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*Special issue paper*

# Developing a competence framework for cognitive analytic therapy

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**Objective.** This paper describes the development and summarizes the content of a competence framework for delivery of cognitive analytic therapy (CAT).

**Design.** The framework was developed using the evidence-based method developed by Roth and Pilling (2008, *Behavioural and Cognitive Psychotherapy*, *36*, 129).

**Methods.** A review of the CAT outcome literature identified where CAT interventions had evidence of efficacy. Standard texts on CAT were primary sources for details of theory and practice. This process was supported by an expert reference group (ERG). The role of the ERG was to provide professional advice on areas where the evidence base was lacking, but where CAT interventions were commonly used by therapists trained in the model.

**Results.** A framework was produced and structured in terms of core knowledge, core skills, and meta-competences (which require therapeutic judgement rather than simple adherence to a treatment protocol).

**Conclusions.** The framework enables trainees, service users, service managers, and commissioners to better understand a) the core features of CAT and b) what competences need to be in place for CAT to be skilfully delivered in practice.

## Practitioner points

- It is possible to define the core competences of CAT.
- Whilst generic competences are important, there are five CAT-specific domains of competence.
- The CAT-specific competences reflect the three-phase structure of the therapy: reformulation, recognition, and revision.

Cognitive analytic therapy (CAT) was developed in the 1980s by Anthony Ryle with the aim of creating a focussed, brief, researchable, and safe intervention for people with



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complex mental health problems accessing services in the public sector (Ryle, 1990). It is widely practised in the UK, in both NHS and private settings (Ryle, Kellett, Hepple, & Calvert, 2014); there are now 770 accredited CAT therapists practising in the UK with 240 in training. It now also has a wide international following (Potter, Kerr, & Kanninen, 2017). CAT draws on a cognitive reformulation of psychoanalytic object relations theory and Vygotskian activity theory. Practically, CAT integrates aspects of cognitive behavioural therapy (e.g., functional analysis, collaborative empiricism, and between session 'homework' tasks) with psychodynamic methods (e.g., working with transference and countertransference) within a collaborative and relational framework (Ryle & Kerr, 2002). CAT has a tripartite structure. Early sessions focus on developing a reformulation of target problems into reciprocal roles and target problem procedures. These are described in terms of unmet needs and unmanageable feelings from early life, which lead to habitual patterns of cognitive appraisal, intention, actions, and consequence. CAT contends that these sequences persist in adult life and typically fail to meet the person's aims and needs (Ryle, 1990). However, they are understood to be resistant to change, as they are embedded in procedural memory and the person is not consciously aware of the pattern they are enacting, both with themselves and others. The second phase of CAT focusses on promoting recognition (i.e., awareness) of these reciprocal roles and associated problem sequences, both in everyday life and as enacted within the therapy relationship. The development of an 'observing self' during the recognition phase of CAT is seen as a necessary precursor to change (Ryle, 1995). The third, final phase aims to revise these roles and patterns. Ways of exiting from the problem procedural sequence are identified by the therapist and client working collaboratively. Cognitive and behaviour change techniques are used, both within and between sessions, to create new, healthier, more flexible roles and procedures. Ryle (1997) also discusses more complex client presentations in terms of partially dissociated self-states, and for such clients, CAT therapists use the multiple self-states model (MSSM; Pollock, Broadbent, Clarke, Dorrian, & Ryle, 2001) within the tripartite structure. In each of these three phases, CAT therapists make explicit use of the Vygotskyan concept of the 'Zone of Proximal Development' (ZPD) to adjust the aims, content, and pace of therapy. Therapists are constantly judging what the client cannot yet do unaided, but will be able do with the aid of 'scaffolding' provided by the therapist's active support. Beyond the individual's ZPD, the support of the therapist is ineffective and the potential for therapeutic failure is high. The revision phase of CAT also pays close attention to the end of the therapy as problems or issues with ending will have been highlighted in the reformulatory process.

Initially, there was insufficient research evidence to justify the popularity of CAT as a pragmatic therapy method (Margison, 2000), but over time the evidence base for CAT has become more substantial and convincing. Calvert and Kellett (2014) conducted a systematic review which identified 25 quantitative outcome studies of CAT and assessed their methodological quality. In the main, quality was acceptable; 52% of studies were rated high quality. However, $n = 1$ studies and small-scale studies of outcomes in routine practice far outnumbered randomized controlled trials. This review concluded that CAT is a 'promising intervention across a range of diagnostic groups'. Since this date, further studies have added to the evidence base (e.g., Calvert, Kellett, & Hagan, 2015; Evans, Kellett, Heywood, Hall, & Majid, 2017; Kellett, Hall, & Compton-Dickinson, 2018; Kellett, Stockton, et al., 2018; Sandhu, Kellett, & Hardy, 2017) but well-controlled studies with adequate sample sizes are still lacking. In this respect, the evidence base is deficient, and further research is required. Marriot and Kellett (2009) analysed routinely collected outcome data from a service offering CAT, CBT, and person-centred therapy for

depression and interpersonal problems. They concluded that all three therapies delivered by the services appeared equally effective. A more recent meta-analysis concluded that patients with a range of presenting problems appear to experience durable improvements in their difficulties after completing CAT and that CAT significantly outperformed controls in the randomized controlled trials (Hallam, Simmonds-Buckley, Kellett, Greenhill, & Jones, 2020). It is worth noting that whilst CAT was originally designed to be a first-line therapy, in practice CAT is often offered to those who have failed to benefit from other approaches, or who have more complex interpersonal problems. For example, in the Marriot and Kellett study (which contrasted CAT, CBT, and person-centred therapy), all therapies performed similarly, but only the CAT service treated clients with personality disorder diagnoses.

