

The development of the Compassion Focused Therapy Therapist Rating Scale (CFT-TRS).

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by
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Declaration

I hereby declare that this is an original piece of work and it has not been submitted for any other academic award. This work has been checked to ensure that it is complete prior to submission. I have identified all material that is not my own work and this is recorded in the reference lists.

The development of the Compassion Focused Therapy Therapist Rating Scale (CFT-TRS).

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Thesis Abstract

The literature review aimed to systematically review whether higher ratings of therapist competence predicted better treatment outcomes in cognitive behavioural therapy (CBT). A systematic search was completed of four electronic databases. A total of 16 relevant articles met inclusion criteria. Findings provided variable support for therapist competence predicting better treatment outcomes in CBT. However, the findings indicated a stronger link between competency and outcome in anxiety treatments. There was evidence that therapeutic alliance and therapist adherence may have influenced the link between therapist competence and outcome, and competencies such as 'structuring' and 'homework setting' were shown to be strongly related to outcome. Limitations of the included papers included small sample sizes, biases in the sampling of therapists and insufficient ratings of tapes to establish a reliable measure of therapist competence. Further research and ongoing review is needed that uses more robust methodologies.

The aims of the research were to develop a useful measure of therapist competence in compassion focused-therapy (CFT) that could be used to assess therapist competence in research trials, clinical practice and training. Eleven experts were involved in the development of the CFT therapist competence scale (CFT-TRS). The Delphi method was used to develop and operationalise the competencies over five rounds. The CFT-TRS included 23 competencies and these were separated into fourteen CFT unique therapist competencies and nine microskills. There was high agreement about the included unique and generic competencies, however there were differences in opinion between experts about the content of items and item overlap. The scale can be used as a learning guide for delivering CFT, to assess therapist competence for CFT training courses or clinical practice, and to assess fidelity in research trials. Future research is required to understand and evaluate the psychometric properties of this scale.

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List of abbreviations

Acceptance and commitment therapy (ACT)
Cognitive analytical therapy (CAT)
Cognitive behavioural therapy (CBT)
Cognitive Therapy Competence Scale for Social Phobia (CTCS-SP)
Cognitive therapy scale (CTS)
Collaborative case-conceptualisation rating scale (CCCRS)
Compassion-focused therapy (CFT)
Dialectical behavioural therapy (DBT)
Improving access to psychological therapies (IAPT)
Independent expert panel (IEP)
Intraclass correlation coefficient (ICC)
Mentalisation based therapy (MBT)
Randomised controlled trial (RCT)
Survey expert panel (SEP)
Therapist Behaviour Rating Scale-Competence (TBRS-C)

Literature review

Do competent therapists really matter? A literature review investigating whether higher therapist competence improves treatment outcome in Cognitive Behavioural Therapy.

Abstract

Objectives. Therapist competence has been suggested to be related to better treatment outcomes in cognitive behavioural therapy (CBT). However research has highlighted a large variability in the strength of this relationship. The processes underlying the link between therapist competence and treatment outcome are not well understood. The aim of the current paper was to systematically review whether higher ratings of therapist competence predicted better treatment outcomes in CBT. Therapist competence was rated using a CBT therapist competence scale. This was rated by clinicians experienced in CBT. The review aimed to synthesise and appraise recent evidence.

Methods. A systematic search was completed using PsychInfo, Scopus, Web of Science, and Medline. A total number of 16 relevant articles met inclusion criteria and were critically reviewed to assess the link between therapist competence and treatment outcome.

Results. The papers were evaluated using an established critical appraisal tool (Downs & Black, 1998). The evidence reviewed provided variable support for therapist competence predicting better treatment outcomes in CBT. However, the findings indicated a stronger link between competency and outcome in anxiety treatments. There was evidence that therapeutic alliance and therapist adherence influenced the link between therapist competence and outcome. Specific competence subscales, such as 'structuring' and 'homework setting' were shown to be strongly related to outcome.

Conclusions. Many of the included studies had methodological limitations in terms of small sample size, biases in the sampling of therapists and insufficient ratings of tapes to establish a reliable measure of therapist competence. Further research and ongoing review is needed that uses more robust methodologies. It is recommended that training and supervision continue to focus on therapist competence throughout a therapist's career to optimise treatment outcomes.

1. Introduction

1.1 Therapist competency scale

Cognitive behavioural therapy (CBT) has been widely accepted as an effective evidence-based treatment for individuals experiencing a range of mental health problems (Cuijpers *et al.*, 2016; National Institute for Health & Clinical Excellence, 2010). However, there remains questions about the therapist factors that might contribute to better outcomes in CBT (Hundt *et al.*, 2013). One such therapist factor is therapist competence, which has been defined as the extent that a therapist has the level of skill and knowledge required to deliver a treatment to achieve its anticipated effects (Fairburn & Cooper, 2011; Waltz *et al.*, 1993). The current systematic review aimed to investigate recent evidence concerning therapist competence in CBT.

A widely used method for assessing therapist competence in CBT is the evaluation of treatment sessions using a therapist competence scale. The scales are commonly focused on the theory and techniques that are unique to the intervention (Barber *et al.*, 2007). A therapist is required to pay attention to treatment specific competencies, general therapeutic techniques, and to have the ability and judgement to adapt between both depending on the presentation of the client (Barber *et al.*, 2007). A total score is generated by a rater and if it is above a certain threshold the therapist will be deemed to be 'competent' (Fairburn & Cooper, 2011).

1.2 Therapist competence and CBT outcomes

One might assume that therapists rated as more competent would obtain better client outcomes than those less competent. However findings reported in the literature are inconsistent. There are difficulties defining therapist competence and this has created challenges developing methods to accurately measure competence (Barber *et al.*, 2007). Some studies in CBT have found significant competence-outcome links (Ginzburg *et al.*, 2012; Kuyken & Tsivrikos, 2009; Okiishi *et al.*, 2003; Podell *et al.*, 2013; Strunk *et al.*, 2010). However, other studies have found limited evidence of a link between therapist competence and treatment outcome (Bryant *et al.*, 1999; Hoffart *et al.*, 2005; Hogue, Henderson *et al.*, 2008; Weck, Richtberg *et al.*, 2013; Weck, Rudari *et al.*,

2013). These mixed findings suggest that competence-outcome relations are currently not well understood.

A number of studies have focused on components of competence to try and understand their links with treatment outcome. Two studies investigated clients with depression and focused on therapist competence in the 'collaborative conceptualisation of clients presenting problems' and found some evidence that it improved treatment outcomes (Abel *et al.*, 2016; Gower, 2011). Some studies have reported that 'homework compliance' was associated with better treatment outcomes (Kazantzis *et al.*, 2010), but found limited evidence to support any relationship between therapist competence in 'homework skills' and treatment outcomes. Two studies focused on CBT for depression and found a relationship between 'homework compliance', therapist competence and responsiveness to treatment, but no relationship between therapist 'homework skills' and treatment outcome (Bryant *et al.*, 1999; Weck, Richtberg *et al.*, 2013). Ryum *et al.* (2010) focused on CBT for personality disorder and found that higher ratings of therapist competence in 'assigning homework' was related to significantly improved outcomes. These mixed findings do not appear to support any clear relationship between specific aspects of therapist competence and treatment outcome.

Other variables have been proposed as important for treatment outcomes. *Therapeutic alliance* has been described as the collaborative bond between therapist and client (Weck Richtberg *et al.*, 2015) and it has been found to be a moderately good predictor of treatment outcome (Horvath *et al.*, 2011). *Therapist adherence* has been described as the degree to which a therapist delivers the manualised techniques and methods of an intervention (Webb *et al.*, 2010). There have been mixed findings regarding the relationship between *therapist adherence* and treatment outcome (Hogue, Henderson *et al.*, 2008). Some studies have controlled for confounding variables, including *therapeutic alliance* (Trepka, *et al.*, 2004), therapist qualification (Davidson *et al.*, 2004) and *therapist adherence* (Brown *et al.*, 2013). However, Webb *et al.* (2010) reported that many *therapist competence and therapist adherence* studies have not controlled for such confounding variables which may have biased their findings (Webb *et al.*, 2010). Given these inconsistencies it is very difficult to gain a clear

understanding about the relationship between *therapist competence* and treatment outcomes.

The successful delivery of CBT requires *therapist adherence* (how frequently the therapist adheres to the prescribed CBT skills) and *therapist competence* (how well the prescribed skills are delivered). The constructs of *therapist competence* and *therapist adherence* are conceptually distinct, but there appears a hierarchical relationship between them. Adherence is a prerequisite for the competent delivery of CBT, but *therapist adherence* does not necessarily mean the therapy has been delivered competently (Muse & McManus, 2013). In training and clinical practice it is recommended to consider both these concepts simultaneously because they are both important for delivering therapy. However research trials should measure competence and adherence separately to provide greater understanding regarding their individual relationship with treatment effect or lack of effect (Perepletchikova & Kazdin, 2005).

1.3 Previous reviews

Previous literature reviews have explored the current research on treatment integrity and treatment outcome. Treatment integrity includes components of *therapist competence* and *therapist adherence*. Two reviews concluded that only a small number of studies addressed treatment integrity and treatment outcome and found that research was difficult to interpret (Perepletchikova & Kazdin, 2005; Perepletchikova *et al.*, 2007). Muse and McManus (2013) focused on the different methods used to assess *therapist competence* and concluded that there are significant limitations in the evidence base. They recommended using multi-method assessments to assess *therapist competence*. Fowler *et al.* (2011) reviewed and discussed the methods used to assess *therapist adherence* and *therapist competence* in CBT for psychosis. This review highlighted the limited number of papers available. Rakovshik and McManus (2010) reviewed the literature on how CBT training enhances *therapist competence*. They concluded that training in CBT leads to increased *therapist competence*, which was positively related to treatment outcome. Similarly, Kazantzis (2003) explored the research on *therapist competence* in CBT and reviewed the current measures of *therapist competence*. This review concluded that new measures that have separated

therapist competence and *therapist adherence* hold promise for accurately measuring *therapist competence* in research studies.

Barber *et al.* (2007) conducted a literature review that discussed the conceptual issues related to therapist competence and they completed an evaluation of therapist competence and outcome. This review consisted of 16 studies and included all psychological therapies. They found a positive, yet weak relationship between therapist competence and treatment outcome. They concluded that the inconsistent findings were due to small sample sizes and that the variability in competence was small because studies recruited experienced therapists. However, this review did not use systematic methods to critically appraise the evidence and it was not specifically focused on therapist competence. Zarafonitis-Müller *et al.* (2014) completed a meta-analysis that explored therapist competence and whether this improved patient outcomes in therapy. Seven competency studies were reviewed and they found a small effect size (Zarafonitis-Müller *et al.*, 2014). However, the full text of this review was not available in English language.

Webb *et al.* (2010) conducted a meta-analysis to examine whether *therapist adherence* or *therapist competence* were related to treatment outcome. This review identified 17 studies that examined *therapist competence* and treatment outcomes and they focused on all psychological therapies. They reported that overall the effect size estimate was not significantly different from zero. However, in their moderator analysis they reported a significant effect size ($r=0.28$) for those studies targeting depression. A limitation of this review was that the included studies had significant heterogeneity in their reported effect sizes. The focus on all psychological therapies might have contributed to the heterogeneity in their findings because *therapist competence* scales measure different items in different therapies

1.4 Summary and rationale

In an attempt to overcome some of the limitations of previous reviews and to provide an up-to-date synthesis of current literature the present review focused specifically on the

relationship between *therapist competence* and treatment outcomes in CBT. The review by Barber *et al.* (2007) was limited because they included studies that used combined *therapist competence* and *therapist adherence* measures and they completed a narrative rather than a systematic review. In the most recent meta-analysis by Webb *et al.* (2010) they included all psychological therapies and reported significant heterogeneity. Unlike previous reviews, the present review focused solely on CBT. This focus was chosen to reduce heterogeneity of included studies and to explore the unique competencies that are measured in CBT. It only included studies that used valid and reliable therapist competency scales. The main aim of this review was to address the question: Does a higher rating of therapist competency that is measured using a validated tool, predict better treatment outcomes in CBT?

2. Method

2.1 Inclusion criteria

To achieve the specific objectives of this review the included studies had to meet the following specific inclusion criteria: (a) studies used a validated therapist competence scale that was rated by CBT practitioners and not by the therapist or patient; (b) studies evaluated individual face-to-face CBT, rather than group, family or couple therapy; (c) studies were written in English language; (d) treatment outcome was measured by a minimum of one validated outcome measure administered before and after therapy; (e) a quantitative methodology was used; (f) studies were required to be published and peer reviewed research papers. The included studies were not restricted by year of publication. Third wave CBT approaches were not included because the focus was on traditional CBT due to the specific competencies.

2.2 Search strategy

A comprehensive search strategy was developed to identify relevant studies for inclusion in the review. First, a scoping exercise was conducted to establish the breadth of literature in this area. The keywords for relevant studies were also noted to assist with the development of search terms. In August 2016 and March 2017 Medline,

PsychINFO, Scopus and Web of Science were each searched using a systematic strategy. The search terms were variations of keywords relating to treatment and competence, for example 'cognitive behavio* therapy' AND Competenc* (See Appendix A). Broad search terms were chosen to ensure that relevant papers were not missed. Initially the titles and abstracts were checked for relevance and all duplicates were removed. The remaining studies were obtained in full text to check whether they met the inclusion/exclusion criteria. Once relevant articles were found their reference lists were manually checked to identify any studies for the review.

2.3 Study selection

Details of the short-listing process for relevant papers are presented in Figure 1. All electronic hits were imported to Refworks. The combined searches retrieved 8723 articles and after duplicates were removed 7353 articles were remaining. The titles and abstracts of the remaining papers were checked for relevance. Of these 7198 papers did not meet inclusion criteria. 155 papers were obtained in full text. These articles were assessed for eligibility using the inclusion and exclusion criteria. Articles were excluded if they made no direct therapist competence and treatment outcome link, if they evaluated a psychological therapy other than CBT or if they had no validated treatment or competency outcome measure. Twenty-six articles remained and relevant data was tabulated and reviewed using the inclusion/exclusion criteria. The remaining 16 articles were included in this review.

2.4 Data extraction

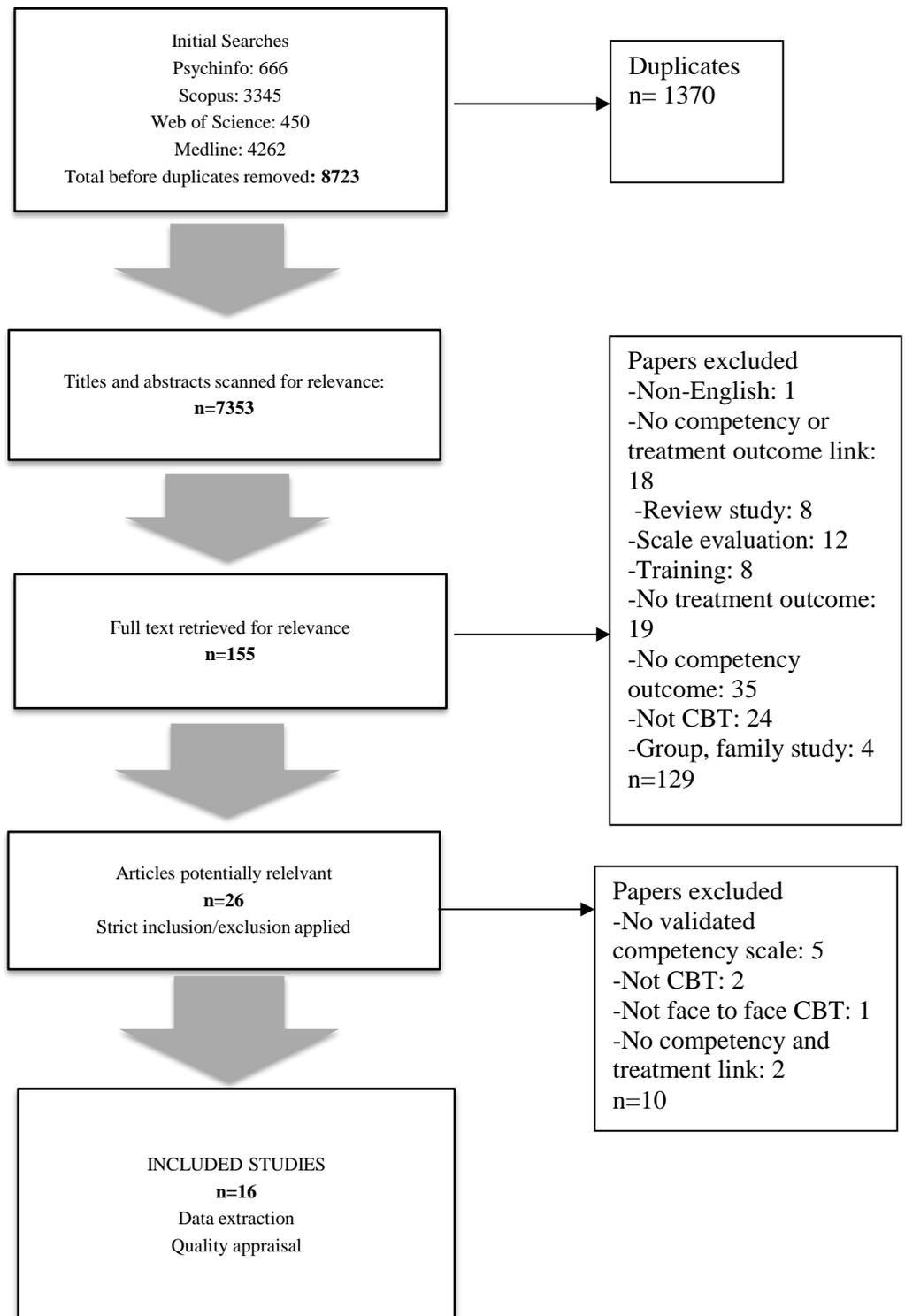
To prevent data extraction bias and to standardise the process of data extraction, a data extraction form was developed (Bettany-Saltikov, 2012; Jonnalagadda *et al.*, 2015). The data extraction form was based on the Cochrane handbook data collection form for randomised and non-randomised control trials (Higgins & Green, 2011) (See Appendix B). This form was designed to help meet the methodological expectations of Cochrane review standards for collecting and reporting information about studies (Higgins & Green, 2011). The features extracted from the studies included, study design, population, sampling, intervention, outcome measures, competence measures, analysis,

findings and conclusions. The form helped to extract data on selection bias, performance bias, detection bias, attrition bias and reporting bias. The data extraction forms were completed for each potential study and all relevant data was extracted prior to data synthesis.

2.5 Quality appraisal

The synthesis used the quality critical appraisal tool developed by Downs and Black (1998). This appraisal tool was chosen because it provided an overall score for study quality and is applicable for both healthcare intervention studies and experiential designs. The Downs and Black (1998) checklist assesses study quality using five headings; reporting, external validity, internal validity, confounding variables, and statistical power. The checklist is reported to have high internal consistency reliability, high test-retest reliability and high inter-rater reliability (Crowe & Sheppard, 2011). All of the studies included in the review were appraised for study quality and appropriateness. Results are summarised in Appendix C. All studies included in this review used secondary data therefore the appraisal tool was adapted for this purpose.

Figure 1 *Flow chart of study inclusion and exclusion*



3. Results

A total of 16 studies met inclusion criteria. Key participant demographics and characteristics are summarised in Appendix D. The main outcomes of the included studies are presented in Appendix E. The characteristics and quality of the studies are reported and the main findings are summarised.

3.1 Description of studies

3.1.1 Participants

The total number of participants in the included studies were 1,997 (range 20 to 1247) and they were treated by 280 therapists (range 4 to 43). A total of 2854 video or audio tapes (range 20 to 1247) were rated by judges to assess therapist competence. Five studies did not report the participants and therapists age or gender (Branson *et al.*, 2015; Jolley *et al.*, 2015; Norrie *et al.*, 2013; Shaw *et al.*, 1999; Westra *et al.*, 2011). The mean age of all participants was 37.7 (range 15.5 to 49.6)¹ and the mean age of the therapists was 35.2 (range 28.5 to 45)². One study focused on an adolescent sample (Hogue *et al.*, 2008), whereas all other studies included adult participants. The participant population was 57% female (range 19% to 73.1% female)³ and the therapist sample was 69.8% female (range 25% to 100% female)⁴. There were a total of 37 judges (range 1 to 5) who rated the video tapes in 15 of the studies. One study did not report the number of raters because this was a large-scale training study with a higher number of judges in comparison to the other studies (Branson *et al.*, 2015). The average

¹ Based on 11 studies reporting age.

² Based on 10 studies reporting age.

³ Based on 11 studies reporting gender.

⁴ Based on 12 studies reporting gender.

numbered years of previous clinical experience in the sample of therapists was 6.6 years (range 0 to 42)⁵.

3.1.2 Interventions

All the included studies used a CBT intervention that treated a clinical sample. Five studies included data that treated depression (Abel *et al.*, 2016; Shaw *et al.*, 1999; Strunk *et al.*, 2010; Trepka *et al.*, 2004; Weck *et al.*, 2013), three studies included data treating anxiety (Ginzburg *et al.*, 2012; Weck, Richtberg *et al.*, 2015; Westra *et al.*, 2011), two studies analysed data treating personality disorder (Norrie *et al.*, 2013; Ryum *et al.*, 2010), four studies assessed more than one clinical problem (Branson *et al.*, 2015; Hogue *et al.*, 2008; Weck *et al.*, 2014; Weck, Grikscheit *et al.*, 2015), one study focused on psychosis (Jolley *et al.*, 2015) and one study used data from a panic disorder population (Weck *et al.*, 2016). Six studies were conducted in Germany (Ginzburg *et al.*, 2012; Weck *et al.*, 2013; Weck *et al.*, 2014; Weck, Grikscheit *et al.*, 2015; Weck, Richtberg *et al.*, 2015; Weck *et al.*, 2016), five studies were conducted in the United Kingdom (Abel *et al.*, 2016; Branson *et al.*, 2015; Jolley *et al.*, 2015; Norrie *et al.*, 2013; Trepka *et al.*, 2004), four studies in the United States of America (Hogue *et al.*, 2008; Shaw *et al.*, 1999; Strunk *et al.*, 2010; Westra *et al.*, 2011) and one study took place in Norway (Ryum *et al.*, 2010).

3.1.3 Outcome and competence measures

All the included studies aimed to assess whether higher levels of therapist competence increased treatment outcome. All studies used validated and reliable treatment outcome measures. The Cognitive Therapist Scale (CTS: Young & Beck, 1980; Young & Beck, 1988; Young & Beck, 1990) including the German version (Weck *et al.*, 2010) was the most common scale administered to assess therapist competence and this was used in twelve of the included studies (Ryum *et al.*, 2010; Shaw *et al.*, 1999; Strunk *et al.*, 2010; Trepka *et al.*, 2004; Weck *et al.*, 2013; Weck *et al.*, 2014; Weck, Grikscheit *et al.*, 2015; Weck, Richtberg *et al.*, 2015; Weck *et al.*, 2016; Westra *et al.*, 2011). Two studies used the CTS alongside an additional therapist competence scale (Jolley *et al.*,

⁵ Based on 12 studies reporting previous clinical experience.

2015; Norrie *et al.*, 2013). A further study used the Cognitive Therapy Scale-Revised (Blackburn *et al.*, 2001; Branson *et al.*, 2015), Abel *et al.* (2016) used the Collaborative case-conceptualisation rating scale (CCCRS: Padesky *et al.* 2011). Ginzburg *et al.* (2012) used the Cognitive Therapy Competence Scale for Social Phobia (CTCS-SP: Clark *et al.* 2006), while Hogue *et al.* (2008) evaluated competence using the Therapist Behaviour Rating Scale-Competence (TBRS-C: Hogue *et al.*, 1994).

Nine studies evaluated therapy sessions using videotapes (Ginzburg *et al.*, 2012; Hogue *et al.*, 2008; Ryum *et al.*, 2010; Weck *et al.*, 2013; Weck *et al.*, 2014; Weck, Grikscheit *et al.*, 2015; Weck, Richtberg *et al.*, 2015; Weck *et al.*, 2016; Westra *et al.*, 2011), six studies rated sessions using audiotapes (Abel *et al.*, 2016; Branson *et al.*, 2015; Jolley *et al.*, 2015; Norrie *et al.*, 2013; Shaw *et al.*, 1999; Trepka *et al.* 2004), whilst Strunk *et al.* (2010) assessed sessions using videotapes and audiotapes.

3.2 Effects of therapist competence and treatment outcome

3.2.1 Summary of outcomes

Nine studies found a significant relationship between therapist competence and improved treatment outcomes. Abel *et al.* (2016) reported a significant relationship between therapist competence in 'conceptualising clients presenting problems' and improved depression symptoms. Ginzburg *et al.* (2012) found significant effects for therapist competence and improved outcomes on both measures of anxiety. Westra *et al.* (2011) reported that highly competent therapists produced better outcomes on anxiety measures. While, Weck *et al.* (2014) and Weck, Richtberg *et al.* (2015) investigated anxiety treatments and found therapist competence significantly predicted better outcomes. Ryum *et al.* (2010) found significant effects for the link between treatment outcome and therapist competence in 'homework skills' for clients diagnosed with personality disorder. Similarly, Norrie *et al.* (2013) concluded that more competent therapists could reduce suicidal acts in clients with a diagnosis of personality disorder. Strunk *et al.* (2010) investigated depression and found that higher therapist competence ratings predicted session-to-session symptom change early in treatment. Trepka *et al.*

(2004) focused on CBT for depression and found higher therapist competence predicted significant improvement.

Shaw *et al.* (1999) found limited support for the competence/outcome relation, but reported that the 'structure' and 'skill' subscale significantly predicted improved outcomes on one of the depression outcome measures. Branson *et al.* (2015) found little evidence of a general association between therapist competence and outcome, but reported significantly more clients treated by the most competent therapists demonstrated consistent improvement in their anxiety. Five studies found no main effects for therapist competence and treatment outcome (Hogue *et al.*, 2008; Jolley *et al.*, 2015; Weck *et al.*, 2013; Weck, Grikscheit *et al.*, 2015; Weck *et al.*, 2016).

Overall, these studies found some evidence that therapists rated as more competent produce better outcomes in CBT. However, these findings are mixed and the relationship does not appear to be straight forward.

3.2.2 Competency components

Some of the components of competence were reported to be better predictors of outcome than others. Abel *et al.* (2016) found a significant relationship between the variable 'competence in conceptualising client presenting problems' and treatment outcome in depression. They found that more hope and emotional processing predicted lower depression scores at follow-up. Shaw *et al.* (1999) found that the 'structure' and 'skill' subscale of the CTS more strongly predicted outcomes in depression. The 'structure' scale included items related to 'agenda setting', 'pacing' and 'homework setting', whereas the 'skill' subscale relates to 'general therapy' skills and specific CBT skills. A similar finding was reported by Ryum *et al.* (2010) who found a significant relationship between higher therapist competence in 'setting homework' and treatment outcomes.

Ginzburg *et al.* (2012) found that six competence items significantly predicted treatment outcome, four were specific to anxiety treatment skills and two were more general CBT skills ('interpersonal effectiveness' and 'efficient use of time and pacing').

The moderation analyses completed by Strunk *et al.* (2010) found higher competence and patients with higher levels of anxiety predicted subsequent symptom change. Such findings are important because they suggest that certain elements of competence might be more predicative of outcome in different populations and treatments.

3.2.3 Conditions treated

The current review found some evidence that more competent therapists delivering anxiety treatments might obtain better treatment outcomes. Five of the anxiety studies reported a significant relationship between higher therapist competence and improved treatment outcomes (Branson *et al.*, 2015; Ginzburg *et al.*, 2012; Weck *et al.*, 2014; Weck, Richtberg *et al.*, 2015; Westra *et al.*, 2011). Furthermore, Strunk *et al.* (2010) investigated depression and found the relationship between therapist competence and symptom improvement was largest amongst clients with higher levels of anxiety. Such findings are important because elements in anxiety treatments might improve the relationship between therapist competence and treatment outcome. However, Hogue *et al.* (2008) treated clients with anxiety and found no effects for the relationship between therapist competence and treatment outcome. However, this study focused on adolescence with a diagnosis of substance misuse and it has been noted that this group can be a unique and challenging group to treat (Hawkins, 2009). They also reported low level of interrater reliability between raters. Therefore it may be that therapist competence studies are more difficult to conduct with samples of adolescents with a co-morbid diagnosis.

Overall anxiety intervention studies might be important when trying to understand how therapist competence links with treatment outcome, however the majority of studies only analysed a small number of tapes to establish therapist competence and did not control for confounding variables.

3.2.4 Moderator variables

Some of the studies reported the relationship between *therapist competence* and treatment outcome was influenced by *therapeutic alliance*. Three studies found

therapist competence was not associated with improved outcomes, but that *therapeutic alliance* was (Weck *et al.*, 2013; Weck, Grikschiet *et al.*, 2015; Weck *et al.*, 2016). However, Weck, Grikschiet *et al.* (2015) reported that *therapeutic alliance* acted as a mediator between *therapist competence* and treatment outcome. Similarly, Weck, Richtberg *et al.* (2015) found *therapist alliance* mediated competence and outcome and found a non-significant trend between higher *therapist competence* and treatment outcome. Trepka *et al.* (2004) and Ryum *et al.* (2010) found higher *therapeutic alliance* and *therapist competence* produced better treatment outcomes and *therapist competence* remained significant even when *therapeutic alliance* was controlled for. However, caution is needed when interpreting these findings because treatment outcome assessors were not blind to group allocation and the studies analysed a small number of tapes. Therefore it is unclear whether an accurate measure of *therapist competence* was obtained.

