CAT competence:
culturally relative construct, political lever, or useful training tool?

Glenys Parry, Louise McCutcheon, Gabriele Stabler, Esther Gimeno Castro, Dawn Bennett, David Harvey, & Allyson Waite.

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Overview

- Introduction to the international CAT competence project
- The context of competence
- Competence frameworks
- Show how to navigate the UK framework on-line
- Our project: what we did
- Our project: what we found
  - Australia & New Zealand
  - Spain & Chile
  - Summary
- Implications and future directions

International CAT competence project

- Group of interested CATs decided to investigate CAT in different countries: UK, Australia, New Zealand, Spain and Chile.
- To establish whether or not CAT is practised in the same way internationally.
- To produce an International CAT competence framework to guide CAT training and practice across the world.
- Today is our chance to show what we found and discuss the implications
- Later our workshop is an opportunity to explore the framework in depth, and its uses in CAT training

Investigators

- Glenys Parry (UK)
- Louise McCutcheon (Australia)
- Gabriele Stabler (Spain)
- Esther Gimeno Castro (Spain)
- Dawn Bennett (UK)
- David Harvey (UK)
- Allyson Waite (New Zealand)

And special thanks to:

- Perla Bendov for liaising with Esther on the Chilean perspective
- All the CATs who participated in the consensus generation & focus groups
- Prof Tony Roth for comments on the research protocol
- Katri Kanninen & other ICATA training group members for their support of the project.

Here: Glenys, Louise, Dawn & Gabriele

What is competence?

- Possessing adequate skill, knowledge or capacity for successful completion of a task.
- More than just delivering a therapy 'by the book' or 'according to protocol'

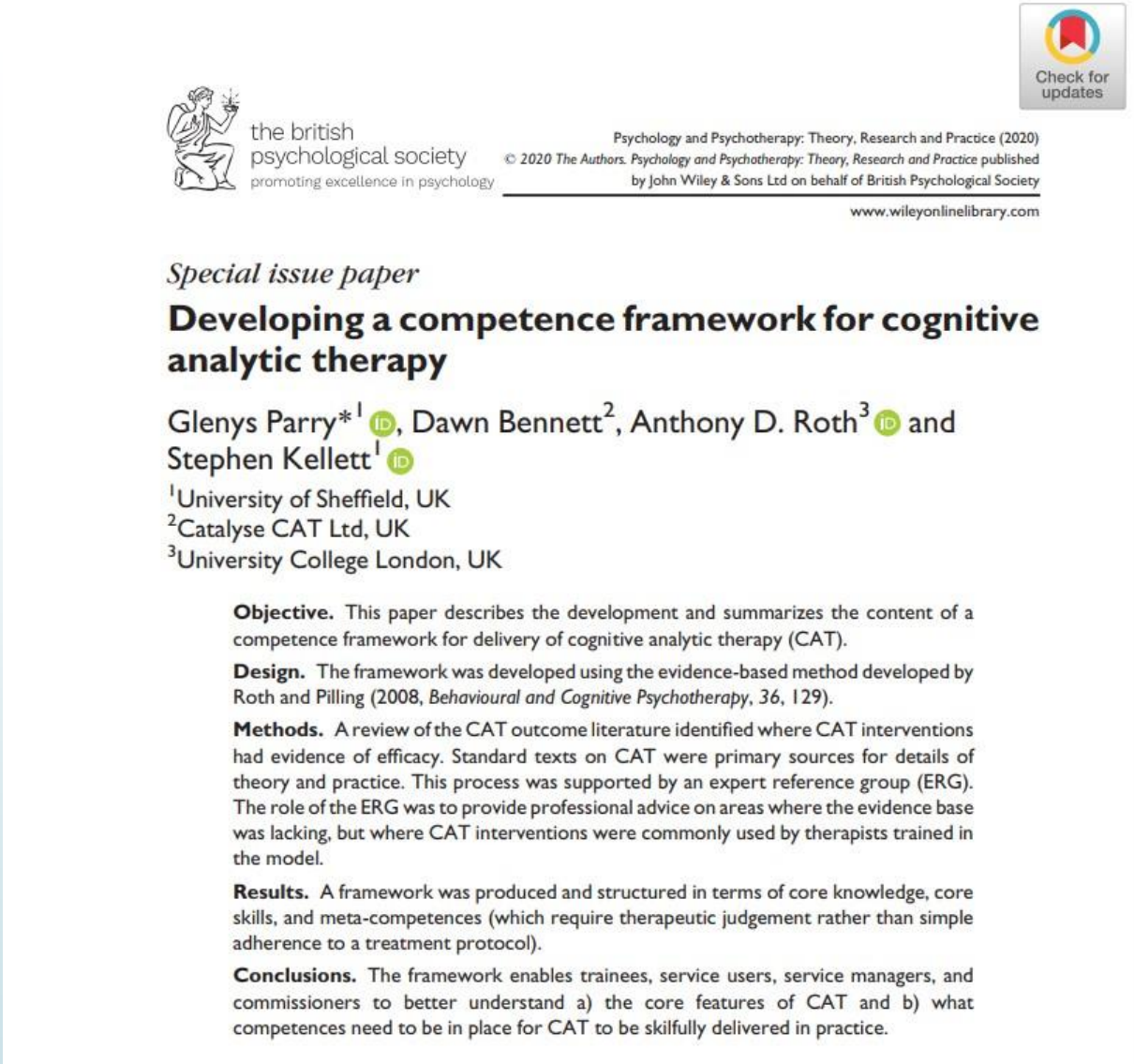
- Therapy is complex, with multiple choice points in a dynamic interpersonal relationship
- Competence requires skill and judgement in navigating these, choosing how to respond in the moment, and deciding which techniques to use whilst maintaining the therapeutic alliance.
- Particularly important in CAT, which does not follow a standardised protocol, despite the structure.