Cognitive analytic therapy is now practised extensively in the UK and continues to develop internationally, so that training centres and associated supervision structures are now well established (Marx, 2001; Pickvance, 2016). It is therefore timely, (for research, supervision and training in this method to progress) to define the specific competences that are quintessential when delivering CAT.

### *Specifying and assessing therapist competence*

Therapist competence goes beyond adherence to a treatment manual or protocol (Waltz, Addis, Koerner, & Jacobson, 1993). It has been defined as 'the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served' (Epstein & Hundert, 2002). It is possible to be adherent to a therapeutic model but to deliver therapy in a less then competent manner. For example, an adherent but incompetent CAT therapist could produce a narrative reformulation that was outside the patient's zone of proximal development, so rendering it meaningless to them. A competent CAT therapist should be able to offer a bespoke therapy for each patient, whilst retaining and using the core features and tools of the model. As this example illustrates, a competent therapist is capable of critical thinking and analysis, and will exercise professional judgement on how best to deliver a therapy in specific circumstances (Kaslow, 2004). In this way, adherence to a therapy manual can be seen as a necessary but not sufficient condition for competence (Kazantzis, 2003).

Treatment integrity in CAT, for research purposes, would mean that there is adherence to the three-phase structure of CAT and that the therapist works with the client in a competent manner (Perepletchikova & Kazdin, 2005). Understanding the relationship of treatment integrity to outcome is not straightforward; one meta-analysis concluded that there is no overall evidence that adherence and competence benefit therapy effectiveness (Collyer, Eisler, & Woolgar, 2019; Webb, DeRubeis, & Barber, 2010). However, negative or ambiguous results were unsurprising given a range of methodological difficulties. First, studies were overdependent on secondary analysis of randomized trials. Second, trials are under-powered for the analysis of therapist effects. Furthermore, primary studies were rare, and there was a wide variation in the methods used to sample and to assess competence. Both papers note that analysis of moderator variables was limited by the heterogeneity in measurement approaches.

The assessment of competence has improved through the development of standardized measures for judging how competently a therapy has been delivered, both for the appraisal of generic competence in a method (e.g., *Cognitive Therapy Scale – Revised*; Blackburn *et al.*, 2001; *UCL-CBT Scale*; Roth, 2016) and disorder-specific competence

(e.g., *Cognitive Therapy Competence Scale – Social Phobia*; von Consbruch, Clark, & Stangier, 2012). In CAT, Bennett and Parry (2004) developed a sessional rating scale (Competence in CAT measure: CCAT) where raters make global judgements of ten domains of competence, based on more detailed descriptions of observable therapist performance (e.g., 'The therapist collaboratively draws a diagrammatic reformulation of the client's current difficulties', 'The therapist appropriately handles agreement and disagreement over the content of the written and/or diagrammatic reformulations'). Each individual item within a domain is rated as present, or absent. If present, the rater distinguishes between a competence that was exceptionally well executed and one which was demonstrated but not particularly well. If a specific competence was not demonstrated in the session, the rater distinguishes between therapist errors (a competence that could and should have been demonstrated) and those absent because either inappropriate or difficult to demonstrate in the context. These ratings are then used to anchor a global judgement of the overall therapist competence within that domain. The measure has been used in randomized controlled trials (Chanen *et al*., 2008; Clarke, Thomas, & James, 2013; Kellett, Stockton, et al., 2018) to check whether CAT was delivered to an acceptable criterion, and to investigate the impact of treatment integrity on outcome. It has been widely adopted in CAT training and supervision to identify whether trainees are mastering the skills taught and to give feedback on what is required to meet a criterion of competence (Kellett & Bennett, 2016). It can also be a method of enabling and structuring self-reflection in continuing professional development.

Psychotherapy competence rating scales have been criticized for lacking validity and reliability (Barlow & Brown, 2020; Fairburn & Cooper, 2011). A number of methods can be used in research trials which aim to improve reliability, for example by initial rater training and continuing checks of 'rater drift', using consensus meetings, feedback of outlying ratings, and regular calibration of scores across a group against a standard exemplar (e.g., Bennett & Parry, 2004; Roth, 2016). However, in routine practice, without regular calibration of scores between raters, scale reliability is poor (Kühne, Meister, Maaß, Paunov, & Weck, 2020). For this reason, Roth, Myles-Hooton, and Branson (2019) raise concerns about their use in summative assessment of competence, particularly in training.

Measurement of competence requires scale developers first to specify the competences to be assessed. A different but complementary approach to specifying competences (but not to assess them) is the method developed by Roth and Pilling (2008) as part of the Improving Access to Psychological Therapies (IAPT) programme, which required a set of modality-specific competence frameworks to develop the national IAPT training curriculum. These frameworks differ from lists of competence items in that they are structured into competence domains. They now include CBT, systemic, psychodynamic, and humanistic therapies, and therapies for specific conditions such as working with personality disorders, bipolar disorder, and psychosis (www.ucl.ac.uk/core/competence-frameworks/).

The Roth and Pilling method begins with a review of research evidence, which gives reason to believe that the competences it sets out are likely to make a difference to outcome, because they have been included in a treatment guide or have been used as a fidelity measure in a successful clinical trial. Where there is less direct evidence that elements of a therapy model are linked to treatment efficacy, the role of expert professional opinion is important in supplementing or interpreting evidence (Parry, Roth, & Fonagy, 2005.)