Therapist adherence was found to effect the relationship between *therapist competence* and treatment outcome in some studies. Three studies found no significant effect for *therapist competence* and treatment outcome, but reported significant effect for the relationship between *therapist adherence* and outcome (Hogue *et al.*, 2008; Weck, Grikschiet *et al.*, 2015; Weck *et al.*, 2016). However, Ginzburg *et al.* (2012) and Strunk *et al.* (2010) found significant effects for *therapist competence* and treatment outcome, but no effects for *therapist adherence*. Four studies did not control for *therapist adherence* (Abel *et al.*, 2016; Branson *et al.*, 2015; Norrie *et al.*, 2013; Ryum *et al.*, 2010) and Shaw *et al.* (1999) found a positive relationship between *therapist competence* and outcome when *therapist adherence* was controlled for. The relationship between *therapist competence*, *therapist adherence* and *therapist alliance* may be complicated and a clearer understanding of their relationship is required.

3.3 Quality and risk of bias

The Downs and Black (1998) critical appraisal tool helped to determine overall quality of the studies. O'Connor *et al.* (2015) have reported a grading scale to score each paper ('excellent' (24–28 points), 'good' (19–23 points), 'fair' (14–18 points) or 'poor' (<14

points). This grading scale was modified to account for the two items that were deleted from the original scale. Seven of the included papers were graded as 'excellent' (Abel *et al.*, 2016; Hogue *et al.*, 2008; Shaw *et al.*, 1999; Weck *et al.*, 2013; Weck *et al.*, 2014; Weck, Grikscheit *et al.*, 2015; Weck *et al.*, 2016), four were rated as 'good' (Norrie *et al.*, 2013; Strunk *et al.*, 2010; Weck, Richtberg *et al.*, 2015; Westra *et al.*, 2011), and five were assigned a grade of 'fair' (Branson *et al.*, 2015; Ginzburg *et al.*, 2012; Jolley *et al.*, 2015; Ryum *et al.*, 2010; Trepka *et al.*, 2004).

3.3.1 Study designs

Two studies used naturalistic designs (Branson *et al.*, 2015; Jolley *et al.*, 2015) and 14 studies conducted secondary data analyses of randomised controlled trials (RCT). Most of the secondary data was drawn from large scale multisite RCT that included one or two control groups. Some studies analysed the same data: Three studies analysed data from a relapse prevention study on depression (Stangier *et al.*, 2013; Weck *et al.*, 2013; Weck *et al.*, 2014; Weck, Grikscheit *et al.*, 2015); two studies analysed data from an RCT investigating anxiety disorder (Stangier *et al.*, 2010; Weck *et al.*, 2014; Weck, Grikscheit *et al.*, 2015); whilst two studies analysed data from an RCT investigating cognitive therapy versus exposure therapy (Weck, Neng *et al.*, 2014; Weck *et al.*, 2014; Weck, Richtberg *et al.*, 2015).

3.3.2 Selection bias

All studies included in this review were at risk of selection bias. The original RCTs of the secondary data studies reported high internal validity due to the randomisation methods used during treatment allocation. However, the samples included in the secondary data studies were reduced in size from the original study and only a subset of the original sample's tapes were analysed. Therefore the sample may not be representative of that used in the original RCT. Branson *et al.* (2015) recruited the largest sample size and the naturalistic design might have increased ecological validity, but other variables could not be controlled for so this might have limited the reliability of the findings. Seven of the secondary data studies attempted to reduce selection bias by providing a description of how the tapes were selected from the original RCT (Abel

et al., 2016; Hogue *et al.*, 2008; Weck *et al.*, 2013; Weck *et al.*, 2014; Weck *et al.*, 2014; Weck, Grikscheit *et al.*, 2015; Weck *et al.*, 2016).

3.3.3 Detection bias

Four studies did not report whether the judges who rated competence were blind to treatment outcome (Branson *et al.*, 2015; Jolley *et al.*, 2015; Weck *et al.*, 2014; Weck *et al.*, 2016). This might have increased detection and performance bias because the judge's ratings may have been influenced by their knowledge of treatment outcome (Hopp, 2015). One study only used a single judge to rate competence and this may have enhanced the risk of bias and threatened both the internal validity and the reliability of the ratings (Trepka *et al.*, 2004).

The intraclass correlation coefficient (ICC) is a common measure of inter-rater reliability. Cicchetti (1994) classified the ICC values in the following way; below .40 as 'poor', .40 to .59 as 'fair', .60 to .74 as 'good', and .75 to 1.00 as 'excellent'. In the current review ten studies reported the ICC for the mean scale competence scores as 'excellent'. Ryum *et al.* (2010) reported the ICC for individual items ranged from 'good' to 'excellent'. Hogue *et al.* (2008) reported 'poor' to 'fair' ICCs (range .01 to .63). Trepka *et al.* (2004) only used one rater and three studies did not report the ICCs (Branson *et al.*, 2015; Jolley *et al.*, 2015; Shaw *et al.*, 1999).

Five of the studies only analysed one or two therapy sessions per therapist to generate a total measure of therapist competence (Jolley *et al.*, 2015; Norrie *et al.*, 2013; Ryum *et al.*, 2010; Weck *et al.*, 2014; Weck *et al.*, 2016). This is unlikely to have provided a reliable measure of therapist competence. Keen and Freeston (2008) suggested that to establish a reliable measure of therapist competence a minimum of 15 sessions per therapist should be rated when using one judge and a minimum of 19 sessions per therapist when there are two judges. Only two studies rated enough sessions per therapist to meet this recommendation. Shaw *et al.* (1999) rated on average 38 sessions per therapist using two raters and Strunk *et al.* (2010) rated an average of 40 sessions per therapist based on the ratings of two raters.

3.3.4 Attrition bias

The secondary data studies reduced their sample from the original RCT, so the tapes that were analysed were selected from a smaller sample size. There was variation in how studies reported their attrition rates. Seven studies did not provide information on the characteristics of the participants that were excluded from the secondary data analysis (Ginzburg *et al.*, 2012; Jolley *et al.*, 2015; Norrie *et al.*, 2013; Strunk *et al.*, 2010; Trepka *et al.*, 2004; Weck *et al.*, 2013; Westra *et al.*, 2011).

4. Discussion

This systematic review analysed 16 studies to assess whether higher ratings of therapist competence predicted better treatment outcomes in CBT. The studies included a range of CBT interventions that used a number of validated scales to assess therapist competence. The studies included a range of sample sizes that each assessed a different number of therapy sessions. The findings suggested that the relationship between therapist competence and treatment outcome is not straight forward. Several key findings emerged that will be discussed in terms of the specific aims of the review.

4.1 Therapist competence as a predictor for treatment outcomes in CBT

The assumption that more competent therapists inevitably produce better outcomes was not borne out by the current review. This review highlighted the multifaceted nature of *therapist competence* and the complex process involved in determining the components associated with improved treatment outcomes (Muse & McManus, 2013). The findings of this review are in line with previous reviews that found significant heterogeneity across studies and suggested that non-significant findings should be interpreted with caution (Barber *et al.* 2007; Webb *et al.*, 2010). Previous reviews found a similar complex interaction between *therapist competence*, *therapeutic alliance* and treatment outcomes (Webb *et al.*, 2010). However, a unique finding from the current review suggested that *therapist competence* might be a better predictor of outcome in treatments that focus on anxiety. A further distinct finding indicated that specific

therapist competencies, including 'homework setting skills' and 'collaborative skills' may help to improve client outcomes.

4.1.1 Components of competence

A unique finding from the current review was that specific subscales of competence were more strongly related to outcome than others. Competencies in 'structuring' and 'homework skills' were found to be strongly related to improved outcomes in some studies (Ryum *et al.*, 2010; Shaw *et al.* 1999). This was similar to Detweiler-Bedell and Whisman (2005) and Kazantzis *et al.* (2000) who found 'homework setting' improved outcomes in clients with depression. While Simons *et al.* (2010) found that training therapists on specific 'homework skills' was linked with better treatment outcomes. Ginzburg *et al.* (2012) found general skills such as 'pacing' were strongly linked with outcome. This was supported by Schinkothe *et al.* (2015) who investigated CBT for dementia caregivers and found 'general skills' more predictive of outcome. Bryant *et al.* (1999) also found the therapists 'general skills' more predictive of improvement than 'homework skills'. Such findings suggest that therapist competence is a dynamic concept that should be measured carefully and adapted according to treatment and client group.

4.1.2 Condition being treated

The current review found more significant findings in the anxiety studies. This finding is unique when compared to the meta-analysis by Webb *et al.* (2010) who reported that therapist competence was significantly related to treatment outcome in the studies that treated depression. However, Webb *et al.* (2010) had not included studies that examined anxiety treatments and their review focused on all psychological therapies. The distinct finding from the current review implied that higher therapist competence in CBT for anxiety might predict better outcomes than those found in studies that focused on other treatments. This finding was supported by Brown *et al.* (2013) who found higher therapist competence significantly predicted better treatment outcome in telephone CBT for anxiety. This was similar to Haug *et al.* (2016) who focused on CBT for anxiety and

found a significant link between therapist competence and treatment outcome using a combined competence/adherence scale. These findings suggested that anxiety treatments might have certain components that amplify the competence/outcome relationship.

4.1.3 Moderator variables

The current review found that *therapeutic alliance* might mediate the outcome/competence relationship. Horvath *et al.* (2011) completed a meta-analysis that investigated *therapeutic alliance* and treatment outcome and they reported higher effect sizes than the meta-analysis conducted on therapist competence/*adherence* and treatment outcome by Webb *et al.* (2010). However, findings in the *alliance/outcome* studies have been less consistent when other variables have not been controlled for (Barber, 2009). Some of the studies in this review found significant *alliance/outcome* links, but not *competence/outcome* links, which was similar to previous studies (Gibbons *et al.*, 2010; Creed & Kendall, 2005). The current review found several studies did not control for potential confounding variables. The majority of studies in this area have significant heterogeneity, small sample sizes and they have lacked control of confounding variables. The relationship between *therapist competence* and *therapeutic alliance* remains complex.

4.2 Quality assessment

The conclusions from the current review are restricted by methodological limitations. The overall quality of studies varied from 'excellent' to 'poor' and there was some risk of bias in all the included studies. The studies that used secondary data analysed a smaller sample size in comparison to the sample in the original RCT. No studies described the participant sample not included in the secondary data analysis, which reduced the generalisability of the findings.

Most of the therapists recruited for research studies are often competent and experienced (Brown *et al.*, 2013). Fifteen studies recruited a sample of qualified

therapists for their RCTs. This reduced the variability in their level of competence, which may have limited how applicable the findings are to clinical practice. Branson *et al.* (2015) included trainee therapists from a large-scale training programme for Improving Access to Psychological Therapies (IAPT). This may have increased variability in therapist competence and they found some evidence to support that therapist competence improved treatment outcomes. However, the IAPT services are only available in the UK, so findings may not be generalisable to other countries. The quality of this study was limited by its naturalistic setting, particularly regarding the lack of control of confounding variables.

Weck *et al.* (2016) reported that a minimum sample size of 84 participants was required to detect moderate correlations between therapist competence and treatment outcome. Twelve of the included studies had less than 84 participants limiting their power to detect effect sizes. Similarly, in 14 of the studies the number of therapy sessions rated per therapist was not sufficient to produce reliable measures of competence. This is problematic because if therapist competence is measured inaccurately then it limits the reliability and validity of the findings. However, the majority of studies measuring therapist competence are often costly and time-consuming due to the requirement of experts to evaluate competence (Ginzburg *et al.*, 2012). This often leads to reduced sample sizes and it can restrict the methodological rigour of these studies.

Some of the included studies reported 'poor' to 'moderate' ICCs and so this brings into question the reliability of some of the ratings of competence. Finally, some studies did not control for confounding variables, specifically *therapeutic alliance*, *therapist adherence*, co-morbidity, age and severity of problem, which was also reported in the review by Webb *et al.* (2010).

4.3 Strengths and limitations

Strengths of the current review were that it was systematic, provided a critical appraisal of recent studies and focused on the inclusion of high quality studies. A limitation of the review was the inclusion of validated competency scales led to several studies being

excluded. Some of the excluded studies found that higher therapist competence was significantly associated with improved therapy outcomes (Brown *et al.*, 2013; Davidson *et al.*, 2004; Kuyken & Tsivrikos, 2009; Meier *et al.*, 2015). It might have been beneficial for this review to have included studies that also used a non-validated measure of therapist competence. This might have enhanced the findings because some of the excluded studies developed their own specific competency tools related to the therapy being delivered. This might have measured therapist competence more accurately than broader therapist rating scales (Muse & McManus, 2013). This review only included peer reviewed studies to ensure that quality was maintained. However, a limitation of this is that it can introduce publication bias because published studies can sometimes give more favourable treatment effects (Ahmed *et al.*, 2012). The systematic searching was completed by one author and may have increased the risk of error or bias.

4.4 Clinical implications and future research

The findings from this review has several implications. There is evidence to suggest that therapist competence may improve treatment outcomes, however there are still many processes that are not well understood. There is a clear need for more research in this area. Future studies need to increase methodological rigour to reduce risk of bias. For example, using larger samples to increase power to detect differences, ensuring all therapists have a minimum of 15 sessions rated to increase the likeliness of obtaining a reliable measure of therapist competence, and they should select a sample of therapists with a range of experience. To distinguish between the factors that may cause change in treatment outcomes, future studies need to ensure they have controlled for confounding variables. The current review found that anxiety treatments might increase the competence/outcome link, so research is needed to investigate this further.

This review found higher levels of client 'hope' and 'emotional processing skills', and higher therapist 'collaborative skills' seemed to improve treatment outcomes (Abel *et al.*, 2015). This was similar to Podell *et al.* (2013) who reported that higher therapist competence in 'collaborative skills' predicted better treatment outcomes in adolescence with anxiety. This finding was perhaps not surprising given the research that exists on the recovery model (Bonney & Stickley, 2008). This model conveys that clients with

mental health problems value professional relationships that convey hope, collaboration and shared power (Borg & Kristiansen, 2009). Therefore this might suggest a relational link between higher therapist competence in 'collaborative skills', client 'hope' and treatment outcome (Constantino, 2012; Wampold, 2015). Thus further research investigating this relationship might be beneficial.

It seems important that therapists delivering CBT continually assess their own competency throughout their careers to ensure they continue to provide effective treatments. Continuous training and supervision that specifically targets therapist competence for specific interventions would be of value. A further consideration is to assess therapist competency using a multitude of methods to ensure optimum treatment outcomes are achieved. For example, using standardised role plays with therapists to measure competence and rating therapy sessions (Muse & McManus, 2013). Specific therapist competencies, such as 'homework skills' seemed to show a link with better treatment outcomes. Therefore clinicians should ensure that they remain consistent and competent when setting and reviewing homework with clients when utilising a CBT approach (Burns & Spangler, 2000; Conklin & Strunk, 2015).

5. Conclusion

The current review aimed to systematically review the literature on *therapist competence* and treatment outcomes. The results indicated that *therapist competence* appears to play a role in treatment outcome, however this relationship is complex. The evidence suggested that the research is hindered by methodological limitations. Further research needs to address this by recruiting larger sample sizes, obtaining a reliable measure of *therapist competence* and sampling therapists with a varied level of experience. Treatment outcome was found to be influenced by several therapist factors, including *therapist competence*, *therapeutic alliance*, *therapist adherence*, anxiety symptoms and client expectations. A unique finding that emerged from the current review was the high number of significant effects reported in the studies that focused on anxiety and this suggested that anxiety treatments might have specific characteristics

that act to increase the relationship between *therapist competence* and treatment outcome. Future research might aim to explore what these unique characteristics are.

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Research Report

The development of the Compassion Focused Therapy Therapist Rating Scale (CFT-TRS)

Abstract

Objectives. Compassion-focused therapy (CFT) has shown promise as a treatment for a variety of clinical problems, however existing studies have not adequately addressed issues of treatment fidelity. The aim of the present study was to develop a useful measure of therapist competence in CFT that could be used to assess therapist competence in research trials, clinical practice and training.

Design. The Delphi method was used to develop and operationalise the competencies required for inclusion in a CFT therapist competence scale over five rounds.

Methods. The first round involved a meeting with two experts in CFT to draft the competencies. The second round involved sending out online surveys to nine experts in CFT. Consensus levels and qualitative data were analysed and used to revise and operationalise the scale in a meeting with two experts in round three. In round four the updated scale was used to create a survey and sent out to CFT experts. In round five the scale was refined and finalised in a meeting with a CFT expert.

Results. The CFT therapist competence scale (CFT-TRS) included 23 competencies and these were separated into fourteen CFT unique therapist competencies and nine microskills. There was high agreement about the included unique competencies and microskills, however there were differences in opinion between experts about the content of items and item overlap.

Conclusion. This research has used quantitative and qualitative feedback with eleven highly experienced CFT experts over five rounds to develop the CFT-TRS. Some items were specific to CFT and others overlapped with other psychotherapies. The scale can be used as a learning guide for delivering CFT, to assess therapist competence for CFT training courses or clinical practice, and to assess fidelity in research trials. Future research is required to understand and evaluate the psychometric properties of this scale.

1. Introduction

Compassion focused therapy is a recently developed multimodal approach that draws from a number of ideas, including developmental approaches, Buddhist psychology, neuroscience, social mentality theory and social and evolutionary psychology (Gilbert, 2009a). There is evidence that CFT might be an effective treatment for individuals across a number of mental health problems (Gilbert, 2009a; Gilbert & Irons, 2005; Tirch & Gilbert, 2014). However, one of the difficulties with current CFT research has been a lack of focus on treatment fidelity (Leaviss & Uttley, 2015). One reason for this is that CFT does not have a psychometrically valid scale to assess therapist competence. The current study aimed to develop a measure of therapist competence in CFT for use in research, service evaluation, audit, clinical practice and training.

1.1. CFT model and evidence base

CFT theory has been based on the neuroscientific evidence that has found neural pathways in the brain that support emotional regulation and self-soothing (Depue & Morrone-Strupinsky, 2005; Siegel, 2012). It has aimed to support individuals with high levels of shame and self-criticism (Gilbert & Irons, 2005). Heightened shame and self-criticism can prevent individuals accessing their affect regulation system and they become over reliant on responding to situations from their threat system (Gilbert, 2009a). CFT outlined three basic affect regulation systems that underpin feelings of reassurance, safeness and well-being (Gilbert, 2009a). These systems included: (1) threat-protective system, (2) drive, seeking and reward system, (3) contentment-soothing system (cited by Gilbert, 2014). These systems can become dysregulated and one of the goals of CFT is to help the client regulate them. Overall CFT has aimed to help individuals cultivate compassion and access affiliative emotions, motives and competencies.

A number of studies have reported positive outcomes for the effectiveness of CFT. Gilbert and Procter (2006) investigated compassionate mind training (CMT) in a group setting for individuals with high shame and self-criticism. They reported that CMT significantly reduced depression, anxiety, self-criticism and shame. Similar studies have

investigated CFT group therapy and reported significant improvements in client outcomes at post-treatment (Gale *et al.*, 2012; Judge *et al.*, 2012). CFT has significantly reduced depression and has increased self-reassurance in clients diagnosed with a personality disorder (Lucre & Corten, 2012). Studies investigating CFT for eating disorders have reported positive effects (Gale *et al.*, 2012; Kelly & Carter, 2015). There is growing evidence for CFT as an effective treatment for clients with psychosis (Braehler *et al.*, 2013; Heriot-Maitland *et al.*, 2014; Kennedy & Ellerby, 2016; Laithwaite *et al.*, 2009; Mayhew & Gilbert, 2008), depression (Gilbert & Irons, 2004) and for clients with an acquired brain injury (Ashworth *et al.*, 2011; Ashworth *et al.*, 2015). Other studies have focused on mixed diagnoses and reported positive effects using CFT (Judge *et al.*, 2012). Beaumont *et al.* (2012) compared cognitive behavioural therapy (CBT) with CBT plus CMT and concluded that higher levels of self-compassion are linked to a decrease in anxiety, depression and trauma-related symptoms.

In summary CFT has shown promising results with a range of mental health problems. However more research from large-scale randomised controlled trials is required. The majority of CFT studies were uncontrolled designs and changes were difficult to attribute to the intervention and results should be interpreted with caution (Eccles *et al.*, 2003).

A recent systematic review by Leaviss and Uttley (2015) provided a synthesis of the current CFT evidence base. They included 14 studies and reported that the majority of these studies showed positive outcomes for CFT and these studies were conducted in clinical settings which increased ecological validity. However, this review recommended that further large-scale high quality studies are needed and they reported that future studies should address issues of treatment fidelity.

1.2 Treatment fidelity

There is a requirement for psychological therapies to demonstrate that they are 'evidence based' (Department of Health, 2001). This requires psychotherapy outcome studies to produce high quality studies that ensure treatment fidelity is maintained.

Treatment fidelity is described as the degree to which an intervention is implemented as intended and includes components of therapist competence, therapist adherence and treatment differentiation (Perepletchikova *et al.*, 2007). Therapist competence addresses "the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects" (Fairburn & Cooper, 2011). Therapist adherence is the degree to which the therapist used prescribed procedures and techniques (Perepletchikova & Kazdin, 2005). Therapist differentiation is defined as whether the treatments under investigation differ from each other along critical dimensions (Perepletchikova *et al.*, 2009). Monitoring and assessing treatment fidelity provides a way to ensure treatment has been delivered as intended and validates the conclusions drawn in research trials (Nezu & Nezu, 2008, pp.263-284). To date, studies that have evaluated CFT have failed to fully assess treatment fidelity, consequently it is unknown whether treatment has been delivered as intended and it is difficult for studies to be replicated or applied in a real-world setting.

1.3 Therapist competence

In the last three decades, professional psychology has shifted toward a 'culture of competence' where psychotherapy education and training have adopted competency-based models (Roberts *et al.*, 2005; Sperry, 2010). These models have required therapists to acquire competencies to be considered competent and efficient to deliver psychological therapies (Kaslow *et al.*, 2007). However, there is a lack of agreement between professionals about the key competencies within professional psychology (Lichtenberg *et al.*, 2007). This has resulted in great variation regarding how competencies are developed and how they inform competency based programmes (McIntyre-Hite, 2016). Overall, competency based models in training and education have been adopted as they are seen as contributing to good practice in mental health services and improving the effectiveness of psychological therapies.

Therapist competence has been monitored in psychotherapy outcome studies to provide quality assurance and to increase internal and external validity (Fairburn & Cooper, 2011). A number of studies have investigated whether higher therapist competence has resulted in better treatment outcomes, but findings have been mixed (Webb *et al.*,

2010). Other studies have explored the impact of training on therapist competence and findings have suggested that therapist knowledge tends to improve after training, but training alone does not directly improve therapist competence (Beidas & Kendall, 2010; Beidas *et al.*, 2012; Karlin *et al.*, 2012). In summary therapist competence has been increasingly recognised as requiring assessment and it has been measured in service evaluation, clinical audit, outcome research and training (Bennett & Parry, 2004).

1.4 Therapist competence scales

When therapist competence scales are developed effectively they can specify best practice, increase a studies reliability and validity, and evaluate training and supervision practices (Kohrt *et al.*, 2015; Roth & Pilling, 2008; Slade *et al.*, 1999). Their overall purpose has been to avoid therapist drift, to further understand change factors and to differentiate treatment (Bennett & Parry, 2004; Blackburn *et al.*, 2001). Therapist competence scales have been developed to translate the complexity of the skills practiced by therapists into robust ‘evidence-based’ measures. Roth (2015) noted that therapists strongly favoured competencies from their own treatment modality which provides evidence that items in therapist competence frameworks have high content and construct validity.

Therapist competence scales have mainly focused on limited-domain competencies rather than global measures of competence (Barber *et al.*, 2007). Barber *et al.* (2007) defined limited-domain competencies as the skilful application of the unique (intervention specific) and general therapy techniques of a psychotherapy. Two types of scales have been developed to measure therapist competence: (1) transdiagnostic scales that measure competencies that are not specific to a particular diagnosis, and (2) disorder-specific scales (Muse & McManus, 2013). The current study focused on transdiagnostic scales because CFT is a treatment aimed at a range of psychological difficulties.

Therapist competence has been measured in studies that have investigated CBT (Keen & Freeson, 2008; Roth, 2016), dynamic therapy (Barber & Crits-Christoph, 1996), cognitive analytical therapy (CAT) (Bennett & Parry, 2004), family therapy (Hogue *et*

al., 2008), interpersonal therapy (Chevron & Rounsaville, 1983), emotion-focused trauma therapy (Paivio, *et al.*, 2004), acceptance and commitment therapy (ACT) (Strosahl *et al.*, 2004; Walser *et al.*, 2013), mentalisation based therapy (MBT) (Karterud *et al.*, 2013), and drug counselling (Barber *et al.*, 1996). They have been developed to evaluate the level of competence for psychological training courses (Muse *et al.*, 2016; Tweed *et al.*, 2010). However, scales have differed in their structure, number of items, how they were developed and some scales have measured competence and adherence as a joint construct (Barber *et al.*, 2007).

The most commonly used transdiagnostic scale has been the CBT cognitive therapist scale (CTS; Young & Beck, 1980), which has been revised several times (Blackburn *et al.*, 2001; Brosnan *et al.*, 2007; Bryant *et al.*, 1999; Garety *et al.*, 2008; Stallard *et al.*, 2014). However, studies have reported variability in the inter-rater reliability of this scale. Muse and McManus (2013) suggested this variability was due to inconsistencies in the number of raters using the scale, training, expertise and item overlap. Thus the development of therapist competence scales can be complex and attention should be paid to the feasibility, reliability and validity of the measure.

1.5 Therapist competencies in compassion-focused therapy

Liddell *et al.* (2016) developed a CFT competency framework and this sets out the necessary therapist competencies required to effectively deliver CFT. The framework comprised six key areas of competence and 25 main competencies, which included competencies to create safeness, meta-skills, non-phase specific skills, phase-specific skills, supervision skills and knowledge and understanding. This framework aimed to provide guidance for clinicians and training courses delivering CFT, but cannot be used to measure or assess CFT therapist competence in clinical practice, training or research. However, an unpublished scale called the 'CFT therapy assessment guide' was developed by Gilbert and Wood and the purpose was to assess therapist competence in CFT training programmes. The scale included 45 items assessing microskills, formulation skills, skills in explaining CFT, and contracting. The CFT intervention skills were divided into three different stages of therapy. This scale is difficult to use in practice and research because the scale has not been published and there are a high

number of items that seem difficult to rate. Therefore there are currently no validated therapist competence scales designed to measure the necessary competencies required to competently deliver CFT.

1.6 Method for developing therapist competence scales

The methods for developing therapist competence scales are varied and there are currently no clear guidelines, however methods tend to rely on eliciting competencies from therapy manuals and expert opinion (Barber & Crits-Christoph, 1996; Ogrodniczuk & Piper, 1999). Bennett and Parry (2004) used a more comprehensive methodology to develop a measure of therapist competence in CAT using a number of stages. Their methodology consisted of experts observing tapes of CAT to identify competencies, thematic analysis was used to condense competencies, and a Delphi technique method was used to further define the scale.

1.7 Delphi techniques

Delphi techniques are used to achieve consensus among a group of experts on a certain issue where no agreement previously existed (Keeney *et al.*, 2010). However, methodologies have been defined and conducted differently. According to Heiko (2012), there are four distinct characteristics of Delphi studies that remain the same, and these are anonymity, iteration, controlled feedback, and statistical group response. Boulkedid *et al.* (2011) identified the factors that have differed in Delphi studies were the technique adopted, expert selection, number of rounds and how the method and results are reported. There are currently no universal guidelines for conducting Delphi methods. This allows the researchers to adapt the approach to suit their specific research aims, however this has revealed deficits in the practice and rigour of Delphi techniques (Heiko, 2012).

Iqbal and Pison-Young (2009) noted that Delphi studies typically have carefully selected expert participants and are conducted in a series of two or more sequential rounds. The first round involves the main researcher asking all the participants questions to generate initial ideas. These ideas are collected and analysed and the data is fed back in a questionnaire in round two. The results from the second round are used to

generate a third questionnaire (Hasson *et al.*, 2000). Participants are required to complete their questionnaire's anonymously. They are provided with the comments of others and asked to re-evaluate their earlier responses. This process of controlled feedback is ongoing until consensus is obtained or the desired outcome is reached (Hasson *et al.*, 2000). The advantages of using a Delphi technique to inform decision making includes safety in numbers (i.e. several people are less likely to arrive at a wrong decision than a single person), a controlled process, scientific credibility, and a selected group of experts are more likely to lend some authority to the decision produced (Murphy *et al.*, 1998).

Modified Delphi techniques have been employed to establish the necessary competencies for a variety of disciplines, including mental health workers (Lakeman, 2010), teachers in higher education (Tigelaar *et al.*, 2004), occupational therapy (Holmes & Scaffa, 2009), psychiatry (Sunderji *et al.*, 2016), and clinical psychology (Green & Dye, 2002). The Delphi method has been applied to develop competencies for specific therapies and clinical populations, such as CFT (Liddell *et al.*, 2016), CBT for anxiety and depression (Roth & Pilling, 2008), CBT for psychosis (Morrison & Barratt, 2010), CBT for children and adolescence (Sburlati *et al.*, 2011), suicide risk (Kotowski & Roye, 2017) and eating disorders (Williams & Haverkamp, 2010). Modified Delphi methods have been used in studies to develop therapist competence scales for CAT (Bennett & Parry, 2004), online CBT (Cooper *et al.*, 2015) and motivational interviewing (Barsky & Coleman, 2001). Overall modified Delphi techniques seem an appropriate and useful measure for developing therapist competence scales, specifically for those therapies where the evidence-base is less developed.

