the therapeutic alliance and to repair ruptures in the alliance. CAT promotes a non-judgmental means of identifying, owning and working with mutual enactments, and also stressing, but normalising, the fact that we all have our own 'maps' that we bring to work, so therapists are expected to be reflective about their own contribution. Therapists need to identify imminent threats to, or ruptures of, the therapeutic alliance and to shift the focus to identify the problematic reciprocal role procedures being enacted in the room and work with the client to resolve these. CAT therapists should draw on the empirically-refined CAT model of enactment resolution involving acknowledging the client's experience, carefully exploring the client's experience of what is happening, inviting or proposing a link to the reformulation, offering an explanation of why this may have occurred, inviting their views on this negotiating a shared understanding, facilitating any emotional reactions and how it has been understood. It is suggested that the enactment resolution model also incorporates the step of adapting offered explanations in response to reflections on the 'fit' between therapist assumptions and client experience along lines of socially contextualised factors, relative privilege or power, to help inform and negotiate a shared understanding.

Ability to sustain and consolidate positive change In CAT the therapist will help clients sustain and generalise positive changes including those observed in the session and address procedures which may be enacted as the client starts to experience positive change which for example, may undermine progress, which in CAT terms is a 'snag'.

Ability to monitor positive change (recognition and revision) refers to helping the client to review their progress in recognising and revising key target problems and target problem procedures using CAT rating sheets, measures to monitor change (for example, the States Description Procedure) or other jointly agreed methods or measures. In CAT we would name and monitor both the target problem procedures (for example an 'anxious striving loop') and the target problem or the presenting complaint (for example, exhaustion). It is possible that someone may start to revise the procedure by the end of therapy but still find it difficult to stay well and continue to feel exhausted. Therapists need to attend to both and to check with the client that developing Exits for target problem procedures does lead to improvement in target problems. If not, then there might be other as yet unrecognised procedures contributing to the target problem.

The Recognition and Revision phase
Working with the time limited nature of CAT

Ability to use CAT skills to manage the ending of therapy CAT therapists hold the ending in sight from the beginning, mark session numbers, prepare for ending through discussion, and mark the ending with goodbye letters. Throughout therapy the therapist anticipates and addresses the client's feelings about the ending and its meaning to them and will help them learn to manage feelings of disappointment and loss. In this way the therapist aims to end in a healthy, manageable way as a scaffolding for future relationships but would anticipate when an ending may be likely to be difficult. CAT therapists need to be aware of and able to manage their own feelings about endings.

Ability to produce and use goodbye letters and follow-up Goodbye letters help to focus the therapist's thoughts on this area and are intended to make the process more conscious and manageable for the client. The therapist would usually give a Goodbye letter in the penultimate or final session of therapy. It would include a brief description of the purpose of the letter, and of what the therapy has focussed on, describe the achievements of the therapy, difficulties that have arisen in the relationship, areas the client will need to continue to work on, hopes for the future and affirmation of the follow up session. The therapist would plan a follow up session as this encourages the client to hold the therapy in mind during a long break and provides an opportunity to assess how far the client has managed to retain any gains in the therapy and, hopefully, to make further progress independently.

Ability to work with other organisations and systems involved in the client's care
This section concerns the therapist's liaison with others involved in the care of a client with whom they are doing CAT therapy (it is not referring to the competences required to consult to or with teams). It concerns a CAT therapist's ability to work collaboratively and respectfully with wider systems involved with the client they are seeing, for example, mental health services, social services, safeguarding services, police, benefits agencies, family members and significant others. The therapist's aim is to use the CAT model to improve understanding by members of the wider system and to work with them to identify helpful ways of responding. Additionally, the CAT therapist will be open to seeking appropriate advice from, and consultation with, special interest groups, and

community or cultural agencies, in relation to areas where they have limited understanding of important aspects of the client's abilities, experience or cultural perspective.

Metacompetences

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 (e.g. Bennett-Levy, 2005) which enable therapists to implement therapy in a coherent and informed manner.

Technical flexibility - the ability to respond to the individual needs of a client at a given moment in time - is an important hallmark of competent therapists. The interaction of a particular therapist and a particular client also produces dynamics unique to that therapeutic relationship, 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 client's actions change and the therapist is engaged in a highly charged relationship that needs to be managed. What is required therefore are a range of techniques, complex interpersonal skills under the guidance of very sophisticated mental activities.

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 consensus[7] 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 which present themselves").