One advantage of the Roth and Pilling method is that it provides a standardized approach to understanding and comparing competences across different therapy models. Since all psychological therapies hold much in common as well as their modality-specific techniques, the similarities and differences between them can be better understood through a common method for specifying competence. The validity of the frameworks for CBT, psychodynamic and humanistic therapies in identifying modality-specific competences was supported via a Q-sort comparison (Roth, 2015). The Q-sorts demonstrated that practitioners of the three therapy types strongly favoured items from their own modality framework and eschewed items from the others.

These frameworks describe what is expected of a competent practitioner in any given method (and so do not specify a hierarchy of knowledge and skills between, e.g., novice and 'expert' practitioners). In this respect, competence *frameworks* differ from competence *measures*, which aim to assess and describe the most competent practice of a therapy, and typically provide a range of scores indicating level of skill. Although the frameworks are not organized in terms of a hierarchy, in practice of course, practitioners do vary in the extent to which they can demonstrate the full range of competence, and the demonstration of competence also varies between clients and between sessions with the same client. This is likely to be particularly evident when training in any psychotherapy model (Bennett-Levy & Beedie, 2007).

Another method to specify aspects of CAT practice was used by Taylor, Jones, Huntley, and Seddon (2017) to explore CAT practice with those facing experiences of psychosis. They used a formal consensus-generating technique, an adapted form of the Delphi method, with a sample of expert practitioners working clinically with psychosis. An initial workshop generated items of CAT practice specific to this population and two rounds of ratings established consensus on which were key elements. Whilst this method worked well for an adaptation of an established therapeutic method for a specific population, the Roth and Pilling method aims to set out the whole ethos and practice of a given model on the basis of existing research, training materials, textbooks, and professional practice. This involves a more 'granular' set of over a hundred competence descriptors, most with a number of sub-items. This is too many for a formal Delphi method, hence the need for a different way to develop consensus.

### *The need for a competence framework*

The intended audience for the framework is not only cognitive analytic trainees, therapists, supervisors, and trainers, but those who manage, commission or research these therapies. As such, these frameworks are indicative rather than prescriptive – they are used as a support tool and a guide to best practice, not as a substitute for clinical judgement nor an 'instruction manual' for how the therapist must or should relate to the client. This is particularly important for a therapy such as CAT, which whilst theoretically driven and structured around a clear set of therapy tasks, does not use disorder-specific protocols. This is why Tyrer (2013) mentioned CAT as an example of skilled and humanized psychotherapy.

The value of such a framework in de-mystifying CAT and laying out its key features must be balanced against the risk of it being reduced to a series of technical steps. In fact, CAT (in common with many forms of psychological therapy) cannot be reduced to a series of technical competences, not least because of the need to make moment-by-moment judgements and adjustments within a complex collaborative relationship (Coyne, Constantino, & Muir, 2019). This responsive use of a human relationship is seen by

Peterfreund (1983) as an essentially heuristic, as distinct from algorithmic, process. It is important to hold in mind that CAT is founded upon and guided by a theoretical knowledge base and a relational philosophy and that all of its 'techniques' are grounded in and flow from this position. Clearly, CAT therapists need to understand the theoretical rationale for what they are doing, not deliver CAT as a mere set of techniques. Once the narrative and sequential diagrammatic reformulations have been negotiated and agreed between therapist and patient, the methods used to support recognition and revision of problem procedures vary considerably (Ryle & Kerr, 2002). These change methods often use techniques drawn from other therapies, such as behavioural activation, compassion-focussed exercises, behavioural exposure, and cognitive methods, all delivered with sensitivity to what is being enacted within the therapy relationship. The specific methods are always grounded in the client's reformulation. Therefore, the techniques used can be highly idiosyncratic and are a matter of clinical judgement, particularly as the therapist needs to be working within the patient's zone of proximal development.

Critics of the competence mapping approach argue that it draws on the views of a small group of professionals, fails to cover all opinions on what are the essential competences (Owen-Pugh & Symons, 2013), and sets too high a bar for delivery in routine services. There is a risk that this approach demands such a high prerequisite skill set that only a small and exclusive set of therapists could achieve the necessary competence (Thomas, 2015). However, it can be argued that mapping competences does not require that they all be delivered and that simply specifying and structuring these competences does not set a bar of any height. Furthermore, we believe the method we have adopted mitigates these potential difficulties by reviewing a wide range of CAT literature and, through external consultation, ensuring that the final product is recognized by practitioners as accurately reflecting their standard clinical practice.

Another inevitable limitation of the framework is that its focus is the practice of formal cognitive analytic therapy, rather than applications of cognitive analytic principles in health care, of which there are many. For example, the principles of CAT have been applied to training nursing and support staff to work more effectively with their clients in community health teams (Thompson *et al.*, 2008), prisons (Roper, 2018), dementia care (Sutton, 2003), and eating disorders services (Newall, 2012). A short form, guided self-help based on CAT has also been developed to inform the work of Psychological Wellbeing Practitioners in IAPT services (Meadows & Kellett, 2017). A CAT-informed approach has been used in assessing young people presenting with self-harm (Kraupl-Taylor, Ng, & Low, 2008) and in early intervention clinics for 'pre-borderline' adolescents (Chanen, McCutcheon, & Kerr, 2014). The expansion of 5-session CAT consultancy to support the work of secondary care services with complex clients has highlighted the need for a CAT consultation competence scale (Kellett *et al.*, 2019) to mirror the recent development of a CBT version (Bucci, Hartley, Knott, Raphael, & Berry, 2019). CAT has a model for consulting to teams using contextual reformulations and as an organizational development method, but this was beyond the scope of the current framework, as was the use of CAT in groups (Hepple, 2012).

