Assessing Competences Against the Cognitive Behaviour Therapy Framework

Self-Assessment Tool

Introduction

In September 2007 the Department of Health published **"The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders"** (Anthony D. Roth and Stephen Pilling, DOH, September 2007). The publication was the result of a project commissioned by the Improving Access to Psychological Therapies (IAPT) programme, with additional funding from Skills for Health and the Centre for Outcomes, Research and Effectiveness (CORE). This project stemmed from a recognition that the success of the IAPT initiative would rest on the success of competent practitioners who were able to offer effective CBT interventions at both a low and high-intensity level.

Roth and Pilling describe a model which identifies the activities that characterise effective CBT interventions for people with anxiety and depression, and locates them in a 'map' of competences (see Figure 1). The model organises the CBT competences into five domains (generic, basic, specific, problem-specific and metacompetences) and presents a 'map' of how the competences fit together.

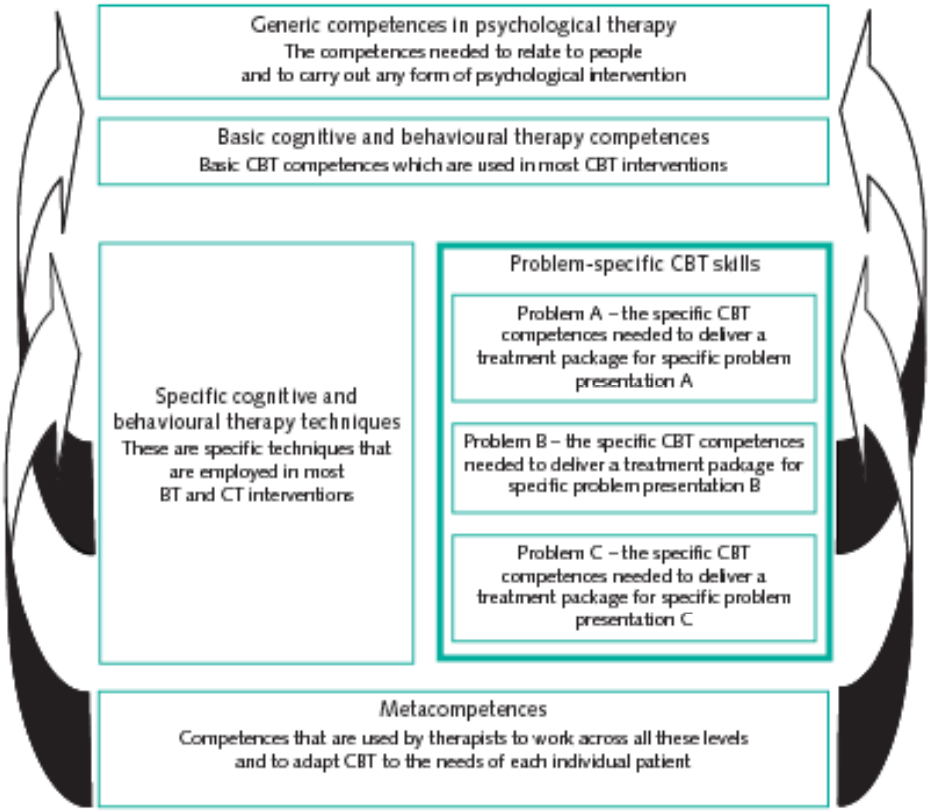
In their report they outline a variety of potential uses for the CBT competence framework, including its use in commissioning, service organization, clinical governance, supervision, training, registration and research. Their report also suggests how relevant work in the area could be developed,

One if the first developments has been an audit tool to help education providers assess how closely their training programmes include the development of the knowledge, skills and experience included in the competence framework. This provides an essential tool for IAPT education providers, particularly for high intensity training, to help them ensure that the training they are providing will equip their trainees with the appropriate skills that will be needed in their work in the new IAPT services. The work will also assist those education providers who provide a more general training in CBT and/or core professional training (applied psychology, allied health professional training, nursing and psychiatry) to assess how far their own programmes allow for the development of the competences outlined in the framework.