1.8 Rationale

Studies measuring the effectiveness of CFT are showing promise, however it has a limited 'evidence base' and existing studies have not adequately addressed issues of treatment fidelity. Therefore a CFT therapist competence scale is required to use in research to confirm that treatment is being delivered as intended and valid conclusions can be drawn. The CFT competence framework (Liddell *et al.*, 2016) provided an extensive list of CFT therapist competencies, but the items were not operationalised or

measurable and it was not designed to assess therapist competence. The Gilbert and Wood 'CFT therapy assessment guide' is an unpublished scale and this is not suitable for purpose because it was never finalised, some of the items are not measurable, specific or easy to rate, and it was not designed using a scientific methodology. Therefore a measure of CFT therapist competence is required to set out the specific, observable and measurable competencies that can be used to assess the knowledge and skills of individuals delivering CFT therapy sessions. Such a scale is needed to help identify best practice for CFT, evaluate CFT trainee therapists, and used to enhance clinical practice and clinical supervision (Kohrt *et al.*, 2015)

1.9 Aims and objectives

The aim of the present study was to develop a useful measure of therapist competence in CFT that could be used to assess therapist competence in research trials, clinical practice and training. The present study used a Delphi methodology (Linstone & Turoff, 2002) to develop a consensus for the generated and operationalised competencies to ensure that the scale represented the views of a range of experts in CFT.

2 Method

2.1 Design

To achieve the specific aims of the current study a modified Delphi method was adopted. This method was chosen because it is widely used for achieving convergence of opinion from experts and has been used in areas where consensus has not been established. The majority of Delphi studies are conducted using a modified Delphi procedure (Boukdedid *et al.*, 2011). The current study used a modified Delphi technique to ensure that the methodology correctly represented the aims of the study. A modification made to the first stage involved initial interviews with experts in CFT who were outside the group of participants involved in the surveys. This method was chosen because the aim of the first stage was not to generate new ideas, but aimed to condense previous work conducted in CFT competencies. Using a small group discussion with two experts outside the survey panel allowed for greater and longer exploration of CFT

competencies. This modification has been reported by Avella (2016). Original Delphi techniques have used a series of sequential rounds; however, the current study was divided into two stages over five rounds. Stage one involved developing the competence items and stage two involved operationalising the scale. This was chosen because developing and operationalising competencies can be complex and the face-to-face interviews during stage one, three and five allowed for ideas and disagreements to be discussed and explored. The competence items and behavioural anchors were revised and edited by experts over a number of rounds to develop items that were specific, observable, distinguishable and measurable.

2.2 Participants

The participants consisted of two groups of CFT experts. Two experts in CFT were identified as the independent expert panel (IEP) members and they were involved in the development and editing of the scale. The remaining participants were identified as the survey expert panel (SEP) and they were involved in the online surveys that used a Delphi technique.

2.2.1 Independent expert panel

The IEP included two experts in CFT. One was the founder of the Compassionate Mind Foundation and has significant experience in training and supervising the model nationally and internationally. He teaches and supervises on a university based CFT Post Graduate Certificate Course. The second expert was an original board member of the Compassionate Mind Foundation. He is Course Director of a university based CFT Post Graduate Diploma course.

2.2.2 Survey expert sample

The SEP were required to have extensive knowledge and skills in CFT and of general therapy skills. Therefore the participants were required to have significant experience, knowledge, training and supervisory practice in CFT. The following inclusion criteria was applied to the sample:

- Is a member of the Compassionate Mind Foundation board or they are trained and supervised by a member of the board.
- Has experience supervising clinicians in CFT.
- Has been involved in devising CFT treatment protocols or training others in CFT.

CFT is a relatively new therapy and the sample of experts was drawn from a small pool of approximately 20 clinicians. Twelve participants were interested in taking part in this study and nine of these consented to participate. Studies using Delphi methods have included a range of sample sizes, but Delbecq *et al.* (1975) reported 10 to 15 experts could be sufficient if the group is homogenous.

2.3 Recruitment

The IEP made initial contact with the expert participants and provided them with information about the study. Once agreement had been obtained from the participants the researcher was provided with their contact details and informed them about the purpose of the study. The researcher sent out the participant information sheet (Appendix R) and the consent form (Appendix S) and gained consent from those wishing to participate.

2.4 Materials

Round one meeting

A schedule was devised for the initial meeting that aimed to develop the draft items for the CFT therapist competence scale (Appendix F). This included the aims of the meeting and the materials used to support the discussions. The CFT competency framework (Liddell *et al.*, 2016) and the Gilbert and Wood therapy assessment guide were used to guide discussions and decisions.

Round two survey

The data generated from round one was presented in a survey (Appendix G). Participants were asked to rate on a five-point Likert scale how important each item was for inclusion in a CFT therapist competence scale and to suggest any changes and comment on how this item might be measured and observed in practice.

Round three meeting

The data generated from the survey was analysed and presented in two separate tables. One table included the comments participants made about changing the item. The second table consisted of comments that were made about how the item might be operationalised. This data was used as a guide for the discussion during the meeting in round three. All participants involved in the survey were sent the anonymised survey comments and a description of the edits made to the items included and the items excluded (Appendix H).

Round four survey

Data generated from the previous rounds were used to draft the CFT competence scale. This scale was presented in a survey (Appendix I). Each competence was presented as a question. Participants were required to rate on a five-point Likert scale whether each item had been accurately described and operationalised. Participants were asked to comment on any changes that they would make.

Round five

Amendments and suggestions were collated and analysed and all participants were sent the final draft of the therapist competence scale. Final edits were completed and the scale was sent out.

2.5 Procedure

2.5.1 Round one: Developing the scale items

The first stage involved drafting the initial items for inclusion in the CFT therapist competence scale. The main researcher met with the IEP. The discussions lasted approximately five hours. Each item was measured against whether this item could be observed in routine clinical practice. Items were included in the scale if the IEP both agreed that they were necessary for inclusion in a CFT therapist competence scale. All discussions were recorded on a digital recorder and the researcher made detailed notes throughout.

Round one: Analysis

The researcher collated all the information from the digital recorder and the written notes. Attention was paid to the items the IEP had reached agreement on and the items where differences in opinion occurred. The researcher documented the included and excluded items and provided clear rationales for each decision. The researcher analysed the data and this produced 30 items that were considered necessary for inclusion in the draft CFT therapist competence scale.

2.5.2 Round two: Survey development

The 30 items identified from round one consisted of 17 CFT specific therapy skills and 13 microskills. This information was presented in a survey and sent to the SEP (Appendix G). The survey was designed and administered online using survey monkey. A separate question was used to present each competence. Participants were asked to rate how important they felt each competency was for inclusion in a CFT therapist competence scale. This was rated using a five-point Likert scale. This scale included the following options: (1) 'not important', (2) 'somewhat important', (3) 'moderately important', (4) 'important', (5) and 'very important'. The participants were asked to comment on the score they had provided and suggest any changes that might be required. A separate question was included to generate comments about how each item might be observed and measured in clinical practice. All participants were thanked for

their participation and sent the decisions made about each item and the anonymised comments from the other participants.

Round two: Data collection

The survey was sent out to all nine participants. There was no closing date set to maximise participation. The researcher sent weekly reminders to the participants that were yet to complete the survey. The survey was closed after 11 weeks when all nine participants had completed their feedback. All responses were collected and analysed.

Round two: Analysis

The researcher reviewed all the completed surveys. The researcher analysed the quantitative data first to establish consensus for each item. The ratings from nine participants were entered into a Microsoft Excel spreadsheet. The researcher calculated the summary statistics, including the percentage agreement, the mean, and the standard deviation for each item. For the item to be included in the scale, 80% of participants had to rate four or higher on the five-point Likert scale. This high level of consensus was chosen because the group was assumed to be homogeneous and participants were required to have an expert level of knowledge of CFT.

The qualitative comments for each item were transferred into a word processing document. The comments were checked for accuracy and the researcher gained familiarity with the data. Content analysis was used to analyse the qualitative data (Graneheim & Lundman, 2004). This approach has been defined as ‘the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns’ (Hsieh & Shannon, 2005). Content analysis has been used to analyse written data to identify patterns of words and their frequency. The purpose of using content analysis in the present study was to summarise common issues mentioned by the SEP for each competence (Vaismoradi *et al.*, 2013). This information was used to provide summaries of the comments to guide the round three meeting with the IEP. The qualitative comments were used to validate the inclusion and exclusion of competencies.

2.5.3 Round three: Operationalising the items

The analysed data from round two and the draft CFT therapist competence scale was used to structure the IEP meeting. The researcher met with the IEP. The meeting aimed to finalise the items for inclusion in the scale and operationalise the items. This meeting lasted approximately five hours. The meeting followed a strict structure and involved focusing on each competence separately. Any changes to the item's description were discussed first and then the behavioural indicators for each competence were developed. The comments from the round two survey were used to make changes to the items and operationalise each competence. All discussions were recorded on a digital recorder and the researcher made detailed notes throughout the discussions.

Round three: Analysis

All information was collated and the researcher paid attention to any differences of opinion about the item description or the behavioural indicator. The researcher used the notes from the meeting and the audio recording to amend the CFT therapist competence scale.

2.5.4 Round four: Survey development

Amendments to the scale were made based on the analysis that was completed in round three. A second survey was developed and included 23 competencies and these were separated into individual questions (Appendix I). Each item provided a description of the competence, points to be considered when scoring and the behavioural anchors. Zero indicated inappropriate or absent skill while four represented skilful enactment. Behavioural descriptions for the inappropriate or absent anchor and the skilful enactment anchor were provided. Participants were asked to rate on a five-point Likert scale whether the item accurately described and operationalised each competence. An open-ended question was asked to generate suggestions for changes to the items or the scale.

Round four: Data collection

The survey was sent out to all nine participants. The closing date was set for three weeks. All responses were collected and analysed. Eight participants responded to the survey.

Round four: Analysis

The data was analysed using a similar method to round two. The quantitative data was entered into Microsoft excel and the summary statistics were calculated. The consensus level was changed for this round because the aim was to edit and revise the scale items. Therefore, a stricter consensus level was applied of 80% of participants had to rate five on the five-point Likert scale. The items that did not reach consensus were re-evaluated and edited based on the comments generated.

The qualitative comments were transferred into a word processing document. The comments for each competence were read numerous times to gain familiarity. Content analysis was applied to the data to help understand and condense the comments. This analysis summarised common issues for each competence. The purpose of this analysis was to inform the discussions during the round five meeting with the IEP and to identify comments to support the refinements and edits made to the scale.

Round five: Final scale

The survey data and the scale were reviewed by the IEP during a face to face meeting. The meeting lasted approximately six hours. Final amendments were made and the scale was sent out to all the participants.

2.5.5. Ethical considerations

Ethical approval was obtained from the relevant bodies prior to the study commencing (Appendix S). All participants received an information sheet and consent form that informed them about what was involved in the study, the risks and their right to withdraw.

3 Results

3.1 Participants

Nine individuals formed the SEP. The panel included four males and five females. Two participants were from the United States, one from Denmark and six from the United Kingdom. The sample consisted of eight clinical psychologists and one psychiatrist. The average years of post-qualification experience was 18.35 (range 7 to 35 years). The average years of CFT experience was 10.63 (range 7 to 18 years). The experts were involved in various roles that aimed to develop and promote CFT, including research, supervision, book writing, delivering therapy (group and individual), protocol development, and public engagement.

The response rate for the survey in round two was 100%. The survey in round four had a response rate of 89% as one participant was unable to complete this round. Both IEP attended the meetings in round one and three. One member attended the final meeting in round five, however the other member was consulted via email and phone. The researcher also maintained contact with the IEP via email throughout the study.

3.2. Scale overview

The CFT therapist competence scale (CFT-TRS) contained 23 competencies and these were divided into 14 unique CFT competencies and 9 generic microskills (Appendix L).

Each competence was developed, defined and operationalised by 11 experts in CFT. The scale has been designed for use across all intervention sessions and during any stage of therapy. The scale has been designed to be administered by practitioners with a good knowledge and experience in CFT. The scale addresses competence and not adherence. The aim of the scale is to assess whether a therapist is delivering CFT to a competent standard. During each round the scale was developed further and the qualitative comments reflected improvements after each round.

Unique CFT competencies

The unique CFT competencies consisted of the skills that are specific to CFT. They are the essential and active components required to effectively and skilfully deliver a CFT intervention. The unique CFT competencies included in this scale are summarised in Table 1. These CFT unique skills are not expected to be observed in every CFT intervention session as the skills required in a session will be dependent on the stage of therapy, the content of the therapy session, and the goals of the session. The scale includes an ‘unable to rate’ marker if the competence cannot be observed in practice and this will differ if the rater is watching an audio or video tape.

Microskills

The second part of the scale are the microskills. Microskills are the basic foundational and essential therapy skills required to deliver therapy. These are skills that therapists should be demonstrating in both CFT and in other forms of therapy such as CBT. Microskills should be present, observed and demonstrated by a therapist in every CFT therapy session. The items included in this scale are therefore generic therapy competencies, however the experts attempted to tailor these to CFT where possible. The microskills included in the CFT-TRS are summarised in Table 1.

Table 1. Summary of the final competencies included in the CFT-TRS.

CFT unique competencies	Microskills
1. Psychoeducation	15. Non-verbal communication to build rapport
2. Recognising motives and emotions	16. Non-verbal communication and motivational/emotional systems
3. Actively working with the three-systems	17. Verbal communication
4. Understanding the relationship between three-systems	18. Pacing
5. Compassionate mind training	19. Socratic questioning
6. Building motivation	20. Paraphrasing and summaries
7. Building courage	21. Agenda setting
8. Cultivating and tolerating affiliative emotions	22. Validation and normalisation
9. Cultivating and tolerating positive emotions in the drive system	23. Mentalisation
10. Functional analysis	
11. Fears, blocks and resistances	
12. Unconscious emotions and processes	
13. Formulation	
14. Multiple selves	

3.3 Summary of findings

In total, 23 competencies were considered necessary by the experts in CFT for inclusion in the final version of the CFT-TRS. The 30 competencies generated in round one were reduced to 23 after analysing the qualitative data and applying the 80% consensus criterion to the nine survey responses in round two. The 23 competencies were operationalised in round three and then the 80% consensus level was applied to the survey responses in round four. Two items met consensus and the remaining 21 items were refined and edited in the round five IEP meeting and these were informed by the SEP qualitative comments. The CFT-TRS was then finalised in the round five IEP meeting.

3.3.1 Item generation

The 80% criterion level was applied to the round two survey responses and their replies are summarised in Table 2 and Table 4. For ease of summary each of the item descriptions included in Table 2 and Table 4 have been summarised into themes. Appendix H shows the full description of initial competence items and the amendments made in round one, two and three. The consensus level for each item ranged between 56% and 100%. Nineteen items reached full consensus and all nine participants rated these items as 100% 'important' or 'very important'. Six items reached an 89% consensus rating, while four CFT unique competencies and one microskill did not meet the 80% criterion. One question was not rated by one participant in the round two survey (item 'normalisation'), however this item was rated 'very important' by all other participants and consensus would have been achieved even if this item had been rated.

CFT unique competencies

Excluded competencies

Four unique competencies did not reach consensus in the ratings provided by the SEP in round two. Three of these competencies were rated as 77.8% 'important' or 'very important' ('understand the human motivation system', 'theory of mind', and 'inference chains and cognitions') and one competence was rated as 55.5% 'important' or 'very

important' ('distinguish between motives and emotions'). These items were excluded from the scale. Table 3 provides the SEP comments to support exclusion of these items.

In addition, the competencies 'cultivate and tolerate emotions' and 'breathing, training, tone of voice and facial expression' were excluded by the IEP in round three. This decision was made based on comments from the SEP regarding item overlap and these are presented in Table 3. However, the IEP agreed that some of the content for 'cultivate and tolerate emotions' should be added to the competence 'builds motivation', and some of the content for 'breathing, training, tone of voice and facial expression' should be added to 'understanding three-systems' and 'building motivation'.

Included competencies

Table 2 shows that one new item was added to the scale and this was named 'multiple selves'. This item was added based on three of the SEP recommendations and the IEP agreed that this competence should be included in round three. Table 2 shows that ten of the CFT competencies were reworded in round three. These were amended by the IEP and their decisions were informed by the comments made by the SEP in round two. The description for the competence 'unconscious emotions' was the only item not amended in round three.

Table 2. Summary of results for the CFT unique competencies in round two.

CFT unique competencies	Participant ratings of necessity of competencies (percentage)						Mean (standard deviation)	Amendments
	Very important	Important	Moderately important	Somewhat important	Not important	Consensus >80%		
1.Psychoeducation	89.9	11.1	0	0	0	100	4.89 (0.35)	Reworded
2.Motives, emotions and three systems.	89.9	11.1	0	0	0	100	4.89 (0.35)	Reworded
3.Understand the human motivation system	67.7	11.1	22.2	0	0	78.8	4.44 (0.92)	Excluded
4.Cultivates emotion systems	78.8	11.1	11.1	0	0	88.9	4.67 (0.74)	Reworded
5.Understanding three-systems.	88.9	0	0	11.1	0	88.9	4.67 (1.06)	Reworded
6.Understand relationship between threat, drive and affiliative system	100	0	0	0	0	100	5.00 (0)	Reworded
7.Builds motivation	100	0	0	0	0	100	5.00 (0)	Reworded
8.Cultivate and tolerate emotions	100	0	0	0	0	100	5.00 (0)	Excluded
9.Breathing training, tone of voice and facial expressions.	100	0	0	0	0	100	5.00 (0)	Excluded
10.Forms and functions of self-criticism	77.8	11.1	0	0	11.1	88.9	4.33 (1.75)	Reworded
11.Theory of mind	56.6	22.2	11.1	11.1	0	77.8	4.22 (1.12)	Excluded
12.Distinguish between motives and emotions	33.3	22.2	33.3	0	11.1	55.5	3.67 (1.60)	Excluded
13.Fears/blocks/resistances	100	0	0	0	0	100	5.00 (0)	Reworded
14.Inference chains and cognitions	55.6	22.2	22.2	0	0	77.8	4.33 (0.88)	Excluded
15.Unconscious emotions	77.8	11.1	11.1	0	0	88.9	4.67 (0.74)	No changes
16.Attachment experiences	77.8	11.1	0	11.1	0	88.9	4.56 (1.07)	Reworded
17.Formulation	100	0	0	0	0	100	5.00 (0)	Reworded
New item: Multiple selves								New item.

Table 3. Qualitative comments for the CFT unique competencies.

Excluded CFT items	Qualitative comments to support exclusion.
Understand the human motivational system	<p>‘This item seems vague. Seems like it would lead to the introduction of error in its current form. Probably useful to include something like this, but would need to be much more precise’.</p> <p>‘this item is not very SMART as it reads currently’</p>
Theory of mind	<p>‘this question may be helpfully combined with the previous one regarding evolution’</p> <p>‘This feels important, but not sure exactly what is meant by "evolved theories of mind.’</p>
Distinguish between motives and emotions	<p>‘This doesn't add anything to what's already covered in 2.’</p> <p>‘I really don't think that I have ever seen any evidence that an intellectual understanding of the distinction between motives and emotions makes any difference in a psychotherapy outcome or is an active process variable in therapy’</p>
Inference chains and cognitions	<p>‘While I see thought-work (when appropriate) to sometimes be very important in CFT, this item is worded in a very classic CBT way ("thought change"), whereas I think CFT generally operates in a much more 3rd-wave form’</p> <p>‘facilitates rather than helps to guide? sentence seems too complex although I get what you are saying as previous’</p>
Cultivate and tolerate emotions	<p>‘Really important to have the toleration of affiliation emotions but again this additional note might be added to one of the items above’</p>
Breathing training, tone of voice and facial expressions.	<p>‘Very important but this again seems to have echoes in the above items’.</p> <p>‘There's a bit of an overlap with 5 (using techniques) and 6 (regulate threat)’</p>

Microskills

Table 4 provides a summary of the consensus ratings for the microskills and the amendments that were made to each item.

Excluded microskills

The microskill item (agenda 1) did not meet consensus and this item was excluded. However, the IEP in round three agreed that some parts should be merged with the ‘agenda 2’ competence to make this item more concise. This was in line with a number of the survey comments which are provided in Table 5. The IEP excluded two additional microskills in round three and these were ‘attuned and connected to client’s whole being’ and ‘notices and reflects on the process of therapy’. ‘Attuned and connected to client’s whole being’ was excluded because it was too difficult to operationalise. ‘Notices and reflects on the process of therapy’ was excluded because the skills of noticing and reflecting were included in other competencies in the scale. The qualitative comments to support this decision from the SEP are provided in Appendix J.

Microskill amendments

Table 4 shows that four item descriptions were not amended and these were ‘pacing’, ‘Socratic questioning’, ‘validates’, and ‘normalisation’.

‘Non-verbal communication’ was rated as ‘very important’ by all participants in the round two survey, but the SEP comments suggested that this item needed to be more specific and CFT focused. In round three the IEP decided to divide the ‘non-verbal communication’ competence into two separate competencies. One item focused on non-verbal communication as a generic therapy skill and the other item included specific CFT non-verbal skills.

General comments from the SEP suggested that a number of microskills should be merged together and in round three the IEP merged ‘paraphrases’ and ‘summarising’ into one competence. The descriptions for the items ‘verbal communication’, ‘agenda 2’, and ‘mentalisation’ were edited and reworded to increase clarity and specificity.

Table 4. Summary of results for the microskills in round two.

Microskills	Participant ratings of necessity of competencies (percentage)						Mean (standard deviation)	Amendments
	Very important	Important	Moderately important	Somewhat important	Not important	Consensus > 80%		
18.Non-verbal communication	100	0	0	0	0	100	5.00 (0)	Two items
19.Verbal communication	100	0	0	0	0	100	5.00 (0)	Reworded
20.Pacing	100	0	0	0	0	100	5.00 (0)	No changes
21.Socratic questioning	88.9	11.1	0	0	0	100	4.78 (0.46)	No changes
22.Agenda 1	33.3	44.4	11.1	11.1	0	77.7	4.11 (1.07)	Excluded
23.Agenda 2	55.6	44.4	0	0	0	100	4.44 (0.52)	Reworded
24.Paraphrases	88.9	11.1	0	0	0	100	4.89 (0.35)	Combined with 25
25.Summarising	66.7	33.3	0	0	0	100	4.67 (0.52)	Combined with 24
26.Validates	100	0	0	0	0	100	5.00 (0)	No changes
27.Normalisation	88.9	11.1	0	0	0	100	4.89 (0.35)	No changes
28.Mentalisation	77.8	22.2	0	0	0	100	4.78 (0.46)	Reworded
29.Attuned and connected to client's whole being	77.8	11.1	0	0	11	89	4.33 (1.75)	Excluded
30.Notices and reflects on the process of therapy	66.7	33.3	0	0	0	100	4.67 (0.51)	Excluded

Table 5. Qualitative comments for the excluded microskills

Excluded microskills	Qualitative comments to support exclusion.
Agenda 1	‘Some clients will benefit greatly from this, but I wouldn't say it's essential for all’. ‘Not as unique in CFT but remains important’
Attuned and connected to client's whole being	‘Not sure what this means. "Whole being"? I'd drop it’.
Notices and reflects on the process of therapy	‘these two sentences don't seem to go together well here - I agree with both but I don't think they are one in the same?’. ‘Clarification needed on the second sentence’.

3.3.2 Operationalising items

The Likert ratings for each competence are summarised in Table 6 and Table 7. The survey responses were reviewed in round five by the IEP. The amendments made to each competence are provided in Table 6 and Table 7. All items were inspected for grammatical or language errors and changed accordingly.

CFT unique competencies

No unique competencies reached consensus and all the unique items and the qualitative comments from the SEP were reviewed and discussed in the round five meeting with the IEP. Table 6 shows that ‘understanding the relationship between three-systems’ was not amended, but the remaining competencies were edited and refined.

Psychoeducation: In round four 62.5% ‘strongly agreed’ that ‘psycho-education’ was described and operationalised accurately (see Table 6). This item described the CFT psychoeducation linked to suffering and our evolved brain. The SEP panel suggested that the use of the word ‘harmful’ might not be in line with CFT language. This was not changed because the IEP agreed the word ‘harmful’ was appropriate to describe the behaviour/reactions caused by our evolved mind.

Formulation: Table 6 shows that 62.5% of the SEP ‘strongly agreed’ that ‘formulation links’ and ‘developing individualised formulation’ were accurately defined. The SEP suggested these two competencies overlapped and Appendix J provides these comments. In round five the IEP agreed to merge these competencies to generate one ‘formulation’ competence.

Building courage and motivation: Table 6 shows that 75% of the SEP ‘strongly agreed’ that ‘building courage and motivation’ was accurately described. The qualitative comments suggested that this item could be two items and that more of a focus on building courage to tolerate distress might be helpful (Appendix J). In the round five IEP meeting this competence was divided into two competencies which were ‘building

courage' and 'building motivation'. 'Building courage' was edited to include more emphasis on the therapist building courage to tolerate distress.

CFT techniques: Table 6 illustrates that 50% of the SEP 'strongly agreed' that 'CFT techniques' was accurately described. The SEP suggested that the title of this item should be changed to 'compassionate mind training' and this was changed in round five together with minor wording changes.

Cultivating and tolerating affiliative emotions: Table 6 shows that 71.4% 'strongly agreed' that 'cultivating and tolerating affiliative emotions' was accurately described and the qualitative comments suggested that the description was representative of the competence (Appendix J). During the round five meeting the IEP added an additional item that was titled 'cultivating and tolerating positive feelings in the drive system' and this competence described the therapist supporting the client to work with their drive system to cultivate positive emotions, such as excitement and pride.

Multiple selves: In round four 57.1% of the SEP 'strongly agreed' that the competence 'multiple selves' was accurately described and operationalised (Table 6). Content was added from the qualitative feedback provided by the SEP in round four and this was used to clarify the language used in this item.

Fear, blocks and resistance: Table 6 shows that 62.5% of the SEP 'strongly agreed' that 'fears, blocks and resistances' was accurately defined. This item was amended in the round five IEP meeting. Changes included adding content about the therapist recognising and addressing the client's fears, blocks and resistances to aid their recovery and to notice these fears as they arise in therapy (Appendix J).

Three-systems model: The three-systems model was included in three competencies and these were 'motives and emotions', 'recognising the three systems', and 'understanding the relationship between three-systems'. The qualitative comments generated by the SEP in round four suggested that these items seemed to overlap (Appendix J). During the round five meeting the IEP agreed that the titles and descriptions of these items

should be refined to address the issue of overlap. These items were changed to ‘recognising motives and emotions’, ‘actively working with the three systems’ and ‘understanding the relationship between three systems’.

Functional analysis: Table 6 specifies that 50% of the SEP ‘strongly agreed’ that the item ‘functional analysis’ was described and operationalised accurately. Appendix J provides a summary of the qualitative feedback from the SEP in round four. The IEP in round five changed the content and language for this competence, including changing ‘behaviour’ to ‘strategies’ and added in ‘formulation links’.

Unconscious emotions and processes: Table 6 shows that 62.5% of the SEP in round four ‘strongly agreed’ that ‘unconscious emotions and processes’ was accurately defined. The qualitative comments by the SEP suggested that this competence needed to be more clearly defined (Appendix J). The round five IEP meeting made several amendments based on these comments.

Table 6. Summary of results for the CFT unique competencies in round two.

CFT unique competencies	Participants level of agreement regarding how accurately each competence was defined (percentage).					Statistics	Amendments
	Strongly agree	Agree	Somewhat agree	Disagree	Strongly disagree	Mean (standard deviation)	Edits made.
1.Psychoeducation	62.5	12.5	25.0	0	0	4.38 (0.98)	Edited: description.
2.Motives and emotions	75.0	25.0	0	0	0	4.75 (0.38)	Edited: title/description.
3.Recognising the three-systems	62.5	37.5	0	0	0	4.63 (0.49)	Edited: title/ least competent anchor.
4.CFT techniques	50.0	37.5	12.5	0	0	4.38 (0.79)	Edited: title/ most competent anchor.
5.Understanding the relationship between three-systems	62.5	25.0	12.5	0	0	4.5 (0.79)	No edits, changed items structure in the scale.
6.Building motivation and courage	75.0	12.5	12.5	0	0	4.63 (0.76)	Separated into two items.
7.Cultivating and tolerating affiliative emotions	71.4	28.6	0	0	0	4.71 (0.41)	Edited: points to consider. New item added.
8.Functional analysis	50.0	25.0	25.0	0	0	4.25 (0.95)	Edited: points to consider/ Most competent anchor.
9.Fears, blocks and resistances	62.5	25.0	12.5	0	0	4.50 (0.79)	Edited: description/ points to consider/ most competent anchor.
10.Unconscious emotions and processes	62.5	25.0	12.5	0	0	4.50 (0.79)	Edited: item description/ points to consider/ most competent.
11.Formulation links	62.5	25.0	12.5	0	0	4.50 (0.79)	Item merged with item 12.
12.Developing individualised formulation	62.5	37.5	0	0	0	4.63 (0.49)	Item merged with item 11.
13.Multiple selves	57.1	42.9	0	0	0	4.57 (0.52)	Edited: points to consider.

