

Running Head: Are competence frameworks fit for practice?

Are Competence Frameworks Fit for Practice? Examining the Validity of Competence Frameworks for CBT, Psychodynamic, and Humanistic Therapies.

Abstract

Practitioners transporting psychological therapies from a research context to clinical settings need to know what competences they should demonstrate to maintain congruence with the evidence base. This study explores the validity of a suite of competence frameworks for CBT, humanistic, and psychodynamic therapies developed to aid the transportation process. Experienced psychological therapists ($N = 111$) undertook a Q-sort of 100 items, drawn from frameworks representing each of the modalities and including a set of pantheoretical 'generic' competences, rating items as characteristic or uncharacteristic of their orientation. There were significant differences in the way competences were assigned, with practitioners strongly favoring items from their own modality framework and eschewing items from the others. These results confirm the validity of the items within the frameworks; their utility and application is discussed.

Key words: Competence, competence framework, Q-sort, psychological therapy

Introduction

There is good evidence for the efficacy of psychological therapies in relation to a wide range of mental health presentations (Roth & Fonagy, 2005), and this has helped to establish the place of talking therapies as a standard part of healthcare provision. However, maintaining the efficacy of an ‘evidence-based’ therapy as it transfers from the research context into a “routine” service setting is not straightforward. Research studies expend considerable time and resources ensuring that trial therapists not only show adherence to the therapy being examined (by restricting the techniques they use to those prescribed by a manual), but also demonstrate competence by applying these techniques skillfully (see Waltz, Addis, Koerner & Jacobson, 1993). The extent of this effort is often obscured in reports of this research (Roth, Pilling, & Turner, 2010), and it seems appropriate to assert that transferring an evidence-based therapy into routine practice should be predicated on the inclusion of appropriate training and ongoing supervision. Neglecting to do so risks maintaining a gap between the efficacy found in trials and the clinical effectiveness found in routine services.

Defining the content of training in psychological therapies (and particularly denoting the specific competences that constitute effective practice) is a critical challenge if psychological therapies are to be implemented in a manner that is faithful to their evidence base. Although a number of competence listings have been published recently (e.g. e.g. Bennett & Parry, (2004); Hatcher, R.L. & Dudley, K, (2007); Kaslow, Rubin, Forrest, Elman, Van Horne, Jacobs & Huprich et al. (2007); Fonagy, 2010; Sburlati, Schniering, Lyneham, & Rapee, 2011; Rodolfa, Greenberg, Hunsley, Smith-Zoeller, Cox, Sammons, Caro, & Spivak. 2013), there is no consensus about the methodology for deriving and assembling these frameworks. As a consequence they are organized and set out in different ways, vary in whether they focus on generic, baseline skills or on specific therapy skills (or both), are

inconsistent in relation to the level of behavioral specificity and adopt differing approaches to scoping the competences (for example, the extent to which they derive content on the basis of practitioners' views, or relate the content directly to the standards set-out in research manuals). Ideally, all should set out the competences that are integral to the range of evidence-based approaches for specific client populations. Unfortunately these can be poorly specified in therapy manuals, meaning that the process of 'extracting' them risks a loss of fidelity. As such, assuring the content validity of a competence framework is a critical challenge.

This paper considers one approach to testing the content validity of competence frameworks developed through the 'Improving Access to Psychological Therapies' (IAPT) program. This major service initiative emerged from debates about the need to make psychological therapies available as part of standard care for people with anxiety and depression (the 'Layard report'; Layard et al., 2006). In response the United Kingdom Department of Health committed to a rapid increase in the number of psychological therapists in the National Health Service (NHS), and hence also committed to a major training initiative. To achieve this, the IAPT program commissioned a set of modality-specific competence frameworks which could be used to develop a national training curriculum.

The development of each framework was guided by an Expert Reference Group (ERG), with members selected on the basis of their expertise and their contribution to research and training in the relevant modality. Under the auspices of the ERG a scoping review was conducted to identify those trials that establish the evidence for efficacy of the approach. Behaviorally-specific competence statements were 'extracted' from the manuals used within these trials (and from associated training materials), and these statements organized into an 'architecture', assembling competences into a higher-order 'map' that sets

out the knowledge and skills associated with the approach. The content of each framework was subject to close review by the ERG and was also sent for non-blind peer review to leading clinicians and researchers and (wherever possible) to those clinicians who developed the techniques being described. A full description of the methodology used to develop the frameworks can be found in Roth & Pilling, (2008). There are now published frameworks for a broad range of modalities (including CBT, psychodynamic, humanistic, and systemic therapies and Interpersonal Psychotherapy) and for clinical groups, including children, adults, older adults, people with psychosis and bipolar disorder and people with personality disorder. All these frameworks are published online (at www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm)

This study focuses on frameworks for the modalities most frequently applied in individual psychological therapies with adults – CBT (Roth & Pilling, 2007), Humanistic Psychological Therapy (Roth, Hill, & Pilling, 2009; henceforth referred to as humanistic therapy) and Psychoanalytic/Psychodynamic Therapy (Lemma, Roth, & Pilling, 2009; henceforth referred to as psychodynamic therapy). These frameworks all contain the same common element: a domain of ‘Generic Therapeutic Competences’ (such as an ability to engage clients, or to develop the therapeutic alliance). This reflects a long tradition within psychological therapy research proposing a set of common capacities that underpin all psychological interventions (e.g., Frank, 1971). As such, it is important to examine how therapists construe generic competences in relation to the theoretically consistent elements of their therapy.

The construct validity of a competence framework is critical to its utility and applicability, and the method we adopted to develop them attempted to assure this by basing competence statements on the published and unpublished manuals used in clinical trials; in

principle this should ensure that these descriptions accurately reflect the modality they are intended to exemplify. However, it is important to test this assertion empirically, since the intent of framework development is to produce a set of descriptors that are theoretically and pragmatically coherent, and (as a consequence of this internal coherence) distinguishable from frameworks for other modalities.