Why does it matter?

- Qualification is often defined by training inputs:
  - How many hours of supervised practice
  - How many hours of formal teaching
  - How many case reports are written up and assessed etc.
- Competence-led training focusses on training outcomes: what the trainee demonstrates in practice
- The UK Competence in CAT measure (CCAT: Bennett & Parry, 2004) found an orderly relationship between
  - level of experience and CCAT score and
  - CCAT score and client outcome.
- A different approach to understanding what knowledge and skills a CAT therapist has, is the idea of a *competence framework*.

What is a competence framework?

- Roth & Pilling (2008) in response to UK national health service advice on commissioning psychological therapies & funding training
  - Describes what is expected of a competent therapist
  - setting out in clear, lay language
  - what therapists need to know and what skills they acquire to practise
- NOT a measure of competence; descriptive not metric
- Frameworks were approved on cognitive behavioural, psychodynamic, counselling, systemic, interpersonal, humanistic, but not CAT
- ACAT lobbied for a CAT competence framework & funded it: a political context
- CAT Framework was developed with the University College London method
  - with Tony Roth, Dawn Bennett, Glenys Parry, Steve Kellett & contributions from Ian Kerr, Jason Hepple & Liz Fawkes



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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.

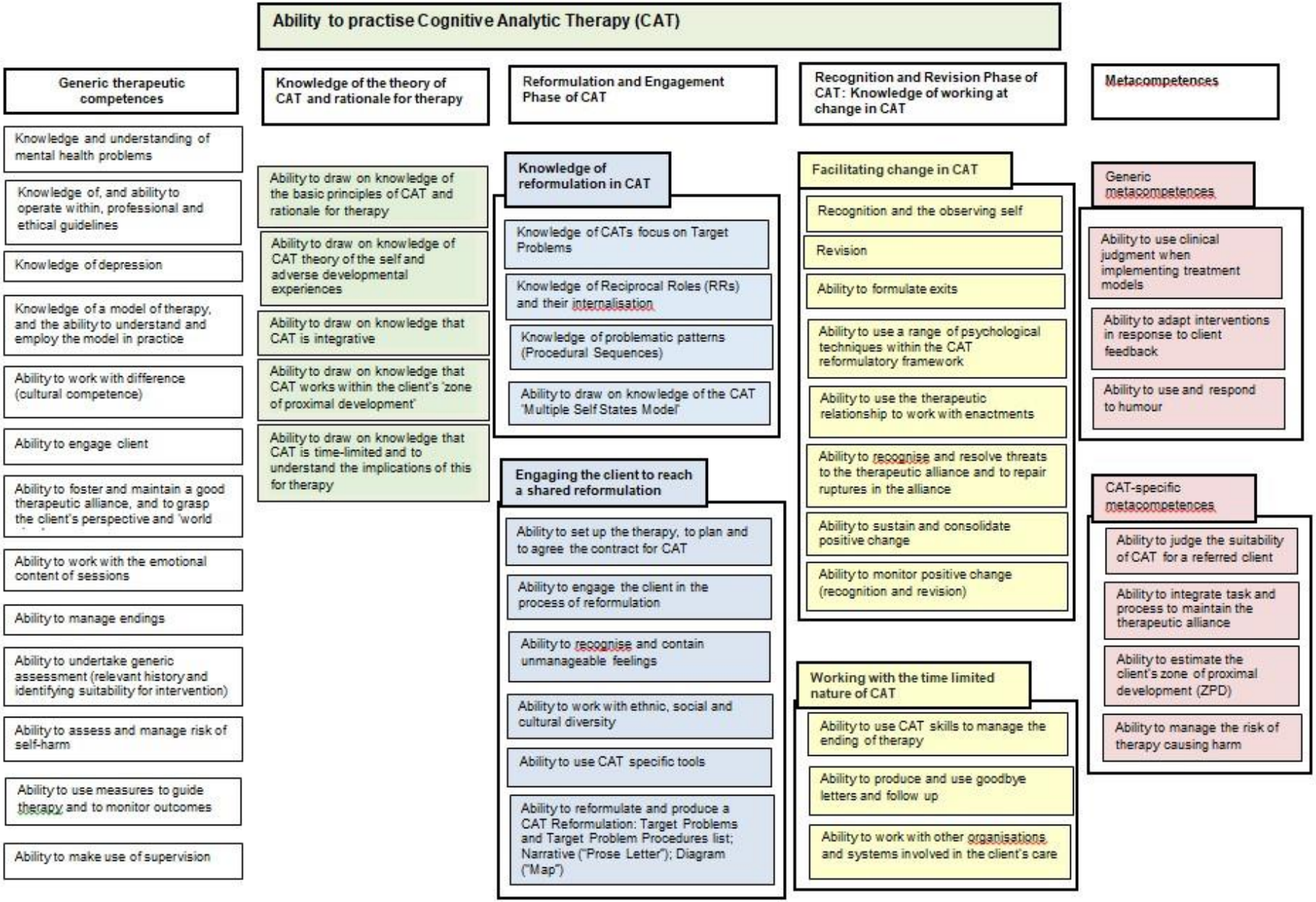
- Open Access UCL Research: Developing a competence framework for cognitive analytic therapy
  https://discovery.ucl.ac.uk/id/eprint/10110694/

Why have a competence framework?