### *Aims*

1. To identify the psychological knowledge and skills (competences) required to practise cognitive analytic therapy.

2. To structure these competences in terms of a range of domains, in a way that makes them accessible to their intended audience.
3. To distinguish between generic and CAT-specific domains of competence.
4. To match and mirror the structure of the competences of CBT, psychodynamic and humanistic therapies, which have then shaped national training curricula for these therapies.

## Methods

### *Developing the framework*

The method developed by Roth and Pilling (2008) was used to develop the framework. Initial work on identifying competences drew on a wide range of sources.

Primary resources were standard texts on CAT (e.g., Ryle, 1990, 1995; Ryle & Kerr, 2002; Ryle, Leighton, & Pollock, 1997), the Competence in CAT measure (Bennett & Parry, 2004) and national UK training curricula.

For research papers up to and including 2013, we drew on the Calvert and Kellett (2014) systematic review which used the search term 'cognitive analytic' in electronic databases PsycInfo, Medline, and CINAHL. This search identified 250 papers. Studies were then excluded for the following reasons: non-English-language papers, unpublished theses, books, book chapters, or book reviews, CAT not cited, insufficient psychometric outcomes, qualitative methodologies. A final sample of 25 research papers was retrieved for inclusion, dated between 1987 and 2013. These included single-case experimental designs (e.g., Kellett & Hardy, ); randomized controlled trials (e.g., Clarke *et al*., 2013); quasi-experimental studies (e.g., Chanen *et al*., 2008); and practice-based effectiveness studies (e.g., Marriott & Kellett, 2009). Research published since 2013, using the same search strategy, was also identified, including a pilot trial of CAT for bipolar disorder (Evans *et al*., 2017) and a patient preference trial for group CAT in a forensic setting (Kellett, Hall, et al., 2018). In addition, research identifying specific factors associated with outcome was considered (e.g., Bennett, Parry, & Ryle, 2006; Daly, Llewelyn, McDougall, & Chanen, 2010; Kellett, Stockton, et al., 2018; Ryle & Golynkina, 2000; Sandhu *et al*., 2017).

The IAPT framework on 'Working with personality disorders' had already included a section on CAT for this client group (alongside other approaches such as CBT and DBT), which was another source available to the current developers. Initial competence lists were drawn up from these sources, which included both knowledge and skills items such as 'knowledge of internalized reciprocal roles governing interpersonal relating and self-management'; 'An ability to draw on knowledge that CAT is a "reflective" model, and assumes that the therapist's own reciprocal roles and role procedures may be elicited by the therapeutic relationship and may interact with those of the client'; 'skill in taking a client history in an empathic, relational way, listening for the dialogical movement between reciprocal roles'.

The development of the framework was overseen by an expert reference group (ERG), composed of experts in the field, including researchers, trainers, and expert practitioners.[1] With the exception of Professor Roth, who contributed expertise in the framework development method, all were experienced cognitive analytic psychotherapists, trainers, and supervisors. Other relevant experience within the group included NHS management,

[1] *Members of the ERG were Dawn Bennett, Elizabeth Fawkes, Jason Hepple, Stephen Kellett, Ian Kerr, Glenys Parry and Anthony Roth.*

health services research, IAPT, CAT research, and course accreditation. The work proceeded with an iterative process of reviewing the competence lists, discussing the best way to structure them, remedying omissions and errors, and providing a detailed review of the wording to remove ambiguity and make the content accessible to a non-CAT audience. The penultimate draft approved by the ERG was then circulated to a wider group of CAT trainers who had recognized authority in the field, to be sure that the practice described in the framework reflected broad clinical consensus among researchers and clinicians, and was not an idiosyncratic production of a small group.

Rather than a tiered approach, the competences were organized in terms that map on to the three phases of CAT. Underpinning these is a range of generic therapeutic competences and meta-competences, both of which are essential for CAT but also held in common with other psychotherapy methods. In line with the method developed by Roth and Pilling (2008), decisions about which items were allocated to the general, meta-, and specific competence categories were undertaken by reiterative discussion and consensus within the ERG, and confirmed by external review.

The CAT-specific competences were grouped into

1. Knowledge of the basic principles of CAT and rationale for therapy
2. Reformulation and engagement phase
   a. Knowledge of reformulation in CAT
   b. Engaging the client to reach a shared reformulation
3. Recognition and revision phases
   a. Knowledge of working at change in CAT
   b. Facilitating change in CAT
   c. Working with the time-limited nature of CAT
4. CAT-specific meta-competences.

### *Testing the validity of the framework*

The completed framework and the interactive map were made available online and two groups were convened to assess the extent to which (1) the content was recognized by the accrediting body as a valid summary of CAT practice and (2) the online version could be navigated and found to have clarity, helpfulness, and applicability.

In the first, members of the Training Committee of the Association for Cognitive Analytic Therapy, the professional body which accredits CAT Practitioners, were asked to provide feedback on its validity and its usefulness.