The present study examines the validity of the three frameworks by asking experienced practitioners to rate the concordance between items contained in the three frameworks and their sense of what constitutes standard practice in their modality. Answering this simple question is methodologically challenging; using a Likert scale may be unhelpful because therapists may not discriminate sufficiently between items, and many competence descriptions will be identified as being (at least somewhat) relevant to all therapies. The implication is that a simple rating system is unlikely to gain much traction on those competences seen as especially characteristic or uncharacteristic of a modality. A methodology that is well suited (and indeed designed) to enhance discrimination is the Q-sort (McKeown & Thomas, 1988). Although this employs a Likert-like rating scale, it fixes the number of items that can be placed at each point, with very few items located at the extremes of the scale and most placed towards the center (with frequencies that approximate to a normal distribution). This means that raters need to be highly selective about the items placed at the extremes of the scale – precisely the area in which most researchers are interested.

The hypotheses tested in this study are that:

1. Participants will differentially select as ‘characteristic’ items that are associated with the framework representing their particular theoretical orientation

2. Participants from all three modalities will be equally likely to identify generic items as ‘characteristic’, and more likely to identify generic items as characteristic than items from ‘alternative’ frameworks
3. When identifying items as uncharacteristic of their modality:
 - i) therapists will draw on competence frameworks other than the one intended to describe their therapeutic orientation;
 - ii) therapists will not include items from the competence framework that describes their own therapeutic orientation.

Method

Selection of Items for the Q-sort

Items for the Q-sort were obtained from four sources: the competence frameworks for CBT, humanistic and psychodynamic therapies (published online at www.ul.ac.uk/CORE/), and from the list of generic competences common to (and included in) all three frameworks. The aim was to select a total of 100 items, comprising 25 modality-specific competences from each of the three frameworks (sourced from the areas of the framework that set out the basic competences believed to characterize the approach), along with a further 25 generic therapeutic competences. While including more items would guard against the risk of excluding important competences, there is a limit to how many items participants can hold in mind and rate with any reliability. Reflecting this, most Q-sort studies adopt an upper limit of 100 items (Cross, 2005).

Reducing the total number of competence descriptions in the frameworks to a ‘representative’ subset of 25 items required a systematic approach to data reduction, since the relevant domains included approximately 790 statements (260 CBT, 232 humanistic, and 298

psychodynamic, as well as 105 generic). A strategy of randomly selecting items was rejected because the ‘level’ of competence statements varies widely, in that some are higher-level descriptions of competences associated with the approach, while others address very narrow and specific area of practice. As such, it made sense to restrict items in the Q-sort to higher level (broader) descriptions of therapeutic practice. With this in mind all items were reviewed by the author, (who has extensive clinical and research experience with all three modalities). Within each modality, a first ‘edit’ removed all items where the focus was very narrow and where items would be hard to understand once removed from the context in which they were written (for example, because they were designed to be read in the context of preceding or subsequent competences). This reduced the pool of items by approximately 70%. A second edit removed items where the language used was so specific to a modality that it could only belong to that therapeutic approach (and hence might be automatically inimical to other modalities) and where the problem could not be overcome by a minor rewording of the original competence description¹. After screening for overlap and repetition, this left a much reduced pool of items (47 CBT, 38 humanistic, 51 psychodynamic, and 41 generic) from which 25 statements from each domain were identified using an approximation to random selection (printing each competence description on a card, turning these face-down and selecting 25 cards).

Participant Recruitment

¹ Some technical language was retained where editing would have changed the meaning of the competence (for example, removing the word ‘Socratic’ from the phrase “Socratic questioning” has a major impact on its meaning when used in a competence description)

In order to recruit participants with reasonable levels of therapeutic experience, email advertisements were sent to therapists via modality-specific psychotherapy organizations in the United Kingdom: for CBT the British Association for Behavioural and Cognitive Psychotherapies (BABCP), and for humanistic therapy the British Association of Counselling and Psychotherapy (BACP). In the absence of a single ‘umbrella’ organization representing psychodynamic therapists, email advertisements were sent via the service managers of clinics and organizations specializing in psychodynamic psychotherapy. The advertisement outlined the study and explained that we were seeking individuals experienced in and committed to a single modality (rather than those who practiced integratively). Interested participants were directed to a website where informed consent was obtained, a face sheet was completed, and the Q-sort procedure was explained.

Recruitment took place between September 2011 and July 2012, with successive waves of advertising aiming to achieve balanced numbers of therapists from each modality.

Participants

A total of 146 participants logged on to the site and submitted a Q-sort (56 CBT; 54 humanistic, and 36 psychodynamic). Initial data inspection suggested that some participants started but did not complete the sort, or failed to reorder the competence descriptions from their original positions. To detect this, each sort was correlated with the original ordering of competences, and 35 participants with a correlation ≥ 0.25 were removed. Analysis is based on the remaining 111 participants (38 CBT, 42 humanistic, and 31 psychodynamic).

The aim of sampling from among more experienced therapists was achieved (Table 1); the mean age for all participants was 50.05 years, with a mean of 14.37 years of practice. Across all modalities a substantial number of practitioners had undertaken specialist training

beyond their base professional training (26 CBT, 29 humanistic, and 25 psychodynamic), ranging from specialist training of various durations to short courses covering specific areas of practice.

CBT participants were younger than humanistic and psychodynamic practitioners ($F = 14.84$, $df = 2,103$, $p < .001$) and had less experience ($F = 3.757$, $df = 2,108$, $p < .026$).

Across all modalities women constituted the greater proportion of participants. There was a wide representation of professional backgrounds (Table 2) with some variance in relation to modality: reflecting UK training patterns, most humanistic practitioners were counselors, while only one clinical psychologist practiced using a humanistic approach.