- To better understand the core features of CAT and what is necessary for CAT to be skilfully delivered in clinical practice
- To be visible alongside other psychotherapies
- To influence those commissioning, funding and using CAT and CAT training.
  - service commissioners, managers, funders, service users and the interested general public.
- To help with curriculum design in CAT training and elements of competence to be assessed during training
- But there may be negative consequences too…
  - Cultural differences may be ignored or supressed
  - Specifying our therapy model could reduce it to a list of technical competences

Introduction to the UK CAT Competence framework

- An interactive 'map' of competence headings which
  - identifies all the areas of knowledge and skill,
  - organises 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.
- The CAT framework and specific competences are designed to be viewed online
- Publicly available alongside those of other psychological therapy models http://www.ucl.ac.uk/core/competence-frameworks/
- Competence Framework for Cognitive Analytic Therapy (CAT) | UCL Psychology and Language Sciences - UCL – University College London


Ability to practise Cognitive Analytic Therapy (CAT)
Generic therapeutic competences
Knowledge and understanding of mental health problems
Knowledge of, and ability to operate within, professional and ethical guidelines
Knowledge of depression
Knowledge of a model of therapy, and the ability to understand and employ the model in practice
Ability to work with difference (cultural competence)
Ability to engage client
Ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world
Ability to work with the emotional content of sessions
Ability to manage endings
Ability to undertake generic assessment (relevant history and identifying suitability for intervention)
Ability to assess and manage risk of self-harm
Ability to use measures to guide therapy and to monitor outcomes
Ability to make use of supervision
Knowledge of the theory of CAT and rationale for therapy
Ability to draw on knowledge of the basic principles of CAT and rationale for therapy
Ability to draw on knowledge of CAT theory of the self and adverse developmental experiences
Ability to draw on knowledge that CAT is integrative
Ability to draw on knowledge that CAT works within the client's 'zone of proximal development'
Ability to draw on knowledge that CAT is time-limited and to understand the implications of this for therapy
Reformulation and Engagement Phase of CAT
Knowledge of reformulation in CAT
Knowledge of CATs focus on Target Problems
Knowledge of Reciprocal Roles (RRs) and their internalisation
Knowledge of problematic patterns (Procedural Sequences)
Ability to draw on knowledge of the CAT 'Multiple Self States Model'
Engaging the client to reach a shared reformulation
Ability to set up the therapy, to plan and to agree the contract for CAT
Ability to engage the client in the process of reformulation
Ability to recognise and contain unmanageable feelings
Ability to work with ethnic, social and cultural diversity
Ability to use CAT specific tools
Ability to reformulate and produce a CAT Reformulation: Target Problems and Target Problem Procedures list; Narrative ("Prose Letter"); Diagram ("Map")
Recognition and Revision Phase of CAT: Knowledge of working at change in CAT
Facilitating change in CAT
Recognition and the observing self
Revision
Ability to formulate exits
Ability to use a range of psychological techniques within the CAT reformulatory framework
Ability to use the therapeutic relationship to work with enactments
Ability to recognise and resolve threats to the therapeutic alliance and to repair ruptures in the alliance
Ability to sustain and consolidate positive change
Ability to monitor positive change (recognition and revision)
Working with the time limited nature of CAT
Ability to use CAT skills to manage the ending of therapy
Ability to produce and use goodbye letters and follow up
Ability to work with other organisations and systems involved in the client's care
Metacompetences
Generic metacompetences
Ability to use clinical judgment when implementing treatment models
Ability to adapt interventions in response to client feedback
Ability to use and respond to humour
CAT-specific metacompetences
Ability to judge the suitability of CAT for a referred client
Ability to integrate task and process to maintain the therapeutic alliance
Ability to estimate the client's zone of proximal development (ZPD)
Ability to manage the risk of therapy causing harm

International project: method

- **Research Questions**
  - Do all *domains* of competence in the UK framework characterise CAT practice across national borders?
  - Within domains, which *items* of competence are found to define CAT across national borders?
  - Are there, by contrast, items of competence that are specific to a national context?
- **Method**
  - Formal consensus-generating methodology where sufficient CAT therapists are practising (Australia & Spain)
    - 'Expert' workshop, voting via email, 85% agreement=consensus
  - In New Zealand & Chile, fewer CATs, so first stage completed followed by focus group discussion of items without formal voting
  - All these groups worked independently, no conferring.
  - Major work on translation into Spanish and back-translation to English & resolution of discrepancies