In the second, three CAT trainees, three CAT practitioners and two (non-CAT) NHS service managers were asked to rate the online framework on the dimensions of clarity, helpfulness, applicability, and the degree to which the framework was theory-driven.

## Results

### *The map of cognitive analytic competences*

A simple list of competences is hard for the user of the framework to structure, especially if they are unfamiliar with the field. For this reason, the framework development method sets out a 'map' of competence headings which identifies all the areas of knowledge and skill, organizes them into a series of domains, and helps to show the ways that the different

sets of competences inter-relate, particularly over the course of a therapy. This structure works across a wide range of domains of psychological interventions, not just specific psychological therapies for complex mental health problems, but frameworks for psychological therapies supervision, self-harm and suicide and multidisciplinary paediatric services (Pilling & Roth, 2014; Roth & Donnan, 2019). The map of domains is intended to be viewed online in an interactive format, so that each heading in each domain can be linked to a full account of the competences. An important aim is to ensure each competence statement is concise and comprehensible on its own, so the text enables users to understand what is needed without extensive cross-reference elsewhere.

Figure 1 shows the map of competence domains for cognitive analytic therapy; individual items of competence are nested within each of these. Because the framework and specific competences are designed to be viewed online (at www.ucl.ac.uk/core/competence-frameworks/ ), what follows is only a synopsis of its content.

### *CAT-specific competences: Theoretical knowledge and the rationale for therapy*

The first CAT-specific domain describes knowledge of CAT theory and the rationale for therapy. It lists competences relating to basic principles, theory of the self and adverse developmental experiences, CAT as an integrative therapy, the concept of the 'zone of proximal development', the time-limited nature of CAT, and implications for therapy.

Examples of the competences in these domains are given in Figure 2.

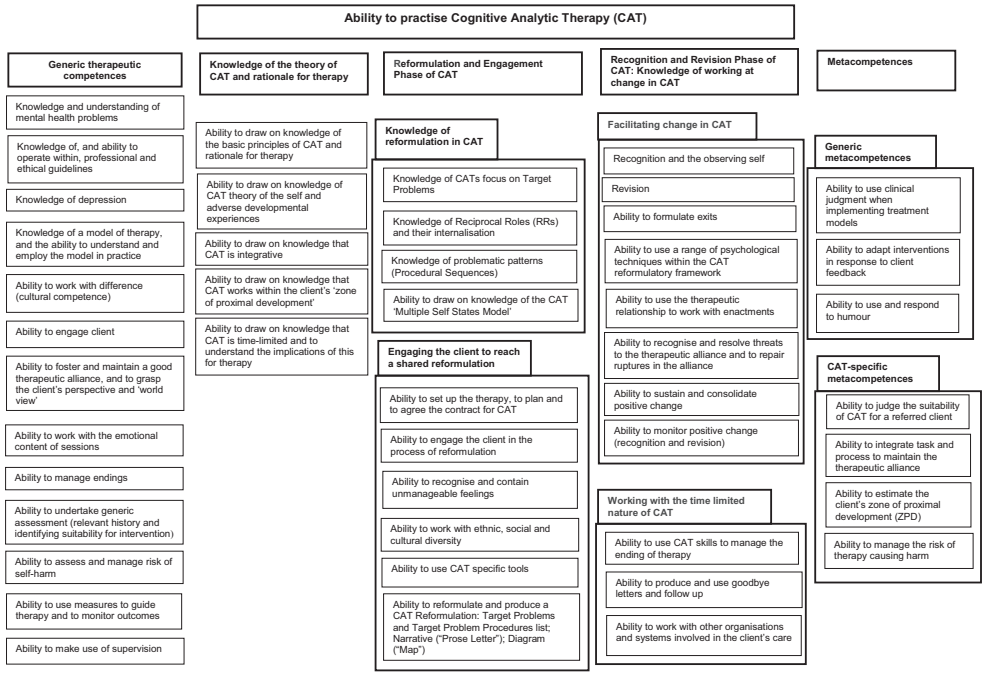


**Figure 1.** Map of competence domains in cognitive analytic therapy

**Ability to draw on knowledge of the basic principles of CAT and rationale for therapy**

| |
|---|
| An ability to draw on knowledge that CAT is a brief, focused therapy that integrates cognitive and analytic perspectives in a coherent theoretical framework |
| An ability to draw on knowledge that CAT is an interpersonal (or relational) therapy that focuses on repetitive patterns in the way people think, act, feel and relate to themselves and others, and that these patterns: |
| are habitual and automatic because they are based in procedural memory, and are termed 'procedural sequences' |
| are learned through developmental experiences, and are developed by everyone, regardless of the nature of their experiences |
| are strategies to cope with developmental experiences |
| in the face of adverse experiences, are 'survival strategies' and reflect the way the person managed to cope |
| may cause unintended problems and limit current goals where they no longer achieve their aim or serve a useful function |
| can be worked with in the therapeutic relationship |
| An ability to draw on knowledge that CAT involves helping the client develop better awareness of these patterns (procedures), and so be able to make changes to them |

**Ability to draw on knowledge that CAT works within the client's 'zone of proximal development'**

| |
|---|
| An ability to draw on knowledge that CAT aims to work within the client's 'Zone of Proximal Development' (ZPD), which means that: |
| CAT works within the zone of those things which the client cannot yet do unaided, but can do with the aid or "scaffolding" provided by the active support of another (e.g. with the support of a therapist, the client may be able to begin to recognise more of their own negative feelings and find ways to express these) |
| CAT builds on that which the client can already do for themselves unaided (e.g. a client may be insightful about the things that cause them to become anxious, but have very limited insight into their own anger) |
| CAT aims to extend the client's zone of understanding and ability, so that they can subsequently manage without the support of the therapist in this area of functioning |
| An ability to draw on knowledge of the adverse impact of therapist interventions that are outside of the ZPD, for example:: |
| a premature and challenging comment that leads to intense shame in the client who reacts by withdrawal or by recruiting retaliatory and critical RRs |
| 'undershooting' the ZPD by making a comment that is not challenging enough that leads the client to feel overly supported and reliant on the therapist with recruitment of idealising and specially caring RRs |

**Figure 2.** Two examples of competence items from the domain: knowledge of the theory of CAT and rationale for therapy.