INSERT TABLES 1 AND 2 ABOUT HERE

Q-sort Procedure

The Q-sort was conducted online using a bespoke Flash program² (accessible at www.ucl.ac.uk/clinical-psychology/CORE/qsort/index.php). This included a guide to Q-sort methodology and a brief questionnaire asking for demographic information and details of professional practice and qualification. To make the sort more manageable, it was divided into two phases: in the first phase, participants assigned an initial rating, and in the second, participants revised their ratings until all items accorded to the required Q-sort distribution. Thus, initially each competence description was displayed successively (in the same order for all participants) and a rating assigned using a nine-point scale ranging from 1 (*extremely*

² The author is indebted to Celeste Schneider for generously making available an original prototype program, and to Charmian Dawson for developing the program used in this study.

characteristic of my modality) to 9 (*extremely uncharacteristic of my modality*). Once all 100 items had been assigned an initial rating, participants moved to a second screen in the program for the final Q-sort. This screen showed the number of items permitted at each point of the scale, and the current assignment of items. The sort was completed by reassigning items until they were appropriately distributed. The anchor points and distribution of the Q-sort are shown in Table 3. Items placed at ranks 1–3 endorse competences as characteristic of the participant’s modality, (respectively extremely, very or fairly characteristic of the participant’s modality), while placing an item at ranks 7–9 indicates that competences are judged to be fairly, very or extremely uncharacteristic of the participant’s modality. Because the central rankings (4–6) indicate items that are viewed neutrally or as slightly characteristic or uncharacteristic, the principal hypotheses were tested by examining the source of competences placed at ranks 1–3 and at ranks 7–9.

INSERT TABLE 3 ABOUT HERE

To ensure that the distribution was adhered to, an indicator at each point of the scale showed both the number of items placed and the number of items permitted, accompanied by a visual reminder (when incorrect numbers of items were placed in a column, colored bars were displayed to indicate that there were too few or too many items; when the correct number was allocated, the colored bars disappeared). Participants could pause and store their Q-sort at any point and return to it at a later stage.

Statistical Analysis

Testing the validity of modality-specific items

The level of consistency between ‘intended’ and observed modality assignment was determined for each participant by examining:

a) The 25 items placed at ranks 1–3 (competences considered to be characteristic of a modality), and identifying the proportion of items from the framework representing their particular theoretical orientation;

b) The 25 items placed at ranks 7–9 (competences considered to be uncharacteristic of a modality), and identifying the proportion of assignments items from the framework representing their particular theoretical orientation.

Both analyses can be seen as yielding an ‘accuracy of assignment’ index relative to each participant’s modality group.

Testing the validity of generic items

The primary hypothesis is that, across all participants, the same proportion of generic items will be identified as characteristic of their own orientation. A supplementary hypothesis is that generic items are more likely to be seen as characteristic than items intended to be representative of modalities other than the participant’s own (put more concretely, a CBT participant would be expected to favor generic items as characteristic of their practice, compared to psychodynamic or humanistic items). The first hypothesis was tested by considering the number of generic items assigned to ranks 1–3. The second hypothesis was tested by comparing the mean frequency of selection of generic items relative to the frequency of modality-specific items.

Results

a) Proportion of Items Chosen From Each Domain of Competences

Tables 4 and 5 and Figures 1 and 2 show the pattern of assignments of competences at the tails of the Q-sort distribution (at ranks 1–3 [respectively, extremely, very, or fairly characteristic of the participant’s modality] and at ranks 7–9 [respectively, fairly, very or extremely uncharacteristic of the participant’s modality]). Taking the percentage of items placed at these ranks by participants from each modality gives an overview of the ‘average’ Q-sort for each approach.

INSERT TABLES 4 and 5 and FIGURES 1 AND 2 ABOUT HERE

i) Contrasting the distribution of items from participant’s ‘own’ and ‘other’ modality frameworks

Participants from all three modalities were significantly more likely to identify items drawn from their own modality framework as ‘characteristic’. An ANOVA contrasting assignments by participants from each modality across the four competence categories yielded a significant interaction term ($F_{6,324} = 190.1, p < .001$) and large effect sizes for each of the groups ($\eta^2 = 0.797, F_{3, 111} = 412.2, p < .001$ for CBT therapists; partial $\eta^2 = 0.752, F_{3, 123} = 110.2, p < .001$ for humanistic therapists; $\eta^2 = 0.778, F_{3, 90} = 115.7, p < .001$ for psychodynamic therapists).

Turning to competences rated as ‘uncharacteristic’, participants from all three modalities were significantly more likely to eschew competences if they derived from frameworks other than their own; as indicated in the shaded areas of Table 5, it was rare for them to identify items from their own framework as ‘uncharacteristic’. An ANOVA contrasting assignments by participants from each modality across the four competence categories again yielded a significant interaction term ($F_{6,324} = 134.9, p < .001$) and large

effect sizes for each of the groups ($\eta^2 = 0.875$, $F_{3, 111} = 256.7$, $p < .001$ for CBT therapists; partial $\eta^2 = 0.687$, $F_{3, 123} = 90.04$, $p < .001$ for humanistic therapists; $\eta^2 = 0.904$, $F_{3, 90} = 283.97$, $p < .001$ for psychodynamic therapists).

ii) Generic items

In relation to the primary hypotheses described above, there was a significant difference in endorsement of generic items across modalities ($F_{3,6} = 212.00$, $p < .001$), although this is attributable to the significantly lower rate of endorsement by psychodynamic participants compared to CBT and humanistic therapists. In relation to the secondary hypothesis, participants from all modalities were indeed significantly more likely to endorse generic items as characteristic of their approach than they were to endorse items from frameworks other than their own ($F_{2,216} = 195.50$ $p < 0.001$).

b) Analysis of Item Endorsement

The quantitative analysis confirms that therapists from each modality have distinctive patterns of item endorsement. However, identifying the content of both endorsed and eschewed items is a necessary step to making this analysis meaningful. Examining the proportion of participants who strongly endorsed (at ratings of 1, 2 or 3) or eschewed competences (by assigning a rating of 7, 8, or 9) gives a sense of the ‘consensus’ within practitioners of each modality, and also consensual differences between modalities.

Defining the proportion of endorsements needed to indicate a consensus is inevitably arbitrary: setting cut-points too high will yield few competences for inclusion, while setting them too low will provide little discrimination between items. A further complication is that, in relation to eschewed competences, there is such a marked skew in the pattern of item

endorsement of the modality-specific competences that unless the cut-point is set high, there is a risk that the ‘consensus’ would simply be the eschewal of most of the 25 items drawn from modalities other than the participant’s own framework.