The second development is a self-assessment tool that can be used by individual

therapists and IAPT/CBT services. The tool provides an indication of how far the therapist and/or their supervisor feel that the breadth and level of the competences on key elements of the framework have been attained and as a result what areas may still need to be developed. It is not a test but purely a self-report system with the aim of helping therapists and services identify training needs. It can also provide a record and print out on each of the key elements of the framework to help keep track of a therapist's development of competences in CBT.

Figure 1: Outline model for CBT competences



Competences can be downloaded from the website of the Centre for Outcomes, Research and Effectiveness (CORE):

www.ucl.ac.uk/CORE/

Full details of the competences framework are given in Appendix 1

The step-by-step guide

A. Starting the Self-assessment

Save the two files “Self-assessment of CBT competences.xls” and “Competency Mapping Tool Step By StepGuide.doc” onto your computer

1. Click on “Self-assessment of CBT competences.xls” icon

2. A notice giving a security warning about macros may appear in which case you should click the box Enable Macros. The programme will only work if you enable macros on your computer. (*note: macros cannot be enabled on Xcel used by the Mac OX*)

3. Another notice appears as

> Self-assessment of CBT competences.xls” should be opened as read-only unless you need to save changes to it. Open as read-only?

   Click No.

4. The Self-Assessment of CBT Competencies grid then opens together with a Competency mapping tool bar with 5 icons:

   Step-By-Step Guide – which allows you to return to this document
   Competency Framework – which takes you to the Roth/Pilling Framework
   Name – allows you to enter and change your name and service details
   Summary – provides a summary of assessment and allows you to print document
   Save – saves your self-assessment

   A screen requesting Name and Service Details also appears

   Enter your name and service and then press OK

   This then transfers you names and service to the top of the page

B. Finding your way around the competences framework

5. You will now see a spreadsheet with 4 columns. If you cannot see all the columns then use the View menu to zoom to the correct level (probably 75%) to allow this to happen.

6. There are 7 worksheets which make up the self-assessment tool. These are:

   Generic, Basic, Specific; Phobias; Panic; OCD; GAD; PTSD; Depression

   Use the 7 tabs at the bottom of the page to view each of the worksheets

7. Start by looking at the “Generic, Basic, Specific” worksheet by clicking on the tab at the bottom.

   In addition to listing the *areas of activity* (in **bold** type coloured blue) under the three domains (Generic, Basic, Specific), the worksheets also details the individual competences which make up each area of activity. To reveal the individual competences for each area of activity areas click on the ‘+’ button in the margin to expand them (these are coloured cream). You can reduced back to the area of activity by clicking on the **“ -** “ sign

   For example by clicking the “ + ” sign to the left of the **GENERIC THERAPEUTIC COMPETENCES** heading (line 7) this will opens up the 9 areas of activity: “Knowledge and understanding of mental health problems”, “Knowledge of, and ability to operate within, professional and ethical guidelines” and so on.

   The number of individual competences that relate to each of the activity areas is indicated in brackets and by clicking once again on the “ + ” sign in the left hand column this will open up the individual competences related to that particular area of activity.

   Lines 7 – 133 detail the **GENERIC THERAPEUTIC COMPETENCES**
   Lines 134 – 266 detail the **BASIC CBT COMPETENCES**
   Lines 267 – 432 detail the **SPECIFC BT AND CT COMPETENCES**

C. Entering your self-assessment information

7. You are now ready to enter your self-assessment in column G

   By clicking on the relevant box in column G and clicking on the arrow to the right that appears you can check the competence as either Green (I have fully developed this competence), Amber (I have developed part of this competence) or Red (I do not have this competence).

   As a short cut it should also be possible to type the letter G, A or R to achieve the same result. If this doesn’t work then use the drop down menu.