### *CAT-specific competences: Reformulation and engagement*

Next, competences in the reformulation and engagement phase of CAT encompass theoretical knowledge and applied clinical skills. Theoretical and declarative knowledge includes the focus on Target Problems, knowledge of Reciprocal Roles and their internalization, procedural sequences and Target Problem Procedures, and the Multiple Self-States Model. Skills include setting up the therapy, how to plan and agree the contract

for CAT, engaging the client in the process of reformulation, recognizing and containing unmanageable feelings, ability to work with ethnic, social and cultural diversity, using CAT-specific tools (e.g., the psychotherapy file), ability to reformulate including lists of Target Problems and Target Problem Procedures, and producing both narrative and diagrammatic forms of collaborative reformulations.

Examples of the competences in these domains are given in Figure 3.

### *CAT-specific competences: Recognition and revision*

Third, in the recognition and revision phase, facilitating change includes skills in fostering recognition, self and relational awareness and the observing self, supporting revision of problem patterns and formulating exits from them, ability to use a range of psychological techniques within the reformulatory framework, using the therapeutic relationship to work with enactments, ability to recognize and resolve threats to the therapeutic alliance and to repair ruptures in the alliance within a CAT model, sustaining and consolidating positive change, and to monitor change to recognition and revision skills. There follows a domain focussed on working with the time-limited nature of CAT, using CAT skills to manage the ending of therapy, to produce and use joint goodbye letters, structured follow-up, and to work with other organizations and systems involved in the client's care.

Examples of the competences in these domains are given in Figure 4.

### *CAT meta-competences*

Finally, the framework considers CAT meta-competences. These permeate all areas of CAT practice and involve making judgements about whether and when to use a specific CAT technique and to customize the intervention to the needs of the individual client. Here are listed competences relating to judging the suitability of CAT for a referred client, integrating task and process to maintain the therapeutic alliance, estimating the client's Zone of Proximal Development and working within it, and managing the risk of therapy causing harm to the client.

Examples of meta-competences in these domains are given in Figure 5.

#### *Validity study 1: Feedback from the ACAT training committee*

All members found the framework to be an accurate description of the model, confirmatory of how they work as therapists and consistent with CAT texts (e.g., Ryle & Kerr, 2002). Other comments included: 'an excellent structure for training purposes, giving clarity for trainees'; 'It will be a framework for course curriculum and assessment'; 'training committee will find it useful in reviewing practitioner training courses'. There were two comments which led to changes to the wording of competence items.

#### *Validity study 2: Feedback from CAT trainees, CAT practitioners, and NHS managers*

All members rated the framework highly; none of the ratings fell below 88% on a scale from 0 to 100% for clarity, helpfulness and applicability. The extent to which it was theory-driven was rated highly by trainees and practitioners (scoring over 90%) and only slightly less so by NHS managers (85%). Generally, practitioners gave the framework the highest approval ratings.

**Knowledge of problematic patterns (Procedural Sequences)**

- An ability to draw on knowledge that CAT focuses on problematic reciprocal role 'procedures' termed *target problem procedures*
  - an ability to draw on knowledge that this focus is because target problems are underpinned by reciprocal role procedures
- An ability to draw on knowledge that the reciprocal role procedure (RRP):
  - refers to a cognitive, emotional and behavioural sequence consisting of: appraisal, emotion, aim, action, consequence and re-appraisal
  - that the procedure is the whole sequence and includes actions and consequences
  - that the sequence is usually out of awareness
  - that reciprocal role procedures are ubiquitous in human experience and are only problematic when they do not meet their aim and instead reinforce the original repertoire, making it difficult to learn from experience, for example:
    - a presenting problem of 'recurrent exhaustion and headache' may lead to the target problem: 'I find it difficult to look after myself and keep myself well' underpinned by procedure "I feel inadequate so I aim to be above criticism, so I anxiously strive to achieve, which leads to exhaustion and headache, and I go off sick, which confirms my sense of being inadequate"
- An ability to draw on knowledge that a person cannot occupy a role without enacting it procedurally, for example:
  - a reciprocal role (e.g. 'unavailable rejecting' other to 'rejected and lonely' self) is enacted and maintained through the sequence 'Feeling lonely and anticipating rejection, I seek constant reassurance from a partner, which leads to them increasing their distance, which confirms that I am not wanted'
- An ability to draw on knowledge that reciprocal roles can only be inferred, and that this is done through observing reciprocal role procedures