For the purposes of this analysis, cut-points for ‘item seen as characteristic’ were set at ‘endorsement by more than 50% of respondents’, and ‘endorsement by fewer than 10% of respondents’. For ‘item seen as uncharacteristic’, cut-points for generic competences were set at endorsement by more than 50% of respondents’, and somewhat more rigorously (at “endorsement by more than 60% of respondents”) for modality-specific competences. To control for multiple testing when examining the significance of differential patterns of endorsement between modalities, alpha was set at $p < .002$.

Rating of generic competences by therapists from all modalities

Generic competences are intended to represent skills common to all approaches; as such, the development phase of each modality framework included scrutiny by members of the relevant Expert Reference Group aimed at confirming whether this set of competences was consonant with their approach. In the Q-sort, practitioners from each modality varied in their endorsement of specific competences in ways that seem to reflect the assumptions and stance of their model (as shown in Table 6). Using the criteria for consensus described above, CBT practitioners identified four competences that relate to the use of measures and to the articulation of specific therapy goals, and humanistic practitioners identified three items that relate to the adoption of a non-judgmental and empathic stance, and the importance of supervision. Turning to generic competences that were seen as uncharacteristic, there was a very high level of consensus among both humanistic and psychodynamic practitioners regarding four items that relate to precisely those areas endorsed as characteristic by CBT

practitioners -- the use of measures and the articulation of specific therapy goals. Given this inverse pattern of assortment, it may be that these items cannot be considered to be truly generic (an issue discussed further below).

INSERT TABLE 6 ABOUT HERE

Rating of CBT competences by humanistic and psychodynamic therapists

As shown in Table 7, a consensus of humanistic participants endorsed only one CBT competence as ‘characteristic’ of their modality – “An ability to see the world through the perspective of the client’s beliefs” (endorsed by 63.3% of humanistic therapists, in contrast to 22.58% of psychodynamic participants). Of note, only 26.32% of CBT participants endorsed this item as characteristic, suggesting that (at least in terms of its phrasing) this item may not be an accurate indicator of CBT practice. Overall, a mean of just 9.24% (median 4.8%) of humanistic therapists and 4.38% (median 3.22%) of psychodynamic therapists ranked CBT competences at ranks 1, 2 or 3.

Because such a high proportion of CBT competences were seen as uncharacteristic (13/25 rated by humanistic therapists and 19/25 by psychodynamic therapists were above the cutoff point of 60%), Table 6 includes only those competences where more than 80% of participants rated the competence as uncharacteristic. These seem to relate to planning structured activities such as practice assignments or behavioral experiments, and to activities that directly help the client focus on the role and impact of cognitions.

INSERT TABLE 7 ABOUT HERE

Rating of humanistic competences by CBT and psychodynamic therapists

As shown in Table 8, none of the humanistic competences were endorsed as characteristic by CBT or psychodynamic therapists at a level above the cut-off. CBT therapists identified as ‘uncharacteristic’ five items, two of which relate to one of the core assumptions of the humanistic approach (the notion of an inherent capacity for growth); the others refer to authenticity, to working with material that is outside the client’s consciousness and to self-disclosure. Psychodynamic therapists also identified self-disclosure as uncharacteristic of their approach.

INSERT TABLE 8 ABOUT HERE

Rating of psychodynamic competences by CBT and humanistic therapists

As shown in Table 9, none of the psychodynamic competences was endorsed as characteristic by CBT therapists, but humanistic therapists endorsed one competence, related to the ability to tolerate ambiguity in the client’s communications.

In relation to competences seen as uncharacteristic, CBT therapists identified 17/25 psychodynamic competencies as above the cut-off; for this reason only items rated by more than 80% of CBT therapists are included in Table 9. These seem to relate to the maintenance of a stance that facilitates the free flow of associations and feelings on the part of the client, and a focus on tracking the therapeutic process in order to help identify the client’s ‘internal world’ of conflicts. For humanistic therapists, the eschewed competences focus on the use of clarification and confrontation, on the use of a formulation that includes “developmental deficits, unconscious conflicts, and recurring interpersonal patterns”, and on the exploration of specific themes in the context of an “agreed focus of therapy”.

INSERT TABLE 9 ABOUT HERE

Discussion

The primary aim of this study was to establish the content validity of the competence frameworks for CBT, humanistic and psychodynamic practice by examining the pattern of endorsement of competence descriptions by experienced therapists from each of these modalities. The principal hypotheses were strongly confirmed: therapists differentially endorsed items from their ‘own’ competence framework as characteristic of their approach, identified as ‘uncharacteristic’ items drawn from frameworks other than their own (or from the generic competences), and at no point identified as ‘uncharacteristic’ competences from their own framework. This pattern of endorsement was statistically significant across all three modalities, and was strongly maintained at the tails of the Q-sort distribution (which focus attention on items seen as most characteristic or uncharacteristic of the approach). As such, the validity of modality-specific items within each framework (or at least, of those items included in the Q-sort) appears to be confirmed, with their content relating well to the ways in which practitioners of each orientation conceive of their activities.

The same generic items are included in all the frameworks, on the assumption that these are equally pertinent to, and accepted by, all practitioners. All participants rated the generic items as more characteristic of their ‘own’ approach than competences from ‘rival’ frameworks, suggesting that these are indeed competences that are encompassed by all approaches, and supporting the decision to include them as baseline competences for all modalities. Nonetheless, psychodynamic practitioners were significantly less likely to endorse generic items as ‘strongly characteristic’ than were CBT and humanistic practitioners

– respectively, 14% compared with 27% and 24%. Whether this is reflected in their practice is a moot point, but certainly psychodynamic therapists' construal of their model appears more homogenous and coherent than is the case for CBT or humanistic practitioners.