The lists are divided into two areas. **Generic Metacompetences** are common to all therapies, and broadly reflect the ability to implement an intervention in a manner which is flexible and responsive. **CAT specific Metacompetences** refer to the implementation of CAT in a manner consonant with its philosophy. These include a) an ability to judge whether CAT is likely to be a safe and effective therapy for a client seeking help; b) how best to optimise what the client is capable of with the help of the therapist (the 'zone of proximal development'; c) the risk of harm as therapy progresses: for example, judging a client's distress tolerance when working within a CAT framework; d) how in CAT the therapist needs to move between task and process flexibly, to have an ability to move between working on the tasks of therapy (such as developing the reformulation) to attending to relational process issues (such as ruptures in the therapeutic relationship or the client's response to specific "tasks" of therapy (e.g. avoiding completing the Psychotherapy File).

Implementing the competence framework

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

[7] Through discussion and review of metacompetences by the Expert Reference Group

Do clinicians need to do everything specified in a competence list?
The competence lists are based on descriptions of CAT in therapy textbooks, guidelines and empirically derived models of practice. Some of these techniques may be critical to outcome, but others may be less relevant, or on occasions irrelevant. Even where there is research evidence which suggests that the intervention works we are less certain about which components actually make for change, and exactly by what process.

It needs to be accepted that the competences which emerge 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 which can be used to sift effective from potentially ineffective strategies. This means that competence lists derived from this process may include therapeutic cul de sacs as well as critical elements.

Does this mean that clinicians can use their judgment 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, guidelines 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 the competence lists 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 judgment, rather than opinion.

A final point (raised earlier in this document) relates to the fact that because the CAT field contains some variations in practice, for example in methods used to facilitate revision, based on additional training models and core profession, clinicians will necessarily be selecting only those areas of the specific competence domain that fit to their expertise and model of practice. Although this means that it is completely legitimate for therapists to be selective about which areas of the framework they adhere to, within each area the expectation is that all competences are probably relevant to practice.

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, but this observation really applies to the model as a whole rather than its specific elements. There is some research on process in CAT therapy that provides evidence on which to base judgments about the value of specific activities e.g. enactment resolution model but comment on the relative value of competences may well be premature.

The impact of treatment formats on clinical effectiveness: The competence lists in this report set out what a therapist should be able to do[8] but do not comment on the way in which therapy is organised and delivered (for example, the duration of each session or how sessions are spaced) but it is assumed that CAT is delivered once weekly, with sessions of 50 minutes duration and as a time limited intervention. Such considerations will undoubtedly shape the clinical work undertaken, and for a time limited model, the consensus of the ERG was that these variations will have implications for the skills that therapists deploy. Treatment formats are sometimes identified in manuals and

[8] they are *competences* not a prescriptive list of everything a therapist must do in all circumstances

research protocols, with the schedule constructed so as to match to clinical need and the rationale for the intervention. Information about the ways in which therapies are best implemented is usually found in clinical guidelines, such as those produced by NICE.

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 (2010) reviewed the training and ongoing supervision associated with the delivery of therapy in the exemplar trials which 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 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 associated with trials is neglected.

Applying the competence framework

This section sets out the various uses to which the CAT competence 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 may be developed

Commissioning: The CAT framework can contribute to the effective use of health care resources by enabling commissioners to specify the appropriate levels and range of CAT therapy 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 which services could be expected to adhere to.

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 – they will enable:

- the identification of the key competences required by a practitioner to deliver CAT interventions
- the identification of 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 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. Monitoring the quality and outcomes of psychological therapies is a key clinical governance activity; the framework will allow providers to ensure that:

- CAT 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 Health Care Professionals Council (HCPC) and other similar bodies

Supervision: The CAT competence framework potentially provides a useful tool to improve the quality of supervision by helping supervisors to focus on a set of competences which are known to be associated with the delivery of effective treatments. Used in conjunction with the supervision competence framework (available online at www.ucl.ac.uk/CORE/) it can:

- provide a structure which helps to identify the key components of effective practice in CAT
- help in the process of identification and remediation of sub-optimal performance

Supervision commonly has two (linked) aims – to improve the performance of practitioners and to improve outcomes for clients. The CAT 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 competencies which can guide and refine the structure and curriculum of training programmes (including pre and post-qualification professional trainings as well as the training offered by independent organisations)
- providing a system for the evaluation of the outcome of training programmes

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. CAT has a measure of competence developed prior to this framework that lists observable competencies and has known psychometric properties (Bennett and Parry 2004). It has been used with audio-tape of sessions in clinical trials and to evaluate the outcome of training.

Concluding comments

This report describes a model which identifies the activities which characterise effective CAT interventions, and locates them in a “map” of competences.

The work has been guided by two 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 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 interventions are actually delivered and hence facilitates their use in routine practice.

Putting the model 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 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 judgment and self-awareness 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 which 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.

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