**Ability to engage the client in the process of reformulation**

- An ability to hold in mind within each session, which of the three overlapping phases of CAT (*'reformulation'* '*recognition',* or *'revision'*) is salient
- An ability to adopt an empathic but boundaried therapeutic stance which emphasises the development of a collaborative relationship, encouraging active participation between the client and the therapist
- An ability to attend to the client's narrative, listening for recurrent relational themes, enacted or experienced in relation to a number of significant others (e.g. recurring themes of feeling controlled or rejected in relationships)
- An ability to explore the impact of key relational experiences on the client's developing sense of self, for example:
  - their experiences of others as a child
  - what they learned about him/herself and others through relationships with important figures in childhood
  - the impact of childhood trauma, loss, abuse or neglect on the client's developing sense of self
  - wider, social and cultural influences on the development of the self, mediated (for example) by family or school
- An ability to use tools empathically, such as the CAT-specific 'Psychotherapy File' (which lists common traps, dilemmas and snags), a family tree and a life chart in order to explore the client's experiences
- An ability to identify a procedural narrative, for example, looking for repeating themes, patterns and roles that the client is enacting (for example traps, snags and dilemmas)
- An ability to recruit the client to working collaboratively in
  - exploring these themes through discussion and mapping the sequences
  - noticing how the story is told and areas that seem to be missing or confused
  - becoming aware of how the client relates to the therapist and the task
- An ability to help develop an understanding of the client's reciprocal role repertoire by drawing on self-awareness of the feelings the client and their narrative elicit in the therapist

**Figure 3.** Two examples of competence items in the reformulation and engagement phase.

**Ability to recognise and resolve threats to the therapeutic alliance and to repair ruptures in the alliance**

| |
|---|
| An ability to identify an imminent threat to, or rupture of, the therapeutic alliance and to shift the focus to identify the problematic RRPs being enacted in the room and work with the client to resolve these by: |
| refocusing attention to the therapeutic alliance |
| acknowledging the client's experience and helping them express their thoughts and feelings about what is happening in the session |
| carefully exploring the client's experience of what is happening |
| inviting or proposing a link to the reformulation (or if this has not yet been developed, linking to a pattern or other shared understanding) |
| offering an explanation of why this may have occurred (for example, that patterns of relating may repeat across all relationships, including the therapeutic relationship) |
| inviting the client's view as to whether this provisional link and explanation makes sense to them and accounts for what has happened in the session |
| negotiating a shared understanding of the experience, aiming to reach a shared consensus |
| facilitating any emotional reactions to this experience and identifying how it has been understood |
| maintaining a focus on this process until the threat to the alliance is resolved |

**Ability to produce and use goodbye letters and follow-up**

| |
|---|
| An ability to use "goodbye letters" with the client including: |
| writing a letter to the client in which the therapist empathically and constructively: |
| summarises change to reciprocal roles and procedures indicating what has, and has not been achieved in the course of the therapy |
| highlights the potential for self-sabotage, anticipating any problems the client may have in response to the ending and in the future |
| plans relapse prevention, noting how progress can be maintained and the importance of continued practice of exits and revised procedures |
| communicates something of their own feelings about the ending of the therapeutic relationship |
| engaging the client in writing a goodbye letter for the therapist, giving an honest account of their experience of therapy, the ending and the future |
| managing the process of sharing letters in the final or penultimate session, responding to the emotional responses of the client (and the therapist), and acknowledging any mixed feelings about ending (e.g. disappointment and anger as well as positive feelings such as appreciation and gratitude) |
| noting areas of convergence between the therapist's and client's letters as well as points of difference, and the significance of these |
| ensuring that the client has copies of both letters to take away (as a memento of the work undertaken together and the progress that has been made) |
| Where clients may have particular difficulties in relation to loss or abandonment (meaning that the ending of therapy will have particular significance for them), an ability to recognise this by exchanging goodbye letters prior to the penultimate session (to allow longer for working through the ending) |

**Figure 4.** Two examples of competence items in the recognition and revision phase.

## Discussion

This paper has set out the methods used to identify the competences required to enable sound and safe CAT practice. This has produced a summary and synthesis of the key

**Ability to judge the suitability of CAT for a referred client**

| |
|---|
| An ability to judge whether CAT is likely to be a safe and effective therapy for a client seeking help |
| In making this judgement, drawing on knowledge that although CAT is highly inclusive and offered to many clients seen as unsuitable in other models, some people may still be unsuitable for psychotherapy, at least at the time of assessment |
| An ability to judge the extent of contra-indications for CAT, including acute psychotic disorders, active and continuous substance abuse, multiple prescribed medications, serious acute physical disorders, or an active risk of violence |
| An ability to judge whether the client is able to give informed consent to treatment, having been given clear explanation of potential risks, realistic expectation of benefit, and time to make an informed decision |
| An ability to judge one's limits of competence, and take this into account when making an offer of therapy |

**Ability to integrate task and process to maintain the therapeutic alliance**

| |
|---|
| An ability to judge when it is appropriate to work on the tasks of therapy (such as developing the reformulation) or to switch attention to the relational process (such as RR enactments or ruptures in the therapeutic relationship or the client's response to specific "tasks" of therapy e.g. avoiding completing the Psychotherapy File) |
| An ability to recognise when a process issue or RR enactment arises and to judge whether it would be useful to engage the client in reflection on this at that point in time |
| An ability to judge when the task-oriented aspects of CAT are likely to evoke reactions in the client which are characteristic of the client's particular RRs (e.g. resentful compliance, dismissiveness, or idealisation). |

**Ability to estimate the client's zone of proximal development (ZPD)**

| |
|---|
| An ability to judge how best to optimise what the client is capable of with the help of the therapist, which would otherwise be beyond their ability |
| An ability to judge how far to be in advance of the client, stretching and challenging the client, but not so far ahead that they are unable to maintain their motivation or to use the intervention |