Although the results offer support for the broad applicability of generic competences, it is important to recognize that some generic items were perceived as inimical by both psychodynamic and humanistic therapists: items describing the use of measures to monitor therapy and explicit structuring of therapy sessions were judged as uncharacteristic of these approaches. This is consonant with the theoretical positions of these approaches, but mirrors debate within the ERGs guiding the development of the psychodynamic and humanistic competence frameworks. On theoretical (and traditional) grounds each of these groups was initially hesitant about inserting measurement and session structure into their framework, but decided on their inclusion in order to reflect the ways in which these approaches are being delivered in many healthcare settings. As such, a distinction might be drawn between what is seen as characteristic from a purely theoretical perspective, and what might be accommodated in relation to developments in the field. By way of example, the manual for Dynamic Interpersonal Therapy (DIT; Lemma, Target, & Fonagy, 2011) specifies the need to include both careful session structuring and the explicit integration of session monitoring into the therapy, and in doing so embraces these generic techniques and concerns.

There are a number of methodological issues that could constrain the interpretation of these results. First, the Q-sort was, of necessity, conducted on a subsample of the competences contained in the competence frameworks; as such it cannot be assumed that the patterns observed in this study would generalize to a different set of items, or indeed the framework as a whole. Although the method adopted to identify the Q-sort sample is systematic and replicable, it may be open to bias, not only because item selection was only

undertaken by the author, but simply because there are many ways of defining (and therefore selecting for) the ‘representativeness’ of competences, and the approach taken is one of many possible methods (each with their own advantages and disadvantages). The problem is evident, even if a solution is not.

Second, it is possible that participants ranked items as ‘characteristic’ simply because the wording made it easy to recognize their provenance. In order to contain this risk, the competences selected for inclusion in the sort were subjected to minor rewording, or removed where the language used was so specific that it could only belong to one modality. However, this process can be taken only so far before a methodological dilemma emerges: it would be equally problematic to include only items that are rendered sufficiently ‘anodyne’ to obscure their origins – the risk being that these would be unrepresentative of the wider framework. A compromise is inevitable, and on this basis some items contained modality-specific technical phrases because editing would have changed the meaning of the competence statement. (For example, removing the word ‘Socratic’ from the following [CBT] competence makes the technique being alluded to so diffuse so as to alter its meaning: “An ability to make . . . use of Socratic questioning techniques aimed at helping the client to discover useful information that can be used to help them to discover alternative meanings . . .”). Given the challenge of controlling for ‘legibility’ it is important to accept the bias that this could introduce, with rankings for at least some items being made on this dimension rather than the one intended.

Third, it is difficult to determine the representativeness of the participants. Therapists were recruited via an email advertisement, a route that makes it difficult to discern the proportion (and characteristics) of individuals who declined the invitation, or who may have declined participation once they understood the time and commitment required (almost one quarter of individuals who started the Q-sort did not complete it). Although the number of

participants undertaking the Q-sort was considerably higher than is usual with this methodology, these are small samples, and generalization to the wider community of practitioners needs to be cautious. While the sample appears to be biased towards an older and more experienced group of therapists (making it more likely than not that their judgments are based on a sound – and, in this sense, representative – knowledge of the principles associated with their modality) this is not something that can be assumed, since exposure to practice does not guarantee expertise.

Fourth, the competences were presented in the same order to all participants. Although it would have been technically feasible to write a program that presented the competences in a different (random) order for each participant, this would have complicated data management and analysis. This risk was viewed as more problematic than controlling for the influence of the initial setting of the competences, which (as described above) was managed by correlating the initial and final sorts.

Finally, there are problems of interpretation arising from the constraints that the Q-sort places on the number of items at the extremes of the distribution. Because of this limitation in choice, rankings could be seen as relative rather than absolute, reflecting the requirement that some items have to be prioritized over others (and there being no option to deviate from the set numbers at each point of the scale). As such, some rankings may be misleading. For example, while there was a consensus among psychodynamic therapists that the use of formal measures was uncharacteristic of their modality, this cannot be taken to mean that psychodynamic therapists never use such measures. Relatedly, the anchor points (characteristic through to uncharacteristic) invite a judgment in relation to the model in the abstract, rather than the actual practice of each therapist – in other words, a competence rated as uncharacteristic could still form part of a practitioner's technical repertoire.

Despite the shortcomings of this study, it does confirm the content validity of the modality-specific items contained within the frameworks and included in the Q-sort, suggesting not only that these competences are an accurate and reliable description and characterization of the approach taken by each modality, but that each set of descriptions is appropriately distinct from the others.

One area for future research is the use of Q-sorting to contrast the idealized descriptions of competence contained in the competence framework against the ways these are applied in routine clinical settings. A critical gap between research and practice is variation in the fidelity with which manualized treatments are transported, and the reasons for this variability. The Q-sort method gives a number of entry points for exploring this—for example, asking practitioners to Q-sort in relation to “the most important competences used in your last case”, or “those competences you consider most mutative” would yield profiles of what practitioners consider pertinent to their practice, or their sense of the competences they see as exerting traction, and analysis of Q-sorts would identify where similarities and differences lie across modalities. This has both theoretical and practical application, since there is evidence that practitioners overestimate differences between themselves and clinicians from other orientations (e.g., Larsson, Broberg, & Kaldo, 2013). As such, there is obvious value in empirical exploration of those areas where clinicians demonstrate integrative practice, and where their practice is distinctive.

The competence frameworks have great potential as a platform for research, particularly as a basis for developing systems for rating adherence and competence in clinical practice and in clinical trials. The need for such scales is clear: reliance on a clinician’s sense of the competences they employ only take us so far when addressing a number of vital questions such as the (elusive) relationship between therapist competence and outcome (e.g.

Webb, DeRubeis, & Barber, 2010), and the identification of mutative components of an intervention. A number of such scales have been developed, but their inter-rater reliability can be unacceptably low when they are used outside research environments where teams of raters are trained towards a consensus interpretation of the scale (e.g. Barber, Liese & Abrams, 2003; Gordon, 2006).