8. You can either choose to self assess yourself against

   (1) the main areas of activity which are coloured blue (for example in the **GENERIC THERAPEUTIC COMPETENCES** domain this would require entering the information on rows 8, 15, 29, 48, 57, 95, 99, 104 and 116) or

   (2) if you are unsure if you have the competences in the area of activity then you can rate on each of the individual competences.

9. When you have completed an area of activity go onto the next one. If you have expanded the area of activity to fill in all the individual cometences then click on the “ –“ to reduce it back to the main area of activity before moving on so your screen isn’t too cluttered.

D. Saving your Self-Assessment.

10 The self-assessment may take some time if you are going though each individual competence so you may wish to save your self-assessment as you progress and come back to it at a later time. You can do this by clicking the Save button in the Competency mapping Toolbar. This will then ask you for a File name and it is suggested that you save using your own name or initials

E. Printing out your self assessment

11. You can use the Summary icon in the tool bar to produce a summary page on the area that you have been working on or have completed and print this out.

By clicking on Summary a page appears with details of your self-assessment which you can save or print out.

This summary and print out will then give an overview of the areas that you feel confident that you have already achieved full competence (green), those that appear to need at bit more development (amber) and those that you have identified as still to be developed (red).

And it is as simple as that!

Discussion with your clinical supervisor should be used to help identify how best gaps in competences can be developed and the resources that will be needed in terms of knowledge and skills

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Appendix 1

Full details of the competences

The map of CBT competences

Using the map

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

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

Generic therapeutic competences (see column 1 of Figure 2)

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

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

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

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

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

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

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

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

observations through practice assignments.

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

The structured nature of CBT is often misunderstood, with therapy seen as a series of techniques delivered in a didactic manner by a directive therapist who (in effect) tells the client that their way of thinking is 'wrong' and shows them how to think in a more constructive manner. This caricature is common, but unhelpful on at least two counts. If CBT were to be implemented in this way it would be unlikely that enduring change would result. And as should be clear from this report, it would not really be CBT.

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

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

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

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

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

The first two competences refer to agenda setting, firstly in relation to the therapy as a whole and secondly for each session. Next is the ability both to plan and to review 'homework' or 'practice assignments'. As discussed in the later sections of this report, these are actually two activities; there is evidence that reviewing homework makes it more likely that clients will carry it out, and also that many therapists set homework but fail to review it (Roth and Pilling, in preparation, b). Since carrying out homework is associated with better outcomes, there is obvious value in distinguishing setting homework from the process of its review. The last competence shown in pale green focuses on the use of summaries and two- way feedback to structure the session, using careful listening and observation to give feedback to the client about how the therapist understands them, and eliciting feedback from the client to help the therapist appraise their understanding of the issues under discussion. Along with periodic explicit 'capsule' summaries, this process makes an important contribution to the structure of the session.

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

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

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

Ending therapy (single competence shown in white): Finishing therapy in a planned manner is important not only

because clients (and often therapists) may have strong feelings about ending, but also because this allows for discussion of how the client will manage on their own. This process is aided by ensuring both that the likely schedule for sessions is signaled from the outset and that there is explicit discussion towards the end of therapy that is oriented to thinking about the maintenance of gains. This usually includes a review of progress and any concerns that the client has about how they will manage after therapy ends, connecting this to a discussion of what the client has learned and thinking about how this can be applied in the face of future challenges such as risk of relapse.

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

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

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

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

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

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

All these techniques involve discussion within the therapy session, but it is usually important that they are brought alive through the use of 'behavioural experiments'. These are assignments that help the client to test out the validity of their cognitions and beliefs. Carrying out the assignment also helps them to become more aware of the way in which they perceive and react to events and to those around them, further contributing to the process of self-understanding. Although behavioural experiments can be carried out in the session, they are particularly helpful when carried out in the client's everyday life; on this basis they are a core activity in CBT and make a fundamental contribution to the process of change.