Microskills

Non-verbal communication: Table 7 shows that ‘non-verbal communication’ met consensus, but the competence ‘CFT principles and non-verbal communication’ did not meet consensus and only 42.9% of the SEP in round four ‘strongly agreed’ that this was accurately defined. A number of qualitative comments from the SEP suggested that these two competencies should be merged together because they overlapped (Appendix K). This issue was discussed in the round five meeting and the titles of these items were changed to ‘non-verbal communication to build rapport’ and ‘non-verbal communication and motivational/emotional systems’.

Agenda setting: Table 7 shows that 37.5% of the SEP in round four ‘strongly agreed’ that ‘agenda setting’ was accurately defined and operationalised. There was only one comment about this item from the SEP and this made it difficult to interpret this low score or to make amendments. Therefore in the round five IEP meeting this item was not amended.

Paraphrasing and summaries: Table 7 shows that 50% of the SEP ‘strongly agreed’ the consensus level for ‘paraphrasing and summaries’ was accurate. The qualitative comments suggested that this skill could be linked to formulation and the CFT model (Appendix K). These comments were used to make amendments to the scale in the round five IEP meeting.

Socratic questioning: ‘Socratic questioning’ reached a 75% consensus level in round four (Table 7). One comment from the SEP highlighted that open and closed questions should be specified and this was added to the scale in the round five meeting with the IEP.

Mentalisation: Table 7 shows that 42.9% of the SEP in round four ‘strongly agreed’ that ‘mentalisation’ was accurately described and operationalised. The SEP comments suggested that this item required a description of ‘mentalisation’ and perspective taking needed to be clarified. These comments were used to amend this item in the round five meeting.

Table 7. Summary of results for the microskills in round two.

Microskills	Participants level of agreement regarding how accurately each competence was defined (percentage).					Statistics		Amendments
	Strongly agree	Agree	Somewhat agree	Disagree	Strongly disagree	Mean (standard deviation)	Median	Edits made
14. Non-verbal communication	87.5	0	0	0	12.5	4.50 (1.51)	5.00	Met consensus, but title defined to distinguish from item 15.
15. CFT principles and non-verbal communication	42.9	28.6	0	14.3	12.5	43.71 (1.6)	4.00	Edited: title/description/ most competent anchor.
16. Verbal communication	87.5	12.5	0	0	14.3	5.00 (0)	5.00	Met consensus.
17. Pacing	62.5	37.5	0	0	0	4.63 (0.53)	5.00	Edited: least competent anchor.
18. Socratic questioning	75.0	12.5	12.5	0	0	4.63 (0.79)	5.00	Edited: points to consider
19. Paraphrasing and summaries	50.0	25.0	12.5	12.5	0	4.13 (1.46)	5.00	Edited: points to consider.
20. Agenda setting	37.5	50.0	0	12.5	0	4.00 (1.41)	4.00	No edits.
21. Validation	50.0	37.5	0	12.5	0	4.13 (1.46)	5.00	Merged with item 22.
22. Normalisation	62.5	37.5	0	0	0	4.63 (0.49)	5.00	Merged with item 21.
23. Mentalisation	42.9	28.6	28.6	0	0	4.17 (0.98)	4.50	All parts edited.

4. Discussion

The aims of the current study were to generate the competence items and their behavioural anchors necessary for inclusion in a CFT therapist competence scale. Eleven participants with expertise in CFT contributed to the development of this scale over five rounds. A meeting with the IEP was used to draft the initial items in round

one. In round two an online survey was sent to gather consensus ratings and opinions from experts, which resulted in seven items being excluded. Round three involved defining the behavioural anchors in a meeting with the IEP. Online surveys were sent out in round four. An 80% criterion was applied to the ratings and the qualitative comments were analysed using a content analysis. Two items met consensus and the remaining 21 competencies were refined. Round five involved the IEP reviewing the survey responses. Final amendments were made and the final scale comprised 23 competencies and these were separated into 14 unique CFT competencies and 9 generic microskills. This is the first study that has attempted to reach consensus regarding the CFT competencies required for a CFT therapist competence scale.

The primary aims of this study were met. The CFT-TRS has provided the necessary competencies that a group of experts consider to be essential for the delivery of CFT. The consensus approach adopted for this study is considered a heuristic technique (Hasson *et al.*, 2000), therefore the findings are developed during a process of discussion, debate and decision-making. This inevitably produced differences in opinion.

4.1 Summary of findings

4.1.1 Scale overview

The modified Delphi method has been widely and successfully used to generate competencies using a panel of experts over a number of rounds (Barksy & Coleman, 2001; Bennett & Parry, 2004; Cooper *et al.*, 2015; Green *et al.*, 2002; Lakeman, 2010; Liddell *et al.*, 2016; McIntyre-Hite, 2016; Morrison & Barratt, 2010; Sburlati *et al.*, 2011; Sunderji *et al.*, 2016; Williams & Haverkamp, 2010). However the unique methodology used in the present study has not been reported in previous research developing therapist competency scales. Previous studies have usually paid less attention to the development of the competencies and have focused on testing the scales psychometric properties (Blackburn *et al.*, 2001; Chevron & Rounsaville, 1983; Ogrodniczuk & Piper, 1999; Paivio, *et al.*, 2004; Vallis *et al.*, 1986; Young & Beck,

1980). Whereas the current study focused on generating and operationalising the competencies in preparation for assessing the psychometric properties in a future study.

The current study has built on the CFT framework developed by Liddell *et al.* (2016). This framework provided an extensive list of CFT competencies, however the framework was not intended to measure therapist competence and the items were not clearly operationalised. A limitation of this framework was the lack of reference to motivational systems, which is suggested to be a key component of CFT (Gilbert, 2014). The current study has used the expert's knowledge and experience of CFT literature and theory to produce a 23-item therapist competence scale that is specific, measurable and evidence-based. The CFT-TRS is strongly influenced by CFT literature on motivation systems and appears to cover the essential elements of CFT.

4.1.2 CFT unique competencies

There were fourteen CFT unique therapy skills that were identified as essential for the CFT-TRS.

Consensus levels for round two

The current study found that there was high agreement amongst the included and excluded unique CFT competencies in round two. This high level of agreement will likely increase the content validity of the scale and this will be beneficial when the scale is psychometrically tested for validity and reliability. This might help to address criticisms of previous therapist competence scales that they lack validity and do not measure what they purport to measure (Fairburn & Cooper, 2011). Experts practicing in the same treatment modality tend to have high agreement on the core components of that therapy, as cited by Roth (2015) who found that therapists endorsed unique competencies from their own practicing therapy and never identified competencies that were uncharacteristic of their therapy.

Consensus levels for round four

An iterative process was used to gradually improve and refine the scale and a number of experts provided comments highlighting their satisfaction with these improvements. However, the experts had differing opinions regarding the content and behavioural anchors of some of the competencies. This is not surprising given the experts differences in training, theoretical orientations and the range of psychological problems they work with (Lichtenberg *et al.*, 2007). Reaching agreement about the key elements of competencies is a common issue within professional psychology and when a therapist competence scale is not defined or operationalised sufficiently it can result in poor inter-rater reliability (Muse & McManus, 2013). However an iterative process can often improve the development of therapist competence scales (Roth, 2016).

Competencies with higher agreement

Psychoeducation

‘Psychoeducation’ was described as a key part of a CFT intervention and a core CFT therapist skill. This competence described the therapist’s ability to demonstrate an understanding of the key CFT psychoeducation concepts. There were some differences in opinion about the use of the word ‘harmful’ behaviours/reactions in the description. However, the term ‘harmful’ was in line with Gilbert (2009a; 2014; 2016) whom described suffering being due to the problems with our evolved brain (‘tricky brain’) and the ‘harmful’ nature of our evolved social motivational systems and emotional systems, and these systems can get played out/cultivated in people’s patterns of experiences and emotional memories (their emotional, cognitive, motivational and behavioural patterns). The ‘psychoeducation’ element was highlighted in the CFT framework under the competence ‘accessibly introduces understanding of the model as it relates to the client’ (Liddell *et al.*, 2016).

Formulation

The two ‘formulation’ unique competencies included in the initial draft was condensed down to form one ‘formulation’ competence. This competence included elements that were specific to CFT formulation skills, such as the ‘unintended consequences’ and

‘safety strategies’ of behaviours (Gilbert & Procter, 2006). Formulation skills are an essential feature of all psychotherapies and are featured in other therapist competence scales including CAT (Bennett & Parry, 2004), CBT (Barber *et al.*, 2003; Blackburn *et al.*, 2001) and CBT for children and adolescence (Stallard *et al.*, 2014).

Building Courage and Motivation

In the round five IEP meeting the competence ‘building courage and motivation’ was divided into two competencies and these were ‘building courage’ and ‘building motivation’.

Building Courage

‘Building courage’ described the therapist’s ability to help the client build courage to tolerate and work with suffering. This item was amended in round five based on the SEP comments to include more focus on the therapist helping the client develop the courage to tolerate distress. Having the courage to tolerate distress are key features in CFT (Cree, 2010; Gilbert, 2009a; Gumley & MacBeth, 2014; Kolts, 2016; Mayhew, 2015). Building courage to work with suffering using the compassionate mind is supported by neuroscience. For example, in a study by Kim *et al.* (2009) a compassionate attitude triggered feelings of intrinsic reward in participants. Courage to tolerate distress has been important within other therapies, including dialectical behavioural therapy (DBT) (Linehan, 1993a; 1993b).

Building Motivation

The competence ‘building motivation’ was defined as the therapist helping a client to build their compassionate motivational system to build compassion for themselves and others. Motivation has been described as the building block for other compassionate attributes and this has been noted in a study focusing on building compassionate care (Cole-King & Gilbert, 2011). Motivation has not tended to feature as a therapist competence in other psychotherapies, however CBT approaches have discussed ‘motivation for change’ and they described this being a prerequisite for successful therapy outcomes (Simmons & Griffiths, 2014, pp.172-180),

CFT Techniques

The competence identified as ‘CFT techniques’ in the first round was changed to ‘compassionate mind training’ in the final round. This competence focused on the therapist helping the client train their soothing system by using specific techniques, including soothing rhythm breathing, body posture exercises, voice tone, facial expressions and compassion-focused imagery. The compassion-focused imagery is used to stimulate the soothing system that is linked to social affiliation, care and wellbeing (Gilbert, 2009b). The CMT competence maps onto other therapies, including CBT breathing training (O’Donogue *et al.*, 2004, pp.59-64), DBT (Linehan, 1993b) and mindfulness practices (Feldman *et al.*, 2010). Similar items have been used in other therapist competence scales, such as ACT ‘present moment’ competence (Strosahl *et al.*, 2004; Walser *et al.*, 2013) and the mindfulness-based teaching assessment, ‘guiding mindfulness practices’ competence (Crane *et al.*, 2013).

Cultivating and Tolerating Affiliative Emotions

The competence ‘cultivating and tolerating affiliative emotions’ described the therapist supporting the client to cultivate and engage their capacities for affiliative emotions, to help the client tolerate and manage their distress and suffering (Gilbert, 2009a; Gilbert, 2015b). This is in line with previous research describing the important role affiliative emotions and affiliative connections play in regulating the threat system (Gilbert *et al.*, 2008; Siegel, 2012, pp.267-306). This item was edited in round five to include more of a focus on distress tolerance of emotional difficulties and this maps on to similar competencies of ‘affect focus’ and ‘regulation of arousal’ for MBT (Karterud *et al.*, 2013).

Cultivating and Tolerating Positive Emotions in The Drive System

‘Cultivating and tolerating positive emotions in the drive system’ was added in the final round, but no feedback from participants was generated. This competence described the therapist helping the client work with their drive system to cultivate and tolerate feelings of pleasure and excitement, and behaviours of approach and engagement. This is supported by research that has noted that the drive system is mediated by

dopaminergic (Depue & Morrone-Strupinsky, 2005), but this competence has not been identified in other psychotherapies and this suggests it is unique to CFT.

Multiple Selves

‘Multiple selves’ was added in round three based on the expert’s recommendations. The ‘multiple selves’ practice is based on an understanding that the different motivational systems can interact, compete and suppress each other (Gilbert, 2015a). ‘Multiple selves’ involves the therapist supporting the client to engage with their different emotional states (for example, anxious-self, angry-self or sad-self) and the client is supported to shift into their compassionate-self to work with the different emotional state (Kolts, 2016). This competence relates to a specific component of therapy, which is similar to the ‘phase specific’ competencies identified in the study by Liddell *et al.* (2016).

Fears, Blocks and Resistances

The ‘fears, blocks and resistances’ competence described therapists helping the client work with fears and blocks to compassion, motivations or feelings. This has been reported by Gilbert *et al.* (2011) who suggested that individuals high in shame and self-criticism can be fearful of positive emotions, compassion from or for others and self-compassion. This idea of ‘resistances’ has been covered in the Yale adherence and competence scale for substance use in the competence ‘resistance to twelve step facilitation’ (Carroll *et al.*, 2000).

Competencies with differences in opinion

Affect Regulation Systems

Three competencies described the CFT affect regulation systems and there were differences in opinion about these overlapping. To decrease overlap their title descriptions were changed in the round five IEP meeting. One emphasised understanding and was named ‘recognising motives and emotions’, the other described identifying when the client was in a particular system and was named ‘actively working

with the three-systems’, and the other focused on the interplay and relationship between the systems and was titled ‘understanding the relationship between three systems’. These competencies described the therapist being able to help the client develop knowledge and skills to work with their threat-protective system, their drive and reward system, and their contentment-soothing system. This model was described widely in the CFT literature and was supported by the neuroscience research that has shown there are three regulation systems that can regulate affect and alleviate suffering (Depue & Morrone-Strupinsky, 2005; Gilbert, 2015). However, the difference in opinion about these competencies overlapping seemed to suggest that experts included in the study might use the three-systems model differently. This might be explained by the different client groups they worked with, for example eating disorders might have a larger focus on the competitive-drive system (Goss & Allan, 2014), whereas psychosis might have more focus on the threat system (Braehler *et al.*, 2013). These competencies are in line with the competence ‘facilitates client to use techniques to regulate affect by building up soothing system and bringing three systems into balance’ from the CFT framework (Liddell *et al.*, 2016).

Functional Analysis

A number of experts had different opinions about whether this item was a separate competence or whether it overlapped with the ‘formulation’ competence. ‘Functional analysis’ described the therapist’s skill in supporting the client to functionally analyse the forms and functions of their safety strategies. However, in CFT conceptualising shame and self-criticism are noted as forms and functions of safety strategies and these have implications for formulation (Gilbert & Procter, 2006) and this suggests that functionally analysing forms and functions of safety strategies may have links with formulation. This competence has similarities to the CBT competence identified by Roth and Pilling (2007) of ‘identifying and working with safety behaviours’.

Unconscious Emotions and Processes

There were differences in opinion about ‘unconscious emotions and processes’ and whether this item was specific to CFT. This competence links with the idea in CFT of helping a client reveal unconscious conflicts and exploring their fear of expressing

emotions (Gilbert, 2009a). This has been noted by Gilbert *et al.* (2014) who reported that individuals with depression were more likely to avoid feelings of sadness. Here there was considerable overlap with other therapies, including MBT competencies ('use of countertransference' and 'transference and the relation to the therapist') (Karterud *et al.*, 2013), CAT competence ('assimilation of warded-off, problematic stress and emotions') (Bennett & Parry, 2004) and the 'ability to work with the counter-transference' competence identified for psychodynamic therapies (Lemma *et al.*, 2008). This overlap with other therapies might explain some of the difference in opinion about whether this item was essential for a CFT approach.

4.1.3 Microskills

There were nine microskills identified for inclusion in this scale and these are designed to assess general therapy skills and are essential for establishing and building rapport. Experts were encouraged to operationalise these using CFT terms. Consensus was high in round two. The microskills generated less qualitative feedback and less disagreement compared to the CFT unique skills. Experts often have higher levels of agreement on generic therapeutic competencies that are applicable to all psychotherapies (Morrison & Barratt, 2010).

Verbal Communication

'Verbal communication' reached high consensus throughout the study. Verbal communication covered important CFT concepts, including 'de-shaming', 'common humanity', 'uncommon humanity' and 'not your fault, but your responsibility' (Gilbert, 2009; Neff, 2003; 2011).

Microskills with Differences in Opinion

Non-verbal Communication

In the round three IEP meeting an additional non-verbal communication competence was added, but the SEP had differences in opinion about whether these items

overlapped. To decrease overlap their title descriptions were amended in the round five IEP meeting and one focused on building rapport and was named ‘non-verbal communication to build rapport’ and the other described the use of non-verbal communication to work with the three-systems to build the compassionate mind and was named ‘non-verbal communication and motivational/emotional systems’. Non-verbal communication such as voice tone, body posture and facial expression are reported widely in the CFT literature (Gilbert, 2007, pp.106-142; Gilbert & Irons, 2015, pp.127-139; Welford, 2016, pp.133-150). The competence non-verbal communication was referred to in the revised cognitive therapy scale (Blackburn *et al.*, 2001) but it was not a separate competence and it was not identified in the CFT framework (Liddell *et al.*, 2016).

Mentalisation

There were differences in opinion about the content included in the ‘mentalisation’ competence and whether this competence should be included in the unique skills or the microskills. This competence was refined and changed in the round five IEP meeting to a greater extent than other microskills because of the differences in opinion. This competence described the therapist helping the client to develop mentalisation skills and these are described as the higher order competencies that enable humans to infer and think about the mental states of self and others (Liotti & Gilbert, 2011). This competence maps onto the competencies defined in the MBT therapist competence scale including ‘adaptation to mentalising capacity’, ‘acknowledging positive mentalising’, and ‘stimulating mentalisation through the process’. ‘Mentalisation’ was identified in the Gilbert and Wood unpublished therapy assessment guide.

Agenda Setting

There were differences in opinion about whether ‘agenda setting’ was a standard part of a CFT session. During the IEP meetings being competent in ‘agenda setting’ was described as an essential skill for a CFT therapist on the CFT diploma courses, but other experts implied that it might not be essential. In a case illustration of CFT for brain injury ‘agenda setting’ was an important element (Ashworth *et al.*, 2011). ‘Agenda setting’ is an important part of CBT and is an essential competence in CBT therapist

competence scales (Blackburn *et al.*, 2001; Vallis *et al.*, 1986; Young & Beck, 1980). Therefore this item remained on the scale as being necessary for delivering CFT.

Miscellaneous

There were some concerns that the microskill competencies replicated the CTS. This was an important point because a number of the microskill competencies mapped on to the CTS (Young & Beck, 1980). This is perhaps not surprising given that CFT is a multimodal approach that has been developed from other approaches including CBT. The competencies that mapped onto a CBT therapist rating scale included, 'agenda setting', 'pacing', 'guided discovery' and 'verbal' and 'non-verbal communication'. However, an important distinction is that a CBT approach is focused on tracking cognitions, whereas a CFT approach also tracks the motives and searches for patterns of experience and emotional memory. For example, a therapist using Socratic questioning to track a motive in CFT will involve a different process to a therapist tracking a cognition in CBT. Despite the potential overlap with a CBT scale, these skills were agreed as essential for a CFT session and they seem essential for relationship building. This supports the current evidence regarding therapeutic relationship being a key ingredient for change and positive therapy outcomes (Ackerman & Hilsenroth, 2001; 2003).

4.2. Strengths and limitations

This is the first study to operationalise the unique and generic competencies required to deliver CFT. This research provides a comprehensive understanding of the active and behavioural components of a CFT intervention. A strength of the research was the adapted Delphi method that allowed for flexibility. The research attempted to increase rigour by gathering data over five rounds, which included approximately 16 hours of face-to-face meetings with the IEP and two survey rounds that generated quantitative and qualitative data. The combination of quantitative and qualitative data may have improved the validation of answers and helped to develop ideas. The highly-experienced panel of CFT experts should have ensured content validity was high and their knowledge would have been drawn from clinical experience, research, systematic

reviews and personal experience (Goodman, 1987). The anonymity of the online survey facilitated ideas that were unbiased by other experts and this decreased subject bias because the experts remained anonymous to each other (Goodman, 1987). The online surveys enabled a geographically dispersed group of experts to participate in the study. A further strength was the low attrition rate and only one participant did not complete the survey in the fourth round.

The main limitation of this study was the small sample size, however the number of experts meeting the threshold for inclusion was limited. The study wanted to maintain the higher expertise of participants rather than have a broader range of participants with less expertise. Smaller sample sizes have been used in Delphi studies when experts have similar training and a real understanding in the field of interest (Akins *et al.*, 2005). The generalisations that can be made are limited because a different CFT panel may reach different conclusions. A disadvantage of using online surveys was the lack of richness and depth that might have been obtained from a focus group (Iqbal & Pison-Young, 2009). The IEP meetings were conducted face-to-face and this was helpful to discuss and explore ideas, however the IEP views might have been more heavily weighted in the decisions because of the exploration and discussion involved in gathering this data. The current study relied on experts to generate and develop competencies, whereas it might have been beneficial to identify these from live or recorded therapy sessions. This might have ensured the competencies were clearly observable and measurable in practice. However, a future study aims to evaluate the psychometric properties of this scale and further refinements could be made.

4.3. Clinical Implications

The CFT-TRS has provided the necessary competencies required for a therapist to competently deliver CFT. This scale has uses for clinical practice, training and research.

Clinical practice

This study adds to existing literature on CFT theory and the components required to deliver a CFT intervention (Gilbert, 2009; 2014). The unique CFT competencies

included in the scale were all supported by CFT literature and it was informed by 11 highly experienced CFT experts. Other therapist competence scales have been less clinically useful because they have been designed to measure treatment integrity in clinical trials, and often competencies have been drawn from treatment manuals. However, the CFT-TRS is more applicable to clinical settings and has included the views of clinicians who work in a range of clinical settings. The scale was developed to work with different clinical presentations, therefore the scale is applicable for use in a range of settings. It can offer guidance to clinicians about delivering a CFT intervention or could be used as a tool to assess current CFT competence. This scale could be used by practitioners delivering CFT and their supervisors to assess their current level of competence and to highlight areas a therapist may need to develop (Sharpless & Barber, 2009).

Uses in training

The CFT-TRS provides a concise, useable and practical scale and would be a useful tool to assess therapist competence during therapy sessions for the CFT Diploma courses and provide consistency across courses. The CFT-TRS might be used by trainee CFT therapists and their assessors to highlight areas of development. This can influence collaborative learning when the therapist and assessor evaluate the competencies jointly. It can provide trainees with clear behavioural indicators about how CFT is delivered competently which might aid learning and professional development. The CFT-TRS can be used throughout a CFT training course to map out therapist's development and progression.

Uses in research

Treatment fidelity measures are important for use in outcome studies because they assess whether treatment has been delivered as intended and increase the likeliness of valid conclusions being drawn (Perepletchikova *et al.*, 2009). The current CFT outcome studies have not assessed treatment fidelity because no measure currently exists. This has limited the current CFT evidence base and has been a criticism of current CFT

outcome studies (Leaviss & Uttley, 2015). Therefore, the CFT-TRS could be an appropriate scale to assess treatment fidelity.

4.4. Future research

The next stage required to develop the CFT-TRS would be to understand and evaluate the psychometric properties. This would require establishing whether the scale could be reliably and validly used to observe and evaluate CFT sessions. This is in line with previous studies that have assessed the psychometric properties of therapist competence scales (Bennett & Parry, 2004; Blackburn *et al.*, 2001; Chevron & Rounsaville, 1983; Ogrodniczuk & Piper, 1999; Paivio *et al.*, 2004). The most common approach has been for experts to use the scale to rate recorded therapy sessions (Bennett & Parry, 2004). This method has involved a number of experts rating a large number of live recorded sessions to establish reliability and validity. Experts would be required to jointly rate sessions to establish inter-rater agreement and item consistency. Validity assessments could involve testing the current scale alongside an established therapist competence scale or therapeutic alliance scale that measures similar constructs. The validity needs to be established to provide a total score, and a threshold score for judging the session to have been delivered sufficiently (Fairburn & Cooper, 2011). Once the psychometric properties are established the CFT-TRS would be suitable for use within research, service evaluation and audit.

In addition, training would be helpful prior to using this measure. Barber *et al.* (2007) reported that training can address issues with inter-rater reliability because it helps to standardise interpretations of the competencies. It would be useful to obtain feedback from the current experts on the amendments made in the final round. Feedback from CFT experts not included in the study would help to check validity of the included competencies.

4.5. Conclusion

The current study drafted the therapist competencies thought to be essential for the effective delivery of a CFT intervention. This scale was amended using online surveys

and face-to-face meetings with experts in CFT. There was high agreement about the included unique and generic competencies. Differences in opinion between experts were focused on the content of items and item overlap. Each round aimed to improve and develop the scale based on expert's feedback. A strength of this research had been the flexible methodology incorporating quantitative and qualitative feedback using several rounds with highly experienced CFT experts. The unique CFT competencies were heavily supported by the evidence-base and they included the distinct and essential elements of CFT. The microskill competencies contained distinct features relevant for CFT, but had significant overlap with CBT, mentalisation and CAT scales. This overlap was expected and supports the evidence on therapeutic rapport being key in all therapies. This scale has several implications for clinicians, supervisors, training courses, audit, service evaluation and research. The scale can be used as a learning guide for delivering CFT, to assess therapist competence for CFT training courses or clinical practice, and to assess fidelity in research trials. Future research is required to understand and evaluate the psychometric properties of this scale.

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Critical Appraisal

1. Research process

1.1 Project selection

My interest in this project started prior to training when I worked as an assistant psychologist and developed an interest in compassion-focused therapy (CFT). I completed a three-day training course and started to use some of the principles during my therapeutic work with female clients on a forensic ward. I was drawn to this area for my doctoral research and was very keen to pursue this research when it was suggested. The additional focus on therapeutic competencies enhanced my interest further because I hoped it would increase my knowledge and understanding about delivering CFT and therapies more generally. Investigating therapist competence seemed pertinent given the current climate regarding 'evidence base' practice and competency based training programmes (Kaslow, 2004). Therapist competence scales also fitted with my own experience as a trainee clinical psychologist and having my therapy skills formally assessed using a therapist rating scale. I feel there were advantages choosing a research project that I had interest in, that fitted with my current training experience and had a focus on CFT.

1.2 Peer review and ethics

The initial idea for this research project was to develop and validate a CFT therapist competence scale. The initial proposal was quite comprehensive and I had not given thought to the amount of work required to develop a scale. This proposal was reviewed by the university and feedback highlighted the high amount of work involved in a short time frame. During supervision with my academic supervisor we discussed making changes to my research project. The aim changed to focus on developing the candidate items and the behavioural indicators for a CFT therapist competence scale. There were a few methodological changes made, including using online surveys instead of focus groups, adding an additional member to the independent expert panel and participant sample included CFT experts with extensive knowledge and training in CFT.

One of the challenges I faced planning the methodology for this project was the small amount of previous research studies that detailed how therapist competence scales had been developed. Many studies provided only brief descriptions of how the items were generated, and their focus had been to validate the scale. Previous scales had often generated items directly from therapy manuals or used expert opinion. However, one of the research papers that provided a more detailed description of the process to generate competence items was the cognitive analytical therapy scale (Bennett & Parry, 2004). This study helped to guide some of the ideas for the current research project. I felt that the rigorous process involved in the current study and the Bennett and Parry study has not been commonly used to generate the competence items or behavioural indicators.

The next stage involved applying for ethical approval. There were several changes being made to the ethical process and there was confusion about what approvals were required. This process took much longer than anticipated due to the wider organisational changes that were happening. However, it was eventually decided that the application should go through university ethics and this was a quick and smooth process and no further amendments were required.

1.3. Developing the draft scale

The first stage of the research project involved a full day meeting with the independent expert panel (IEP). This day was extremely productive, thought provoking and inspirational. I came away with the initial draft of the CFT scale, but I also came away with a greater understanding about CFT and my interest in this approach was sparked further. This initial stage started well in advance and I was feeling optimistic about the process.

1.4. Recruitment

The recruitment of participants had been somewhat out of my control. The participants were contacted by one of the IEP and if they were interested I sent an email containing details about the study. I was aware of some of the shortcomings of the Delphi method, including the study being heavily dependent on the continued commitment of the participants and the time required to commit to the iterative process. The research on

Delphi methods also highlights that having direct contact with the participants influences the response rate and I was aware that all my contact was going to be by email. One of the initial challenges had been getting the consent forms back from participants and this process took a lot longer than anticipated. I was aware that I only had a small pool of participants that met the inclusion criteria and this part of the study was quite anxiety provoking. If I was to use this methodology again in the future I would ensure that the first round involved face to face contact to avoid these difficulties.

1.5. Survey development

Round two survey

There was a long gap between round one (developing the draft CFT scale) and designing the survey for round two. Therefore, I had to revisit the audio recordings and my notes from the meeting in round one to familiarise myself with the material. There was a lot of information to process from the first round and I had to spend some time thinking about the most pertinent questions and information that I required from the participants. I made the decision to present each competence as a question. I was aware that I needed to obtain quite a lot of information, including ratings about how important each competence was for inclusion in a CFT therapist rating scale, recommendations for changes to the description and comments about how each item could be observed and measured in practice. I tried to increase the response rate by sending out regular email reminders. I was conscious of the work pressures of participants and felt cautious about adding to that. However, the time taken to receive all responses back was a lot longer than I had planned for and this felt out of my control. I felt pressure to wait for the surveys back due to the small sample size and I wanted to ensure that as many CFT experts contributed to the scale. On reflection, I think I could have increased response rates by setting a clear deadline when I sent out the survey. I felt that perhaps I had not fully briefed the participants about the amount of work I was asking them to complete in this initial stage, so maybe their responses took longer to complete. This was perhaps because I had assumed there would be less competencies in the initial draft of the scale.