Three features of the framework suggest their particular utility for the development of a new scale:

1. Their fidelity to the therapeutic approaches they describe, given that the provenance of the competence descriptions lies in the manuals used to guide clinical trials, and the review and subsequent endorsement of these competence descriptions by expert clinical researchers;

2. Their organization into differing domains, and within domains the grouping of competences into discrete areas of activity, resulting in a set of high-order specifications of competences and areas of clinical input seen as central to good practice;

3. Their hierarchical structure, with some areas of competence flagged as superordinate to others, requiring them to be present in order for 'subordinate' competences to be rated as skillful. For example, the CBT framework specifies an overarching requirement for practitioners to take a collaborative approach to the work, meaning that therapists who fail to demonstrate this cannot be rated as competent in any domain. (There is a long-standing debate (e.g., Waltz, Addis, Koerner, & Jacobson, 1993) about the distinction between, and measurement of, adherence and competence, and this structuring automatically sets out criteria for judging when a set of actions might be adherent but not competent.)

Preliminary work on scale development has been undertaken for both generic therapeutic competences (Roth, 2013a) and for CBT competences (Roth, 2013b). The outline structure of both scales reflects the architecture and hierarchy of the competence frameworks.

Items in the scale focus on therapist actions that raters can be expected to observe directly from the session and from the session material, with a minimum of inference. Extensive use is made of behavioral descriptors (drawn from the framework) illustrating the actions that a rater can expect to observe when the competence is being demonstrated: the intent is to guard against raters relying on idiosyncratic (and hence unreliable) definitions of a skill. For example, there are six ‘anchors’ underpinning the item rating “the ability to implement guided discovery and Socratic questioning”. These are indicative, in that they describe different ways in which this skill manifests, and so act as prompts rather than being scored in their own right. A further feature is that the scale is comprehensive in coverage, but adaptable both to the phase of therapy and to the specific intervention package being implemented, with a scoring system that relates only to the areas of competence that would be expected in a specific session. For example, in relation to the phase of therapy, while ‘developing a shared formulation with a client’ is an activity that should always be present in the assessment phase of an intervention, its absence from a mid-therapy session has no implications for judgments about therapist competence. Further, the scale recognizes that specific interventions for specific presentations need to have a different content and emphasis – for example, an intervention for depression should follow a different course and emphasis from an intervention for a specific anxiety disorder, a requirement explicitly reflected in the CBT competence framework. On this basis (and drawing on the framework to derive content) the scale includes a ‘portfolio’ of intervention options; the critical operational point is that summative scores are based only on those competences that the rater expects to see being demonstrated. This scale is now being piloted, and psychometric data will follow.

References

- Cross, R. M. (2005). Exploring attitudes: The case for Q methodology. *Health Education Research: Theory and Practice, 20*, 206-213.
- Barber, J.P., Liese, B.S., & Abrams, M.J. (2003). Development of the Cognitive Therapy Adherence and Competence Scale. *Psychotherapy Research, 13*, 205-221.
- Bennett, D. & Parry, G. (2004). A measure of psychotherapeutic competence derived from cognitive analytic therapy. *Psychotherapy Research, 14*, 176–192.
- Fonagy, P. (Ed) (2010) *Digest of National Occupational Standards for Psychological Therapies* (retrieved from <http://www.skillsforhealth.org.uk/>).
- Frank, J. D. (1971). Therapeutic factors in psychotherapy. *American Journal of Psychotherapy, 25*, 350–361.
- Gordon, P.K. (2006). A Comparison of Two Versions of the Cognitive Therapy Scale. *Behavioural and Cognitive Psychotherapy, 35*, 343–353.
- Hatcher, R.L. & Dudley, K, (2007). Initial training in professional psychology: The practicum competencies outline. *Training and Education in Professional Psychology, 1*, 49–63.
- Kaslow, N. J., Rubin, N.J., Forrest, L., Elman, N.S., Van Horne, B.A., Jacobs, S.C., Huprich, S.K. et al. (2007) Recognizing, assessing, and intervening with problems of professional competence. *Professional Psychology: Research and Practice, 38*, 479–492.
- Larsson, B.P., Broberg., A.G. & Kaldø, V. (in press). Do psychotherapists with different theoretical orientations stereotype or prejudge each other? *Journal of Contemporary Psychotherapy*. Advance online publication. doi: 10.1007/s10879-013-9231-2

- Layard, R., Clark, D., Bell, S., Knapp, M., Meacher, B., Priebe, S., et al. (2006). *The depression report; A new deal for depression and anxiety disorders*. London, The Centre for Economic Performance's Mental Health Policy Group, London School of Economics. Retrieved March 1, 2013, from http://cep.lse.ac.uk/textonly/research/mentalhealth/DEPRESSION_REPORT_LAYARD.pdf
- Lemma, A., Roth, A. D., & Pilling, S. (2009). *The competences required to deliver effective Psychoanalytic/Psychodynamic Therapy*. Retrieved March 1, 2013, from http://www.ucl.ac.uk/clinical-psychology/CORE/Psychodynamic_Competences/Background_Paper.pdf
- Lemma, A., Target, M., & Fonagy, P. (2011). *Brief Dynamic Interpersonal Therapy*. Oxford: Oxford University Press.
- McKeown, B. F., & Thomas, B. D. (1988). *Q-methodology*. Newbury Park, CA: Sage Publications.
- Rodolfa, E., Greenberg, S., Hunsley, J., Smith-Zoeller, M., Cox, D., Sammons, M., Caro, C. & Spivak, H. (2013). A Competency Model for the Practice of Psychology. *Training and Education in Professional Psychology*, 7, 71–83.
- Roth, A.D. (2013a). *UCL rating scale for competence in CBT*. Unpublished manuscript.
- Roth, A.D. (2013b). *UCL rating scale for core and generic therapeutic competences*. Unpublished manuscript.
- Roth, A. D., & Fonagy, P. (2005). *What works for whom? A critical review of psychotherapy research* (2nd edn). New York: Guilford Press.
- Roth, A. D., Hill, A., & Pilling, S. (2009). *The competences required to deliver effective Humanistic Psychological Therapies*. Retrieved March 1, 2013, from

http://www.ucl.ac.uk/clinical-psychology/CORE/Humanistic_Compentences/clinicians_guide.pdf