**Figure 5.** Three examples of CAT-specific meta-competence items.

features of competent CAT organized into a conceptual map, with details of the competences themselves easily accessed online, entitled '*The Competence Framework for Cognitive Analytic Therapy (CAT)'*. This framework describes the various techniques and activities which need to be integrated in order to carry out CAT effectively and also for the therapist to be aligned with theory, evidence and best practice. The map contains a blend of generic, specific, and meta-psychotherapeutic competences. CAT-specific domains of competence are underpinned by the reformulation, recognition, and revision structure of the therapy and also a list of CAT-specific meta-competences (i.e., setting out the 'overarching' competences of CAT therapists that are relevant across a wide range of clinical settings, that facilitate adaptation and flexibility on the part of the therapist, and which entail the use of clinical judgement).

One aim in developing a CAT competence framework was to match and mirror the efforts that have been made to define the competences of CBT, psychodynamic and humanistic therapies, which have then shaped national training curricula for these therapies. In the same way, the CAT framework lays out the knowledge and skills required

to facilitate safe and effective CAT, for use by trainees, trainers, supervisors, service users, managers, researchers, and commissioners.

### *Limitations*

An obvious, and well-acknowledged, limitation of the 'competence framework' approach is that although these competences are thought to describe best practice on the basis of current evidence, it is impossible to claim that they are all essential to good outcome, and the meta analytic evidence does reflect this (Webb *et al.*, 2010). However, it is difficult to design any ethical research that isolates specific competences from the nexus of therapy activities to test which are dispensable.

Whilst the competences identified were founded in the reformulation, recognition, and revision structure of the therapy, it is acknowledged that in clinical practice that there is often 'bleed over' between the three phases (Ryle & Kerr, 2002). For example, there can be no revision without initial recognition and this has been evidenced in CAT for depression (Sandhu *et al.*, 2017). Also, the competences of CAT are likely to change and evolve as the evidence base for the therapy expands and changes practice. It is also possible that the importance of the competences may differ according to the complexity of client presentation.

The framework development process used also had limitations. In particular, although CAT is practised internationally and the competences were derived from international sources, members of the ERG were from the UK and external review and testing for validity and accessibility was confined to the UK. This leaves the framework at risk of UK bias, and this limitation should be addressed by future validation work within international CAT centres.

The results of the external review with a group of CAT trainees, CAT practitioners, and NHS Service Managers suggest that the framework had clarity, was helpful, applicable, and theory-driven. However, the ratings were limited to reported opinions and ratings collected by the framework developers, and arguably are subject to response bias. An independent survey with a larger sample (e.g., therapists from other theoretical approaches, service users and service commissioners) would be more informative. A study of how the framework is actually used in practice could more effectively test whether it meets its aims.

### *Practical implications*

The clinical and training implications of the new framework are numerous. CAT practitioner training courses internationally are now able to assess the extent to which course content matches the competences map, as an aid to curriculum development. CAT trainees will be able to review their progress in acquiring CAT competence, with greater awareness of domains where they require further support through supervision and deliberate practice of a specific competence. Training appraisals could be matched to the framework to provide useful structure. CAT supervisors can use the framework to scaffold supervision activity to aid and track competence development in trainees. CAT practitioners can usefully reflect on a series of sessions or cases, and even without formal quantitative assessment of competence, can reflect on their areas of strength and relative weakness in the pursuit of skill enhancement. Those commissioning and managing CAT services are given insight into the range of competences that they should expect from qualified staff. Finally, and crucially, the framework can be interrogated by service users and other members of the public, to enhance understanding of what is involved in CAT, to guide their potential choice of CAT as a therapy.

The framework opens new avenues for future research. For example, it would be possible to validate (or fail to validate) the CAT-specific domains of competence through a replication of the Roth (2015) Q-sort study, to compare the responses of CAT practitioners, CBT practitioners, and psychodynamic therapists. The need for continued development of competence measures has been highlighted by Barlow and Brown (2020) in their systematic review of 13 such measures including the CCAT. The comprehensive coverage provided by the framework gives a basis for such research-led improvement. A further research question is the extent to which the competence framework is useful and could be adapted for those applying CAT principles in other settings.

### *Conclusion*

The utility of competence mapping has been evident in other psychological therapies commonly used in the public sector in terms of summarizing the skills necessary for safe and effective delivery. The CAT competence framework produced now enables this complex relational model to be better understood in terms of pragmatic individual competence items. These items also usefully reflect the three-phase structure of the approach. The integrative nature of CAT means that practitioners do not do cognitive work in isolation from analytic work and vice versa. The map produced has therefore emphasized that competent CAT requires the assimilation of both cognitive and analytic components across each of the phases of the therapy in the effort to support enduring relational change for the patient. The widespread use of this framework in training, supervision, research, and routine practice, alongside the compatible CCAT measure (Bennett & Parry, 2004), is now indicated.

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## Conflicts of interest

All authors declare no conflict of interest.

## Author contributions

Glenys Parry (Data curation; Investigation; Resources; Writing – original draft; Writing – review and editing). Dawn Bennett (Conceptualization; Data curation; Investigation; Project administration; Writing – review and editing). Anthony D. Roth (Conceptualization; Investigation; Methodology; Supervision; Writing – review and editing). Stephen Kellett (Investigation; Resources; Writing – review and editing).

## Data availability statement

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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