This process taught me that in the future I should fully inform participants about the level of commitment required. If conducting research using stages I would ensure there are smaller gaps between rounds and set clear deadlines for the material to be returned.

Round four survey

I was able to put some of my learning into practice during the round four survey. The survey in round four was much shorter and I set a clear deadline from the start. I sent out weekly reminders and I felt that the ongoing email contact with some of the participants helped increase their response times. The length of time between rounds three and four was shortened to only a few days, I feel this helped to keep the momentum of the study going. I ensured that I sent updates to all participants about the study and informed them about the changes that had been made to the scale after their feedback had been analysed. I received most of the responses back within three weeks. However, I encountered some technical difficulties trying to receive one of the responses back. At this point I was feeling a lot of anxiety about meeting the deadline on time and being able to complete the analysis to a good enough standard. However, I was able to work through this issue by having regular email contact with the participant, contacting my academic supervisor and exploring other options to complete the survey. There were some challenges using online surveys for a Doctoral research project because I feel that that this approach does not fit well with the time pressures and deadlines that have to be abided by for the course. However, I think if this project was completed with flexible deadlines it would have been more enjoyable. I think some of the advantages of this approach was having the rare opportunity to learn and gain knowledge about CFT from experts with extensive knowledge and experience.

1.6.Delphi methodology

I was aware of some of the disadvantages of using a Delphi methodology. I had very little awareness about this methodology prior to commencing this research project, so this encouraged me to try and gain more understanding about how this approach had been used to develop psychological scales. An advantage of this approach was conducting the research without the need to bring experts together, so there was the

opportunity to recruit participants from other countries. The flexibility of this approach was beneficial, but this approach has been criticised for lack of methodological rigour. To add rigour to this approach I attempted to add precision by using 80% consensus criterion, completing content analysis to manage and structure feedback, I maintained anonymity between survey participants and gave participants feedback about their comments and the research process when necessary. At times the lack of clear guidelines about implementing this method was anxiety provoking and I would often re-read papers to ensure that I was on the right track.

1.7. Analysis

I defined the consensus level for both surveys at 80%. In the first survey each competence had to have at least 80% agreement as 'important' or 'very important'. In the second survey items had to reach 80% endorsement as 'strongly agree'. I made my decision for a higher consensus level based on the small sample size and there only being a single panel of experts. I made the criteria stricter in the second survey because there was one less participant and I wanted to focus more on editing and tightening the scale. For some items the consensus levels had been rather variable. In the first survey the consensus levels were quite high and some items were only just below the 80% cut-off. The qualitative comments and the comments from the IEP helped to validate the exclusion of items that had not met the 80% consensus. The qualitative aspect of the research helped to keep me on track and helped to provide justifications for including and excluding items.

I had previous experience conducting qualitative analysis, including interpretive phenomenological analysis and thematic analysis. However, I had never analysed written material from surveys. I had a dilemma about what method of qualitative analysis I was going to use. I investigated content analysis and thematic analysis and felt that content analysis would be most useful for the type of data I had. My rationale was based on content analysis being suitable for the simple reporting of common issues in written data and the analysis was required to validate participant's ratings and inform subsequent rounds. The initial process of sorting through the data was quite time-consuming because there had been a lot more comments than I had anticipated.

However, once the headings had been organised the data appeared much less overwhelming.

A disadvantage analysing data generated from a survey was being unable to query answers and this felt quite frustrating at times. Although there were certain advantages about recruiting participants who did not have to physically meet, I sometimes wondered about the advantages a focus group might have had on the development of the scale. I felt that the data was missing a certain level of depth and richness that a focus group could provide. It might have allowed for further exploration of the agreements and disagreements. I tried to immerse myself into the data, but it was difficult because the data was broken up into the different competencies and headings

1.8. Defining competencies for the scale

One of the challenges developing the scale was the different range of opinions generated by the experts. At times this process felt overwhelming and not straightforward. One of the challenges was analysing data for a CFT scale without the expert knowledge and this left me feeling completely reliant on the expert panel to generate all the data for this scale. I often felt a lack of control during parts of this research project and at times this felt difficult to manage. However, during each round I received some positive feedback about the amendments to the scale and this helped me to feel like I was on the right track. The face-to-face meetings with the IEP were paramount. They were productive meetings in terms of their aims, but they also alleviated some of my anxieties about the competencies and the different opinions. For example, they reassured me that I was on the right track and they helped to validate and add reason to the decisions that were made. The face-to-face element also provided human contact and verbal communication, which allowed for ideas to be explored and debated in a productive way. These elements were all missing from the surveys, however I think it was helpful to have experience of both methods. I felt that they complemented each other, they both acted to validate one another and each round met its aim to develop the scale further.

At times developing a therapist competence scale went against some of the values and ideas that I had about therapy. I sometimes worried that therapy is moving more and more toward a manualised, rigid and standardised approach and I wondered whether this scale might contribute toward that movement. However, an intervention informed by CFT was not designed to be a fixed and rigid approach, rather it is a more fluid, multimodal framework designed to work with a range of difficulties. This helped to alleviate some of my concerns. I can see the usefulness and advantages of therapist competence scales in terms of helping to ensure that CFT therapists are delivering CFT effectively and their role in developing research studies for scientific CFT evidence. However, I am also aware of some of the disadvantages of using these scales in practice, including the mixed evidence regarding the relationship between therapist competence and treatment outcome (Webb *et al.*, 2010), the issues regarding measuring client sessions (different client difficulties, number of sessions to rate to establish competence) and the influence of therapeutic alliance on therapy outcomes. During my reading around this area I did come across the benefits of using role plays to assess therapy sessions, which might increase the reliability and validity of using therapist competence scales (Fairburn & Cooper, 2011).

2. Personal learning and professional development.

This process has provided a great learning experience both personally and professionally. It has increased my interest in CFT and I would hope to continue developing this during my career.

2.1 Clinical development

At the time of completing my research project I was on placement in the Early Intervention for Psychosis (EIP) team and I was able to implement some of the CFT principles. I have found that CFT provides clients with an easily accessible understanding about their current difficulties. This research has helped me to understand the benefits of a CFT approach for clients with high levels of self-criticism, self-blame and shame. This model seemed to fit very well with the difficulties that someone experiencing psychosis had. I particularly found the CFT psycho-education

beneficial because it helped to engage clients in a non-threatening and non-blaming way. It provided clients with an understanding about how their difficult experiences may have developed, which in a medically driven organisation seemed very uplifting for the clients.

The research allowed me to learn more about the three-part emotional regulation system. I found this system has helped clients understand their difficult experiences, specifically their heightened sensitivity to internal and external threats. I have used this system to measure goals in therapy. For example, a client wanted to build up their soothing contentment system to help reduce their heightened threat response and we were able to draw this out to evaluate how much they had achieved this goal in therapy. Overall, having the opportunity to complete this research project has been extremely valuable as a clinician working with clients with mental health difficulties. I feel the learning I have gained from this experience has benefitted my clinical work and hopefully had a positive impact on my clients. I also hope that I will continue to develop and learn more about CFT in the future.

2.2 Personal development

My journey through this research project has been a mixture of positive and negative experiences. Whilst going through the more difficult moments I became increasingly aware of how important it was to look after myself. I had already been trying to practice mindfulness and during some of the teaching at university they guided us through some of the exercises that I was familiar with from the compassionate mind training workbook. I think completing research in CFT and using this in practice with clients acted as a reminder to practice compassionate exercises and to ensure I was being compassionate toward myself. I felt that CFT was more than just a therapy for clients in distress, but there were elements that were helpful for all individuals such as completing mindfulness exercises, compassionate practices, having compassion for self and others and developing a self-care strategy. It appeared to me that being able to teach and support clients to be more compassionate to themselves and others, required practicing and using the strategies myself. This area would be interesting to think about more in

the future. I would also be interested to investigate the research available on CFT in staff groups or whether it has been used with staff teams working on mental health wards. I felt that certain mindfulness and compassionate exercises can be helpful at certain times, but there were moments during this research process that self-practice increased my levels of stress. I think this had been because it brought up difficult feelings, which I had perhaps not fully been aware of given the levels of stress I was feeling at the time. This made me think about some of the difficult experiences our clients might have when we ask them to engage with such practices. I also hoped that this research project would add to the evidence on CFT and hopefully benefit both therapists and clients.

Overall, this research project provided me with an opportunity to learn and develop my skills in developing, planning and implementing a research project. Throughout this research project there were many learning opportunities and the most pertinent one has been the knowledge I have learnt about CFT and I will certainly take this forward in my clinical practice. Producing this thesis has been both rewarding and challenging. It was difficult to always maintain motivation and there were moments when things felt too far out of my control. However, I feel I have developed knowledge, resilience and an interest in developing my research skills in the future.

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Appendices

Appendix A

Search terms

Search terms used in each of the electronic databases

Treatment	Variations of competence
Cognitive behavio* therap*	Therap* competenc*
Cognitive therap*	Clinical competenc*
Behavio* therap*	Assess* competenc*
CBT	Intervention competenc*
Psychotherap*	Skill use
Therap* outcome	Therap* skill*
Psycho* therap*	Skill acquisition
	Clinical skill*
	Treatment integrity

Appendix B

Data extraction form

Author and date	
Title and source	
Key words	
Aims/ objectives	

Study eligibility	Study design? (RCT)
	Participants? (therapists, clients and raters)
	Types of intervention
	Types of comparison
	Types of outcome measures
INCLUDE:	EXCLUDE:
	Population description
	Setting
	Inclusion criteria
	Exclusion criteria
	Methods of recruitment
Methods	Aims of study
	Design
	Unit of allocation
	Start date
	End date
	Duration of participants
	Ethical approval
Risk of bias	Random sequence generation
	Allocation concealment
	Blinding of participants
	Incomplete outcome data

	Selective outcome data
	Other bias
Participants	Population
	Setting
	Inclusion criteria
	Exclusion criteria
	Method of recruitment
	Total No randomised
	Clusters
	Withdrawal/exclusion
	Age
	Sex
	Race/ethnicity
	Severity of illness (clients)
	Experience of therapists and raters
	Blinding of raters
Intervention and recording of competence	Group name
	No. randomised
	Description
	Duration of treatment
	Timing
	Delivery
	Rated sessions (length, number)
	Method used to record sessions
	How were sessions chosen to rate
	Additional information
Treatment and competence outcome measures	Outcome name
	Time points of measures
	Time-interval between measures
	Outcome definition
	Person measuring/ reporting

	Unit of measurement
	Scales: upper and lower limits
	Validated?
	Missing data?
	Assumed risk estimate
	Power
Analysis	Statistical methods
	Missing data
	Statistical power
Results	Comparison
	Outcome (treatment and competence)
	Time point
	Results
	Baseline data
	No of missing data
	Unit of analysis/ appropriateness
	Reanalysis
Applicability	Important populations excluded from this study
	Aimed at disadvantaged groups
	Does it address review questions
Conclusions	Key conclusions
	References to relevant studies
	Strengths and weaknesses

Appendix C

Critical appraisal checklist for included studies (Downs & Black, 1998)

Checklist. Are each of these clearly described?	Abel <i>et al.</i> (2016)	Branson <i>et al.</i> (2015)	Ginzburg <i>et al.</i> (2012)	Hogue <i>et al.</i> (2008)	Jolley <i>et al.</i> (2015)	Norie <i>et al.</i> (2013)	Ryum <i>et al.</i> (2010)	Shaw <i>et al.</i> (1999)	Strunk <i>et al.</i> (2010)	Trepka <i>et al.</i> (2004)	Weck <i>et al.</i> (2013)	Weck <i>et al.</i> (2014)	Weck, Grikscheit, <i>et al.</i> (2015)	Weck, Richtberg <i>et al.</i> (2015)	Weck <i>et al.</i> (2016)	Westra <i>et al.</i> (2011)
1.Hypothesis/ aims	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2.Outcomes measured	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Participant characteristics	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
4. Interventions?	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5. Distribution of principal confounders in participants	Yes	No	No	Yes	No	Part ially	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes

Critical appraisal checklist for included studies continued....

Checklist. Are each of these clearly described?	Abel <i>et al.</i> (2016)	Branson <i>et al.</i> (2015)	Ginzburg <i>et al.</i> (2012)	Hogue <i>et al.</i> (2008)	Jolley <i>et al.</i> (2015)	Norie <i>et al.</i> (2013)	Ryum <i>et al.</i> (2010)	Shaw <i>et al.</i> (1999)	Strunk <i>et al.</i> (2010)	Trepka <i>et al.</i> (2004)	Week <i>et al.</i> (2013)	Week <i>et al.</i> (2014)	Week, Grikscheit, <i>et al.</i> (2015)	Week, Richtberg <i>et al.</i> (2015)	Week <i>et al.</i> (2016)	Westra <i>et al.</i> (2011)
6. Main findings	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. Estimates of the random variability	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8. Adverse events	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9. Attrition characteristics of the tapes not included in the analysis	Yes	Yes	No	Yes	No	No	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	No
10. Actual probabilities for competence/outcome reported	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Critical appraisal checklist for included studies continued....

11. Sample representative of where recruited	No	Yes	No	No	Yes	No	No	No	No	No	No	Yes	Yes	No	No	Yes	No
12. Sample representative of entire population	No	No	No	No	No	No	No	No	No								
13. Staff, place and facilities representative of treatment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes								
14. Were those measuring outcome blind to treatment outcome	No	No	No	Yes	No	Yes	No	Yes	Unk now n	Unk now n	Unk now n	Yes	Yes	Yes	Yes	Yes	

Critical appraisal checklist for included studies continued....

Checklist. Are each of these clearly described?	Abel <i>et al.</i> (2016)	Branson <i>et al.</i> (2015)	Ginzburg <i>et al.</i> (2012)	Hogue <i>et al.</i> (2008)	Jolley <i>et al.</i> (2015)	Norrie <i>et al.</i> (2013)	Ryum <i>et al.</i> (2010)	Shaw <i>et al.</i> (1999)	Strunk <i>et al.</i> (2010)	Trepka <i>et al.</i> (2004)	Weck <i>et al.</i> (2013)	Weck <i>et al.</i> (2014)	Weck, Grikscheit, <i>et al.</i> (2015)	Weck, Richberg <i>et al.</i> (2015)	Weck <i>et al.</i> (2016)	Westra <i>et al.</i> (2011)
15. Attempt to blind the judges rating competence to main outcome	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Unknown	Yes	Yes	No	Yes
16. Data dredging	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17. Statistical tests appropriate	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18. Compliance with intervention	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Critical appraisal checklist for included studies continued....

Checklist. Are each of these clearly described?	Abel <i>et al.</i> (2016)	Branson <i>et al.</i> (2015)	Ginzburg <i>et al.</i> (2012)	Hogue <i>et al.</i> (2008)	Jolley <i>et al.</i> (2015)	Norrie <i>et al.</i> (2013)	Ryann <i>et al.</i> (2010)	Shaw <i>et al.</i> (1999)	Strunk <i>et al.</i> (2010)	Trepka <i>et al.</i> (2004)	Weck <i>et al.</i> (2013)	Weck <i>et al.</i> (2014)	Weck, Grikscheit, <i>et al.</i> (2015)	Weck, Richtberg <i>et al.</i> (2015)	Weck <i>et al.</i> (2016)	Westra <i>et al.</i> (2011)
19. Main outcome/ competence measures reliable and valid	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
20. Was selection bias limited	Yes	Unknown	No	Yes	No	No	No	No	No	No	Yes	Yes	Yes	No	Yes	No
21. Was the sample chosen over different time period	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	No	Yes	Yes
22. Randomisation in original study	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Critical appraisal checklist for included studies continued....

Checklist. Are each of these clearly described?	Abel <i>et al.</i> (2016)	Branson <i>et al.</i> (2015)	Ginzburg <i>et al.</i> (2012)	Hogue <i>et al.</i> (2008)	Jolley <i>et al.</i> (2015)	Norrie <i>et al.</i> (2013)	Ryum <i>et al.</i> (2010)	Shaw <i>et al.</i> (1999)	Strunk <i>et al.</i> (2010)	Trepka <i>et al.</i> (2004)	Weck <i>et al.</i> (2013)	Weck <i>et al.</i> (2014)	Weck, Grikscheit, <i>et al.</i> (2015)	Weck, Richberg <i>et al.</i> (2015)	Weck <i>et al.</i> (2016)	Westra <i>et al.</i> (2011)
22. Randomisation in original study	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
23. Randomisation concealed	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
24. Confounding variables analysed	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
25. Participants not selected for analysis considered	Yes	No	No	Yes	No	Yes	No	No	No	No	No	Yes	No	No	Yes	No
26. Sufficient power	No	Yes	No	No	No	No	No	Yes	No	No	Yes	Yes	No	No	Yes	No
Total score	23	15	16	23	13	19	19	22	19	16	23	24	23	21	24	20

Appendix D

Summary of demographic information

Reference	Sample size CBT group only (n)		Therapy sessions analysed (n)	Mean age (years)		Gender female (%)		Raters	Intervention	Study design
	Participants	Therapists		Participants	Therapists	Participants	Therapists			
Abel <i>et al.</i> (2016).	50	11	125	49.6	39.2	73.1	90.9	2 in total.	CBT for depression	Secondary data analysis from an RCT.
Branson <i>et al.</i> (2015)	1247	43	1247	-	38.6	-	67.4	Experienced CBT therapists. Single marker	CBT for depression and/or anxiety	Naturalistic study.
Ginzburg <i>et al.</i> (2012)	34	10	68	34.8	33.7	47.4	80	5 PhD and clinical psychologists.	Cognitive therapy for social anxiety disorder.	Secondary data/ RCT.
Hogue <i>et al.</i> (2008)	62	4	192	15.5	40	19%	50	2 raters coded each tape.	CBT for adolescence with co-morbid substance misuse.	Secondary data/ RCT
Jolley <i>et al.</i> (2015)	20	9	20	-	-	-	-	Course supervisors and one other marker.	CBT for psychosis.	Secondary data analysis from a preliminary evaluation.
Norrie <i>et al.</i> (2013)	24	5	26	-	-	-	-	2 clinical psychologists.	CBT on suicidal behaviour in borderline personality disorder.	Secondary data analysis/ RCT.

Summary of demographic information continued.

Reference	Sample size CBT group only (n)		Therapy sessions analysed (n)	Mean age (years)		Gender female (%)		Raters	Intervention	Study design
	Participants	Therapists		Participants	Therapists	Participants	Therapists			
Ryum <i>et al.</i> (2010)	25	6	25	34.6	-	56	-	2 independent raters	Cognitive therapy for cluster C personality disorder.	Secondary data analysis/ RCT.
Shaw <i>et al.</i> (1999)	36	8	302	-	-	-	25	2 PhD psychologists.	Cognitive therapy for depression.	Secondary data analysis/ RCT
Strunk <i>et al.</i> (2010)	60	6	240	40.0	45.0	58	33.3	First and second author.	Cognitive therapy for depression.	
Trepka <i>et al.</i> (2004)	30	6	30	34.3	-	70	100	First author	Cognitive therapy for depression.	Secondary data analysis
Weck <i>et al.</i> (2013)	80	26	80	48.3	33.8	68.8	80.1	2 clinical psychologists studying their PhD.	CBT for recurrent depression.	Secondary data/ RCT.
Weck <i>et al.</i> (2014)	84	50	84	41.2	31.6	59.5	78	4 raters Master degree in clinical psychology.	CBT for anxiety, hypochondriasis and depression.	Secondary data/ RCT.

Summary of demographic information continued....

Reference	Sample size CBT group only (n)		Therapy sessions analysed (n)	Mean age (years)		Gender female (%)		Raters	Intervention	Study design
	Participants	Therapists		Participants	Therapists	Participants	Therapists			
Weck, Grikscheit <i>et al.</i> (2015)	61	32	175	45.0	31.6	55.7	78.1	2 Clinical psychologists.	CBT for social phobia, hypochondriasis and depression.	Secondary data/ RCT.
Weck, Richtberg <i>et al.</i> (2015)	68	26	99	38.1	30.9	57.1	76.4	2 Master level clinical psychologists	CBT for health anxiety.	Secondary data/ RCT.
Weck <i>et al.</i> (2016)	84	34	84	33.9	28.5	63.1	79.4	4 Master level clinical psychologists.	CBT for panic disorder.	Secondary data/ RCT.
Westra <i>et al.</i> (2011)	32	4	32	-	-	-	-	4 Clinical psychology gradates.	CBT for generalised anxiety.	Secondary data/ RCT.

Appendix E

Table of results and outcomes of interest.

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Abel <i>et al.</i> (2016).	Collaborative case-conceptualisation rating scale (CCCRS: Padesky <i>et al.</i> 2011).	The Becks Depression Inventory (BDI-II; (Beck et al., 1996)	Two-way mixed ANOVAs were conducted to ascertain whether client hope, emotional processing and therapist competence in case-conceptualisations were associated with sudden gains. Sudden gains were (present/not) was the between groups factor and time-point (session two baseline/pre-gain was the repeated measure.	There was no main effect of time on the competence of case-conceptualisation, but there was a significant main effect of sudden gains status. p < .02	Therapists showed greater competence in case-conceptualisations when treating patients with sudden gains (large and stable symptom improvement). Patients that had a sudden gain were significantly more likely to have better treatment outcomes, and therapists treating these patients had higher competence ratings.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Branson <i>et al.</i> (2015)	Cognitive Therapy Scale-Revised (Blackburn <i>et al.</i> 2001).	PHQ-9 (Kroenke <i>et al.</i> , 2001) Generalised Anxiety Disorder (GAD-7; Spitzer <i>et al.</i> , 2004)	<p>To test the associations between therapist competence and patient outcomes mean competence ratings were calculated for each therapist (during and post training). Spearman Rho correlations between mean CTS-R scores and patient outcome variables were calculated.</p> <p>Correlational analyses (Spearman Rho) were used to explore whether stage of treatment or treatment response effected competence/outcome relationship. To see if outcomes differed between the most and least competence therapists, therapists were grouped by mean CTS-R score into one of three competence groups (top 10%/ mid-range, bottom 10%). Chi-squared analyses were conducted and then investigations of standardised residuals were complete.</p>	<p>Spearman Rho correlations between mean CTS-R and outcome: $r = .70$ to $r = .267$</p> <p>Most and least competent analyses: No significant differences between the groups on the PHQ-9 ($p > .08$). Reliable change on the GAD-7 differed significantly between groups (GAD-7: $p > .007$)</p> <p>Standard residuals: Fewer patients than would be expected experienced no reliable change in their symptoms of anxiety if treated by the top group ($n = 80$, expected 98.7, $Z = -1.9$) More patients than expected experienced a reliable improvement ($n = 164$, expected = 143.2, $z = 1.7$). When treated by the bottom group more patients than expected experienced a reliable deterioration: ($n = 8$, expected = 3.9, $z = 2.1$).</p>	<p>Most competent therapists experienced significantly less change in anxiety. The least competent had significantly more patients deteriorate in symptoms. Limited support for an association between therapist competence and treatment outcome.</p>

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Ginzburg <i>et al.</i> (2012)	The Cognitive Therapy Competence Scale for Social Phobia (CTCS-SP: Clark <i>et al.</i> 2006).	Clinical Global Impression Scale (CGI: Clark, Ehlers <i>et al.</i> , 2006); Liebowitz Social Anxiety Scale (LSAS: Liebowitz, 1987)	To determine whether competence, adherence and/or patient difficulty predicted clinical outcome, hierarchical linear modelling (HLM) with random intercept was carried out. Separate HLM were computed for two outcome variables (CGI-I and LSAS). All three variables (competence, adherence and patient difficulty) were entered into each model. Two 2 level models were specified with patients at level 1 and therapists at level 2.	The HLM model accounted for 48% of the variance in the primary outcome variable (CGI-I). Only competence was a significant predictor of CGI ($\beta = .79$, $p < .001$). The HLM for the LSAS explained 20% of the outcome variance and competence was the only significant predictor ($\beta = .59$, $p < .01$) An indirect path between competence and outcome via patient difficulty was added and this reduced the goodness of fit.	Competence was a significant predictor for the CGI and the LSAS outcome measures. Adherence and patient difficulty were not significant.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Hogue <i>et al.</i> (2008)	Therapist Behaviour Ratings Scale-Competence (TBRIS-C)	Marijuana use frequency: timeline follow-back (Sobell & Sobell, 1996). Personal experience inventory (PEI; Winters <i>et al.</i> 2002)	Latent growth curve modelling was used to analyse individual client change and was completed in three stages. Stage one: a series of growth curve models was tested to find the overall shape of the individual change trajectories for the five outcome variables. This was complete to find out whether the study sample was comparable with that demonstrated in the original RCT. Stage two: therapist adherence scores were added as a covariate. Stage three: adherence and competence variables, treatment condition and their interaction terms were added to the models.	No main effects for competence were found on any outcome variable. There were significant adherence effects for Drug use frequency in CBT (mean slope = -0.41; pseudo- $z = -2.27$; $p < .05$; 95% CI = 2.45, -2.09).	Stronger adherence predicted a greater decrease in drug use from baseline to six months posttreatment. No main effects for competence were found on outcome variable.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Jolley <i>et al.</i> (2015)	Revised Cognitive Therapy for Psychosis Rating Scale (R-CTPAS: Rollinson <i>et al.</i> 2008); Cognitive Therapy Scale (CTS: Young and Beck, 1980).	BDI-II. Becks anxiety Inventory (BAI; Beck <i>et al.</i> , 1996). Depression, anxiety, stress scales (Lovibond & Lovibond, 1995). CORE-OM (Evans <i>et al.</i> , 2002). Psychotic Symptoms Rating Scale (PSYRATS; Haddock <i>et al.</i> , 1999).	A repeated measures ANOVA was used to analyse change in outcome measures by Time (x2, pre or post) and Outcome-type (x2, affect or psychotic symptoms), co-varying for therapist and number of sessions. Effect sizes were calculated from partial Eta squared values. Correlational analyses were used to examine the associations between therapist competence and positive clinical change.	The CTS total, subscale and items scores were not associated with either affective or psychotic symptom outcomes (r values < 0.4, $p > .1$). For the R-CTPAS no subscale was significant, but there was an association with higher scores on the assessment and engagement factor with less improvement in affect.	CTS and R-CTPAS were not associated with any outcome measure.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Norrie <i>et al.</i> (2013)	BOSCOT Rating Scale (Davidson, 2007); Cognitive Therapy Rating Scale (CTRS: Young & Beck, 1990).	The Acts of Deliberate Self-Harm Inventory (Davidson, 2000)	<p>There were three parts to the analysis and these included:</p> <ul style="list-style-type: none"> -Time lag of a treatment effect analyses used standard ITT statistical techniques. -For the inter-relationships between therapist competence and number of sessions attended of therapy and outcomes, the variates (sessions offered, attended, cancelled, did not attend, duration of sessions) were grouped together above or below their median. Then two sample t-tests were conducted on the other variates of interest. -Instrumental variable regression modelling was used to investigate the influence of quantity and quality of therapy on outcome. They used Complier Averaged Causal Effects model and presented three estimates (unadjusted; adjusted for four baseline factors strongly associated with outcome in suicidal acts (being single, age, age at first deliberate self-harm, quality of life); and the adjusted analysis was complete again, but with the interaction of treatment with each of these four baseline predictors to check whether the exclusion criteria would hold. 	<p>The most competent and least competent therapists treated clients with the lowest average baseline suicidal acts. Complier Averaged Causal Effects model results included the adjusted analyses and these increased the treatment effect for therapist competence in CBT and suicidal acts from -0.91 to -1.93. ($p = .003$). When more competent therapists offered >15 sessions this was associated with less suicidal acts ($-2.17, p = .008$)</p>	<p>One suicidal act averted over 2 years approximately doubles when treated by more competent therapists.</p> <p>More competent therapists that deliver more than 15 sessions seems to improve outcomes for clients with personality disorder.</p>

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Ryum <i>et al.</i> (2010)	CTS (used only the homework assignment subscale)	The Symptom Checklist-90 (SCL90; Derogatis <i>et al.</i> , 1973). The Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983). Inventory of Interpersonal Problems (IIP; Horowitz <i>et al.</i> , 1988).	Hierarchical multiple regression was used to assess the relationship between therapist competence in assigning homework and mid- and post- treatment outcome. Multiple regression analyses were completed for mid-treatment (after 20 sessions) and post-treatment (after 40 sessions). Pre-scores of the outcome variable were entered first, and then therapist competence in assigning homework for each outcome variable was added second.	Higher ratings of therapist competence in assigning homework was related to significantly improved outcomes on all measures at both mid- and post- treatment ($p < .05$). Post-hoc analyses were completed and results remained significant even when controlling for initial symptom improvement after session four. Therapist competence in agenda setting and global therapist behaviours in supportive strategies and work enhancement strategies did not predict mid- or post-treatment outcome.	Higher ratings of therapist competence in assigning homework was related to significantly improved outcomes on all treatment outcomes.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Shaw <i>et al.</i> (1999)	CTS	The Hamilton Rating Scale for Depression-17 (HRSD-17; Hamilton, 1960). SCL-90.	<p>In the first stage of the analysis an ANOVA was performed to assess whether there were differences in competence ratings due to research sites, therapists and patients. Separate hierarchical multiple regression analyses were completed for each outcome measure (HRSD-17, BDI, SCL-90). The order of entry was controlled to obtain the unique contribution of competence. The total score on the CTS was added after controlling for other variables (pre-treatment symptom level, facilitative conditions provided by the therapist and adherence.</p> <p>A final analysis was complete that evaluated the unique variance predicted by the structure and skill subscales and whether it predicted outcome (HRSD-17). These subscales were then analysed to see if they contributed to BDI or SCL-90 scores.</p>	<p>The results of the ANOVA showed that there were significant effects due to patients and therapists.</p> <p>The hierarchical multiple regressions: When the prescore on the HRSD-17 and facilitative condition and adherence were entered first the CTS score accounted for 15% of the variance in termination HRSD-17 scores ($p < .02$). Both the BDI ($p > .28$, accounted for 3% of the variance) and the SCL-90 ($p > .24$, accounted for 4% of the variance) were nonsignificant.</p> <p>The analysis to understand whether the specific aspects of therapist competence (structure and subscale) contributed to the HRSD-17 outcome showed that the structure subscale was responsible for the CTS total score: bivariate correlation was -3.7, accounting for 14% of the variance; skill subscale bivariate correlation 0.1 accounting for .01% of the variance. When facilitative conditions provided by the therapist and adherence were controlled for it contributed to a significant 19% of the variance $p < .01$.</p>	<p>The analyses showed limited support for the relationship between therapist competence and therapy outcome in depression. However, the results found that HRSD outcome measure accounted for 15% of the variance when adherence and facilitative conditions provided by the therapist were controlled for.</p> <p>The structure subscale was related to whether patients showed significant improvement on the HRSD. However both the BDI and the SCL-90 were in the expected direction, but no significant effects were found.</p>