What did we find? Australia

- Phase 1: 9/13 'experts' participated; reached 100% consensus: 12 items carried forward to phase 2
- Phase 2: 48 members with 2+ years of training invited, but poor response rate. 15 people reviewed changes
- Changes: most were either linguistic (e.g. gender-neutral pronouns) or removing UK-specific terms (e.g. NHS)
- One new competence added:
  - 31.4 - An ability to be aware of one's own RRPs, and to actively use this during the therapy.
    - 31.4.1 - An ability to monitor one's own responses, at the same time as working with the client in the therapy
    - 31.4.2 - An ability to reflect on this in supervision openly
    - 31.4.3 - An ability to acknowledge when this leads to unhelpful enactments, and to address or repair this
    - 31.4.4 - An ability to use this helpfully with the client

What did we find? New Zealand

- Only 2 out of 7 participated, qualitative comments
- The framework largely fitted the New Zealand context
- Main differences were nuanced:
  - Same linguistic comments as Australia
  - Some meta-competences not specific to CAT
  - Differences in emphasis: less use of 'traps, snags, dilemmas', more use of mapping
  - for Māori and other ethnicities, many CAT tools have content which may not be valid from a cultural perspective, hence mapping may be more appropriate.
  - Independently arrived at the need for an additional competence in awareness of therapists' own patterns & countertransference, and awareness of how/when to bring this into the therapy process

What did we find? Spain

- Expert workshop: 10 CAT trainers/supervisors discussed and voted on 37 items of competences
  - No items eliminated, but some reworded and additions made
- Phase 2: 11 therapists, all changes achieved consensus after two rounds of voting
- Examples of differences and additions:
  - Some points, as before, are minor linguistic ones, e.g. 'target problem procedures' are just 'problem procedures'
  - Emphasis that CAT is part of the family of integrative models of therapy and is a bio-psycho-social and spiritual therapy.
  - More techniques that may be integrated into CAT were added, e.g. somatic methods, EMDR, paradoxical intention.
  - Zone of Proximal Development (ZPD)applies to therapists as well as clients.
  - Reciprocal roles can be internalised directly or vicariously
  - Much more detail on the Multiple Self States Model, the polyphonic self and additional competences when working with dissociation.

What did we find? Chile

- Five Chilean therapists discussed the framework
- Most changes and comments were linguistic, on the difference between Spanish and Chilean words
- Examples of issues raised by the Chilean therapists
  - Self-observation diary or journal is a symptom diary in Chile
  - Concept of polyphonic self without dissociation is important (as in Spain)
  - Propose mention of suicidal risk and how to work with it in CAT
  - Sometimes, the patient requires co-therapy with a doctor or psychiatrist for symptomatic treatment or associated psychiatric pathology

Summary of findings

- The skills and knowledge needed to practise CAT competently are broadly consistent across the countries in this study.
- Greater addition material in Spanish cultures than Australia & New Zealand
- None of the additional material seemed fundamentally different from practice elsewhere
- Refinements may be a matter of emphasis, e.g. CAT is both relational and integrative, focus may shift
- Some tools may be fundamental, others optional?
- Local practice may reflect influential CAT theorists, e.g. Steve Potter, Carlos Mirapeix, Mikael Leiman, Ian Kerr.

So what and where next?

- Reassuring that the CAT model seems very robust
- But several questions are raised:
  - Would this finding be replicated in other countries?
  - Does it matter if local circumstances lead to variations in practice?
    - Example of therapy length; cutting number of sessions to fit funding available.
  - Which CAT tools are useful but discretionary and which are essential?
  - What are the implications for training internationally?
  - Are there competences ALL trainings should include?
- You can participate in this project by coming to our workshop after coffee
- For copies of this presentation email g.d.parry@sheffield.ac.uk