- Roth, A. D., & Pilling, S. (2007). *The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders*. London: Department of Health. Retrieved March 1, 2013, from http://www.ucl.ac.uk/clinical-psychology/CORE/CBT_Compentences/CBT_Compentence_List.pdf
- Roth, A. D. & Pilling, S. (2008). Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy*, 36, 129-147.
- Roth, A. D., Pilling, S., & Turner, J. (2010). Therapist training and supervision in clinical trials: Implications for clinical practice. *Behavioural and Cognitive Psychotherapy*, 38, 291-302.
- Waltz, J., Addis, M. E., Koerner, K., & Jacobson, N. S. (1993). Testing the integrity of a psychotherapy protocol: assessment of adherence and competence. *Journal of Consulting and Clinical Psychology*, 61, 620-630.
- Webb, C.A., DeRubeis, R.J., & Barber, J.P. (2010). Therapist Adherence/Competence and Treatment Outcome: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*, 78, 200–211.

Table 1
Demographic characteristics of participants

	<i>N</i>	Age Mean (<i>SD</i>) Range	Length of experience Mean (<i>SD</i>) Range	Gender	
				Male <i>N</i> (%)	Female <i>N</i> (%)
CBT therapists	38	43.58 (11.80) 26-62	11.55 (10.85) 1-40	11 (28.9)	27 (71.1)
Humanistic	42	55.76 (9.56) 39-86	14.57 (6.55) 3-30	5 (11.9)	37 (88.1)
Psychodynamic	31	50.16 (8.15) 31-66	17.42 (8.29) 2-33	8 (25.8)	23 (74.2)

Table 2
Professional affiliation of participants

	Psychotherapist	Counselor	Clinical Psychologist	Other [#]
CBT	10	3	15	10
Humanistic	7	34	1	0
Psychodynamic	10	5	13	3
Total across all modalities	27	42	9	13

[#] 4 Psychiatrists, 2 Social Workers; 7 with no data

Table 3
Q-sort rankings and item distribution

Rank & label	1 Extremely characteristic of my modality	2 Very characteristic of my modality	3 Fairly characteristic of my modality	4 Slightly characteristic of my modality	5 Neutral: neither characteristic or uncharacteristic	6 Slightly uncharacteristic of my modality	7 Fairly uncharacteristic of my modality	8 Very uncharacteristic of my modality	9 Extremely uncharacteristic of my modality
N° items at each rank	5	8	12	16	18	16	12	8	5

Table 4
 Mean percentage (*SD*) of items from each modality framework ranked at 1, 2, and 3
 (respectively extremely, very or fairly characteristic) in relation to the participant's modality

	CBT participants % (<i>SD</i>)	Humanistic participants % (<i>SD</i>)	Psychodynamic participants % (<i>SD</i>)
Generic competences	26.52 (17.70)	24.0 (21.22)	13.93 (13.75)
CBT competences	55.05 (21.22)	9.24 (13.32)	4.38 (6.38)
Humanistic competences	12.10 (11.01)	46.95 (24.12)	17.03 (12.00)
Psychodynamic competences	3.57 (4.01)	19.90 (15.18)	64.90 (15.81)

Table 5

Mean percentage (*SD*) of items from each modality framework ranked at 7,8, or 9 (respectively fairly, very or extremely uncharacteristic) in relation to the participant's modality

	CBT participants % (<i>SD</i>)	Humanistic participants % (<i>SD</i>)	Psychodynamic participants % (<i>SD</i>)
Generic competences	9.05 (7.75)	21.80 (26.25)	23.61 (28.92)
CBT competences	4.21 (4.98)	46.85 (30.62)	64.0 (29.54)
Humanistic competences	28.73 (19.66)	6.85 (5.96)	12.38 (15.37)
Psychodynamic competences	57.89 (24.33)	22.76 (19.88)	3.09 (6.41)

Table 6

Consensus ranking of generic competences

Generic competences ranked as characteristic (rank 1, 2, or 3) by >50% or <10% of respondents

	CBT therapists	Humanistic therapists	Psycho-dynamic therapists
An ability to help the client identify/select target symptoms or problems, and to identify which are the most distressing and which the most amenable to intervention [#]	65.8	2.4	0
An ability to use and to interpret relevant measures at appropriate points throughout the intervention, with the aim of establishing both a baseline and indications of progress [#]	60.5	7.1	3.2
An ability to share information gleaned from measures with the client, with the aim of giving them feedback about progress [#]	55.3	2.4	0
An ability to help the client articulate their goals for the therapy, and to gauge the degree of congruence in the aims of the client and therapist [#]	52.6	11.9	0
An ability to listen to the client's concerns in a manner which is non-judgmental, supportive and sensitive, and which conveys a comfortable attitude when the client describes their experience [#]	28.9	78.6	19.4
While maintaining professional boundaries, an ability to show appropriate levels of warmth, concern, confidence and genuineness, matched to client need [#]	31.6	69.0	19.4
An ability to use supervision to discuss the personal impact of the work, especially where this reflection is relevant to maintaining the likely effectiveness of clinical work [*]	18.4	57.1	45.2

* Pearson Chi-square $p < .002$; # Pearson Chi-square $p < .001$; shaded area = endorsement by >50% of respondents

Generic competences ranked as uncharacteristic (rank 7, 8, or 9) by >50% or <10% of respondents

	CBT therapists	Humanistic therapists	Psycho-dynamic therapists
An ability to use and to interpret relevant measures at appropriate points throughout the intervention, with the aim of establishing both a baseline and indications of progress [#]	5.26	73.81	67.74
An ability to share information gleaned from measures with the client, with the aim of giving them feedback about progress [#]	5.26	73.81	83.87
An ability to draw on knowledge of commonly used questionnaires and rating scales, and to select measures relevant to the client's presentation [#]	2.63	90.47	87.10
An ability to help the client identify/select target symptoms or problems, and to identify which are the most distressing and which the most amenable to intervention [#]	0.0	64.29	90.32