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Strunk <i>et al.</i> (2010)	CTS-revised (Young & Beck, 1988)	BDI-II. HRSD-17.	<p>Repeated measure regressions were used to estimate the competence ratings as predictors of session-to-session symptom change across the first four sessions. BDI scores from sessions two to five (dependent variable) and BDI scores from the prior session were entered as a covariate.</p> <p>The second stage involved examining the average competence rating for each therapist (first four sessions) as a predictor of symptom change in the first four sessions and end of treatment outcome.</p> <p>Longitudinal random coefficients models were used to estimate symptom severity from session four to end of treatment.</p> <p>Three primary models were used: A model of session-to-session symptom change (assessed with the BDI), a model of subsequent symptom change through till the end of treatment (assessed with the HRSD), and a model of subsequent symptom change through till the end of treatment (assessed with the BDI).</p>	<p>Session-to-session symptom change (BDI): Competence significantly predicted session-to-session symptom change across the first four sessions ($p < .05$). Exploratory analyses found the following items had the largest effects: agenda setting ($p < .001$), focusing on key cognitions ($p < .01$), pacing ($p < .01$), and homework ($p < .01$). Competence and long-term symptom change following early sessions (HRSD and BDI): Higher competence ratings were predictive of lower HRSD scores at posttreatment ($r = .33$, $t(50) = 2.45$, $p = .02$). In the same model using the BDI a non-significant trend was found, $r = .24$, $t(50) = 1.72$, $p = .09$.</p> <p>Four potential moderators were examined: Age of onset, chronic depression, personality disorder and anxiety.</p> <p>-In the session-to-session analyses age of onset ($p < .05$) and anxiety ($p < .05$) had significant interactions with competence.</p> <p>-In the prediction of posttreatment depression severity moderator analyses the only significant interaction to emerge from these models was that of anxiety and competence in predicting HRSD posttreatment severity.</p>	<p>These results support that competence ratings predict session-to-session symptom change early in treatment, when patients improve most rapidly. Early competence ratings also predicted end-of-treatment symptom severity on the HRSD, but not the BDI. Moderation analyses showed that higher competence and patients with higher levels of anxiety predicted subsequent symptom change in the session-to-session and the long term analyses.</p>

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Trepka <i>et al.</i> (2004)	CTS	BDI-II.	<p>Univariate analysis of variance was used to examine the extent to which therapist differed on competence, alliance and outcome. Severity of depression was controlled by covarying BDI screening scores.</p> <p>Correlations were calculated between posttreatment (end of treatment and four month follow-up) BDI and both alliance and competence.</p>	<p>The initial analyses showed that therapists differed significantly between therapists.</p> <p>Alliance was significantly associated with outcome for the whole sample ($r(27) = -.50, p < .01$) and the completer sample ($r(18) = -.59, p < .01$).</p> <p>Competence was significantly associated with outcome for the completers ($r(21) = -.47, p < .05$) and follow-up ($r(16) = -.54, p < .05$), but not for the whole sample ($r(30) = -.28, p > 0.5$). The items measuring CBT techniques was significant for the whole sample ($r(30) = -.33, p < .05$), the completers ($r(21) = -.59, p < .05$) and the follow-up ($r(16) = -.54, p < .05$).</p>	Higher therapist competence predicted significant improvement on BDI scores in the patient sample that completed treatment.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Weck <i>et al.</i> (2013)	CTS German scale: Weck <i>et al.</i> (2010).	Time to first relapse: DSM-IV	Preliminary cox regression analyses were completed to examine whether demographic variables, clinical variables or the use of antidepressant medication were associated with the days to relapse. Cox regression analyses were used to determine the effects of adherence, competence and alliance on the risk of relapse.	The preliminary analyses revealed no significant effects for the variables on the risk of relapse. The cox regression analyses showed that therapist competence and therapist adherence were not significant predictors for the number of days to relapse. Adherence and competence were highly correlated ($r= 0.75$, $p < 0.001$). Therapeutic alliance was a significant predictor of the time to relapse.	Therapist competence was not linked to better treatment outcomes in depression. However, therapeutic alliance was a significant predictor of time to relapse. Therapist competence and therapist adherence were highly correlated and this might question whether different constructs were actually evaluated.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Weck <i>et al.</i> (2014)	CTS German scale.	Data from three RCT's assessing depression, anxiety and hypochondriasis.	<p>Path analysis models were used to assess validity of therapist adherence and therapist competence ratings on session segments compared with those ratings based on entire sessions.</p> <p>-Within treatments: Two path-analysis models were specified with adherence and competence as predictor variables and the treatment outcome as the criterion variable. One was a group model that assumed no differences between session segments and whole sessions, and the other was a two-group model that compared session segments with entire sessions.</p> <p>-Across treatments: Both for session segments and entire sessions two path-analyses models were specified with adherence and competence as predictor variables and the treatment outcome as the criterion variable. The first correlation assumed no differences between the three treatments. The second was a multi-sample path analyses model (all treatments) with separate parameter estimates. Then these were compared to see which was most superior solution. Then the superior model based on session segments can be compared with entire sessions.</p>	<p>There was no relationship between therapist adherence and therapy outcome in any of the analysed models</p> <p>The relationship between therapist competence and therapy outcome was significant for the treatment of anxiety in session segments ($p < .05$) and entire sessions ($p < .01$). However, they were not significant for major depression or hypochondriasis.</p>	Therapist competence was only significant on predicting treatment outcomes in anxiety.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Weck, Grikscheit <i>et al.</i> (2015)	CTS German scale	Patient outcome data from three RCT's were divided into clients that were treatment successes and treatment failures.	<p>Outcome models: Path analyses models were used to analyse the relationship between adherence, competence alliance and outcome. Treatment outcome (treatment success vs. treatment failure) was the categorical dependent variable.</p> <p>Model one: Adherence and alliance were the predictors, and the treatment outcome was the dependent variable.</p> <p>Model two: For model two alliance was specified as the predictor variable mediating the effect between competence and outcome. Adherence was specified with a mediating effect on therapy outcome via competence and alliance.</p>	<p>Model one: Only the moderation of adherence with alliance yielded significant effects on the treatment outcome ($r = .24, p < .05$). Higher levels of alliance was associated with a stronger relationship between adherence and treatment outcome.</p> <p>Model two: Alliance had a small effect on treatment outcome, whereas competence had a large effect on alliance. There was no significant effect of competence on treatment outcome, however competence had a mediating effect on treatment outcome via alliance.</p>	<p>Therapist competence was not significant in treatments classified as successes or failures. Therapist competence was not associated with treatment failure or treatment success in depression, anxiety or phobia treatments. Therapeutic alliance was found to be a significant moderator of the adherence and outcome link. Therapeutic alliance was a significant mediator between competence and outcome, and competence and alliance was a significant mediator between adherence and outcome.</p>

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Weck, Richtberg <i>et al.</i> (2015)	CTS German scale	H-YBOCS (Weck <i>et al.</i> , 2013)	<p>The initial analysis was a Multitrait-multimethod matrix to explore the method specific variance of the assessment perspectives. The treatment delivery factors (adherence, competence, and alliance) constitute the traits and the rating perspectives (rater, therapist, patient, and supervisor) constitute the methods for the sample.</p> <p>Path analysis model were conducted using the pre-post score from the H-YBOCS and therapeutic alliance and therapist competence in the middle session as a mediator variable. Therapeutic alliance and therapist competence in the early session were specified as predictor variables. It was assumed that therapist competence in the middle session would have an indirect effect via therapeutic alliance on therapy outcome.</p>	<p>Results from the CBT group that were rated by experts were: There was a significant correlation between the H-YBOCS and alliance ($r = 0.36$; $p = 0.03$). Significant correlations by trend were found between the H-YBOCS and the competence ($r = 0.30$; $p = 0.08$). There was a non-significant relationship between adherence and outcome.</p> <p>Further analyses explored alliance and competence (adherence was excluded because it showed a poor fit). In the modified path analysis model therapist competence and therapeutic alliance accounted for 6% of the variance in the H-YBOCS. ($\chi^2 = 4.81$, d.f. = 5, RMSEA = 0.00, CFI = 1.00, SRMR = 0.04)</p>	Therapist competence and therapeutic alliance were associated with treatment outcome, but therapist adherence was not. The relationship between therapist competence and therapy outcome was mediated by therapeutic alliance.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Weck <i>et al.</i> (2016)	CTS German scale	The Assessment Form of Patient Interpersonal Behaviour (AFPIB; Richtberg <i>et al.</i> ,2016). The Brief Symptom Inventory German version (BSI; Franke, 2000). The Panic and Agoraphobia Scale (PAS; Bandelow, 2000). The mobility Inventory (MI; Chambless <i>et al.</i> , 1985)	Path analysis model were used. The PAS and MI post and follow-up scores were used as criterion measures. The models mediating variables were therapist competence, therapist adherence and therapeutic alliance, and the interpersonal behaviour measured in session one (these were correlated with each other. The predictor variables were age, gender, number of diagnoses, and the BSI score at pre-treatment.	Therapist adherence ($p= .01$) and therapeutic alliance ($p = .03$) showed moderate to large effects on change scores on the MI outcome measure at follow-up. Adherence and alliance were also linked to better treatment outcome at follow-up. Therapist competence did not have an effect on treatment outcome.	Therapist competence was not a significant predictor of treatment outcome, but therapeutic alliance and therapist adherence were significant predictors of therapy outcomes at six month follow-up.

Table of results and outcomes of interest continued...

Study	Competence measure	Treatment outcome	Analysis	Significance value	Results & conclusion
Westra <i>et al.</i> (2011)	CTS	Penn State Worry Questionnaire (PSWQ; Meyer, <i>et al.</i> , 1990). Anxiety Disorders Interview Schedule for DSM-IV (Brown <i>et al.</i> , 1994).	An analysis of variance (ANOVA) examined the outcome measure (PSWQ) over time (baseline, post-CBT, and 6- and 12-month follow-up and therapist competence. Mediation analyses: Step one required the predictor variable (competence) to be significantly correlated with outcome (worry reduction). Step two required the predictor variable to be significantly correlated with the proposed mediator (outcome expectations, treatment credibility, and alliance). In Step three, the relationship between the proposed mediator and outcome was examined while controlling for the impact of the predictor on the proposed mediator.	An ANOVA examining therapist (four levels) differences in competence revealed a significant therapist effect, $F(3, 25) = 8.79, p = .001$, accounting for 51% of the variance. Therapist differences in outcome generally mirrored their client outcome. Mediation analyses: Step one: Therapist competence was significantly associated with outcome (PSWQ) ($t = 3.16, p = .004, \beta = -.50, R^2 = .25$). Step two: Higher therapist competence was associated with higher client outcome expectations (controlling for anxiety change) ($t = 3.72, p = .001, \beta = -.58, R^2 = .34$). Step three: Higher outcome expectations were associated with lower posttreatment PSWQ scores (controlling for therapist competence) ($t = 2.69, p = .013, \beta = -.48, R^2 = .34$).	Therapists with higher competence produced better outcomes in worry. Client outcome expectations fully mediated the relationship between therapist CBT competence and client posttreatment outcome.

Appendix F

Agenda for Round one: Independent expert panel meeting

The aim of this first round is to complete an initial list of the necessary competencies that will be included in the first draft of the therapist competency scale. There should be clear reasons for including and excluding items. By the end of the day there should be a list of competencies that the scale developers agree are the most important markers for assessing the knowledge and skills of individuals delivering CFT. The competencies should be necessary, specific, observable and measurable.

Agenda for the day:

- To have the names, addresses and email addresses for all the participants that have shown interest in the study
- To decide on the structure of the scale, e.g. unique CFT skills and general therapy skills.
- To ensure that items can be observed and measured in a CFT session.
- To develop the initial draft of the CFT rating scale.
- Vicky to ensure that there are clear rationales for inclusion and exclusion of competency items.

Items used to base the discussions

- CFT competence framework (Liddell *et al.*, 2016).
- CFT therapy assessment guide (Gilbert & Wood)
- CFT postgraduate diploma taped clinical session marking criteria

Overall question to be addressed in stage 1:

- What are the candidate items required to develop a useful measure of therapist competence for routine practice in compassion focused therapy?

Appendix G

Round two survey

Compassion Focused Therapy Therapist Rating Scale (CFT-TRS).

1. Information about this survey

Dear participant,

Thank you for agreeing to take part in this study. This is the first stage of the research that aims to develop the competencies included in the Compassion Focused Therapy Therapist Rating Scale (CFT-TRS). The items included in this survey were developed with Professor Paul Gilbert and Dr Ken Goss.

The survey is separated into two parts. The first part will show the unique Compassion Focused Therapy (CFT) skills and the second part will include the micro skills.

- The unique skills are those that are unique to CFT assessment, formulation and intervention. These items should describe the fundamental skills required to deliver CFT and the major therapeutic techniques and strategies employed by CFT therapists.
- The micro skills include general therapeutic skills required to deliver psychotherapy interventions, but they should also describe how these are unique to CFT.

This scale will be used to assess whether therapists are competent to deliver CFT sessions. Each competence needs to be observable in clinical practice and it must be specific and measurable. The scale aims to assess a therapist's capacity to provide treatment to an acceptable standard. This requires evaluating the therapist's knowledge of CFT and its use, and the therapist's ability to implement it.

Please complete the following information in as much detail as you can. Each question contains a competency that has been developed during the first stage of this research. You are required to rate each item on how important it is for inclusion in the CFT rating scale. You will rate each competence on a 5 point Likert scale.

Example of the scoring level:

Not Important	Somewhat important	Moderately Important	Important	Very Important
1	2	3	4	5

For each item I would like you to rate how important you feel each competency is for inclusion within a CFT therapist competence rating scale. This scale aims to be used in routine clinical practice, CFT training courses and research.

For each item you will be asked to make comments about each competence. This will include the reasons why the score was given and any changes you think might be helpful to the item, how this competency might be observed, demonstrated or measured in practice and how each competency can be unique to CFT?

Questions to consider when completing each item:

- To what extent do you see CFT therapists talking about or focusing on each of these items in

sessions?

- How much do you focus on each of these items in your own practice of CFT?
- How might these items be observed or measured in clinical practice?
- How would you know that a therapist is doing each of these items in practice?
- How is this item unique to CFT?

Thanks again for your participation and I look forward to receiving your response.

Compassion Focused Therapy Therapist Rating Scale (CFT-TRS).

2. The unique CFT competencies

The unique therapy skills are those that are specific to CFT assessment, formulation and intervention. These items should describe the fundamental skills required to deliver CFT and the major therapeutic techniques and strategies employed by CFT therapists.

1. The therapist provides psycho education. The therapist conveys and understands how and why the evolution of the human brain has built-in biases and problems that make us very susceptible to harmful behaviours to ourselves and others.

Not important Somewhat important Moderately important Important Very important

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.

2. The therapist helps the client to distinguish between motives and emotions that can be categorised as threat focused drive, reward focused and soothing contentment focused the evolved functions.

Not important Somewhat important Moderately important Important Very important

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.

3. The therapist demonstrates an understanding about the human motivation system to help build compassion-focused motives, competencies and sense of self-identity.

Not important Somewhat important Moderately important Important Very important

1. Comment on the score you have rated and note any changes you might want to make.

2. Comment on how this item might be observed and measured in clinical practice.

4. The therapist understands how and when to cultivate each of the emotion systems.

Not important Somewhat important Moderately important Important Very important

1. Comment on the score you have rated and note any changes you might want to make.

2. Comment on how this item might be observed and measured in clinical practice.

5. The therapist knows how to train in the soothing process using posture training and visualisations.

Not important Somewhat important Moderately important Important Very important

1. Comment on the score you have rated and note any changes you might want to make.

2. Comment on how this item might be observed and measured in clinical practice.

6. Does the therapist help the client understand the relationships between their threat, drive and affiliative soothing system, for example are they able to use their affiliative soothing to regulate their threat system.

Not important Somewhat important Moderately important Important Very important

1. Comment on the score you have rated and note any changes you might want to make.

2. Comment on how this item might be observed and measured in clinical practice.

7. The therapist helps to build motivation and courage to tolerate and work with suffering and supports the client to develop techniques to regulate affect by building up their soothing system. If the client seems stuck does the therapist actively work to build their motivation.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.

8. The therapist supports the client to cultivate and tolerate affiliative emotions.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.

9. The therapist supports the client to build skills to manage their distress using their body, breathing training, facial expressions and voice tones.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.

10. The therapist focuses on helping the client understand the forms and functions of self-criticism and their link to safety behaviours.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.

11. The therapist uses evolved theories of mind to address shame, self-blame and self-referencing.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.

12. The therapist helps the client distinguish between motives and emotions.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.

2. Comment on how this item might be observed and measured in clinical practice.

13. The therapist focuses on the fears, blocks and resistances to compassionate motives and emotions.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.

2. Comment on how this item might be observed and measured in clinical practice.

14. The therapist helps to guide the client to explore their cognitions, uses inference chains, thought monitoring and thought change when appropriate.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.

2. Comment on how this item might be observed and measured in clinical practice.

15. The therapist pays attention to unconscious emotions and processes to help understand the clients difficulties in a CFT framework (transference, countertransference).

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.

2. Comment on how this item might be observed and measured in clinical practice.

16. The therapist attempts to support the client to understand their early attachment experiences, memories and early emotional experiences, then attempts to link these with the clients core motives and self-identities.

Not important Somewhat important Moderately important Important Very important

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.

17. The therapist collaboratively develops an individualised CFT formulation with the client to help them make sense of their difficulties within a CFT framework, which helps to guide the intervention. (Does the formulation focus on the clients internal/external threats, safety/protective strategies, unintended consequences?).

Not important Somewhat important Moderately important Important Very important

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.

18. In summary are there any other unique therapy skills that you feel are relevant and important for inclusion within a CFT therapist competence scale?

Compassion Focused Therapy Therapist Rating Scale (CFT-TRS).

3. The CFT micro skills

The micro skills include general therapeutic skills required to deliver psychotherapy interventions, but they should also describe how these are unique to CFT.

19. The therapist uses appropriate non-verbal communication to relate to the client and build rapport, using silences, change of voice tone and pitch, facial expressions, body postures, modelling breathing, appropriate eye-contact and openness. (Is the use of non-verbal communication suitably used to target specific CFT principles, e.g. to activate an affect in the client and help the client to access and soothe their amygdala?).

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

20. The therapist uses verbal communication to convey the CFT model in a de-shaming and de-pathologising manner. The therapist expresses a shared sense of belonging and appropriately uses common humanity and uncommon humanity in response to the client ('it is not your fault').

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

21. The therapist uses an appropriate pace for the session. (Is the session paced to meet the client's needs, does it maintain focus and is it responsive to the client?)

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

22. The therapist uses Socratic questioning, dialogues and guided discovery to explore and open up the clients motives, emotional experiences, patterns of experience, cognitions and behaviours?

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

23. The therapist collaboratively develops an agenda for the session and uses this to maintain focus during the session.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

24. The therapist is able to reflect on whether the agenda for the session is helpful for the client, and if necessary to change the focus on the session collaboratively with the client?

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

Empathy skills.

25. The therapist paraphrases appropriately.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

26. The therapist uses appropriate summarising skills.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

27. The therapist validates.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

28. The therapist uses normalisation to convey a sense of common humanity.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

29. The therapist encourages the client to develop their own mentalisation skills.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

30. The therapist demonstrates that they are attuned and connected with the client's whole being.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

31. The therapist notices and reflects on the process of therapy. They can monitor the client's ability to 'be understood'.

Not important	Somewhat important	Moderately important	Important	Very important
<input type="radio"/>				

1. Comment on the score you have rated and note any changes you might want to make.
2. Comment on how this item might be observed and measured in clinical practice.
3. What are the unique ways that CFT therapists complete this micro skill?

32. In summary are there any other micro skills that you feel are relevant and important for inclusion within a CFT therapist competence scale?

Appendix H

Information provided to participants about items amended

Original item	Edits to the item	New item
<p>1.The therapist provides psycho education. The therapist conveys and understands how and why the evolution of the human brain has built-in biases and problems that make us very susceptible to harmful behaviours to ourselves and others.</p>	<p>Item reworded.</p>	<p>The therapist provides psycho-education. The therapist demonstrates an understanding of and is able to convey to the client how the human brain has evolved with built-in biases and problems that make humans very susceptible to harmful behaviours to themselves and others.</p>
<p>2.The therapist helps the client to distinguish between motives and emotions that can be categorised as threat focused drive, reward focused and soothing contentment focused the evolved functions.</p>	<p>Item reworded.</p>	<p>The therapist helps the client to distinguish between motives and emotions that can be categorised as threat-focused, drive-reward focused and soothing-contentment focused and their evolved functions.</p>
<p>3. The therapist demonstrates an understanding about the human motivation system to help build compassion-focused motives, competencies and sense of self-identity.</p>	<p>Item excluded.</p>	

Continued...

Original item	Edits to the item	New item
4. The therapist understands how and when to cultivate each of the emotion systems.	Item reworded.	The therapist is able to recognise when they need to help the client develop and appropriately use each of their three emotional regulation systems.
5. The therapist knows how to train in the soothing process using posture training and visualisations.	Item reworded, with an added part from item 9.	The therapist is able to use CFT techniques to help the client train their soothing system. For example, using practices with soothing rhythm breathing, body posture exercises, voice tone, facial expressions and imagery.
6. Does the therapist help the client understand the relationships between their threat, drive and affiliative soothing system, for example are they able to use their affiliative soothing to regulate their threat system.	Item reworded.	The therapist helps the client to understand the relationship between their threat, drive, affiliative soothing system. For example, they are able to use their affiliative soothing system to regulate their threat system. This is used to manage the client's distress.

Continued

Original item	Edits to the item	New item
7. The therapist helps to build motivation and courage to tolerate and work with suffering and supports the client to develop techniques to regulate affect by building up their soothing system. If the client seems stuck does the therapist actively work to build their motivation.	Item reworded and the second part was merged with item 8.	The therapist helps to build their compassionate motivation and courage to tolerate and work with suffering. For example, the therapist supports the client to develop techniques to regulate affect by building their soothing system.
8. The therapist supports the client to cultivate and tolerate affiliative emotions.	Part added from item 7.	The therapist supports the client to cultivate and tolerate affiliative emotions and supports the client to manage their distress using their body posture, breathing training, facial expressions and voice tones.
9. The therapist supports the client to build skills to manage their distress using their body, breathing training, facial expressions and voice tones.	Excluded, but merged with item 5 and 8.	

Continued....

Original item	Edits to the item	New item
10. The therapist focuses on helping the client understand the forms and functions of self-criticism and their link to safety behaviours.	Item reworded and parts added from item 11.	The therapist is able to help the client functionally analyse the forms and functions of safety behaviours. For example, the forms and functions of self-criticism or shame and how this links to safety strategies.
11. The therapist uses evolved theories of mind to address shame, self-blame and self-referencing.	Item excluded.	
12. The therapist helps the client distinguish between motives and emotions.	Item excluded.	
13. The therapist focuses on the fears, blocks and resistances to compassionate motives and emotions.	Item reworded.	The therapist helps the client to understand any fears, blocks and resistances to compassionate motives and emotions.

Continued...

Original item	Edits to the item	New item
14. The therapist helps to guide the client to explore their cognitions, uses inference chains, thought monitoring and thought change when appropriate.	Item excluded.	
15. The therapist pays attention to unconscious emotions and processes to help understand the client's difficulties in a CFT framework (transference, countertransference).	No changes.	The therapist pays attention to unconscious emotions and processes to help understand the client's difficulties in a CFT framework (transference, countertransference)
16. The therapist attempts to support the client to understand their early attachment experiences, memories and early emotional experiences, then attempts to link these with the client's core motives and self-identities.	Item reworded.	The therapist helps to support the client to formulate within a CFT framework. For example, linking their early attachment experiences, memories, and early emotional experiences with the client's core motives and self-identities.

Continued...

Original item	Edits to the item	New item
<p>17.The therapist collaboratively develops an individualised CFT formulation with the client to help them make sense of their difficulties within a CFT framework, which helps to guide the intervention. (Does the formulation focus on the clients internal/external threats, safety/protective strategies, unintended consequences?).</p>	<p>Item reworded.</p>	<p>The therapist helps to support the client to formulate within a CFT framework. For example, linking their early attachment experiences, memories, and early emotional experiences with the client’s core motives and self-identities.</p>
<p>New item from comments.</p>	<p>New item: multiple selves</p>	<p>The therapist is able to help the client differentiate and use the compassionate mind to integrate conflicting parts of self.</p>

Continued....

Original item	Edits to the item	New item
<p>18.The therapist uses appropriate non-verbal communication to relate to the client and build rapport, using silences, change of voice tone and pitch, facial expressions, body postures, modelling breathing, appropriate eye-contact and openness. (Is the use of non-verbal communication suitably used to target specific CFT principles, e.g. to activate an affect in the client and help the client to access and soothe their amygdala?).</p>	<p>Item divided into two.</p>	<p>The therapist uses appropriate non-verbal communication to relate to the client and build rapport (i.e. uses silences, change of voice tone and pitch, facial expressions, body postures, modelling, breathing, appropriate eye-contact and openness).</p>
		<p>The therapist uses non-verbal communication to target specific CFT principles (i.e. therapist activates an affect in the client to access and soothe their amygdala)</p>
<p>19.The therapist uses verbal communication to convey the CFT model in a de-shaming and de-pathologising manner. The therapist expresses a shared sense of belonging and appropriately uses common humanity and uncommon humanity in response to the client ('it is not your fault').</p>	<p>Added in 'but your responsibility'</p>	<p>The therapist uses verbal communication to convey the CFT model in a de-shaming and de-pathologising manner. The therapist expresses a shared sense of belonging and appropriately uses common humanity and uncommon humanity in response to the client (i.e. 'not your fault, but your responsibility').</p>

Continued....

Original item	Edits to the item	New item
20.The therapist uses an appropriate pace for the session. (Is the session paced to meet the client's needs, does it maintain focus and is it responsive to the client?)	No changes.	The therapist uses an appropriate pace for the session. (is the session paced to meet the client’s needs, does it maintain focus and is it responsive to the client).
21.The therapist uses Socratic questioning, dialogues and guided discovery to explore and open up the client’s motives, emotional experiences, patterns of experience, cognitions and behaviours?	No changes.	The therapist uses Socratic questioning, dialogues and guided discovery to explore and open up the client’s motives, emotional experiences, patterns of experience, cognitions and behaviours.
22. The therapist is able to reflect on whether the agenda for the session is helpful for the client, and if necessary to change the focus on the session collaboratively with the client?	Item excluded, but parts added to 23.	The therapist can collaboratively set an agenda and reflects on whether the agenda for the session is helpful for the client, and if necessary to change the focus on the session collaboratively with the client.

Continued....

Original item	Edits to the item	New item
23. The therapist collaboratively develops an agenda for the session and uses this to maintain focus during the session.	Item reworded and merged with item 22.	
24. The therapist paraphrases appropriately.	Combined with item 25.	The therapist appropriately uses paraphrasing and provides summaries.
25. The therapist uses appropriate summarising skills.	Combined with item 24.	
26. The therapist validates.	No change.	The therapist validates.
27. The therapist uses normalisation to convey a sense of common humanity.	No change.	The therapist uses normalisation to convey a sense of common humanity.
28. The therapist encourages the client to develop their own mentalisation skills.	Item reworded.	The therapist helps the client to develop their own mentalisation skills.
29. The therapist demonstrates that they are attuned and connected with the client's whole being.	Item excluded.	
30. The therapist notices and reflects on the process of therapy. They can monitor the client's ability to 'be understood'.	Item excluded.	

Appendix I

Round four survey

Operationlising the CFT competence items

Dear participant,

This is the second part of the study to develop a CFT-therapist competence scale that will be used in research, training and clinical practice. This stage aims to carefully define and operationalise the items required for a CFT therapist competence scale.

Thank you for all your input in the initial stage of the study. This information was collated and analysed. Some of the comments generated from the previous survey were used to operationalise each of the updated items. Professor Paul Gilbert and Dr Ken Goss developed these further in a meeting that took place on the 28.2.2017. You should have received two email attachments. One has provided all the comments gathered from the previous round, which can be used to assist you with any comments you wish to make in this round. The second attachment has briefly highlighted the items that were edited and excluded from the previous round. These are just to provide you with information about the changes and comments generated from the round.