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

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

Problem Specific competences (see column 4 of Figure 2)

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

The lists in this domain are intended to read as a coherent description of the critical elements of (and pathways through) each intervention. Working through the list should identify the elements which, taken together, constitute the treatment 'package' and hence best practice. By intent the problem-specific lists include some repetition of basic or specific CBT

competences, partly because this makes them easier to digest and partly because some interventions modify standard CBT techniques in order to apply them to a particular disorder. Nonetheless, it should be clear that the effective delivery of problem-specific interventions will always rest on a range of generic, basic, specific and metacompetences.

In a number of instances there are competence lists for more than one approach to a disorder. This reflects the fact that within CBT there can be differences in the way a disorder is conceptualised, and hence in the emphasis placed on different aspects of intervention. As there is strong evidence for the effectiveness of all the approaches listed in this domain, it is for the therapist (perhaps in conjunction with the client) to decide which intervention to select.

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

Meta competences (see column 5 of Figure 2)

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

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

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

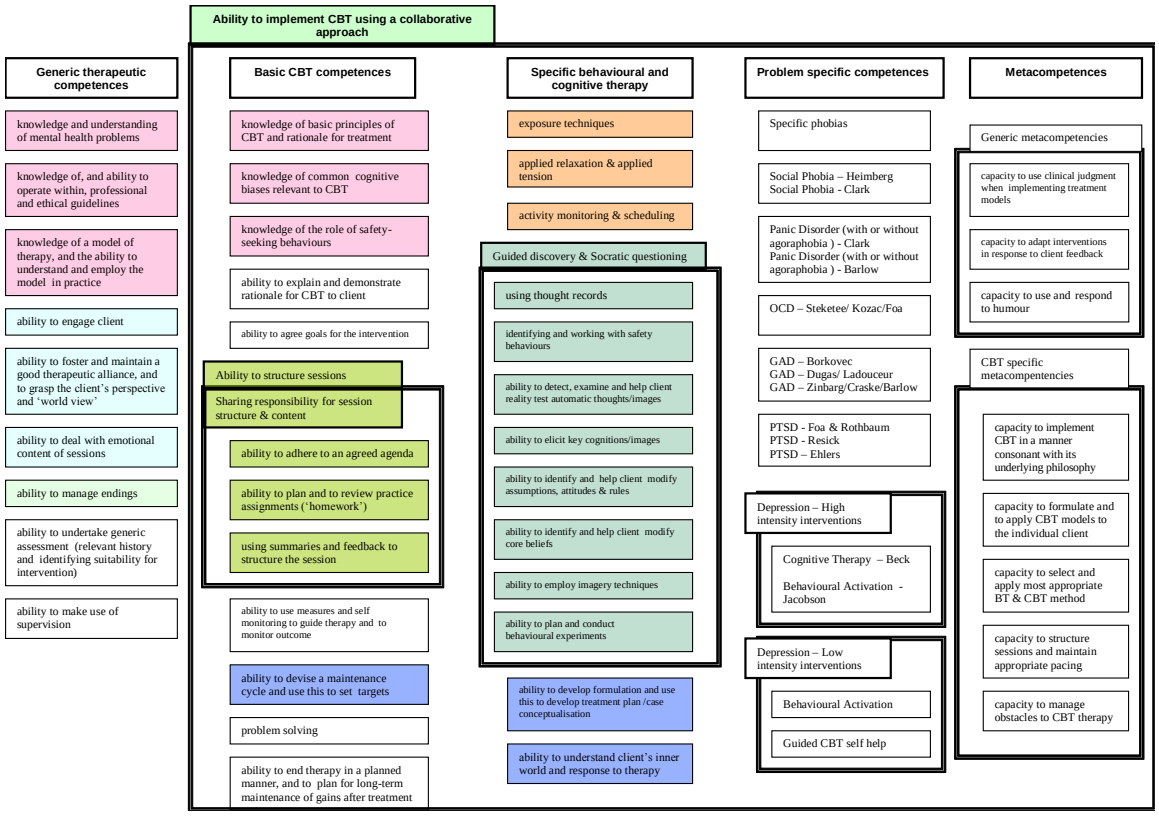

Figure 2