* Pearson Chi-square $p < 0.002$; # Pearson Chi-square $p < 0.001$; shaded area = endorsement by >50% of respondents

Table 7
Consensus ranking of CBT competences

CBT competences – endorsement as ‘characteristic’ by humanistic and psychodynamic therapists	Humanistic therapists	Psycho-dynamic therapists	(CBT therapists)
An ability to see the world through the perspective of the client’s beliefs [#]	63.3	22.58	26.32

* Pearson Chi-square $p < .002$; # Pearson Chi-square $p < .001$; shaded area = endorsement by >50% of respondents

CBT competences – endorsement as ‘uncharacteristic’ by humanistic and psychodynamic therapists	Humanistic therapists	Psycho-dynamic therapists	(CBT therapists)
An ability to formulate a therapy plan for each session that helps the client a) to identify and modify unhelpful thinking and b) to recognise and change the cognitive patterns leading to dysfunctional ideation and behaviour [#]	83.33	100.00	0.0
An ability to carry out a functional analysis – the causal, functional relationships between a specified set of target behaviours [#]	95.23	100.00	18.42
An ability to tailor “practice assignments” to the individual client, ensuring that this is appropriate to the stage of therapy and in line with the case conceptualisation [#]	83.33	100.00	2.63
An ability to devise behavioural experiments which can directly test the validity of a client’s beliefs or assumptions about themselves or the world, which help them construct and/or test new, more adaptive beliefs, and which can be carried out in the session or as homework [#]	83.33	100.00	5.26
An ability to integrate “practice assignments” into therapy by offering the client a clear rationale for homework, by clarifying the client’s attitude to homework and checking their understanding of its importance [#]	85.71	93.55	2.63
An ability to work with the client to identify and plan specific changes to activities, identifying any thoughts (assumptions or beliefs) which might make it difficult for the client to implement these changes [#]	71.42	87.10	0.0
An ability to structure the therapy session by regularly giving feedback to the client, and by eliciting regular feedback from the client [#]	(38.10)	80.65	5.26
An ability to ensure that the client is able to identify their automatic thoughts and emotions, by verbally eliciting examples of specific situations and their accompanying automatic thoughts in the session [#]	66.67	80.65	2.63
An ability to help clients elaborate on initial reports of automatic thoughts in order to identify thoughts both about the situation itself and the client’s thoughts about their reaction to the situation [#]	90.48	80.65	0.0

* Pearson Chi-square $p < .002$; # Pearson Chi-square $p < .001$; shaded area = endorsement by >80% of respondents

Table 8
Consensus ranking of humanistic competences

Humanistic competences – endorsement as uncharacteristic by CBT and psychodynamic therapists	CBT therapists	Psycho-dynamic therapists	(Humanistic therapists)
An ability to draw on knowledge that people have a fundamental capacity to sense whether an action contributes to growth and that emotional experiencing plays a key role in this awareness [#]	63.15	35.48	35.48
An ability to help clients experience feelings which may be out of current awareness, by helping them focus their attention inwards in order to become more aware of their feelings	57.89	7.14	6.45
An ability for the therapist to communicate their central belief in the client’s capacity to discover inner resources for growth and problem-resolution	52.63	32.26	2.38
An ability to maintain consistency between what is experienced by the therapist and the way in which this is portrayed in the therapeutic relationship	55.26	9.52	9.68
An ability to self-disclose and communicate experience of the client to the client, especially where this is relevant to the client’s concerns and likely to facilitate rather than impede the client’s therapeutic progress [#]	50.00	64.51	11.90

* Pearson Chi-square $p < .002$; # Pearson Chi-square $p < .001$; shaded area = endorsement by >50% of respondents

Table 9
Consensus ranking of psychodynamic competences

Psychodynamic competences – endorsement as characteristic by CBT and humanistic therapists	CBT therapists	Humanistic therapists	(Psycho-dynamic therapists)
An ability to tolerate uncertainty and ambiguity when trying to understand the client’s communications so as to not foreclose exploration [#]	10.52	63.3	74.19

* Pearson Chi-square $p < .002$; # Pearson Chi-square $p < .001$; shaded area = endorsement by >50% of respondents.

Psychodynamic competences – endorsement as uncharacteristic by CBT and humanistic therapists	CBT therapists	Humanistic therapists	(Psycho-dynamic therapists)
An ability to allow the therapist’s own subjective associations and ideas to form in response to the client’s communications [#]	97.37	30.95	3.22
An ability to allow the emergence of spontaneous communication of feelings, thoughts, fantasies, daydreams or dreams so as to gain access to the client’s imaginative world [#]	97.37	26.19	0.0
An ability to allow the client to talk without imposing any formal structure or direction in the sessions [#]	89.47	7.14	3.22
An ability to attend to the specific quality of the feelings, thoughts, flow of associations and fantasies that are evoked in the therapist during the exchanges with the client so as to hypothesise about what the client may be expressing indirectly. [#]	84.21	21.43	0.0
An ability to draw on knowledge of the use of clarification and confrontation to gradually bring feelings, fantasies and behaviours to the client’s attention and as the basis for eventually making an interpretation [#]	84.21	66.67	0.0
An ability to draw on knowledge that a formulation should take into account the respective contributions of relevant developmental deficits (including early traumata), unconscious conflicts, recurring interpersonal patterns and expectations of others and areas of resilience [#]	31.58	76.20	6.45
An ability to help the client explore specific themes relevant to the agreed focus of therapy through the use of techniques such as clarification, confrontation and interpretation [#]	57.89	59.52	32.25

* Pearson Chi-square $p < .002$; # Pearson Chi-square $p < .001$; shaded areas = endorsement by >80% of CBT participants or >50% of humanistic participants

Figure 1. Mean percentage of items from each modality framework ranked at 1, 2, or 3 (respectively extremely, very or fairly characteristic) in relation to the participant's modality.

Figure 2. Mean percentage of items from each modality framework ranked at 7, 8, or 9 (respectively fairly, very or extremely uncharacteristic) in relation to the participant's modality.