The purpose of this second survey is to get your opinion about whether each competence has been accurately defined and operationalised. The second aim is to gain your expert views regarding any changes that should be made.

Each question describes and operationalises a different therapist competence. The item includes a description of what the competence is and the key features and points to consider when scoring. The five point scale extends from 0 where the therapist has demonstrated little or no competence in that aspect of therapy (absent or inappropriate competence) to 4 where the therapist demonstrated high competence and skill (skilful enactment).

Thanks again for your input it has been invaluable and we look forward to reading through all your comments in the next round.

1. Does this item accurately describe and operationalise this CFT competence?

ITEM 1: Psycho-education

Item description: The therapist provides psycho-education. The therapist demonstrates an understanding of and is able to convey to the client how the human brain has evolved with built-in biases and problems that make humans very susceptible to harmful behaviours to themselves and others.

These points should be considered when scoring:

- The therapist discusses key concepts, such as old-new brain loops (i.e. are key CFT concepts covered?)
- The appropriateness of delivery. (i.e. their understanding of the model, understanding of the client).
- The skilfulness of methods used (i.e. appropriate reflections, uses clients own experience, supports client to reflect on own experience, manages client's responses)

0: Absent or inappropriate

Absence or highly inappropriate discussion about psycho-education. The therapist shows little understanding of the key concepts. The therapist shows little skill in responding to the client's own experiences.

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4: Skilful enactment

The therapist shows a good understanding of the key psycho-education concepts. The therapist uses CFT material to make appropriate links with the client's key issues. The therapist ensures that the client understands the material being discussed. The psycho-education material is used to help the client move forward in therapy.

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
<input type="radio"/>				

Comment on any changes that you would make?

2. Does this item accurately describe and operationalise this CFT competence?

ITEM 2: Motives and Emotions

Item description: The therapist helps the client to distinguish between motives and emotions that can be categorised as threat-focused, drive-reward focused and soothing-contentment focused and their evolved functions.

These points should be considered when scoring:

- The three-circles model is correctly understood and explained.
- Skilful and appropriate feedback is given.
- The content is delivered alongside reflection, guided discovery, summarising.

0: Absent or inappropriate

Therapist fails to make reference to the three-circle model, uses inappropriate feedback and makes no links between theory and the client's experience.

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4: Skilful enactment

Therapist appropriately explores the three-circle model and uses this to help the client understand their experience and move the client forward in therapy. Therapist relates the three-circles model to examples in the client's life.

Strongly disagree

Disagree

Somewhat agree

Agree

Strongly agree

Comment on any changes that you would make?

3. Does this item accurately describe and operationalise this CFT competence?

ITEM 3: Recognising the three-systems

Item description: The therapist is able to recognise when they need to help the client develop and appropriately use each of their three emotional regulation systems.

These points should be considered when scoring:

- Therapist links the three-circles model appropriately with the client's current experiences.
- The therapist appropriately identifies and responds to the material the client brings and links this with their three-systems.
- The therapist engages the client in their systems during specific contexts of therapy (exposure work, behavioural activation, multiple selves work).
- Appropriate examples are discussed to help the client understand and engage with their different systems.

0: Absent or inappropriate

Therapist makes no attempt to explore or recognise the client's three-systems. Therapist lacks understanding of the three-systems. Therapist is not empathically attuned with the client.

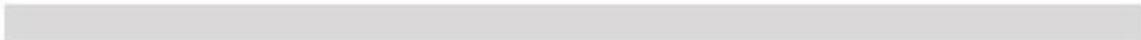
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4: Skilful enactment

Therapist is attuned with what system the client is in and whether this system is helpful. Therapist shows curiosity and supports the client to understand what system they are in and what other system may need to be cultivated to work with their issues. Therapist is sensitive and attentive to the client's changes in affect and links these with their emotional regulation systems.

Strongly disagree Disagree Somewhat agree Agree Strongly agree

Comment on any changes that you would make?



4. Does this item accurately describe and operationalise this CFT competence?

ITEM 4: CFT techniques

Item description: The therapist is able to use CFT techniques to help the client train their soothing system. For example, using practices with soothing rhythm breathing, body posture exercises, voice tone, facial expressions and imagery.

These points should be considered when scoring:

- Skilfully delivers and models CFT practices providing the client with opportunities for guided discovery, practicing, eliciting feedback and reflecting on experience.
- Provides clear rationale for practices, i.e. soothing system and parasympathetic system.

0: Absent or inappropriate

Therapist fails to use or inappropriately uses CFT techniques. The therapist lacks understanding about the purpose, rationale or theory about CFT techniques.

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4: Skilful enactment

Therapist skilfully and appropriately engages the client in CFT techniques and these are suited to the client's presenting issues. There is a clear rationale provided to the client and they understand this. The therapist elicits feedback, offers and elicits reflections and encourages practice in between sessions. The techniques are used to help move therapy forward and helps the client build a skill base.

Strongly disagree

Disagree

Somewhat agree

Agree

Strongly agree



Comment on any changes that you would make?

5. Does this item accurately describe and operationalise this CFT competence?

ITEM 5: Understanding the relationship between three systems

Item description: The therapist helps the client to understand the relationship between their threat, drive, affiliative soothing system. For example, they are able to use their affiliative soothing system to regulate their threat system. This is used to manage the client's distress.

These points should be considered when scoring:

- Therapist knowledge and understanding about the balance and interplay between the three-systems.
- The therapist collaboratively works with the client to help understand the relationship between their three-systems and helps the client understand how their systems work (i.e. uses socratic questions, guided discovery, CFT psycho-education)
- Appropriate examples are provided and linked with the client's experience and their three-systems (i.e. how we might regulate threat if we have underdeveloped soothing system)

0: Absent or inappropriate

Therapist fails to show an understanding about the relationship between the three-systems. The therapist describes information that is not relevant or didactically teaches them without checking their understanding. Offers generalisations that do not fit with the client's presenting issues.

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4: Skillful enactment

Therapist demonstrates a thorough knowledge of the relationship between the three-systems. The therapist collaboratively engages the client to help them understand their own interplay between their systems. Therapist uses appropriate and meaningful examples to instruct the client in using their soothing system to regulate threat.

Strongly disagree Disagree Somewhat agree Agree Strongly agree

Comment on any changes that you would make?

6. Does this item accurately describe and operationalise this CFT competence?

ITEM 6: Building motivation and courage

Item description: The therapist helps to build their compassionate motivation and courage to tolerate and work with suffering. For example, the therapist supports the client to develop techniques to regulate affect by building their soothing system.

These points should be considered when scoring:

- Therapist discusses a scaffolding approach to build courage to work with suffering. (I.e. build skills, encourage practice, skill up in what the client fears, challenges the client without overwhelming them and recognises that it will be difficult).
- Shares and elicits examples to encourage engagement with suffering.
- Therapist is attuned with the client and uses appropriate techniques to support client to feel safe to engage with suffering (I.e. voice tone, soothing rhythm breathing, body posture).

0: Absent or inappropriate

Therapist shows no recognition that the client will need courage to overcome difficulties or tolerate distress.

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4: Skilful enactment

Therapist demonstrates a good understanding of a scaffolding approach to help build up the client's courage and draws on examples to help the client engage with their suffering. Therapist is attuned with the client's emotional responses.

Strongly disagree Disagree Somewhat agree Agree Strongly agree

Comment on any changes that you would make?

7. Does this item accurately describe and operationalise this CFT competence?

ITEM 7: Cultivating and tolerating affiliative emotions

Item description: The therapist supports the client to cultivate and tolerate affiliative emotions and supports the client to manage their distress using their body posture, breathing training, facial expressions and voice tones.

These points should be considered when scoring:

- Exploration of affiliative emotions and skilfully elicits fears, blocks and resistances.
- Therapist supports the client to work on developing their affiliative emotions i.e. using the compassionate self, compassionate other, giving and receiving compassion.
- The therapist reflects with the client what their experience is trying to cultivate and tolerate emotions and provides encouragement to practice techniques in their daily life.

0: Absent or inappropriate

Therapist fails to explore how the client experiences affiliative emotions. They fail or inadequately identify the clients fears, blocks or resistances.

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4: Skilful enactment

The therapist helps the client to explore how they experience affiliative emotions. They identify any fears, blocks or resistances collaboratively with the client. Therapist supports the client to work on developing and tolerating their affiliative emotions.

Strongly disagree Disagree Somewhat agree Agree Strongly agree

Comment on any changes that you would make?

8. Does this item accurately describe and operationalise this CFT competence?

ITEM 8: Functional analysis

Item description: The therapist is able to help the client functionally analyse the forms and functions of safety behaviours. For example, the forms and functions of self-criticism or shame and how this links to safety strategies.

These points should be considered when scoring:

- The therapist supports the client to understand their safety behaviours and the therapist elicits and explores the function it has served.
- The therapist skilfully facilitates exploration with the client about their fear of removing self-criticism/ self-blame/ self-referencing to establish function and this is appropriately linked back to the formulation. (i.e. normalising, validation, 'it is not your fault', common humanity, understanding complex brain processes).
- Elicits pros and cons of self-criticism.
- Therapist can distinguish between shame and guilt and checks the client understand this.

0: Absent or inappropriate

The therapist fails to help the client understand the functions of their safety behaviours.

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4: Skilful enactment

Therapist helps the client identify their safety behaviours. Therapist explores the client's behaviours and their functions and discussed the pros and cons of their behaviour and this is linked back to the formulation.

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
<input type="radio"/>				

Comment on any changes that you would make?

9. Does this item accurately describe and operationalise this CFT competence?

ITEM 9: Fears, blocks and resistances.

Item description: The therapist helps the client to understand any fears, blocks and resistances to compassionate motives and emotions.

These points should be considered when scoring:

- Skilfully explores the blocks to compassion and discusses with the client why and how these blocks might have developed.
- Reflects on this process with the client and helps the client to understand where their threat system is creating blocks.
- Noticing the fears and blocks when they come up. Therapist uses skills to help the client work on fears, blocks and resistances (i.e. socratic questioning, validation, reflective listening, allying with the defensive function of the resistance, exploring ambivalence, functional analysis, affect matching, limited emotional self-disclosure)

0: Absent or inappropriate

The therapist fails to recognise or address the clients fears, blocks and resistances. Therapist shows a lack of understanding about these concepts.

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4: Skilful enactment

Therapist sensitively recognises and addresses the client's fears, blocks and resistances. They explore this with the client and check the client has understood.

Strongly disagree

Disagree

Somewhat agree

Agree

Strongly agree

Comment on any changes that you would make?

10. Does this item accurately describe and operationalise this CFT competence?

ITEM 10: Unconscious emotions and processes

Item description: The therapist pays attention to unconscious emotions and processes to help understand the client's difficulties in a CFT framework (transference, countertransference)

These points should be considered when scoring:

- The therapist notices when the client is finding it difficult to explore certain areas.
- The therapist directs the client's attention to the fears they are not talking about and helps the client to begin to explore this.

0: Absent or inappropriate

The therapist responds at face value and does not try to get behind an emotion and does not respond or address what the client is fearful of.

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4: Skillful enactment

Therapist directs the client's attention to the fears that they might not want to face or explore. They notice issues the client might be unconscious of.

Strongly disagree

Disagree

Somewhat agree

Agree

Strongly agree

Comment on any changes that you would make?

11. Does this item accurately describe and operationalise this CFT competence?

ITEM 11: Formulation links

Item description: The therapist helps to support the client to formulate within a CFT framework. For example, linking their early attachment experiences, memories, and early emotional experiences with the client's core motives and self-identities.

These points should be considered when scoring:

- Therapist demonstrates sound knowledge of attachment theory.
- Formulation links are developed collaboratively with the client and it makes sense to the client.
- Therapist makes appropriate and meaningful links with the client's three-systems and links these to their motives and self-identities.
- Skilfully elicits and explores client's early life experiences (i.e. uses guided discovery, facilitates insight, Socratic questioning).

0: Absent or inappropriate

Therapist formulates inaccurately and incompetently. Therapist is not collaborative and the session is didactic. Therapist fails to link early experiences to the client's core motives and self-identities.

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4: Skilful enactment

Therapist collaboratively helps the client to formulate in a CFT framework. Therapist shows sound knowledge of how early life experiences and attachments link with the client's three-systems and their core motives and self-identities. Therapist checks the client has understood. The formulation helps to move the client forward in therapy.

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
<input type="radio"/>				

Comment on any changes that you would make?

12. Does this item accurately describe and operationalise this CFT competence?

ITEM 12: Developing individualised formulation

Item description: The therapist is able to collaboratively develop an individualised CFT formulation to help the client make sense of their difficulties within a CFT framework.

These points should be considered when scoring:

- The formulation demonstrates a shared understanding of the client's difficulties using guided discovery.
- The therapist uses a formulation template and/or clearly discusses the formulation with the client.
- Therapist ensures the client understands the formulation and it is used to move therapy forward.
- Therapist shows a clear understanding of CFT theory and knowledge.
- The formulation is translated into the intervention work in an intelligible manner.

0: Absent or inappropriate

The therapist fails to develop a collaborative CFT formulation. The therapist shows an inadequate understanding of the CFT model.

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4: Skilful enactment

Therapist collaboratively develops a CFT formulation that the client understands. Therapist uses the formulation to move the therapy forward and to inform the intervention work. The formulation is clear, understandable and is referred to in a timely, helpful and appropriate way. The therapist has clear understanding of CFT theory.

Strongly disagree Disagree Somewhat agree Agree Strongly agree

Comment on any changes that you would make?

13. Does this item accurately describe and operationalise this CFT competence?

ITEM 13: Multiple selves

Item description: The therapist is able to help the client differentiate and use the compassionate mind to integrate conflicting parts of self.

0: Absent or inappropriate

The therapist fails to recognise or explore complex patterns of emotions, motives, physiological states. The therapist is unable to explore conflicts from a compassionate perspective or use compassionate competencies to regulate these conflicts.

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4: Skilful enactment

The therapist can facilitate the client's guided discovery to identify potential complex patterns of emotions, motives and physiological states to the same trigger. (E.g. angry, anxious, and sad responses to an argument with a loved one). The therapist can help clients to understand these conflicts from a compassionate perspective (e.g. as understandable multiple safety strategies that are not their fault) and to use compassionate competencies to regulate these conflicts.

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
<input type="radio"/>				

Comment on any changes that you would make?

14. Does this item accurately describe and operationalise this CFT competence?

ITEM 14: Non-verbal communication

Item description: The therapist uses appropriate non-verbal communication to relate to the client and build rapport (i.e. uses silences, change of voice tone and pitch, facial expressions, body postures, modelling, breathing, appropriate eye-contact and openness).

0: Absent or inappropriate

Therapist is disinterested, preoccupied, speaks too fast or not enough, topic hops, presents as defensive and body language is not open.

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4: Skilful enactment

Therapist presents as relaxed with an open posture. They use a soothing voice tone and use encouraging eye-contact to enhance engagement.

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
<input type="radio"/>				

Comment on any changes that you would make?

15. Does this item accurately describe and operationalise this CFT competence?

ITEM 15: CFT principles and Non-verbal communication

Item description: The therapist uses non-verbal communication to target specific CFT principles (i.e. therapist activates an affect in the client to access and soothe their amygdala)

0: Absent or inappropriate

Therapist fails or inadequately uses non-verbal communication.

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- 2
- 3

4: Skilful enactment

Therapist explicitly uses their voice tone, facial expression and body posture to activate and cultivate emotions to regulate threat-based emotions.

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
<input type="radio"/>				

Comment on any changes that you would make?

16. Does this item accurately describe and operationalise this CFT competence?

ITEM 16: Verbal Communication

Item description: The therapist uses verbal communication to convey the CFT model in a de-shaming and de-pathologising manner. The therapist expresses a shared sense of belonging and appropriately uses common humanity and uncommon humanity in response to the client (i.e. 'not your fault, but your responsibility').

These points should be considered when scoring:

- CFT is conveyed in a warm, non-judgemental, de-shaming and compassionate manner.
- Therapist uses client's own experiences within the context of the model.
- Communicates CFT principles and makes references to evolutionary contexts (i.e. 'evolved tricky brain', 'we all just find ourselves here').
- Therapist uses appropriate self-disclosure.
- Therapist shows a good understanding of the research findings dealing with consequences of childhood adversity.

0: Absent or inappropriate

Therapist does not verbally convey CFT model and fails to address common humanity. Therapist infers that the client's difficulties are their fault, there is something wrong with them or blames their irrational thinking.

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4: Skillful enactment

Therapist conveys CFT principles and they are spoken in a warm, non-judgemental, de-shaming and compassionate manner. Therapist ensures that the client understands. Therapist shows sound knowledge of safety strategies, 'not your fault' and common humanity.

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
<input type="radio"/>				

Comment on any changes that you would make?

17. Does this item accurately describe and operationalise this CFT competence?

ITEM 17: Pacing

Item description: The therapist uses an appropriate pace for the session. (is the session paced to meet the client's needs, does it maintain focus and is it responsive to the client).

These points should be considered when scoring:

- The pacing of the session is suitable to client's needs.
- Time-management and clear structure.
- Therapist remains responsive to the client, whilst managing digressions appropriately.
- Therapist maintains focus and responds appropriately to the client.
- Therapist actively works with the client's affect (i.e. therapist asks the client to notice how they feel, and attempts to connect them with their bodily physiology).
- Therapist helps engage client in their compassionate self and creates space for mind and body to shift into different motivational systems.
- Frequent summaries are used to keep the session on track.

0: Absent or inappropriate

Therapist has poor time-management and the session seems rigid. Therapist rushes through, talks quickly or gets stuck in repetitions.

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- 3

4: Skilful enactment

Therapist speaks at an appropriate pace that is suitable for the client. Therapist is able to reflect, build understanding and moves therapy forward. There is a clear structure and the therapist manages digressions appropriately.

Strongly disagree Disagree Somewhat agree Agree Strongly agree

Comment on any changes that you would make?

18. Does this item accurately describe and operationalise this CFT competence?

ITEM 18: Socratic questioning

Item description: Therapist uses Socratic questioning, dialogues and guided discovery to explore and open up the client's motives, emotional experiences, patterns of experience, cognitions and behaviours.

These points should be considered when scoring:

- Therapist uses Socratic questioning and guided discovery to help the client reflect on their own issues and problems in an open and curious way.
- Therapist helps the client to draw on their innate ability to generate alternative perspectives.
- Therapist is able to use Socratic questioning to leave time for the client to reflect and draw on their own conclusions.
- Therapist uses open questions and is inquisitive.

0: Absent or inappropriate

There is an absence of Socratic questioning and guided discovery. The session is mainly didactic and the therapist uses closed questions.

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4: Skilful enactment

Therapist uses guided discovery in a skilful manner and it is used to link the client's core themes and issues. Effectively shifts from psycho-education to guided discovery. Socratic questioning is used to help the client reflect on their own issues to generate their own conclusions.

Strongly disagree

Disagree

Somewhat agree

Agree

Strongly agree



Comment on any changes that you would make?

19. Does this item accurately describe and operationalise this CFT competence?

ITEM 19: Paraphrasing and Summaries

Item description: The therapist appropriately uses paraphrasing and provides summaries.

These points should be considered when scoring:

- Therapist provides sensitive summaries and paraphrasing that is used to structure the session.
- Therapist demonstrates that they are attuned to the client and uses appropriate tone.
- Therapist provides verbal feedback that summarises the main points of the session.
- Summaries are used to check the client's understanding.
- Summaries and paraphrasing is used to link the client with more affect-laden language.
- Therapist models the qualities of compassion (i.e. active listening, mirroring).
- Therapist encourages the client to take an active role during the session.

0: Absent or inappropriate

Therapist fails to use appropriate summaries or paraphrasing.

1

2

3

4: Skilful enactment

Therapist uses summaries to identify key themes in the client's narratives. Therapist paraphrases salient issues. Therapist checks the client has understood. Therapist models the qualities of compassion and encourages the client to take an active role in the session.

Strongly disagree

Disagree

Somewhat agree

Agree

Strongly agree

Comment on any changes that you would make?

20. Does this item accurately describe and operationalise this CFT competence?

ITEM 20: Agenda setting

Item description: The therapist can collaboratively set an agenda and reflects on whether the agenda for the session is helpful for the client, and if necessary to change the focus on the session collaboratively with the client.

These points should be considered when scoring:

- An agenda is set in an appropriate and collaborative way.
- Therapist is adept at eliciting frequent feedback both verbal and non-verbal and frequently checks that the session is on track.
- Therapist demonstrates flexibility between adhering to the agenda and creating space for the client to share important issues.

0: Absent or inappropriate

Session does not maintain focus and the agenda is not followed. The therapist allows the session to go off track. Agenda is inappropriate or not set.

1

2

3

4: Skilful enactment

The therapist collaboratively sets an agenda with the client. The agenda is suitable for the available time. The therapist shows a high level of skill in checking for feedback and ensuring the session is on track. The therapist demonstrates flexibility between focusing on the agenda and allowing the client to explore important issues.

Strongly disagree

Disagree

Somewhat agree

Agree

Strongly agree



Comment on any changes that you would make?

21. Does this item accurately describe and operationalise this CFT competence?

ITEM 21: Validation

Item description: The therapist validates.

These points should be considered when scoring:

- Therapist provides appropriate and sensitive validation (i.e. helps the client understand the fear of change in therapy and the fear of treading new paths).
- Therapist emphasises connectedness and creates an emotional rather than just a cognitive experience.
- Therapist uses language that is de-shaming and sensitive.
- Validation focused on CFT principles (i.e. emphasises the development of understandable safety strategies)

0: Absent or inappropriate

Therapist is invalidating. The therapist uses language that is shaming, insensitive and blaming.

- 1
- 2
- 3

4: Skilful enactment

Therapist provides appropriate and sensitive validation that enhances the therapeutic relationship. The therapist skilfully validates using CFT principles.

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
<input type="radio"/>				

Comment on any changes that you would make?

22. Does this item accurately describe and operationalise this CFT competence?

ITEM 22: Normalisation

Item description: The therapist uses normalisation to convey a sense of common humanity.

These points should be considered when scoring:

- Therapist normalises the client's experience to increase engagement and this is guided by evolutionary theory and adaptation to certain social environments.
- Therapist links the client's experience to others and to common human experience.

0: Absent or inappropriate

Therapist fails to normalise the client's experiences. The therapist shows little understanding of evolutionary theory and common humanity. The client feels dismissed and blamed for their problems.

1
2
3

4: Skilful enactment

The therapist sensitively, empathically and appropriately validates the client's experiences and this helps to move the therapy forward. Therapist shows excellent understanding of evolutionary theory and differentiates between common and uncommon humanity

Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
<input type="radio"/>				

Comment on any changes that you would make?

23. Does this item accurately describe and operationalise this CFT competence?

ITEM 23: Mentalisation

Item description: The therapist helps the client to develop their own mentalisation skills.

These points should be considered when scoring:

- Therapist encourages the client to use third person perspective.
- There is a focus on the use of affiliative/soothing emotions and compassionate responding to facilitate mentalisation skills.
- Therapist refers to CFT theory (i.e. refers to new brain abilities and the difficulty to access these during times of heightened threat.)

0: Absent or inappropriate

Therapist does not acknowledge mentalisation skills and does not encourage the client to develop these. Therapist has no capacity for self-reflection. Unable to hold self and other in mind and does not help the client to do this.

1
2
3

4: Skilful enactment

Therapist encourages the client to develop mentalisation skills and uses examples from the CFT model (i.e. new brain, affiliative and soothing emotions). Therapist can mentalise one's own mind and helps the client to do this. Therapist develops capacity for patient curiosity.

Strongly disagree Disagree Somewhat agree Agree Strongly agree

Comment on any changes that you would make?

Appendix J

Qualitative comments: Unique CFT competencies from round four

Item	Qualitative comments
Developing individualised formulation	<p>‘But could be collapsed into the above’.</p> <p>‘am thinking that there is quite a bit of overlap again’.</p>
Building motivation and courage	<p>‘This is, for me, a most important item. It seems to go beyond simply engaging motivation and into courage. This could almost be two items’.</p> <p>‘Distress tolerance could be more to the fore-ground in terms of wording here’.</p>
Cultivating and tolerating affiliative emotions	<p>‘This is very useful, and representative. I might add still another item about tolerating threatening emotions and threat-based emotions. Not cultivating those, but tolerating them.’</p>
Fears, blocks and resistances	<p>‘In my experience, working with fears, blocks, and resistances is an ongoing part of the therapy - the rating scale could be altered to reflect it, e.g. "The therapist recognizes and facilitates client exploration and working with fears, blocks, and resistances in an ongoing way throughout the therapy.’</p> <p>‘I think the headline description should be more than understanding. It requires engaging strategies to moderate FBRS [fears blocks and resistances] towards someone's recovery i.e. there is a purpose that goes beyond understanding’.</p>
Three -systems Motives and emotions: Recognising the three-systems: Understanding the relationship between three systems.	<p>‘very clear’</p> <p>‘I really like the way the content delivery is included’</p> <p>‘Potentially some overlap with the above item’</p> <p>‘Potential overlap with some of the items above’.</p> <p>‘overlap with items 2 and 3’.</p> <p>‘The item is highly accurate in what it measures’.</p>
Functional analysis	<p>‘The wording on the "4" rating is a bit awkward. I'd change it to, "Therapist explores the client's behaviours and their functions in relation to both antecedents and consequences in the context of the formulation.’</p> <p>‘The word 'behaviours' and 'strategies' are used interchangeably here. I think it would be better to stick with one (strategies is preferable in my opinion as it covers more) Could this extend to 'functions of their safety strategies and symptoms/experiences'?’.</p>
Unconscious emotions and process	<p>‘This item needs to be a bit clearer (transference/counter-transference could be unpacked more as they are only fleetingly mentioned)’.</p> <p>‘Is there a more modern CFT way of referring to unconscious emotions, e.g. avoided / feared / difficult?’</p> <p>‘Love this item - maybe nice to add something like’</p>

Appendix K

Qualitative comments: Microskills from round four

Item	Qualitative comments
CFT principles and Non-verbal communication	<p>‘I can’t see there is a big enough difference between this item and the former’.</p> <p>‘Could be folded into previous item as the previous items is not as CFT specific’.</p>
Microskills	<p>‘How do we conceptualize and account for agenda setting in CFT? I have seen it referenced, but it hasn’t been standardized and elaborated upon as much as I might have thought. I understand the need for the item, but I am concerned that we mirror the CTRS a bit too much on some of the items.’</p> <p>." I would also be a bit careful here, because this reads as more consistent with a Beckian approach than CFT. Often our structure is more fluid.’</p> <p>‘I fear that we are again pulled back towards the cognitive therapy rating scale with this item.’</p>
Paraphrasing and summaries	<p>‘I think what you are pointing to here relates much more to reflective listening and compassionate presence, validation, historical validation, relating the current circumstances to the model and case conceptualization and attunement.’</p>
Mentalisation	<p>‘Could clarify third person perspective’</p> <p>‘The "how" of shaping mentalisation skills is missing here’.</p> <p>‘Anything about perspective taking/mentalizing the minds of others?’</p> <p>‘this is a very important item! however it needs to describe what mentalising is’</p>

Appendix L

The final version of the CFT-TRS

ITEM 1: Psychoeducation

The therapist provides CFT focused psycho-education. The therapist demonstrates an understanding of and is able to convey to the client how the human brain has evolved with built-in biases and problems that make humans very susceptible to harmful behaviours/reactions to ourselves and others.

These points should be considered when scoring:

- The therapist discusses key concepts such as old-new brain loops.
- Therapist shows appropriateness of delivery. (E.g. their understanding of the model, understanding of the client).
- The therapist demonstrates skilfulness in the methods used (appropriate reflections, uses clients own experience, supports client to reflect on own experience, manages client's responses).

Unable to rate: X

Absent or inappropriate				Skilful enactment
0	1	2	3	4
Less competent				More competent
Absence or highly inappropriate discussion about psychoeducation. The therapist shows little understanding of the key concepts. The therapist shows little skill in responding to the client's own experiences.				The therapist shows a good understanding of the key psycho-education concepts. The therapist uses CFT material to make appropriate links with the client's key issues. The therapist ensures that the client understands the material being discussed. The psycho-education material is used to help the client move forward.

ITEM 2: Recognising motives and emotions

The therapist helps the client to distinguish between motives and emotions that can be categorised as threat-focused, drive-reward focused and soothing-contentment focused and their evolved functions.

These points should be considered when scoring:

- The three-circle model is correctly understood and explained.
- Skilful and appropriate feedback is given.
- The content is delivered alongside reflection, guided discovery, summarising.

Unable to rate: X



Absent or inappropriate	0	1	2	3	4	Skilful enactment
Less competent					More competent	
<p>The therapist does not to make reference to the three-circle model, uses inappropriate feedback and makes no links between theory and client's experience.</p>					<p>The therapist appropriately explores the three-circle model and uses this to help the client understand their experience and move the client forward in therapy. The therapist relates the <u>three-circles</u> model to examples in the client's life.</p>	

ITEM 3: Actively working with the three-systems

The therapist is able to recognise when they need to help the client develop and appropriately use each of their three emotional regulation systems.

These points should be considered when scoring:

- The therapist links the three-circle model appropriately with client's current experiences.
- The therapist appropriately identifies and responds to the material the client brings and links this with their 3 systems.
- The therapist engages the client in their systems during specific contexts of therapy (exposure work, behavioural activation, multiple selves work).
- Appropriate examples are discussed to help the client understand and engage with their different systems.

Unable to rate: X

Absent or inappropriate				Skilful enactment
0	1	2	3	4
Less competent			More competent	
<p>Therapist makes no attempt to explore or recognise the client's three-systems. Therapist lacks understanding of the 3 systems. Therapist is not empathically attuned with what system the client is in.</p>			<p>Therapist is attuned with what system the client is in and whether this system is helpful. Therapist show curiosity and supports the client to understand what system they are in and what other system may need to be cultivated to work with their issues. Therapist is sensitive and attentive to the client's changes in affect and links these with their emotional regulation systems.</p>	

ITEM 4: Understanding the relationship between three systems

The therapist helps the client to understand the relationship between their threat, drive, affiliative soothing system. E.g. they are able to use their affiliative soothing to regulate their threat system. This is used to manage the client's distress.

These points should be considered when scoring:

- The therapist demonstrates knowledge and understanding about the balance and interplay between the three systems.
- The therapist collaboratively works with the client to help understand the relationship between their three-systems and helps the client understand how their systems work (e.g. uses Socratic questions, guided discovery, CFT-psychoeducation)
- Appropriate examples are provided and linked with the client's experiences and three-systems (e.g. how we might regulate threat if we have underdeveloped soothing system)

Unable to rate: X

Absent or inappropriate	0	1	2	3	4	Skilful enactment
Less competent					More competent	
<p>The therapist does not show an understanding about the relationship between the three systems. The therapist describes information that is not relevant or didactically teaches them without checking their understanding. The therapist offers generalisations that do not fit with the client's presenting issues.</p>					<p>The therapist demonstrates a thorough knowledge of the relationship between the three systems. The therapist collaboratively engages the client to help them understand their own interplay between their systems. The therapist uses appropriate and meaningful examples to instruct the client in using their soothing system to regulate threat.</p>	

ITEM 5: Compassionate mind training

The therapist is able to use techniques to help the client train their soothing system. For example, using practices with soothing rhythm breathing, body posture exercises, voice tone, facial expressions and imagery.

These points should be considered when scoring:

- Skilfully delivers and models CFT practices providing the client with opportunities for guided discovery, practicing, eliciting feedback and reflecting on experience.
- Provides clear rationale for practices, e.g. soothing system and parasympathetic system.

Unable to rate: X



Absent or inappropriate				Skilful enactment
0	1	2	3	4
Less competent			More competent	
<p>The therapist does not use or inappropriately uses CFT techniques. The therapist lacks understanding about the purpose, rationale or theory about CFT techniques.</p>			<p>The therapist skilfully and appropriately engages the client in CFT techniques and these are suited to their client's issues. There is a clear rationale provided to the client and they understand this. The client elicits feedback and reflections on the exercises within the session. The therapist encourages practice in-between the sessions and elicits feedback. The techniques are used to help move therapy forward and help the client build a skill base.</p>	

ITEM 6: Building motivation

The therapist helps the client to build their compassionate motivational system. E.G. the therapist provides CFT psychoeducation, guided discovery and skills training to develop the compassionate mind. The therapist helps the client to develop their motivation to offer compassion to themselves and others and to receive compassion.

These points should be considered when scoring:

- The therapist helps the client explore the way their current compassionate mind works.
- The therapist helps the client explore how compassionate motivation could help the client engage with and alleviate/prevent the suffering of themselves or others.
- The therapist helps the client to explore how the compassionate mind of others may be helpful for the client.

Unable to rate: X

Absent or inappropriate				Skilful enactment
0	1	2	3	4
<p>Less competent</p> <p>The therapist shows no recognition of the client's current compassionate motivations. The therapist does not help the client develop their compassionate motivations.</p>				<p>More competent</p> <p>The therapist helps the client to recognise and reflect on their current compassionate motivations and how these may be helpful to the client and others. The therapist helps the client to develop compassionate motivations within a CFT framework. The therapist encourages in session and out of session practice and reflection on the development of compassionate motivations.</p>

ITEM 7: Building courage

The therapist helps to build courage to tolerate and work with suffering. E.G. the therapist supports the client to develop techniques to regulate affect by building their soothing system.

These points should be considered when scoring:

- The therapist discusses a scaffolding approach to build courage to work with suffering. E.g. build skills, practice, skill up in what we fear, and challenge but not overwhelm.
- The therapist helps the client to recognise the need to tolerate and not immediately respond to distress to help them understand and work with suffering using a compassionate mind.
- Shares and elicits examples to encourage engagement with suffering.
- The therapist is attuned with the client and uses appropriate techniques to support the client to feel safe to engage with suffering (e.g. voice tone, soothing rhythm breathing, body posture).

Unable to rate: X



Absent or inappropriate				Skillful enactment
0	1	2	3	4
Less competent				More competent
<p>The therapist shows no recognition that the client will need courage to overcome difficulties and tolerate distress.</p>				<p>The therapist helps the client to understand the need to tolerate distress in order to understand and engage with it. The therapist demonstrates an understanding of a scaffolding approach to help build up the client's courage and draws on examples to help the client engage with their suffering. The therapist is attuned with the client's emotional responses.</p>

ITEM 8: Cultivating and tolerating affiliative emotions

The therapist supports the client to cultivate and tolerate affiliative emotions and supports the client to manage their distress using their body posture, breathing training, facial expressions and voice tones.

These points should be considered when scoring:

- The therapist helps the client explore affiliative emotions and skilfully elicits fears, blocks and resistances. These could be in the therapeutic relationship, within a group context or in the client's life experience.
- The therapist supports the client to work on developing their affiliative emotions e.g. using the compassionate self, compassionate other, giving and receiving compassion.
- The therapist reflects with the client what their experience is trying to cultivate and tolerate emotions and provides encouragement to practice techniques in their daily life.

Unable to rate: X

Absent or inappropriate	1	2	3	4	Skilful enactment
0					
Less competent					More competent
<p>The therapist does not explore how the client experiences affiliative emotions. They do not or they inadequately identify the client's fears, blocks or resistances.</p>					<p>The therapist helps the client to explore how they experience affiliative emotions. They identify any fears, blocks or resistances collaboratively with the client. The therapist supports the client to work on developing and tolerating their affiliative emotions.</p>

ITEM 9: Cultivating and tolerating positive feelings in the drive system

The therapist supports the client to cultivate and tolerate drive-based motivations and feelings in the drive system, including feelings of pride (in self and others) and excitement.

These points should be considered when scoring:

- The therapist helps the client explore positive emotions in the drive system and skilfully elicits fears, blocks and resistances. These include difficulties in giving and receiving drive-based experiences from the self or others.
- The therapist helps the client to explore how their drive system works currently, and any intended and unintended consequences of how their drive system works (e.g. linking pride to potentially harmful safety strategies).
- The therapist supports the client to work on developing their drive system, particularly if they struggle to access this, and to use this motivational system to encourage behavioural change and enhance well-being.
- The therapist reflects with the client what their experience is trying to cultivate and tolerate emotions in the drive system. They encourage practice of techniques in their daily life.

Unable to rate: X

Absent or inappropriate			Skilful enactment
0	1	2	3
Less competent		More competent	
<p>The therapist does not explore how the client experiences their drive system. They do not or inadequately identify the <u>clients</u> fears, blocks or resistances to the drive system.</p>			<p>The therapist helps the client to explore how they experience the drive system. They identify any fears, blocks or resistances collaboratively with the client. The therapist supports the client to identify the intended and unintended consequences of their drive system. The therapist helps the client develop their drive system if necessary.</p>

ITEM 10: Functional analysis

The therapist is able to help the client functionally analyse the forms and functions of safety behaviours. E.G. the forms and functions of self-criticism or shame and how these link to safety strategies.

These points should be considered when scoring:

- The therapist supports the client to understand their safety strategy and the therapist elicits and explores the function it has served.
- The therapist skilfully facilitates exploration with the client about their fear of removing a safety strategy (e.g. self-criticism) to establish its function.
- The therapist uses normalising, validation, 'it is not your fault', common humanity, and understanding complex brain processes to work with the client's self-criticism/self-attack toward their safety strategy if necessary.
- The therapist explores the intended and the unintended consequences of the safety strategy.
- Therapist can distinguish between shame and guilt and checks the client's understanding.

Unable to rate: X

Absent or inappropriate				Skilful enactment
0	1	2	3	4
<p>Less competent</p> <p>The therapist does not help the client understand the functions of their safety behaviours.</p>				<p>More competent</p> <p>The therapist helps the client identify their safety strategies. The therapist explores the functions of their safety strategies and their intended and unintended consequences. If appropriate they link this back to a wider formulation. The therapist addresses self-criticism/shame in relation to safety strategies and their consequences.</p>

ITEM 11: Fears, blocks and resistances.

The therapist helps the client to recognise, understand and work with any fears, blocks and resistances to compassionate motives and emotions and change.

These points should be considered when scoring:

- The therapist notices and helps the client notice fears, blocks and resistances as they arise in therapy.
- The therapist skilfully explores the blocks to compassion and discusses with the client the function and nature of these blocks (e.g. for self-protection) and addresses any shame and self-criticism the client may have in relation to these.
- The therapist helps the client to develop skills in recognising and understanding their fears, blocks and resistances.
- The therapist reflects on this process with the client and helps the client to understand the function of blocks.
- Therapist uses skills to help the client work on fears, blocks and resistances, e.g. Socratic questioning, validation, reflective listening, allying with the defensive function of the resistance, exploring ambivalence, functional analysis, affect matching, limited emotional self-disclosure).

Unable to rate: X

Absent or inappropriate	0	1	2	3	4	Skilful enactment
Less competent						More competent
	<p>The therapist does not recognise or address the client's fears, blocks and resistances. The therapist shows a lack of understanding about these concepts.</p>			<p>The therapist sensitively recognises and addresses the client's fears, blocks and resistances. They explore this with the client and address shame and self-criticism in relation to fears, blocks and resistances as necessary. The therapist helps the client develop skills in recognising and addressing their fears, blocks and resistances outside of therapy.</p>		

ITEM 12: Unconscious emotions and processes

The therapist pays attention to unconscious emotions and processes to help understand the client's difficulties in a CFT framework (transference, countertransference). i.e. the therapist notices any relational patterns that are being played out between themselves and the client (that may represent some implicit learning from the past) and they use this directly or indirectly to facilitate the process of therapy.

These points should be considered when scoring:

- The therapist is able to use their own emotional reactions in therapy to identify and explore potential unconscious emotional processes in the client and themselves and use this to aid the therapeutic process.
- The therapist notices when the client is finding it difficult to explore certain areas.
- The therapist directs the client's attention to issues or processes that the client is not talking about.
- The therapist helps the client to explore and work on these processes.

Unable to rate: X

Absent or inappropriate	0	1	2	3	4	Skilful enactment	
Less competent					More competent		
	<p>The therapist responds at face value and does not try to get behind an emotion and does not respond or address what the client is fearful of.</p>			<p>The therapist reflects upon the therapeutic relationship with the client to help the client identify processes and emotions the client may not be aware of. The therapist directs the client's attention to themes and issues that the client may be finding difficult to explore in therapy. The therapist helps the client to work on these themes and issues during therapy. The therapist helps the client to develop their own capacities to mindfully reflect on and work on process issues, including avoidance of painful topics.</p>			

ITEM 13: Formulation

The therapist is able to collaboratively develop an individualised CFT formulation to help the client make sense of their difficulties within a CFT framework.

These points should be considered when scoring:

- The formulation demonstrates a shared understanding of the client's difficulties using guided discovery.
- The therapist uses a formulation template and/or clearly discusses the formulation model with the client.
- The therapist ensures the client understands.
- The therapist shows a clear understanding of CFT theory and knowledge.
- The formulation is translated into the intervention work in an intelligible manner.

Unable to rate: X

Absent or inappropriate				Skilful enactment
0	1	2	3	4
Less competent				More competent
<p>The therapist does not develop a collaborative CFT formulation. The therapist shows inadequate understanding of the CFT framework.</p>				<p>Therapist collaboratively develops a CFT formulation that the client understands. Therapist uses the formulation to move the therapy forward and to inform the intervention work. The formulation is clear, understandable and is referred to in a timely, helpful and appropriate way. The therapist has clear understanding of CFT theory.</p>

ITEM 14: Multiple selves

The therapist is able to help the client differentiate and use the compassionate mind to integrate conflicting parts of self.

These points should be considered when scoring:

- The therapist introduces the concept of multiplicity and links this to the client's experiences.
- The therapist highlights the functionality of having different aspects of self using a CFT model.
- The therapist explains the concept of conflicts within the self-using the CFT model. The therapist helps the client to explore their conflicts if they are either the core presenting problem or that demonstrate safety behaviors that need to be addressed.
- The therapist helps the client to explore the useful function of the compassionate self to address multiple self-conflicts and to help the client to pay attention to and respond appropriately to the wisdom of each part of the self (e.g. to be able to respond appropriately to threat).
- The therapist helps the client to address multiple selves using compassionate competencies.

Unable to rate: X

Absent or inappropriate				Skilful enactment
0	1	2	3	4
<p>Less competent</p> <p>The therapist does not recognise or explore complex patterns of emotions, motives, physiological states. The therapist is unable to explore conflicts from a compassionate perspective or use compassionate competencies to regulate these conflicts.</p>				<p style="text-align: right;">More competent</p> <p>The therapist can facilitate the client's guided discovery to identify potential complex patterns of emotions, motives and physiological states to the same trigger (e.g. angry, anxious, and sad responses to an argument with a loved one). The therapist can help the client to understand these conflicts from a compassionate perspective. (E.g. as understandable multiple safety strategies that are not their fault) and to use compassionate competencies to regulate these conflicts.</p>

CFT Microskills

ITEM 15: Non-verbal communication to build rapport

The therapist uses appropriate non-verbal communication to relate to the client and build rapport, e.g. uses silences, change of voice tone and pitch, facial expressions, body postures, modelling, breathing, appropriate eye-contact and openness.

Unable to rate: X

Absent or inappropriate					Skilful enactment
0	1	2	3	4	
Less competent					More competent
The therapist is disinterested, preoccupied, speaks fast/not enough, presents as defensive and body language is not open.					The therapist presents as relaxed with an open posture. They use a soothing voice tone to skilfully explore and moderate the client's non-verbal communication. The therapist uses encouraging eye-contact to enhance engagement.

ITEM 16: Non-verbal communication and motivational/emotional systems

The therapist uses non-verbal communication to elicit and enhance motivational or emotional systems (e.g. the therapist helps the client access their soothing, threat or drive-system).

Unable to rate: X

Absent or inappropriate					Skilful enactment
0	1	2	3	4	
Less competent					More competent
The therapist does not and/or inadequately uses non-verbal communication.					The therapist explicitly uses their voice tone, facial expression and body posture to help the client activate and cultivate motivational or emotional systems, (e.g. compassion or anger) in with the goals of therapy, e.g. when exploring multiple selves or developing compassionate self.

ITEM 17: Verbal Communication

The therapist uses verbal communication to convey the CFT model in a de-shaming and de-pathologising manner. The therapist expresses a shared sense of belonging and appropriately uses common humanity and uncommon humanity in response to the client (e.g. 'not your fault, but also your responsibility').

These points should be considered when scoring:

- CFT is conveyed in a warm, non-judgemental, de-shaming and compassionate manner.
- The therapist uses client's own experiences within the context of the model.
- Communicates CFT principles and makes references to evolutionary contexts (e.g. 'evolved tricky brain', 'we all just find ourselves here').
- Therapist uses appropriate self-disclosure.
- Therapist shows a good understanding of the research findings dealing with consequences of childhood adversity.

Unable to rate: X

Absent or inappropriate				Skilful enactment
0	1	2	3	4
<p>Less competent</p> <p>The therapist does not verbally convey the CFT model and they do not address common humanity. The therapist infers that the client's difficulties are their fault, there is something wrong with them or blames their irrational thinking.</p>				<p>More competent</p> <p>The therapist conveys CFT principles and they are spoken in a warm, non-judgemental, de-shaming and compassionate manner. The therapist ensures that the client understands. The therapist shows sound knowledge of safety strategies, 'not your fault' and common humanity.</p>

ITEM 18: Pacing

The therapist uses an appropriate pace for the session (Is the session paced to meet the client's needs, does it maintain focus and is it responsive to the client).

These points should be considered when scoring:

- The pacing of the session is suitable to client's needs.
- Time-management and clear structure.
- The therapist remains responsive to the client, whilst managing digressions appropriately.
- The therapist maintains focus and responds appropriately to the client.
- The therapist actively works with the client's affect (e.g. therapist asks the client to notice how they feel, and attempts to connect them with their bodily physiology).
- The therapist helps engage the client in their compassionate self and creates space for mind and body to shift into different motivational systems.
- Frequent summaries are used to keep the session on track.

Absent or inappropriate				Skilful enactment
0	1	2	3	4
Less competent				More competent
<p>The therapist has poor time-management and/or the session seems rigid. The therapist rushes through, talks quickly or gets stuck in repetitions. The therapist does not keep the session on track, resulting in time not being available for important topics</p>				<p>The therapist speaks at an appropriate pace that is suitable for the client. The therapist is able to reflect, build understanding and moves therapy forward. There is a clear structure and the therapist manages digressions appropriately.</p>

ITEM 19: Socratic questioning

The therapist uses Socratic questioning, dialogues and guided discovery to explore and open up the client's motives, emotional experiences, patterns of experience, cognitions and behaviours.

These points should be considered when scoring:

- The therapist uses Socratic questioning and guided discovery to help the client reflect on their own issues and problems in an open and curious way. They are also able to use open and closed questions when appropriate.
- The therapist helps the client to draw on their innate ability to generate alternative perspectives.
- The therapist is able to use Socratic questioning to leave time for the client to reflect and draw on their own conclusions.

Unable to rate: X

Absent or inappropriate			Skilful enactment
0	1	2	3
Less competent			More competent
<p>There is an absence of Socratic questioning and guided discovery. The session is mainly didactic and the therapist uses closed questions.</p>			<p>The therapist uses guided discovery in a skilful manner and it is used to link the client's core themes and issues. Effectively shifts from psycho-education to guided discovery. Socratic questioning is used to help the client reflect on their own issues to generate their own conclusions.</p>

ITEM 20: Paraphrasing and Summaries

The therapist appropriately uses paraphrasing and provides summaries.

These points should be considered when scoring:

- The therapist provides summaries and paraphrasing during the session.
- Summaries are used to check the client understand the key concepts/formulation within the session.
- The therapist uses voice tone and body language to amplify/modify motivational/emotional systems.
- The therapist provides verbal/visual feedback that summarises the main points of the session.
- Summaries and paraphrasing is used to link the client with more affect-laden language.
- The therapist encourages the client to use their own summaries and paraphrasing during the session/at the end of the session.
- Summaries and paraphrasing are used to link the client to CFT psychoeducational material or the client's formulation.

Unable to rate: X

Absent or inappropriate				Skilful enactment
0	1	2	3	4
Less competent			More competent	
<p>The therapist does not use appropriate summaries or paraphrasing.</p>			<p>The therapist uses summaries to identify key themes in the client's narratives. The therapist paraphrases salient issues. Therapist checks the client has understood. The therapist models the qualities of compassion and encourages the client to take an active role in the session.</p>	

ITEM 21: Agenda setting

The therapist can collaboratively set an agenda and reflects on whether the agenda for the session is helpful for the client, and if necessary to change the focus on the session collaboratively with the client.

These points should be considered when scoring:

- An agenda is set in an appropriate and collaborative way.
- Therapist is adept at eliciting frequent feedback both verbal and non-verbal and frequently checks that the session is on track.
- The therapist demonstrates flexibility between adhering to the agenda and creating space for the client to share important issues.

Unable to rate: X

Absent or inappropriate					Skilful enactment
0	1	2	3	4	
<p>Less competent</p> <p>Session does not maintain focus and the agenda is not followed. The therapist allows the session to go off track. Agenda is inappropriate or not set.</p>					<p style="text-align: right;">More competent</p> <p>The therapist collaboratively sets an agenda with the client. The agenda is suitable for the available time. The therapist shows a high level of skill in checking for feedback and ensuring the session is on track. The therapist demonstrates flexibility between focusing on the agenda and allowing the client to explore important issues.</p>

Appendix M

Epistemological stance

The researcher adopted a ‘critical realist’ epistemological position whilst completing this thesis. This was chosen because this position takes the stance that scientific research can be used to apply knowledge, but that this knowledge is amenable to change and open to criticism. This seemed a pragmatic approach that acknowledged that the world is complex and has multiple perspectives and this fitted with the mixed methods design employed in the research to develop a compassion-focused therapy therapist competence scale. This approach takes a critical stance and suggests that scientific research can be improved at a later stage and this aligned with the aims of this research.

Appendix N

Chronology of research process

Research Proposal submitted to peer review	January 2016
Submitted to University Ethics Committee	February 2016
Ethical Approval Granted	February 2016
Recruitment for the independent expert panel	April 2016
Data collection: Round one meeting	May 2016
Recruitment for survey expert panel	September – December 2016
Data collection: Round two survey	January - February 2016
Analysis of round two data	January 2017
Data collection: Round three meeting	February 2017
Data collection: Round four survey	February- April 2017
Data collection: Round five meeting	April 2017
Write up	April- May 2017

Appendix O

Guidelines to authors for journal targeted for research

Target journal: Clinical Psychology and Psychotherapy

Excerpt from 'Author Guidelines' retrieved 22 May 2017 from

[http://onlinelibrary.wiley.com/journal/10.1002/\(ISSN\)1099-0879/homepage/ForAuthors.html](http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1099-0879/homepage/ForAuthors.html)

MANUSCRIPT STYLE

The language of the journal is English. 12-point type in one of the standard fonts: Times, Helvetica, or Courier is preferred. It is not necessary to double-line space your manuscript. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.

- During the submission process you must enter the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)**.
- Enter an **abstract** of up to 250 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
- All articles should include a **Key Practitioner Message** — 3-5 bullet points summarizing the relevance of the article to practice.
- Include up to six **keywords** that describe your paper for indexing purposes.

Types of Articles

- **Research Articles:** Substantial articles making a significant theoretical or empirical contribution.
- **Reviews:** Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies.
- **Assessments:** Articles reporting useful information and data about new or existing measures.
- **Practitioner Reports:** Shorter articles (a maximum of 1200 words) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

Title and Abstract Optimisation Information. As more research is read online, the electronic version of articles becomes ever more important. In a move to improve search engine rankings for individual articles and increase readership and future citations to Clinical Psychology & Psychotherapy at the same time please visit [Optimizing Your Abstract for Search Engines](#) for guidelines on the preparation of keywords and descriptive titles.

Illustrations. Upload each figure as a separate file in either .tiff or .eps format, the figure number and the top of the figure indicated. Compound figures e.g. 1a, b, c should be uploaded as one figure. Grey shading and tints are not acceptable. Lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Where a key to symbols is

required, please include this in the artwork itself, not in the figure legend. All illustrations must be supplied at the correct resolution:

- Black and white and colour photos - 300 dpi
- Graphs, drawings, etc - 800 dpi preferred; 600 dpi minimum
- Combinations of photos and drawings (black and white and colour) - 500 dpi

The cost of printing **colour** illustrations in the journal will be charged to the author. The cost is approximately £700 per page. If colour illustrations are supplied electronically in either **TIFF** or **EPS** format, they **may** be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the *Wiley Online Library* site.

REFERENCE STYLE

In-text

Citations

The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper. Cite as follows:

1. **A typical citation of an entire work consists of the author's name and the year of publication .**
Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.
2. **If the author is named in the text, only the year is cited .**
Example: According to Irene Taylor (1990), the personalities of Charlotte. .
3. **If both the name of the author and the date are used in the text, parenthetical reference is not necessary.**
Example: In a 1989 article, Gould explains Darwin's most successful. . .
4. **Specific citations of pages or chapters follow the year .**
Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).
5. **When the reference is to a work by two authors, cite both names each time the reference appears .**
Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .
6. **When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al.* (meaning "and others") .**
Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al.*, 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al.* in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.
7. **When the reference is to a work by a corporate author, use the name of the organization as the author.**
Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).
8. **Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .**
Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .
9. **Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows .**
Examples:
 - List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
 - Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
 - List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

Reference List

APA – American Psychological Association

References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

Appendix P

Guidelines to authors for journal targeted for literature review

Target Journal: Clinical Psychology Review.

Excerpt from 'Guide for Authors' retrieved 22 May 2017 from

<https://www.elsevier.com/journals/clinical-psychology-review/0272-7358/guide-for-authors>

Article

structure

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Of note, section headings should not be numbered.

Manuscripts should ordinarily not exceed 50 pages, *including* references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the on line version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text.

It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least through the prior calendar year) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (<http://www.prisma-statement.org/statement.htm>) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is

not required, but is recommended to enhance quality of submissions and impact of published papers on the field.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Appendix Q

Consent form

CONSENT FORM

Study number:

Participant identification number for this trial:

Title of Project: The development of the Compassion Focused Therapy Therapist

Rating Scale (CFT-TRS).

Name of main Researcher: Victoria Horwood

Please initial each

box

1. I confirm that I have read and understood the participant information sheet dated _____ version __ for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Person
taking consent

Date

Signature

VERSION1 DD/MM/YY

Appendix R

Participant information sheet

Participant information sheet for expert supervisors

Study title: The development of the Compassion Focused Therapy Therapist Rating Scale (CFT-TRS).

Invitation and brief summary:

You are being invited to take part in a research project that aims to develop a Compassion Focused Therapy (CFT) therapist rating scale. Prior to consenting to participate in this study the following information should be read through to explain the purpose of the study, any risks, and contact information. Validated therapist Competency scales are widely used within other treatment modalities. They can be useful within research studies, clinical practice and within training to help measure whether therapists have reached a recognised standard of competence. There are currently no psychometrically evaluated CFT therapist rating scales and the purpose of this study is to develop a measure of therapist competence that can be used within training, research and clinical practice.

What's involved?

The study will use a formal professional consensus method, which is a systematic and robust method that uses a panel of experts to gain consensus in a minimum of two rounds. This study will involve two rounds. Round one will aim to establish the competency items that should be included and excluded in the CFT competency scale. This will be achieved in three stages. In the first stage two CFT supervisors will be interviewed to develop the initial draft of the scale, which will be recorded and transcribed. A survey will be designed and sent to all participants. The survey will determine levels of agreement for each candidate item and participants will be required to provide any further comments about options for change. This information will be collated and stage three will involve taking the information back to the initial scale developers to develop the final version of the scale items.

Round two will involve the development of the behavioural indicators for levels of competence for each item. To achieve this, expert supervisors in CFT will be interviewed via Skype to develop the initial behavioural indicators. This interview will be recorded and transcribed. This information will be collated and used to develop a survey. The survey will be sent out to all participants to establish levels of consensus. The final version of the CFT competency scale will

be put together and then sent out to all participants to establish that the minimum level of consensus has been achieved.

Data from the interviews will be recorded onto a transportable audio recording device and will be kept on the researcher's persons in transit from the interview to the place of storage. All the data collected for this study will be saved to a password protected file on a University account requiring a password to access the computer. The consent forms will be stored in a locked cabinet at the [REDACTED] During the write up no information will be used that could identify participants. When the study has been complete the data will be transferred to a password protected system at the [REDACTED] [REDACTED] and will be destroyed after a period of five years.

What are the risks and/or advantages of taking part in this research?

There are no risks to taking part in this research study. The benefits of this study is that it will contribute toward the development of CFT in training, clinical practice and research.

Further information

This study is being completed by a trainee Clinical Psychologist at the [REDACTED] and this piece of research will form part of the main researchers DCLinPsy thesis. During the write up of the study no identifiable participant information will be used. After you have read through this information sheet and you decide to take part in this study, you will be required to sign the consent form. After the study has been written up the findings will be disseminated to yourselves, the [REDACTED] and submitted for publication within a peer reviewed journal. If you have any further questions please do not hesitate to contact the main researcher on [REDACTED]

Thank you for considering your involvement in this study.

Contact details of main researcher
Miss Victoria Horwood

[REDACTED]

Appendix S

Letters from Ethics committee

[REDACTED]

24/02/2016

Ethics Reference: [REDACTED]

TO:

Name of Researcher Applicant: Victoria Horwood

Department: Psychology

Research Project Title: The development of the Compassion Focused Therapy Therapist Rating Scale (CFT-TRS).

Dear Victoria Horwood,

RE: Ethics review of Research Study application

[REDACTED] has reviewed and discussed the above application.

1. Ethical opinion

The Sub-Committee grants ethical approval to the above research project on the basis described in the application form and supporting documentation, subject to the conditions specified below.

2. Summary of ethics review discussion

The Committee noted the following issues:

The application addresses appropriately the ethical issues that may arise.

3. General conditions of the ethical approval

The ethics approval is subject to the following general conditions being met prior to the start of the project:

As the Principal Investigator, you are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Research Code of Conduct and the University's Research Ethics Policy.

If relevant, management permission or approval (gate keeper role) must be obtained from host organisation prior to the start of the study at the site concerned.

4. Reporting requirements after ethical approval

You are expected to notify the Sub-Committee about:

- Significant amendments to the project
- Serious breaches of the protocol
- Annual progress reports
- Notifying the end of the study

5. Use of application information

Details from your ethics application will be stored on the [REDACTED]. With your permission, the Sub-Committee may wish to use parts of the application in an anonymised format for training or sharing best practice. Please let me know if you do not want the application details to be used in this manner.

Best wishes for the success of this research project.

Yours sincerely,

[REDACTED]
[REDACTED]